SPR Learning Review - Jake

1 Critical Events

'Jake was a smart, articulate, and creative boy who was full of potential. He was at his happiest when he was using his talents, most notably writing, and performing his music. This gave him an outlet to share honest, and often painful, reflections on his life and future'.

Voice of Jake, via his family

Jake was 17 years old when he took his own life. He died one month before his 18th birthday.

2 Safeguarding Concerns

- Dual Diagnosis (Mental Health and Substance Misuse), in later years his sense of self became cemented within his substance misuse.
- Multiple placements
- Missing from Education
- Multiple presentations at the Emergency Department
- Multiple contact with London Ambulance Service
- Multiple contact with Police
- Self-Harm

3 Findings

Many of the issues highlighted in this report have been identified as national problems. Two key areas that presented challenges have recently been the subject of national review (Drugs, CLA).

A repeated theme in this review is of services being unable to provide a framework within which to support Jake with his emotional and mental health until his substance use was better controlled.

There is a need to ensure offers of Early Help are effective and have a family focus. Research suggests that difficulties in the early years impacts on parent-child relationship.

Jake was made the subject of a care order just before his 16th birthday. Once in care, there was insufficient clarity about where he should live. He went home when he wanted and at times when he did not have a placement. He wanted to return home permanently and this was consistently recorded as the plan for Jake, but it is unclear how this was to be implemented.

Children communicate through their behaviour. Clinicians in schools need to facilitate recognition of the help seeking nature of challenging behaviour and offer a timely response so school exclusions are not seen as the only option.

Late entry into care is a national issue and the importance of seeking alternatives for this age group is key.

In the last 3 years there were approximately 40 presentations to ED, 178 liaisons with the police. There were multiple 'red flags' and the risks were known but were not collectively understood or owned. There was a lack of wrap around care and attention to contextual safeguarding.

Jake was a high-risk category for suicide. Five months before his death the nation went into lockdown due to the Covid-19 pandemic. Two additional factors coincided; Jake's alcohol consumption increased, alcohol is a depressant, it is possible that it lowered his mood and contributed to a rapid decline in his mental health in the last six months.

Additionally, appointments moved from primarily face to face to virtual. Jake had several cancelled court dates and some face-to-face appointments and as a child who said he was anxious, unhappy and did not like himself it was likely to have had an adverse impact on his mood.

4 Learning

Practitioners expressed care and concern for Jake and were committed to supporting Jake through this time when he was high risk with 'challenging behaviour'.

Practitioners were keen that this review seeks to increase awareness of possible preconceptions or biases of professionals based on family's socio-economic status.

When offering Early Help, it needs to be effective and have a family focus. Research suggests there is a need to focus on key relationships and recognise living losses in a child's life.

Development of reflective forums for staff that provide containment and support to multi agency staff in the network.

An integrated Substance Misuse/CAMHS offer would have been beneficial for Jake.

Drug use amongst children/young people is on the increase so there is a need for greater awareness of the types of drugs in use amongst young people and local campaigns/training regarding drug education – in particular drugs such as Xanax.

When risks are escalating and there are conflicting views within/between agencies about how to respond. The multi-agency group need the opportunity to reflect with senior MA management and agree when 'enough is enough', that something different needs to happen rather than continuing with 'more of the same'.

It is vital that IROs take an active role in the lives of children in care and are supported in raising and resolving obstacles that get in the way of multi-agency integrated care planning and risk mitigation. Some clinicians were unaware of the role of the Independent Reviewing Officer.

5 Achieving Change

- Reflect on the findings and discuss the implications for your practice/team.
- Outline steps that can be taken forward.
- The full SPR Report can be downloaded from croydonlcsb.org.uk