Luton Safeguarding Children Board
Serious Case Review Overview Report in respect of
Child M

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FINAL

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1. Section 1: Summary of Child M's Case and Why it was Chosen for Serious Case Review

1.1 Child M was an adolescent who took her own life in 2017. Child M was from one of Luton's South Asian communities. Her death followed one year after the suicide of another adolescent from Luton's South Asian communities, known as Child L, and the subject of another Serious Case Review.

1.2 The decision to carry out a Serious Case Review was made under Regulation 5 of the Local Safeguarding Children Boards Regulations.

1.3 Regulation 5 of the Local Safeguarding Children Boards Regulations sets out the requirement for LSCBs to undertake reviews of cases in specified circumstances. The LSCB's role is:

> 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned
>
> (2) For the purposes of paragraph (1) (e) a serious case is one where:
>
> (a) abuse or neglect of a child is known or suspected; and
>
> (b) either - (i) the child has died; or **(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.**

1.4 Cases which meet one of these criteria (i.e. regulation 5 (2) (e) and (b) (i) or 5 (2) (a) and (b) (ii) must always trigger an SCR.

1.5 This meant the criteria for a Serious Case Review were met and the chair of the Safeguarding Children Board wrote to the National Child Safeguarding Practice Review Panel to confirm this in November 2018. At the same time, very sadly, the Chair was in a position to notify the national panel of the death of a third adolescent from Luton's South Asian communities, who had taken their own life in 2018. The Luton Safeguarding Children Board had taken immediate action to co-ordinate a response from agencies in Luton that a third tragic death might require. The context of the Child L review was, however, one that had changed again, and the independent reviewer was briefed accordingly.

Terms of Reference and Methodology

1.6 Working Together 2015 is the framework that applies for this review and says the following.

1.7 Final SCR reports should:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence
- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and

- Be suitable for publication without needing to be amended or redacted
- LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done
- When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case.

The Terms of Reference

1.8 The board had previously commissioned a Serious Case Review into the death of Child L and set out not to repeat investigation of systems issues that were the same, but to recognise the different issues for Child M. There was one research area from Child L's case however that the board wished to see further explored, and this was the way that practitioners approach diversity. Put side by side, the research questions for these two reviews were:

Child L	Child M
How well are we in Luton currently identifying and responding to adolescents at risk of deliberate self-harm or suicide?	How do CAMHS staff appropriately engage and support young people who pose risks of self-harm and suicide?
How well do we listen to, and act upon, the wishes and feelings of children and young people?	How do Schools and Alternative Learning Provision analyse, manage risk and work with families and other agencies?
How well do we understand and address issues of culture, ethnicity, religion and diversity in our assessments of children and families?	How are issues of race, language, culture and religion dealt with in safeguarding and child protection processes?

By taking this approach, the board wished to make the most of learning and the review process but as importantly, to respect the individual stories and circumstances of these two children.

Contact with the family

1.9 The parent was written to initially and then contacted in order to share the report. However a number of visits were cancelled by them and then put on hold due to COVID. Over the summer some further attempts were made, but were not successful.

2. Methodology

2.1 It was agreed that workshops for professionals would be set up to explore the three key areas in the Terms of Reference. The aim of this was twofold:

- To gather information from professionals who work directly with young people in Luton, which had been a valued aspect of the Child L review
- To offer professionals a chance to come together and learn from each other with the goal of helping them address the complex practice issues names in the Terms of Reference

2.2 The SCR sub group of Luton Safeguarding Children Board met with the author and confirmed this approach on 6 September 2018 and the workshops began in November 2018.

2.3 The workshop topics were each identical to one of the lines of enquiry in the Terms of Reference:

- How do Child and Adolescent Mental Health Services staff appropriately engage and support young people who pose risks of self-harm and suicide? [note: 'CAMHS' is a distinct service, with criteria and nationally agreed ways of working, for children and young people with the greatest levels of need in relation to mental health]

- How do Schools and Alternative Learning Providers analyse, manage risk, and work with families and other agencies.?

- How are issues of race, language, culture and religion dealt with in safeguarding and child protection processes?

2.4 The Reviewer was asked to draw on his experience, as well as relevant data provided by the Board, in order to share relevant local and national learning, and to include these in this report. There were agreed aims for the workshops in terms of what professionals would leave the sessions with. They are not included here but have informed the follow on work for this review.

Independence

2.5 To meet the requirements of Working Together 2015, Errol John, was commissioned to carry out the SCR. Errol is a qualified social worker with an extensive career in children and families work in the statutory and charity sector, managing a range of services for adolescents at risk (child sexual exploitation, trafficking, substance misuse, mental health, youth offending). He is the co- author of "The Quest for Equality" a training manual to assist social welfare agencies in their work on equality and diversity issues.

Agencies involved in this review

2.6 Three workshops were held between October / November and the end of December 2018. A fourth workshop was facilitated for senior managers to share the themes from all of the workshops. A further session was held to share the preliminary findings with the SCR sub group of the Board. 42

practitioners attended the workshops, representing the Luton organisations involved with Child M.

- Safeguarding in Education team
- Providers of Luton's Alternative Learning services
- The community NHS trust that provides school nursing
- The mental health NHS trust that provides Child and Adolescent Mental Health Services
- The hospital NHS trust that provides acute care
- Bedfordshire Police
- Luton Council Children's Social Care - Early Intervention and Prevention; Social Work Service; Multi Agency Safeguarding Hub (the part that takes referrals)
- The NHS Commissioning Group
- Flying Start – a service of agencies working with younger children, and therefore not involved with Child M, but whose attendance was hoped to inform discussion on early intervention with families

3. Section Three – The Findings

3.1 Five themes emerged from the workshops:

- The changing context of adolescents'/young people's world
- Race, language, culture and religion - Developing Competence
- Working Together – Is mental health everybody's business?
- Working with parents/carers
- Issues for schools in identifying and responding to vulnerabilities

Finding 1: The changing context of adolescents' world

Professionals are struggling to understand how best to support adolescents in the new and challenging context that they are growing up in.

3.2 **Adolescent Development** – what research tells us. Historically adolescence is a time of remodelling the brain's reward system. Psychologically it is characterised by low resistance to peer influences, low levels of future orientation and low risk perception, often leading to increases in risk taking behaviour and poor self- regulation. It is a time of identity formation, the call for greater autonomy, and the development of new interests including emerging interest in sexual and romantic relationships. School and family environments are critical social contexts during this period to support healthy and safe adolescent development. It is also important to remember that it is a period during which young people are oriented towards what is right and proper. They are developing a sense of behavioural maturity and learning to control their impulsiveness. The social and emotional skills, knowledge and behaviours that young people learn in schools and in the family can help them to build resilience and set the pattern for how they will manage their mental health throughout their lives.

3.3 **Developments in social media and new technologies** mean that adolescents and young people are spending vast amounts of time in front of screens, on computer games, social media platforms and so forth, at a time when the quality, security, and stability of social contexts is particularly important. It is perhaps not surprising that late childhood and early adolescence are often when the first symptoms of most mental disorders emerge.. In this way the media, particularly social media, shapes attitudes, values, and behaviours in this age group more than at any other time in history. For adolescents and young adults, these new channels promote access to an extended social network, without geographic or cultural constraints, bringing the potential for engagement with new ideas and like-minded individuals.

3.4 **There are potentially great benefits from strong social digital connections** during this time, and it is important to remember that they do in many respects bring a number of positives to all of us who use them. But these same media can equally amplify vulnerabilities from intense emotions. Whilst participating in the emerging social media environment adolescents /children and young people are potentially exposed to a variety of risks.

3.5 **Impact on adolescent development:** The ways in which adolescents make decisions (including those affecting their health and well-being) differ from those of adults. Their sensitivity to peers in decision making is often targeted by teen-oriented entertainment and marketing and also more sinister groups and individuals. The potential of the new media to amplify social and behavioural contagion is already apparent around adolescent violence, mental health, suicide, and self-harm. According to The Lancet report, a global study on adolescent health and well –being (2016), social contagion is a further factor in up to 60% of adolescent and young adult suicides. Deliberate self-harm has increased and is also common in adolescents, particularly in females, and heightens risks for subsequent suicide. 1

3.6 **The increase in self harm** appears to have become a social norm. Growing numbers of adolescents seem to have become desensitised to violence and as a consequence do not report concerns for themselves or others.

3.7 **The internet has created a number of new risks** as well as changing the level of risk in relation to age old issues. The challenges young people and parents face in adolescence are changing quickly. What is acceptable for example in terms of trying / taking drugs or alcohol in a time when they can be accessed in multiple ways? The table below attempts to set out how risks have changed with the access to digital technologies.

3.8 **The changing environment**: The social networks and roles of adolescents today differ markedly from those growing up in the late 20th century. The environment young people grow up in today is fundamentally different from those of past generations. Key among these differences are:

- changes in the structure and function of families,

[1] Our Future: a Lancet commission on adolescent health and well- being. 2016 University of Columbia.

- changes and pressure within the education system,
- greater exposure to a range of media (online, digital, commercial) and
- wider peer networks via platforms such as Instagram, Facebook etc.

Each influence can function positively or negatively on the health and emotional well-being of young people.

Risk	**Risks that have changed as a result technology**	**New threats arising from technology**
Bullying	Use of social media to maintain	social contagion around self-harm and eating disorders
Sex	Grooming for sex Sexual exploitation	sexting (sharing of sexual images) retraumatisation as a result of ease of replicating and sharing
Commercial exploitation	Ease of access to gambling Online targeted advertising	identity theft addiction to gaming money laundering county lines
Drugs / alcohol	Being able to buy illegal drugs and legal highs	
Radicalisation	Multiple channels to groom	Use of secure methods to communicate

3.9 One in four girls is clinically depressed by the time they turn 14. The UK government-funded study 2(Millennium Cohort Study) found that 24% of 14-year-old girls and 9% of boys the same age have depression. That means that about 166,000 girls and 67,000 boys of that age across the UK are depressed. The findings are based on how more than 10,000 young people that age described how they were feeling. The data has prompted fresh questions about how social media, body image issues and school-related stresses affect young people's mental welfare. Dr Praveetha Patalay, the lead author of the research, said the findings revealed "worryingly high rates of depression" among 14-year-old girls and the "increasing mental health difficulties faced by girls today compared to previous generations". The study also strongly suggests that being from a low-income family increases the risk of depression and that ethnicity is potentially a key factor too. Difficult experiences in childhood – including bereavement,

[2] Millennium Cohort study. UCL and Liverpool University

domestic violence. neglect and family breakdown can also have a serious impact, often several years down the line.

3.10 **Workshop participants feedback :** During the workshops the practitioners confirmed that the issues outlined above resonated with their experiences. They agreed that collectively as professionals they have not yet caught up with the rapid growth in digital technology and social media and the risks that it poses to adolescents. There is complexity about the issues young people are facing today and professionals are trying to get to grips with this new world and find the best ways to respond.

3.11 **Professionals across all agencies reported** that they witnessed a growth in young people self-harming and that it is difficult to differentiate those who are most at risk because it has become normalised. The pathways to harm are complex and differ from individual to individual, e.g., peer pressure, through social media, different forms of abuse, exam stress, family issues, for some young people it could be a combination of some or the cumulative effect of all of those issues which eventually lead to a young person committing suicide.

3.12 **Participants reported** that they are relatively confident in their own ability to both identify and respond to harm faced by adolescents by different people and in different contexts. However, this confidence was lower as the context of harm moved further from the home/family settings. The contexts where professionals felt less confident were in relation to risk from peers or adults online, in their neighbourhoods and social settings. Professionals who were not specialists were less confident in identifying and responding to young people who harm themselves and tended to refer to specialist agencies like CAMHS. Where professionals were more confident in their practice, they attributed this to training, practice experience, supervision, peer support and case experience with adolescent safeguarding.

3.13 **There was unanimous agreement** that strategies to reduce and prevent adolescent self- harm and suicide must involve listening to their voices, and the meaningful participation of adolescents in promoting and supporting mental health and well- being initiatives e.g. peer education and support networks, youth health advocates and so on. Such strategies should also consider their decision-making processes and support their capacity to make reflective decisions, considering risks and consequences. Approaches that focus on developmental mental health risks such as bullying, interpersonal violence, and social media risks are worth testing. Although digital and social media have been implicated as risk factors, online and mobile phone interventions can play a positive part in prevention and promotion of access to clinical and other services.

Questions for the Luton Safeguarding Children Board:

- How can the LSCB and commissioners support practitioners working within the safeguarding system in Luton to develop their confidence and skills to support adolescents in this different world?
- How can organisations improve the ability of professionals to work with young people in relation to their safe use of technology to communicate, collaborate and socialise ?

Finding 2: Work with Parents and Carers

3.14 **Parents as well as professionals are struggling to keep up with and respond to the changing context** within which adolescents are growing up. Parents feel disempowered and solutions are needed to support and equip them to deal with the modern day challenges their children experience so they can keep them safe from harm.

3.15 **Workshop participant Feedback**: Parenting capacities, such as monitoring and supervision of activities are important for reducing health risks. Beyond this function, families are likely to have a central role in how adolescents learn to respond to new emotional experiences that emerge in and around puberty. Parents are important reference points for the adolescent in learning how to respond to more intense experiences of sadness, anxiety, and anger. The extent to which parents are able to express and respond to emotions is likely to have a major effect on this capacity in their adolescent children.

3.16 **Working and engaging with parents** continuously is a critical part of the safeguarding process, including them as change makers and viewing them as experts in their own lives can sometimes be challenging particularly if there are the dynamics of race, language, faith and culture.

3.17 **Understanding what "help" looks like within the context of the family** and for the child/adolescent is important, sometimes however we operate on professional assumptions rather than allowing the family and child/adolescent to educate us about who they are and what they believe. This requires a culture where professionals understand the wider family network and who holds the power in the family.

3.18 **Professionals reported** a number of instances of young people being returned home from hospital after suicide attempts without any guidance on how to reduce the risk of a further attempt. Parents should be given support and advice on how to protect their child following a suicide attempt. The timing is good for this, as CAMHS are currently supporting parents to manage their children's mental health issues and willing to be part of the drive to educate parents and education staff. Participants are keen to develop a programme for parents around emotional well-being and self -harming.

3.19 **Discussions also considered the support that parents required** to help them keep their children safe in contexts outside of the home environment. There is the potential for learning from Contextual Safeguarding to be introduced to support young people and parents.

- When managing dynamics between child/adolescent and dysfunctional parents, it is important to understand that at times the parent may be a vulnerable person themselves.
- How do we interpret their behaviours?
- How do we become more accessible/ available to support parents with taking responsibility?
- How do we manage tensions between seeing parents as experts and disguised compliance?

- How do we approach and incorporate the dynamics of race, faith, religion and culture in our assessments of parenting capacity when there are safeguarding concerns?

Questions for the Luton Safeguarding Children Board:

- Was there sufficient curiosity about the way this child and their family engaged with each other?
- Was enough account taken of history and the impact that had on the ability of family members to parent and support the child?

Finding 3: Race, Language, Faith and Culture

3.20 **There are gaps** in practitioners' skills, knowledge, confidence and competence in addressing issues pertaining to race, language, faith and culture. This has to be addressed so that professionals working within the safeguarding and child protection systems in Luton can develop their competence in providing appropriate and effective services to the diverse communities in Luton.

3.21 **Analysis of serious case reviews** found that professionals sometimes lack the knowledge and confidence to work effectively with families from different racial and cultural backgrounds. It is important to address this, particularly given the growing concerns over harmful practices linked to cultural traditions such as female genital mutilation and forced marriage. Some professionals lack knowledge about specific cultures and religions and do not feel confident in challenging harmful parenting practices. Professionals want to be respectful of families' cultural and religious practices but the desire to be culturally-sensitive can sometimes result in safeguarding concerns being over looked and professionals accepting lower standards of care. Culturally sensitive practice is needed that can challenge claims that certain behaviours are the norm without losing sight of the children's welfare needs.

3.22 **Whilst working with parents from different cultural groups on mental health**, there can be differences in understanding such as;

- Differences in the ways in which we describe mental health issues; some cultures have a limited vocabulary for emotion words and the notion of "mental illness," does not exist.
- There may also be differences in perception about the causes of these issues, "God must be mad with us," "She is being punished for her early promiscuity" etc.
- There might also be differences in the ways professionals and families think the issues can be solved e.g. individual therapy, medication, prayer, reiki, chi gong, meditation.

3.23 **Reasons cited for the deficits include**:

- Absence of dedicated space to focus on these issues
- Lack of knowledge
- Training on equality and diversity in general has declined and did not have the prominence of former years.

- Training that is available tends take the form of brief one-off events to comply with legislation, procedures or in response to a complaint or crisis around diversity.
- Fear of saying the wrong thing
- Fear of being labelled racist or being complained about
- The issues are rarely discussed in team meetings or supervision
- They not are not routinely built into annual appraisal performance objectives.

All of the above may have led to lack of exploration, discomfort, silence and potentially to inappropriate and ineffective service provision.

Why are these issues important?

3.24 **Luton is ethnically diverse**, with approximately 55% of the population being of Black and Minority Ethnic (BME) origin, with significant Pakistani, Bangladeshi, Indian, East European and African Caribbean communities. In recent years, there has been a significant shift in the population with more people from Eastern Europe, particularly Poland, Romania and Bulgaria. A study by Mayhew Harper Associates in 2011 showed concentrations of new communities of Congolese, Somali, Ghanaians, Nigerians, Turks and Zimbabweans in Luton. Foreign students coming to the University of Bedfordshire has also increased the diversity. In certain wards such as Biscot and Dallow, 95% of under 18s are from BME backgrounds with approximately three quarters of these from Asian/Asian British backgrounds.

3.25 **There is increasing diversity in Luton's schools**. The number of white British pupils has fallen from 9,318 in 2011 to 7,841 in 2016. The Asian and other white groups have both increased and the total proportion of Black Minority Ethnic groups has risen from 68 per cent in 2011 to 75 per cent in 2016. The number of pupils of East European origin has nearly doubled between 2012 and 2016. This is shown in the increase of the other white category with an increase from 1,621 in 2012 to 3,004 in 2016.

3.26 **Child M was one of three adolescents from South Asian backgrounds who have committed suicide in Luton over the past three years**. The Serious Case Review of Child L's death set out to answer the following question: How well do we understand and address issues of culture, ethnicity, religion and diversity in our assessments of children and families? In the Child L Serious Case Review, the reviewers noted their concern that the review team were not able to surface sufficient information about how these factors affect the way services are delivered and therefore could not answer the question.

Black and Minority Ethnic (BME) young people and mental health:

3.27 **Specific research** on children and young people from black and minority ethnic communities and mental health is sparse. Existing data suggests variation in the prevalence of mental disorders between young people from different black and minority ethnic groups.

Prevalence of mental health disorders (age 5-16)

Ethnicity	Prevalence (%)
Black	9.2
Pakistani and Bangladeshi	7.8
Indian	2.6
White	10.1

3.28 **There are some differences by gender**; for instance, in girls aged 11-16, 7.6% of those from black backgrounds, and 7.5% of those from Pakistani and Bangladeshi backgrounds, had an emotional disorder, compared to 6.2% of girls from white backgrounds; while a high prevalence of boys from black backgrounds were diagnosed with a conduct disorder.

3.29 **Research from the National Institute for Health and Care Excellence (NICE)** has suggested that there is a high prevalence of self-harm in young South Asian women aged 16-24 years and that the time of onset and how they manage the condition is different to white women 3(NICE, 2012). Young South Asian women appear to be more likely to self-harm between the ages of 16-24 than white women and less likely to attend A&E with repeat episodes of self-harm. However, recent research found that young black women, aged between 16-34 years, were more likely to self-harm than young Asian women (Cooper et al., 2010)4. Research is required into factors contributing to self-harm, so that services can effectively tackle the root causes.

Table 2 : Millenium Cohort Study

Ethnicity	percentage
Mixed heritage	28.6
White	25.2
Bangladeshi	15.4
Black african	9.7

3.30 **The Millenium cohort study 5,** identified 14 year old girls from mixed heritage backgrounds (28.6%) as being of higher risk of depression. In their book " Mixed Experiences " (Dr Cathy Street and Dr Dinah Morley) argue that, where other risk factors are present in the lives of mixed race young people, the experience of being mixed adds to challenges those young people face and can be a contributing factor to the development of mental disorders. Research from the group People in Harmony shows that discrimination and prejudice from both white and black groups can combine to ostracise young people of mixed race.

3.31 **Children and young people from BME groups** are less likely to engage with services which could intervene early to prevent mental health problems escalating. There are a number of barriers which put young people from black and

[3] NICE 2012
[4] Cooper et al., 2010,
[5] Millennium Cohort Study -UCL and Liverpool University

minority ethnic groups off accessing mental health services. Before young people will talk openly about their problems, they have to feel that they are safe, can trust their practitioner and are confident that what they say will be kept confidential 6(Malek, 2011). However, services are not always culturally sensitive and some young people have reported that in their experience professionals didn't have the skills or understanding of different cultural or ethnic backgrounds. For others, language is a problem and often a translator is not available.

3.32 **Research has also found** that young people from black and minority ethnic communities want practitioners to have a greater awareness of and show an interest in religious and cultural issues. People want to be treated as individuals and practitioners should address their individual needs, rather than just assume that because they come from a particular ethnic background they will have specific cultural needs.

3.33 **Black and minority ethnic individuals may also be more likely to experience socio-economic factors** which contribute to poorer mental health 7(Marmot Review, 2010). The Marmot Review found a strong relationship between social gradient and common mental health problems, with a two-fold variation between the highest and lowest quintiles. Factors including deprivation, unemployment and poor housing may all influence mental health outcomes. Black and minority ethnic families are also more likely to reside in low-income and workless households; live in overcrowded conditions in poorer pre-1919 housing.

3.34 **Historical issues of discrimination within the mental health system and other factors:** A recent independent government review of the Mental Health Act found that black people were 4 times more likely to be detained under the act than their white counterparts. There is evidence that black and minority ethnic individuals are 40% more likely than white counterparts to come into contact with mental health services through the criminal justice system, rather than through referral from GPs, they are also less likely to be offered talking therapies for mental health conditions. 8 (Kane, 2014).

3.35 **There have been a number of explanations for these differences**; the stigma around mental health in some communities, limited awareness of and/or a reluctance to engage with statutory services at an early stage of illness, possibly due to previous poor experiences or the belief that services are not "culturally appropriate". Cultural differences in the way that mental health is perceived may also decrease the likelihood of individuals seeking care before reaching crisis point. This can include 'different understandings of what constitutes a mental health problem, different cultural expressions of distress including the way symptoms are expressed, and differing expectations of services Other reasons include unconscious bias and discrimination which has led to differential processes, treatment and outcomes. Professor Claudia Bernard from Goldsmiths University in London addressed the issue of racism on mental health at a recent seminar:

> "The UK is just waking up to the impact of racism on mental health". The impact of racism on people's mental health and families capacity to cope is an

[6] Malek 2011
[7] (Marmot Review, 2010).
10(Kane, 2014).

"uncomfortable truth" that social workers need to be supported to confront in their day to day practice.

3.36 **Organisations working with black and minority ethnic communities** around mental health have recognised, and responded to, many of these issues. Understanding their work and highlighting best practice is crucial to continued work on tackling poor mental health outcomes in black and minority ethnic communities.

Workshop participant feedback

3.37 **In discussion about the reasons why there appears to be discomfort and silence** around issues of race, language, faith and culture a number of reasons were put forward:

- Participants valued the opportunity to have a dedicated space to focus on these issues. Some of them had worked in the borough for 3 to 4 years and reported that this was the first time they had been in such a forum.
- Training on equality and diversity in general has declined and did not have the prominence of former years. The training that is available take the form of brief one off events to comply with legislation or in response to a complaint or crisis around diversity.
- The issues are rarely discussed in team meetings or supervision and not routinely built into annual appraisal performance objectives.
- The complexities and challenges they face in working with diverse communities are either poorly addressed in training sessions or not addressed at all, or they are given basic information "dos and dont's" regarding legislation or information on other cultures that inadvertently may promote cultural stereotypes.

- Facilitating discussion, thinking and learning about these subjects is extremely challenging and brings with it a certain amount of discomfort. People are sometimes afraid to speak their mind or ask questions for fear that it may cause offence, appear ignorant or might be labelled as racist leading to a complaint.

3.38 **During the workshop, delegates considered the social, political, economic and psychological context** in which the work is taking place and the impact of those dynamics on their interaction with the diverse communities in Luton. The make- up of the work force, the cultures of their respective organisations and unconscious bias also featured in discussions. The need to have ongoing dialogue with different communities around safeguarding and mental health to raise awareness and enlist support was seen as important.

3.39 **Participants reflected on the extent to which political issues such as the war on terror**, funding to prevent radicalisation, Brexit, Rotherham, Rochdale, Oxford etc, FGM, witchcraft and spirit possession, has driven the agenda and influenced the way in which practitioners think about and work with the diverse communities in Luton.

3.40 **The stress caused by racism and discrimination on people's mental health should not be underestimated** as it can undermine some families' capacity to parent well. It is important for practitioners to understand the emotional impact on parents and children of managing in a "hostile environment". For some

the racism and discrimination they experience maybe very overt but for a lot it is the day to day racial subtle aggression- the slurs, innuendos, non-verbal messages that convey to those groups that they are ”other” and that they don't belong.

3.41 **Culturally sensitive practice is needed** that can challenge claims that certain behaviours are the norm, without losing sight of children's welfare needs. Practitioners need the space for reflective supervision to explore any fears about families thinking “ I am a racist”. Training about process and procedures is the easy part, the more challenging part is for people to confront their fears. That is the role of supervision and training and also for confronting as a team.

3.42 **Cultural competence**, is respectful of and responsive to the beliefs, practices and cultural and linguistic needs of diverse communities. There are five essential elements that contribute to an individual professional's, and a whole service's, ability to become more culturally competent. The professional and/or service must:

- Value diversity, valuing diversity means accepting and respecting differences. Even how one chooses to define family is determined by culture. Diversity between cultures must be recognised, but also the diversity within them. People generally assume a common culture is shared between members of racial, linguistic, and religious groups, but individuals may share nothing beyond similar physical appearance, language, or spiritual beliefs.
- Cultural self-assessment, through the cultural self–assessment process, staff are better able to see how their actions affect people from other cultures. The most important actions to be conscious of are usually taken for granted.
- Consciousness of the dynamics of cultural interactions, there are many factors that can affect cross–cultural interactions. There often exists an understandable mistrust towards members of the dominant culture by historically oppressed groups.
- Institutionalisation of cultural knowledge, the knowledge developed regarding culture and cultural dynamics must be integrated into every facet of a service or agency. Fully integrated cultural knowledge is the only way to achieve sustained changes in service delivery.
- Adapt to diversity, the fifth element of cultural competence specifically focuses on changing activities to fit cultural norms. Cultural practices can be adapted to develop new tools for treatment - i.e. a child or family's cultural background provides traditional values that can be used to create new interventions.

Questions for the Luton Safeguarding Children Board:

- Do practitioners truly understand the effects of discrimination and take it into account in their assessments and care plans?
- How do Board members as systems leaders, promote the ideas of race or culture in multi-agency working in Luton?
- How can the LSCB support the development and creation of tools/resources that recognise these distinct dynamics to assist practitioners in building their, knowledge, skills, confidence and competence?

- Would there be benefit in the LSCB undertaking an audit of assessments to establish the extent to which these issues are reflected?

Finding: 4 Working Together – Is Adolescent Mental Health Everybody's Responsibility?

Mental Health is not fully integrated into safeguarding systems in Luton. Self- Harm and suicidal feelings are often treated as purely mental health issues. This means that many of the factors contributing to the way the child feels may remain unaddressed.

3.43 **Context - Suicide and Deliberate Self Harm:** Preventing teenage suicide is a national challenge, research shows that accurately assessing risk is very difficult. The current culture of self-harming, dark thoughts and depression among young people makes it very difficult to differentiate those at most risk. Young people's suicide threats and attempts are often interpreted as teenage histrionics rather than cries for help. It is likely that even with the best risk assessment models, prevention of teenage suicide is often an impossible task.

3.44 **Most adolescent suicides are unplanned**, 25% of completed suicides by adolescents show some evidence of planning. Most adolescent suicides are impulsive acts, however in many cases there has been a history of suicide attempts and Deliberate Self Harm (DSH). Incidents of (DSH) has increased in Luton and also nationally. The pathways leading to the harm that adolescents experience are complex, not least because they involve adolescent choices and behaviours.

3.45 **Self-harm is not usually triggered by one isolated event** but by a set of circumstances that leave young people overwhelmed and unable to manage their feelings. It is not the core problem but a sign and symptom of underlying emotional distress, and often used as a way of coping. Self-harm should be differentiated from from a suicide attempt since self-harm may be the means by which the child or young person tries to survive emotional pain, rather than a desire to end their life. In some cases however it can be part of the same continuum, since they are both symptoms of acute distress and there is evidence that people who self-harm are at increased risk of suicide.

3.46 **It is well documented in research studies** that all types of maltreatment such as neglect and abuse, exposure to domestic violence etc, can affect a child's emotional, psychological and mental wellbeing, and these consequences may appear immediately or years later, manifesting in self destructive behaviours. While the negative effects on health and development can often, though not always be reversed, this requires timely identification of the maltreatment and appropriate intervention.

3.47 **In the Serious Case Review relating to Child L, the reviewers warned** " In a context where levels of deliberate self- harm (DSH) by young people are increasing, there is a risk of not exploring whether DSH, including a serious overdose, is either a safeguarding issue and/or indicates the onset of mental health problems for individual children, increasing the chances that some children will be left at risk."

3.48 **Suicidal feelings are often treated as purely mental health issues**. This means that many of the factors contributing to the way the child feels may remain unaddressed. It also means that in cases where a child is not found to be suffering from depression, professionals could mistakenly be reassured that a child will not attempt to take their own life.

3.49 **This raises a number of challenges and questions for professionals**:

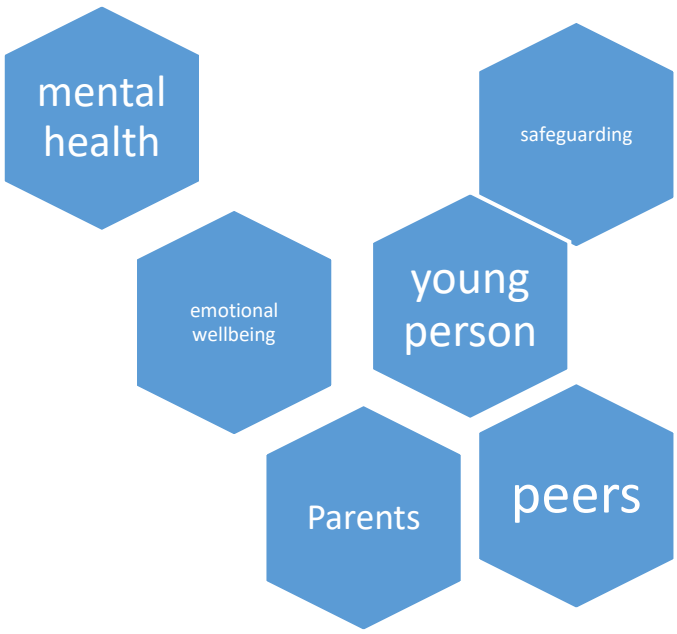
- At what point does self-harm become a safeguarding issue?
- Should self-harm and suicidal feelings be treated as a child protection issue and trigger a similar level of response to children at risk of harm from others?
- Does it only trigger a safeguarding referral if the young person who has self-harmed has made a disclosure?
- Should all the services working with a child be informed if a child is feeling suicidal, has attempted to kill themselves or self-harmed as they all have a role in protecting the child?

3.50 **Serious Case Reviews highlight the difficulty of how to help a young person whose needs are complex** but do not fall neatly into a system i.e criminal justice, children's social care, mental and health systems, or who do not reach the threshold for urgent intervention or for child protection. These young people either fall between services or are supported by a range of professionals who struggle to know how best to help. This is especially challenging when the young person and or their parents/ carers are unwilling or unable to engage with the services offered. Pockets of information held within different agencies are sometimes not shared, or are unable to be accessed, are overlooked or deemed not relevant, which hampers effective treatment solutions.

3.51 **Child and Adolescent Mental Health Services Feedback** - The workshop posed the question - How do CAMHS staff appropriately engage and support young people who pose risks of self-harm and suicide? CAMHS services in many of the cases involving child deaths by suicide are involved as the agency with case responsibility, they are viewed as the experts and agency to go to for advice and make referrals too. CAMHS was the case holder at the time of the death of both Child M and Child L. Child deaths have significant impact on staff who have been working closely with the young people and also impacts the organisation as a whole.

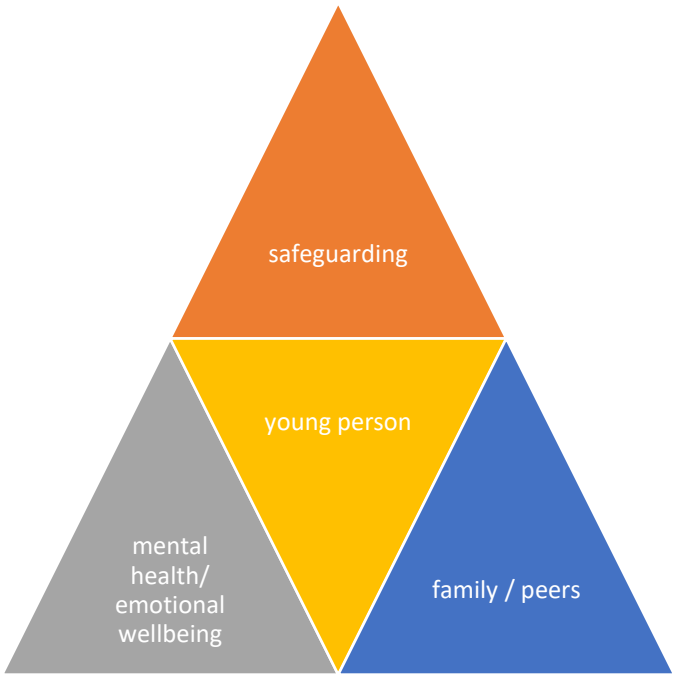
3.52 **CAMHS staff** who attended the workshop were disappointed with the poor representation from other agencies that is referred to at the beginning of this report, and felt that in the context of " Working Together" it was a reflection that currently mental health is not viewed as everybody's responsibility. There was acknowledgement that others valued their particular expertise in this area of work. However when there are child deaths or things go wrong, staff felt that there is a blame culture and lack of ownership on the part of all of the organisations in the safeguarding system. Participants felt that there is a need for shared ownership, responsibilities and accountability which does not belong solely to a single organisation. There was an ongoing theme throughout all of the workshops about the positioning and status of mental health within the safeguarding and child protection systems. Practitioners agreed that mental

health needs to be more fully integrated into safeguarding systems and processes. The current understandings are represented visually below.



3.53 **Different facets are boundaried with quite clear separation between them** and therefore tend to operate in relative isolation. Hence everyone struggles to make sense and connect across the system.

The diagram below attempts to visually describe how the system needs to wrap around the young person.



3.54 **Participants said** that a barrier to effective multi- agency collaboration is that partners were having to work within the guidelines of different documents e.g., Working Together, Safeguarding in Education, different threshold documents which are not being used together. As a consequence there are mixed messages and sometimes common sense gets lost in the process and sometimes because of the process. In relation to individual and collective ownership it was acknowledged that "I" and "WE" changes in terms of ownership. The assumption in "WE" is that others are dealing with the issue once a referral has been passed on. Individuals need to take responsibility for their own role in the process.

3.55 **Historically across the country** most of the funding available for safeguarding and child protection has been allocated to younger children and not adolescents. Adolescent-specific suicide prevention strategies should be implemented in schools, the community, and the health system aimed at increasing help-seeking for suicidal thoughts and behaviours; identification and referral of at-risk young people e.g by health and children's social care professionals, teachers, parents, community groups, peers etc; the reduction of risk factors for suicide; and promotion of mental health well- being.

3.56 **A number of positive examples of multi -agency initiatives were shared during the workshop including**:

- CAMHS provides support to families and schools following suicide
- CAMHS and Early Help schools liaison team.
- CAMHS delivering training in schools and other settings
- Pan Beds Suicide prevention plan
- Pan Beds self- harm pathway

Question for Luton Safeguarding Children Board

What steps can the LSCB take to promote a culture of collective ownership and ensure that adolescent mental health is integrated into safeguarding systems and processes?

Finding Five: Issues for schools in identifying and responding to vulnerabilities

The impact of cuts in other services has meant that schools are now having to deal with a much wider range of issues that may potentially impinge upon their ability to effectively safeguard pupils.

3.57 **Key issues from workshop**: School staff are perhaps best placed to notice how children are because they have contact with the same child on an almost daily basis. They can see changes such as in a child's appearance, behaviour, alertness or appetite and provide a degree of monitoring of the child's welfare, in effect, they can be the "eyes" for other professionals working with the young person. For older children in particular, school can be a safe and predictable environment that provides some respite from difficult or chaotic home circumstances. It was noted however that schools are no longer the safe space they used to be, incidence of self-harm in schools has grown, children do not feel safe anywhere because of the social media world we live in. Nationally Teachers and school staff have reported that they have insufficient knowledge about

wellbeing and mental health to be able to confidently support their students. In June 2015, the Teacher Voice Omnibus Survey reported that two thirds of teachers felt they lacked the appropriate training to help identify mental health issues in pupils. Just 32% felt they had received appropriate mental health awareness training for their job role, and over half of teachers named training on mental health and wellbeing as one of the most useful strategies a school can employ to support pupils' mental health. A recent survey of primary head teachers found that less than 40% felt confident that their staff would know how to respond if a pupil had a mental health crisis (Place2Be and National Association of Head Teachers, (2016). Teachers want to be able to promote the emotional wellbeing of their pupils, but need the training and support to do so.

3.58 **Workshop participants identified some of issues that were currently impacting** on their ability to cope with the growing numbers of young people presenting with mental health and emotional well-being problems in schools. Staff believe that unrealistic expectations have been placed on schools as a result of cuts in other services and as a result they are now having to deal with a wide range of problems in addition to their core task and without additional resources. Year on year there has been a reduction in the school nursing service, pastoral support and dedicated resources to deal with safeguarding concerns in schools.

3.59 **The review highlighted the range of criteria and frameworks that staff in schools can potentially be dealing with** in relation to adolescent mental health. These include 'Working Together to Safeguard Children (2018), Safeguarding Children in Education, Mental Health and Behaviour in Schools (2018) and also thresholds of different agencies. The documents can be confusing and contradictory. The 'Mental Health and behaviour in schools' guidance for example says that it will help schools identify 'whether a child or young person's behaviour may be related to a mental health problem, and how to support them in these circumstances'. The behaviour language in the document is not congruent with the mental health language, the descriptions included in it talk about "poor and disruptive behaviour, bad or unusual behaviour" In the context of mental health this is not helpful. There is little consideration that behaviour is one manifestation of mental ill-health and even suggests that one useful strategy could be 'behaviour modification'. Other outdated language includes saying that one risk factor is 'low IQ'.

3.60 **Within the school setting there are a number of opportunities for education staff to intervene** to protect children or prevent harm. Supervision was seen as critical in supporting staff and when functioning well, it is seen as a positive and empowering system by practitioners and managers alike; facilitating reflective practice and continuous improvement. The sample of professionals at the group were not clear that this ideal was always present in reality

3.61 **In order to be as protective and effective as possible** schools should promote good mental well-being for all pupils, and one way to achieve this is to ensure that the school is a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems. Current initiatives being piloted in schools with CAMHS and Early help were seen as very positive.

3.62 **Quality recording and monitoring systems are essential**. Having processes in place for clearly recording concerns and ensuring they are in one

place so that all information would be available to supervisors; for compiling and using chronologies in individual cases; and for ensuring that incidents are not just recorded but reviewed as well. Simple systems such as keeping a page per pupil rather than simply documenting incidents in date order in a diary can enable patterns to emerge and individual cases to be viewed in their entirety. Participants felt that since the introduction of the General Data Protection Regulation 2018, there was more reluctance to share any information [the perception is important as it impedes when in reality GDPR should enable] The more challenging and vulnerable the children become the more difficult sharing information becomes.

Conclusion

The learning review workshop process set out to explore in more detail 3 questions that arose following the death of Child M in order to understand practice from the viewpoint of practitioners and organisations; and also the circumstances in which professionals work together to safeguard children.

The process identified areas of good practice currently taking place, systems and processes that are in development; and also some improvements that were needed to consolidate good practice in relation to 5 key themes that emerged from the workshops.

A number of issues were identified in relation to each theme which have implications for future safeguarding practice with children and young people who self-harm and are at risk of committing suicide. Questions and issues have been listed for the LSCB and partner agencies to consider and take forward.

It is hoped that the findings from this learning review into the death of child M will be translated into programmes of action by the LSCB which will lead to sustainable improvements and the prevention of death, serious injury or harm to children and young people.

Appendix One - Support and training needs:

Findings: The review has identified distinct support and training needs for children and young people, parents/carers and practitioners.

1. **Children and young people:**
    - Meaningful engagement and participation of adolescents in promoting and supporting mental health and well- being initiatives
    - Developing peer education and support networks
    - Recruitment training and support of peer mentors/ educators, youth health advocates etc.
    - Curriculum materials/resources that support their capacity to make reflective decisions, considering risks and consequences. Approaches that focus on developmental mental health risks such as bullying, interpersonal violence, and social media risks.
    - Utilise the positive aspects of social media to facilitate online and mobile phone interventions to support prevention and promotion of access to clinical and other services.
    - Extend services access and availability- evenings and weekends,
    - How can young people be supported online and also through the use of apps

2. **Parents and carers**
    - guidance for parents and carers on how to reduce the risk of a further self – harm or suicide attempt, they should be given support and advice on how to protect their child following an attempt.
    - Build upon the work that CAMHS is currently doing to support parents and carers to manage their children's mental health issues.
    - Upskill a pool of multi-agency champions to educate parents and education staff around emotional and mental well-being.
    - Develop resources to help parents and carers keep their children safe in wider contexts outside of the home environment.
    - Partnership working with parents and carers to develop programs and resources

3. **Professionals**
    - Opportunities for practitioners to improve their own knowledge and use of social media to engage young people and alert / educate parents of dangers and risks.
    - Multi -agency forums to further explore some of the issues and questions raised in the report in relation to collaborative working.
    - Specifically noted for school staff but also applicable for staff in a variety of settings:
        - a clear understanding of the needs of pupils with mental health needs;

- an awareness of some common symptoms of mental health problems: an understanding of what is, and isn't, a cause for concern;
- an understanding of what to do if they think they have spotted a developing problem;
- strategies to ensure that stigma is reduced and pupils feel comfortable talking about mental health concerns.
- Specific support and training regarding race, faith, religion and culture:
    - Develop a training and development strategy along with resources to support roll out
    - Create opportunities for practitioners to develop their confidence and competence.
    - Community engagement to educate, be educated and enlist support in safeguarding children in Luton
    - Build performance objectives into supervision and appraisal processes
    - Undertake discrete pieces of research to better understand if and how national trends in mental health and BME communities are reflected in Luton.
- A teaching profession that feels sufficiently trained to speak about mental health and approaches issues confidently, would lead to an open and inclusive culture that would benefit students and teachers, and reduce stigma about discussing mental health in the classroom.
- With regard to training, staff should be helped to develop their knowledge to include:
    - a clear understanding of the needs of pupils with mental health needs;
    - an awareness of some common symptoms of mental health problems: an understanding of what is, and isn't, a cause for concern;
    - an understanding of what to do if they think they have spotted a developing problem;
    - strategies to ensure that stigma is reduced and pupils feel comfortable talking about mental health concerns.