



Practice review report: Child M

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularly around multi-agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

Child M was 14 years old when she died by suicide in Milford Haven in April 2012.

As Child M had been on the Child Protection Register at the time of her death and a number of agencies were involved in her care, a decision to undertake a serious case review was taken by Pembrokeshire Safeguarding Children Board.

The subsequent report was published in January 2014.

Circumstances of, and challenges faced by, the individual

1997 Child M was born in Pembrokeshire but lived in Cornwall with her brother and parents until they separated in 2000.

2001 She moved back to Pembrokeshire with her mother and brother.

2009 Child M approached her school's form tutor with concerns about her mother's drug taking and its effect upon the family, she also felt isolated and misunderstood at school. This resulted in a referral to the school counsellor and she attended six sessions.

2010 In March, Child M alleged to a teacher that her mother was hitting her and she did not want to return home. This resulted in a referral to the Child Care Assessment Team at Pembrokeshire County Council. Child M moved to live with her maternal grandmother. This arrangement lasted less than a month, and in April, Child M moved to live with her father in Cornwall.

2010 Cornwall Children's Services received a referral from Redruth Drug and Alcohol Team, and on attempting to see Child M, they were informed that she had returned to Pembrokeshire to live with her mother.

Four months before this move, Child M's mother's partner had been cautioned by police for cannabis production at her mother's address in Pembrokeshire.

The move to her mother's house lasted for 15 days at which point Child M ran away and was missing for 17 hours.

There followed a brief period where she stayed with the mother of a friend before settling back with her maternal grandmother, this arrangement lasted until June.

2011 During this period a core assessment and child in need plan were completed. The plan sought to rebuild Child M's relationship with her mother.

In July, Child M moved again to Cornwall to be with her father. The following three months saw Child M run away twice, and move between Cornwall and Pembrokeshire.

In September, Child M was admitted to hospital in Bridgend following an attempt to hang herself. A transfer to Worthybush Hospital in Pembrokeshire followed and a child protection strategy meeting took place.



Child M was placed on the Child Protection Register and through a child protection plan referrals were made to the Specialist Under-18s Drinking and Drug Service, as well as the Child and Adolescent Mental Health Service. Child M stayed with her maternal aunt until placed in foster care in December 2011.

2012 In January, Child M made allegations of rape that had occurred prior to her becoming a looked after child. A joint Section 47 enquiry was initiated but the outcome was no further action as Child M had withdrawn the allegations.

During this period in foster care, Child M received services from the Specialist Under-18s Drinking and Drugs Service, her social worker, social work assistant and school health nurse. Children and Adolescent Mental Health Services had initially provided 1:1 support but this was discontinued at Child M's request.

In March, a break in Child M's foster care took place and for these three days she was placed with respite carers.

A looked after child review took place on 28 March where it was reported that Child M's mood and behaviour had improved.

Child M died on 2 April 2012.

What happened?

The events suggest that Child M had experienced an upbringing that provided early exposure to substance misuse and a lack of stability in her home life. This contributed to her increasingly dysfunctional behaviour, putting her at risk. The apparent trauma she experienced led to the initial suicide attempt, and although all services were then engaged in addressing her needs, these were unable to prevent a later successful suicide.

Why it happened?

The serious case review clearly states that "It must remain uncertain whether there were any steps that, if taken, would have prevented Child M's death".

Lessons learnt from these events:

- delays in carrying out police inquiries where allegations of serious sexual assault/abuse have been made must be avoided
- multi-agency co-operation and planning could be improved particularly where there has already been a serious traumatic incident
- Children and Adolescent Mental Health Services could have been given a more significant role in leading and coordinating therapeutic interventions
- in the first year following a traumatic episode/suicide attempt, no child or young person should be able to discharge themselves from any service without a multi-agency risk assessment
- workers from all agencies should continue to receive training as implemented by the Welsh Assembly Government in 2008, *The Suicide Prevention Action Plan*. It has since been replaced by *Talk to me 2: Suicide and self-harm prevention strategy for Wales 2015-2020*. <http://gov.wales/topics/health/publications/health/reports/talk2/?lang=en>.
- Child M had expressed reservations about the plan to return her to her mother's care. In hindsight, greater weight could have been given to her views and opinions
- the key question in the care and permanency planning process for all children and young people is "does this child or young person have an adult acting as a responsible parent in his/her best interests?". This question could have been asked at an earlier stage in the process.



Report recommendations

All agencies should have the resources in place to ensure a timely response to children and young people who make sexual assault allegations.

Pembrokeshire Safeguarding Board should develop a multi-agency protocol for the assessment of children and young people with mental health problems and/or risk taking behaviours.

Pembrokeshire Safeguarding Board should identify a multi-agency training package to provide key staff and foster carers with skills in recognising and supporting young people at risk of risk-taking behaviours and/or suicidal ideation or depression.

The above training package should include warning signs guidance, where to get help and how to refer information for foster carers, school staff, youth leaders and so on.

Pembrokeshire Safeguarding Board should develop advice materials about how to seek help and support concerning self-harm, risk taking and mental health issues for schools and other youth-oriented services.

Pembrokeshire Safeguarding Board to request Children's Services in Pembrokeshire to report on multi-agency planning arrangements for adolescents living away from home.

Citation Pembrokeshire Safeguarding Children Board (2014)
Serious case review in respect of Child M: executive summary.
Pembrokeshire: Pembrokeshire Safeguarding Children Board.