EAST SUSSEX
Local Safeguarding Children Board

LSCB
Learning from Reviews

June 2017

SCR Child M

- Child M was aged 17 in March 2013 when she died as a result of a drug overdose taken while in the company of at least one adult. This was the last in a series of overdoses that Child M took which had resulted in hospital admissions and serious health concerns from May 2011 onwards. She was a looked after child in the care of ESCC at the time of her death and was only weeks from her 18th birthday.
- Child M grew up in Surrey and lived there for the majority of her life. In September 2011, when she was 16 years old, Child M moved to East Sussex. Child M had a long history of substance misuse. Child M had lived in Surrey and Hampshire for some months prior to her death, but because she was looked after by East Sussex at the time of her death, the responsibility to undertake the SCR fell to East Sussex LSCB.

SCR Child M

- This SCR is about;
  - exploitative relationships
  - working with children who abuse drugs and alcohol and are resistant to attempts by family and professionals to encourage them to change their behaviour
  - working arrangements in cases where services are being provided for adults and children
  - work with children who move either in a planned way or go missing across local authority boundaries
  - work with 16/17 year olds.

SCR Child M

- The SCR is 88 pages in length.
- The SCR Overview Report was completed in October 2014 but could not be published until after the Inquest in to Child M's death which was held in June 2016.
- Due to the delay in publishing and relevant practice developments since 2014, some updates were added to the report ahead of publication.

SCR Child M

- Could Child M's death have been predicted and if so could it have been prevented (Overview Report author's view).
- Between April 2011 and her death nearly two years later Child M repeatedly injected ketamine and heroin and she overdosed on a number of occasions. She paid little attention to the guidance of her parents and other family members or to the professional advice that she received about the risks of this and how they might be avoided and chose instead to place her trust in other drug users.
- Child M's pattern of behaviour placed her at a very high level of risk and there were only limited steps that the professionals involved could take to prevent her from overdosing. Had Child M not died in March 2013 it is highly likely that she would have overdosed again and at some point she is very likely to have done herself lasting, serious harm or killed herself. Professionals made substantial efforts to safeguard Child M including steps, unusual in the case of a 16 and 17 year old, to place her in care and in secure accommodation. Ultimately, only Child M could make the choice to stop behaving in a self-destructive way.

SCR Child M

- Recommendations and Actions:
- 28 agencies from several local authority areas and regional agencies contributed to the SCR; over 70 recommendations were made. Broad themes were:
  - Better sharing of information at the point of referral and case transfer
  - Improved risk assessment, including the recording of risk assessments
  - Policy and practice in relation to young people who repeatedly go missing

SCR Child M

- Recommendations and Actions:
  - The response of acute hospitals when they have contact with young people who overdose
  - Health provision for looked after children
  - Improving responses to the needs of children who are being treated in Tier 4 psychiatric inpatient units
  - Use of language by professional when a relationship is an exploitative one (i.e. Mr C was referred to as Child M's boyfriend by agencies – this had an impact on perception of risk)