



SUMMARY:

Alex, who was 15 years old at the time of her death, lived with her mother and step-father. Prior to her death there was no involvement with services other than universal services. Alex took her own life by hanging although it was not possible to determine what her intention was at the time she took this action. Five to six months prior to her death three of Alex's friends had approached school staff to report that she had been self-harming. Police investigations following her death revealed that she had been a victim of abuse from a distant family member who subsequently took his own life.

KEY LEARNING:

1. Three factors now known to be associated to Alex's death; self-harm, abuse and depression, however prior to her death agencies were only aware of self-harm.
2. Professionals need to be equipped with the knowledge to recognise self-harm and take appropriate action according to their role
3. Students may become aware of friends who self-harm or have suicidal thoughts and should be supported to know how to respond
4. If a child who is self-harming refuses an offer of support this should be viewed as something which potentially increases his/her level of risk.
5. Parents and carers require support in recognising the risks that may be posed by individuals and have strategies available to protect children from that risk.
6. Police Services need to be intrusive in their management of registered sex offenders and make use of dynamic risk assessment tools available to them.

IMPROVING PRACTICE

Here are some suggestions for improving practice:-

- Share this bulletin in team meetings and during supervision.
- Familiarise yourself with the NSCB [Self-Harm and Suicidal Behaviour](#) chapter of the Interagency Safeguarding Children Procedures and be clear about when and how you would use it.
- Familiarise yourself with the Nottinghamshire Police [Child Sex Offender Disclosure Scheme \(Sarah's Law\)](#) which allows anyone concerned about others working, living or in contact with children to raise their concerns with the Police.
- The NSCB provides a range of training opportunities which are relevant to this review and can be booked via the [NSCB website](#)
- The full report regarding this Serious Case Review is available in the [Learning from Practice](#) section of the NSCB website. The online [NSCB inter agency safeguarding procedures](#) provide detailed guidance across the range of safeguarding issues.