

### **Introduction**

This summary/briefing is aimed at practitioners (and their managers) who are working with children, young people and their families in Leicester. It outlines the key messages from a learning and improvement review that was commissioned by the LSCB following the death of a 15-year-old child, Brandon, who sadly took his own life. Whilst there was no indication that Brandon had been subject to child abuse or neglect, this review was informed by the broader definition of safeguarding that reflects the provision of 'safe and effective care' in the context of family life and the delivery of services.

The review recognised the learning and improvements already instigated across local services in Leicester. Some of these changes relate directly to Brandon's experiences, whilst others have resulted from broader developments in services to children, young people and their families. This summary provides a short synopsis of the case and the learning points from the review.

### **What is the purpose of a multi-agency Learning and Improvement Review?**

An independently-led multi-agency learning and improvement review may be commissioned by the Chair of a Local Safeguarding Children Board for cases that do not meet the full criteria for a serious case review (SCR) but where there are likely to be lessons to be learned in the way that individuals and organisations work together to safeguard and promote the welfare of children. The conduct of this type of review is outlined in statutory guidance Working Together (HM Government, 2015).

An important principle of such reviews is the need to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than with the benefit of hindsight. Family members, as well as practitioners, are invited to contribute to the findings.

### **What happened in this case?**

Brandon had been diagnosed with a mixed anxiety and depressive disorder. At the time of his death he was not attending school and had become isolated from his friends. Concerns about bullying had been raised, and whilst the school found no evidence to support this, it appears that Brandon's perceptions and lived experience was of being a victim.

A significant feature of this complex case was that Brandon actively refused to engage with the services that were offered. This placed immense pressure on his family who were trying to support and help their son in very challenging circumstances. Services tried to be flexible, offering telephone, texting and written contact. Care was frequently provided 'via consultation with parents'. However, this may have reinforced his disengagement.

As Brandon's mental health deteriorated, professionals became aware of episodes of self-harm and his expressions of suicidal ideation. These were risk-assessed and although consideration was given to a period of in-patient care, clinicians did not believe that this would be in his best interest.

Despite the involvement of universal health services (GP and school nursing), a hospital emergency department and children's ward, child and adolescent mental health services (CAMHS), audiology services, the early help service, school staff, education welfare service, educational psychology, an alternative education service and the police service, Brandon's case became 'stuck' with little progress made in assessing the extent of his mental health needs and in ensuring his safety and recovery. Multi-agency work was not effective, there was drift and delay in specialist assessments, and the family were held captive by his illness.

Brandon's death has caused immense sadness to his family, friends and to his care providers. We should note the expert opinion, provided for the NHS serious incident review, that suicidal ideation is seemingly common, yet suicide is a rare outcome and extremely difficult to predict.

### What is the key practitioner learning from this review?

Brandon's view of what was happening, and what would be helpful to him, was largely absent, due in part to the difficulty in engaging him in his care, but also in the drive to be responsive to the concerns as expressed by his parents.

***The views and lived experience of the child should be central to care-planning and delivery. The use of an independent advocate is recognised as good practice, especially for those who are feeling threatened or vulnerable in accessing their mental health care.***

***The responsibility for ensuring engagement should rest with the practitioner, and not with the child or young person.***

Whilst there was evidence of a high-level of contact between agencies and professionals, no one practitioner took the opportunity to fulfil a 'lead professional' role, bringing Brandon, his family and colleagues together to co-ordinate an agreed multi-agency assessment and plan with clear and timely outcomes and a focus on his recovery and return to school.

***The role of lead professional should be undertaken by the practitioner best placed to do so. Their leadership should help to bring together an effective multi-agency team around the child and family. Consider how this role is supported by your agency.***

Supporting young people with mental health crises is a role that should be shared with schools, primary care, children's social care and youth justice services, and is not a role for children's mental health services alone.

***The importance of multi-agency support to children and young people with suicidal behaviour is reflected in the Leicester Safeguarding Children Board procedures. These highlight the importance of effective multi-agency relationships and good information sharing processes, so that the vulnerability and risk factors for individual children and young people may be properly understood and responded to.***

At the time of Brandon's illness, a crisis, recovery and home-treatment team (CRHT team) for children and young people in the city was not in place. This service was introduced in April 2017.

***Practitioners should ensure that they understand the services offered by the CRHT team and the mechanisms for referral for children and young people experiencing a mental health crisis (see below).***

Brandon had been missing education for an extended period; a factor that was certainly raised as a concern by his parents. After it became clear that he was too unwell to attend his mainstream school, arrangements were made for input from a home tutor, with a view to attendance at the hospital school. There was considerable slippage in these arrangements as well as a delay in progressing an education and health care plan (EHCP) to inform this provision.

***The LSCB has asked education leads to provide assurance regarding the process for monitoring the education of children who have low attendance at school and require alternative provision. Practitioners should be aware of children who are missing education and be proactive in ensuring that alternative provision is in place. Where an EHCP has been proposed, this should be completed in a timely manner.***

The apparent sudden deterioration in his mental health and emotional wellbeing was clearly linked by Brandon and his family to bullying within the school. This factor has, in turn, been consistently recorded by those involved in his care. The allegations of bullying, including sexualised comments, were robustly investigated and addressed by the school.

***Recent government guidance (see below) on bullying has raised the issue of 'banter' as a form of bullying. Practitioners working in education services should be aware of local policies and procedures for tackling this form of bullying.***

Further information and sources of help and support: [SPOC for Early Help/CSC](#); [LSCB contact details](#); [PAPYRUS web-page](#); [CRHT team web-page](#)