Suffolk Safeguarding Partnership

Case Summary

Amelia had resided in Supported Accommodation (SA) since July 2018. At the time of her death, age 17, she was open to Children's Social Care and was supported via a Child in Need plan and a Supervision Order.

Amelia was a young person who showed insight and understanding of her own problems. She had a brother and was supportive of her mother and grandmother. Amelia had witnessed domestic violence towards her mother. Amelia became involved with older males and there were concerns regarding exploitation. Amelia engaged well with the Make a Change Team and good progress was made.

Emergency services were called late morning by one of Amelia's friends (also a resident at SA) as Amelia had not responded to friends who had been trying to raise her for approx. 30 minutes (knocking on her bedroom door and calling her mobile). Paramedics arrived on scene and were immediately joined by a second crew. Police arrived soon afterwards, and Amelia's bedroom door was forced open. The door was locked from the inside with no possible access without a key.

Amelia was found on her bedroom floor with a belt around her neck. She had asphyxiated on the belt. Amelia was pronounced dead on the scene. It was clear she had been dead for some time.

A note was found by police in an open storage box on a shelving unit.

On the evening prior to her death Amelia and others from the supported accommodation were drinking at a local pub. She had also attended a house party later that night. Amelia was described as very intoxicated, and she had been using illegal drugs. She was also believed to be taking prescribed medication.

Amelia returned to her supported accommodation in the early hours of the morning. It is understood she was last seen around 6am and then again on CCTV two hours later. It is known she had an argument with a friend who she had been in a same sex relationship earlier prior to this. Her friend was also a resident and there had been concerns that at times this was a controlling and abusive relationship from both sides. It is understood Amelia was aware the accommodation provider was looking to signpost her to what they hoped to be more appropriate accommodation to meet her needs, but she believed she was going to be evicted.

Amelia had a history of self-harming behaviours for which she was open to mental health services. She was last seen by her Psychiatrist three days before her death where no concerns were raised that she was suicidal.

Amelia attended the local further education college and had had some support from a specialist Youth Support worker.

Summary of Learning

- Where cases are open in Children's Services practitioners must ensure all workers, who are working with the child/young person in the plan are keep abreast of changes being made to the plan. This should include educational establishments and any key workers working with the child/young person in that establishment.
- All workers must be kept informed when a person is disengaging from services, via the plan and lead worker. If there is a change of worker, new lead workers must be updated on the case by the supervising manager.
- All agencies must ensure their recording systems indicate when children and young people are open to or receiving other services and which services these are. Practitioners need to be mindful of being clear about who is involved in the case to ensure that any other practitioners picking up the record/case can make sense of it e.g., the Emergency Duty Service, Health Visitors, GPs, new workers.
- Accommodation providers must inform the lead worker early if a young person is at risk of being moved out of the accommodation or of being made homeless, to ensure support and services can be put in place.
- Training on exploitation be made available for accommodation/housing providers. It should include the role of the Make a Change Team.
- Accommodation providers to be supported to develop or improve information sharing protocols for sharing information with other agencies.