Child 10

01 Background

Child 10 was a care leaver and was 18 when he died. He came into care due to neglect & parental substance misuse. Attempts to return him home failed and he remained in care on a Care Order. The court more than doubled his level of direct contact with his mother, which had a detrimental effect on his emotional development. Two very close members of his family committed suicide.

02 Safeguarding Concerns

Child 10 was a care leaver and was 18 when he died. He came into care due to neglect & parental substance misuse. Attempts to return him home failed and he remained in care on a Care Order. The court more than doubled his level of direct contact with his mother, which had a detrimental effect on his emotional development. Two very close members of his family committed suicide.

03 The Incident

Self-Harm and threats to take his own life increased in later teens, as did Child 10's challenging behaviour. His vulnerability increased as he went missing and started to offend. Children's Social Work and CAMHS worked with Child 10 often with positive results, he resisted involvement at times. He took his own life in the midst of a crisis and was found by his personal advisor that day.

04 The Review

A single agency review was completed by Children's Social Care as Child 10 was 18 when he died. The focus was the last three years of his life and the services involved during that time. Residential care and independent living arrangements were looked at, as were the planning and review processes. Individual workers formed good working relationships with Child 10 and there were periods when he made good progress. There was a lack of agreement between agencies about the child's needs and he was also confused about what would be best for him.

05 The Findings

LAC Processes were not applied robustly as needed; **'a strong parent'** was needed to address trauma and counteract negative family influences; the lack of engagement with services and spiralling vulnerability should have been treated as a high level of risk for the child; **pressure caused** by a pay-day loan company contributed to the trauma for this child – a vulnerable person. At 17 the child was often viewed as an adult when he had not developed as such. There was a lack of **Respectful Challenge** to family and **Professional Challenge** between agencies who disagreed.

06 Recommendations

Care Leavers in transition need clear, robust Pathway Plans.
The role of the Personal Advisor is key to the child and must be fully supported.
Decision making for a Looked After Child should involve all agencies and fully consider their views.
The Voice of the Child is crucial, especially when they need help to express it.
Clear and regular Risk Assessments must be completed on children at risk of suicide.

07 Implementing Change

1. Reflect on the findings and discuss the implications for your service/practice.

2. Outline the steps you and your team will take to improve practice in line with the recommendations.

7 Minute Briefing

Tameside Safeguarding Children Board

Child 10 - Action Plan

Name of Organisation ....

Team Manager ....

Name of Section & Team ....

Contact Details ....

Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

1.

2.

3.

Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Board will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.

Child 10 - Action Plan

What actions have been agreed to improve practice?

What needs to happen?	Who will do it?	By When?	How will you know when it has been done?	How will you know if it has worked?

Tameside Safeguarding Children Board

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