Argyll & Bute Child Protection Committee

Learning Review Summary

Child A

Report Prepared by

The Review Group

June 2022

1. Learning Review Criteria

Argyll & Bute Child Protection Committee took the decision to undertake a learning review as it met the criteria set out the national guidance[1] in that

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¢KŜ ℕŜØƛŜø LJℕ2ØƛŘŜŘ űKŜ άX2LJLJ2ℕűdzyƛűè ₹2ℕ ƛy-depth analysis and critical reflection in order to gain greater understanding of inevitably complex situations and to develop strategies to support practice and improve systems acroăă I·ƎŜyŎƛŜăɛ¢ óLJпú

The Review wishes to acknowledge the impact of ¸t !Ωă death for his family and for those workers who knew him and who were affected personally by his death.

The Review Group wish to thank all those who participated in the review process.

2. Review Process

A multi agency review group was established comprising of representatives from Social Work, Lead Officer CPC, Health, Education, Police and Justice Services. The review group was chaired by the independent chair of the Child Protection Committee. Overall, the Group met on four occasions between April and November 2021.

The remit of the Group was to review all information and to identify areas for learning and gaps in service provision as well as areas of good practice.

Agency reports and chronologies were requested from all partner agencies and an integrated chronology was prepared. Agency representative critically reviewed their own agency information I·yŘ LJℕ2ØƛŘŜŘ I·y I·yl·fèăλă 2₹ űKŜƛℕ I·ƎŜyŎèΩă ƛyØ2fØŜYŜyű øƛűK YP A and his family.

A reflective workshop was held on 20 September 2021 with practitioners who were involved with education, health and social work services. The Teams session was facilitated by the CPC Chair and Lead Officer and afforded staff the opportunity to reflect on their involvement with YP A and his family and to explore this within a wider multi agency context. Practitioners were fully engaged in the workshop and through reflection and discussion identified potential areas of learning.

[1] National Guidance for Child Protection Committees Undertaking Learning Reviews, 2021 Scottish Government

3. YP A and the Circumstances that Led to the Learning Review

YP A was born on 10 December 2003 and tragically took his own life on 26 February 2021. YP A went missing from home and was found in the woods nearby having taken his own life. YP A and his family were known to social work services at the time of his death.

The main focus of agency involveϒŜyű ΚΙŘ ōŜŜϒ ǿƚűK ¸t !Ωă ƧfŘŜℕ ăƚōfƚyƎ ǿΚƧ ΚΙŘ ōŜŜϒ known to social work services since 2015. In 2019 YP A was referred to CAMHS due to suicidal thoughts and he was supported by CAMHS over a number of months. When the country went in to COVID lockdown YP A struggled with his mental health and found it difficult to engage with education services and remote learning.

children will require formal intervention from CAMHS, many will require supports such as the school counselling service etc.

4.2 Interface between Justice Social Work and Children & Families

When Justice services became involved with ¸ t !Ůă 2fŘŜℕ ăλōfλyƎ, he had moved out the family home. There was evidence of information being shared with partners in relation to the sibling but no evidence of information being shared with C&F services. There is no evidence that as part of their assessment consideration was given to the impact of ΰKŜ ăλōfλyƎŮă behaviour on his younger siblings. There were no joint meetings across adult and children services which could have ensured comprehensive assessment of the needs of all YP in the family home which may have resulted in consideration being given to the use of YPSP or IRD to review concerns and agree actions.

There was no interface between adult protection services and C&F services.

4.3 Chronologies

There was evidence of single agency chronologies within Education but no family multi agency chronology which would have helped both C&F and CJ assess the risk not only to ¸ t !Ůă 2fŘŜℕ ăλōfλyƎ but to YP A and his younger brother.

An integrated chronology is a very effective risk tool that provides practitioners with up-to-date λyŦ2ℕY˙l·ΰλ2y˙l·ō2ʤzΰ ŎKl·yƎŜă λy˙l· ŎKλfŘŮăκŦl·Yˇλfè Ůăℕ ŎdzYˇăΰl·yŎŜă l·yŘ Ŏl·y˙λŘŜyΰλŦè λyŎℕŜl·ăŜŘ ℕλă˥ øKλfŜ also providing evidence of change both when families are doing well and when things are becoming more problematic. The use of chronologies sits within the national practice model and should be used by all professionals to oversee and assess thei06 (s)-8s theicl h up hi se.

5.4 Criminal Justice Services with YP A's Older Sibling

Justice Services have been involved with ¸t !ůă 2fŘŜℕ ăλōfλyƎ and the family for some time and there was evidence of continued to support and intervention and engagement with Mum.

5.5 Supports and Processes in School Following YP A's Death

The school management team and central team came together to identify and support a range of opportunities to support YP to grieve and to support staff. Health and wellbeing input for YP was provided by those teachers the YP knew and trusted.

Educational Psychology supported the school during this very difficult period and a safe space was set up in school and this was used by both pupils and teachers. Educational Psychology held an open debrief session for education staff and the school chaplains were in school on a rotational basis.

YP came into school and met in small groups in the cafeteria and while they did not want adult involvement, teaching staff were always available and had oversight on the YP and were able to monitor how the YP were doing.

¸t !ůă LJŜŜℕ ƎℕƧdzLJ was supported directly by a member of staff, and this allowed the young men to talk about how they were feeling and to reflect on YP Aůă ŘŜI·úK◊

The school arranged for Head Strong to deliver a session supporting parents to know what to look for and importance of linking with the school. There was good involvement with parents and the session was recorded so parents could review after the event.

The school arranged for young people to line the street to show respect as staff and young people were not able to attend the funeral. For many young people this was their first experience of loss/grief and this activity gave pupils and teachers the opportunity to grieve together.

These actions have generated a strong sense of community and family within the school.

6. Learning Outcomes

Learning Outcome 1

The Child Protection Committee may wish to seek an update on the progress of the realignment of the CAMHS service. The newly appointed CAMHS manager should provide the CPC with a response to the findings of this review in order that the CPC can seek assurance that the concerns raised by CAMHS professionals are being addressed and workers are being supported on delivery high quality services to children.

The CPC should request a report on the numbers of YP experiencing mental health difficulties and how many YP are being referred to CAMHS and to other mental health and wellbeing services in order to Ǝl·λy I· ŏfŜI·ℕ dzyŘŜℕăúI·yŘλyƎ 2Ŧ ¸tůă YˆŜyűI·f ŔŜI·fűK λy ! ℕƎèff ɔ .dzúŜ I·ű úKλă ûλYˆŜ◊