Practice Learning Circle concerning a teenage child, September 2025

7 POINT BRIEFING

1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a practice learning circle concerning a teenage child following their sudden and tragic death in September 2025. The child's death was as a result of an attempt to end their life by suicide.

The areas the learning circle identified included the following:

- Ability of services in being able to alter outcomes for a child who has experienced significant and prolonged childhood trauma
- Impact of sexual abuse and correlation to suicide ideation
- Keeping a child safe who has been identified as having serious intent to end their own life
- Extent to which services understand the influence of parents who live outside of the child's home

2 WHO WAS THE CHILD AND THEIR FAMILY?

The child was in their mid-teens at the time of their death and resided in Wakefield with their father for three years. The child has a half sibling who resides outside the area and their mother also resided in an area outside of Wakefield. The child's mother and father were separated.

3 SUMMARY OF THE INCIDENT

Emergency services were contacted upon discovery of a child was found un-responsive at home. The child was resuscitated and taken to hospital where the child received care. Due to the level of injury sustained, medical professionals tragically determined the child's injuries being incompatible with life and they died in the following days.

4 KEY POINTS AND ANALYSIS FROM THE LEARNING CIRCLE

- **Ability of services to alter outcomes for a child with significant and prolonged trauma**

Multi-agency assessments
assessed father's stability support and considered psychotherapy and inpatient admission. The leaning circle reflected on the trauma of this scale often results in long-term emotional instability, meaning even high-quality intervention may not fully mitigate risk.

High-intensity and responsive intervention
was provided by services acting proactively with weekly sessions, and increased contact after suicide attempts. Therapeutic parenting support was also provided.

Child's early trauma
remained a persistent influence on emotional regulation and risk despite strong support. The learning circle recognised the depth and chronicity of trauma meant outcomes were inherently difficult to alter especially when harmful influences remain present.

- I**mpact of sexual abuse and correlation to suicide ideation**

Child's experience of suicidal ideation and attempts:
The child experienced emotional dysregulation, suicidal thoughts, self-harm and previous attempts to end life by suicide. Services reflected on the child's experience as a victim of sexual exploitation and abuse which occurred when they lived outside of Wakefield, that significantly increased the child's vulnerability.

The criminal justice process:
The child disclosed being a victim of a sexual offence. The learning circle acknowledged while necessary, the criminal justice process can retraumatise victims, especially when perpetrators make contact which increased the child's emotional distress.

- **Keeping a child safe with serious intent to end their own life**

Mental Health support:
Mental Health Services escalated support appropriately, including twice weekly contact after previous attempts to take their own life occurred. In the days leading up to the incident which caused their death, the child presented as stable and future-focused. Despite this, it was recognised the trauma sustained from a young age was seemingly always present for them.

Inpatient admission:
It was reflected on whether the child should have accessed an inpatient unit sooner than they did. Given the strict and robust requirements in assessment as part of the mental capacity act the decisions made were appropriate. Further, given the child's presentations there was a risk being admitted would have heightened their vulnerability to suicide. The support father was providing at home for the child, also factored into the decisions being admitted into an inpatient unit was not in their best interests prior to this occurring around six months prior to their death.

Need to strengthen safety and discharge plans:
The learning circle identified the joint working would have been enhanced further by ensuring all safety and discharge plans were visible across agencies.

Strong effective joint working:
The learning circle identified strong examples of effective joint working services, one example included the work between mental health worker and school who were in regular communication throughout the support.

- **Extent to which services understand the influence of none-resident parents**

Understanding risks posed by none-resident parent:
Mother remained a significant influence despite the child living with father. On reflection it was unclear as to the line of sight services maintained consistently in respect of mother, how this was assessed, informed planning and intervention.

None-resident parental contact:
Contact was intended to be supervised, but records indicated unsupervised contact occurred with mother. Adolescents with trauma histories may seek contact with unsafe parents due to attachment disruption, making risk management more complex.

Stronger cross-border communication:
The learning circle identified the need for stronger cross-border communication and clearer monitoring of parental contact would have improved understanding of risk.

Cross boarder findings:
The learning circle identified the need to share findings from the review with out-of-area services for wider learning, but to also ensure this supports the safeguarding arrangements for the child's half sibling.

5 WHAT WILL WSCP DO WITH THESE FINDINGS?

- The learning circle generated individual, group and system recommendations which are being overseen and implemented by WSCP multi-agency subgroups which are represented by services who work or volunteer with children and families.
- WSCP will hold practice review briefings to disseminate the learning and analysis to the children and family's workforce.

6 NEXT STEPS

- The findings of the practice learning circle have been approved by WSCP, and work is underway in implementing the learning from the incident.
- Share findings from the practice learning circle with out of area service.

7 RESOURCES

There are a range of national and local resources, guidance, and training in relation to safeguarding children on the WSCP website.

Wakefield Safeguarding Children Partnership