

**Local Child Safeguarding Practice Review (LCSPR)**

# **“Jesse”**

**Executive Summary**

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**INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW**

* 1. Kent Safeguarding Children Multi-Agency Partnership received a practice review notification in relation to Jesse. Jesse expressed that they were transgender and had autism.
	2. The notification was received after an incident when Jesse, attempted to end their life. Jesse was taken to hospital with non-serious physical injuries. Jesse has now recovered, back at school and doing well emotionally and physically.
	3. A key part of undertaking a LCSPR is to gather the views of the family regarding the services they received from agencies and share findings of the review with them prior to publication. It was not possible to meet face to face due to the ongoing national response to a pandemic. The author spoke to Jesse via video conferencing and Jesse’s mother over the telephone; their thoughts and views have been included when learning and recommendations were considered.
1. **KEY EVENTS**

The review focussed on several key events to understand the strengths of multi-agency working and to recognise gaps and areas where improvement may be required.

**Event One: Call from Jesse identifying suicidal ideation.**

**Event Two: Jesse called Police alleging assault and abuse by mother**

**Event Three: Jesse Self Harmed by cutting**

**Event Four: Near Miss Episode**

# **GOOD PRACTICE**

* Evidence of some good multi agency working between police and CAMHs.
* School offered a plethora of support regarding autism and emotional health.
* Hospital recognised that Jesse was an open case for Children’s Social Care and alerted them to the self-harm episode.
* Police provided respite for Jesse by taking them to friends overnight when tensions were high at home. That was followed by a referral to social care and a strategy meeting.
* The GP practice offered appointments to discuss issues that had led to not attending appointments in other services.
* The administration team in the GP practice identified that Jesse had not attended therapy appointment and acted appropriately and promptly to ensure the GP re-referred.

Research by Social Worker of transgendered issues and taking advice about how best to communicate with Jesse.

A family meeting was facilitated by the Social Worker.

Awareness by several agencies of good practice in terms of the Equality Act.

Clear evidence of individual practitioners taking time to listen to Jesse.

# **FINDINGS**

# **Autistic Spectrum Condition; Diagnosis and Support**

* + Several agencies believed Jesse to have a formal diagnosis of Autism; this was not the case.
	+ Equality Act applied effectively in terms of autism and transgender.
	+ It was a CAMHS Psychiatrist, who recorded the formal diagnosis of ASC - High Functioning Autism, Asperger’s Syndrome, however there was no formal screening undertaken.
	+ Discourse between professionals regarding a need to formally diagnose or not.
	+ The right for formal diagnosis supports future planning.
	+ Jesse was very passionate about being at school giving structure to life that helps to manage days, as an explanation for defaulted appointments not recognised.

**Learning Point 1:** It is important that there is clarity on the process of diagnosis of ASC i.e.is screening required mandated?

**Learning Point 2:** Understanding for professionals in clarifying the basis of diagnosis is important.

**Learning Point 3:** Nice Guidance provides evidence bases for diagnosis, support, and management and are useful reference points.

**Gender Dysphoria**

# Opportunity to establish relationship with a trusted adult led to disclosure.

# Jesse quickly wanted to be known by all as another gender.

* + Complexities for young people with autism to understand and articulate their feelings.
	+ Statistically, there is an over representation of co-occurrence of ASC and gender dysphoria.
	+ Those with high functioning ASCs are capable of making informed decisions.
	+ Culture may be more important than ethnicity.
	+ Jesse did not have support for gender dysphoria issues due to non-attendance and waiting lists.
	+ Professionals generally did not know that Jesse was not attending appointments
	+ Jesse’s family struggled with the pace of Jesse’s requests for interventions to delay puberty.
	+ Jesse’s voice was not clearly heard.
	+ Internet support helped Jesse; Mother was not sure that this was helpful and blocked access increasing tension.
	+ Lack of known services to support adolescents with gender dysphoria

**Learning Point:** Gender dysphoria is an increasing concern and presentation in young people, therefore staff need to have access to support and expertise to guide them.

**Learning Point:** Exploration of concerns that parents have regarding negative press issues should be explored rather than being accepted at face value, particularly where there are no alternative commissioned services.

**Learning Point**: Exploration of barriers to provision of appropriate support servicesfor young people with gender dysphoria should be based on the needs of the young person and not the service or parents.

 **Multi agency working and communication**

* + Good support for Jesse when in crisis.
	+ Checking back on what other services were providing done through parents not professionals.
	+ CAMHS risk assessed Jesse as high risk; School and Children’s Social Care not made aware. Communication regarding this was not clear.
	+ GP not always notified of non-attended appointments.
	+ Assumptions made of reasons for non-attendance and not explored by any service.
	+ Good use of Child Protection procedures initially but ongoing assessment not inclusive of all those working with Jesse.
	+ Systems issues with information gathering at Multi Agency Front Door access to Children’s Social Care.
	+ School did not access support from CAMHs regarding disclosures that Jesse was researching ways to end their life.
	+ System errors in Children’s Social Care resulted in referrals and further information regarding Jesse’s self-harm not being known by Social Worker.
	+ Child and Family Assessment outcome focussed on the tangible elements of home life and relationships and case stepped down to Early Help.
	+ Whether the children were young carers was not assessed within the Child and Family Assessment. ‘Think Family’ was not embedded in practice.
	+ Early Help offer not immediately available due to holidays of family and professionals.
	+ Jesse probably acted in the moment and desire to end life on that day not understood.

**Learning Point:** Protocols for assessment provide a framework for all agencies to follow when a referral is received into Children’s Social Care.

**Learning Point:** A shared understanding of any impact of ethnicity and culture should inform multi agency working.

**Learning Point:** Effective multi-agency working includes professional challenge where there is a concern that any partner agency is not following policy, procedure or protocol.

**Learning Point:** Multi agency working can ensure that information regarding defaulted appointments can be explored and understood in context.

**Learning Point:** Effective multi-agency working ensures that all those working with a child and family have information from each agency to inform their individual work.

**Learning Point:** The voice of the child must be central to any assessment so that the child does not just tell their story, but they are heard, and appropriate plans ensue. The voice of the parent should not take precedence over the voice of the child.

1. **RECOMMENDATIONS**

Jesse’s mother told the author that life is much better now, and that Jesse is no longer self-harming or talking about ending their life. This evidences that there are services that are successfully able to support young people like Jesse and identifies strong practice that should be harnessed, celebrated and shared.

This review has recognised the work that has already started in the locality in relation to the recommendations from the recently completed Thematic Review of Suicide in Children and Young People. The findings of that review related to suicide are no different to this review, it is the addition of transgender and ASC that added further complexities in understanding the risk, acknowledging the rising tide of concern and the escalation of Trigger Event Phases.

Recommendations are therefore based on what good practice in this set of circumstances would look like. This is based on increasing knowledge and skills in the workforce and ensure that there is access to expertise in this complex area. When we peel away those unique complexities, other learning is related to that already known, i.e. effective multi-agency working, professional challenge and hearing clearly the voice of the child. Many agencies listened to what Jesse was saying, but actions did not lead to evidence that they were heard and understood.

Where agencies have made their own recommendations in their Agency Review Reports, KSCMP should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

1. **Autism Spectrum Conditions**
	1. All relevant agencies to remind staff of the formal screening and referral pathway for ASC and to follow NICE Guidance in the support and treatment for ASC screening and management.
	2. Agencies must give definitive guidance to staff and feedback to partnership on their stance on necessity for referral and diagnosis.
	3. KSCMP should seek assurance and updates from commissioners, that the issues of waiting lists for assessment and diagnosis are being addressed.
2. **Gender dysphoria and pathways for support.**
	1. KSCMP will work with The Education People – Inclusion Support Service Kent to access and deliver training to professionals regarding gender dysphoria along with the learning for this review.
	2. Briefing to be prepared to signpost professionals to The Education People – Inclusion Support Service Kent website regarding supporting young people with gender dysphoria. This is subject to completion of the current review that is underway. KSCMP will request updates on progress of this.
3. **Assessment**
	1. KSCMP partners to provide assurance that the Kent Procedures are being proactively promoted and that agencies understand their role in child and family assessments, professional challenge and escalation.
	2. Ensure that all relevant agencies assessment frameworks give due regard to impact of culture and ethnicity.
	3. All agencies must provide evidence to KSCMP partnership regarding the requirement to record ethnicity, other protected characteristics and vulnerabilities in records.
4. **Escalation**

Kent and Medway Policies and Procedures Sup Group members should have assurance that the updated Kent Escalation Policy is understood by partners and used to conclusion and resolution of an issue.

1. **Single and Multi-agency case file audits**
	1. Ensure that the following system updates and learning from this review are effective and consolidated in practice;
* Voice of the child.
* Impact of ethnicity and culture.
* Gathering of health information for strategy meetings.
* Thorough follow up of ‘was not brought’ episodes.
* Use and efficacy of the updated Kent Escalation Policy.
	1. KSCMP should seek to understand what worked well for Jesse post incident, add this to the learning from this review and share as evidence of strong practice.