7 Minute Briefing: ASH

Date: October 2023

1. Background

This review relates to a young person (ASH) who died by suicide at the age of 17 years. The youngest of 2 siblings, ASH's parents separated when ASH was just 8 years old and both siblings went to live with Mother. At the age of 14 years ASH's behaviour started to deteriorate at School and there were concerns raised about possible child exploitation and substance misuse. ASH went to live with Father and his new partner and a decision made to commence home schooling. Prior to ASH's death there is evidence of substance abuse, drug dealing and being involved in county lines. Mum returned to live in her native country after the divorce proceedings were finalised, and invited ASH to accompany her but ASH decided to stay in the UK.

2. Key Life Events

- Sexually abused by another child whilst at Primary School – not reported to Police but ASH moved to private school
- At Secondary School ASH's alleged abuser was in same School - no action taken as School were unaware of the history.
- Ash became involved in smoking and drugs and associated with a group of young people known for anti social behaviour
- At 14 years Parents divorced and ASH moved to live with Father and partner. Decision made by Father to home school ASH
- At age 15 ASH was attacked in the street – believed by Father to be a drug deal gone wrong but not reported to Police. ASH later admitted both drug taking and drug dealing.
- At age 16 Ash was seen by a private paediatrician and diagnosed with ADHD. Medication was prescribed.

3. Key Findings (1)

Unwillingness of parents to share information or work with statutory services, presented a challenge for practitioners who have a responsibility to understand and identify those factors which might increase risk of harm for a child or young person

The death of Ash highlighted the importance of assessments which identify the root cause of behaviours through understanding the child in the context of their history. Cumulative stresses in a young person's life need to be understood.

The signs that Ash may be vulnerable to criminal exploitation began whilst living with Mother but intensified after the move to live with Father. There were accumulating concerns which taken together should have prompted a multi-agency strategy discussion in Surrey, if all concerns had been known and shared at that time.

4. Key Findings (2)

Where medical and psychological assessments are carried out by private consultants it is vital that findings are communicated to GPs in local community services so that they can be included in multi agency decision making. The private diagnosis of ADHD and the prescribing of medication was not shared with other services, including the GP.

The decision to educate Ash at home coincided with a move to live with his father and a change of area. The decision was made in good faith but the effect of this was that ASH became invisible to all services. There is currently no legal obligation for a parent to register or inform a local authority that their child is being educated at home.

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5. Recommendations (1)

Partnerships should work closely with parents to explore barriers to open and honest dialogue with statutory agencies. These findings should be used to develop the skills of practitioners in exercising appropriate curiosity, understanding how biases might affect responses and reducing barriers to information sharing.

Staff development strategies need to ensure that practitioners understand the impact that parental acrimony and conflict may have on children and are able to use this knowledge to inform all assessments and responses.

Supervision arrangements should be reviewed to ensure that: professional curiosity is embedded in practice, practitioners make the necessary enquiries when a child is being home schooled and that in families where parents have separated, all adults with parental responsibility are being consulted throughout the process.

6. Recommendations (2)

Review current national guidance and ensure that a patient's GP is copied into all private consultations for all children under 18. Consider how to engage at a local level; with private providers and families who use private provision, to encourage appropriate information sharing with NHS services.

To lobby the Department of Education to give local authorities enhanced powers and greater access to children that are being electively home educated (EHE) so that they can carry out their safeguarding responsibilities more effectively.

To develop local multiagency EHE safeguarding procedures and staff development activities in light of the findings of this case.

7.Further Reading

The full report for Child ASH review can be found on the SSCP website

Surrey Thematic Review of Probable Adolescent Suicides Surrey Thematic Review of Probable Adolescent Suicides 18 month update report (Mar 22)

Surrey Suicide Prevention Toolkit