Salford Safeguarding Children Partnership

Child GI MACR 7 Minute Briefing

1. Background

Child GI was described as a happy, confident, mature teenager who loved life had varied hobbies and was academically above average with the potential to achieve well. Child GI had smoked "weed", drank alcohol and socialised with older peers. The family situation was complex and Child GI lived at home. Parents had separated recently but worked together, with their family involvement to support the children. Child GI had disclosed violent episodes by older sibling, whose days were unstructured, was subject to alternative education including Elective Home Education. Historically the family were offered early help interventions.

2. Safeguarding Concern and Incident

Child GI died by suicide at home.

Previously Child GI was subject to Children's Social Care Section 17 support due to escalating self-harming, risk taking behaviours and morbid thoughts. Following a serious self-harming incident Child GI became subject to a Child Protection Plan under emotional harm although the decision for professionals was unanimous the category was a "*struggle*" due to conflicting information relating to parenting capacity.

Shortly before Child GI's death, there were significant transitions and unstructured days including suspension from school and (discharged from tier 4 CAMHS day care provision without a robust multi-agency plan of provision.

3. Findings

Multi-agency partnerships should;

- Use A Think Family Approach with complex families inclusive of all children
- Multiagency approach to early intervention.
- Avoid silo working in planning, providing intervention, assessing outcomes and managing risk.
- Focus on impact of Adverse Childhood Experiences (ACE)
- Focus on escalating incidents and outcomes
- Be child focussed and not system focussed.
- Recognise troubled children can at times be seen as the most troublesome.

4. Findings Cont...

- Manage the support needs of parents as carers and have realistic expectations of their capacity to provide care.
- Assess family and parental perspectives of "attention seeking behaviours"
- Understand the risks of multiple transitions for a child
- Avoid the duplication of service provision. Ensure clear roles
- Follow CP process re non-accidental injury
- Avoid a "cast of thousands" for the child to tell the story.
- All partners should commit consistently

5. Recommendations

1) Think Family/multiagency approach in assessing, planning coordinating and providing intervention. Analysis of family and environmental factors is key to understand risk/parental capacity.
2) Develop a multiagency protocol to support the assessment, planning and provision of care to children exhibiting emotional and mental distress.
3) Align mental health and safeguarding pathways for children experiencing mental/emotional distress to ensure the plan meets the needs of the child.

6. Recommendations

4) Ensure development opportunities and good quality supervision is accessible for practitioners when working with children with mental illness and are exhibiting self-harming behaviours and suicidal intent.
5) Parents/carers of children who are mentally ill with coexisting suicidal intent, morbid thoughts and impulsivity and self-harming behaviour require support. The pathway and offer should be defined
6) GMMH to provide assurance to the SSCP that the recovery plan following the root cause analysis has been implemented.

7. Implementing Change

- Reflect on the findings and discuss the implications for your service/practice.
- Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations