Learning from Local Case Reviews: X and Rachel

June 2019

Malcolm Ward
Independent Reviewer

city & hackney safeguarding children board

safeguarding children is everyone's responsibility

Purpose

- To share the lessons from two local learning reviews.
- To think about young people in distress which leads to self-harm and suicidal thinking or actions.
- To think about the impact of that distress and the challenging behaviours that can accompany it on the family & peers
- and on agencies, including non-specialist agencies, involved with the young person and or family.
- To reflect on our own practice and what the lessons may mean for us.

The Reviews

Two young people who took their own lives in late 2016 & early 2017, both aged 16 years.

The reviews can be found at:

X http://www.chscb.org.uk/wp-content/uploads/2019/03/CHSCB-Local-Review-X-FINAL.pdf

Rachel http://www.chscb.org.uk/wp-content/uploads/2019/05/CHSCB_Local_Review_Rachel_-_FINALM.pdf

Both reviews have appendices summarising key relevant research and useful resources for practitioners

chscb

What is a Multi-Agency Learning Review?

- Formal review - learning lessons to improve practice & systems
  A range of methodologies
- Statutory basis in Working Together 2015 – but not an SCR
- Not about blame - Accountability not culpability
- Seeks to understand what happened and why
- Should involve the subject, family and practitioners – if possible
- Independent Reviewer/s (and Panel members)
- Proportionate Evidence-based Avoids hindsight bias
- **Uses the case as an example of the whole system to inform LSCBs and agencies of what may need to be improved in systems**
- Anonymous (usually)
- Published – usually at the end of all other formal processes

chscb

Methodological Approach for the Reviews

- A systems learning approach – i.e. reviewing systems rather than just individual actions in this case – looking for relevant context, links and causality within and across multi-disciplinary systems
- Individual Agency Management Reports IMRs from each Agency and some key case documents – including discussion in house with practitioners
- Conversation/s with family members who wished to participate – Partnership in learning & acknowledging their acute loss and questions
- Practice Focus group– involving the practitioners and managers
- Reviewing related policy and procedures – how they were used and any gaps
- Research and data
- Review Panel Commissioned by the LSCB Chair and agreed by the LSCB
- Focussed timescale relevant to the work over the recent period but taking into account any relevant past history
- Anonymous publication Action Plan To make a difference

chscb

Local Learning Review - X

chscb

X

Adolescent

In a stable family – parents in professional roles

X described by his family as bright, full of life, loving, anxious, altruistic, funny, quirky, popular and at times stubborn

Historically – Community based Psychology Services involved from time to time from primary tears as X showed symptoms of anxiety at times through his life .

X had previously responded well to brief counselling/CBT for anxiety

X took his life shortly after his 16th birthday

Agencies involved in the final 12 months:

Secondary school: School not aware of acute anxiety issues – or involvement with psychology services, X well supported by family, a good all round student, able and popular, sporting – although in his final year sport sometimes took second place to partying

GP: X, with parents, sought advice and treatment for chronic blushing which was affecting him emotionally – X had researched via the web a possible surgical treatment which he thought was the only thing that would cure him; topical and medical treatments were offered but X thought they were unsuccessful and declined psychological referral

Specialist hospital team/s: 3 referrals by GP for dermatology – local hospital saw X and advised against surgery, one Department declined referral and the third was, unbeknown to X, arranging an appointment

chscb

Critical incident/ death

- X returned home in the early hours, from drinking with friends, he later reported continuing to drink. He took an overdose of paracetamol & Xanax, which he had been using illicitly for some time to manage his anxiety - he left a suicide note – he intended to die – but on waking he no longer wished to die.
- He alerted his father, an ambulance took X to the local ED.
- X was assessed medically & psychologically, including risk of further self-harm / suicidal intention. He disclosed self-medicating with Diazepam, and later Xanax, for the 8 months. SHO consulted with the Child & Adolescent Psychiatric Registrar & with Parent.
- X assessed as not at immediate risk of suicide, to be monitored by family & referred to CAMHS for follow up. Discharged home.
- Parents monitored him at intervals through the night.
- He took his life after researching a suicide website (in the early hours) which was explicit about methods.

chscb

Findings/ Lessons from the X review - 1

- X's suicide could not have been predicted

Mental health assessments after an overdose

- A systems lesson in relation to the mental health assessment after X's overdose was how well informed practitioners are about the impact of Xanax and whether X may have become addicted and, if so, what the withdrawal symptoms may be & how they should be considered within a risk assessment.
- In hindsight - a question about whether X deliberately misled the SHO by concealing his true state of mind (when he may also still have been under the influence of Xanax). *Disguised compliance?*
- There was good multi-agency co-operation between services during the assessment (SHO/CAMHS Registrar) and afterwards.
- Assessing 16 & 17 year olds within adult ED/hospital services? There is flexibility to admit to a children's ward, based on patient's presentation & need.
- Increase in availability of CAMHS to ED but not 24/7.

chscb

Findings/ Lessons from the X review - 2

Support to X and his family prior to his death

- At the time of his death X was unaware that his request to be re-referred for consideration for surgery was moving forward. *Keeping patients informed.*
- How much should a school be informed of a student's health assessments and treatments if there is not a safeguarding issue and there is not consent? This is a proportionate issue. A possible systems lesson is that parents can worry about how schools will judge a child who has emotional or mental health problems.
- Better understanding of young people's drug use and challenge. School had taken at face value when X had claimed that cannabis he had belonged to someone else. How to explore possible drug use without alienating young people.
  Drug awareness & impact education for young people (and parents).

chscb

Findings/ Lessons from the X review - 3

Lessons from hindsight – but not available to practitioners prior to X's death

- Drug and alcohol use by young people - bereaved peers spoke after X's death of patterns of drug taking locally; this is hidden from parents and teachers.
- There is a need for a public health preventative approach to understanding and tackling drug use by young people, which Young Hackney provides.
- Since his death there has been increased awareness raising for students and parents within the school; including services from which young people can get confidential advice.
- It is important to understand the use of newer and more powerful drugs which are being used / promoted (e.g. Xanax). Practitioners need to be informed of its prevalence and its possible impact and side-effects.

chscb

Findings/ Lessons from the X review - 4

Lessons from hindsight – but not available to practitioners prior to X's death

After a child's death (or serious injury) when police are investigating it is important that information and lessons from investigations are fed back into the child protection systems contemporaneously;

information from X's phone was made available to the Inquest but could have been shared earlier with safeguarding agencies with regard to the **impact of suicide websites** on vulnerable young people.

Findings/ Lessons from the X review - 5

Lessons from wider research about adolescent self-harm and suicide

See: **Suicide by Children and Young People; 2017**
https://www.hqip.org.uk/wp-content/uploads/2018/02/8iQSvI.pdf

& NCISH Annual report 2018
https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-annual-report-2018/#.W8CTcvZFyUk

The research shows common themes in suicide by children & young people - provides useful context for possible antecedents which indicate a child may be at risk of serious self-harm or suicide. Not all applied to X – but for practitioners awareness of these risk factors may lead to professional curiosity and useful conversations or referrals.

See next slide

chscb

Research into suicide by young people

Common themes

Family factors (such as mental illness); Abuse and neglect; Bereavement and experience of suicide (by others); Bullying; Suicide-related internet use; Academic pressures, especially related to exams; Social isolation or withdrawal; Physical health conditions that may have social impact; Alcohol and illicit drugs; Mental ill health, self-harm and suicidal ideas

Common antecedents *More prevalent for females (but also in males)*

Previous contact with social care/local authority services (at any time); A history of self-harm; Contact with CAMHS (at any time); Self-harm by cutting; Psychiatric diagnosis; (Being or having been) a looked after child; Bereaved; Experienced abuse; Bullied; Self-harm by self-poisoning; Contact with youth justice/police (at any time); Excessive alcohol use

Illicit drug use & No prior contact with services more prevalent in males under 20 – but also present for females.

chscb

Findings/ Lessons from the X review - 6

Supporting Peers' Awareness and Peers as Supporters

Family questioned who young people turn to for help and support, especially young men (like X) who may find it harder to talk about feelings.

Role of peer mentors?

Supporting young people to recognise when their peers are in difficulty.

Encouraging young men to seek help.

X Review – Recommendations:

- Public health campaigns on drug use
- Importance of considering drug use in mental health assessments for self-harm & suicide
- How do schools transfer information about vulnerability?
- CHSCB Internet Safety Policy to be reviewed
- Availability of child and adolescents mental health specialists to Emergency Departments (out of hours)
- Public Health Suicide Prevention Strategy for Young People
- Embedding practice to ensure that in Rapid Review, after a suicide, risk to other young people of self-harm or suicidal actions is considered
- Availability of regular mental health advice to schools
- Schools conference – on suicide, mental health, school response to critical incidents
- Access to young person's digital use after death to risk assess and understand the cause of death

chscb

Local Learning Review - Rachel

chscb

Rachel

Adolescent

Parents separated - in professional roles – wider family supportive

Rachel was bright and was predicted to do well in her GCSEs but could be acutely stressed by her school work;

She was politically aware but could be troubled by the world as it was seen through the media – which she scrutinised – including in the night ;

She used the web to research mental health issues;

It was suggested that she was influenced by peers who also had emotional health problems;

She became difficult to live with if challenged about her behaviour.

Query about autism or Asperger's Syndrome but not fully established.

Historically – Intermittent involvement of psychology and mental health services first in primary school and occasionally in secondary school.

Rachel, took her life aged 16 – at the start of spring term in year 11

Agencies involved in the final 13 months:

GP: encouraged by a peer Rachel saw her GP alone, and disclosed low mood, overdoses and self-harm over 6 months (hidden from her mother)

From this point:

CAMHS continuously: as a community patient and at times an in-patient or a day patient

School: (The same school as X)

In several crises: (overdoses, running away, serious self-harm)

Police, Ambulance Service & Emergency Department

Children's Social Care was informed and undertook a C&F Assessment but agreed with mother that there was not a role for CSC

Rachel used ChildLine (anonymously) (Hindsight)

chscb

Key issues in assessment & treatment - 1

- Issues re diagnosis – challenges in diagnosing young people
- Rachel initially seen as having depressive episode with underlying perfectionist traits; later query emotional dysregulation & possible personality disorder.
- Responses – medication or CBT. Concerns about medication side effects.
- Safety Plans in place from this point.
- CAMHS from Jan 2016 – self-harm regularly,
- Rachel often anxious about school, both about going to school but also about being absent.
- Self harm (cutting) and potential suicidal behaviour (overdosing and separately ligature/s) .
- Rachel's need for supervision was often intense – but the type of supervision not always spelled out.
- Care Coordinator appointed for the CPA – became a key long term treatment relationship.

chscb

Key issues in assessment & treatment - 2

- What risky behaviour can a family manage at home and what requires in-patent treatment and supervision?
- SSRI medication (but soon ceased as possible adverse reaction) Family therapy Individual therapy
- Feb 2016 Day Patient Adolescent Unit - continued cutting but not so seriously
- March - cutting and overdose of hidden medicine
- April – Community CAMHS – diagnosis mixed anxiety and depressive disorder.
- Eating issues – not eating or purging. Continued self-harm.
- Overdose ED / In-patient briefly. Reactive. CSC informed.
- May – diagnosis – anorexic conditions, emotional dysregulation, ongoing suicidal thoughts and query emerging personality disorder.
- June – Rachel found with a noose / and other suicidal issues and notes over several episodes

chscb

Key issues in assessment & treatment - 3

- July – stress of mock exams & early GCSE
- Regular meetings with Care Coordinator and Family Therapy
- Holiday away with a friend's family – went well
- August – anxiety about GCSE exam result - threatened to kill herself if did not get A* (Achieved an A) Safety Plan in place
- Overdose – significant (planned) Assessed in ED - also cuts to her arms. CSC advised
- ***Impulsivity*** *as an issue in adolescent harming behaviour.*
- September Patient in Adolescent Unit Rachel participated well in the therapies. By end of September transferred to Day Unit
- Gradual re-introduction to school
- October – discharged from Adolescent Unit to CAMHS Community Team
- Overdose (serious) to ED. Recent cutting. Risk assessment agreed that she could return home under mother's care (a peer's suicide (X) , among other things, affected her)

chscb

Key issues in assessment & treatment - 4

- Rachel in 10 pilot Dialectical Behaviour Therapy sessions – to which she responded well / parents offered parallel parents group
- November Mother becoming overwhelmed by issues of Rachel's health and care; challenge of how to manage Rachel's difficult behaviour at home (plus impact on younger sibling)
- Dip in Rachel's coping behaviour – Safety Plan revised
- To ED – self-harm by cutting – increasing pattern of self-harm
- December Additional stress – planned change of Care Coordinator, DBT sessions coming to an end, death of cat and worry about school exams (plus recent death of peer) Risk of self-harm seen as chronic
- Medication to be re-considered. No suicidal ideation noted.
- Rachel's school grades lower – agreed on health grounds not to do exams. Cutting.
- End of relationship with Care Coordinator 1
  Transfer to new Coordinator

chscb

Key issues in assessment & treatment - 5

- December Overdose / went missing, suicide note found – sectioned by Police and brought to ED. Family requesting in-patient bed but assessed as community treatment better & discharged to family, with additional adult / family supervision in place.
- Continued assessment – no suicidal ideation but self-harm. SSRI Medication re-started & being monitored. Safety Plan revised. Seen to be less suicidal & self-harming less – ***was she truthful?***
- DBT sessions ended
- Medication increased – Rachel more energetic – but self-harm increasing; denied suicidal thoughts. Monitoring by phone.
- New Year Overdose / missing as Rachel anxious about going back to school. Police section 136. Assessed in ED. Rachel maintained that she was no longer suicidal. Returned home.
  Query **serotonin syndrome –** to be monitored.
- Plans for Rachel to return to school. Self-harmed over weekend & went to ED. Low mood but not suicidal.
- Monday Rachel felt well enough to go to school. Unable to cope in lessons / sat out of class. Left school at lunch.
  Rachel took her life.

chscb

Findings/Lessons from the Rachel review - 1

Learning Review informed by MH Trusts' Sudden Untoward Incident Report (SUI), Inquest, submissions from Family, Agency Reports and Focus Group with Practitioners.

Key Line of Enquiry 1 Diagnosis, risk assessments and treatment of adolescents who self-harm and who have chronic anxiety and impulsivity with acute suicidal ideation or behaviour, including self-harm – including use of SSRI medication for low mood

MH Trust SUI

- Pattern of increasing risk may have been underestimated
- Depressive episodes may have been under-treated with medication
- Dissonance of Rachel's assurances that she was not feeling suicidal when shortly after she would take potentially fatal overdoses
- Query about research on use of SSRI medication in young people
- Should Rachel have been admitted as an in-patient when sectioned by Police? Risk assessments were thought to have been thorough.
- Should Rachel have returned to school? This was a reasonable plan. However, school did not know the level of risk.

chscb

Findings/Lessons from the Rachel review - 2

CHSCB Review

- A wider view of family was required, by agencies, beyond Rachel's parents.
- More assessment of impact on mother and family members required - lack of a Carer's Assessment. Mother's professionalism belied that she was not coping.
- How can parents express their worries to professional staff privately – i.e. not in front of the adolescent patient?
- How is the dynamic of impulsivity understood in risk assessments?
- Disguised compliance – young people learn from others how to make the system work and may not be truthful about feelings or thoughts if they are likely to result in a section or in-patient treatment.
- Peer influence, social media, internet use and media – how to assess how much a young person's thoughts and behaviour are affected or troubled by these influences.

chscb

Findings/Lessons from the Rachel review - 3

- SSRI Medication and Adolescents – monitoring research and following NICE guidelines, supporting parents who have concerns and advising them what side effects to monitor.
- Hiding medication – monitoring of medication use to be considered.
- Voluntary in-patient treatment / alternatives – could more have been done to encourage Rachel to take up in-patient treatment? Are there other alternatives – e.g. wrap around care, weekend community support to families, etc?
- Care Programme Approach, Treatment Plans and Safety Plans Inconsistencies in the way that Safety Plans are produced and shared with families. They require sufficient detail and clarity about why they supplement or replace previous plans.

How are these shared with key partner agencies so that they fully understand the risks and their role?

chscb

Findings/Lessons from the Rachel review - 4

- Changes in Treatment Teams / Practitioners – systems issues which can have an impact on a patient/carers.
  Different approaches by the Adolescent Unit and Community Team.
  Trust and investment in therapeutic relationships by the patient & family.

- Research into wider context of adolescent self-harm and suicide – see the Appendix of the review and also slides above for X

- Emergency Departments and assessment of young people in mental health crisis – are there other approaches/ settings?
  E.g. Community Havens

chscb

Findings/Lessons from the Rachel review - 5

Key Line of Enquiry 2 Supporting young people with mental health problems in a community school setting – the challenge for schools

- Adolescent mental health in schools See the responses (2018) to Green Paper: *Transforming Children & Young People's Mental Health Provision*, 2017
- Exam stress
- Mental Health First Aid Training for Schools – take up
- Liaison with and support from CAMHS / School mental health policies
- School based Student Safety Plans – contingencies & safe (supervised) arrangements for time out / quiet spaces
- Information sharing protocols in relation to identified students
- How are other schools learning from deaths like X and Rachel?
- Need for a school critical incident support plan – to support students & staff after a death/incident

chscb

Findings/Lessons from the Rachel review - 6

Additional Findings

- Investigation and safeguarding / digital media – access to young person's digital media after death – to understand and to assess need to safeguard others

- Understanding impact of social media on young people's decision-making and actions – practitioners understanding research into media influences / impulsivity

- Peer support after suicide – value of having a template for an immediate response in advance / in case

Rachel Review – Recommendations:

- Expedite Local Strategy for Prevention of Suicide by Young People
- *Rachel's mother also made a number of recommendations which are being considered as part of this strategy; they are listed in the review)*
- Build on positive experience of Mental Health in Schools Project (WAHMS)
- Conference for Head Teachers to share lessons for schools more widely
- Review take up of Mental Health First Aid Training in local schools
- Review guidance / management of the Care Programme Approach & write ups / provision of Safety Plans for adolescents
- Review how the impact of stress on carers/families is considered in assessments – including the possible need for a Carer's Assessment by Children's Services
- Rapid Review after suicide to consider possible impact / risk to other young people – including access to digital footprint
- Review guidance to schools on critical incidents to ensure that it covers child deaths and support to students and staff
- Consult with Police and Coroner to ensure that a young person's electronic equipment can be accessed to gain a fuller public health picture of causes of child deaths.

chscb

You may use these slides to share the learning within your agency to promote wider understanding of and support to young people and their families.