MSCP LLR Briefing sheet

Learning Lesson Review Andy - April 2022

Local Safeguarding Children Partnerships undertake Learning Lessons Reviews (LLRs) when partners feel there is multi-agency learning that can be identified in the case. The purpose of such reviews is to learn lessons and improve practice. This publication aims to share the learning from the Andy LLR to allow professionals to reflect on their own practice.

Trigger event

Andy was 15 years old when he died from hanging. He had been found by his mother in the back garden of his house, after an unremarkable and seemingly uneventful evening leading up to his suicide. He had been transported home by his father the previous evening after a stay of eight days with him. His stay with his father was reportedly incident free.

On the eve of his suicide, Andy entered the home in an unremarkable frame of mind with no active indication that he was contemplating taking his own life. His demeanour appeared positive and he gave his mother no reason for concern. In the early hours, Andy had online contact with a female where he was heard to say: 'why have you done it again?' It is difficult to establish the exact significance of this utterance, but it may relate to Andy feeling that this was just one more rejection in a chain of disappointments and rejections that characterised his life.

Summary of known background

Andy was White British and ordinarily living with his mother, but occasionally staying with his father. His parents had separated when he was two years old. Medical records indicated that he was a child that was 'constantly active all day' and it was recorded that he had poor eye contact and was behaviourally impulsive.

At the age of six years old he received a formal diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and as he matured, he was awaiting a further assessment for Autistic Spectrum Condition (ASC). Medical reports indicated that he suffered with sleep difficulties.

There were nine incidents of police involvement with the family related to Andy's behaviour. Andy first came to the attention of Children's Social Care at the age of twelve years after he made an allegation of physical assault against his mother. These incidents triggered a series of professional meetings and investigations.

There were a string of incidents and events over three years prior to Andy's death that offer some background and context to his suicide. These events relate to climbing over the school balcony, fire-setting, writing a suicide note, intra-familial assaults, making threats of suicide, self-harm, not taking his ADHD medication, Covid 19 and a disputed overdose.

In 2019 a referral was made for Early Help support and Kent Fire and Rescue Service (KFRS) were contacted regarding Andy's fire starting behaviour. Early help support was offered to the family with the focus to support Andy and his mother with their mental health need.

Andy's behaviour had shown some improvement after the intervention of Early Help and KFRS. Andy's fire-setting behaviour in the house had diminished and his relationship with his mother had improved. His school attendance was said to be 100% and he received positive school reports.

Mother reported that Andy had experienced sleep difficulties since the age of 4-5 years old. Recently, his sleep difficulties had deepened and were perturbed. According to mother, Andy had inverted sleep patterns, sleeping all day and staying up all night playing on his xbox.

In April 2020, South East Coast Ambulance Service (Secambs) attended following a call from Andy's mother as Andy had taken an overdose of 5 co-codamol tablets, his mother's prescription medication. Andy was taken to Medway hospital. Since the lockdown, Andy had been experiencing worsening behaviour and mental health. He had not been taking his medication and his mother was struggling to manage his behaviour, poor sleep patterns, personal hygiene and diet.

Families experience

The reviewer spoke to Elizabeth, Andy's mother who provided her perspective to the learning. Elizabeth felt let down by professionals who in her view promised help and assistance, which never materialised. She described a breach of trust in professionals who professed to be helping. This impacted negatively on her trust in professionals and her relationship with

Andy's school. Elizabeth felt that professionals were too quick to judge and to make presumptions about her relationship with Andy, without taking the time to see them together and to establish the facts.

Findings

The table below provides a summary of the key findings:

MSCP Key Findings
The relationship between suicide and ADHD/ASC
Capturing the bigger picture
Holistic practice and professional curiosity
Out of the blue
A family under pressure
Post-suicide support and help
ADHD medication as a protective factor
The importance of sleep and rest in the generation of positive mental health and psychological well-being
The impact of coronavirus and lockdown
Social Media & Online Chats

There is clinical evidence to suggest that those who have a diagnosis of ADHD are more at risk of suicide than those without a diagnosis.

The immediate events leading up to Andy's tragic death suggest there are no active intentions or indications on the eve of his suicide that may account for his actions. It comes 'out of the blue'. Yet if one widens the focus there are clues that put together tell another story. It is a narrative of suicide threats, fire-starting, a suicide note, an overdose and self-harm.

A family in hot dispute and open conflict does not provide the stability, cohesion, consistency, predictability, and constancy that is required for optimal development and positive mental health in children and young people. Therefore, it is vital that for families who are struggling to work together to receive sufficient help to set aside their differences and collaborate.

Conclusions

Suicide is an international phenomenon that has come to dominate the health and public services of advanced and developing countries. The World Health Organisation (WHO) records suicide as the second leading cause of death amongst 15 to 29 years old.

The global pandemic of coronavirus and the impact of lockdown created unprecedented conditions in the context of suicide risk, contributing to the scenario of a 'perfect storm.' This scenario is likely to be true for Andy and many young people who have so tragically lost their lives to suicide. The construct of the rising tide of risk and concern, charts the risks, escalations and concerns involved in the suicide process, including a family under pressure, which was marked by accusations, allegations, and intra-familial incidents.

These family dynamics reached 'crisis point' and mother struggled to manage Andy's behaviours, sleep patterns and nocturnal disturbances. Professionals did respond to mother's calls for help with some interventions making a positive difference to the family. There may be an argument that professionals tend to be 'incident focused' with an evolving pattern of incident, assessment, strategic meetings, discharge, and closure. In the case of Andy due recognition was not given to the bigger picture of his call for help through fire-setting, suicide threats, a suicide note and an overdose. The impact of coronavirus and lockdown contributed to Andy believing that it represented a school holiday and his decision to have a medication break removed an important protective element. In conclusion, Andy may have suffered one rejection too many and in a poignant and desperate act of self-rejection, he took his own life by hanging.

Action taken as a result of the learning

Whilst the review was ongoing, agencies had already taken the following action:

- During the covid-19 pandemic, Medway Children's Services contacted young people matching Andy's profile to proactively offer support and ensure the parents/ carers were alert to the young persons emotional wellbeing;
- Initial findings from this review were shared by the reviewer at a multi agency conference for professionals in 2021 hosted by the Kent and Medway Children and Young People Suicide Prevention Network;
- Youth Suicide Awareness Prevention training was provided through West Kent Mind to all partners along with the Kent and Medway e-learning training, Suicide Prevention, and other relevant training resources.

Recommendations

- For clinicians and practitioners to have a fuller understanding of the association between suicide and ADHD/ ASC and the mediating variables that create co-morbidity
- The development of inter-agency networks that reflect professional curiosity across all agencies
- For practitioners to have a robust understanding of the bigger picture of suicide process rather than being 'incident led'
- Families under pressure require timely assessment and intervention in a manner that promotes family unity, conflict resolution and working together for the benefit of the young person. Parenting programmes and Early Help interventions have demonstrated positive efficacy in this area
- Professional agencies should provide postvention, debrief and assistance sensitively acknowledging the needs, timeframe, level of intervention as requested by the family.