7 Minute Briefing: Child B 2018

Date: March 2021

1. Background

In 2020 the SSCP reviewed the death of a teenager who had taken their own life by suicide (hanging). Child B had no history of mental illness and no formal mental health diagnosis. 8 months before death the family had raised concerns regarding increased isolation and self harming and this was followed by several overdoses which had resulted in hospitalisation.

2. Context

Child B's family environment was uncomplicated, loving and very supportive.

8 months prior to death the school viewed Child B as "lovely, always smiling, lots of friends and a good student who was predicted to do well in exams"

Child B started to express low moods around 6 months prior to death and a rapid deterioration in mental health was recognised . A referral to specialist mental health services was made at that time.

3. Key Lines of Enquiry

- How effectively did agencies work together to safeguard Child B in response to his increasing anxiety and deteriorating mental health?
- Was the school response to Child B's emerging needs sufficient?
- Could more have been done to support Child B?
- Were police referrals into the MASH appropriately responded to?
- How did agencies respond to "Child B's voice"
- How effective was family mediation and support for the family
- At the time of Child B's second paracetamol overdose was there sufficient assessment of Child B's increasing risk of suicide?
- Was the response to Child B's deteriorating mental health appropriate and timely?

4. Findings (1)

There was evidence of good and exemplary practice by individual services and practitioners, particularly around record keeping, accounts of practice and assessments undertaken. However the things that did not go well were:

- Decision-making and practice were affected by unresolved differences of opinion between professionals within the multi-agency safeguarding network.
- Because the differing perspectives of the various agencies involved with Child B were not exposed, they never informed an agreed and integrated assessment of risk.
- Multi agency information sharing was good, but the difficulty lay in making sense of that information.

5. Findings (2)

Further issues highted were:

- **There was no opportunity for constructive challenge between agencies and disagreements became embedded as conflicts, which gave rise to distrust between agencies. This was compounded by a lack of professional curiosity.**
- **Each organisation generated and worked to various kinds of safety plans, risk management plans and plans to meet Child B's needs. This was confusing and unhelpful.**
- **The use of a range of different risk assessment protocols was profoundly confusing for Child B and parents. This highlights the importance of integrating risk assessment documents so that they can inform an effective, multi agency risk-minimisation plan**

6. Recommendations (1)

- Specialist mental health services to engage in effective collaboration and meaningful co-working with the team around the child, the child's parents, and the child's informal network of care throughout their involvement with children
- Need for more proactive planning for end of service involvement and transition across to other services
- All risk assessment procedures to be transparent and easily understood by practitioners across different settings.

7. Recommendations (2)

1. Ensure all staff are aware of and consider the range of early help services available to children and families whilst awaiting specialist assessment.
2. All plans to be rationalised to ensure integrated, coherent, consistent and holistic multi agency working
3. Consider use of Risk Minimalisation Plans
4. SSCP to seek assurances that frequently occurring difficulties between agencies do not compromise working together
5. Ensure all practitioners understand and are confident to use the Professional Disagreement Escalation Policy.
6. ICPC thresholds related to children who attempt serious harm or suicide to be implemented consistently and always managed with a team around the family.

See also:

Thematic Review of Adolescent Suicides in Surrey

Suicide Prevention Toolbox