CSCP
Croydon Safeguarding Children Partnership

Child Safeguarding Practice Review

'Jake'

July 2022

Look at me, look at me…….

Jake's lyrics

"Oh no, just another drug overdose,

I'm out of this world on my drug of choice.

Getting through this life with my sanity,

It's got me paranoid, got me panicky.

I'm gonna die soon, but do I really have a choice?

I'm a renegade, but when death comes how will I be portrayed?

Death is my destiny, keep dropping Xans till they tell me rest in peace"

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1.0 Executive Summary

This Child Safeguarding Practice Review (CSPR) is about Jake, a male adolescent, who killed himself one month before his 18th birthday. It considers Jake's needs and the involvement of a wide range of services in his care. It also considers relevant legislation, policy, practice, and procedure, reflects on research, literature and national guidance, and draws learning from the extensive experience and wealth of knowledge held by those who work within the multi-agency safeguarding arena.

The CSPR process does not seek to find blame or hold individuals or organisations to account[1]. Rather the purpose is to reflect on the circumstances that led to a child's death and to understand the child's and family's experience of multi-agency services. It is an opportunity to consider what the learning might be for staff and services and how services might be improved to safeguard children and families in similar circumstances.

Jake was bright and articulate and seemed to have the advantages of most middle-class children. However, difficulties emerged early in his life and by the age of 9, behavioural problems were apparent that continued into early adolescence when he struggled with his emotional life, disengaged from education, and began smoking cannabis. Jake's drug & alcohol use increased year on year and his sense of who he was became cemented in his drug use. In parallel his behaviour became more threatening, self-harming and difficult to manage. He repeatedly said he would not live to his 18th birthday. Jake was received into care, initially on a voluntary basis and later on a care order. He lived in several foster homes and residential units.

Jake was referred to many services but engaged with very few and it was clear there were occasions when there were missed opportunities to provide a different response to meet Jake's needs. The need for self-motivation to engage in, for example, drug services meant that it was difficult to work with Jake until near the end of his life. A repeated theme in this review is of services being unable to provide a framework within which to support him with his emotional & mental health until his substance use was better controlled. The question of who was responsible for finding him a secure placement to begin this work – CAMHS or Social Care - is also key.

Several clinicians and staff who formed close relationships with Jake contributed to this review. They were highly committed to his welfare and although at times opinions differed about how to best meet Jake's needs, they nevertheless continued to work together as a professional group. Even with hindsight it is not possible to say that Jake would still be alive if there had been a different response. As T. Joiner[2] notes, there are limits to the interventions provided to people intent on taking their own lives.

Many of the issues highlighted in this report have been identified as national problems. Two key areas of Jakes life, that presented challenges to Jake and his family and to the various services involved, have recently been the subject of national review:

There is a considerable increase in children using drugs, after a long period of a downward trend. Those seeking treatment have a number of complex needs, including mental health needs that can only be met through a combination of specialist treatment and wider social and health care.

Dame Carol Black, Review of Drugs. February 2020[3]

[1] Working Together to Safeguard Children 2018 & Child safeguarding Practice Review Panel: Practice Guidance DfE 2019

[2] Why People Die By Suicide. T. Joiner 2007.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/897786/2SummaryPhaseOne+foreword200219.pdf

Between 2011/12 and 2019/20, there was an increase of almost 150% in the number of 15-year-olds in proceedings, and a 285% increase among 16-year-olds. There is a need for further research to understand the reasons why older children are being brought into care proceedings in increasing numbers.

Older children and young people in care proceedings, 2021. Nuffield Family Justice Observatory[4]

A national review of children's social care[5] is underway in acknowledgement of the burden this system is under. Nationally, early intervention is considered inadequate; there are long-standing problems accessing suitable placements for Looked After Children and poor outcomes for children received late into care. After a decade of austerity public sector agencies were struggling to offer the necessary services to meet demand. This is likely to continue as councils respond to Covid-19 related pressures.[6] There are also few drugs detox and rehabilitation services available in spite of increasing drug use. The government launch in December 2021 of the new drug strategy 'From Harm to Hope: A 10-year drugs plan to cut crime and save lives'[7] may help in this respect.

The majority of recommendations in this report are of national significance. However, there are also local issues to be addressed and Croydon Safeguarding Children Partnership are committed to working across the partnership to achieve the necessary changes.

Finally, we recognise that this is a long report. It is a reflection of the complexity of this case and our wish to give meaning to and understand Jake's experience. We wanted to listen to Jake's voice and the voices of his family and many practitioners involved in his care. A shorter briefing paper is available to accompany this paper.

[4] Roe, A., Alrouh, B., and Cusworth, L. (2021). Older children and young people in care proceedings in England and Wales. Summary. London: Nuffield Family Justice Observatory.
[5] https://childrenssocialcare.independent-review.uk/wp-content/uploads/2021/06/case-for-change.pdf
[6] https://ifs.org.uk/uploads/7-What's-happened-and-what's-next-for-councils-.pdf
[7] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/

2.0 Reason for this review

One month before his 18th birthday Jake took his own life by jumping in front of a train. The full circumstances of his death will be examined by the coroner in due course. Jake was a white British child living in a semi-independent unit in the London area. At that point he was the subject of a Care Order. After his suicide, the Safeguarding Children Partnership held a Rapid Review to consider the circumstances and concluded that his death met the criteria for a Child Safeguarding Practice Review and the National Child Safeguarding Review Panel was advised accordingly.

2.1 Purpose and methodology

The purpose of a CSPR is to learn lessons through a systems analysis of the single and multi-agency work undertaken to support children[8] and their families. This CSPR seeks to understand professional practice in context, identifying systemic factors that influence the nature and quality of work with children and families that are generalisable beyond the specific subject of the review. The aim is to provide a proportionate and meaningful account of what happened from the perspective of the child and to add reflection and learning into the local safeguarding system.

2.2 Process of review

Independent reviewer and CSPR chair: An independent reviewer, Elizabeth Murphy[9], worked alongside an independent chair, Bridget Griffin[10]. Bridget has significant experience as an author of Serious Case Reviews and more latterly Child Safeguarding Practice Reviews. Elizabeth is a Child & Adolescent Psychotherapist who has extensive experience of clinical work and of leading child and adolescent mental health services.

CSPR Panel: A panel was appointed to work with the independent reviewer and chair. The panel comprised representatives drawn from the services who provided services to Jake. These representatives were independent, in that they had no direct involvement with Jake or his family and no management responsibility for the services that were provided during the period under review. Due to a change in role the panel was joined later by a staff member who had previously worked as a manager in the drug & alcohol service and moved to post as a Project Officer for the Safeguarding Partnership. This person had some direct contact with Jake – the possible conflict of interest was acknowledged and mitigated against.

The Chair, independent reviewer and panel considered key documents and other information, interviewed relevant staff and met to discuss and agree findings and recommendations.

Research questions & documentation: Independent agency reports and an integrated chronology informed this review. The independent reviewer and chair had access to a range of other relevant reports from across the agencies.

Involvement of families & practitioners

Family perspectives: The independent reviewer and chair had the privilege of meeting Jake's mother, father and siblings during the course of the review. The following quotes are taken from what they shared.

- **Mother –** He was a real dare devil; you could do fun things but everything had an edge to it. He became like my project. He was *charming, cheeky & vibrant*
- **Father -** He used to come to football with my brothers. Family became less & less important and in the end, I only saw him on my own. He was *disobedient, strong willed & funny*

[8] In line with legislation, the term child, or children (applied to all who are under the age of 18) will be used throughout
[9] MACP (Member of the Association of Child Psychotherapists)
[10] CQSW, BA (hons), MA (Tavistock & Portman and MHT), SCIE accredited reviewer

- **Siblings –** We all loved him dearly, at times he was unreachable, at times we were scared of him. He was *cheeky, clever, determined, thoughtful, creative, unapologetic, charming & lovable*

Grateful thanks are extended to Jake's family for the time they gave to this CSPR. Their contribution to the learning, and their desire to prevent other families from suffering such unbearable loss, cannot be commended highly enough.

Practitioner involvement: Practitioners were invited to contribute to this review through agency reports, one to one meetings with the independent reviewer and chair and through a practice learning event (PLE). This event was attended by practitioners who knew Jake and also by other experienced practitioners currently working with children in the local area. Practitioners' and clinicians' deep commitment to Jake was evident; it was clear that they worked hard to support him and were devastated by his death. Practitioners gave valuable insights into service provision based on their wide experience of partnership working in Croydon.

Delay

There has been a delay in completing this CSPR. The original plan was for this review to be completed by staff within the partnership who were independent of the case. However, issues of capacity and staff turnover meant that this could not be achieved and as a result CSCP decided to commission an external lead reviewer and chair.

The Learning: Aspirations and Recommendations

Substantial learning has been identified during this CSPR which requires action on both a local and national scale. It is a requirement for local safeguarding children partnerships to take forward the recommendations and evidence that actions taken have meaningful impact. Some of the learning from this CSPR is clearly aspirational. It was felt important to document CSCP's aspirations whilst also concluding with recommendations that lead to tangible actions that can be promptly delivered for the benefit of children and families.

3.0 Summary of Jake's life

Jake was a white child of British heritage born into a relatively affluent family. Mother described him as 'a bright, vibrant and easy child to begin with'. The parents separated when he was 3 months old. Father left the family home, mother suffered from Post Natal Depression (PND) and she reported that there was an atmosphere of threat and aggression within the parental relationship. Mother said Jake was unaware of this but research suggests that this may have had an impact on Jake[11].

As a young boy, mother said Jake loved the playground, thrived at sports and at football would analyse everyone's performance. Mother described him as a "dare devil" who loved theme parks and risk. He was competitive and had a "real pride and he couldn't have it dented". Both parents reported a history of challenging but manageable behaviour from an early age which escalated when he was about 10 years old.

Jake had 3 older siblings who lived with him in his early years and gradually moved out of home to attend university during his adolescence. The last of his siblings (his sister who was 6 years older than Jake) left home when he was 12 years old. Jake was first referred to CAMHS by school when he was 9 years old. His first school exclusion was in Year 5. In Year 6 he won a scholarship to a private school, and it was agreed he should move. There were continued concerns about his behaviour and well-being in the private school as he struggled in that environment and he requested to return to a state school. After 2 years his school place was withdrawn. Aged 13 he moved school again and subsequently had 5 school placements and periods out of education. Jake struggled with his emotional life throughout adolescence. He frequently took class A drugs, self-harmed and expressed suicidal thoughts. He was a very vulnerable child who was at risk of harm in the community. Jake was 15 when he was accommodated by the local authority and 16 when a care order was made. He lived in 4 foster placements and 3 residential/semi-independent placements. At any one time he was involved with a large number of agencies. At the end of his life Jake had agreed to attend drug detox and rehabilitation. Arrangements were in place for him to be admitted and there was a hope and belief that he was turning a corner.

3.1 Events prior to Jake's death

Jake was arrested three days before his death by the British Transport Police (BTP) following a domestic incident with his partner. Both appeared to be intoxicated. Jake was in custody for almost 19 hours and attempted to self-harm (banging his head against the custody desk and tying ligatures around his neck). There is no evidence that he was medically checked. He was not seen by a psychiatric liaison nurse (PLN) as he was said to be aggressive. He was released from custody the next day into the care of staff at his semi-independent home.

Father told this review that he saw Jake the following day and said he was 'chatty and good company'. They talked about Jake's 18th birthday the following month. Jake said he'd like to go to the pub with his brother and father so he could have his 'first legal drink'.

After this outing Jake returned to the residential unit, he face-timed his father who reported that Jake was very distressed and later that evening staff called the police because of his aggression and distress. He was subsequently reported as missing. Jake went to a friend's house and was tearful, he said he was suicidal and requested an ambulance. Jake left before the ambulance arrived. He returned to the unit in the early hours of the morning, collected a T-shirt and left again.

[11] https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-effects-on-children

Later that day, one month before his 18th birthday, Jake went to a local train station and jumped onto the tracks in front of a fast-moving train. He died immediately from his injuries. Significantly the ensuing toxicology report stated that Jake was not over the alcohol level and had only a small amount of cannabis in his system from the day before.

On the same day staff were meeting to plan Jake's move to a Drug & Alcohol Detox Unit. He was not aware that a placement had been identified.

3.2 Jake

It took some time to develop a clear view of who Jake was and what he enjoyed from reading the documents presented to this review. However, during conversations with family members and professionals who were close to him, a picture of Jake emerged. He loved sport when younger and in years 7 & 8 at school was the only boy selected for the rugby, football & cricket teams. Jake had dreams and aspirations; he wanted to be a musician, illustrator, substance use counsellor. He liked rap artists Lil Peep & Lord Apex and recorded his own music. He told people that he took drugs & alcohol to stop feeling what he was feeling and that he did not want to be in care, he wanted to live at home with his family. He felt that he didn't fit in. He was an angry young man and could be frightening. One professional said "sometimes his anger was justified", "He needed to be listened to, then he'd calm down and you could explain…."

4.0 FINDINGS

4.1 Good Practice

There was clearly genuine care, concern for and commitment to Jake. In conversations with family and staff they described their extreme distress following his suicide and we were aware how hard they had all worked together especially in the last six months of his life when services were also dealing with the Covid-19 pandemic and the impact it had on practice and service delivery. It was a chaotic, uncertain and frightening time for Jake as his risk escalated, and for staff as they struggled to respond. At the outset of our review mother was keen that the staff who worked with her and Jake knew that she appreciated their efforts to support him in a 'broken system' and wanted to thank them for the support they provided. While the body of this report will focus on aspects of his care that may have been more effective and question some of the decisions made, this should not overshadow the good practice that took place.

Each agency identified and acknowledged Jake's high level of risk. Jake from the age of 15 years was involved with the Youth Justice Service (YJS) at various points and each time he was referred he was allocated to the same YJS practitioner with whom he had developed a trusting relationship and consistently engaged in work with her. We heard about some excellent child centred and flexible practice.

In Jake's last mainstream secondary school, he was offered support from 'Mighty Men of Valour' that the family confirm was helpful at that time. Unfortunately, this service ended when the funding finished.

About 10 months before his death, Jake moved to his last residential placement. The move was carefully planned and there was evidence of good information sharing concerning needs and risks. Training was available to the unit staff on the impact of substance use on children, especially Xanax. Many of the staff had experience working with children who used substances and they developed creative solutions to care for Jake. For example – they offered access to a therapist on site and a music studio to foster his interest in music and recording.

There were many agencies involved in Jake's care, often as many as 10+, and as his needs & risks were identified appropriate referrals were made to services.

While the issue of transitioning children to other teams especially when they are in crisis warrants further consideration, there was evidence of a thoughtful transition to the leaving care team. This team worked hard to keep the network together, were aware of the risk Jake posed to himself and met regularly with mother and multi-agency colleagues to share information and request that more secure accommodation be sourced to keep him safe. We heard of differences in the network about how best to respond to and contain Jake during this time but it is commendable that the multi-agency team continued to work collaboratively especially in the context of the Covid pandemic.

Supporting Good Practice: Staff need to be well supported to provide the best possible service to children and families. This is challenging and distressing work in a context where there are no easy answers and resources are finite. Crucially therefore, there need to be reflective forums that provide containment and support to multi-agency staff in the network. These forums should be an integral part of multi-agency work with children. Examples were given of how some team managers go 'that extra mile' to ensure they are available, responsive and take ownership of risk with their team, but this was not consistent. We heard that staff can request counselling sessions if they feel distressed by their work but it is not offered proactively and is not always easy to access. Whilst these things are important, they do not replace the need for reflective multi-agency forums. This has been identified in other SPRs and needs to be addressed across agencies.

Aspiration 1: Provide comprehensive support to staff who are dealing with challenging, high-risk work. Specifically, in addition to supervision, multi-agency reflective forums should be established as part and parcel of multi-agency practice. This is both a local and national issue.

It is acknowledged that in the last year systemic training and supervision has been offered to practitioners in CSC. The emerging picture is that team supervision and reflection on cases has improved. However, this should be consistently provided and built into the current multi-agency system as an expectation.

Recommendation 1: CSCP to consider how multi-agency reflective forums will be built into multi-agency meetings/panels and other current established processes. The outcome of these changes should be reviewed and measured through use of practitioner feedback and incorporated into multi-agency audits.

4.2 PREVENTION AND INTERVENTION

'….*it's a joy to be hidden but a disaster not to be found'*[12].

'*Treading water is not enough.* *We must make and take opportunities to help children differently, through earlier attention to the difficulties that face those closest to them. This would include a renewed focus on tackling parental needs as soon as they arise, through a family lens and with greater understanding across all services of complex trauma and its impact on how people respond when they feel under threat and in distress'*.[13]

[12] Winnicott, D.D. (1963). 'Communicating and not communicating leading to a study of certain opposites. In The Maturational Processes and the Facilitating Environment. London Karnac Books 2007.
[13] C. Parker & J. Tunnard (2021). *Why are older children in care proceedings?* Nuffield family Justice Observatory.

When Jake was born, the family was experiencing many difficulties. The months immediately preceding and following his birth were difficult for the family. Mother said she suffered from Post Natal Depression (PND), that father's drinking was problematic and the parental relationship was volatile. Jake's father moved out when Jake was an infant and there followed an acrimonious separation. Mother was a single parent raising four children with little support. It is not known what impact this had on Jake's emotional development, although his mother reports that Jake "was a vibrant, easy child to begin with". It is understood that the extended family offered some help, and mother attended some support groups and had medication for her depression, however the difficulties were not deemed to meet the threshold for more sustained and focused intervention. Due to the passage of time, it is difficult to know what services may have been helpful and whether the judgement that the threshold for early help had not been met was reasonable.

At primary school, Jake initially did well academically and in sport, however both parents report a history of challenging behaviour from an early age that escalated when he was about 10 years old. Mother said she was always expecting "a tap on the shoulder" from a teacher about a misdemeanour. She did a lot to scaffold her son and described being like his 'project manager' e.g., going on school trips, becoming a cub leader. Jake communicated his distress through his behaviour and in year 4 was first referred to CAMHS by his school for behavioural difficulties – hitting, swearing and outbursts - but did not meet the threshold for accessing CAMHS services and was referred to Educational Psychology.

Although he did well in tests and liked to be top of the class, Jake's difficulties continued in secondary school. He was awarded a scholarship to private school and it was hoped that greater social and academic challenge would help him settle and focus. However, instead it led to him becoming more disengaged. By the age of 13 years, he started to self-harm and smoke cannabis which he said helped him cope with his feelings. His behavioural difficulties, anxiety and low mood became more obvious and he started to lose weight. By the age of 14 years, he had become threatening at home and at school, was using drugs more frequently (definitely cannabis but possibly other drugs) and displayed increasingly worrying behaviour. He had a number of school exclusions due to aggression, drug use and lack of attendance.

A growing number of services were now involved – CAMHS, CSC, and emergency services including police and presentation at the Emergency Department (ED)[14]. The family were offered Functional Family Therapy (FFT) but described it as "tame, lame, overpromised & underdelivered". It is unclear if at this time anyone was monitoring Jake's drug use or if it was considered to be only casual cannabis even though Jake was clear he used it as a form of self-medication. Mother reported that 'at every turn' she had to rely on her own resources, she attended parenting classes and privately sourced and paid for Non-Violent Resistance (NVR) training. She remained open to suggestions from agencies about how to support and reflect on her son's needs.

Conclusion: 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[15]. Children communicate through their behaviour, it is possible that Jake's behaviour went unrecognised and that he may have been seen as bad, rather than sad.

[14] Emergency Department (ED) also known as Accident & Emergency (A&E) is a general hospital out-patient department, open 24/7, specialising in emergency medicine.
[15] Adverse childhood experiences (ACEs) and attachment, https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

The Early Intervention Foundation reports insufficient evidence around what works to support families facing problems such as those identified by Jake's mother. There is little centrally commissioned research and local services lack capability and capacity to evaluate their programmes (2018). We are now more aware of the importance of these critical years and the impact of these early years on future development/outcomes[16] and there is increased awareness of the impact parental conflict on children and their emotional development. The National Mortality Data base [17] research on suicide identifies a number of variables in the sample of children, and whilst it is important to stress that these children had experienced a collection of shared life experiences, the highest variable (69%) of children who took their own lives experienced parental separation or 'living loss'. A Nationwide project Reducing Parental Conflict[18] has been established. Local services have been strengthened, particularly better early identification in nurseries and primary schools e.g. 'inclusive forums' where children with behavioural challenges can be discussed, these forums include Educational Psychologists so it is less likely that signs that may have been missed in the past will be now.

While thresholds to CAMHS remains an issue, the panel were unclear if, in these early years, CAMHS was the right service. It is understood that children were often referred to CAMHS because of the limited number of other services available. In Croydon funding is now available to develop services to support emotional wellbeing in schools to increase awareness of issues and strengthen service offer. In addition, a Single Point of Contact (SPOC) for emotional health and wellbeing has been established; a centralised system for all referrals to services. CSC is currently developing a directory of all local services and can signpost children and families to a range of services to meet their needs.

In a recent study 'Why are older children in care proceedings?' the Nuffield Foundation found that school exclusions are a clear factor for children with the most vulnerability: '*absence from school is a trigger for heightened vulnerability, we must actively challenge policy and practice around school exclusions'* (2021). It calls for a more effective strategy to avoid/address school exclusion and the impact on the child and the wider system. Practitioners at the Practice Learning Event (PLE) also questioned whether the socio-demographic status of this family led to an assumption that they would be able to cope with their challenges and there was little more that could or should be provided to them by public services.

This profile of needs warrants a coordinated response and inclusion of substance use services with an understanding of the impact of drug use on the developing child. Where appropriate, drug services for children need to be integrated into care planning/assessments early in the process.

Aspirations:

Help Seeking 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 to deal with these difficulties. Language such as 'behavioural problems' was agreed not to be helpful, rather it is important to understand the child's emotional communication driving the behaviour. Education must be part of the multi-agency planning for children especially when school exclusions are suggested so that the impact on children and families is considered.

[16] Adverse childhood experiences (ACEs) and attachment, https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

[17] https://www.hqip.org.uk/resource/national-child-mortality-database-programme-suicide-in-children-and-young-people-thematic-report-2021/#.Yhny2C-l10u

[18] https://www.gov.uk/government/collections/reducing-parental-conflict-programme-and-resources

Drug use and misuse: Drug use among children is on the increase[19] so there is a need for greater awareness of the types of drugs in use – in particular drugs such as Xanax - and information about the addictive impact of benzodiazepines, their availability, affordability and their impact on the child's mood. This needs to be ongoing work as panel acknowledged that the types of drugs, method of use and accessibility is fast changing. The tendency to normalise drug & alcohol use in young people was identified as a local and national issue especially the type of drugs available, their pharmacological interaction, effect on the child's physical health and the likely trajectory if drug use continues. This could be achieved through the involvement of specialist drugs workers and/or training for teachers and parents.

Early Intervention: Early Intervention services should be strengthened and professionals must give greater consideration to family identity, roles and adversity to help increase parental awareness of how early life parenting may impact on child development. There is a tendency especially with very young children to think 'they'll grow out of it', which can minimise and negate the child's communication. Early intervention needs to be targeted at specific developmental stages, each of which requires a different response to improve understanding of the child's presentation in the context of their development, family constellation and environmental & social factors. Children in early adolescence are generally difficult to engage in services such as CAMHS but this work is significant and can provide the child an opportunity to establish a link with people who can help and enable a child to keep coming back to services. In addition to the primary school's forum, secondary schools now have 'team around the school' multi-agency meetings that involve all Croydon agencies. It is hoped that this will lead to better identification of need and service response to child and family.

Discrimination: Practitioners were keen that this review seeks to increase awareness of possible preconceptions or biases of professionals based on family's socio-economic status. Multi-agency networks need to be aware of potential class discrimination and consider whether services respond differently to families from different backgrounds.

Recommendations

Visibility of pathways: It is recognised that there are significant improvements in early intervention services in Croydon over the past few years particularly with the establishment of multi-agency forums for nurseries/primary schools and secondary schools and the implementation via SPOC of the Emotional Health & Well Being Service referral pathway. A new directory of all statutory and voluntary services in Croydon is being developed. A method of updating it and reviewing its effectiveness also needs to be established. However, caution should be used to ensure that referrals are not made to multiple services without the necessary review of impact and outcome of intervention for the child.

Recommendation 2: CSCP to promote the directory of statutory and voluntary services to achieve awareness of this directory so that services and referral pathways are visible and known to all agencies.

Drug use training: Young people's methods of drug use, mixing of drugs and attitude towards drugs is changing rapidly. Croydon's Substance Misuse Support provider has recently changed. The CSCP have been working with Contract Managers to ensure a suitable training program is provided within the contract.

Recommendation 3: CSCP to promote this training across multi-agency partners and have oversight of evaluation and impact. In addition, CSCP to liaise with public health and commissioners to consider what can be provided in terms of a local campaign regarding drug education.

[19] Review of Drugs, (2020). Dame Carol Black

Challenging assumptions: Multi-agency reflection panels (Ref: Recommendation 1)

Recommendation 4: The CSCP to raise awareness of intersectionality and the use of an appropriate framework or tools to consider a child's presenting needs and service response. These panels also need to provide an opportunity to assess the number of services involved with a child, their engagement and impact.

4.3 RESPONDING TO RISK IN ADOLESCENCE – a Multi-Agency Framework

4.3.1 Accommodation away from home (S20) and Late into care

a) ACCOMMODATED AWAY FROM HOME (S20)

Jake was referred to Children's Social Care (CSC) when he was 14 years old. All the reports comment on his risk-taking behaviour, aggression, absconding from school, repeated incidents of self-harm, suicidal thoughts and frequent attendance at the hospital Emergency Department (ED) when under the influence of drugs. Although his engagement was variable, by age 15 at least 10 agencies were involved in his care - Police, London Ambulance Service (LAS), CAMHS, Substance Use Service, YJS, Education, CSC, YUVA[20] (a service for young people who use violent/abusive behaviour), Child Health and universal services such as ED and his GP. He had two managed school moves, several exclusions, four referrals to CAMHS, had been referred to Multi-Agency Safeguarding Hub (MASH), allocated to Early Help (Functional Family Therapy & family resilience). There was involvement by police because of his aggression in the home and he was made subject to a Referral Order and required to engage with YJS. All agencies agreed that Jake's substance use impacted on his mental health; he was using cannabis and alcohol, threatened suicide and self-harmed.

Jake was accommodated under S20[21] by CSC following a presentation at ED when he had taken Xanax. At this time mother refused to take him home due to his increased aggression and she did not feel that anyone was listening to her repeated concerns. He was placed in emergency foster care for 4 nights. Mother took him home after he telephoned her from a train station and said that he would 'throw himself under a train' if he could not return home. By the end of the month, he was accommodated again and remained in care.

That summer Jake's fourth foster placement broke down due to his drug use in the home, physical assaults, staying out late and missing eppisodes. He was also excluded from school. It was decided to seek a care order and the plan agreed in court was for Jake to be supported in a residential placement with continuing CAMHS and substance use input and with a parallel plan for a secure order. The independent assessor for the care proceedings stated that Jake had features of depression that would need treatment at some point but that the main issue was his *'significant drug dependency problem'*.

b) LATE INTO CARE

In recent years there has been growing recognition of the increasing number of older children and young people coming before the family courts, and the diversity and complexity of their needs. Responding to the needs of these young people presents a challenge to the child protection and family justice systems, which have, until recently, primarily focused on protecting younger children from risks within the family home.[22]

[20] DVIP Young People Using Violence and Abuse (YUVA).
[21] Section 20 (S20) is a voluntary care arrangement based on agreement between; the person or people with Parental Responsibility, the child and the local authority.
[22] Roe, A., Alrouh, B., and Cusworth, L. (2021). Older children and young people in care proceedings in England and Wales. Summary. London: Nuffield Family Justice Observatory.

Jake was made the subject of a care order just before his 16th birthday. Risks were escalating – he had been excluded from school, his foster placements had broken down, his drug use had increased alongside an increase in his aggressive behaviour. 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. Until recently it was unusual to place an older child (16 years onwards) on a care order and the outcome for these children is known to be generally poor. The grounds for Jake's care order was 'beyond parental control' but it is not clear what being in care would provide that was different and better to home. While Jake was hard to engage there were no meaningful discussions about how he understood and felt about this decision. There were limited discussions with other agencies about the impact of a care order or exploration of other options for achieving a better outcome for Jake. There was no Family Group Conference (FGC) to involve Jake and his wider family in the care plan.

The CSC report reviewing Jake's care states *'The care proceeding appeared to be relatively straightforward and again there was no significant disagreement between the local authority and the parents about the need for a care order or indeed the care plan. Again …. there was no follow through with an FGC which is a normal expectation prior to care proceedings. The care proceedings did not appear to add substantially to an understanding of the risk of significant harm or how to safeguard Jake'.*[23]

Once the care order was granted, there was no Legal Planning Meeting (LPM) to determine if Jake met the threshold for Secure Unit and if not, what other options could be considered to keep him safe pending a more robust and effective community plan. At the time of the care order the parallel plan was for a welfare secure placement. When this was raised in the network there was a view that a secure placement would be a short-term solution and not meet Jake's needs and there were concerns that staff would lose his trust if this plan was pursued as Jake did not want to move out of the area.

Jake repeatedly said he was sad & hurt that he was in care saying: 'why do I have to go back, why do you push me out?'. Once on the care order he moved further away from family, became more entrenched in drug culture and his identity as a drug user.

During Looked after Reviews (LARs) there was limited engagement with Jake. As stated in the internal CSC review of this case (January 2021) 'CLA reviews were held regularly but were largely ineffective in offering support and challenge in relation to the planning or Jake's safety'. There was an acknowledgement about the quality of the care planning and permanence planning at this time. This was highlighted in a CSPR recently completed in Croydon[24].

This was a critical point in Jake's life. There may have been over optimism in the system about his engagement with services and the scale of his substance use problem may have received insufficient attention. While he said he was resistant to any drug treatment programme there were indications when he was just 16 years old that he wanted help and opportunities appear to have been missed. While there were many network meetings, mother reports that a key professional was often missing causing delays. It was acknowledged that he needed more containment and specialist placements, possibly secure and the multi-agency system was aware of his level of risk.

[23] CSC internal report January 2021.
[24] CSCP CSPR Chloe (2021)- awaiting publication.

It is unclear why more active community or residential substance use services were not sought both when he was placed on S20 and when he was received into care. The question that arises is: Was there a generic response to his needs by using care rather than a more bespoke response i.e. services to address his growing drug dependency and consideration of work with Jake and his family to support him? Jake's mother raised worries about the plans for Jake and a lack of response to her calls at senior management level. Whilst there was evidence of a senior manager taking an active role in the case oversight, it did not appear that a more creative/bespoke response to Jake's needs could be provided.

Conclusion: Opportunities were missed to reflect on Jake's escalating and complex psycho-social needs (including substance use) and how to organise a timely, coordinated multi-agency response. There was contact with mother but limited contact with the wider family to better understand the family functioning and the impact of Jake's disturbance and distress on family members. The impact of decisions and planning across the multi-agency network to review his needs and care planning was not evident and in particular the education service was absent from the process. At this time Jake was allocated a new Social Worker, moved to a different CSC team and had his first residential placement. This coincided with increased drug use, missing episodes and concerns about some peer relationships resulting in a more reactive response. Issues about the limited capacity in the services provided by Virtual School at this time were noted in a recent CSPR completed in Croydon[25] The combination of these factors may have added to the lack of multi-agency planning.

Increasing numbers of children are coming into care late. The Nuffield Family Justice Observatory state '*The family stories showed that the children were not in care proceedings because of either intrafamilial or extrafamilial harm. Rather, they were a continuum of extrafamilial concerns that varied from low to very high, and these external concerns were in addition to the intrafamilial reasons for issuing proceedings.'* (October 2021). Jake did not have the more typical presentation of a child at risk of sexual exploitation or involvement with gangs. It is unclear how being in care was thought to benefit him and what it could offer that could not be provided by specialist support for him and his family. The family, while frightened by the levels of violence within the home, were keen to be involved with services.

If the care order was to facilitate access to secure accommodation, with inhouse substance use and child health services, then it is hard to understand why this was not followed through. Secure accommodation may have enabled professionals to assess Jake while not under the influence of drugs and given a more accurate insight into his emotional needs & mental state with the hope of better understanding what drove his self-medication. It may have provided a pause in the system that would give the multi-agency team a chance to plan more effectively for his needs. It is not entirely clear why this did not happen although it is important to note that there was an Ofsted inspection of CSC during this time (2017) and the assessment was 'inadequate'. The high number of S20's as opposed to care orders was criticised. This would have impacted on decision making and on staff morale.

Although use of S20/S31[26] 'can create some short-term physical safety, and give agencies a sense of false relief, this is often short lived and can be to the detriment of the child's relationships and psychological well-being' (Firmin, 2019). Jake did not fit neatly into any standard category; he came from a more middle-class demographic and the primary drivers seemed to be family discord, not 'fitting into the world', a child with a sensitive personality, complicated by drug use.

[25] CSCP CSPR Chloe (2021) – awaiting publication

[26] **Section 20 (S20)** of the Children's Act is a voluntary care arrangement based on agreement between; the person or people with Parental Responsibility, the child and the local authority. **Section 31 (S31)** of the Children's Act is a court order placing the child in the care of a designated local authority, with parental responsibility being shared between the parents and the local authority.

These are national problems, the idea that children should not be accommodated (S20) for long and need to be placed on a care order (S31) may well be evidenced for some children but this should not be a blanket approach and should be carefully thought about for each child when their unique needs and circumstances should be considered alongside gaining an understanding of the meaning of a Care Order to the child. It may be addressed in the current review of children's social care[27] with consideration about the responsibility of other agencies e.g. Education, Health, CAMHS in agreeing solutions for the care of these children. Late entry into care is a national issue and the importance of seeking alternatives for this age group is key[28]. More time is needed to reflect on a child's psycho-social needs including substance use. In Jake's case, the impact of drug use on his behaviour, well-being and development made it very hard to address his underlying emotional and mental health. In this world of complexity, there is a risk that agency working can become split in a belief that one agency may have a resource or a service that could be 'the solution', it is important that services support practitioners to work creatively and effectively together in these circumstances.

Risk management and keeping children safe is a huge challenge for families and professionals. Plans for children co-produced with their family and the multi-agency group require time and attention. Careful planning affords a better possibility to embrace the concept of corporate parenting, to bridge the gap between child and family when the relationship has broken down and to provide joined up care. A flexible approach is needed, otherwise the response is fragmented and too big for either the child or individual parts of the network to manage. The question that arises is: Could the resources, financial and other, available via care be used to support the family to work with and understand their child's needs?

Aspiration: A multi-agency framework is needed for children at high risk who are not engaging in services and do not fit into the usual category of gang affiliation and sexual exploitation. Jake did not fit the usual profile for children who come to the attention of CSC but the usual responses were used. Therefore, there needs to be an informed multi-agency, child-centred and creative response to their needs relating to mental health and drug use that considers the alternatives to a care order and in what circumstances a care order may be helpful.

Recommendations

Review of Care Panel for entry into care & care plans: It is understood that care plans are now routinely reviewed on a monthly basis with particular reference to the effectiveness of the Independent Reviewing Officer (IRO) and the support they give. Prior to receiving a child into care Croydon recently established a Care Panel with multi-agency representation including education & health so information can be triangulated. This panel discusses whether entry to care is most appropriate after 15 and prioritises the child's need for attachment over the family struggles.

Recommendation 5: CSCP to seek assurances that robust systems are in place to review care planning informed by the Nuffield Foundation research (October 2021).

School Exclusions: Since Jake's death the Virtual Schools have secured specific funding for 2022/23 and possibly the following 3 years and will now be involved with all children who have a Social Worker (SW), not just those in care. However, there is no confirmed funding for children post 16 and this was highlighted as an issue in both the 'Chloe' and 'Jake's' CSPRs. This is a national issue and requires a policy change.

[27] https://childrenssocialcare.independent-review.uk/wp-content/uploads/2021/06/case-for-change.pdf

[28] The Nuffield Family Justice Observatory is currently carrying out research with young people, families and professionals to understand the experience before entering and during care. The aim is to understand the impact of decisions made on the outcomes for the children, families and communities. https://www.nuffieldfjo.org.uk/project/older-children-young-peoples-experiences-support

Jake was excluded from primary school and there is evidence of poorer outcomes for children where this happens.[29] Changes around exclusions will follow from a current consultation '*Revised behaviour in schools guidance and suspension and permanent exclusion guidance'*. The government's directive on behaviour is moving to a zero-tolerance approach, which in such complex cases is unhelpful. Again, this is a national issue[30].

Recommendation 6: CSCP to continue to have oversight of local developments to reduce exclusions which includes intervention at the earliest possible point and to raise at a national level the need for strengthened guidance, with less opportunity for variation as identified in 2019 the Timpson report[31]

Data & Commentary regarding funding for virtual schools to provide support post 16 should be included to provide assurance that this is not an area being overlooked.

4.3.2 IDENTITY & BELONGING/ YOUTH CULTURE

a) Identity & belonging

Joy and fun are absent from stories of Jake's adolescence. His siblings were academically high achieving and he had aspirations but there is little sense that these were promoted. He became increasingly withdrawn and it is hard to see who he was - his uniqueness. Concerns centred on his 'violent outburst, spitting, hitting', '(belief that) everyone hates him'. His voice, from meetings and reports that should have included him, e.g., LAC reviews and PEPs, was absent. He had limited engagement in these meetings and when he did attend, he commented on all the people who did not know him or had never met him before making decisions about his life.

Statutory processes including Looked after Reviews (LARs) and Personal Education Plans (PEPs) are important processes in the life of a child who is in care. The documents produced hold important information about the child's past and articulate plans for a child's immediate and future care. The LAR focuses on the care plan and how a child will be cared for and the PEP ensures that the child's educational needs and aspirations are prioritised. They can offer a child a coherent narrative about past social and educational experiences and encourage their future plans. LARs and PEPs are regularly reviewed to consider what is needed to help a child achieve and in turn this can help to foster a child's identity. Adolescence is a time when identity and belonging are crucial; it is unclear how these processes acknowledged these important aspects of Jake's life.

School/education is important to a child; it is normal, it provides a structure and opportunities to master social, emotional and academic skills and can promote a felt sense that the child belongs to a school community. Particularly since his transition to secondary school Jake struggled to engage in the day-to-day structure of school. When Jake was 15 an educational psychology assessment recommended that an Education and Health Care Plan (EHCP)[32] be done to identify what support Jake might need to help him engage in education. It is unclear why this was not followed up or why it was not actively pursued in the PEPs and LARs.

The sense of belonging to a school community, however reluctant the student, should not be underestimated. Jake found out he was excluded from his last college placement when he tried to enter and his pass did not work. The college was unaware that he was looked after or that he had mental health needs and this may have added to the sense that he was not cared for and thought about.

[29] Croydon Vulnerable Adolescent Report, Croydon Safeguarding Children's Board Vulnerable Adolescent Review 2019.
[30] In Croydon if a child has a SW and there is a risk of exclusion, they would be reviewed by the Fair Access Panel (FAP) to offer support in the hope of avoiding exclusion.
[31] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/807862/Timpson_review.pdf
[32] Education, Health and Care Plan (EHCP) is a legally binding document that outlines a child's education needs and any additional health and social care needs. Provision required to meet the needs are detailed and funding if needed can be made available to achieve the plan and remain in education.

Neither the PEPs or the LARs offered much assistance in encouraging a creative, individual response to find a solution to Jake's lack of education (PEP) or in being clear how his return home could be achieved (LAR). There seemed to be a gap in understanding of how to respond or use existing processes when a child has a complex mix of social, emotional, risk, substance use issues, including being out of education.

As he moved further from his family, disengaged from school and the possibility of positive achievement, he became more entrenched in a drug culture and isolated from mainstream life.

In his last year his behaviours had escalated to such an extent, he became difficult to get close to, but this wasn't always the case. Residential unit staff talked about him wanting to sit with them and be around adults who cared for him and who he trusted. His siblings described taking him when he was younger for milkshakes and having fun together. In the last months staff worked hard to keep him safe and were clearly very worried about him. The sense is of a young boy who felt abandoned and moved from one crisis to another. He appeared to be part of lots of worlds but belonged to and claimed by few.

b) Youth Culture

….. his music his rap music he got into that, and the whole culture (Jake's father)

He had aspirations to be a musician/rap artist. (practitioner)

In this review, we considered Jake's music choice/peer group affiliation/youth subculture and its impact on him. We discussed whether as safeguarding practitioners we understand these factors sufficiently and if in our eagerness to engage reluctant children, we normalise or validate a subculture that may have a negative influence. Jake listened to Lord Apex and Lil Peep, who is now dead from a drug overdose, and who promoted drug use, self-harm and messages of suicidal intent. Without necessarily endorsing or normalising them, a child's interests can give us useful insights into their state of mind to help support them to engage with services.

Little is known about the quality and range of Jake's friendships. In adolescence they are important to the development of identity and social skills, *'peer friendships can fulfil important attachment functions (such as providing a 'safe haven') especially when relationships with parents are less secure (Nickerson and Nagle, 2005). However, despite providing resilience in the face of risk, friendships can at times also increase risk'*[33]. One practitioner said she found it "scary when you see someone so young start with drugs at that level" not only in terms of the physical and psychological impact on Jake's development but also the social impact. This practitioner said Jake would have been engaging with people who have "complex issues, behaviours become accepted in that circle, your morals and values change." Jake identified with a youth culture and peer group where drug taking, risky behaviour and self-harm were more the norm. We need to identify and understand the pressures facing young people who are part of such groups and how we can use our resources/staffing to guide them to healthier options.

Conclusions

Identity and belonging: An individual's development is a lifelong process and is an interaction between inner processes and external factors. Research on adolescent development describes the formation of personality during this developmental stage[34] when a sense of belonging, of being seen and claimed are critical. This can be difficult to achieve but, in particular for looked after children, a stable placement and engagement in education are important components. Jake had neither.

[33] That Difficult Age: developing a more effective response to risk in adolescence. RiP Nov 2014.

[34] Erickson, E (1968). *Identity, Youth and Crisis*. New York:Norton; Meeus, W. (1996). *Studies on identity development in adolescence: an overview of research*. Journal of Youth and Adolescence.

Neither the LARs or PEPs gave ideas about Jake's future aims. The LARs/pathway plans stated that he was to return home with little sense of a realistic plan about how this was going to be achieved and on a practical level where he was going to live once 18. There is no sense of what adulthood held for him. It is possible to see how this lack of a sense of future may have led to Jake becoming disenchanted and identifying with a peer group that listened to music in which drugs, self-harm and suicidal intent are promoted. This may have been significant in disrupting the development of his own identity as a young man.

Engagement in purposeful activity has benefits to the child's sense of self and helps them develop their self-identity. It provides an opportunity for positive interactions with those around them and the possibility of avoiding a descent into self-destructive behaviour. There was a lot of creative thinking in the network about engaging Jake in his music. His last placement set up a studio for him and many workers met him in the studio and used the backdrop of his music to start conversations. Getting the right balance between engaging the child, showing interest while also challenging the meaning of lyrics, and thinking about what the child is communicating and the possible impact of the artist's message on the child is difficult and needs sensitive, informed management. In the panel and PLE there were lively discussions about how far we understand youth culture and particularly the types of drugs in use (especially Xanax), their impact and availability.

Aspirations: Staff described how rigid systems around children place an onus on the child to change and 'fit in'. A suggestion from the PLE was that LAC reviews should be smaller and more child focussed with views gathered from the wider professional group beforehand. We heard of developments in Croydon of letter writing after a LAR that contains information about plans and a clear narrative. This is positive - it may provide a clearer narrative for the child about decisions with details of transition, future plans and options for the child and how they may achieve them.

Whatever the circumstance, looking for meaning and hope in children is vital so they feel encouraged to fulfil their aspirations. In the midst of the distress and difficulties we must acknowledge a child's talents and foster them to build a sense of hope, belief, self-esteem and progress.

Recommendations

LARs and PEPs: LARs and PEPs should be adapted to ensure they are child centred with clear plans and an understanding of how they will be delivered. Plans must consider a child's identity and belonging and how this is being promoted, involve family members and include the active involvement of education. There also needs to be quality assurance and oversight of the LARs to ensure they are realistic and achievable and include views and contributions from multi-agency partners. Recommendations made in CSPR Chloe are relevant, therefore no further recommendations are required.

Youth Culture: Staff in the panel and PLE agreed the need to identify and understand issues arising out of youth culture and debated the respective benefits of dedicated staff versus upskilling the wider staff group. There was debate about how to avoid a silo culture and how to increase awareness and knowledge building in the wider system, tap into established wisdom about where and how to get advice while also ensuring access to specialism. It was understood that the CSCP offers protected time every month where the wider partnership members can request allocated times to discuss safeguarding themes.

Recommendation 7: CSCP to consider how current training and awareness raising forums can be used to facilitate an understanding *Youth Culture* and the findings in this CSPR.

4.3.3 JAKE AND HIS FAMILY

'Maintain the lifeline'

A crucial vulnerability to extrafamilial harm relates to losses that stem from weak or poor relationships, separations, bereavement and other traumatic events or circumstances. It follows that a top priority in supporting children is a concerted effort to mend and sustain existing relationships so that children retain as many links as possible with people who love them, and so that they get the best possible support to restore fraught and fractured relationships with their parents, brothers and sisters and other relatives. Added to this is the value of professionals who are curious about children's lost connections and diligent about exploring what they might have to offer.'[35]

It is not appropriate to give full details about the family background so general themes are discussed.

Throughout Jake's life his father had regular contact. As a child they met and stayed at the paternal grandparents. Both parents had new partners. In later years Jake reported that he was closest to father and thought he was like him. However, the nature of Jake's connection with his father was not explored and therefore not known. There was very limited contact with father by agencies, examples were given of their interaction that suggested father may have needed support in meeting Jake's needs and his presence in his life as a source of strength or protection was unknown - yet for Jake he was a consistent and important figure in his life.

Jake's place in the family was unclear - why he seemed so different to his siblings and the impact of family changes on him. It is noted in many reports that mother was actively involved with all agencies and repeatedly communicated her concerns to the network. Involvement from the wider family was not actively pursued and there was no thorough exploration with Jake and his family about their relationships and family functioning. His siblings were unaware of the change in legal status when Jake was received into care. Without wider family discussion and consideration of the decision there was no family narrative about why Jake was in care.

As a child Jake had been close to many in his extended family, going to football matches and family occasions but in his last few years he drifted apart and spent most of his time with his friends – his place in the family was becoming unclear.

During this review it was established that Jake had a large extended family which included three birth siblings, uncles, aunts, cousins, grandparents, and household members, many of whom held important roles in Jake's life for several years but agencies did not involve them in discussions about Jake's care or about the significance of their relationship with Jake. There was no sense of their views about care plans/ how they could be more involved in safety/care planning and what individual or family support they needed.

Conclusion – involving families

A recent CSPR in Croydon[36] has identified the importance of engaging family members when working with children who are in the care of the LA. This CSPR highlighted the following **'**At various times there was an acknowledgement that relationship work was needed but this lacked a coherent plan. It seemed that the requirement to deal with urgent matters drove out the capacity to deal with important matters such as this. This has been acknowledged in the independent review of children's social care interim report: '*Process continues to dominate over direct work with families'.*

[35] C. Parker & J. Tunnard (2021). Why are older children in care proceedings? Nuffield family Justice Observatory.

[36] CSCP CSPR Chloe (2021) – awaiting publication

Services recognised the need to promote wider family involvement and challenge a tendency to privilege one parent's voice over another. Adolescence is about individuation – the child moves from the family not the other way around. Relationships are central to an adolescent's well-being and if not attended to there are 'missed opportunities to work as a team *with the adolescent* and often *their family* in combating risk…If we do not recognise and work with adolescent agency and choice, it will remain a potent force in their various vulnerabilities'[37].

All practitioners were clear that mother was very active in the multi-agency group while involvement with the wider family in thinking around what support Jake and the family needed was absent. Unfortunately, 'invisible fathers' is a common issue identified in a recent report by the National Panel.[38] This report notes that practitioners tend to not see fathers. It emphasises that allowing fathers to step back should not be happening with every effort made to allow them to engage with services and be the best father they can be.

The panel and PLE considered ways to engage the whole family in thinking about a child's needs to better understand their behaviours and help them retain an emotional connection so they do not feel abandoned by the adults caring for them. Support to the family, recognising them as 'central repair agents in their child's recovery'[39] also needs to be considered. Mother described navigating services when Jake was alive as 'a lonely place to be'; the repeated attendance at ED, the many meetings and phone calls. This experience continued after his death when she and the family were 'left with their grief'.

Across services, a whole family approach is required when meeting a child's needs. It is important to have more than one family member's narrative, and to include both parents, siblings and wider family as appropriate. If some family members are not included it is important that the rationale for this is clear and in the best interest of the child. Family group conferences are one way to achieve this and should be considered by the different agencies involved in all cases to assist decision making and care planning. A recommendation from the PLE is that professionals already involved in a child's care be trained to do this work rather than bringing in new people to manage these discussions.

Recommendations

Family Involvement: Professionals are committed to increasing and strengthening work with families, but lack of staff capacity is said to be a barrier. This is echoed in the interim report to government The Case for Change[40]. CSCP will continue to engage in this review to urge the government to focus on this issue. The need for family involvement is recognised by managers and practitioners across services in the local area, the importance of this work was identified in the recent CSPR 'Chloe' in the section entitled 'The importance of family, friends and kinship': *where it recognises that: to make a recommendation that the CSCP should ensure SW caseloads are reduced to enable social workers to take on direct work with children and families and that there are sufficient resources in place to ensure that skilled practitioners are in place to facilitate this work* was unrealistic and beyond the gift of CSCP. It noted that these are systemic national issues that require a national response:

[37] That Difficult Age: developing a more effective response to risk in adolescence. RiP Nov 2014.

[38] The Myth of Invisible Men, September 2021. The child safeguarding review panel.
[39] Croydon Vulnerable Adolescent Report, Croydon Safeguarding Children's Board Vulnerable Adolescent Review 2019.
[40] https://childrenssocialcare.independent-review.uk/wp-content/uploads/2021/06/case-for-change.pdf

'*The need to nurture this tribe for children who are looked after is recognised in Croydon – it is known well and understood. The inhibitors are a lack of skilled resources and capacity to do the work. There is a plan in place to recruit systemic practitioners who would be able to do this work. However, once again, the issue remains that if insufficient financial resources are available and if social workers continue to be unable to do their jobs - this will not be possible. These are issues that are well known to government across all political groups, they have existed for many years and have been identified in numerous reports*[41] *over time. National action is needed; therefore, no recommendations are made*'[42]. CSCP have recognised that there is learning to be gained from Croydon YJS and other services about what works well (and what is possible within current resources/capacity) and work is currently happening to identify how this learning can be extended to the wider workforce.

Recommendation 8: CSCP are encouraged to continue to learn from what works well when working with families and consider examples of innovative practice set out in the recently published guidance from Coram/BAAF and UCL.[43]

Recommendation 9: CSCP to review with services support offered to families and for this to be revisited at the Rapid Review meetings and at Safeguarding reviews.

4.3.4 PLANNED V's EMERGENCY SERVICES and CONTEXTUAL SAFEGUARDING

*…….WE GO FROM HOUSE FIRE TO HOUSE FIRE WITH NO TIME TO REBUILD THE HOUS*E – (practitioner)

From the age of 15 Jake had contact with emergency services; the Metropolitan Police Service (MPS), the British Transport Police (BTP), the London Ambulance Service (LAS) and Emergency Department (ED). In his last year this contact increased significantly and some days the police were called several times in one day. Calls concerned disturbance in the street, aggression at home or in the residential unit, Jake being distressed and angry, threats to kill himself and fights at train stations. Restraint was applied particularly in the last year of his life. Calls to the LAS included concerns about his physical health (being unconscious or sustaining injury to his head following use of alcohol and drugs) and/or aggression and threats to kill himself. ED involvement related to use of alcohol and drugs, suicidal ideation, aggressive behaviour and assault.

In this last year there were 45 Merlin Missing persons records relating to Jake's absences from his placements.[44] Jake came to police attention as a vulnerable young person but also as a perpetrator of crime, usually against those who were caring for him. In most interactions he was under the influence of alcohol and/or drugs. Jake was subject to more than 20 crime reports as a perpetrator.

[41] Such as: *The Munro Review of child protection: a child centred system*. 2011 DfE. *No Good options*: Report of the Inquiry into Children's Social Care in England. All Parliamentary Group for Children. NCB March 2017. *Storing up trouble. A post code lottery of children's social care*. All Parliamentary Group for Children. NCB July 2018

[42] Croydon CSPR Chloe 2021

[43] Coram/BAAF and UCL (2021). Developing and maintaining relationships for care-experienced people.

[44] Some of these were for short periods and the police have suggested in their internal review that they should cluster missing persons incidents, where the child briefly returns home before leaving again, as one continual incident rather than as isolated incidents with individual reports. This seems sensible to more accurately capture the child's vulnerability and risk.

Jake developed a deep animosity towards the Police and alleged he was manhandled and mistreated by them. A psychiatric report two months before he died stated: '*I also took into consideration the fact he expressed his anger about the police allegedly causing him the facial trauma he presents with. I am concerned the intervention of the police could lead to a behavioural escalation that would put him at higher risk than what his mental health needs appear to currently require'.* Police responding to these emergencies were front line officers who were probably the least equipped to deal with children like Jake. As identified in a recent SCR[45] systemic gaps in service provision and training can place frontline emergency services in a difficult position. *An unintentional consequence for the child is that they are re-traumatised and may get a criminal record* and the frontline staff may feel ill equipped and unsupported to deal with the crisis.

MPS reports were shared with CSC but in Jake's final year the MPS were only invited to one strategy meeting. Many incidents were recorded on individual agency systems. Some gaps have been identified by BTP[46] and plans are in place to address these. However most importantly an overarching plan for Jake between emergency services was missing. Jake was seen by several teams in different geographical areas and up to date information on his status and needs was not always available. It is unclear where or how the information from emergency services was shared to help design a plan for his safety. In his last few months Jake was in crisis. He was often taken to ED by the LAS or Police, needing both medical and mental health assessment and intervention, and was intoxicated and/or in an aggressive and distressed state. There were many instances when Jake was very difficult to contain; he could be frightening, aggressive, risky, and threatening.

Contextual safeguarding is a framework for social work assessment and intervention that focuses on the context a child lives in, rather than primarily on the family, when harm is occurring outside of the home. This framework was referenced in the reports about Jake but it was unclear how it was actioned. The expectation is that all services including emergency services would be involved in thinking about a child and their needs. Such a joint approach may have provided a better understanding of risks in all agencies and an opportunity for a more flexible multi-agency response.

It seemed that staff in the community felt ill-equipped to deal with Jake's behaviour so police and LAS were called. Mother reports that when she called CSC and CAMHS requesting help when Jake was distressed and aggressive in the home, she was told to call the police and/or LAS. The multi-agency system needs to consider if repeated use of emergency services is the most appropriate response to a child with educational, social, emotional and mental health needs with the added complexity of substance use problems. These children need a coordinated multi-agency response that includes emergency services (LAS, police, ED) and education, CSC and CAMHS.

Conclusion

The responsibility for the child and any solutions must include all agencies and at all levels. In many circumstances, the current system of services and support does not adequately recognise the range and seriousness of the risks adolescents face. The report That Difficult Age (2014) states: *'Responses are often insufficient or too heavy-handed. Problematic behaviours by looked after young people disproportionately trigger responses that label, stigmatise and destabilise them, and this further compromises their life chances and well-being. Such actions include placement changes, forceful restraints and police involvement, all of which would be far less likely in response to the same behaviours by young people not in the care system. These responses may compound difficulties and are in contrast to other approaches that can deal appropriately with the behaviour without inviting such risks – such as informal restorative and authoritative parenting practices.'*[47]

[45] Sam Gould SCR Cambridgeshire (2021)
[46] BTP identified issues with CYP/1 & DASH and see footnote 31 for MPS.
[47] That Difficult Age: developing a more effective response to risk in adolescence. RiP Nov 2014.

ED provision and emergency response is ill-equipped to meet the needs of high risk 16–18-year-olds like Jake and the cycle of repeatedly calling police or LAS for children in such circumstances should be revised. The statutory processes in place are geared more towards intrafamilial difficulties than contextual risk. For Jake, as well as his emotional and mental health needs, much of the risk was contextual and the multi-agency system does not seem to be sufficiently set up to address this which contributed to the overuse/reliance of emergency services to manage the risks and provide containment to Jake. A better focus on contextual risk may allow us to change our responses to and relationships with the children and young people we serve.

In Jake's last year, front-line staff worked hard to engage him and keep him safe. There were regular network meetings and thinking about what more could be done. At times there were conflicting ideas within and between agencies about how to manage his care, especially around the use of a welfare secure order but frontline staff pulled together. Some clinicians from CAMHS and CSC described how "it felt like we were working collaboratively". They were concerned about Jake's risk, number of ED presentations and drug use however, as the year progressed and there was increased involvement of the police and LAS information does not seem to be triangulated in the immediate network. The police informed CSC of their contacts but were rarely involved in meetings. It seemed there was a peripheral awareness that Jake had frequent contact with the police but no exploration of the pattern of interactions or an informed and coordinated multi-agency response.

Aspirations:

Out of Hours (OOH) system: The current out of hours CSC system needs review. Many families and children know who to call during the day (Mon-Fri 9am-5pm) but are not aware that they can call the OOH service and this information needs to be publicised. The OOH service is not resourced or supported to give a more immediate, hands-on response. It is acknowledged that better links are needed across agencies' out of hours departments so known children get a better response and that there is early identification of children who may need an emergency response. While the partnership wants to strengthen these services the way they are configured and resourced limits their capacity. National action is needed on this issue.

ED and other emergency services: Locally there needs to be better identification and response to children who are repeated attenders at ED and emergency services. Police, BPT, LAS and ED need to be part of the strategy meeting if they are regularly involved. Information must be triangulated. Robust mechanisms are needed locally, possibly using the Complex Adolescent Panel, to ensure information sharing. In the last 18 months LAS have developed a dedicated mental health response car staffed by a mental health nurse and paramedic. It operates from 11am-11pm 7 days a week. Currently there are two response cars in the borough (1 East & 1 West) and 5 pan-London. Early results are promising and it is hoped this important development will be extended and become a permanent service offer.

CAMHS & ED: There needs to be a local review of the response to high-risk children like Jake who are taken to ED to ensure that they have a CAMHS assessment. We heard about a High Intensity User service being developed at SLAM CAMHS for children who are frequent users of crisis services or have several in-patient admissions. It is a short-term intervention and it is not clear if they will work with children who also use drugs. A service like this could be strengthened if based in local services so information and knowledge about the child is shared rather than repeated assessments by clinicians who do not know the child's background and risks. Again, there is a national resourcing issue.

Police: As already agreed by MPS, where a child reported missing briefly returns "home", for example to collect clothes, and then immediately leaves again this is to be treated as a continuous missing episode so the missing persons team can be involved. Police emergency response officers have a generic training to deal with a range of emergencies, not specifically children with emotional, behavioural and mental health needs involving drug and alcohol use. The response of the mental health cars discussed above depends on how the initial alert to police is framed. For 'Jake' the alert would have focussed on his drugs and alcohol use and his disorderly behaviour. The police missing person coordinators were starting to get involved in Jake's care however an improved use of Trigger plans may have worked better. These plans contain more detailed information about the child's setting and what different providers can do e.g. the difference between a children's home and a semi-independent unit that cannot restrain children. The MPS now have an 'Identified Complex Concern' category and an improved diary system for missing children. This is expected to identify issues more quickly so multi-agency colleagues can be involved in planning at an earlier stage.

BTP have limited resources for crisis responses however a recent BTP pilot initiative Harm Reduction Teams (HaRT) is a triage response for High Frequency Presenters currently based on decisions with regard to S136. HaRT works with community mental health practitioners to offer a more intensive response and provide crisis intervention and prevent access to train tracks. They now use an App to report incidents that are forwarded to the Vulnerability Unit. Incidents are screened daily and information shared with GPs, mental health and other services with an aim to reduce risk on the railway.

Recommendations: A number of the changes that are needed require a national approach to improving the response to children and families out of hours, equipping emergency services to provide a child centred response and strengthening the integration of NHS and LA services to meet the needs of children in crisis. CSCP are advised to raise with the current national review (The Case for Change) the national changes that are needed. In the meantime, it is suggested that CSCP address with respective agencies the following actions:

- Explore with LAS the possibility of extending LAS Mental health response cars to improve the timing and quality of emergency responses in the borough.
- Changes in MPS in relation to reporting of missing persons and to record single episodes when children are missing in quick succession. MPS to raise awareness of and improve use of Trigger plans and support about how these might be used across the multi-agency group that can also include placement information.
- BTP liaise with CSCP to explore use of HaRT and App used to report incidents to the Vulnerability Unit, in Croydon.

In the last 3 years there were approximately 40 presentations to ED, 178 liaisons with the police and Jake was regarded by CSC 'as one of the most high-risk children'. 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 (17-year-old, white male approaching adulthood with no future plans and with a complex profile including drug use) fitted the profile for risk of suicide. Mother and several practitioners stated their concern that Jake would kill himself and there was a sense that local practitioners did not know what to do. It is critical going forward especially when risks are escalating and there are conflicting views within and between agencies about how to respond, that the multi-agency group has the opportunity to reflect with senior multi-agency management and agree when 'enough is enough', that something different needs to happen rather than continuing with 'more of the same'.

Alongside these changes a stronger multi-agency framework, where shared information about risks can inform better safety planning, is needed. A 'who, what, where, when, why' response agreement will help ensure the child's and staff's safety. Therefore, the following multi-agency recommendation is made:

Recommendation 10: CSCP to oversee the development of multi-agency plans for children where contextual risks exist and, as in this case, when risks do not fit into the usual categories of gang affiliation and sexual exploitation there is also an urgency to ensure a timely response. This plan should include all emergency services who are likely to be involved and this should be shared with placement providers. These agreements must include detailed safety plans particularly when a child has known risks e.g. missing episodes, aggressive behaviour, drug use.

4.4 DRUGS & ALCOHOL/MENTAL HEALTH & WELL-BEING/RISK – MODELS OF CARE

'The needs of young people who have drug use problems can only be met through a combination of specialist treatment and wider health and social care, which addresses all the challenges they face including their family circumstances. The significant reduction in resources across the children and young peoples' sector combined with the reduction in specialist treatment provision means that there is unlikely to be sufficient capacity to respond to the needs of children and young people, particularly if the increases in drug misuse and complex needs continue'[48]*.*

Drugs & Alcohol

Staff have emphasised the importance to Jake of his identity as a drug user. He enjoyed talking about drugs and wanted to impress others with his knowledge. Particularly in his last two years it was rare that he was not under the influence. He had a history of polysubstance misuse (Xanax, ketamine, cocaine, DMT, Ecstasy, MDMA, heroin and alcohol) and had several 'accidental' overdoses. One staff member reported "he needed a period of sobriety to know how he felt because he was never sober". Jake was 'self-medicating', and in a case like this, a young developing child, this is a form of self-harm. He was intelligent and would have been well aware that he was not achieving, feeling a failure, so it is likely that his 'bad boy' 'drug boy' identity helped mask his vulnerabilities, anxieties and helplessness.

While in care there were discussions with Jake about engaging with substance use services. He was referred several times but refused this. Two months before he died, he was referred again, there was some engagement, and the service began to source a detox placement. Prior to this he was also referred to the SLaM Addictions Complex Service[49] but they did not become involved and redirected to the local substance use service. **Substance use services for children follow the adult model and a child needs to be motivated and willing to engage, features that were absent in Jake's case.** He attended very few health assessments and was largely out of education so little was happening to help him form a more positive identity and developmental path. He was struggling with his feelings of dislocation and displacement so one can understand how he could not at that point give up the one thing that made him feel better – drugs. The requirement that children are motivated to engage when accessing drug/detox treatment is too great an expectation. There are also limited detox/rehab places specifically for children who at a young age develop addictions.

[48] Dame Carol Black (2020). Review of Drugs Part 1
[49] SLaM Addictions Complex Service – a tertiary service that requires funding

Drug use featured significantly and yet the local provision was limited, as was the access to specialist drug and alcohol treatment. Towards the end of Jake's life a rehabilitation unit was identified however there were delays in referral and follow up due to staff annual leave. For children with entrenched and complex presentations and where the local services are not able to meet their needs there must be easy access to specialist provision to offer both consultation, direct work as needed and with the staffing capacity to offer continuity of care when there is staff leave.

Emotional & mental health needs

In his earlier childhood Jake had been referred to CAMHS, deemed to have behavioural problems, and diagnosed with Conduct Disorder but there did not seem to be an exploration of what feelings and emotions were driving him. Latterly when there was an acknowledgement that he had some social communication difficulties, self-harm including ingestion of harmful substances (bleach), longstanding anxiety and depressive features, the focus had for too long been on his behavioural presentation. Perhaps there was diagnostic overshadowing of his feelings so his communications were reduced to Conduct Disorder as opposed to seeing him as a vulnerable, sensitive child who was struggling in the world. His mother said about his teachers "there were a couple of teachers who got him and if they got him, he thrived". Jake was challenging but it is unclear what stopped people 'getting him' and seeing him as an emotionally sensitive, depressed boy who struggled in the world to communicate his experience. Was there a gender bias at operation where vulnerability for boys is experienced as behavioural problems whereas girls evoke a more protective response?

In assessments Jake was largely uncooperative and his emotional world was not in view, but he gave some clues. Aged 15 in a CAMHS assessment he said he used to be 'a little worry kid……that when he was 8 years he worried about his GCSE's'. At secondary school, as his drug intake increased, he admitted that he had become more paranoid and anxious. When assessed by the independent psychiatrist for the care proceedings he asked 'are you trying to see if I'm a sociopath?'. It would suggest that Jake was worried about who or what he'd become.

Aged 16 Jake had a period when he regularly attended CAMHS AAFS T4[50] appointments but struggled to benefit from treatment. This work ended after one year as his attendance was reducing and erratic and the service is in any case usually only offered for one year. Local CAMHS remained involved and worked with the network given the escalating risk. The summer before Jake died local CAMHS referred to the T4 Enhance Treatment Service (ETS)[51] to ask that they attempt direct risk management work. Their involvement was brief and Jake did not engage.

Risk of suicide

Jake's mental health and drug use were intertwined and one could not be treated without the other. During his adolescence he repeatedly told services that he would kill himself and was explicit about the method (trains were frequently mentioned). After incidents of self-harm, he was described as being remorseful, saying he did not want to die but was overwhelmed by his feelings. CAMHS safety plans were written and shared. They note the risk of harm from: accidental overdoses, respiratory failure, seizures, high risk of accidental injury due to intoxication and 'high risk of deterioration of mental health due to impact of ongoing substance use, increased risk of self-harm and suicidal ideation and intent whilst either under the influences of substance or in a withdrawal state'.

[50] Adolescent at Risk Forensic Service (AAFS) a Tier 4 service not based in the local community. This team offers focussed time limited intervention, including CBT, DBT.
[51] Enhance Treatment Service (EST)T4 CAMHS, not based in local borough but offers short term intervention including home visits and risk management.

The risk of suicide was high for Jake especially in his final year and he said he would not live to the age of 18 years. Data from the National Child Mortality Database Programme shows suicides are more common in white boys, that suicides increase with age and numbers for 17-year-olds is three times that of children aged 16 years. Common factors included loss and/or conflict in key relationships, mental health needs, risk taking behaviour, problems with service provision and in school[52].

Jake was already in a high-risk category for suicide and then five months before his death the nation went into lockdown due to the Covid-19 pandemic. Staff, particularly CSC, CAMHS and the residential unit staff, worked exceptionally hard at this time. It was a frightening and uncertain time for all. Two additional factors coincided; Jake's alcohol consumption increased as he could not access other drugs. Initially this was thought to be better than him using other drugs but there is a high possibility that in fact it lowered his mood and contributed to a rapid decline in his mental health in the last six months. Second, 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.

In the last year when he was in crisis, unable to consistently engage and seen by multiple services a familiar service dilemma occurred: should he have been detained under the Mental Health Act, had a secure placement or gone to drug rehabilitation? On many occasions he had either left ED or was discharged once his medical injuries were attended to before he had a CAMHS assessment. He attended ED six weeks before he died and the community CAMHS consultant was clearly considering in-patient admission as he informed bed management about the possible need for a bed. However, Jake left ED before he was assessed. He was assessed the next day by a different psychiatrist and felt not detainable under the MHA. Given the level of risk, his repeated presentations, his threats to kill himself and levels of intoxication, the question must be asked, if he was not detainable what was the plan other than to discharge him to the community where neither community services or he were able to keep him safe? The same week YJS/CAMHS/Substance use service all managed to see Jake to carry out a joint assessment to avoid duplication. The YJS practitioner reported that Jake had scored his mental state as '0' and claimed that he had wanted to 'jump in front of a train at a local Train Station'. He listed a number of contributing factors linked to his mental state including relationships/paranoia/Court appearances/Police and generally feeling very anxious. He stated that alcohol provided him with more courage to act on some of his feelings. Jake had follow-up appointments with both CAMHS and the substance use team. While the risk of suicide is mentioned in plans (it's not clear these plans were shared with police or LAS) and in-patient admission was not agreed it is not clear what tangible resources/structures were put in place to help him and to help community staff to reduce his risk and keep him safe.

4.4.1 MODELS OF CARE FOR CHILDREN WITH A COMPLEX AND HIGH-RISK PRESENTATION

The drugs treatment market operates in a very similar way to that of adult social care. Like in the adult social care market, drug treatment providers have been squeezed, staff are paid relatively badly and there has been high turnover in the sector and a depletion of skills, with the number of medics, psychologists, nurses and social workers in the field falling significantly. The unregulated role of drug and alcohol or recovery worker, which is inconsistently and poorly defined, makes up the vast majority of the workforce. The number of training places for addiction psychiatrists has plummeted from around 60 to around 5, meaning there is no capacity to train the next generation of specialists[53].

[52] National Child Mortality Database Programme (NCMD): Suicide in children and young people thematic report 2021 https://www.hqip.org.uk/wp-content/uploads/2021/10/REF206_NCMD-Suicide-in-Children-and-YP-Report-v20211013_FINAL.pdf
[53] Dame Carol Black (2020). Review on Drugs Part 1

The NHS Five Year Forward View (2015) outlines the need for the development of new care models for promoting health and well-being. It invites partnerships to co-design and establish new care models as a way of addressing some national challenges. These include emergency services and the need to provide 'meaningful local flexibility' and to 'break down the barriers to how care is provided'. Using Jake's experiences as an example this section will focus on the latter, in particular how do we provide services to children who have mental health, substance use and high-risk presentations.

Jake knew he was seen as a boy who needed to change his behaviours but he could not change without addressing his drug and alcohol use, yet substance misuse was a key feature throughout his adolescence. Where services saw him together, Jake was able to articulate his distress, hopelessness and reasons for drug taking. He may have benefited from an integrated CAMHS & substance use service offer. The services are commissioned separately but the impact on the individual of both are interrelated and the risks high. This is something Jake reiterated throughout his life. He was more cooperative and insightful when not under the influence of drugs. The number of separate services and consequently the number of individual appointments would have been difficult to manage for a boy leading such a chaotic lifestyle. Services can have the view that there is little that can be done for children who do not engage with treatment. Often for these children the truth is that ***they cannot engage*** in services because of their levels of psychological damage and sense of hopelessness. The irony is that Jake did in fact engage with staff he knew and trusted. It is important that services with the necessary specialism are accessible to children otherwise engagement and risk management are undermined and, as we saw in this case, the use of emergency services increases.

Jake had been referred to the substance use service on three occasions by the age of 16 years but refused to engage. There are limited drug detox/rehab facilities for under 18s. It is likely that an integrated multi-agency offer (where drug services, CAMHS, Education, YJS, CSC, Health, work more closely together) could have provided a more efficient and effective response. This could also help ensure that the impact of a decision made by one agency e.g. exclusion from school, could be considered in relation to the child and other things going on in their lives. It may also mean that support to the child and family that was deemed helpful did not end when the placement ended, strengthening risk management, safety planning and delivery of care. Throughout, individual agencies did some good work and frontline staff worked collaboratively, the CAMHS consultant carried out home visits, the YJS practitioner clearly had a good relationship. His residential unit had a safety plan before he came to them, offered substance use training to staff and worked hard to hold a very distressed and challenging child. From the individual agency reports there was concern about his safety and well-being however this was not followed through with an overarching robust safety plan that considered how and where best this child's needs were met. Given his level of addiction, emotional history and development stage it was a big ask to think that he could engage in the stages of addiction recover[54] to be able to consent to any treatment – many adults can't. The integration of service offer or 'new model of care' is important here. Jake had complex needs, was held by many different services and engaged with few thus making it difficult to grasp the complexity of his needs and easier for him to fall between the gaps.

Safety plans were written for Jake and shared with some professionals; however, it is not clear until the last 4 months of his life if the risk Jake posed to himself was adequately considered. There is a danger that services normalise drug use in adolescence as a rite of passage, to be expected, rather than acknowledging the risks. This coupled with the rapid changes in drug supply routes and types of drugs available needs addressing in services if we are to understand the scale of the problem and protect children. There needs to be a greater focus in services about how to help children who have mental health needs and who are also at significant risk because of drug use.

[54] Six stages of addiction recovery- precontemplation, contemplation, preparation, action, maintenance and termination.

Jake needed more containment than community services could offer but he did not fit into the normal 'boxes' available to the system. At a senior level it was decided that welfare secure would not help. Given that decision it is unclear why other options or proactive involvement of substance use services were not considered. CAMHS did a psychiatric review five weeks before Jake died with a view to use the Mental Health Act and the clinical decision was that he was not detainable. It was not until the last few months of his life that Jake agreed to attend a drug detox and rehabilitation centre.

Conclusion: *'It must be recognised that addiction is a chronic health condition, and like diabetes, hypertension or rheumatoid arthritis, it will require long-term follow-up. Discharge after short-term treatment is currently used as a measure of success, but should be stopped, as it ignores the fundamental relapsing and remitting nature of the condition. Trauma (physical, sexual or psychological) and mental ill-health are the drivers and accompaniment of much addiction. They are co-morbidities rather than separate problems for a 'dual diagnosis'. Commissioners of substance misuse services and NHS mental health services must ensure that individuals do not fall between the cracks'.*[55]

Drug addiction such as Jake's cannot be viewed as self-inflicted, he was a child at a developmentally risky stage who had a complicated and challenging array of problems. 'Policy, practice and daily interactions should all employ and reflect the principle of 'helping to keep adolescents safe and well' through this life stage'[56]. Children with this level of complexity need easy access to the resources and expertise of the multi-agency group particularly of CSC, CAMHS, substance use, Education and Health. Fragmentation and a lack of integration of agencies is a common feature. Jake was deemed 'beyond parental control' and placed on a care order aged 16 years. He openly talked about his suicidal intent and that he did not expect to live to the age of 18 years. While a secure welfare order was briefly considered, there ensued a familiar debate about whether he should be detained under the MHA, placed in secure or go to drug rehabilitation. Meanwhile his risk increased.

Where a child needs more containment but neither in-patient or welfare secure is deemed appropriate the result is often, especially in high-risk cases that CSC and CAMHS are left arguing about the best way forward. This is unfair on frontline staff and of course on the child. Given the limited options available it also means alternative solutions are less likely to be considered. As the 2014 research in practice document states 'Although a good deal of strong practice does exist, all too often services do not recognise or respond to underlying causes of risks, do not adequately 'work with the grain' of adolescent development, do not consistently draw on the strengths of young people, their families and peers, and do not support practitioners sufficiently to manage the complexity involved in working with adolescent risk'[57]. Children like Jake need a multi-agency response that also includes emergency services (LAS, police, ED), child health and education. 'A significant minority of young people experience multiple risks, which can make it more difficult to identify casual risks and resultant risks and can segment or silo the service response – further challenging those working with young people'[58]. It is important to consider how a multi-agency system can be supported to find the right approach for a child whose risk and needs cannot be met by existing pathways. In the last six months frontline staff were responding to Jake's often daily crises but there appears to be a lack of follow through in planning when he was placed on a care order and a lack of leadership generally in the multi-agency planning.

[55] Dame Carol Black, (2021). Review on Drugs, Phase 2.
[56] That Difficult Age: developing a more effective response to risk in adolescence. RiP Nov 2014
[57] That Difficult Age: developing a more effective response to risk in adolescence. RiP Nov 2014
[58] That Difficult Age: developing a more effective response to risk in adolescence. RiP Nov 2014.

Particularly in the latter part of Jake's life professionals understood the risk he presented, and this was well evidenced in plans, but with little sense of confidence in what could be done to reduce it. While it was recognised that his mental health needs could not be addressed until his substance use was reduced there was difficulty helping him achieve this especially as CAMHS and substance use services are commissioned separately, the thresholds are high and the child's willingness and motivation to engage are needed before they can access services. Issues considered in panel included how drug use is understood and whether we can ensure that children with addictions get the necessary support to help them access services.

Aspiration: It was acknowledged that as community-based services have reduced through lack of money it has become harder for core services to balance the necessary generic response with access to specialist support. Thresholds for entry into services are high and as noted above there is an expectation in substance use services that the child is willing and motivated to engage. CAMHS cannot treat the mental health need until there is a reduction in drug use. When he was last assessed under MHA, Jake was deemed not detainable because at that assessment he denied suicidality. However, given his history should an assessment like this be based on one moment in time without reference to very recent risk behaviour and concerns in the network? This tension between CAMHS and CSC is longstanding and needs a national review to support local services and safeguard children.

Recent LA financial difficulties appear to have exacerbated the reduction in available services. Financial resources, service design and more robust care pathways for complex children are national issues and there needs to be guidance to support local services to meet the needs of their population. A whole system change is needed to enable intervention alongside police and ambulance colleagues for children and families in a critical state. The Case for Change review and the recent 10-year drug plan is an opportunity to review this - a seismic shift in service design and offer is needed with a collective multi-agency commitment but it is acknowledged that this needs to be led at a national level.

Recommendation 11: CSCP to encourage relevant bodies to provide national strategic guidance and resources for integration of CAMHS, substance use and social care services so a more robust offer is available to children and their families and access to specialist substance use services as needed.

Aspiration: We need to foster shared responsibility across agencies to understand the child's risks including suicide so services can work together to mitigate the risk. This needs to be supported at director level so that interagency conflict and difference of opinion is addressed and the children remain at the centre of the decision making and planning. Collaborative work could provide opportunities to develop other pathways such as bespoke education provision, trauma informed response, short term use of welfare secure or MHA as appropriate.

Recommendation 12: Agree at local director and senior management level in CSC, CAMHS, Health (including ED), Education, Police (BTP & MPS), LAS and commissioning the main principles (when are there enough 'red flags') for in-patient admission, welfare secure or some other response reflecting a shared commitment to medium and long-term plans for these children. This has to include clarification about who is the lead agency in the child's care to ensure multi-agency ownership of care for children who are known to be at high risk.

The role of Independent Reviewing Officers (IROs): IROs have a key role in overseeing the plans for children who are looked after and have a duty to escalate and resolve concerns relating to a child's care plan. 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. We were struck by how many clinicians were unaware of the role of the IRO and had not fully appreciated the importance of communicating their concerns about care plans. IRO's to children with such high risk locally need to work actively with other agencies so ensure care plans are effective. CSPR 'Chloe' has identified relevant issues, this CSPR provides further evidence about the actions that are needed to promote the role of the IRO.

4.4.2 Commissioning and placements

'Provide safe havens

We must resolve to bridge the yawning gap in suitable provision for older children with complex difficulties who need to be in care. The adverse impact on their safety and development, and the parallel frustration of practitioners, managers, and often their families, in finding suitable placements and provision, have confronted us for too long'[59].

From the end of October 2017 Jake had 4 foster and 3 residential placements. From March 2016 he had 5 school placements. There were issues about quality and suitability of all placements and all ended because of difficulties managing his risk and behaviour. On occasion school and 'home' placements were terminated at the same time. There is little evidence of coordinated decision making in this respect and little sense of the impact on him. There is consensus across agencies that he needed help and treatment for his drug addiction and its impact on his mental health and suicidal behaviour.

The review panel and PLE agreed that there needs to be better consideration of the impact of single agency decisions including school, for children with complex difficulties. When dealing with high levels of risk, children and frontline staff would benefit from an integrated multi-agency service for Looked after Children. This is a commissioning task to provide better care for children who fall between CSC, CAMHS, substance use, police, LAS, ED, YJS and other agencies.

There was agreement that sourcing placements is problematic. There are few good placement options for children such as Jake. Local commissioning services need to work with multi-agency partners to identify the right homes in the right places with the right support. However, the lack of specialist provision for drug rehabilitation, especially for children who have developed addictions early in their lives, with the need for integration of CAMHS and substance use specialism is a national issue.

In this review all agencies described difficulties sourcing appropriate placements. Placements tend to end just when young people need them most. Limited placement availability means agencies need to look out of area or agree to suboptimal placements/provision. The increase in privatised placements has led to a market driven system for limited placements and/or increased use of unregulated placements rather than what is the best provision for a child in the medium to long term.

Conclusion & recommendations:
This national Commissioning Quality Standard should exist alongside strong local leadership, with local authorities working closely with NHS organisations and wider recovery partners. Joint local plans should be produced across all local organisations involved in treatment and recovery. Commissioners should also work more collaboratively with providers and introduce longer commissioning cycles of at least 5 years, to encourage service stability and improvements to quality. Commissioning arrangements should mirror NHS practice where there is a move away from competition towards collaboration'.[60]

This crisis in identifying suitable placements for children is highlighted in the Case for Change review (2021). It recommends better local coordination of decisions about placement moves, and often simultaneous school exclusions, to assess the impact and whether alternative solutions can be agreed. Although this is a national issue, systems should also be reviewed locally to improve coordination. It is also recommended that LA & NHS commissioning departments discuss with local services how to better integrate CAMHS, CSC teams and other specialisms when working with Looked after Children including co-location of services as suggested in NICE/SCIE LAC guidance[61].

[59] C. Parker & J. Tunnard (2021). Why are older children in care proceedings? Nuffield family Justice Observatory.

[60] Dame Carol Black, (2021) Review of Drugs, Phase 2.

[61] NICE National Institute for health and Clinical Excellence and Social Care Institute for Excellence (2010). Looked-after children and young people: promoting the quality and life of looked after children and young people. London, UK: NICE (PH28).

Nationally - The issue of placements has been picked up in several recent reviews, including CSPR 'Chloe', however there is not an integrated response for children and families especially where the child has the additional layer of complexity of drug use and has additional mental health and educational needs. The agency reports in this review demonstrate that this is a systemic problem with implications for a large group of children.

Recommendations: In the CSPR 'Chloe' there is an acknowledgement that suitability of placements is an ongoing issue that requires a national response. While we wait for this response, Recommendation 5 from CSPR 'Chloe' is relevant: 'CSCP to identify opportunities within the current system to provide multi-agency support to carers in the local area (informed by initiatives in other areas) and for this scaffold of care to be detailed in a child's care plan and reviewed in LAR's and multi-agency planning meetings'.

5.0 CONCLUSION

This is a painful and tragic case. Jake's family loved him, many of the clinicians we talked to cared deeply for him but because of his internal difficulties and rejection of services that could have helped him, he needed a system (including when necessary secure measures) that could mitigate his increasing risks until he was able to accept the help. Sadly Jake 'fell through the gaps' of our current system. There were single agency decisions about why he did not meet criteria for secure detainment and in-patient admission and remained out of education that can be justified in isolation but taken collectively they are uncoordinated. Risk management and responsiveness was much harder for services because of Covid-19 but many of the issues raised in this report predate the pandemic – they are national issues requiring a systemic national response.

There were a number of 'red flags' and opportunities missed because information was not shared or updated across agencies to understand Jake's pattern of interactions with services and the impact of delays in response. As a 17-year-old, transitioning to adulthood with his level of need and no concrete plans for the future he was high risk for suicide. While the risks were known by the system there was not sufficient multi-agency leadership. We need greater integration of a functioning, co-operative multi-agency system so the burden of this work can be properly supported. Children need to be seen and heard. Alongside this we need to review and frontload support to family, not only in the moments of crisis.

It would have been painful to get to know Jake, to feel the weight of his despair and hopelessness. He was angry, frightened, frightening and challenging. He rarely engaged in services that could have helped him but we need to distinguish between children who *will not* and who *cannot* engage. When children express feelings of hopelessness – of not wanting to live - the system must try to save them from themselves until they stabilise. Certainly, safety plans were in place but it is not clear they had meaning to Jake or if he felt sufficiently understood to properly engage with them. This work is emotionally demanding, confusing and draining. Too often CSC and CAMHS are left to battle out who should take a lead in responding to a child in urgent need. All agencies are responsible and a multi-agency framework (both frontline and at director and commissioning level) that allows practitioners to understand levels of distress and risk is essential. The challenges in this case are not specific to one area and evidence the shortfalls in the care of many of our most vulnerable children.

It is vital to end this report with Jake's voice, as told by his family. 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.

Jake was a child that you either got or you didn't – those that did were rewarded with his charming and vibrant company. His family are hugely thankful for all the people that went out of their way for Jake and championed and supported him, even in the hardest of times.

Jake's death leaves heartbreak and a huge void in his family's life. We know the legacy of suicide loss can impact future generations and Jake's family are now left to navigate this path and incomprehensible trauma. Their hope is that lessons can be learned from Jake's story and concrete multi-agency action is taken to safeguard other vulnerable young people and meet their unique needs.

6.0 Recommendations

Recommendation 1: CSCP to consider how multi-agency reflective forums will be built into multi-agency meetings/panels and other current established processes. The outcome of these changes should be reviewed and measured through use of practitioner feedback and incorporated into multi-agency audits.

Recommendation 2: CSCP to promote the directory of statutory and voluntary services to achieve awareness of this directory so that services and referral pathways are visible and known to all agencies.

Recommendation 3: CSCP to promote this training across multi-agency partners and have oversight of evaluation and impact. In addition, CSCP to liaise with public health and commissioners to consider what can be provided in terms of a local campaign regarding drug education.

Recommendation 4: The CSCP to raise awareness of intersectionality and the use of an appropriate framework or tools to consider a child's presenting needs and service response. These panels also need to provide an opportunity to assess the number of services involved with a child, their engagement and impact.

Recommendation 5: CSCP to seek assurances that robust systems are in place to review care planning informed by the Nuffield Foundation research (October 2021).

Recommendation 6: CSCP to continue to have oversight of local developments to reduce exclusions which includes intervention at the earliest possible point and to raise at a national level the need for strengthened guidance, with less opportunity for variation as identified in 2019 the Timpson report.

Recommendation 7: CSCP to consider how current training and awareness raising forums can be used to facilitate an understanding *Youth Culture* and the findings in this CSPR.

Recommendation 8: CSCP are encouraged to continue to learn from what works well when working with families and consider examples of innovative practice set out in the recently published guidance from Coram/BAAF and UCL.

Recommendation 9: CSCP to review with services support offered to families and for this to be revisited at the Rapid Review meetings and at Safeguarding reviews.

Recommendation 10: CSCP to oversee the development of multi-agency plans for children where contextual risks exist and, as in this case, when risks do not fit into the usual categories of gang affiliation and sexual exploitation there is also an urgency to ensure a timely response. This plan should include all emergency services who are likely to be involved and this should be shared with placement providers. These agreements must include detailed safety plans particularly when a child has known risks e.g. missing episodes, aggressive behaviour, drug use.

Recommendation 11: CSCP to encourage relevant bodies to provide national strategic guidance and resources for integration of CAMHS, substance use and social care services, so a more robust offer is available to children and their families and access to specialist substance use services as needed.

Recommendation 12: Agree at local director and senior management level in CSC, CAMHS, Health (including ED), Education, Police (BTP & MPS), LAS and commissioning the main principles (when are there enough 'red flags') for in-patient admission, welfare secure or some other response reflecting a shared commitment to medium and long-term plans for these children. This has to include clarification about who is the lead agency in the child's care to ensure multi-agency ownership of care for children who are known to be at high risk.

7.0 Glossary of terms

AAFS – Adolescent at Risk Forensic Service

BTP – British Transport Police

CAMHS – Child & Adolescent Mental Health Services

CLA – Child Looked After

CSC – Children's Social Care

CSCP – Croydon Safeguarding Children's Partnership

CSPR – Child Safeguarding Practice Reviews

ED – Emergency Department (also known as A&E).

EH – Early Help

EHCP – Education and Health Care Plan

FFT – Functional Family Therapy

FGC – Family Group Conference

IRO – Independent Reviewing Officers

LA - Local Authority

LARs - Looked After Reviews

LAS - London Ambulance Service

LPM – Legal Planning Meeting

MASH - Multi Agency Safeguarding Hub

MHS – Mental Health Act

MPS - Metropolitan Police Service

NHS - National Health Service

NICE – National Institute for health and Clinical Excellence

NVR – Non-Violent Resistance training

PEPs – Personal Education Plan

PLE – Practice Learning Event

PND – Post-natal Depression

SCIE – Social Care Institute for Excellence

SCR – Serious Case Review

SLAM – South London and Maudsley NHS Foundation Trust

SPOC – Single Point of Contact

YJS – Youth Justice Service

YUVA - Young people Using Violence and Abuse