Lessons Learned and practice pointers

- All staff working with children should ensure they read and understand the Childhood Neglect Guidance – this can be accessed at http://northumberlandlscb.proceduresonline.com (chapter 1.5.4)
- All staff working with children should familiarise themselves with the procedure and care pathway for the management of self harm and or suicidal behaviour in children and young people. This can be accessed at http://northumberlandlscb.proceduresonline.com (Chapter 1.4.33)
- Children's Social Care should always allocate cases involving attempted suicide to an experienced Social Worker who has completed relevant training and is well acquainted with the care pathway.
- Where children up to the age of 18 attend A & E due to self-harm or substance misuse, referrals to support services should be made, as set out in procedure – http://northumberlandlscb.proceduresonline.com (Chapter 1.4.33)
- Thresholds for risk of significant harm should be clearly understood by all agencies – the Multi-Agency Thresholds Document can be accessed at http://northumberlandlscb.proceduresonline.com (Chapter 1.1.2)
- If there are any concerns that a child is in need of protection, the usual Child Protection procedure should be followed.
- All agencies and professionals share a responsibility for effective joint working arrangements.
- Professionals should NOT be content to accept assurance from parents that children are safe and ok. The wishes and feelings of the child must be sought and clearly listened to.
- Adolescents should always be viewed as children, not adults.

Details have been changed to protect the identity and privacy of family members and professionals involved in this case.

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Keeping Children and Young People Safe from Harm, Abuse and Neglect

Northumberland Safeguarding Children Board

Highlighting Lessons from Management Review

Local

Date of Review: December 2012
Local Authority: Northumberland
Name: Matthew

Outline

Matthew hanged himself in 2011. Matthew's family were known to Children's Services, Education and Health agencies from 1993 when Matthew's older sibling alleged his father had injured him. Thereafter, there were further instances of excessive physical chastisement of the children and several serious accidents which were indicative of neglectful parenting.

Matthew's Father was sentenced to 12 years in Prison for committing murder, 5 years prior to Matthew's death. Matthews Mother experienced difficulties in looking after him and his siblings, in terms of their behaviour.

Matthew had previously attempted to hang himself on two other occasions, which resulted in a referral to specialist mental health service. Although three appointments were not kept, two were attended and the mental health service discharged him, concluding that he was not suffering from a mental illness.

Additional support was put into place for the family on a Child in Need basis. Serious violent episodes occurred within the family, perpetrated by Matthew's older sibling. At the time of his death, Matthew was attending vocational training, and there were no concerns regarding substance misuse. Matthew had a close relationship with his Grandfather who died weeks before Matthew took his own life.

Summary of Findings

1. There was a failure on the part of all agencies and professionals to fully recognise, the potential significance and seriousness a suicide attempt by a child or young person represents.

2. No appropriate action was taken regarding Matthew's suicide attempt despite there being 2 sets of multi-agency policies and procedures in place that specifically set out the pathways and context required to do this – NSCB has produced new procedures for the **management of self harm and or suicidal behaviour in children and young people**, this replaces the 2 previous procedures and includes a care pathway. This can be accessed at http://northumberlandlscb.proceduresonline.com (Chapter 1.4.33)

3. Matthew was categorised as Child in Need and multi-agency working was not sufficiently robust to ensure an effective response to risk. This allowed failure to respond to a pattern of events that escalated in the latter part of Matthew's life. It was compounded by changes to arrangements for managing contacts, coordinating information and referrals to children's social care.

4. Throughout the review period there appears to have been a difficulty on the part of all agencies and professionals in recognising the incidence and prevalence of violence within the family and between siblings.

5. At a key point in the review period the suicide attempts were seen solely as a mental health issue. An effective mental health perspective could have informed multi-agency working, as opposed to being focussed on eligibility.

6. Matthew's older sibling was the subject of continuous and significant interventions by a number of key agencies. The incidence and nature of his presenting behaviours should have raised concerns for the safety of other family members, but did not serve as a trigger for intervention under safeguarding procedures.

7. There were 2 episodes of ‘Child in Need’ led intervention and assessment; these did not result in a level of understanding, analysis and joint working that challenged the view that the parent was able to meet the needs of the children and keep them safe.

8. It does not appear that any agency considered that attempted suicide or other indicators of risk could have resulted in the application of the 'significant harm' criteria. Had this have been applied, it would have provided a framework for more effective joint working within an established and reasonably robust process.

9. Although some professionals had regular contact with Matthew and had a sense of who he was and what his world was like, they were not sufficiently empowered by the system for their knowledge to be influential.