Learning from Rapid Review – Leigh

Background

Leigh was a transgender young person who identified as male who changed his name to reflect his identity. He died by suicide at home in 2024 while subject to a Child Protection Plan (CPP), which had recently transferred from a neighbouring authority.

Leigh and his siblings had long-standing involvement with services due to domestic abuse, parental conflict, alcohol misuse and poor home conditions. The family received support through Early Help and Child in Need before being escalated to child protection.

Leigh was a vulnerable young person who experienced emotional harm within a home affected by domestic abuse and had a strained relationship with his stepfather. He struggled due to safeguarding concerns and exposure to DA had significantly impacted on Leigh's mental health over time, presenting through self-harm and suicidal ideation, although he could thrive in safe and supportive environments.

Key Issues Identified

- The relationship between Leigh's experiences of abuse and neglect, including domestic abuse and their poor mental health in adolescence was not fully understood. This, combined with concerns around gender identity, did not fully translate to the safeguarding assessment or plan.
- Safeguarding plans focused too much on adult behaviour and not enough on Leigh's needs.
- Key partners were often missing from safeguarding meetings, which meant plans were not joined up and professionals did not share a complete understanding of risk.
- Mental health services were not consistently asked to contribute at critical points, leading to poor information-sharing and gaps in how agencies understood Leigh's emotional and mental health needs.

Key Issues Continued

- Serious incidents, including disclosures, self-harm and an overdose, did not lead to agencies coming together to review risks or plan next steps.
- Professionals did not challenge missed appointments, service withdrawal or safeguarding decisions, resulting in missed opportunities to strengthen protection.

Key Issues Continued

- Transfers between local authorities and services were poorly coordinated, causing delays, missed referrals and confusion about who was responsible.
- Risks from education settings, online activity and peer relationships were not fully explored together, meaning important factors affecting Leigh's wellbeing were overlooked in multi-agency planning.
- Key actions, including specialist referrals, were not completed, and there was no shared system for checking that essential tasks were followed through.

What worked well

There was a strong, trusting relationship between Leigh and his social worker, with his voice clearly reflected in planning.

The college offered consistent pastoral care and a robust safeguarding response, supported by effective partnership working between social care, the family and education at key points.

Moving Forward in Practice

Understand the Child's Experience –

- Reflect on how young peoples lived experience were understood and whether their voice was central to planning.
- Consider current cases: ensure children's voices are clearly captured.

Review Multi-Agency Engagement –

- Reflect on how agencies collaborated and barriers to full engagement.
- Ensure key agencies are involved in meetings and invited to meetings: challenge non-attendance.

Assess Mental Health Pathways –

- Reflect on clarity of referral processes and communication of safeguarding concerns.
- Check referral routes for CAMHS and escalation where risks increase.

Strengthen Safeguarding Practice –

- Reflect on responses to disclosures and strategy meetings to assess risk.
- Convene strategy meetings promptly when risks escalate.

Quick Support Links

You are asked to reflect on the learning from this case and consider what it means for your own service and day-to-day practice.
Review the resources designed to support children and young people who identify as transgender to ensure professionals across Oldham can provide informed, consistent guidance and signposting.
Training and further guidance based on the key learning from this review is available on the OSCP website, and practitioners are encouraged to access this to further develop their skills, knowledge and confidence in supporting young people effectively.

Website: www.oldhamsafeguarding.org
Email: OSCP.group@Oldham.gov.uk

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