Hull Safeguarding Children Partnership

Line Of Sight Theme:
Timely responses to self harm

Line of Sight (LOS)

The LOS process is a core function of the Hull Safeguarding Children Partnership (HSCP).

The process provides learning opportunities across the partnership to strengthen multi- agency working and focuses on improving outcomes for children and young people.

The process identifies specific learning themes through audit and multi-agency analysis. Learning is implemented across the partnership to improve practice across the safeguarding system

Who Requested the LOS?

Hull University Teaching Hospitals

Why was the LOS Requested?

A review was requested to explore the multi-agency response to this young person and whether this was timely, proportionate, and responsive to their needs. This includes the effectiveness of ensuring their safety and wellbeing and the co-ordination of responses by the agencies involved. There was consideration given to the pathways in place, which would support the decision making and actions in similar circumstances.

Background Information

A Line of Sight was held in relation to a young person, who was subject to an Interim Care Order and Deprivations of Liberty. The young person resided in a Local Authority children's home and required 2:1 support.

The concerns for this young person included frequent missing episodes and a risk of suicide or death by misadventure. There were over 20 attendances to the emergency department (ED) in a six-month period.

On the most recent ED attendance, there was a 12-hour period before presenting to hospital following a paracetamol overdose. The consultant in ED raised concerns in the delay to seek medical care which could have resulted in potentially life-threatening implications.

Factors in the review considered the roles and responsibilities of partner agencies to keep this young person safe and how the young person's needs were being met by all agencies involved.

Key Lines of Enquiry

- Were partner responses timely and appropriate?
- What was the factors which resulted in delayed presentation?
- How did partner agencies work together to meet the young person's needs?
- Was intervention effective to ensure the safety and wellbeing of the young person?

Hull Safeguarding Children Partnership

Key practice themes and learning

Key Practice Themes and Learning

1. Right Care Right Person

- The review considered the importance of understanding wider contextual issues which resulted in the delayed presentation to the emergency department. These included wait times for ambulance services, missing episodes, and responsibilities of professionals to transport to the emergency department.
- It is crucial that children and young people receive the right care from the right person in a timely manner to ensure their safety and wellbeing. This approach is adopted as a model in Humberside Police and is aimed at ensuring the right practitioner responds to needs as opposed to relying on one service.

2. Understanding Care and Responsibilities

- The review highlighted a need to develop a pathway which outlines clear responsibilities of corporate parents' when a looked after child requires crisis intervention and/or presenting at the emergency department.

3. Information Sharing and Record Keeping

- Practitioners need to consistently share information and triangulate this to provide a holistic picture of the presenting risks. The importance of relevant professionals being present at multi-agency meetings was highlighted and for minutes and actions to be circulated in a timely manner to ensure consistency of information on systems (i.e. risk management meetings). This, in addition to ensuring that the missing persons Philomena Protocol is followed and action plans are completed and shared with relevant agencies.
- In circumstances where DOL is granted by the Court there is need for Children's Social Care to share this information with all relevant agencies and for agencies to ensure that this is recorded within their individual records. It is important that agencies are aware of the requirements within the order so they can ensure the expectations can be met to keep the child safe.

Key Practice Themes and Learning

4. Out of Hours Support

- It is crucial that partners understand the function of the Hull Emergency Duty Team (EDT), particularly when support is required out of hours.
- This will ensure that emergency plans for children are subject to all relevant check and risk assessments.
- It is also important that relevant information is recorded on the system by Children's Social Care so that EDT have access to up to date information so appropriate plans can be made in an emergency situation.

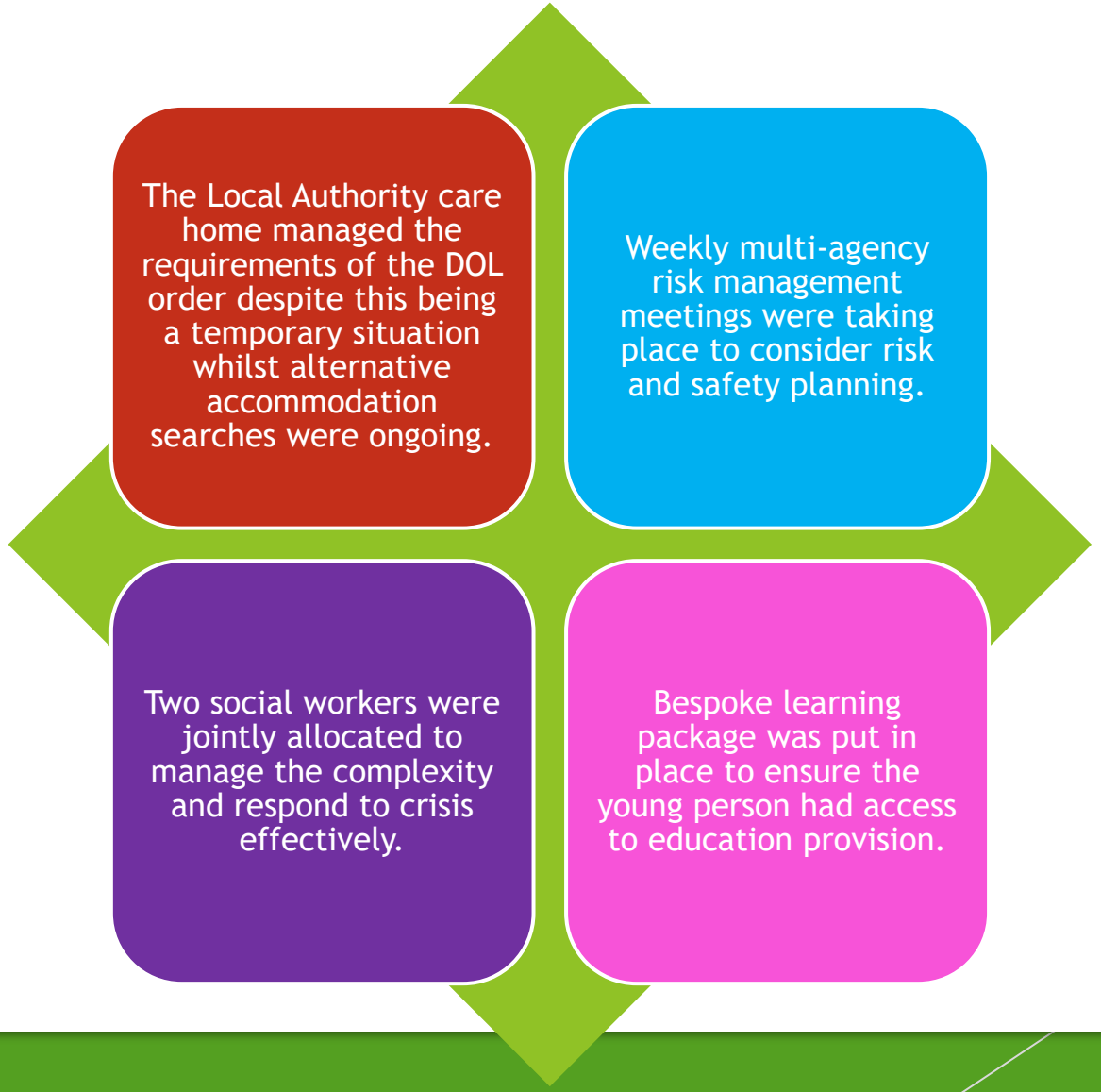
5. Escalation and Resolution

- Where issues between agencies arise involving the safety and welfare of children or young people, matters should be resolved in a timely manner. Partner agencies should utilise the HSCP Escalation and Resolution Policy to resolve professional differences.

6. Practitioner responses to overdose

- It is important that professionals recognise the severity of paracetamol overdoes which can result in liver failure and long-term health implications, including death. This requires prompt attendance to the Emergency Department so any medical intervention can be provided at an early stage.

Good Practice Identified



Hull Safeguarding Children Partnership

Useful Information

- Right Care Right Person – Humberside Police | College of Policing
- Escalation and Resolution - Professional Resolutions... (trixonline.co.uk)
- Thrive Directory Thrive Directory of Support (simplebooklet.com)
- HSCP Escalation and Resolution policy
- Training courses – Hull Collaborative Partnership
- Emergency Duty Team 01482 300304- Mon- Thurs 5pm- 8.30am and Friday 4.30pm – Monday 8.30am
- Worried about a child | Hull
- Information Sharing (trixonline.co.uk)
- DfE non statutory information sharing advice for practitioners providing safeguarding services for children, young people,parents and carers (publishing.service.gov.uk)
- Paracetamol (Calpol, Disprol, Hedex, Panadol) | Medicine | Patient
- Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)
- Suicide Prevention Ambassador Training A5 Leaflet.pdf
- Self-harm | Advice for young people | Get help | YoungMinds
- Self-harm in children and young people | Barnardo's (barnardos.org.uk)
- Top Ten Care leavers A4 poster_Layout 1 (hull.gov.uk)

1. Background and Concerns

A Line of Sight was held in relation to a young person, who was subject to an Interim Care Order and Deprivations of Liberty. The young person resided in a Local Authority children's home and required 2:1 support.

The concerns for this young person included frequent missing episodes and a risk of suicide or death by misadventure. There were over 20 attendances to the emergency department (ED) in a six month period.

On the most recent ED attendance, there was a 12 hour period before presenting to hospital following a paracetamol overdose. The consultant in ED raised concerns in the delay to seek medical care which could have resulted in potentially life-threatening implications.

Factors in the review considered the roles and responsibilities of partner agencies to keep this young person safe and how the young person's needs were being met by all agencies involved.

2. Purpose of the Review?

A review was requested to explore the multi-agency response to this young person and whether this was timely, proportionate, and responsive to their needs. This includes the effectiveness of ensuring their safety and wellbeing and the co-ordination of responses by the agencies involved. There was consideration given to the pathways in place, which would support the decision making and actions in similar circumstances.

3. Key Lines of Enquiry

- Were partner responses timely and appropriate?
- What was the factors which resulted in delayed presentation?
- How did partner agencies work together to meet the young person's needs?
- Was intervention effective to ensure the safety and wellbeing of the young person?

4. Key Learning

Delayed Presentation- factors included wait times for ambulance services, missing episodes, and responsibilities of professionals to transport to ED. It is crucial that young people receive the right care from the right person in a timely manner to ensure their safety and wellbeing.

Responses to Overdoses- It is important that professionals recognise the severity of paracetamol overdoes which can result in liver failure and long term health implications, including death. This requires urgent attendance to the emergency department for assessment and any required treatement to intiaited as soon as possible.

Care and Responsibilities- The review highlighted a need to develop a pathway which outlines clear responsibilities of corporate parents' when a looked after child requires crisis intervention and/or presenting at ED.

Information sharing and record keeping- Practitioners need to consistently share information and triangulate this to provide a holistic picture of the presenting risks. The importance of relevant professionals being present at multi-agency meetings was highlighted and for minutes and actions to be circulated in a timely manner to ensure consistency of information on systems (i.e. risk management meetings). This, in addition to ensuring that the missing persons Philomena Protocol is followed and action plans are completed and shared with relevant agencies. In circumstances where DOL is granted by the Court there is need for Children's Social Care to share this information with all relevant agencies and for agencies to ensure that this is recorded within their individual records. It is important that agencies are aware of the requirements within the order so they can ensure the expectations can be met to keep the child safe.

Out of hours support- It is crucial that partners understand the function of the Hull Emergency Duty Team (EDT), particularly when support is required out of hours. This will ensure that emergency plans for children are subject to all relevant check and risk assessments. It is also important that relevant information is recorded on the system by Children's Social Care so that EDT social workers have access to up to date information to make appropriate plans in an emergency situation.

Escalation and Resolution - Where issues between agencies arise involving the safety and welfare of children or young people, matters should be resolved in a timely manner. Partner agencies should utilise the HSCP Escalation and Resolution Policy to resolve professional differences.

5. Good Practice

- The Local Authority care home managed the requirements of the DOL order despite this being a temporary situation whilst alternative accommodation searches were ongoing.
- Weekly multi-agency risk management meetings were taking place to consider risk and safety planning.
- Two social workers were jointly allocated to manage the complexity and respond to crisis effectively.
- A bespoke learning package was put in place to ensure the young person had access to education provision.

6. Next Steps

- This 7-minute guide will be shared across the partnership to compliment discussions, training and learning in relation to identifying and responding to children and young people who self harm.
- Annual Thrive Conference to be held across the partnership in September 2023.
- Bitesize guide around 'right care right person' to be disseminated across the partnership.
- Pathway and procedure to be developed in relation to roles and responsibilities of all agencies for children who are looked after who require immediate responses and crisis intervention.
- Training to support practitioners with key learning points is available through the HSCP Learning Programme 2023/ 2024 and attached links (detailed above).
- Audit activity to be driven through Learning and Improvement subgroup.

7. Further information – links

- Right Care Right Person – Humberside Police | College of Policing
- Escalation and Resolution - Professional Resolutions... (trixonline.co.uk)
- Thrive Directory Thrive Directory of Support (simplebooklet.com)
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