Nottinghamshire SAFEGUARDING CHILDREN Board

LEARNING & IMPROVEMENT BULLETIN: Serious Case Review QN17 – 'Peter'

SUMMARY:

'Peter' was 16 years old when he tragically took his own life. His mother and father had split up early in his life and he lived with his mother and 4 siblings/half-siblings. There were some difficulties in the home environment and relationships between family members were on occasions strained. There was a history of suicide within the wider family. Around the age of 13 concerns began to emerge around self-harm, suicidal ideation and his emotional well-being. As time progressed further issues became apparent including a possible eating disorder, OCD traits and Peter appeared to be struggling with his sexual identity. Support was provided to Peter by a number of services particularly the school, school nursing and the GP, there was also a referral to CAMHS services. He was making good progress academically and expected to achieve good results in his GCSE's. At the age of 16 Peter disclosed to a teacher that he was being sexually exploited and had been sexually abused in the past. A referral was made to Children's Social Care, a CSE assessment completed and a multi-agency CSE meeting held. Whilst his parents attended the meeting Peter choose not to and he took his own life shortly after.

At the inquest the Coroner concluded "I do not think that even those who knew him very well, particularly his parents, could have predicted what he would do- what is not predictable is not preventable."

KEY LEARNING:

1. There was a good working relationship between the School nurses, the school and the family GP, however, this work would have been strengthened through use of the Early Help Assessment Form (EHAF).
2. Earlier involvement of CAMHS may have been beneficial and professionals need to consider options to protect a child who disengages from services.
3. Police and Children's Social Care communicated well to coordinate their response to episodes of missing from home and followed the correct procedures.
4. Once an initial disclosure is made by a child any further interviews should be agreed as part of a strategy discussion with the agencies involved.
5. When making a verbal referral to the MASH the referrer should provide a summary of all the key concerns and any follow up information provided in writing should be fully considered.
6. Whilst concerns around CSE can sometimes be non-specific practitioners need to be aware that the threshold for significant harm may be met and ensure that Section 47 child protection enquiries are initiated where this is the case.
7. For CSE meetings to be effective it is important that all relevant agencies are appropriately engaged otherwise information exchange and action planning can become problematic.
8. Careful consideration should be given as to how the outcomes from multi-agency meetings are fed-back to the child including who is best placed to do this and what the potential impact of the meeting on the child is likely to be?

IMPROVING PRACTICE:

Here are some suggestions for improving practice:-

- Share this bulletin in team meetings and during supervision.

- The full Serious Case Review overview report is available in the Learning from Practice section of the NSCB website.

- Make use of the NSCB Early Help Assessment Form to identify what indicators of need are present at level 2 or 3 of the Pathway to Provision.

- Read the Interagency Guidance Safeguarding Children and Young People from Sexual Exploitation which also includes a useful CSE Multi-Agency Risk Assessment Tool.

- The NSCB provides a range of training opportunities which are relevant to this review and can be booked via the NSCB website.

- The online NSCB inter agency safeguarding procedures provide detailed guidance across the range of safeguarding issues.