Essex Safeguarding Children Board
Child Safeguarding Practice Review
Child DD – Learning Summary

Background

Child DD died by suicide at age 16; at the time of her death, she was a Looked After Child living in semi-independent accommodation. Child DD had been known to Social Care from a young age. Child DD had experienced significant trauma, including adoption breakdown, mental health challenges, and multiple placement disruptions.

Effective Practice

There was significant evidence of effective practice over the years with many practitioners who were utterly committed to Child DD and regularly and consistently responded to and supported Child DD. This includes Social Workers, outreach worker, foster carers, SIA support workers, CAMHS, GPs and Designated Safeguarding Leads and pastoral staff in her schools working hard singly and together to support Child DD whilst clearly recognising her strengths, her vulnerabilities and the risks.

Recommendations and themes from the review

Information Sharing and Multi-Agency Working

- Raise awareness of the need for explicit information sharing for 16+ children, including overriding consent when necessary.
- Streamline multi-agency meetings where appropriate and ensure all relevant agencies are included to assess cumulative harm.
- Improve GP involvement in multi-agency meetings, especially for mental health and suicide risk cases.
- Ensure commissioned medical reports are shared with relevant agencies, particularly in health.

Placement and Care

- Provide specialist support and training for foster carers managing children with suicidal ideation.
- Continue lobbying nationally on placement sufficiency and engage in Regional Care Cooperatives.

Adoption and Legal Framework

- Review how family contact is managed for looked-after children, especially when it may cause harm.
- Consider reciprocal secondments between post-adoption and family support teams to align thresholds and responses.

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Mental Health and Engagement

- Review progress of the thematic reviews on teenage suicides in relation to the need to commission specialist training to support the wider children's workforce's understanding of suicide and suicidal ideation.
- Improve access to Health-Based Places of Safety for children under the Mental Health Act.
- NELFT to audit and report on the effectiveness of new arrangements from the PSII action plan.
- Ensure multi-agency practitioners consider the best approach to contacting the nearest relative during Mental Health Act Assessments.
- NELFT to explore more flexible and alternative therapeutic approaches for children refusing traditional services.
- Prioritise maintaining trusted relationships between children and practitioners, even if changes in status/remit.
- Provide real-time reflective spaces for practitioners managing suicidal risk

The Impact of Covid-19

It is notable that Child DD's adoption breakdown occurred shortly after the Covid pandemic. It was felt this added to a build up of events and difficulties at home, which ultimately led to Child DD becoming a Looked After Child.

Resources & Reading for Professionals

- Suicide: learning from case reviews – NSPCC
- Young Minds – Resources for Professionals
- Risk in the Community – Requests for support, tools & resources

Signposting for children and young people you work with

- Papyrus HOPELineUk - a confidential support and advice service for young people under the age of 35 who may be having thoughts of suicide/ anyone concerned a young person may be having thoughts of suicide.
- Kooth - a free online counselling service for young people in Essex.
- Essex Directory of Services