Buckinghamshire BSCB Safeguarding Children Board

Learning from a Case Review

Learning for services arising from the suicide of a young woman

Background

In February 2018, a 21 year old woman *(who will be referred to as E through out this review)* took her own life by hanging following an argument with her boyfriend; he was not present at the time of her death.

Whilst this situation did not meet the criteria for a Serious Case Review (children) or Safeguarding Adult Review, it was felt that there was a lot that agencies could learn from the case. Buckinghamshire Safeguarding Children Board commissioned an independent author to meet with practitioners from the agencies that had some involvement in the woman's life to identify any significant learning points.

E had many adverse experiences in her short life. Her parents divorced when she was 3.
E contacted Oxford Health requesting help when she was 14, this was due to a difficult relationship with her father, around a year later there was an incident where E punched him which resulted in him slapping her across the face.

Around this time she was also excluded from school due to her aggression. E's mother was diagnosed with a terminal illness and died when E was 15. E was testing boundaries – drinking, smoking and going missing.

E lived with an aunt for a short while following her mother's death; 'sofa surfed' with friends and family, a foster family, her boyfriend, a residential home, the YMCA and had a period of homelessness. She presented at A&E drunk, having taken overdoses and self-harmed.
E alleged she had been sexually assaulted, but later did not support the claim. E was deemed vulnerable by the police due to staying out all night, consuming alcohol and associating with unknown men in cars. There were allegations of domestic abuse.

There was a period of around a year where E experienced some stability, it was noted that this had a positive impact on E and that she had direction in her life. She had stable housing, was attending college and working at a high level, although needed support and encouragement to maintain her confidence.

Aged 21, E sent texts to indicate *'she had had enough and wanted to be with her mother'*

Assessments

After contacting Oxford Health at the age of 14, E completed ten counselling sessions with MIND. A Common Assessment Framework assessment was completed which identified services that could offer support eg Child Bereavement and Relate.
When E was 15 a referral to Children's Social Care was made followed by a second referral 6 months later. A 'hard to reach meeting' took place when E was 16.
Once E had reached 18, information obtained in the MASH was not shared with anyone as E either did not consent or lack capacity to give consent.

Support

E completed ten counselling sessions with MIND, the family received high levels of professional intervention including Family Group Conferencing and 1:1 parenting support. It was difficult to involve some services such as Child Bereavement as the children were unaware of how ill mum actually was.
The school nurse had seen E as a 'frequent visitor' complaining of nausea and vomiting. The second referral to social care focussed on E's younger brother who was living with his father. At the age of 16 E became a Child Looked After. The Specialist Nurse from the LAC health team followed up concerns with E and was tenacious in maintaining contact with E and her care.

Assessment, planning & thresholds

The CAF was undertaken **after** E had self-requested support from MIND, not as part of a referral process. It is stated there was a lack of involvement by bereavement support due to the children not understanding how ill mum was, however E had requested support six months earlier because her mum was terminally ill.

There were missed opportunities to intervene before the needs of the family met statutory thresholds.

The CAF did not address how the children would be cared for and helped after the death of their mum. A referral to social care did result in an assessment for the younger child.

Adult Social Care would have been involved in offering support to the family but there is no evidence of any joint working. The incident between dad and E should have resulted in a strategy meeting. E was not effectively parented from the age of 15.

Child Looked After

E's links were within High Wycombe including her mother's grave. She was placed out of county on two occasions going missing after only 7 days in one. It is significant that E's placement in a semi-independent placement was in High Wycombe.

Accommodation

After the death of her mother E had many moves of address both before during and after her time in care.

This lack of stability affected the impact offers of help and support could make both geographically and emotionally. It also had a detrimental impact on her lifestyle and her physical and mental health thereby increasing risk and rendering her more vulnerable.

Risky Behaviours

E was exhibiting risky behaviours before her mother died. What underpinned this behaviour - was it ever explored with her? Following her mother's death the behaviours increased and included allegations of sexual assault and domestic violence.

Health

E's lifestyle and circumstances had an adverse effect on her physical and mental health. There is a thread of her reporting ill health, abdominal pain and vomiting, alcohol consumption and overdoses. There was a lack of curiosity about these generalised symptoms. College staff noted she was very thin, not eating and consuming a lot of fizzy drinks. E's mental health suffered, with several reports of low mood.

E attended A&E three times following an overdose. E said to the Psychiatric Liaison that two of these were impulsive, however was guarded in her responses. The assessor believed that E had been subject to abuse in the past. It also came at a time when she appeared to be turning her life around. She had suitable housing and was at college.

Bereavement counselling for E was considered at various times and was part of the CAF plan. However, lifestyle factors, being defensive and her reluctance to engage with mental health services meant this never happened.

When E was 19, she did say (to Psychiatric Liaison) that she was willing to consider counselling but was worried this would raise issues that she had 'buried for years'.

Support

Despite her being hard to reach, the professionals in contact with E are described as going 'the extra mile' to try to help and support her. For example:

1. The Specialist Nurse who attended a Hard to Reach Meeting to ensure representation from health, even though at this point E was not a child looked after.
Once she came back into care the Specialist Nurse made frequent contact with E, including home visits to assess, support and advise. Information was then shared appropriately with other professionals.

2. The Aftercare Service recognised her vulnerability and worked hard to maintain contact with E and to support her with practical help as well as several appeals against the decision that she was no longer eligible for housing under the Leaving Care Housing Protocols.

3. College staff were very supportive, providing opportunities for E to talk about her anxieties and helping her with strategies to manage them.
At one point, when she had no money for bus fare, a staff member went out to her home to give her a bus pass.

Conclusions

E was a troubled young person who nevertheless demonstrated insight by asking for help from services when she was 14. She demonstrated the ability to achieve in education and to communicate with agencies that she did work with. However, E lived through many adverse life experiences such as the difficult relationship with her father and the loss of her Mother.

As the impact of these experiences on her life began to increase, agencies began to have less insight into what was causing her presenting needs (anger, use of alcohol, life choices).
This led to an increasing gap between service responses and E.

E took her own life at a point when it was thought that she was settled and 'doing well'.

Key Learning

- Practitioners must be able to recognise the impact bereavement has when carrying out risk assessments. This should be considered both pre and post the death of a family member where appropriate.
Rigorous plans and interventions should be in place to support children.
- When it is known a parent is terminally ill all agencies should 'think family' and work alongside the ill parent to assess and plan for the future care of the children.
- When a child becomes a child looked after, if there is no suitable placements available in the area and they have to move away, the maintenance of important links and connections should be addressed within their care plan.
- There is a need for a longer, managed transition period from children's to adult services especially when a young person is in education.