Child G

01 Background

Child G was almost 17 when he took his own life. He had self-harmed and threatened suicide since his early teens. His family found his behaviour challenging and difficult to manage. He was diagnosed with Aspergers Syndrome but this was not fully understood by him, his family and some of those involved with him.
Child G lived at home with his parents and a sibling until the time of his death.

02 Safeguarding Concerns

In their attempts to manage Child G's behaviour, relationships became very strained between him and his parents. Attachments were damaged and the parent/child relationship became emotionally abusive. As his behaviour escalated, Child G's vulnerability increased and parental tolerance and understanding diminished. Engagement with services was strained as parents disagreed with suggestions that they could manage their son differently.

03 The Incident

Child G's behaviour spiralled out of control. He self-harmed and threatened suicide.
The Police were called several times to his home to deal with what his parents described as 'naughty' behaviour. Following a family row at home Child G went to his room and took his own life.

04 The Review

A multi-agency critical review was held, the aim of which was to 'identify any improvements in practice and develop and share good practice methods' Child G received universal services with extra help at school and eventually, involvement with CAMHS, the Police and Children's Social Care.
Engagement with services was impaired by the mismatch between parental perceptions of Child G's need and those of services involved.
This was the focus of the review.

05 The Findings

A lack of understanding of **Aspergers Syndrome** meant Child G's needs were not fully understood and assessed.
The **impact on behaviour** of this condition was also not fully appreciated. **Emotional Harm** of Child G was not fully recognised and discussed with parents. **Parental Resistance** was not named nor met with **Respectful Professional Challenge**.
There was a focus on the challenging behaviour of the child at the expense of **recognising his vulnerability.**

06 Recommendations

To promote in the workforce via Training, development and supervision:

- Understanding of Autism and potential impact on a child's behaviour
- Knowledge of the signs of Emotional Harm
- A culture in which Respectful Challenge is an expected element of practice in Safeguarding Children
- Recognition of the Vulnerability of Teenagers

07 Implementing Change

1. Reflect on the findings and discuss the implications for your service/practice.

2. Outline the steps you and your team will take to improve practice in line with the recommendations.

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Child G - Action Plan

Name of Organisation .....

Team Manager .....

Name of Section & Team .....

Contact Details .....

Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

1.

2.

3.

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Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Board will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.

Child G - Action Plan

What actions have been agreed to improve practice?

What needs to happen?	Who will do it?	By When?	How will you know when it has been done?	How will you know if it has worked?

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