Multi-Agency Learning Review
Self-Harm

FOCUS

The learning review was in respect of the service provided to a 14 year old boy who had an admission to hospital in September 2017 and was included in a multi-agency audit completed early this year.

BACKGROUND

The audits for child 4 again highlighted a case in which the agencies involved were not all fully aware of the issues the child was experienced; children's services and school were primarily concerned with child 4's anger and the family dynamic, with little information or knowledge around self-harming behaviour, whereas self-harm was the focus of the HYM input. It would be expected that effective multi-agency working would enable a holistic view of the child's needs to be developed, but in this case there were gaps and contradictions in what was known to agencies, and the CIN plan was not evident in order to understand how agencies had contributed to a multi-agency piece of work. Changes to child 4's circumstances following an allegation of assault by his Mum, lead to a significant improvement in his engagement with services and a reduction in risk. However, there were concerns around handling and recording in relation to this incident which warrants further exploration. It was highlighted that the GP had significant concerns around child 4, but there was little correspondence from social services in relation to the support he was receiving.

DISCUSSION

The session was well attended, unfortunately the representative form CSC who had work with the family was unable to attend but a team manager with good knowledge of the family was able to attend. Each agency provided a brief summary of their involvement including any concerns that they had.
The main issues appear to be around why the S47 investigation which was progressed for the subject's girlfriend but not the subject and there is no recorded rational behind this decision in the CSC records
Concerns were raised that the GP was unaware of the involvement of other services at the time of a visit to the surgery
There was conversation about the access to HYM and the referral process. On this occasion the young person had been initially declined despite a report that he had said 'wanted to die' What was not clear was the process and the amount of work that support the decision

LEARNING POINTS

1. There is a need for better communication with GP when young people are open to Tameside Families Together

Action- Tameside Families Together are to seek permission of all their Service users to write to their GP ensuring that the GP is updated on interventions.

2. All agencies and Service users need to understand the HYM process for making decision.

Action- HYM to produce a flowchart with explanations to show how decisions are made.

3. A clear rationale for the decision about the S47 needs to be added to the case file so that the reasons why the S47 were not progressed. **(GS to action)**