Pan-Dorset Safeguarding Children Partnership

SERIOUS CASE REVIEW
S39 – CHILD A

Independent Reviewer
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INTRODUCTION

1. This Review concerns a teenage boy who died in 2019. The inquest, held in March 2020, recorded death by misadventure, as the coroner was satisfied that he took his own life but did not intend to do so. To preserve his anonymity the child is known as Child A. His mother is referred to as Ms AM.

2. Child A was an active child who enjoyed sport and being outdoors. He attended school regularly, participated in after-school activities and was achieving his potential. He was popular with his peers and had a number of close friends.

3. Child A lived with his mother, Ms AM, in an affluent area of the county. Child A's parents had separated, when he was about eight years old, and he had little contact with his father. The subsequent divorce appears to have been traumatic for Child A and reports from his friends and family indicate he struggled with his feelings right up to the time of his death

4. When he was 12 years old, Child A experienced a further loss when his mother's new partner, with whom he had formed a close relationship, moved out of the family home. Despite their best intentions, there was no continuity of contact and Child A was talking to a counsellor about his sadness and anger about this in the days leading up to his death.

5. At the time of his death, Child A was at home, drinking alcohol and in touch with friends on social media about the recent break-up of his relationship with a girlfriend. For Child A's family, and those who knew him, Child A's death was a great shock. The practitioners are an experienced group and at no time did they consider him at risk of self-harm or suicidal behaviour.

AGENCY INVOLVEMENT

Agency	**Involvement**
CAMHS, 2012	In 2012, Child A's parents separated. Child A was angry and upset and his GP referred him to CAMHS. An assessment concluded his feelings were very raw and he was not ready for therapy, he did not want any further work at that time. Child A's father moved abroad and he did not see him for about a year.
GP	Ms AM struggled to cope with the separation and was treated by the GP for depression. Child A continued to struggle with his feelings and, in 2014, Ms AM discussed her concerns about Child A with the GP with a view to a possible re-referral to CAMHS. Child A

	was reported to have said of himself that "he'd be better off dead."
Police, 2012/13 and 2018	In 2012, the police warned Ms AM following incidents of anti-social behaviour following the breakdown of her marriage. In 2018 Ms AM's relationship with a new partner ended. Child A was reported to be very upset. The police noted a further episode of anti-social behaviour from Ms AM in relation to the separation and spoke to her. The incident was considered to be a potential public order offence (not a domestic incident) and, as Child A was not present, there was no reason to share the information.
School	In November 2018, Child A was receiving support from a counsellor at school and spoke about his low self-esteem and lack of confidence and questioned whether "it was worth going on." The counsellor assessed that Child A showed no suicidal ideation and his mood improved over the next few weeks. At the same time Child A reported difficulties at home including arguing with his mother, an assault, increasing violence over the previous four months, domestic abuse in his parents' previous relationship and his concerns about his mother's well-being. The school made a safeguarding referral to Children's Social Care.
Children's Social Care, 2018	Children's Social Care carried out an assessment, within the Child in Need Framework. Children's Social Care concluded the issue was primarily about "over chastisement" and a Team around the family (TAF) meeting was held to discuss support for the Child A and parenting skills work for his mother. Children's Social care concluded there was no further role for them and the case was closed.
School, 2018	Ms AM requested additional support from the school for Child A. School staff were alert to Child A's needs and monitored his mood and behaviour. This included sometimes being distracted and tired, but nothing which was unusual for a child of his age. His behaviour at home was reported to be that of a "proper teenager" and his mother was considering referring him to a private counsellor to help him address his anger.

	Child A had two sessions with the school counsellor and discussed his distress about not seeing his mothers' former partner and also what was going well for him. His academic work was described as slipping and plans were put in place to address this.
Private Counselling	In 2013, the GP records indicate Child A was seeing a private counsellor, no details were available to the Review. During 2018 and up to the time of Child A's death, there were several mentions of the possibility of private counselling for Child A and his mother. Although Ms AM received a service, Child A was able to use the counselling service at school.

ANALYSIS OF PRACTICE

6. The single episode of multi-agency working came from the referral by the school to Children's Social Care in November 2018, six months before Child A's death.

Referral and Assessment

7. Child A reported difficulties in his relationship with his mother, which led to a Safeguarding Referral from his school to Children's Social Care. Referral information was detailed, clearly recorded and passed promptly to the local Multi-Agency Safeguarding Hub. (MASH) Children's Social Care decided an assessment would take place within the Child in Need framework and a Social Worker visited the school and spoke to Child A and his mother. This was followed up with a home visit.

8. Although the referral information included reference to ongoing violence, a possible injury and parental behaviour, the referral was not considered to meet the threshold for a multi-agency Strategy Discussion (Section 47 enquiries.)

9. The decision to work within the Child in Need (CIN) framework appears to be based on the need for a proportionate response to a high number of similar referrals about adolescents reporting relationship difficulties without corroborating evidence. The plan was to speak to Child A and his mother the next day and arrangements were made for him to stay with friends overnight.

10. Children's Social Care completed the assessment and concluded that the key issue was "over chastisement", which had come about as a result of Child A's challenging adolescent behaviour and his mother's frustration. The assessment indicated Ms AM would benefit from parenting skills work and she was given appropriate information about how to access this. It was also considered that Child A would benefit from support and counselling, which was available to him at school. Ms AM agreed that she would not use physical chastisement in the future.

11. Children's Social Care decided there was no further role for them and convened a meeting with school staff and Ms AM to agree the plan before closing the case. Despite the intention to close the case, the process by Children's Social Care as a Team around the Family meeting (TAF), although the only practitioners involved were school staff and the social worker who was closing the case.

12. The referral process worked well and the assessment was carried out promptly.

13. Because Children's Social Care had decided the case did not meet the threshold for Child Protection enquiries, there was no Strategy Discussion and information, which was available, did not become known until after Child A's death. Further enquiries could have found that Child A's mother had been treated for anxiety and depression and had been warned by the police about anti-social behaviour relating to the breakdown of her relationships.

14. Discussion with practitioners about the referral process highlighted the potential for misunderstanding about decision making and the information available to Children's Social Care. The assumption made by the school (based on information about how to make referrals) was that referrals made to the MASH always lead to the seeking of information and input into decision making from health and the police.[1]

15. In addition, Children's Social Care decided to step-down the case and held a meeting at the school described as a "Team around the Family" (TAF) meeting. The title suggests more than one agency would be involved and, as the purpose of the meeting was not made clear, school staff expressed surprise that other practitioners were not invited.

Early Help

16. Within the County, resources are available from an Early Help service known as the Family Partnership Zone (FPZ) which can offer, for example, parenting skills work. In effect, the meeting was a Children's Social Care case closure meeting. In the referral, the school had indicated that family therapy might be an appropriate outcome following the referral, this suggestion appears to have been lost in subsequent discussions.

Information Sharing

17. The information, potentially available from police and health (GP), was not included in the assessment and there was insufficient enquiry and analysis about the impact on of the reported escalation in violence and parental behaviours on Child A.

Participation of Fathers

18. At the time of the assessment, Child A had had no contact with his father for a year. The assessment team was newly formed and had exceptionally high caseloads; it was not unusual at that time that absent parents would not be contacted or included in Child in Need assessments.

19. Practitioners report that practice has since evolved and absent parents are now routinely invited to participate in assessments; case audits include monitoring this aspect of assessment practice.

EVENTS LEADING UP TO CHILD A'S DEATH

20. In the six months following the Child in Need assessment, close monitoring at school indicated some tensions at home, episodes when Child A was angry and distracted, all of which was seen by the school as normal adolescent behaviour.

[1] The referral process has since changed and information for referrers is now clear about how decisions to proceed are made.

21. Two weeks before his death, Child A referred himself to the school counsellor and had two sessions in the ten days leading up to his death. The content of the discussion was around Child A's feelings of rejection from his mothers' former partner and what was described as typical adolescent feelings about wanting more time to do the things he liked. By the second counselling session, Child A appeared to have a more positive outlook and was making plans for the immediate future.

ASSESSING RISK IN ADOLESCENTS

22. During this Review, closer exploration of the events in Child A's life and building a more complete picture suggests Child A demonstrated sporadic indicators of distress, although never to the point where he was considered to be at risk of harm.

23. Discussion with practitioners, who participated in the Review, highlighted the challenges as:

    - recognising the impact of childhood trauma, commonly associated with adverse childhood experiences (ACEs)
    - understanding protective factors and how they relate to child's safety and wellbeing
    - In particular, practitioners discussed the challenge of assessing risk and observing the risk trajectory in adolescents who can struggle with emotional regulation and whose behaviour can be dramatic and impulsive.

LEARNING POINTS

A. For all agencies it is important to understand the referral and subsequent decision making process, when a referral is received by Children's Social Care. If the referral is not considered to meet the threshold for Section 47 enquiries (Child Protection), the decision about how to proceed is made by Children's Social Care.

B. It is important not just to understand and explain, but to consider the potential impact of parental behaviours on children, this includes adolescents. Referral information, which indicates risk of harm, must be considered within the Child Protection context for all children, including adolescents.

C. When assessing the presence of "Protective Factors" it is important that practitioners consider both emotional and physical safety and the *absence* of factors as well as those which are evident. For example, parental resilience, established boundaries and parenting skills.

D. For this child, his father, although absent, was an important part of his life. Inviting absent parents (and those with a significant parenting role) to participate in assessments is likely to lead to a more complete picture of the child's life and understanding of family relationships.

E. The research shows that when a teenager takes their own life, stress factors can combine and increase over time and may be triggered by a crisis, for example, a relationship breakdown. For practitioners, this indicates that it is important to see the bigger picture, to fully assess the risk trajectory and not just focus on a single incident.

F. When family members are accessing private services, such as counselling or therapy, there may be information which is hidden from practitioners when they are considering risk. An awareness that there may be unknown risk factors should prompt practitioners to ask questions and check with other agencies (GPs are often the recipients of health information) when assessing risk to children.

RECOMMENDATIONS FOR THE PARNERSHIP

24. Child A's death appeared to be an unpredictable event and a great shock to those who knew him. It is inevitable that, in the course of a practice review, reflections on a child's life and on the work of the practitioners will enable a more complete picture to emerge than that which was known at the time. This inevitably raises the question of whether more could have been done to protect Child A.

25. In this case, there is some generic learning for all agencies working with adolescents and their families. Overall, the work carried out with the family was proportionate

and focussed. There were no indicators of risk, which might have prompted further assessment or intervention.

Recommendations are:

- That the work on developing a Suicide Prevention Strategy is completed and includes specific consideration of teenage suicide.

- That opportunities are made available for practitioners to explore and share knowledge and current research about teenage suicide, to increase understanding and promote an effective multi- agency response.

- That consideration is given to how Early Help can integrate support services for children severely affected by divorce and relationship breakdowns, to reduce the impact of childhood trauma.

- That the Partnership considers if, and how, information held about children by independent service providers (for example counselling services) can be integrated into risk assessments.