

## 1. Background and Concerns

A Line of Sight was held jointly as part of the child death review process to identify learning in relation to a young person who tragically died by suicide.

Factors within the review included poor mental health described as experiencing obsessive and intrusive thoughts of self-harm and suicide (without intent). The young person had access to non-prescribed medication and therapeutic support outside of the UK. At the time of death, the young person was on a waiting list for local mental health support.

Additional factors highlighted in the review included adverse childhood experiences (disclosure of childhood sexual abuse) language and cultural needs, poor parental engagement, declined school attendance and potential undiagnosed learning needs.

Additionally, it was reported that the young person was struggling with their sexual identity.

## 7. Further information – links

[About THRIVE Hull — How are you feeling?](#)

[Race, racism and safeguarding children - GOV.UK](#)

[Information sharing advice for safeguarding practitioners - GOV.UK](#)

[Threshold of Needs Guidance – Hull Collaborative Partnership](#)

['Everyday Bordering' in the UK: Families and Social Care](#)

[DfE non statutory information sharing advice for practitioners providing safeguarding services for children, young people, parents and carers](#)

[Hull and East Yorkshire Mind - We are Hull & East Yorkshire Mind, the mental health charity](#)

[Home - Let's Talk - Hull Depression & Anxiety Services](#)

[Escalation and Resolution - Professional Resolutions...](#)

[The Warren Youth Project | A place for young people in Hull](#)

[NHS Humber Youth Recovery & Wellbeing College](#) – a person-centred community for those aged 11–18. The college is led by young people and explores creative and empowering ways to improve wellbeing through engaging virtual and face-to-face experiences, workshops, sessions, and activities. Includes crisis support advice and resources.

[Mental Health Foundation | Everyone deserves good mental health](#)

[Mental health - NHS](#)

[YoungMinds | Mental Health Charity For Children And Young People](#)

[Samaritans | Every life lost to suicide is a tragedy | Here to listen](#)

[Blossom – Humber Wellbeing Hub](#)



## 2. Purpose of the Review

The Line-of-Sight meeting was conducted to enrich the learning alongside the Child Death Review process. A joint approach between the HSCP and CDR systems allows for learning to be shared more broadly which contributes to wider system learning.

## 3. Key Lines of Enquiry

- Mental health needs identified and responded to in a timely and proportionate way
- Opportunities to identify risk and provide early support
- Timely support and intervention, including risk management and safety planning
- Consideration to culture and identity

## 4. Key Learning

### 1. Assessment of Need

Early intervention, professional curiosity, clear recording, and consistent safety planning are essential to identify unmet needs early, recognise risk indicators, and ensure timely, coordinated mental health support.

### 2. Threshold of Need

Practitioners must explore non-engagement, maintain tenacity when consent is withheld, communicate directly with those holding parental responsibility, and use HSCP threshold guidance to ensure children receive the right support at the right time.

### 3. Escalation and Resolution

Professional disagreements must be addressed promptly and proportionately, with practitioners using the escalation and resolution policy to ensure safe, informed decision-making and effective multi-agency practice.

### 4. Understanding Cultural Needs

Language, culture, and identity must be considered through an intersectional lens, with clear understanding of family networks and use of interpreters to support meaningful engagement and accurate assessment of risk and need.

### 5. Voice of the Child

Practitioners must understand the child's lived experience, identity, history, and mental health journey, ensuring the child's views and preferred support approaches inform assessment and planning.

### 6. Information Sharing

Information must be gathered, shared, and triangulated across agencies so all practitioners hold a consistent understanding of risks, strengths, and safety, enabling effective and coordinated safeguarding.

## 5. Good Practice

- There was evidence of a good working relationships with the school nurse.
- Supportive educational package in place which included provision for children who are new to UK. Staff at the provision are bi-lingual.
- In house therapy offered at post 16 provision.
- When attendance declined, good liaison with NEET services occurred and personalised timetable offered.
- Evidence of referrals to EHASH around concerns of attendance.
- Mental health assessment undertaken whilst in attendance at the emergency department.
- Quick screening in EHASH when notification of missing young person was received, and a strategy discussion held.

## 6. Next Steps

- Strengthen suicide prevention and mental health pathways for children and young people.
- **Map support for minority and diverse communities**, understand access routes, and develop actions to increase confidence and engagement.
- **Review suicide incidents in public spaces** and ensure learning is aligned with and fed into the **Child Death Review process** to support prevention.
- **Share the 7-minute guide** across all partner agencies to support consistent learning and reflective discussion.
- **Promote and utilise HSCP Learning Programme training** to embed key safeguarding learning across the partnership.
- **Ensure all safeguarding partners share review learning internally** within their own organisations to strengthen consistent, system-wide practice.