# Gwent Safeguarding 7 Minute Briefing

# Suicide and self-harm: Child Practice Review (Child K)

## What to do Learning Opportunity

**Reflect** on the case discussed and think of how this situation could have presented in your work with vulnerable individuals?

**Ask** Are there any similarities in cases you have worked or situations you have encountered? Are there clear thresholds between agencies and pathways to address conflict?

**What** would you have done in a similar situation when working with vulnerable individuals? And what are the barriers to practice in your organisation?

**Identify** key support for yourself in your team.

## Briefing

In 2015, the South East Wales Safeguarding Children Board (SEWSCB) undertook a learning event and child practice review into the tragic death by hanging of a teenager in Gwent. These 'messages for practice' are based on what we found when we looked at the young person's story.

This Briefing will look at the published review and will aim to highlight the learning from the findings.

It is important to note that this briefing is a concise summary of learning and not a full copy of the report. The report in full can be accessed using the web link contained below in the footer of this document.

## Key Learning

### The Child's Voice

The young person lacked trust in professionals who faced difficulties in engaging with her. Many did not fully appreciate how the family history might have created barriers for her in allowing workers to fully understand her world. This adolescent was able to disengage with professionals, deny incidents of concern and mask the true extent of her issues. Professionals recognised that she needed to speak to someone but found it difficult as she refused to engage.

Services concentrated on supporting her mother, potentially losing focus on the young person. The Learning Event stressed the difficulty in engaging with adolescents particularly with regard to emotional safety and wellbeing and how a child's presentation and their behaviour should inform our risk assessment.


## What Research Tells Us

Suicide is a major cause of death amongst the 15 to 44 group. In Wales, over the period 2010-2012, it accounted for almost one in five deaths in males aged 15 to 24 years and just over one in ten deaths of that age. (Welsh Government, 2015, 'Talk to Me Suicide and Self Harm Prevention Strategy for Wales 2015-2020)

## Key Learning: Working without full knowledge of family history

The learning event concluded that for the young person's case there was an over reliance on information from family members. People accepted information from the young person's mother without further analysis / challenge or a consideration of alternative explanations. There was no real assessment of the mother's motivation or capacity to take protective action. This would have been helped by sharing the historical overview of family functioning.

## Key Learning

### Quality of referral and interagency communication

It appeared that agencies made assumptions about other people's roles and responsibilities; how other professionals were responding to and dealing with information and what everyone knew (or didn't know).

This led to a presumption that risks were being addressed when in fact they weren't. Perceptions about knowledge and expertise between agencies created a barrier to effective professional challenge.

The Learning Event questioned how professionals might feel more confident and enabled to ask pertinent questions of others, and to use supervision and support more effectively to reflect and analyse concerns. Practitioners discussed the benefit of having 'meaningful conversations' with others particularly around analysis of risk, referral processes and adherence to procedures. It was considered important to understand 'what constitutes a good quality referral' and how to most effectively use multi-agency forums (e.g. core groups) to share case histories and local knowledge.

## Key Learning

### Responding to non-fatal suicidal attempts

Prior to her death, the young person had already made an attempt to seriously harm herself, and had been undertaking high risk behaviours since a much younger age. The agencies involved addressed risk in isolation and there was no bringing together of the wider picture to agree a safety plan. When serious attempts are known it is important that they trigger a multi-agency response within a child protection framework to determine the level of risk and agree a safety plan.


Welsh Government, 2015, 'Talk To Me Suicide and Self Harm Prevention Strategy for 2015-2020
http://gov.wales/docs/dhss/publications/150716strategyen.pdf

The following web link provides you with access to the full Child Practice Review report:
http://www.sewsc.org.uk/fileadmin/sewsc/documents/Published_SCR_CPR/SEWSCB_2-2015_Child_Practice_Review_Case_K_Report.pdf