Bury Safeguarding Children Board

7 minute briefing Mario

The Safeguarding Board produces 7 minute briefings on various current safeguarding issues and learning from reviews. They are intended to be simple so that the reader can absorb the information easily and that teams can use them within meetings as a team based learning exercise.

They are based on a technique developed from the FBI. The content of the briefings will be a mixture of new information or a reminder/repeat of basic information which can help teams think about the application to practice.

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1. Background

Mario was born in 2002 and was the youngest of four siblings born to mother and father, Mario's mother and father divorced in 2012.

Mother subsequently had another child to a different partner.

This Serious Case Review was commissioned by Bury Safeguarding Children Board (BSCB) as Mario took his own life on 4 February 2018.

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2. Safeguarding Concern

There were a number of safeguarding concerns in the years prior to Mario's death. The family were referred to MARAC (Multi-Agency Risk Assessment Conference), in 2012 in relation to mother being a victim of domestic abuse.

Children's Social Care became involved in 2012 due to domestic abuse between father and mother. In 2013 the children were placed on child protection plans under the category of emotional abuse arising from continuing parental conflict and domestic abuse. The case was closed the following year. When parents separated there were movements of the children between mother and father, Mario remained in his father's care. There were also referrals from school to the MASH (Multi-Agency Safeguarding Hub) relating to Mario disclosing that he had been physically assaulted by his father. Also Mario's needs were not considered when services were involved in domestic abuse between mother and other partners.

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3. Incident

Mario was engaged in a school counselling service due to anxiety. There were concerns raised by Mario about his other siblings witnessing domestic abuse at home a number of times, however as Mario was living with his father the impact on him of the domestic abuse from mother's new partner was not considered by any agency. Mario subsequently disclosed physical abuse from his father, when this was referred to MASH it was not evident if the previous domestic abuse by father was considered. Mario also experienced two bereavements, of his grandfather and new born nephew, in a short space of time.

4. Findings

- To his parents and to the practitioners in contact with Mario, his death was completely unexpected.
- Mario's suicide was not an 'out of the blue' event. On closer inspection, several of the antecedents of suicide in children and young people had been present to an extent in Mario's case.
- No service was aware of Mario's self harm. However, Mario experienced emotional abuse as a result of domestic abuse and had experienced physical abuse. He also suffered two bereavements during the year prior to his death.
- Mario began to actively explore suicide in the month prior to his death.
- Practitioners viewed Mario in isolation from the concerns about his wider family. Had any assessment of Mario been completed when opportunities arose after his two disclosures of physical abuse and after sibling 1 contacted the MASH to express concerns about anorexia, it may have been possible to better understand the many issues which had begun to impact upon Mario's emotional health and wellbeing.
- Mario was not considered when assessing risk to siblings, he was an "invisible child" .

5. Recommendations: Key Areas

- That BSCB make use of this SCR as a case study to, amongst other things, increase awareness of the antecedents of suicide amongst children and young people.
- That BSCB shares this SCR with all secondary schools in the local authority area and with Bury Suicide Prevention Group so that it can be used in wider learning.
- That BSCB and partners consider how to embed the 'Think Family' approach.
- That BSCB get assurance from the Local Authority that children and family assessments will include consultations with both parents with parental responsibility and consider the needs of all resident and non-resident siblings and half siblings.
- That BSCB seeks assurance that information about safeguarding concerns are appropriately shared at the point at which pupils transfer between schools.
- That BSCB obtains assurance that the advice provided to partner agencies which contact the MASH is consistently sound.
- That the local Community Safety Partnership seeks assurance that MARAC will consider the impact of domestic violence and abuse on all siblings even if not resident in the immediately affected household.

Full recommendations are detailed in the final report which can be found on the website.

6. What to do

- All assessments should consider the wider family including those resident elsewhere.
- Make yourself familiar with suicide antecedents and the suicide prevention strategy.
- Use a 'Think Family' approach as this ensures support provided by children's, adults' and family services is well co-ordinated and focused on the whole family.
- Visit Public Health England who provide tools to help professionals https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance
- PAPYRUS gives advice to young people and professionals 0800 068 4141.

7. Questions to consider

- Consider if you are familiar with up to date research about suicide.
- Use this Review to engage staff in discussion and learning about teenage suicide.
- Reflect on the findings and discuss the implications for your service/practice/school.