Multi Agency Case Audit
6 Step Briefing
Self Harm

Theme / Cases

- Themes are based on priorities identified by the NSCB.
- QA Sub Group members nominate cases.
- Cases are selected to ensure there is a cross selection of children, their requirements and service intervention.

Process

- Completed chronologies and audit tools submitted for 5 pre-selected cases from each agency.
- Multi agency meeting to examine and analyse each case.
- Learning Summary developed.
- Actions identified as part of MACA Composite Action Plan.

Strengths identified per case

Case 1

- Use of self harm pathway initiated by Northampton General Hospital.
- The Child's school provided practical support to the family.

Case 2

- Good partnership working including CAMHS, Catch 22, Safeguarding Children's Services, Hospital.
- Voice of Child heard and recorded well by agencies.
- Good engagement by agencies with Child and Mother.
- Good sharing of information by agencies.

Case 3

- School made many referrals about this Child, but none were escalated.
- Northampton General Hospital managed this case well when the Child attended A&E.
- CAMHS visited the Child on the Hospital Ward.

Case 4

- Case well managed by Northampton General Hospital.
- Well managed by Northamptonshire services in general.

Case 5

- Case well managed between Northampton General Hospital and CAMHS.

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Findings identified per case

Case 1:

- Failure by Health to consider and understand extent of Mother's mental health issues.
- Voice of Child was not heard or recorded; Safeguarding Children's Services did not explore child's views following loss of contact with Father or the impact of his young carer role for Mother.
- No referrals by Education or CAMHS due to child's lack of engagement and sharing of information by CAMHS.
- Safeguarding Children's Services did not thoroughly explore Early Help provision.
- Lack of understanding and risk assessment by all professionals when a child denies suicidal ideation.
- Lack of understanding of child's escalating poor behaviours, weight loss, erratic behaviour and routine. incidents seen in isolation and not considered by professionals as to underlying cause of deterioration.
- Too many changes of Social Workers.
- Lack of recording of parental voices by all professionals.
- ADHD diagnosis potentially distracted professionals from considering the child's risk of self harming.
- Agencies use different systems to record information and this can make it difficult to share across agencies.

Case 2:

- No evidence of voice of father.
- No contingency plan following Child's suicide attempts.
- Child Sexual Exploitation intermittent yet consistent and risk not assessed by agencies.
- Child well known with many incidents of self harming; issue behind these behaviours not explored.

Case 3:

- Too many changes of Social Worker.
- Safeguarding Children's Service closed or stepped down case without adequate oversight or supervision.
- Voice of Child not heard, listened to or recorded.
- Each incident viewed by Safeguarding Children's Services in isolation rather than holistic oversight of whole history.
- Very poor chronologies – not completed.

Case 4:

- Transferring authority did not provide a transfer of care.
- CAMHS only aware because Child attended Ward as no safe place to go.

Case 5:

- Lack of Voice of Child.
- Self Harm not directly addressed with child, therefore, risk not assessed.
- Poor partnership working - no evidence of liaison with MASH, Early Help or Safeguarding Children's Services.

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Recommendations – Issues Identified Across Multiple Cases

- **Training and Awareness**
  - Professionals from all agencies need a better understanding of self harm, its implications and underlying reasons for behaviours.
  - Teachers need a better understanding of "experimental" behaviours and how to manage and assess risk.
  - All agencies must utilise the Thresholds and Pathways document when assessing cases and ensure case his is accessed.
- **Recording of information**
  - Completion of quality chronologies, by all agencies, is crucial to understand a child or young person's histo better inform risk assessment. Quality, up to date information should be contained.
  - Voice of the Child and recording the voice of the Child is improving, but some cases still showed a lack of.
  - When completing audits, Children's Social Care records must include statutory obligations, when they tool place and whether they were undertaken within the statutory timelines.
- **Supervision and Case Management**
  - Management oversight and accountability is critical with turnover of Social Workers.
  - Handover between Social Workers must be robust.
  - Children and Young People requiring hospital admission for self harm should be referred to Safeguarding Children's Services.
- **Information Sharing**
  - Some sharing of case information is excellent, whilst others it is lacking and heightens risk to child's safety
- **Referrals and Follow Up Activity**
  - Referrals and re-referrals by agencies must be followed up and escalated where necessary and a reliance on being informed of outcomes must not be left to Safeguarding Children's Services.

Good Practice and Evidence as a Result of this Audit and similar Reviews

The NSCB Self Harm Pathway was put in place following an historic Serious Case Review undertaken. The practice guidance on Self Harm can be found in the NSCB Procedures Manual. Please click here.

The Self Harm Toolkit was launched in October 2014. Videos, Toolkit and other relevant information can be found on the Ask Norman website. Please click here.

As part of the NSCB eLearning package the course 'Self Harm and Suicidal Thoughts in Children and Young People' is available and can be taken free of charge by all practitioners using the self registration system or logging in here.