Child M

01 Background

Child M was a bright, accomplished 17 year old who was articulate & confident. She lived with her mother and step-father in Lancashire and spent the last few weeks of her life in Tameside where she had close family members. Child M had displayed a gradual increase in challenging behaviour from the time of her parent's separation & the start of her adolescence. Her difficulties escalated, she was excluded from school and there was concern from her mother and step-father that she was mentally ill. She was never diagnosed with a mental illness.

02 Safeguarding Concerns

Child M was a young person 'In Transition' she had left home following arguments and became less visible as she moved around Tameside. She gave several addresses but could not be contacted at any of them. Child M was referred to Children's Social Care, CAMHS and YOT in Tameside due to her self-harm, substance misuse, offending behaviour and vulnerability. She died before any of these services were able to locate her. She was never defined as a Child in Need or Child at Risk of Significant Harm in either Local Authority

03 The Incident

In response to anti-social behaviour; aggression and assault, Child M was taken into Police custody in Tameside where she remained for two full days. She was medically assessed twice in that time and was deemed unfit for discharge due to her volatile presentation. She was suspected to be under the influence of substances. Eventually she attended court & despite her 'concerning' state was bailed to a relative. She did not go there and was found dead at a local address the next day, she had taken her own life.

04 The Review

A Serious Case Review was conducted by Tameside SCB with the full involvement of Lancashire partners. The review focused upon the final year of Child M's life – her withdrawal from services in Lancashire; escalation in challenging behaviour; the move to Tameside and further increase in her vulnerability. Whilst she had close family members in the area, she did not reside with or seek support from them at her time of most need. The period in custody and after release were considered in detail in the review.

05 The Findings

The Child's Story was not evident in records; assessments were separate and disconnected. Adults found the child's behaviour challenging but did not ascertain the causes. **Domestic Abuse** was present in child's family history and teenage relationships, the house where she died was that of a male with offences for domestic abuse. **Child M was seen as an adult** not a child, her behaviour seen as wilful and frightening. **Her substance use** is likely to have exacerbated her distress, but it was not fully known what she used. **Engagement** with services was left as the child's choice.

06 Recommendations

The impact of school exclusion on Vulnerable children to be assessed and considered in plans for them. **Transfer of Information** about Vulnerable children between Local Authority areas should be robust & accompanied with Risk Assessments. The **Toxic Mix** of family breakdown, move to another area, psychological distress, challenging behaviour, offending behaviour, disengagement with services, substance misuse & involvement with risky adults - should trigger a service response of **Safeguarding**.

16 and 17 year olds to be seen as children

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.

7 Minute Briefing

Tameside Safeguarding Children Board

Child M - 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.

Tameside Safeguarding Children Board

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 M - 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?

Tameside Safeguarding Children Board

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