Child M Learning Briefing

NOTTINGHAM CITY Safeguarding Children BOARD

How this document can be used

- Please read this document carefully and consider the learning in respect of families you are currently working with.
- Keep this document in a handy place to support easy reference in future work.
- Take this document to team meetings and share with colleagues.
- Use this document in supervisions for reference and to support case management / reflective practice.

Case Summary

Child M was a young person who died after being found hanging in her home. She was a young person engaged and doing well in education, with aspirations to achieve. Child M had experienced some disruption and trauma in her early life which led to extensive social care involvement. This ended several years prior to her death. Child M had recently experienced a relationship breakdown. She did not have a history of self-harm.

Learning

The review identified that Child M did not display any outwards signs of distress, she presented as happy and engaged in her studies, and friendship group. The review concluded that there was no information known or held by agencies that would indicate prior to the death that Child M would take the course of action she did. As with any review, the evaluation of professional practice and previous interventions offers a learning opportunity. These universal learning points are set out below.

Managing risks, without criminal charge or conviction

On examination of historic case files, this review identified positive practice in terms of clear communication of risks to the primary parent. This was achieved through:

- Very frank and open discussions
- The use of clear and explicit language to outline risks, without ambiguity
- Communicating a strong message of belief in the child/ young person's account
- Good multi-agency information sharing, and collective communication of a consistent message.

Learning – It is critical that in cases where the Crown Prosecution Service make a *no charge decision* in relation to alleged abuse that Social Workers must clarify and understand the basis for this decision and not assume that the incident did not happen, and/or that no safeguarding actions are required. Workers remaining involved must:

- Not lose sight of the perceived risks – no charge being made does not necessarily mean that abuse has not been perpetrated
- Ensure robust management of any identified risks
- Make clear within case records the reason for no charge decision. In a prominent place that ensures it will be given full consideration in any future involvement.
- Provide appropriate practical and therapeutic support to the child / young person

Closing cases / ending involvement

Issues present in this case:

- The review identified that after a period of statutory involvement, when the case closed to Children's Social Care, the ongoing contact plans and contingency plans were not as well communicated as they could have been.
- This had impact in two ways:
    - Lack of clarity for those remaining involved with the family
    - Lack of clarity at the point of re-referral, resulting in a shift in focus away from critical concerns.

Learning

- Standard practice at the point of closure to social care should include:
    - A robust multi-agency meeting / decision making process*
    - Attendance at that meeting / forum by all key organisations / agencies. If you are unable to attend you should make arrangements to provide information to the meeting, and to obtain the outcome, recommendations and decisions.
    - Full circulation of the minutes and associated plans outlining agreed expectations of those agencies remaining involved.
    - Challenge if you are not clear about decisions or expectations.
    - Full feedback to the family and clear recording of discussions with them and expectations outlined to them.

* In some cases, communication between professionals outside of the Child in Need review meeting may be adequate to support decision making, particularly where cases have been open for a very short time.

Being informed / taking personal responsibility

Issues in this case:

- The review found that several agencies who were involved in the multi-agency support and interventions with this family did not have copies of critical meeting minutes, plans, and closure summaries / information.

Learning

- Individuals must take personal responsibility for ensuring that they receive minutes / plans and associated information for all meetings that they attend. This includes providing a clearly recorded **secure e-mail contact for the circulation of documents.**
- Individuals must take responsibility for checking these documents for accuracy, understanding of actions required, and contact the chair if there are any discrepancies or lack clarity.
- All agencies should have in place a system to prompt and support workers to secure minutes and associated documentation for their own records.

Research informing the review

Key principal

One of the key principals of a learning review is to make use of relevant research and case evidence to inform findings. In this review the author considered research conducted by Manchester University[1]. This study "*Suicide by children and young people"* looked at 285 children who had died as a result of suicide. The study identified ten significant themes and experiences in children and young people who have committed suicide, and Child M was known to have experienced four of these during her life. (See below)

This research reflects the work being undertaken locally to ensure children who have experienced early trauma, and adverse childhood experiences, are properly recognised and supported; even where they do not appear to be presenting concerns.

Ten common themes in suicide by children and young people

1. Family factors such as mental illness
2. Abuse and neglect
3. Bereavement and experience of suicide
4. Bullying
5. Suicide-related internet use
6. Academic pressures, especially related to exams
7. Social isolation or withdrawal
8. Physical health conditions that may have social impact
9. Alcohol and illicit drugs
10. Mental ill health, self-harm and suicidal ideas

Further reading

Derby LSCB SCR, which considered the impact of a legal decision
http://www.derbyscb.org.uk/media/derby-scb/content-assets/documents/serious-case-reviews/DD12-Final-Overview-Report--12-05-14.pdf

Sutton LSCB SCR, which also considered the impact of a legal decision
http://www.suttonlscb.org.uk/files/professionalsdocs/SSCB%20CHILD%20D%20OVERVIEW%20REPORT.pdf

For more information about learning from reviews please visit the
Nottingham City Safeguarding Children Board website at www.nottinghamcity.gov.uk/ncscb

[1]Suicide by children and young people. National confidential inquiry into Suicide and Homicide by people with mental illness (NCISH). Manchester University, 2017