Child Aiden

Local Child Safeguarding Practice Review

South Tees Safeguarding Children Partnership

1. The Review (LCSPR)

Involves the death by suicide of a 16-year-old boy. This was a profoundly tragic and traumatic event that affected his family, professionals, and the wider community. This review acknowledges the lasting impact of such a loss while focusing on learning. Its purpose is to identify opportunities to strengthen support systems and seeks to prevent similar events in the future.

2. Understanding Aiden's lived experience and voice

Aiden lived in a large family cared for by both parents. The family had recently relocated following a violent attack on their home. Life was chaotic, with cumulative neglect, financial strain, overcrowding, poor living conditions, missed health appointments, and the children often appearing unkempt. Professionals struggled to maintain contact or gain access, and the mother strongly denied neglect.

Aiden was referred to CAMHS at six due to behavioural concerns at home and school. He was diagnosed with a moderate learning disability and autism and had an EHCP. He found it difficult to express feelings verbally and often communicated through behaviour. He frequently told family and professionals he 'did not want to be here anymore' and had thoughts of self-harm. School initially felt safe and predictable for him, but in the 10 months before his death, his emotional well-being deteriorated, and he was suspended 15 times. He spoke positively about sports activities, which supported his confidence and self-worth. There were long-standing maternal mental health difficulties, while the father's needs remained unknown and un-assessed.

3. Practice themes to make a difference

The review reflected on key themes that helped the safeguarding partnership to better understand Aiden's lived experiences in the context of his increased vulnerability and the circumstances of his life.

- Understanding children's lived experiences, including how neurodiversity, developmental level, and cumulative neglect interact.
- Building confidence and competence in responding to self-harm and suicide risk, especially for neurodiverse children.
- Strengthening understanding of neglect thresholds, with emphasis on cumulative harm and patterns of care over time.
- Improving cross-boundary working and professional challenge, ensuring the child's needs remain central.

4. What we learned from this review

1	A deeper understanding of children's lived experiences, including how neurodiversity, developmental stage, and additional learning needs shape what they require from parents to thrive.
2	Greater curiosity about underlying vulnerabilities, including parental history, capacity, and situational factors, and how these intersect across all multi-agency assessments.
3	Improved knowledge of how parental mental health difficulties affect parenting capacity, children's care, and overall family functioning.
4	Clearer recognition that neglect thresholds must consider cumulative harm, adversity, vulnerabilities, and parental capacity. Closing or stepping down a case must include discussions with all professionals involved with the family.
5	Stronger understanding of cross-boundary processes, including roles and responsibilities when transferring cases.
6	Increased knowledge about homelessness duties and their relevance to safeguarding.
7	Recognition of the need to fully include fathers, understanding both their role and their support needs.

8	Enhanced application of critical thinking and professional challenge, ensuring decisions are reflective, robust, and centred on the child's needs.

5. Recommendations included

Strengthening multi-agency assessments to fully understand children's lived experiences, considering neurodiversity, developmental level, and the cumulative impact of neglect
Develop multi-agency knowledge and confidence to identify and manage self-harm and suicide risk, with a focus on neurodiverse children.
Ensure thresholds for neglect are consistently applied, focusing on cumulative harm and patterns of care rather than isolated incidents.
Strengthen cross-boundary collaboration and embed effective professional challenge to resolve differences and keep the child's needs central.

6. What can you do?

1	Reflect on what life is like for this child in this situation at this particular time, linking behaviour to possible harm and unmet needs.
2	Use analytical tools, including Chronologies, to identify cumulative harm and the **Six Question Tool** to structure your thinking.
3	Share and seek information with professionals involved with the child and family. Do not assume knowledge is already understood across the network.
4	When families with complex needs move between authorities, hold a multi-agency handover meeting to share essential information, clarify concerns, and confirm responsibilities across Housing, Education (including EHCP), Health, and Children's Services.
5	Access training, resources, specialist input (e.g., CAMHS), and supervision to strengthen your confidence in recognising risks of self-harm, suicide, neurodiversity-related vulnerabilities, and neglect. **Even when it feels difficult, proactively support young people in accessing help and in talking openly. Discussing suicide or self-harm does not raise the risk [1].**
6	Recognise that suicide in young people [2] often, results from multiple vulnerabilities with recent stressors acting as a potential 'final straw'.
7	Use collaborative, visible Safety Plans that place the young person and family at the centre.
8	Apply 'Was Not Brought' policies consistently and share their implications across the professional network.
9	Support families to understand pathways such as EHCP and CAMHS through clear verbal and accessible written guidance to build trust and engagement.
10	Identify and strengthen protective factors, including confidence-building activities and trusted relationships within the family and professional networks.

1&2 NSPCC suicide-learning-from-case-review-briefing.pdf

7. Access the Report

There is a Learning Resource associated with this Review to ADD

Read the full report **here**