Leicester LSCB Multi-agency Audit: Emotional Wellbeing and CAMHS Involvement
Summary Briefing

This summary briefing presents the key findings/recommendations from the audit and is aimed at managers and practitioner working with children and families in Leicester. Please share this briefing with colleagues

Background

- Working Together to Safeguard Children (2015) requires Local safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- Safeguarding children who experience poor emotional wellbeing and/or mental health was identified as an area in which the LSCB required assurance, to better understand compliance and to seek assurance that there was consistent application of the LLR LSCB multi-agency safeguarding procedures and threshold.
- The audit wanted to seek assurance that partner agencies were appropriately identifying and responding to the needs of children experiencing poor emotional wellbeing and mental health, and to capture any learning needs which support improvement in practice aimed at strengthening safeguarding for children. The audit included accuracy of case details, underpinning this was the 'Voice of the Child' and compliance to procedures.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

Methodology

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB audit group, which has representatives from the following agencies:

Leicester City Council	Leicestershire Partnership Trust (LPT)	Leicestershire Police
Clinical Commissioning Group (CCG)	University Hospitals of Leicester (UHL)	LSCB office

Ten cases were identified by University Hospitals Leicester (UHL) for audit and although these were identified by one agency, the intention of the audit was to evaluate the multi-agency response to meeting the needs of and safeguarding the children in these cases.

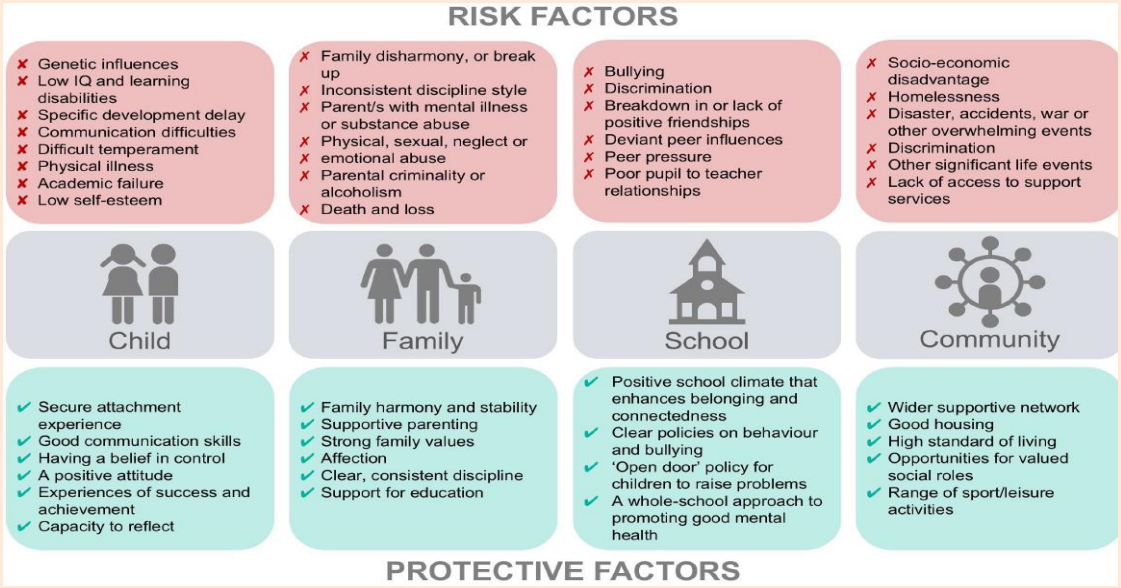
All 10 cases were audited by UHL and LPT (including CAMHS), 8 cases were audited by the Safeguarding Unit for Children's Social Care and Early Help Service (one case was not known and one not within the scope of the audit), 7 cases were in scope of the audit of the 10 cases audited by Leicestershire Police, and 3 cases were audited by the local authority Special Education & Disability Service (SEND) of children known to the service.

Definition

A range of factors can affect children's emotional health and wellbeing, Working Together 2015 defines emotional abuse as:

"The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet their needs of another person. It may include not giving the child opportunities to express their views deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child through it may occur alone"

'The mental health of children and young people in England' report (December 2016), identified the following risk and protective factors for children and young people's mental health:



Further Information

LLR LSCB Resolving Disagreement and Escalation of Concerns procedure
http://llrscb.proceduresonline.com/chapters/p_self_harm.html
LLR LSCB Multi-agency Safeguarding procedures
http://www.leicspart.nhs.uk/_OurServicesAZ-ChildandAdolescentMentalHealthServiceCAMHS.aspx
http://llrscb.proceduresonline.com/chapters/p_suicidal_beh.html
LSCB Website
https://schools.leicester.gov.uk/services/special-education-service/statutory-education-health-and-care-ehc-plans/
LSCB multiagency audit summaries

Key Findings

The audits identified evidence of expected practice, pockets of good practice as well as areas for improvement. The audit group was not sufficiently assured about safeguarding arrangements in relation to 3 cases and the auditors were asked to check this.

- Compliance to procedures was variable across the partnership. Whilst staff within agencies predominantly followed procedures and polices there were instances identified where referrals to Children Social Care should have been made but were not. Not all relevant agencies/practitioners were invited to or attended strategy meetings and meetings held in relation to episodes when the child went missing. There was no evidence that CAMHS staff were involved in strategy meetings. There was a lack follow-up discussions when strategy meetings took place 'out-or-hours'. Awareness and use of the LLR LSCB Self-Harm and the Suicide procedures was not evident.
- Demographic details including ethnicity, language, religion, family members and fathers/partners was not recorded in all the case resulting in missing information. In one case the recording and consideration of the family and child's ethnic background could have helped inform whether the support required and safety planning would meet child's needs and achieve the intended outcomes. In another case, the mother was informed by Children Social Care that they were closing the case by letter due to not having been able to contact the mother by phone. However, it was unclear whether there had any consideration of mother's level of literacy to understand the content and implications of the letter.
- The voice of the child was obtained in most of the cases across partner agencies, however, the understanding of and taking into account the child's lived experience was lacking which was contributed to from a multi-agency perspective by:
  - A lack of professional curiosity, knowledge and understanding of key aspects such exploring diversity (ethnicity, faith, sexuality, etc.) and the cultural/traditional aspects within the family where conflict between the parents (mothers) expectations and the child's expectations impacted on the emotional wellbeing of the child. Terms such as *'parents believed to be spiritual'* were used, but there was a lack of evidence from the audit whether these were explored and considered by practitioners when identifying risks, support and safety planning for the child. This suggests a need for staff awareness around this issue.
  - Focus on the dominant presenting issue of mental health/autism resulting in other factors such as 'grooming'/CSE, Domestic Violence, being less visible and therefore missed in the overall identification and analysis of risks and safeguarding planning for the child.
- There was appropriate application of thresholds for making a referral to Children Social Care, although in one case an earlier referral would have been benefitted the child from a multi-agency consideration of the risks posed and safety planning for child. Referrals from the Emergency Department to CAMHS were timely as per UHL procedures. Referrals to CAMHS by other agencies were appropriate and all planned 7 day follow-up by CAMHS completed as per CAMHS procedure. In some cases there was no record of actions to make a referral to Children Social Care having been actioned and no record of the referrals being received by Children Social Care resulting in these children not being known to them.
- In Children Social Care, in some cases concerns were not acted soon enough. Risk assessments were not appropriate and robust, and lacked exploration of *'…All issues particularly where mental health issues co-exist with a number of other factors such as religion, sexuality, culture and the use of research tools and guidance. Evidence of more professional curiosity also needs to be applied'*. In some cases drift and delay was identified and chronologies should have been more robust and shared with partners. In some cases had the history of involvement been identified and considered it would have led to the appropriate action to be taken. Plans were not SMART in all of the cases and in cases were CSE risks were identified this information needed to be integrated into *'one plan'*. In some case, plans were being progressed without sufficient understanding of the role or contribution of CAMHS where CAMHS workers were due to be allocated. However, reviews were timely and there was management oversight in some cases.
- Education Health Care Plans (EHCP) were not relevant in all ten cases, but in the cases where they were or could have been, the plans were not visible in the child's records or evidenced in planning around safeguarding.
- There was information sharing and communication between partner agencies. Use of electronic records has improved communication between UHL, CAMHS and LPT which has also been supported by the Vanguard system and the Crisis Team resulting in a *'seamless'* service. However, there was a need for more joined-up working to consider all the information known by partner agencies to arrive at a fuller picture of the issues affecting and impacting on the child leading to a more robust and coordinated approach to considering risk posed and safety planning (for example, sharing information on grooming, CSE Domestic Violence, sexuality, religion/faith/belief, traditional practices, etc.). There was a lack of contingency planning for a young person reaching 18 years.

Recommendations: Partner agencies ensure that:

1. Case recording includes full demographic details including ethnic background, preferred language, religion and the family's, fathers/partners details. Recording on case files includes actions identified and undertaken to help identify progress and challenge or escalate decisions made on these.
2. Practitioners within their agency take into account diversity, including impact of sexuality, ethnic background, faith, traditional practices, when considering risks and safety planning for the child, and also in consideration of the child's lived experience.
3. Practitioners consider factors such as grooming, CSE, DV alongside mental health and that information held by them is shared with relevant partners for a co-ordinated approach to identifying all risk factors, and inform support and safety planning.
4. They raise awareness of their agency's procedures and the LLR LSCB procedures including those relating to Self-Harm and Suicide to practitioners within their agency and ensure that practitioners comply with procedures.
5. The LLR LSCB Procedures and Development group consider whether the Self-Harm and also the Suicide procedures require a review.
6. Children Social Care ensure that:
   a. Relevant practitioners from partner agencies, including CAMHS are invited to multi-agency meetings such as strategy discussions/meetings and meetings relating to children missing.
   b. Follow-up discussions/meetings take place with relevant practitioners from partner agencies where strategy discussions/meetings have taken place 'out-of-hours'.
   c. Chronologies, assessments and plans are robust and shared with partner agencies to inform multi-agency safety planning for the child.