Lessons Learned

Warwickshire Safeguarding

Simon's Story….

Simon came from a family where English was not their first language, however Simon was fluent in English and was sometimes relied upon by professionals to translate information for his parents. At the age of 15, Simon suffered a brain injury, which is said to have affected his behaviour and he struggled with his mental health. The following year, Simon made a significant attempted to end his life and was treated in hospital. Simon became an inpatient in hospital under section 2 and 3 of the Mental Health Act 1983 and Simon and his family were supported by a child in need (CiN) plan.

Shortly after his discharge, Simon's mental health deteriorated, and he was detained under again Mental Health Act. The hospital where Simon was accommodated was a significant distance from his family and due to Covid, Simon was unable to visit home. During this period, Simon alleged that he had been the victim of a serious sexual assault but was deemed to unwell to be spoken to by Police at the time. Simon went on to make another disclosure relating to peers at his school being sexually abused whilst under the influence of substances. During his hospital admission, Simon was treated with anti-psychotic medication that caused Simon to gain weight which concerned him.

Simon was discharged from hospital 6 months later with a plan in place to for the Social Worker to support Simon regarding the allegation of sexual assault and a daily phone call from his Care Coordinator. Simon was offered a place at college and the Child in Need plan came to an end.

Simon continued to struggle with his mental health, and he would present at the local hospital stating that he felt unsafe and had suicidal ideation. At his next routine mental health appointment, Simon disclosed feeling unsafe at times and had thoughts to harm himself but had no plans to do so. The agreed plan was to increase his medication and steps were taken to remove anything from the family home that Simon could use to harm himself. Later that day Simon's family and those working with him were unable to make contact with him and it was later discovered that Simon had sadly taken his own life.

What we have learned….

Careful consideration should have been given to the closure of the plan for Simon. His discharge from hospital had been quite recent, there had not been a monitored period of the plan being in place whilst Simon had been in the community. There was little consideration of the family background and history and little evidence that the family was offered support.
Learning for Practice: *A Child in Need Plan should adopt a family wide approach that seeks to identify and address the hidden issues and harm. The plan should have set out clear measurable outcomes for Simon and expectations for his family. It should have included areas of concern and how these would be addressed. Careful consideration should be given to the closure of a plan and how the transition will be managed by a step-down plan.*

Section 85, Children Act 1989 places a duty on local authorities to check on the safety and welfare of children living in residential education or hospital provision for any continuous period exceeding and / or likely to exceed 12 weeks. This requirement was relevant on Simon's first and second admission to hospital. There may have been consideration of section 85 within the context of the Child in Need plan, but this is not evident to this review.
Learning for Practice: *Children Services and other agencies involved with care of children need also to consider section 85 Children Act and how this works with other assessments.*

Lessons Learned (cont.)

Warwickshire Safeguarding

What we have learned (contd.)…

The day before Simon was transferred to tier 4 provision, he made an allegation of a very serious sexual assault. Although Simon was subject to a CiN plan and those working with him were aware of the allegation there was no consideration of a strategy discussion at this stage.
Learning for Practice: *Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, a strategy meeting/discussion should be held. This discussion should include all relevant partners and in a case such as this it should include relevant health professionals and the school. There should be good management oversight to ensure that strategy discussions are appropriately convened and attended.*

The lack of a strategy discussion led to an uncoordinated approach regarding the allegation of which overly focused on the police led investigation and did not focus on what the trauma implications were to Simon and his health.
Learning for Practice: *Where there are allegations of sexual abuse relevant agencies should ensure that the approach is not over reliant on the criminal prosecution. That the child and their family are put at the centre of the approach and that the approach is trauma informed and appropriate support considered.*

Despite the learning achieved from tabletop review following Simon's first attempt to end his life, there continued to be some instances where Simon or his sibling were used to translate/interpret for their parents.
Learning for Practice: *Appropriate translation/interpretation services should be provided at all appointments to support families where English is not their first language and their understanding of what is being discussed is not assured. Where there is a long-term relationship between professionals and families there is scope to pre-plan and the appropriate translation/interpretation support should be arranged.*

Simon had demonstrated a real previous intent to take his life, there had been instances where he had been found with implements, he intended to use to harm himself and talked about suicide. It was recognised that Simon could act impulsively and that on and around the time of his death he was suffering high levels of anxiety.
Learning for Practice: *The circumstances of Simon's case should act as a reminder to all working in this very challenging area of the changeable dynamics of a persons mental health and despite their assurance and future orientation, completed suicide is an potential outcome at almost any stage.*

What do I need to do….

Advice for professionals:

- Read the 7 Minute Briefings on the Use of Interpreters and Translators, The Importance of History in Assessments and Suicide Awareness.
- For further guidance, refer to the WM Child Protection Procedures 1.8 Strategy Meetings/Discussion, 2.11 Self-harm and suicidal behaviour, 2.16 Children living away from home, 2.29 Sexual abuse and Section 85 of the Children's Act 1989.

Advice for communities:

- If you are a young person struggling with your mental health, there are a range of support services available in Warwickshire who can help you. Click here for more information.
- If you are a family member who has been bereaved by suicide, there are a range of support services available on the Warwickshire County Council website.