Learning Lessons Review
Recommendations and Learning
December 2015

1. Terms of reference for Learning Review into a child death

1.1 Purpose of the Learning Review:

1.1.1 To appreciatively inquire into, and identify learning and recommendations for change, the circumstances and background prior to the death of a child in June 2014.

1.2 To identify:

- The nature and character of the young person in question, their qualities and interests and their family life and history based on interviews with immediate family and any young people who knew him and are relevant and have consent and agreement to be interviewed as part of this review.
- Areas of good practice and management in the case itself on a single, joint and multi-agency basis, along with any missed opportunities.
- The integrated journey of the child and young person through services including:

- The nature of the young person's friendship group and peer networks, including an exploration of any additional information which may have been available in this network and any on-going impact on the young people involved.
- To review the content of the young person's Social Media activity to assess any relevant patterns of communication or significant content related to the subsequent death.

1.3 To put the circumstances of this particular case in a wider context of concerns in relation to teenage suicide both locally and nationally by:

- Reviewing CDOP material in relation to suicides in North Yorkshire in the last 5 years and identifying any patterns, themes or trends which need to be addressed as part of a wider learning review.
- Undertaking a desktop review of national research into teenage suicide to identify any research relevant to the learning review along with any best practice guidance.
- Undertaking a desktop review of national research in relation to the impact of social media on young people and self-harm and suicide.

1.4 To make any local recommendations for learning, change and developments in practice management, policy and procedure and leadership and governance in organisations and the wider safeguarding system. To ensure these can be implemented effectively and efficiently and that this will improve preventions, reduce risk and promote the likelihood of a better outcome.

1.5 To bring together the practitioner group involved with the young person, their managers and members of the review team to:

- Build a shared understanding of the young person's journey through life and services.
- Review and identify examples of good practice on a multi and single agency basis.
- Identify and explore any missed opportunities and how they might be avoided in future.
- Make shared recommendations for learning, change and development and review and agree these.

- Promote resilience in future practice and the positive processing of any remaining trauma to support individuals to move on in their practice with an enhanced insight and understanding into what happened and their role within it.

2. Recommendations arising from the Learning Review process:

2.1 Key areas identified:
There are **six key thematic** areas identified through the Learning Review process around which I am making recommendations to the Safeguarding Children Board.

2.2 The six key thematic areas identified are:

- Suicide awareness, prevention and risk assessment.
- Social media, vulnerable young people, identity and risk.
- Safely managing contact and family dynamics in a digital world.
- Placement stability and decision making as situations become more stressful uncertain and risky.
- Integrating and co-ordinating information sharing, communication and support for vulnerable young people as part of the wider system.
- Implications for training and workforce development including preparation and support for foster carers.

2.3 Suicide awareness, prevention and risk assessment:

2.3.1 The Safeguarding Children Board should sponsor a suicide prevention and awareness campaign to run before September 2015. A focus of this campaign should be on making young people aware that they can lose consciousness in seconds if they experiment with self-strangulation. Public Health should also be part of this campaign and it should fit with the wider suicide prevention strategy.

2.3.2 Professionals will need to be aware of this as well as carers. Vulnerable young people in PRUs and CAMHs services may be a priority group for awareness as well as more general promotion through schools and youth groups.

2.3.3 Getting a better understanding of the links between self-harming behaviour and the links to accidental/deliberate death. Consideration should be given to updating the self-harm pathway in the light of this leaning review. This should be completed by September 2015 and include something on the links between self-harming behaviour and accidental/deliberate death.

2.3.4 Improving support for foster carers in relation to self-harm and suicide: This could include:

- Providing basic first aid training
- Linking out of hours support to foster carers.
- Consider attaching a primary mental health worker to out of hours provision.

Plans for this should be put in place by May 2015

2.3.5 Creating guidance protocols, procedures and pathways around how to assess the risk of suicide and what to do next. This work is urgent and should be programmed to be completed as soon as possible and led by the Safeguarding Board.

2.4 Social media, vulnerable young people identity and risk:

2.4.1 CEOPs and NSPCC provide online courses looking at how to keep children and young people safe online. Participants in the Learning Review had positive experience of accessing these programmes. Active consideration should be given to making these programmes or similar material widely available as part of an awareness campaign and a workforce development issue. This should be considered by May 2015.

2.4.2 There is a general workforce development and specific training need around the whole area. For example, the youth service have an official Facebook account with which to keep in contact with young people and one of the Learning Review participants had successfully used this to re-establish contact with vulnerable and hard to reach young people.

They were aware that often vulnerable young people – such as those who were homeless used this to stay in touch as they were always able to find a way to access Facebook. The Safeguarding Children Board should consider how to promote this message in a similar way to approaches around substance misuse and domestic abuse for example. A way forward should be agreed by July 2015.

2.4.3 There needs to be a development of a harm minimisation approach around young people's use of social media with carers and parents supported to follow advice and guidance as to how best to manage access for children and young people.

2.4.4 Further work should be undertaken to identify the implications and potential benefits of the use of social media for children and young people who are looked after. There is a particular need to better understand the complicated range of potential interventions into social media contact with both family and siblings on a managed and unmanaged basis.

2.4.5 Directly intervening to protect children online. The police are developing an enhanced capacity to respond to cybercrime which includes training.

The Safeguarding Children Board should convene a group to consider this issue and to make recommendations back to the Board for September 2015.

2.4.6 Auditing and reporting e-safety concerns involving children and young people. Should a common reporting tool and format be developed? Should all agencies be asked to audit the level of their e-safeguarding concerns?

The Safeguarding Children Board should undertake a review of e-safeguarding reporting processes. A task and finish group should be convened to undertake this work and report back to the Board in September 2015

2.5 Safely managing contact and family dynamics in a digital world:

2.5.1 Through the review we can see that the social worker was actively seeking advice about how to ensure the effective boundarying of mother's contact with the child. We can also see the concerns there were about the nature and impact of this contact.

2.5.2 I recommend that a representative task and finish group be established by Children's Social Care, including legal and CAMHs, to review current experience and guidance to update it to enable workers to be more proactive in seeking to formally boundary contact, including return to court if necessary, if contact is having adverse impacts on the young person and the placement. This work is urgent and should begin as soon as possible.

2.6 Placement stability and decision making as situations become more stressful and difficult.

2.6.1 It is clear from the chronology that whilst there were proactive and dynamic assessments and decision making as the child's situation deteriorated these interventions were less co-ordinated and integrated than was desirable and agencies were making decisions without information which was available to other agencies.

2.6.2 I recommend that the Safeguarding Children Board convene a meeting to consider how and when to introduce a 'pause' meeting into a situation where a vulnerable child or young person's situation is rapidly deteriorating. The purpose of the meeting would be to ensure assessment, planning, decision making and interventions are appropriate integrated and co-ordinated and based on up to date knowledge and information. This meeting should be convened as soon as possible and seek to impact on the decision making processes around other vulnerable young people around when there are currently similar concerns.

2.6.3 We identified a number of mechanisms through which this 'pause' meeting might be enabled:

- As an emergency Looked After Children review.
- As an emergency Child Protection core group.
- As a strategy meeting called on a young person who is a potential harm to themselves.

2.6.4 In addition participants were aware of a number of young people about whom there were significant concerns about self-harm and around which such an approach could be tried out now.

2.7 Integrating and co-ordinating information, communication and support for vulnerable young people as part of the wider system.

2.7.1 I would recommend that a review of the relationship between risk assessment and decision making for admission to the PRU is revised and improved and takes into consideration the particular needs of young people as well as the needs of the PRU.

2.7.2 I would further recommend that agencies formally report to the Board any changes and improvements made to practice in this area. This material should be presented to the next Board meeting.

2.7.3 The Corporate Parenting Group for North Yorkshire should consider how to improve the sharing of information of health issues in relation to Looked After Children when they have a significant impact on the plan for the child. This should be done and actions put in place by July 2015.

2.7.4 The Corporate Parenting Group should also consider how to ensure that carers are aware of GP's and other health professionals involved at all times.

2.8 Implications for training and workforce development, including preparation and support for foster carers:

2.8.1 A number of recommendations in this area have already been made so they are not duplicated here.

2.8.2 In addition further thought needs to be given to the preparation of foster carers receiving young people into their houses in deteriorating and developing circumstances. I recommend that Children's Social Care convene a task and finish group to assess how best to address these issues and to agree a way forward by July 2015.

Learning Lessons Review Recommendations

Implementation plan (version 11)

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
The Safeguarding Children Board should sponsor a suicide prevention and awareness campaign. A focus of this campaign should be on making young people aware that they can lose consciousness in seconds if they experiment with self-strangulation. This appears particularly important given that 12 of the 15 suicides identified in the CDOP review involved hanging and in 5 of these the Coroners verdict was inconclusive in relation to intent. Public Health should also be part of this	NYSCB to develop an awareness and prevention strategy to include; • Development and delivery of Multi-agency practitioner training. • Development of an information leaflet or relevant resource for young people (developed by young people) regarding support for those with suicidal thoughts, support for peers who may be concerned about	NYSCB Business Unit Manager NYSCB Business Unit Manager in conjunction with the Voice Influence and Participation group	Multi-agency training regarding self-harm and suicide to be offered to all NYSCB members. All young people within secondary schools to be in receipt of information leaflet or suitable	March 2016 March 2016	Green Amber

Updated 26/02/2015

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
campaign and it should fit with the wider suicide prevention strategy. This should include information for professionals and foster carers.	their friends and the negative effects of attempted suicide on survival plus consideration of the effect on those who find them.		resource aimed at young people.		
	Public Health will appoint to a Suicide prevention officer for one year within the Prevention and Commissioning Unit, CCG.	Public Health, Health and Improvement Manager	Suicide prevention practitioner in post.	Aug 2015	Green
	Discussion to be undertaken with partners regarding how this information can be included as a theme within the Foster Carers development day planned for October 2015 and clearly established within Foster Carers training programme.	Placement and Fostering Manager	Discussion is held.	June, 2015	Green
Consideration should be given to updating the self-harm pathway in the light of this leaning review. This should be completed by September 2015 and include something on the links between self-harming behaviour and accidental/deliberate death.	No action required as the self-harm pathway, completed in March 215.	Princple Officer, Public Health	Self-harm pathway completed March 2015 http://cyps.northyorks.gov.uk/index.aspx?articleid=30322 .	Sept 2015	Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
Improving support for foster carers in relation to self-harm and suicide: To include: •Providing basic first aid training •Linking out of hours support to foster carers •Consider attaching a primary mental health worker to out of hour's provision.	Fostering Out of Hours support is in place	Placement and Fostering Manager	Details about how to access Fostering Out of Hours support has been circulated.		Green
	A new CAMHS Specification identifies support to Foster Carers but not necessarily out of hours. The out of hours support is being reviewed as part of the work in preparation for a restructure of the Fostering Service		The out of hours support to foster carers has been reviewed as part of the work in preparation for a restructure of the Fostering Service		Green
	No action required as Basic First Aid Training already in place for Foster Carers.	Placement and Fostering Manager	Basic First Aid training is in place for all Foster Carers		Green
Creating guidance protocols, procedures and pathways around how to assess the risk of suicide and what to do next. This work is urgent and should be programmed to be completed as soon as possible and led by the Safeguarding Board.	NYSCB to work jointly with the Suicide Prevention Task Group to develop practice guidance to support practitioners where there is a risk of a child/young person with suspected suicidal thoughts.	NYSCB PO NYSAB PO Public Health Improvement Manager	There is a multiagency agreed practice guidance available on the NYSCB and NYSAB websites	March 2016	Amber

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
CEOPs and NSPCC provide online courses looking at how to keep children and young people safe online. Participants in the Learning Review had positive experience of accessing these programmes. Active consideration should be given to making these programmes or similar material widely available as part of an awareness campaign and a workforce development issue.	NYSCB web site to include links to CEOP and NSPCC e learning regarding keeping children safe on line.	NYSCB PO	NYSCB E-Safety Strategy **www.safeguardingchildren.co.uk/.../ NYSCB%20eSafety%20 Strategy%20February% 202014.pdf** The following links also appear on the NYSCB website: http://www.ceop.gov.uk/ **http://www.thinkuknow.co.uk/** **http://www.kidsmart.org.uk/** **http://www.google.co.uk/familysafety/** **http://www.btinternetrangers.co.uk/** **http://www.gimi.co.uk/index.aspx?articleid=8218** National Self Harm Network www.nshn.co.uk **Self-harm** www.selfharm.org.uk	May 2015	Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
	NYSCB in conjunction with the NSPCC to develop an interactive theatre package for young people regarding E safety Anticipated delivery date June 2015. Delivery is accompanied by information for schools.	NSPCC Lead NYSCB PO	Interactive theatre package for young people regarding E safety is completed by NYSCB.	Sept 2015	Green
	A DVD version of this performance will be made available to ALL North Yorkshire schools via the Red bag.	NSPCC Lead NYSCB PO	A DVD version of this performance will be made available to ALL North Yorkshire schools via the Red bag.	November, 2015 Completed October 15	Green
There is a general workforce development and specific training need around the whole area (of social media). For example, the youth service have an official Facebook account with which to keep in contact with young people and one of the Learning Review participants had successfully used this to re-establish contact with vulnerable and hard to reach young people. They were aware that often vulnerable young people – such as those who were homeless used this to stay in touch as they were always able to find a way to access Facebook.	Discussion to be undertaken with partners regarding how this information can be included as a theme within the Foster Carers development day planned for October 2015 and clearly established within Foster Carers training programme.	Placement and Fostering Manager	Discussion is held.	June, 2015 NYSCB to attended FC conference sept 2015	Green
	Consideration to be given to the production of guidance for Social Worker and Foster Carer's in respect of managing the complexities of social media impact on contact arrangements for young people cared for by the LA	Legal Advisor Placement and Fostering Manager	Report presented to the Case Review Subgroup of the considerations.	6 July 2015	Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
The Safeguarding Children Board should consider how to promote this message in a similar way to approaches around substance misuse and domestic abuse for example. A way forward should be agreed by July 2015.	NYSCB to update communications strategy to include consideration of how the board communicates important messages to young people.	NYSCB IC	NYSCB Communication strategy is completed.	November, 2015 Agreed exe Oct 15	Green
	NYSCB redesigned website includes Twitter and RSS feeds.	NYSCB PO	NYSCB website is redesigned and includes Twitter and RSS feeds.	November 2015	Green
	No action required as training has been undertaken within the Hambleton and Richmondshire areas.	NYSCB PO	Individuals from across the Hambleton and Richmondshire area have been trained in E-Safety through Parenting in the Digital Age.		Green
There needs to be a development of a harm minimisation approach around young people's use of social media with carers and parents supported to follow advice and guidance as to how best to manage access for children and young people.	NYSCB/NSPCC keeping children safe on line training to be offered to NY Foster Carers.	Placement and Fostering Manager NYSCB PO In conjunction with NYCSC WD group.	All Foster Carers are signposted to online training, and to the following links which appear on the NYSCB website: http://www.ceop.gov.uk/ **http://www.thinkuknow.co.uk/** **http://www.kidsmart.org.uk/** **http://www.google.co.uk/familysafety/**	November 2015	Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
			http://www.btinternetrangers.co.uk/ **http://www.gimi.co.uk/index.aspx?articleid=8218** National Self Harm Network www.nshn.co.uk **Self-harm** www.selfharm.org.uk Interactive theatre package for young people regarding E safety delivered June 2015. Delivery is accompanied by information for schools. NYSCB representation and information regarding on line training presented to FC development day Set 2015 A DVD version of this performance will be made available to ALL North Yorkshire schools via the Red bag.		

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
	NYSCB handbook to be developed to provide guidance to parents on e-safety issues and provide links to sites where they can gain more support.	NYSCB PO NSPCC Lead	NYSCB handbook developed and disseminated	Completed April 2015	Green
Further work should be undertaken to identify the implications and potential benefits of the use of social media for children and young people who are looked after. There is a particular need to better understand the complicated range of potential interventions into social media contact with both family and siblings on a managed and unmanaged basis.	Consideration to be given to the production of guidance for Social Workers and Foster Carers in respect of managing the complexities of social media impact on contact arrangements for young people cared for by the LA.	Legal Advisor/ Placement and Fostering Manager	Considerations are reported back to the case review subgroup		Green
	NYSCB/NSPCC keeping children safe on line training to be offered to NY Foster Carer's	Placement and Fostering Manager	Information given to Foster Carer's at conference 2015 and included in information for all new foster carers at induction.	Sep 15	Green
	Discussion to be undertaken with partners regarding how this information can be included as a theme within the Foster Carers development day planned for October 2015 and clearly established within Foster Carers training programme.	Placement and Fostering Manager	Discussion is held.	June 2015	Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
	Information from young people developed within the NYSCB/NSPCC e safety project to be included in LAC information packs.	IRE Safeguarding Manager	Information given to all young people at the point they become looked after by the LA IRO team creating a secure portal; for young people to contain all pertinent information.		Amber
Directly intervening to protect children online. The police are developing an enhanced capacity to respond to cybercrime which includes training. Auditing and reporting e-safety concerns involving children and young people. Should a common reporting tool and format be developed? Should all agencies be asked to audit the level of their e-safeguarding concerns? The Safeguarding Children Board should undertake a review of e-safeguarding reporting processes. A task and finish group should be convened to undertake this work and report back to the Board in September 2015	CSSG's to undertake single agency audit of online safety. Information to be fed into the NYSCB to ensure that the Board is assured that all partners are have due regard to online safety.	Det. Ch. Supt. North Yorkshire Police	Police have developed an information sharing tool for colleagues to share 'soft' information with police regarding issues of e safety and CSE. intelligenceunit@northyorkshire.pnn.police.uk Members of CSSGs have undertaken an audit of e-safety compliance and developed implementation plans to address concerns.		Green
A representative task and finish group be established by Children's Social Care, including legal and CAMHs, to review current experience and guidance to update it to enable workers to be more proactive in seeking to formally boundary contact, including return to court if necessary, if contact is	Consideration to be given to the production of guidance for Social Worker and Foster Carer's in respect of managing the complexities of social media impact on contact arrangements for young people cared for by the LA	Legal Advisor	Legal advice is made available to all SW's on a case by case basis when dealing with issues of supervised contact with parents – this would also		Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
having adverse impacts on the young person and the placement. This work is urgent and should begin as soon as possible.			include issues regarding social media.		
	IRO service to review contact arrangements for all LAC and challenge as appropriate.	IRO Safeguarding Manager	IRO annual report to include analysis of any arises arising regarding unmanaged contact and the impact on looked after children.	May 2016	On-going
I recommend that the Safeguarding Children Board convene a meeting to consider how and when to introduce a 'pause' meeting into a situation where a vulnerable child or young person's situation is rapidly deteriorating. We identified a number of mechanisms through which this 'pause' meeting might be enabled: • As an emergency Looked After Children review. • As an emergency Child Protection core group. • As a strategy meeting called on a young person who is a potential harm to themselves. In addition participants were aware of a number of young people about whom there were significant concerns about self-harm and around which such an approach could be tried out now.	Ensure a multi-agency approach to case decision making through a range of methods.		Current arrangements are in place on a case by case basis to introduce a multi-agency meeting. These include; • Outcomes meetings • Peer group supervision • Core groups • Strategy meetings • LAC reviews • CP reviews		Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
I would recommend that a review of the relationship between risk assessment and decision making for admission to the PRU(and other schools) is revised and improved and takes into consideration the particular needs of young people as well as the needs of the PRU (and other schools).	NYSCB to request ELAC virtual head teacher produce a report which proposes an agreed format for risk assessment (task and finish group to include head teacher from PRU).	CSC LAC VHT	Report is considered by the NYSCB and a risk assessment format is agreed and disseminated.	Sept 2015	
I would further recommend that agencies formally report to the Board any changes and improvements made to practice in this area as a result of the child's death and this Learning Review. This material should be presented to the next Board meeting	This action plan (following agreement) to be monitored within the NYSCB quality assurance and performance subgroup.	NYSCB QAP group chair	Action plan considered as a regular agenda item within QAP subgroup		Green
The Corporate Parenting Group for North Yorkshire should consider how to improve the sharing of information of health issues in relation to Looked After Children when they have a significant impact on the plan for the child. This should be done and actions put in place by July 2015. The Corporate Parenting Group should also consider how to ensure that carers are aware of GP's and other health professionals involved at all times.	Health colleagues to report to the NYSCB regarding the development of the 'blue book' (LAC health passport). Once developed, to be presented at all health assessments with the child/young person to ensure up to date health information is available. Statutory Guidance on Promoting the Health and Well-being of Looked After Children proposes that no LAC should be the subject of temporary GP registration. Practitioners to refer to para. 72 of the Statutory Guidance.	Designated Nurse/Designated Doctor	Report is received and considered by the NYSCB	Sept 2015	Green

Recommendations drawn from the report	CRS Agreed Actions	Responsible member/ agency	Outcome	Timeframe	RAG
In addition further thought needs to be given to the preparation of foster carers receiving young people into their houses in deteriorating and developing circumstances. I recommend that Children's Social Care convene a task and finish group to assess how best to address these issues and to agree a way forward by July 2015.		Placement and Fostering Manager RAS Team Manager	CSC will have considered these issues within the FC induction training and preparation programme		Green