



Lessons Learned

Grace's Story....

In early 2021, 13-year-old Grace made a significant attempt to end her life. Grace was living with her mother, her mother's partner and the youngest two of her siblings in a one-bedroom flat at the time. This event was subsequently followed by another attempt 4 months later.

Grace had a difficult childhood. She has largely lived with adults who had significant vulnerabilities of their own in a neglectful and risky home environment. Grace also experienced disruption due to several moves between family members. Her mother is known to have substance misuse issues and problematic drinking, domestic abuse in her current and past relationships, poor mental health and previous suicide attempts. The children's father is also known to have misused alcohol and substances. Grace's siblings have been known to services at various points during their childhoods, including three periods were subject to a child protection plans due to their parent's substance and alcohol misuse and neglect of the children

Concerns about Grace's emotional state were first shared with professionals in 2020, five months before her significant attempt to end her life. During this time Grace reported to suffer from severe headaches, anxiety, depression, and hearing voices to which support was provided by CAMHS.

Following Grace's attempt to end her life in early 2021, the family were supported under a child in need plan. There were various indicators that Grace's needs were not being met at home in the months that followed the attempt to end her life, and that her mental health was being impacted on by this and her history of emotional abuse and neglect. The decision to escalate to an Initial Child Protection Conference (ICPC) in late 2021 was made after an incident where Grace was taken to A&E due to being very distressed and requiring a CAMHS assessment, followed by Grace's mother's statement that she no longer wished to cooperate with a child in need plan and one of the siblings stating she had been physically assaulted by her mother.

What we have learned....

For Grace, there were indicators at the time being considered by this review that her behaviours were a reaction to long term abuse and neglect and inconsistent and vulnerable relationships with her care givers. The initial focus was on the recent issues in her life that may have led to the overdose, as more information was shared about the family history and the parent's own issues, the more insight there was into the root causes of her issues.

Learning for Practice: *In order to understand what a child might be communicating by their behaviour; professionals need to build a relationship with a child and seek to understand the child's current and past lived experience.*

Several professionals and her mother were aware that Grace was sexually active at a young age. During her hospital stay following the attempt to end her life in early 2021, a CSE questionnaire was completed with Grace by hospital staff, and it emerged that she had a boyfriend in the year above and was sexually active. Grace had been prescribed the oral contraceptive pill at her mother's request some months before, and this happened without the GP seeing or speaking to Grace and accepting her mother's statement that she was in a 'serious relationship' with a boy of a similar age.

Learning for Practice: *Professionals need to think beyond pregnancy prevention when providing advice or prescribing contraception to young people. They need to speak to the young person, consider their history and potential exploitation.*

Lessons Learned (cont.)



What we have learned (cont.)...

Those who were working with Grace and her siblings from 2020 had some understanding that neglect had been an issue when the children had previously lived with their mother but told the review that the extent or longevity of the issues were not fully appreciated. There is a good understanding of the impact of neglect of this type on young children, but less so of the impact of neglect over time or the serious impact of ongoing and long-term emotional neglect on an older child. Grace, her overdoses and voiced wish to die made the professionals involved concentrate on the incident being a response to what was happening at the time and the need to keep her safe in the short to medium term.

Learning for Practice: Professionals need to ensure that they consider the cumulative impact of neglect and emotional harm on children who are struggling with their own mental health when assessing and deciding on the need for support or a plan. A chronology with multi-agency information is essential.

There is no doubt that during the months being considered by this review, the focus of professionals was on Grace. However, there were two other children in the family, one older and one younger. They were likely to have had similar life experiences, including long term emotional abuse and neglect.

There needs to be more consideration to seeking and gaining consent from parents to access relevant health records, even if an assessment is not thought to reach the criteria for a S47 investigation, as this case shows that having information on the parents, for example the mother's recent overdose, is essential to understand the impact on the child.

Learning for Practice: When there are a number of children in the family, with one or some of the children showing the most obviously concerning behaviours, consideration on the impact of this on the other children, as well as their future response to what they experience at home more generally, should always be assessed. This includes seeking and considering information on the adults in the home.

Grace's father stated during the review that he was rarely told about parent's evenings or contacted by the school about any issues. There is also no evidence that he was contacted to gain his support and consent for the CAMHS work. He told the review that he would have wanted to be involved if it was possible.

Learning for Practice: When parents are separated but the child spends time with both parents, however infrequent, efforts should be made to ensure that professionals working with the child engage with the non-resident parent. Better engagement with a non-resident parent is likely to result in better risk assessment, a reduced burden on the resident parent, enhanced resources for the care of children, and better risk management, leading to reduction of harm.

What do I need to do...

Advice for professionals

1. Read the 7 Minute Briefings on [Child Neglect](#), [Children of Parents with Mental Health Problems](#), [Children of Parents who Misuse Substances](#), [Parental Capacity to Change](#), [The Importance of History in Assessments](#), and the [Voice of the Child](#).
2. Read the briefing '[Support for Vulnerable Children from Schools During Lockdown](#)'.
3. Familiarise yourself with WM Child Protection Procedures [2.9 Neglect](#) and [2.18 Sexual Activity in Children and Young People \(including Underage Sexual Activity\)](#).

Advice for communities:

1. For a range of mental health and wellbeing services available for all ages across Warwickshire, visit the [Warwickshire County Council website](#).
2. Safeguarding is everyone's responsibility. If you are worried a child is at risk of abuse or neglect, contact [Warwickshire's Children & Families Front Door](#) to report your concerns.