7 - minute Learning Summary

Local Child Safeguarding Practice Review – ALSAMI

Case Summary

In June 2021, a 14-year-old Wandsworth boy died by suicide, attendance to the home by professionals confirmed this. At the time of his death, Alsami and his brothers and sisters were open to Children's Social Care. A Section 47 enquiry was completed, and a Child and Family Assessment was being progressed to inform threshold and response to need. Alsami was reported to be in good physical health. He was not attending school at the time of his death, as he was waiting on a transfer to a different school, a request made by his mother.

Alsami's mother described him as a "joker" who would make everyone laugh and told her to "be happy".

According to his primary and secondary school teachers ,Alsami was "a quiet student" and "a lovely pleasant young person" . He had many friends and enjoyed his time in school, particularly school plays where he took on a lead role. Alsami took pride in his appearance and was smartly dressed at school.

Background

Alsami was of a British Pakistani ethnic background. He lived with his mother, stepfather, brothers, and sisters. Alsami was known to Children's Social Care for 11 years prior to his death. When Alsami was 4 years old he was placed on a child protection plan following injuries to his inner and outer ear. Alsami and his siblings were subject to abuse and at increased risk of Adverse Childhood Experiences. For example, his older brother and sister were at risk of going missing, afraid of alleged forced marriage and fearful of sexual abuse. Criminal proceedings were brought against Alsami's father for the sexual abuse of his sister, but he was found not guilty.

Alsami's mother experienced Adverse Childhood Experiences from an early age. Alsami and his siblings were subject to a Child in Need plan and later a Child Protection plan, but these do not appear to have had the expected impact on or lead to positive outcomes for children in the family. The family were facing other challenges including the aftermath of sexual abuse allegations and the additional pressure on their mother. Alsami's mother did not feel properly supported during this period and felt professionals were ticking boxes to progress care plans rather than genuinely caring about her wellbeing and support needs.

Alsami was the quiet child in his family. His older brother and sister were the focus of professionals because of their missing episodes and other safeguarding concerns. It was described that he got on well with his older brother and sister, but on one occasion his brother physically hit Alsami and threatened him. Professionals were concerned that the family home environment was 'unsettling and disruptive', following reports that Alsami's siblings were having fights with each other, sometimes using knives.

Conclusion and Recommendations

There is an overarching theme of the intersectionality of race, sex, gender, identity, and religion; how both children and families are thought about and practice is developed, and their voices and experiences are understood by professionals. Since this review commenced, Children's Social Care have been embedding the use of Social Graces tool as part of its commitment to systemic practice, which could be extended to the wider partnership. Along with cultural genograms the Social Graces provides an opportunity to explore and understand the identity and values important to families.

That Alsami took his own life , is very difficult reading for professionals who work very hard to safeguard children. All agencies have reviewed their processes and have highlighted areas that have changed since Alsami's death. There are areas for improvement, and these have been reviewed appropriately and recommendations have been made by each agency for changes in their approach to work with vulnerable teenagers. There are seven key learnings from this review., two areas that require further consideration are the rigour with which processes are employed especially at times of national crisis such as the pandemic and secondly the importance of how the child's background, sex, gender, religion, ideals about masculinity and racial demographic challenges agencies to understand and work with families in crisis.

What did we learn

How to use this briefing:

To ensure impact, 7 minute briefings should be delivered face to face to promote discussions and not included with other day to day issues. Please consider these 3 questions alongside the briefings:

What are your key thoughts and reflections?

How can we ensure the learning is embedded and how will we know this?

How can we integrate the learning into team or service improvement plans?

This 7 minute briefing is a combination of information taken from the LCSPR report. The structure is designed as a reminder to think about 'application to practice'. The briefings do not have all the answers, they are a tool to enable teams to reflect on their practice and systems.

The key learnings are:

1. Knowing the child and his/her lived experience. This review has highlighted the importance of taking time and assertive commitment to understand the lived experience of a child.
2. Ensure that professionals are proactive in understanding and working with the religious, cultural background of children they are in contact with.
3. The impact of Adverse Childhood Experience and childhood trauma on children whether they verbalise their concerns or not.
4. Take particular care and attention towards 'sensitive and quiet' children in a large family group. Ensure that their views, worries, concerns and lived experience are sought and assertively included in plans and any work with them.
5. Purposeful parental engagement which takes account of the parental vulnerabilities, Adverse Childhood Experiences, and childhood trauma on their parenting.
6. Have an informed view about the impact of alleged sexual abuse on all children in the family and in particular male children where the perpetrator is a male and the victims are female children. Take account of research into the impact on male self-image, masculinity, and self esteem of male abuse in families.
7. Contextual Safeguarding. Recognition of the impact of contextual safeguarding to adolescents, especially young men who may be subject of exploitation and fear in communities. The use of current processes and procedures to engage with partnership developments on contextual safeguarding. The partnership will want to develop this in its action plan.

Wandsworth Children Safeguarding Partnership have begun implementing work in the following areas:

1. Action plan based on this review will explore how the partnership will work together to identify and work with triggers or signals from young people.

2. Informed by meeting with Alsami's mother and the school, the chair of the review is implementing learning on young people feeling safe in their communities.

3. WSCP will consider how to support young people so that they have trusted adults to turn to when they are feeling despair.

Wandsworth Children Social Care are developing in the following areas:

1. The understanding of the impact of religious and cultural background on the lived experience of young people has been recognised as an area for development in the Children's Social Care Independent Management Review. The implementation of systemic practice across Children's Services addresses this.
2. Moved to a relationship-based approach to practice across the last year.
3. Has a dedicated project between Early Help and Police which focusses upon incidents close to schools which involve theft, robbery, or threats between young people.
4. Embedding the use of Social Graces tool as part of its commitment of systemic practice.
5. Wandsworth has continued to revise and aligned its contextual offer to adolescents since 2019 and again in 2021. It has a dedicated team that supports children and young people at risk of exploitation and being missing as well as a social work team for adolescents