

Essex Safeguarding Children Board

Child Safeguarding Practice Review

Child JJ

Learning Summary

Background

JJ was 14-years-old when he died by suicide. There has been longstanding involvement of JJ and his family with agencies in Essex. JJ was living with family at the time of his death, following a decision by the family court, the local authority had been unable to find a suitable alternative placement. JJ was an autistic child with ADHD and a learning disability.

Key Learning Points

Early help and whole family approach to domestic abuse

Early help for families is a crucial part of the safeguarding system and must include a coordinated multi-agency whole family approach to domestic abuse. This should focus on the needs of the victim and children in the family, alongside intervention with the perpetrator to reduce the risk of future harm.

- JJ's mother's experience of domestic abuse led to a disrupted childhood, for JJ, as she tried to distance herself from the abuser.
- The long-term impact of this abuse was not adequately understood and too often language within records could be construed as blaming mother as she struggled to respond appropriately to JJ's behaviour.
- Our understanding of domestic abuse has developed since JJ was a small child and a different response would be expected today, with the Domestic Abuse Act 2021 confirming that children are victims in their own right.

Trauma informed approach and a therapeutic response

Our system struggles to provide an effective therapeutic response for children who have many interacting needs including complex mental health needs.

- JJ was a child who was both autistic and diagnosed with ADHD and the totality of his experiences had a profound impact on his emotional wellbeing.
- JJ's dysregulated behaviours, which led to his need for a care placement, were identified as being rooted in childhood trauma, cementing the importance of the right help at an early enough stage.
- One of the challenges was moving beyond seeing JJ as a child with 'complex needs' to understanding each specific need as well as the interaction between them.
- Interventions and care plans for neurodivergent children need to be adapted to meet their needs.

Child to Parent Violence

Child to parent violence and abuse was not recognised as a specific issue that needed to be assessed to plan a coordinated multi agency response based on an understanding of the dynamics of child and adolescent to parent violence and abuse. There are currently no frameworks within Essex to support a multi-agency response or sufficient knowledge across the professional network of agencies who may be able to provide support.

Throughout the time JJ was in his mother's care she reported instances of JJ assaulting or threatening her. On at least five occasions the police were called either by Mother or another family member who was concerned for her safety.

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Key Learning Points

Placement sufficiency

There are insufficient residential care places for young people who require a setting able to meet their therapeutic needs and keep them safe from harm. This leads to children being placed in unsuitable placements and having their liberty curtailed.

- Lack of sufficient placements is a national issue; solutions are being discussed nationally and on a more local level.
- The local authority tried hard to find a placement to meet JJ's needs, but they were unable to find him a suitable placement, this led to extended hospital stays, placement breakdown and ultimately a decision in the family court that returning to live with his Father was the least worse option.
- Lack of suitable placements puts additional strain on the local system designed to find placements and monitor quality. This includes the impact of JJ being looked after in an acute hospital setting and local multi-agency escalation processes.
- The way in which the multi-agency system comes together in the face of seemingly intractable problems in finding placements which can lead to polarisation rather than working together with a strong focus on the needs of the child.
- The daily escalation meetings when JJ was in hospital two have been described as 'extremely uncomfortable' and a battleground, the focus on JJ and his needs became lost. How can we get the system to pause, step back and reflect on how to manage a difficult situation, support practitioners whilst keeping a strong focus on JJ.
- The respective roles of placements finding teams, social workers for the child and quality monitoring of placements can lack clarity especially in circumstances where it is hard to find a suitable placement.

Supervision Orders

Supervision orders may provide a limited safety net where children continue to need a comprehensive multi-agency support plan. Where parents do not wish to engage with a plan but the threshold for return to court is not met, the child is left in a vulnerable situation.

- This is an issue that has been explored nationally and in other local Essex reviews, but this case is another example on the limitations of supervision orders when not accompanied by an outcome focused plan.
- On granting a supervision order, the court places a duty on the local authority to 'advise, assist and befriend' this does not always reflect the complexity of the child's situation including managing risk of harm.
- While the local authority still has a duty to safeguard children, working with parents under a supervision order, without the structure of a child protection plan, can create confusion. Parents may believe the court decision means their child is fully safe in their care, even though a supervision order indicates the child previously reached the threshold of significant harm. Essex guidance introduced in January 2023 requires children to remain on a child protection plan for at least three months after a supervision order is made, but the review found this isn't always followed. This is partly because some supervision orders apply when a child is placed with alternative carers rather than returning home. The lack of distinction between these different situations means the guidance may need updating to ensure consistent safeguarding practice.

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Recommendations

Recommendation One

Essex Safeguarding Children Board should work with the Southend Essex and Thurrock Domestic Abuse Board (SETDAB) to ensure that:

- The components of a whole family approach to domestic abuse are agreed by all agencies and commissioning arrangements support implementation.
- All practitioners working with children and their families across health and social care have a sound understanding of the dynamics of domestic abuse - specifically how to recognise and respond to coercive control.
- There is a suite of practice tools available to support good practice.
- There is a consistent specialist domestic abuse presence in all multi-disciplinary teams in Essex.
- There are regular multi agency audits

Recommendation Two

Essex children's services should clarify the escalation route where practitioners are concerned that lack of transport is increasing risk to a child

Recommendation Three

The implementation of "Of Concern" meetings should continue to be embedded in practice to ensure that risks to young people such as JJ are properly assessed support provided.

Recommendation Four

CAMHS and children's services should work collaboratively to review the offer in Essex to ensure that services are sufficiently flexible to provide wrap around support for young people with multiple needs and takes account of their preferred way of engaging with the service.

Recommendation Five

The Integrated Care Board should review the effectiveness of the role of mental health liaison nurses to ensure that there is sufficient capacity to allow their skills and expertise to provide direct support in acute settings.

Recommendation Six

Essex Safeguarding Children Board should bring the findings of this report to relevant national bodies as further evidence of the harm caused to children by the current regulatory system for residential care and the impact of lack of placement provision.

Recommendation Seven

Where a child with no medical need is placed in a hospital environment because of lack of appropriate accommodation, the multi-agency process for managing this situation needs to be clear and:

- Distinguish between strategic planning and working together to meet the day-to-day needs of the child.
- Any multi agency meetings need to have a clear purpose and involve only the right people at the right level within their organisations.

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Recommendation Eight

The referral process for residential care should be reviewed to ensure that:

- Social workers who know the child and their background complete the information being sent to prospective providers.
- The information is clear about the child's legal status and challenges that they may present within the home.

Recommendation Nine

Within Essex children's services there should be clarity about how concerns about placement quality (below the level of a safeguarding concern) are shared and responded to.

Recommendation Ten

Essex children's services should take steps to review the impact of the 2023 supervision order guidance and ensure that it is clear, fully understood and embedded into practice. This should include:

- establishing the importance of child protection plans taking account of risks established within assessments for care proceedings.
- working with partner agencies to ensure that there is a good understanding of the role and limitations of supervision orders across the multi-agency network.
- establishing action that could/should be taken when there is evidence that the plan might not be working for the child.

Recommendation Eleven

Essex Safeguarding Children Board should work with partner agencies to develop a multi-agency framework for responding to Child and Adolescent to parent violence and abuse. This should:

- Identify the specific challenges associated with this aspect of safeguarding practice and good practice in assessment and response – drawing on current research and experience with third sector organisations.
- Clarify the respective roles and responsibilities of police, health and social care.
- Set out recommended training pathways for practitioners.

Recommendation Twelve

All agencies should review the quality of their supervision systems to ensure that all staff working with children at risk of harm have the opportunity for regular reflective supervision which addresses the emotional impact of the work.

Recommendation Thirteen

Essex Safeguarding Children Board should work with partner agencies to establish a system for multi-agency reflective discussions where the system is struggling to meet a child's needs.

Further Reading and Resources

- [ESCB Website](#)
- [Multi Agency safeguarding and domestic abuse](#)
- [NSPCC – Brain Builder Video](#)
- [Whole Family Approach](#)
- [Child to Parent violence](#)
- [Neurodiversity](#)
- [Voice of the Child](#)
- [Drug and Alcohol use](#)
- [Early Help Drop In sessions](#)