

Essex
Safeguarding Children Board
Child Safeguarding Practice Review
Child JJ

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PREFACE

This report is about a young person (known as JJ throughout this review) who died age fourteen, having taken his own life. JJ had contact with many different people during his life and this report is focused on learning for the agencies who knew him and his family. However, this must not allow us to forget JJ as a person. JJ was a much-loved child within his family and his parents, and other family members have been deeply affected by his death.

JJ's Mother has described him as having bright ginger hair, tropical blue eyes and a smile that could capture a room. She told the review of a fantastic wild child with an incredible sense of humour, the kindest heart and someone who would do anything for anybody less fortunate than himself.

JJ touched the hearts of those who came into contact with him. So many people have described his wicked sense of humour, kindness and amazing smile. He is remembered as a "ball of enthusiasm and excitement", who was desperate to succeed but so often frustrated with himself he could not seem to get things right. Although JJ experienced many challenges which made his behaviour hard to manage, for those who became close to him this was simply his way of expressing distress and unhappiness.

1 INTRODUCTION

- 1.1 This Child Safeguarding Practice Review was commissioned following JJ's death in September 2023. JJ had made a previous serious suicide attempt in 2022 which led to him being in the care of the local authority for 11 months under an interim care order. JJ returned home to live with his father under a supervision order 10 months before his death.
- 1.2 Essex Safeguarding Children Board conducted a rapid review of the involvement of organisations within Essex and concluded that due to the high level of agency involvement with JJ over several years, this case met the criteria for a Local Child Safeguarding Practice Review.
- 1.3 Statutory guidance sets out the purpose of a Local Child Safeguarding Practice Review. This purpose is to identify improvements that can be made to safeguard and promote the welfare of children. The focus of these reviews is learning for the safeguarding system at local and national levels rather than focusing on the actions of individuals. Specifically statutory guidance¹ notes that:

¹ HM Government (2023) *Working Together to Safeguard Children*

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account, as there are other processes for that purpose, including employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside a review or at a later stage. Employers should consider whether any disciplinary action should be taken against practitioners whose conduct and/or practice falls below acceptable standards and should refer to their regulatory body as appropriate. (Page 131)

- 1.4 The review process has sought to understand JJ's experience and has gathered a great deal of information about what happened throughout his life. The review team are indebted to JJ's mother and the many practitioners who have helped us to explore both what happened and why events occurred as they did. It is not appropriate to include in this final report a detailed description of every event as many of them are very personal to JJ and his family, but the final recommendations are drawn from a detailed analysis of all the information provided. The overarching aim of this document is to acknowledge and respect JJ's experiences and reflect on what they mean for improving the safeguarding system for other young people in similar circumstances.
- 1.5 This review has been led by Jane Wonnacott an experienced independent consultant. Although statutory guidance no longer requires the lead reviewer to be independent of all agencies involved with the child, in this case the Essex Safeguarding Partners wished to ensure there was no conflict of interest and that there was appropriate independent scrutiny. The lead reviewer worked with a review team made up of senior professionals from agencies across Essex who had contact with JJ or his family.
- 1.6 JJ's parents were offered the opportunity to contribute to the review. At the start of the review the lead reviewer met with JJ's mother and we are very grateful for her willingness to share insights into JJ's life and the ways in which services to JJ and his family could be improved. JJ's mother's views informed the final terms of reference and key lines of enquiry for the review which are set out in appendix one. The review team understands and respects the wish of JJ's father not to be involved. but this report should be read with the understanding that his views and perspective on events are not included in this final draft.
- 1.7 The review team considered written records and agreed a list of practitioners who should be invited to contribute to the review. Conversations took place between the review team, lead reviewer and 64 practitioners from 15 agencies/organisations. These conversations have helped the team understand more about JJ, the work of so many people who were trying to help him and the challenges and barriers presented by the safeguarding system.

2 SUMMARY

- 2.1 When JJ took his own life, he was living with his father. This was as a result of a family court decision that this was the best alternative in the light of no suitable therapeutic placement being available in a registered children's home. Therefore, first impressions may be that this was another young person who was failed by a childcare system which has insufficient capacity to provide high quality safe care outside the family. This is not an unreasonable conclusion. This review does find that lack of placement choice forced the court to make a decision which was not recommended by the local authority and was the least bad alternative, rather than a positive choice for JJ.
- 2.2 The lack of a suitable therapeutic placement had resulted in JJ being accommodated on hospital wards, an unsuitable regulated placement, an unregulated placement and subject of deprivation of liberty orders on two occasions. The calm consistent environment he needed, especially as an autistic child could not be achieved. This was distressing for JJ and only served to increase his dysregulated behaviours.
- 2.3 The review has heard that JJ was not the only child in Essex staying in hospital where there is no medical need. Often these children have mental health needs (but no formal diagnosis) and are being cared for alongside very physically sick children. This presents challenges for all concerned including paediatric staff who do not feel equipped to respond to their needs. The recent appointment of paediatric mental health nurses in the hospitals where JJ was a patient is therefore to be welcomed.
- 2.4 Limited placement choice also led to JJ being placed in an Ofsted regulated home which the social work team were unsure could meet his needs. This placement failed in its duty of care by allowing JJ to be put in a situation where an allegation was made that he had sexually assaulted another young person. This resulted in him being moved to unregulated accommodation and a police investigation which clearly played on his mind for several months.
- 2.5 However, to solely focus on sufficiency of placements is too simplistic. There were many issues which had affected JJ's emotional wellbeing, and at the time of his death there were insufficient protective factors in his life to provide the support he needed to withstand the challenges he faced.
- 2.6 Although JJ did not have a formal mental health diagnosis he undoubtedly had struggled with poor mental health from a young child. The combination of early childhood trauma (linked to domestic abuse), ADHD, autism and learning difficulties had presented him with numerous challenges which were not then mitigated by a stable family life. The needs of children cannot be separated from the needs of their parents and our safeguarding system struggled to provide the right support at the right time in a way that was acceptable for JJ and members of his family.

- 2.7 At times the system seems to have exacerbated problems. For example, by not fully recognising and responding to the severity of abuse perpetrated by JJ's father and not consistently understanding Mother's and JJ's reactions within the context of domestic abuse/coercive control. Although there were notable exceptions where practitioners gained Mother's trust and worked with her, she too readily seems to have become "a problem" and the potential for maintaining JJ within the family home was lessened. A pivotal moment in the deterioration in Mother's relationship with professionals was JJ's first suicide attempt which led to an emergency protection order and increased contact with Father. From this moment the narrative from professionals changed from describing Mother as potentially part of the solution for JJ, to being part of the problem. By the time of the final care proceedings the only possible option within the family became Father, with the result that JJ's significant relationship with his mother was fractured as she lost faith in the system and withdrew.
- 2.8 The specific issues for JJ point to the problems of ensuring adequate support for young people when their parents have lost faith in public services. Although JJ was subject of a supervision order, this did not provide sufficient safeguards to make sure that he was not hidden from view, and it is notable that in the space of a year he moved from a child who had intense support from a range of practitioners to a child who was not seen at all in the weeks before his death. By this stage it seems that his father felt let down by the failure to find a suitable school place, did not wish to engage with children's social care, and the education outreach service were not commissioned during the summer holidays. This significantly reduced the protective factors in JJ's life but the implementation of the supervision order (which did not have an accompanying outcome focused child protection plan) meant that the degree of risk was underestimated.

3 JJ'S LIFE AND CONTACT WITH SAFEGUARDING ORGANISATIONS

JJ's early years

- 3.1 JJ is Mother's second child. Mother has a child from a first marriage (known in this report as A) and met and moved to live with JJ's father when A was age two. Five years later JJ was born. Father had three children from his first marriage. Records show a long history of offending behaviour including domestic abuse. There is evidence of domestic abuse perpetrated by JJ's father continued through JJ's early years and contributed to an early childhood which involved several moves as Mother sought refuge away from his father and there are descriptions of behaviour by Father which would now be identified as coercive control,² with Father intimidating Mother in order to gain care of the children.

² Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten the victim.

3.2 Father initiated private law proceedings and during those proceedings a S37 report³ focused on the basic care that Father could provide and noted that the children wished to remain with him. It did not explore Mother’s behaviour through the lens of domestic abuse or understand the seriousness of previous domestic abuse or the nature of the coercive control perpetrated by Father. These proceedings resulted in Father being awarded a child arrangements order in respect of both children.

The significance of this period for later work with JJ and his family is that both JJ and his mother were victims of serious domestic abuse perpetrated by his father. This would have had a profound impact on JJ’s emotional development and his relationships with both Mother and Father. From Mother’s perspective, there was a need to acknowledge her experience as a survivor of abuse and understand the impact this had on her responses to professionals involved with JJ.

Understanding and responses to domestic abuse have developed since 2014 and the acknowledgement that children are victims of domestic abuse in their own right became enshrined in law in 2021. Assessments for JJ during this time described him as being in the middle of “family acrimony”, which is now acknowledged to be an inaccurate description of domestic abuse, and more recent domestic abuse policy guidance within Cafcass⁴ is likely to have led to a different response to Fathers application for a child arrangements order.

This review underlines the importance of these developments and the need to ensure that changes become fully embedded into day-to-day practice.

JJ age 5-11

3.3 During this period JJ was mainly living with his father and there was an escalation in causes for concern in respect of both children’s behaviour. JJ was formally diagnosed with ADHD and started on medication and by the age of nine was in receipt of an Education Health and Care Plan (EHCP). He was permanently excluded from primary school and from July 2019 -March 2020 his education was provided by NTAS (National Teacher Advisory Service). He was generally three to four years behind expectations for his age.

3.4 In 2019 after JJ alleged physical abuse by Father, there followed a period of child in need planning. There were also concerns that Father had stopped giving JJ his ADHD medication and was giving him cannabis oil instead. As a result of not being given

³ Section 37 of the Children Act 1989 empowers the court to direct local authorities to conduct investigations into the circumstances of a child. Where it appears to the court that it may be appropriate for a care or supervision order to be made.

⁴ <https://www.cafcass.gov.uk/sites/default/files/2024-10/Domestic%20Abuse%20Practice%20Policy.pdf>

medication JJ was discharged from the neuro behavioural clinic but medication later resumed after Father was worried about his behaviour and was advised to re refer via the GP.

- 3.5 In March 2020 JJ was placed on the roll of a special school for children with social emotional and mental health needs. This was just at the start of the first Covid lockdown and JJ was not educated on site. The school kept in touch with JJ, Father and Mother as JJ spent time with both parents. There were further discussions about the possibility of “respite” in school, followed by unsuccessful attempts by Mother to arrange school transport. By the end of June JJ was living back with his father.
- 3.6 At the end of July plans were in place for JJ to start attending school at the start of the next term. Apart from glimpses via school contacts, little is known about JJ’s life at this time.

JJ’s disclosure of physical abuse by father had not resulted in him being removed from Father’s care, and the first Covid lockdown meant that JJ was largely hidden from view apart from his contact with education. He was no longer subject of a child in need plan, and it seems he was not deemed to be a vulnerable child who was offered on site education until each parent had expressed concerns about his behaviour. By that time, it appears that arranging transport was not possible.

JJ living with Mother (age 11-12)

- 3.7 In September 2020 JJ began to attend the special school on site and after child protection enquiries due to another allegation of physical abuse by his Father it was agreed that JJ would move in with Mother, who then applied to court for a variation on the child arrangements order. A non-molestation order was issued, and Father was only allowed supervised contact with JJ. JJ then remained living with his mother until December 2021.
- 3.8 The allegation of abuse had resulted in a strategy discussion which agreed there would be no police action and a child and family assessment resulted in a child protection conference. At the conference the decision was that the threshold was not met for a child protection plan and a child in need plan was developed to support JJ. This included keeping the assessment team social worker as the allocated social worker to maintain continuity and a wide range of support for both JJ and Mother including contact with a domestic abuse support agency and solution focused work with DBit⁵.
- 3.9 One missing element of the plan is a focus on the extremely serious abuse perpetrated by Father who was not directed to therapy or a perpetrator programme to address his

⁵ DBit work with children and young people identified on the edge of care, using a strengths-based approach to support them to remain in their family whenever safe and possible to do so.

violent behaviour. The work of the plan became focused on maintaining his relationship with JJ via supervised contact.

- 3.10 The school felt that their setting was not suitable for JJ's needs and a bespoke offsite education and outreach programme was arranged, funded by the secondary school. This education and outreach provider (to be referred to as EOP in this report) provided a 14-hour weekly programme including transport and eight hours face to face tuition and outreach support.⁶ All practitioners spoken to for this review have spoken of the importance of the relationships that JJ developed with EOP staff from this point until the July before his death, with one practitioner noting that EOP were standout figures for JJ and were *the most consistent, the most containing, the most therapeutic*.
- 3.11 Mother became increasingly concerned about JJ's low mood and he was referred to CAMHS. She also queried possible autism and he was placed on the waiting list for an ADOS assessment⁷.
- 3.12 A CAMHS assessment was offered for December 2020 which JJ and his mother did not attend and as a result they were discharged from the service. According to Mother this was too long a wait, and she needed urgent help.
- 3.13 The social worker during this time assessed that Mother was doing well and both Mother and JJ worked positively with the social work plan. The ability of skilled staff in EOP and children's social care to develop and maintain relationships over time with Mother and JJ is important to note in the light of later concerns as to whether Mother could work with professionals.
- 3.14 Mother applied to the family court to vary the child arrangements order. A section 7 report⁸ was requested from children's social care which recommended that the child arrangements order should be made in her favour.
- 3.15 Through this time, it is clear from Mother's input to this review that she remained extremely worried about JJ's mental health and did not feel he was getting the help he needed. There were increasing worries expressed by mother about JJ's mental health, aggressive behaviours and most significantly increasing violence and threats of violence towards her. This included punching her, threatening her with knives and digging a grave for her in their garden. On occasions Mother called the police, but throughout, Mother was consistent in her view that despite violence from JJ she would not support prosecution of her son. She also was adamant that the family did not wish to engage with CAMHS.

⁶ EOP explained that if more than 15 hours is funded by Education, they are deemed to be an illegal school. Any additional hours that JJ needed at a later date were therefore funded via CSC.

⁷ The Autism Diagnostic Observation Schedule (ADOS) is a tool used to help clinicians assess autism.

⁸ Under section 7 of the Children Act 1989, in private law proceedings courts can direct either Cafcass or a local authority to report on the welfare of a child.

- 3.16 At the end of September 2021 JJ was taken to hospital by the ambulance service after a report that he had punched Mother in the face. This led to JJ being placed in foster care. An assessment by CAMHS recommended that he should not go home. Mother was not happy with this assessment and felt that JJ needed medication for his depression and that no one was listening to her. Three days later JJ returned home following a request from his mother.
- 3.17 At a subsequent clinic appointment, the decision was to conclude CAMHS involvement as JJ did not need medication and CAMHS could not work with Mother as she would not engage with them.
- 3.18 In October 2021 an initial child protection conference agreed that the child in need plan would continue, and by November 2021 there were reports of JJ saying he had touched Mother inappropriately when she was asleep. Mother later told the social worker that she had spoken to JJ who said that it had not happened.

The period of time that JJ spent living with his mother indicates that it was possible to develop a working relationship with Mother and JJ. This was notably achieved by specific social workers and by EOP. This work required a sophisticated understanding of the factors driving Mother's responses and the ability to listen to her worries about his mental health and respond flexibly with the right help at the right time. It is also significant that although Mother was sure that JJ was an autistic child there was no formal diagnosis, and his responses were not understood by professionals through the lens of neurodiversity.

It is clear however that a concern was developing about Mother's capacity to care for JJ, particularly within CAMHS. As JJ's violence towards Mother escalated, there is little indication of an assessment as to what was driving this behaviour. The issue of assessing and responding to child and adolescent to parent violence and abuse has been identified as a knowledge and skill gap by the team involved at that time. This is explored further in Finding Six.

JJ's suicide attempt and EPO (age 12)

- 3.19 Just before Christmas in December 2021 JJ made a serious suicide attempt by ligature and was found by members of the public in the local park. JJ was taken to Local Hospital 1 and later transferred to a specialist regional hospital where he was placed in an induced coma, and it was uncertain whether he would survive. There was an immediate multi agency strategy meeting on Christmas Eve attended by all relevant Essex agencies which noted that no plan could be formulated as the prognosis was uncertain. Father's non molestation order was waived and both Father and Mother stayed together in a room at the hospital.

- 3.20 After JJ came out of the coma there was a disagreement between parents and hospital staff regarding JJ's care and after consultation between hospital social workers and Essex social care, the decision was made to apply for an emergency protection order (EPO). Mother has told the review that the parents were given only 15 minutes notice of the hearing. She knows professionals described her as angry and confrontational but she would describe herself as "distraught" and unable to think straight.
- 3.21 As a result of the EPO application CAFCASS appointed a children's guardian.
- 3.22 The final psychiatric assessment within the hospital was that JJ was at risk in the context of family relationships, but a Tier 4 hospital bed was not relevant to his difficulties. When JJ was deemed medically fit for discharge there were extensive discussions about discharge arrangements. These culminated in a decision that JJ should be discharged to Local Hospital 1, and Essex CAMHS would look at the ongoing assessment of his mental health needs. Children's social care was to hold a legal planning meeting and consider the threshold for care proceedings and interim care order application.
- 3.23 Staff at Local Hospital 1 have described feeling under pressure from the regional hospital to take JJ and that it was not appropriate for him to be discharged to a general paediatric ward due to the risks posed to other children. However, as the regional hospital is a tertiary centre and needed the beds, in the end Local Hospital 1 felt there was no alternative but to agree to admission.

JJ's suicide attempt was a pivotal moment, as from this point onwards everything changed for him.

Waiving the non-molestation order to allow both parents to stay in hospital was at the time felt to be a compassionate response but on reflection more consideration could have been given to the history of domestic abuse. It is notable that from this moment forwards the positive relationship between mother and social workers changed. Mother was understandably angry and upset and began to be portrayed in the records as difficult and undermining of professionals.

After this episode JJ was heard to refer to his success at bringing his parents back together but on the other hand the EPO and interim care order set off a chain of events which resulted in him living for many months in unsuitable accommodation. The narrative moved from practitioners believing that Mother could look after JJ with the right support, to a negative view of both Mother and Father's parenting capacity.

The EPO was driven by the regional hospital who were perceived as "experts". At the point that it was decided that an EPO was required, there was no Essex social worker, who knew the parents, on site to explore with them why an EPO was being requested. It is hard to understand why a little more time could not have been allowed to explore with them professional's concerns and assessment of what was in JJ's best interests and why. This is a learning point for the future.

JJ's time in Local Hospital 1 (age 12)

- 3.24 On admission JJ was seen by the CAMHS crisis team and a safety plan agreed.
- 3.25 In early January 2022 an interim care order was granted to the local authority.
- 3.26 Mother remained with JJ throughout his stay in Local Hospital 1 and she often advocated on his behalf. She has been described as "difficult" "aggressive" and undermining of professionals but from her perspective she was desperately concerned and upset and wanted to make sure that JJ's needs were met.
- 3.27 It is evident that managing JJ on a general children's ward was not easy and caused staff and other children a great deal of distress. He was supported by the hospital school team and also had daily time set aside with a play therapist. There were daily check-in visits from the CAMHS crisis team, but this was not with a view to offering any direct work with JJ.
- 3.28 JJ was seen by a consultant psychiatrist who noted no evidence of psychotic symptoms and that he would fall into the category of emotional and behavioural problems. By mid-January 2022 JJ was noted to be fit for discharge and the first escalation meeting took place as despite extensive searches no placement could be found.
- 3.29 JJ was seen on the ward by the consultant community paediatrician who then worked to bring forward the ADOS assessment⁹ as JJ remained on the waiting list. The ADOS assessment took place on the ward with the autism diagnosis being confirmed by the paediatrician at the start of February. The Paediatrician hoped that by bringing forward the assessment, JJ's autism could be taken account of in planning to meet his needs.
- 3.30 JJ's behaviour began to deteriorate in hospital. EOP were visiting regularly and were increasingly worried about him, Mother was exhausted and was frequently hit and punched by JJ. An extensive search for residential provision continued but was unsuccessful. By this stage nurses on this ward felt the situation with JJ was untenable and there had been several staff resignations. The Matron for acute services e-mailed the social care team manager due to concerns about JJ's escalating behaviour.
- 3.31 Weekly professional's meetings were taking place to discuss JJ who was deemed to have been "discharged from medical care". A psychological assessment identified that, his presentation was typical of a child who had experienced complex trauma, tests indicated at least a moderate level of depression, but JJ was not considered to be clinically depressed. In the assessors view he needed a residential placement with a minimal number of well-matched other young people.
- 3.32 After further placement searches one placement appeared to be a good match for JJ offering care for young people who have experienced trauma. JJ expressed an interest

⁹ The waiting list at that time was around 15 months.

in this placement as there was a local car racing club. Both parents felt this was a good match and after a visit JJ was discharged from hospital and moved to the placement with 1:1 support.

JJ's time on the ward at local Hospital 1 was extremely stressful for JJ, his mother and all the staff who tried to care for him. A paediatric ward in an acute hospital cannot provide a calm therapeutic environment, yet hospital staff have told this review that it is not uncommon to have young people on the ward who have mental health needs and are there because no other placement can be found. Hospital staff have described a vicious circle whereby the more JJ's behaviour escalated the harder it was to find a placement and he remained in an unsuitable environment which cause his behaviour to escalate further. His violent behaviour towards other children led to him being confined to the ward, although there was no legal basis for this in place at the time.

JJ would talk to the nurses, but they are not mental health trained and worried about the conversations they were having with him. Staff too often felt that they were failing him and would have to absorb all of Mother's anger. Staff left because of the emotional impact of this situation. Matron created drop-in sessions for staff to offer additional support. Wellbeing services were involved and long term psychological support was offered as well as safeguarding supervision.

An additional support now available within Hospital 1 are mental health liaison nurses. Although these nurses became operational across acute hospitals in Essex during 2021/22 they were not in place in Hospital 1 until after JJ was discharged. These nurses are now funded on a recurrent basis by the local Integrated Care Boards and have a high level of expertise and understanding of children with mental health needs. Consequently, they can play a vital role in supporting staff in acute hospitals to care for children with complex mental health needs. Their role is explored further in paragraph 4.33 of this report.

First placement -Time in Local Hospital 2 - First Deprivation of Liberty Order (age 12)

- 3.33 JJ's first placement only lasted five days and police needed to be called three times following threats by JJ to harm himself and others. He went missing from the placement and after being returned, there was an increase in distressed behaviour and he threatened to take his life. An ambulance was called by staff and JJ was taken to Local Hospital 2. The placement gave immediate notice.
- 3.34 JJ was taken to A&E at Local Hospital 2 and a social worker and the team manager stayed with him overnight. He was seen by the CAMHS crisis team and was deemed unsafe and inappropriate for discharge although he did not need a Tier 4 (mental health) bed. After discussions within the hospital, he was admitted to the paediatric ward. A decision was made that it would not be appropriate for Mother to stay with him and

contact was arranged with both parents for two hours each week. Mother has told the review that she was very distressed by the lack of contact with JJ and did not understand why it was so different in Hospital 2, she also felt that the physical conditions within the hospital were unsuitable with JJ suffering from a lack of fresh food and sunlight. Mother describes him putting on a considerable amount of weight. Mother remained in contact with JJ by setting up a You Tube channel and making and sending him videos.

- 3.35 Because of JJ's dysregulated behaviour he needed 1:1 staffing plus security. Concerns about his behaviour were escalated to the hospital chief executive and resulted in a bay of a surgical ward being closed to accommodate JJ. The impact of this was that all elective cleft palate surgery for children in the East of England was cancelled.
- 3.36 EOP saw JJ daily and would take him out. They have also described sitting with him at night until he went to sleep. CAMHS crisis also continued regular checks and children's social care funded 24/7 agency carers. Children's social care did their utmost to alleviate a very unsatisfactory situation, and social workers would deliver food to the hospital as well as coordinating agency care staff and funding EOP to provide additional care beyond their original education brief.
- 3.37 During this time EOP were concerned that JJ's mental health was declining, and he began to open up to them about past physical abuse.
- 3.38 Security was supplied by the hospital (bank security) but when JJ threatened a security guard the guard punched him causing bruising. A police referral resulted in no further action but the guard was removed from the bank and it was fortuitous that the head teacher from the special school was able to give the hospital the name of a security company who specialised in security for troubled young people. Hospital 2 then funded them to give 24/7 care. The review has been told that they were "*phenomenal with JJ – would communicate and play with him*".
- 3.39 As a result of the concerns about JJ's situation Hospital 2 instigated daily escalation meetings. These have been described as tough meetings where the intractable problem of finding an appropriate placement for JJ challenged the whole professional network. Escalation is explored further in Finding Three
- 3.40 A referral was made to the CETR team¹⁰ as JJ was an autistic young person in an acute unit and involved with mental health services. The CETR panel felt that JJ did not require Tier 4 hospital admission due to his needs being primarily safeguarding, and placement suitability. The panel expressed concerns regarding him staying in hospital without a legal framework and children's social care confirmed to the panel that JJ did not reach the threshold for a secure (welfare) order, and they were applying for a Deprivation of

¹⁰ The Care Education Treatment and Review Team meeting about a child or young person who has a learning disability and/or autism and who is either at-risk of being admitted to or is currently detained.

Liberty Order. There was no planned follow up by the CETR team as there was no risk of Tier 4 admission.

- 3.41 During JJ's time in Hospital 2 the psychologist who had provided the previous assessment confirmed that her view remained that JJ's needs would be best met in a specialist residential setting. She did not support an interim placement with Father, based on JJ's allegations of physical abuse and her assessment that Father could not provide emotionally attuned care or accept advice challenge or guidance from professionals.
- 3.42 At a court hearing the DOLS was extended, and the judge was noted in health records not to agree with JJ going home.

The period that JJ was in Local Hospital 2 caused considerable stress to JJ, his family and multi-agency relationships. This was an impossible situation for everyone involved.

For JJ, his living environment could not provide the comfort, emotional warmth and consistent relationships with people close to him that he required. Even physical safety was compromised by the security guard's assault. There was no plan to meet any specific physical and emotional needs associated with JJ's autism diagnosis or mitigate the negative impact of his day-to-day experiences as a neurodivergent child. Although mental health liaison nurses were in post in Hospital 2 this positive development appears to have had minimal direct impact during JJ's stay in Hospital 2 which may have been linked to the role being still in its infancy. This is further explored in paragraph 4.33 and there is a recommendation from this review that the impact of the mental health liaison nurse on direct work with children in acute hospitals is reviewed.

Multi agency relationships became strained, with the danger that a focus on JJ's needs became lost. A great deal of time was spent in escalation meetings which could only confirm that the hospital needed JJ to be moved, and children's social care could not find a placement. Outside these meetings front line practitioners did their best to look after JJ but the emotional strain on everyone involved was immense.

These issues are explored further in Findings Four and Seven.

Move to Residential Provider 2

- 3.43 An Ofsted registered provider, (Residential Provider 2) received a referral for JJ in a solo unit with a locked entrance separate from the main home. The issue of information sharing at the point of referral is explored in Finding Three

- 3.44 The provider was well known to the Essex placements team and there were known concerns about the quality of care in the home. In the light of these concerns and the knowledge that the home was struggling with another young person from Essex, the social work team turned down the placement.
- 3.45 At that time a service manager within Essex was working to increase placements in Essex for Essex children and had visited Residential Provider 2 as part of a quality assurance programme. After a discussion with Residential Provider 2, the service manager reassured the placement team and the social worker team that there was no reason to reject the provider. Although JJ's social worker remained unconvinced about the suitability of the placement, they did not feel they had the grounds to argue any further when the alternative was for JJ to remain in hospital. Roles and responsibilities regarding placement finding are explored further in Finding Three
- 3.46 JJ then moved to Residential Provider 2, Deprivation of Liberty restrictions were removed and CAMHS provided initial advice on managing JJ. After brief honeymoon period JJ's behaviour presented staff with challenges and some resigned. Behaviours included assaulting staff and members of the public and threatening to kill a neighbour's dog.
- 3.47 This review has been told that JJ became infatuated with another female resident and just over two weeks after he moved in there were two swimming outings where children were allowed to get changed by themselves. Serious allegations of sexual assault were made by the girl against JJ and both young people were separately taken to the police station where JJ was arrested. Due to the seriousness of the alleged offences and the need to make sure that forensic samples could be properly obtained, JJ stayed overnight and was interviewed the following day. The social worker acted as Appropriate Adult and JJ was advised by his solicitor to remain silent. Mother has told the review that she sat outside the police station all day but was not allowed to see JJ. Any decisions about who could see JJ would have been made by the custody officer and would have been influenced by the fact that Mother was a witness as she had given a statement to the police regarding JJ's sexual contact with the female. There is evidence that the custody officer assessed JJ's needs using a risk assessment document with 42 questions which included identification of autism. The custody officer acknowledged the potential for distress and JJ was placed under constant observation by a police officer.
- 3.48 JJ was released on bail with conditions which included ensuring he was only in the presence of other children with supervision by trained staff and not to reside in premises with other children. The bail was extended for over two months. This review has heard differing recollections from police and children's social care about the appropriateness of the bail conditions imposed on JJ and the police response to requests for these to be varied. From children's social care perspective, they had been directed by the family court to request more flexible conditions to assist placement finding whereas police believed the conditions were necessary to protect both the public and JJ from further

allegations. Action is being taken outside this review process to prevent similar problems in the future.

- 3.49 As well as different perspectives on the way that bail was managed, the review has also explored concerns about the impact on the criminal justice system on JJ as a vulnerable child. A strategy meeting did take place at the start of the investigation to plan the best way forward, but this meeting was held in respect of both JJ and his alleged victim who was also in care of the local authority. This maintained a focus on JJ as a perpetrator and a more appropriate approach would have been to hold separate meetings for each young person involved.
- 3.50 As JJ could not return to Placement 2, the next two nights were spent at a guesthouse with agency care staff who JJ knew from his time in hospital and he was pleased to see familiar faces, hugging each one on their arrival. A staff member from EOP met JJ the following day to check in with him and let him know they would be seeing him the next day as usual. He was a little hyperactive whilst at the guesthouse, causing some damage but overall managed well with the sudden change of circumstances.

This episode highlights the risks associated with placing children in any residential setting where there are concerns about suitability and the extent to which practitioners felt powerless in the face of no positive solution. The placement on offer was not ideal but it was equally clear that remaining in hospital was detrimental to JJ's wellbeing.

Staff in the home did not fulfil their responsibilities to keep both JJ and the other resident safe, causing JJ ongoing worries about the consequences of police action. Police action and decisions regarding bail conditions resulted in tensions over many months between children's social care and police and a key area of learning is the importance of a strategy discussion which separates the needs of the victim from the needs of the alleged perpetrator. This is particularly important where the perpetrator is also a young person in care.

Placement 3 and Second Deprivation of Liberty Order

- 3.51 JJ moved to a new unregistered placement in a flat with support provided via an agency. Three agency childcare staff from the care agency were in attendance at all times. JJ's social worker worked hard to make the flat homely, buying pictures and other items. However, despite this the accommodation was described to this review by the children's guardian as totally unsuitable with no outside space and situated on a busy roundabout overlooking a school where JJ could watch other young people enjoy their freedom.
- 3.52 Throughout JJ's time in this placement, concerns were raised by EOP and the guardian about the standards of care. As well as concerns there were also some positive

comments with CAMHS noting this was a reasonably settled period. Their view was that their role could only be limited as JJ was not experiencing a mental health disorder and he was not considered ready for psychological therapy. He was also refusing to engage with CAMHS and was subsequently discharged from the service.

- 3.53 The risks of JJ harming himself remained high and on one occasion care staff contacted social care to advise that they had found a knotted cord loop in the bathroom, possibly taken from the drawstring of a pair of shorts. JJ denied any knowledge of it when an attempt was made to discuss this with him.
- 3.54 As JJ was now in an unregulated placement a second DOLs application was filed by the local authority. Weekly placement review meetings took place to ensure his needs were being met which included health, EOP and children's social care.
- 3.55 Meanwhile assessments were continuing for care proceedings. JJ consistently expressed a view that he wanted to live with his father, but parenting assessments did not recommend placement with either parent.
- 3.56 An expert psychiatric report for the care proceedings recorded a diagnosis of ADHD/autism/depressive disorder and complex developmental trauma which the expert believed was sufficient reason to explain the suicidal act. The report commented that autism often means there is more masking of suicidal thinking, and that risks would remain high risk without adult supervision. His aggressive reaction would vary from moderate to high if there were:
- Changes in his pattern of care
 - Distance from parents
 - Exposure to environments and stimuli to which he was particularly sensitive.
- 3.57 The report recommended that JJ should undergo a trial of anti-depressant medication and in July 2022 CAMHS arranged for JJ to see a psychiatrist, with a view to trialling a 6–8-week course of anti-depressant medication. JJ did not attend the appointment and records suggest that this was because he refused to go. Another record notes the reason as "short notice, no preparation time". A Patient Safety Incident Investigation following JJ's death notes that the psychiatrist did not schedule another appointment as they had been told that JJ was doing well in his placement. Also, *the risk of prescribing antidepressants to a child who may not be willing to attend regular reviews poses greater risk than the benefit because of the potential side effects of the medication.*
- 3.58 Meanwhile discussions were continuing with Essex Education/SEND about JJ's future education provision and an updated EHCP.
- 3.59 In August the position statement filed by the children's guardian stated that the guardian supported the local authority care plan to place JJ in a specialist solo residential unit with education and therapy if this could be found. However, this preferred option had not been found despite a long search. She felt a decision regarding further delay to find a placement or to reunite JJ with his father was 'finely balanced,' and addressed the

risks including risk of physical harm. She noted that the mother had changed position to support the move of JJ back to Father, but Father would need assessing and monitoring in line with the expert report's recommendations.

- 3.60 By the time of the court hearing at the end of August Father was asking to have JJ home and gave a picture of how he could meet his son's needs. The children's guardian believed that this would be the least bad scenario for JJ. It was the view of the children's guardian that father had identified areas of change (alcohol use and substance misuse), and had managed to bring these under control and had worked to do all he could do, to bring JJ home. The children's guardian believed a return to Mother would not be safe for her or JJ.
- 3.61 The Judge supported the children's guardian's position that there was no appropriate plan for JJ and that his current placement was not meeting his needs. The Deprivation of Liberty restrictions were ongoing with no end in sight. The court ordered that JJ could be returned to Father under an interim care order with support in line with the young person's wishes. The local authority was ordered to file a revised plan to support JJ's transition to Father's care. The local authority remained of the view that Father was not an appropriate carer for JJ and had hoped for more time to find an alternative placement. However, in the light of there being no likelihood that a suitable placement would be found in the near future, they conceded and produced a revised care plan.
- 3.62 Around this time JJ's social worker (who has been described as always going the extra mile for JJ – including doing his washing whilst in the unregulated placement) was leaving and a new social worker from the children in care team took over.

The decision that JJ should return to live with his father was taken as there was no appropriate therapeutic residential placement, despite extensive searches. The children's guardian could not continue to recommend an unregistered placement and in this situation felt strongly that the accommodation and care arrangements were not meeting JJ's needs. Consequently, the final recommendation to court was the least bad alternative rather than a positive choice.

The local authority could have considered challenging the Cafcass recommendation, but by this time knew that they had tried hard for many months to find somewhere for JJ with no success. This had caused individual practitioners' considerable distress and raises the question of individual and organisational fatigue in situations where problems are intractable. This is explored further in Finding Seven.

Return to live with Father and Supervision Order (age 13-14)

- 3.63 At the end of August 2022 JJ returned to live with his father under an interim care order with a transition plan consisting of agency support in the home including support from the family centre, work with DBit and six weeks of 24-hour carers. At the end of the six weeks Father stated that he no longer needed support from the carers.
- 3.64 DBit have told the review that Fathers' relationship with JJ seemed positive. JJ seemed pleased to be home and Father spoke about his frustration at past events and dislike of the system. JJ would repeat his father's views about children's social care not doing enough to help in the past.
- 3.65 In relation to education, JJ was issued with a revised EHCP. This confirmed that education would continue to be provided by EOP whilst work to identify a substantive education placement would continue. Children's social care authorised and arranged school transport to EOP.
- 3.66 A psychologist completed an updated psychological report for the final family court proceedings which took place in November. This report reiterated concerns about Father's capacity to meet JJ's needs in the long term. Tests for proceedings showed that father was still using cannabis and alcohol, but this was understood to be a reduction from his previous use.
- 3.67 In mid-November 2022 the final order in the care proceedings was made. This was a child arrangements order for JJ to live with his father and a 12-month supervision order to Essex County Council. The local authority was to submit a final care plan to confirm that:
- DBit would remain involved to support the family in respect of contact arrangements.
 - Essex County Council would keep the parents informed with any issue concerning the child's education.
- 3.68 Five days after the final hearing, a virtual child in need review meeting took place to confirm the child in need plan that was to be submitted to the court. Practice today would be different as current guidance stipulates that when a supervision order is made there should be a period of child protection planning. The issue of childcare planning for children subject of supervision orders is explored in Finding Five of this report.
- 3.69 JJ's relationship with EOP continued to be positive, and his key worker has described him opening up in sessions about a variety of issues including his worries about his bail conditions. Health records were positive and Father was felt to be "on board" during this period. The children's guardian also felt JJ was doing well when she made a final visit. At a meeting to say goodbye to his solicitor it was apparent that the ongoing criminal proceedings were playing on JJ's mind.

- 3.70 DBit involvement ended in December and sessions were offered to Mother however, in the light of the court finding in favour of JJ's father, Mother declined the offer.
- 3.71 In January 2023 children's social care transferred JJ from the children in care team to the family support and protection team. His allocated social worker was the supervisor of a student social worker (known as a Frontline Consultant). It was the student who would be the main contact for JJ and his father. At the handover JJ was noted to have settled in his father's care. Father was asking for regular social work visits and made various complaints about Mother, including that she had cancelled contact. This lack of engagement by Mother seems to have been the focus of a virtual child in need meeting in February 2023 where it was noted that she needed to identify a safe adult who could supervise her contact with JJ.
- 3.72 SEND practitioners were not invited to the child in need meeting but in the light of the positive progress there were discussions between the SEND team, EOP and Father about the possibility of JJ transitioning to a school placement in September 2023.
- 3.73 EOP have told the review that around this time JJ's behaviour started to change. He developed a huge interest in his mobile phone – (Snapchat and You Tube) and spent a lot of time out with friends including girlfriends. He shared what was happening openly with his key worker. Mother was in a new relationship and seemed to "pull right back". She is noted as being invited to child in need review meetings in March, April and May 2023 but did not attend.
- 3.74 By April 2023, Father was expressing worries about JJ's mood to the paediatrician and was asking for anti-depressants. There followed liaison between the paediatrician and social worker and a new referral was made to CAMHS. The referral included a concern that JJ was depressed, had left drawings of a stick man hanging by father's bed. It noted that CAMHS support was declined in the past but was being requested now. It was agreed following this referral and a discussion with the social worker that JJ would not sit on the waiting list but would be offered another initial assessment by two senior practitioners.
- 3.75 Worries about JJ continued through May 2023 with EOP noting that JJ became agitated and upset quite quickly. Father also told EOP that JJ was becoming worse at home. By early June Father was asking children's social care for respite for a few days. He was offered carers in the home but declined. Children's social care held a case management discussion which set out a plan for continued support via a child in need plan. Simultaneously SEND Operations spoke with Father who said he was not willing to entertain any provision other than a full-time school placement for JJ, but he was concerned about the distance involved in sending JJ to one possible school.
- 3.76 JJ's behaviour continued to be cause for concern and police records note that in a three month period prior to his death JJ was reported as suspect on eight occasions by different members of the public for minor offences of criminal damage to vehicles and

windows, anti-social behaviour towards shop staff and members of the community. EOP felt he would need to move back to a 2:1 ratio from 1:1.

- 3.77 Father and JJ had a consultation with CAMHS in June 2023 during which JJ said that he did not want to engage with psychiatry or therapy, as he and his father had lost trust in professionals. After further discussion within CAMHS it was agreed that medication was not appropriate and the plan was to feedback to Father, provide consultation to the social worker and discharge JJ from the service.
- 3.78 From June 2023 there were indications that Father was not engaging positively with social workers, and he cancelled a child in need meeting. Mother contacted social workers in July to express concern about Father's substance misuse and although she did not receive a direct response it seems that this prompted an e-mail from the social worker to EOP sharing concerns around Father's alcohol and drug use and asking EOP if someone could explore this with JJ in a subtle way and see if he has any concerns or has noticed any changes.
- 3.79 At the end of the school term EOP were not commissioned to provide support over the summer holidays. They had been commissioned in previous years and recall being very worried about the holiday period for JJ. JJ's current social workers appear not to have appreciated the significance of EOP's relationship with JJ and the role that EOP had played over school holiday periods. Consequently, steps were not taken to secure the budget for this provision. When EOP spoke with JJ about a plan for working with him after the 6-week break, JJ said he would not be coming back as he was going to school.
- 3.80 As JJ was subject of a supervision order, at the start of August a legal planning meeting was convened to consider whether any further legal action was required. This would be usual practice at the nine month point. The outcome was that there was no evidence to suggest that JJ was suffering significant harm in his father's care and the threshold was not therefore met for any further legal action. It was acknowledged that Father and JJ were not engaging with social workers and the meeting considered whether Family Solutions might be a better provision.
- 3.81 In September 2023, EOP were expecting JJ to return and contacted Father who said there was no taxi provision. EOP then tried to organise a local taxi but no one would take on the work as it was not an Essex County Council contract. For two weeks Father was communicating with EOP and was supportive of their attempts to find a way to transport JJ, but he became increasingly frustrated and told JJ's social worker he would not allow a visit until the taxi issue was resolved. He explained that JJ was bored and agitated as he did not have a school but declined the social workers' offer to take JJ to school.
- 3.82 On 20th September 2023 a child in need meeting discussed what needed to happen before the case stepped down from children's services. Father declined to attend and EOP were not invited. The meeting noted the concern that the social worker had not

seen JJ since the beginning of August as father refused to allow visits. The next day the social worker discussed JJ with child in need reviewing officer due to concerns that the family were not wishing to engage with the social work team. Mother had also blocked all contact with the social work team.

3.83 The issue with the taxi was due to be resolved once the SEND team were informed by EOP that transport was not in place. It was to be reinstated on 24th September (the day that JJ took his own life).

3.84 On 24th September 2023 JJ was found by his father at home, having taken his own life by hanging.

Although things seemed to go well when JJ first returned to Father there followed a noticeable deterioration in his emotional wellbeing alongside Father's increasing withdrawal from the support plan. The risks had been well known to practitioners who had known JJ and his family over time and were set out in the documents for care proceedings. However, starting afresh with new practitioners both in children's social care and CAMHS meant that the implications of the detail within these documents was not fully understood. There was an over optimistic approach which did not focus sufficiently on known risks linked to Father's past behaviours and capacity to control others in his environment. Also, the likely impact on Mother of JJ being returned to his Father and the effect on JJ of reduced contact with his mother should have been a significant cause for concern.

Significant issues for JJ therefore appear to be:

- *Mother had withdrawn from contact with JJ and statutory agencies, which was perhaps not surprising given that power and control had been removed from her and given to JJ's father.*
- *Worries about the ongoing criminal investigation into the alleged sexual assault.*
- *Navigating new relationships within an extended family.*
- *Loss of contact with EOP over the summer holiday period and problems in reinstating attendance in September due to transport issues.*

Issues with Essex County Council transport therefore had affected JJ twice – firstly in securing attendance at school when he was living with Mother during 2020 and secondly in the weeks prior to his death. The review has been told that this is not an isolated case and navigating the system for transport provision remains frustrating and negatively impacts too often on vulnerable pupils. In this case one issue seems to be that children's social care had originally arranged the transport to EOP and after they cancelled JJ's attendance at EOP (and the taxi) over the summer holidays, no provision was made to reinstate this in September.

Although practitioners were concerned about Father's refusal to let social workers into the home over the summer, their position was that although there was a Supervision

Order in place, Father could not be compelled to comply. Noncompliance was not seen to have reached the threshold of significant harm whereby the case could be returned to court. An alternative view might be that given the history and concerns set out in the parenting assessment of Father, the escalation in JJ's dysregulated behaviours, combined with Fathers disengagement from a support plan should have indicated a high risk of harm, especially as JJ was not being seen by any professional in the summer holidays.

4 REVIEW FINDINGS

- 4.1 The overarching picture from records and discussions with practitioners is the impact that JJ had on those that knew him. Although very challenging when dysregulated he has been described as an engaging child with a wide smile and a "bundle of joy. It is impossible to read an account of JJ's life without concluding that he was failed by a system which was designed to help and protect him. Within this system there were many people who worked hard to try to meet his needs, but ultimately despite the commitment of individuals, this was not possible, and he took his own life.
- 4.2 The task of this review is to reflect on what happened and where this system needs to change to help other young people like JJ. This is not straightforward as there are so many interconnected and interdependent issues at national, local and individual practice levels. Some aspects of the system have already changed, and practice has improved, but there is more that can be done.
- 4.3 The account of JJ's life confirms the importance of comprehensive help for children and their families at an early age. Help designed to support the whole family and prevent an escalation of problems. Professional records and evidence submitted to care proceedings identifies JJ and his mother as victims of serious domestic abuse perpetrated by his father. Whilst legislation has changed¹¹ and responses to domestic abuse have improved since JJ was a small child, with children now treated as victims of domestic abuse in their own right, the review has found that there is more to do to firmly embed an understanding of the impact of domestic abuse and a whole family response. *Whole family responses to domestic abuse are explored in Finding One.*
- 4.4 JJ had experienced significant trauma from a young age which had affected his mental health. He was also an autistic child with ADHD and a learning disability. However, JJ did not have a formal mental health diagnosis, and this review highlights the problem in providing an effective therapeutic response which adequately addressed all the factors affecting his emotional wellbeing. *This is explored in Finding Two.*

¹¹ Domestic Abuse Act 2021 identified children as victims of domestic abuse in their own right.

- 4.5 It will not always be possible to prevent children needing to be accommodated, and at a national level there are well documented gaps in the system, most obviously the lack of suitable therapeutic help and residential placements for young people such as JJ. Often referred to as young people with “complex needs”, the unique requirements of each young person, (particularly if they have no diagnosed mental health condition) combined with insufficient placement choice may lead (as in JJ’s situation) to unsuitable placements either in an acute hospital, residential care or with family and friends. Deprivation of Liberty Orders, one of the most draconian legal orders may also be used to try and keep young people safe. *The issue of placement sufficiency and how this affected JJ is explored in Finding Three*
- 4.6 Lack of suitable placements puts additional strain on the local system designed to find placements and monitor quality. This includes local multiagency processes, and the review has found that there is an urgent need to clarify the process that should be followed in order to support front line staff and keep a focus on the needs of the child. *Placement finding and quality assurance is explored in Finding Four*
- 4.7 JJ’s situation also raises the issue of the use of supervision orders within the children’s legal system. This has been subject of discussion and review at a national level and was a concern in another child safeguarding practice review in Essex. In 2021, the Public Law Working Group¹² noted ongoing concerns about supervision orders and recommended that the government should review supervision orders with the aim of providing ‘a more robust and effective form of a public law order’. The final Public Law Working Group report in 2023¹³ highlights significant core principles that are important to adhere to when implementing supervision orders which includes the need for “*clear, tailored plans including to address ongoing risks, and the findings and conclusions of the court in care proceedings*”.
- 4.8 Within Essex where a supervision order has been made, expected practice is evolving to provide additional safeguards for the child. Key to safe practice is ensuring that risks identified during care proceedings are properly addressed within post proceedings plans. *How supervision order practice affected JJ is explored in Finding Five.*
- 4.9 The review also highlights the need for a multi-agency response to child to parent violence and abuse. This is known to be an area for practice development beyond Essex. JJ’s violence towards his mother was clearly described within the records but there was no coordinated multi agency assessment and response, and the review has been told

¹² Public Law Working Group. (2021). Recommendations to achieve best practice in the child protection and family justice systems. Final report. Available from: www.judiciary.uk/publications/message-from-the-president-of-the-family-division-publication-of-the-presidents-public-law-working-group-report/

¹³ Public Law Working Group -April 2023 Report (Supervision Orders) - Final<<https://www.judiciary.uk/wp-content/uploads/2023/04/April-2023-Report-Supervision-Orders-Final.pdf>

that there is no practice guidance within Essex, and staff development opportunities have been limited. *Child to Parent Violence and Abuse is explored further in Finding Six*

- 4.10 One practitioner powerfully described trying to help JJ as “sailing a ship that is full of holes”. Working in a situation where a child is suffering but there seem to be no solutions is emotional draining work. The review has found that this led to a situation where multi agency relationships became strained and staff no longer felt able to work in their role. This is damaging for individuals and for the help that can be given to other children such as JJ in the future. *This is explored in Finding Seven*

Finding One

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 perpetrator to reduce the risk of future harm.

- 4.11 Any reflection on JJ’s life cannot escape consideration of the impact on him of living with violence. This violence was directed at his mother from before his birth and there are also allegations that JJ experienced physical abuse at the hands of his father. JJ’s comment to an EOP practitioner that they could not really care for him as they had not been there when he had marks and bruises on his arms is a poignant reminder of the degree to which JJ had been affected by this abuse and his perception that he had not been protected.
- 4.12 JJ’s mother’s experience of domestic abuse led to a disrupted childhood with many moves as she tried to distance herself from her abuser. The long-term impact of this abuse was not adequately understood and too often language (most notably within the mental health and hospital records) could be construed as blaming Mother as she struggled to respond appropriately to JJ’s behaviour. Alongside this, JJ was a child who was both autistic and diagnosed with ADHD and the totality of these experiences had a profound impact on his emotional wellbeing. His later 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.
- 4.13 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 of domestic abuse in their own right. A better understanding of children’s ambivalent feelings towards an abusive parent would have helped practitioners to make sense of JJ’s fear of his father alongside wanting to be with him and ensured that a focus on the need for his father to address his abusive behaviours was not lost. This was particularly important when JJ was eventually placed in his father’s care under a supervision order.
- 4.14 There was enough information known at the time of the first family court proceedings in 2014 to raise concerns about Father as a parent (including the conviction for battery

against his ex-partner) but the decision was made that JJ should return to his care. The children's guardian did make several recommendations, including that Father should engage in an appropriate domestic abuse perpetrator programme, but the importance of this does not seem to have been understood by others working with the family. He did not engage and there was no follow up.

- 4.15 At the time of JJ's first suicide attempt, agencies were quick to relax the non-molestation order and a room at the hospital was provided for Mother and Father. Whilst on one level this was a human response to a father whose child was seriously ill; more thought should have been given the implications for the whole family and the extent to which father might exert control and influence. Subsequently, JJ was overheard by one practitioner to say that his suicide attempt had been successful in bringing both parents back into his life.
- 4.16 Throughout JJ's life, there is minimal focus on what Father needed to do to address his behaviour. When it was named within plans his capacity to control the agenda by refusing to comply meant that by the time JJ was placed with him on a supervision order there was little likelihood that change had happened.
- 4.17 A whole family approach to working with domestic abuse is encouraged from reviews of other situations where children have died or been seriously harmed¹⁴. The most recent Cafcass guidance¹⁵ sets practice within current knowledge and is clear that when assessing those who have been domestically abusive, practitioners must assess the life-long harm caused by domestic abuse. Practitioners should not recommend that a child spends time with a parent who has inflicted this harm on a child and their other parent, without clear evidence that the perpetrator:
- Recognises the harm their behaviour has caused their victims.
 - Has taken responsibility for the harm they have caused.
 - Has taken action to sustain change in their attitude and to stop their harmful behaviour, which has been demonstrated over time, and
 - These changes have resulted in an assessment that the risk of them perpetrating that behaviour has been removed to the point of enabling a recommendation that family time is now in the child's best interests.
- 4.18 Cafcass have also appointed a trained domestic abuse champion in every team, a suite of practice aids and an audit process to monitor how well the new policy is being assimilated. These improvements sit alongside domestic abuse specialists being located in the local Family Justice Board.

¹⁴ The Child Safeguarding Practice Review Panel *Multi Agency Safeguarding and Domestic Abuse*
https://assets.publishing.service.gov.uk/media/63344c9d8fa8f506587dd138/14.149_DFE_Child_safeguarding_Domestic_PB2_v4a.pdf

¹⁵ <https://www.cafcass.gov.uk/sites/default/files/2024-10/Domestic%20Abuse%20Practice%20Policy.pdf>

- 4.19 Within children's social care, domestic abuse perpetrator roles are being introduced within multi-disciplinary teams although this is not currently an Essex wide approach. Three hospitals in Essex have also introduced Independent Domestic Violence Advocates (IDVAs) and today it would also be expected that allegations of domestic abuse by Mother would have led to a risk assessment¹⁶. The description of the type of abuse perpetrated by Father would have almost certainly have put her in a high-risk category and triggered a MARAC¹⁷. A multi-agency safety plan could have complemented child in need planning and established across agencies the level of coercive control exerted by Father on Mother and her children, and the effect this had on their engagement with agencies.
- 4.20 Although knowledge has developed, there are indications from the records that there is more to do to embed a whole family approach to domestic abuse into practice. Specifically:
- Domestic abuse is too often referred as "historic" where the couple are no longer in a relationship. This fails to recognise the long-lasting impact and the potential for emotional abuse and coercive controlling behaviour to continue.
 - Even very recent records refer repeatedly to domestic abuse "between" mother and father, rather than more accurately naming Father as the perpetrator.
 - Relationships are described in terms of "acrimony" between parents rather than distinguishing between parental conflict and domestic abuse.
 - When JJ was placed with his father on a supervision order once again father was able to control the agenda rather than this being considered as part of a pattern of coercive control.
- 4.21 Work with JJ and his mother also shows the importance of relationship-based practice as part of preventative work. There are notable examples of good practice by individual social workers and staff from the alternative education and outreach provision where practitioners were able to form trusting relationship with JJ and his mother. These skilled practitioners were able to articulate an understanding of the way in which JJ and his mother had been impacted by their experiences of abuse and gave a more positive view of the potential for working with them in the community. It is notable that Mother continued to try and contact one social worker after JJ had been allocated to another team and the alternative education and outreach provision shines through the narrative as of crucial importance to JJ. They were described to the review as standout figures who were the *"most consistent, most containing and most therapeutic and gave JJ unconditional positive regard"*. It is unfortunate that by the time JJ was living with father their significance to him, and the need for outreach in school holidays was not fully integrated into the care plan.

¹⁶ In Essex the tool used is DARA (Domestic Abuse Risk Assessment) and other areas use DASH (Stalking, Harassment and Honour Based Violence Assessment)

¹⁷ A MARAC is a Multi-Agency Risk Assessment Conference which is a place where agencies share information about high-risk domestic abuse cases.

4.22 For any children experiencing challenges at home, education provision may provide an important safety net. It is notable that JJ disclosed physical abuse by his father immediately on starting at school in September after the Covid lockdown. As described above, EOP also provided an important safe space for him over several years. However, securing transport proved a challenge at two key points in JJ's life. Firstly in 2020 when he could have attended school as a vulnerable child during Covid lockdowns, it later became known that he was experiencing physical abuse from his father. There is evidence that both Mother and the school were not successful in arranging transport during this time. Secondly, and crucially, in the days before JJ took his own life both EOP and the social worker tried to arrange for a taxi to take him to EOP but could not do so. The taxi had been cancelled by children's social care at the start of the summer holidays when EOP provision was not commissioned for the holiday period. Several practitioners have spoken to the review about the challenges of working with Essex school transport in order to make sure that vulnerable children can attend school. Escalation processes in situations where there are problems in arranging transport are not clear and even practitioners in senior positions have described the system as impenetrable. In this case it seems that it was when the SEND team became involved that transport was arranged but this route was not used in the first instance to resolve the problem. It cannot be known with any certainty whether there would have been a different outcome if JJ had returned to EOP in September but there is ample evidence that so often they were a crucial source of emotional support for him.

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.

Finding Two

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

- 4.23 JJ's needs spanned several systems and raises the question of gaps in provision for young people who do not have a mental health diagnosis, are neurodivergent and need a trauma informed therapeutic response. JJ did not seem to fit neatly into any service on offer and the system struggled to develop a flexible approach which provided a therapeutic response adapted to his unique experiences.
- 4.24 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. The most recent safeguarding pressure report (ADCS 2025)¹⁸ similarly notes that complexity is a term often used and not always clearly defined. It notes: *Ofsted published work in 2024 which defined complexity as 'describing multiple needs which require joined up responses from a range of professional specialists', which underlines the need for adequately resourced and joined up partnership working. The Framework for Integrated Care offers a similar definition (NHS England and NHS Improvement, 2022).*
- 4.25 The need for further development of partnership working across children's mental health and social care is the subject of a recommendation below.

Learning Disability

- 4.26 Throughout the records JJ is described as having a "learning disability" although what this meant for him on a day to day basis is not clearly articulated within his records. He undoubtedly struggled in an education setting and his Mother needed to explain on several occasions that his understanding and response to situations was much younger than his chronological age. The view of many who knew him well is that he was a bright child whose learning needs stemmed from a disrupted early childhood and inability to access education. There are varying descriptions of his level of cognitive functioning and a more specific understanding would have been important in communicating with him, as would consideration of his capacity to tolerate abstract discussions about things that were worrying professionals. It is notable that one social worker who described positive interactions with JJ adapted her communication methods to fit his needs, and there was no expectation that he would engage in "professional" discussions for more than three minutes.

JJ's autism diagnosis

- 4.27 The issue of waiting lists for autism assessments is an issue wider than Essex, and although Mother had tried to tell professionals of her belief that JJ was autistic, he was only eventually diagnosed after his first suicide attempt. The diagnosis only came about at that point because the paediatrician ensured that he moved swiftly up the waiting list as she hoped that an autism assessment and possible diagnosis would help professionals plan appropriately for his needs.

¹⁸ https://www.adcs.org.uk/wp-content/uploads/2025/01/ADCS_Safeguarding_Pressures_Phase9_FINALv1.pdf page 66

- 4.28 This was not entirely successful, as any understanding of JJ's behaviours, and need for reasonable adjustments, as an autistic child seems absent from the records. There is no evidence in any of the reviews and plans that the implications of the autism diagnosis were considered – for example in relation to communication needs and JJ's need for calm/structure/ predictability. Specifically, there is no comment about the impact on an autistic young person of being cared for in a hospital environment. There was little consideration of the fact that suicide rate for autism is high and the risk this posed for JJ in the future. For example, autistic children are 28 times more likely to attempt suicide and one study showed that 15% of autistic children had suicidal thoughts compared to 0.5% of typically developing children¹⁹. Autistic adults are nine times more likely to take their own life and 66% of the autistic population have seriously considered suicide.²⁰
- 4.29 Within the autism community there is discussion about the relevance of a condition (Pathological Demand Avoidance)^{21 22} which is unique to autism and requires a very specific form of communication to avoid parental conflict. Recent research²³ indicates that the needs of these families may not be well understood or met by services. This lack of understanding can lead to judgements about behaviour and parental quality with inadequately tailored support and familial distress. We cannot of course diagnose retrospectively (and PDA as a diagnosis is debated) but JJ's behaviour does suggest elements of demand avoidance and that his violence and threats spiked under stress and fell when calm. This could have been considered following his autism diagnosis and a more flexible personalised approach developed in work with both JJ and his mother.
- 4.30 JJ's autism needed further consideration at the point of the allegation of his sexual assault on another young person. Research into inappropriate sexual behaviours in autistic young people found that such behaviours were often caused by a lack of understanding of normal puberty, the absence of appropriate sex education, and the severity of their autism and comorbid learning disabilities. The education outreach service has commented to this review that they do not believe that JJ fully understood his actions at the swimming pool, and it is clear that there were differing views at the time as to the most appropriate response. Police officers were faced with an allegation of a serious crime and did try to ensure that reasonable adjustments were made during his time in custody. However, it is also clear that there were different opinions about the bail conditions, and disagreements across police, children's social care and the family courts did not result in a coordinated strategy to meet JJ's best interests. A better response would have been for a multiagency discussion across police health and children's social care to agree next steps. This would have included consideration of JJ's

¹⁹ <https://www.autistica.org.uk/downloads/files/Personal-tragedies-public-crisis-ONLINE.pdf#asset:1499>

²⁰ [https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/workshops-\(wave-4\)/wave-4-workshop-2/suicide-and-autism---slides.pdf?sfvrsn=bf3e0113_2](https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/workshops-(wave-4)/wave-4-workshop-2/suicide-and-autism---slides.pdf?sfvrsn=bf3e0113_2)

²¹ <https://www.autism.org.uk/advice-and-guidance/topics/behaviour/demand-avoidance>

²² <https://www.autismawareness.com.au/aupdate/a-brief-history-of-pathological-demand-avoidance>

²³ Nawaz, S., & Speer, S. (2025). What are the experiences and support needs of families of autistic children with Extreme (or Pathological) Demand Avoidance behaviours? *Research in Autism Spectrum Disorders*. <https://doi.org/10.1016/j.rasd.2024.102515>

needs as an autistic child alongside other specific needs. It is clear that worries about the criminal justice process weighed heavily on JJ's mind particularly as he was under bail conditions for a protracted length of time.

- 4.31 The issue of responding to the needs of autistic young people was raised by the Essex coroner in 2022. The specific issues for JJ are different, as unlike the young person concerned, he had not been admitted to a Tier 4 hospital bed. However, his parents were firmly of the view that this was needed. The response by Essex County Council to the Coroner's Preventing Future Deaths report in 2023 notes that: *as part of the ongoing development of the Dynamic Support Register in Southend, Essex and Thurrock, "Of Concern" meetings are held regularly (monthly in Southend and Thurrock and weekly in Essex). During these meetings, young people and their families are considered to look at the co-ordination of support and whether additional support is necessary for those who might be at risk of escalation to hospital admission. This provides community-based oversight of risk management for those young people diagnosed with Learning Disabilities and/or Autism with complex mental health presentations.* It seems that this system was not in place in time to make a difference to JJ, but had it been available it would have provided strategic planning and oversight of risk associated with the interaction of his neurodivergence and mental health concerns.
- 4.32 During the early stages of JJ being placed back with his father, Father did engage with work focused on parenting an autistic child. But the knowledge of the serious risk of suicide for an autistic child whose early childhood trauma was associated with abuse perpetrated by his father should have informed decision making when JJ was still subject of a supervision order, his dysregulated behaviours were escalating and at the same time father was disengaging from services.

Mental Health Provision

- 4.33 Although JJ was consistently assessed as not requiring a Tier 4 mental health bed, he nonetheless was demonstrating through his behaviour extreme emotional distress. His parents and many staff caring for him (especially in hospital) were understandably worried about his mental health. It is positive that since 2022 there are now paediatric mental health nurses in acute hospitals across Essex who provide containment for staff and input for the young people. These posts have been presented nationally as good practice by NHSE²⁴. The review found little use was made of these specialist nurses during JJ's time in Hospital 2 and there is also anecdotal evidence that capacity may not always allow their expertise to be used in direct work in the ward setting. There is therefore a recommendation that there is a review of the effectiveness of their role.
- 4.34 The CAMHS service as it is currently structured was not able to meet JJ's therapeutic needs. He was either in an unsettled environment where therapy was not possible, or his parents did not feel that the offer met his needs. Primarily the view of his parents at

²⁴ NHS England

various stages was that JJ had a mental health condition that required medication whereas this was not the view of the local CAMHS service.

- 4.35 A trial of antidepressant medication had been recommended by an expert in care proceedings. This was followed up by an appointment with a local psychiatrist but from the records it seems that the significance of this appointment was not understood by care staff in the unregulated placement, and he was not actively encouraged to attend the appointment. By the time JJ was living with his father and seen by local services, medication was not believed to be necessary.
- 4.36 In the absence of any formal therapy the importance of the consistent therapeutic relationship developed between JJ and EOP became even more important and the significance of the disruption in this relationship in the month before his death should not be underestimated.
- 4.37 It is possible that the only way in which a comprehensive response to all of JJ's specific needs could take place was in a settled residential environment and this is discussed in Finding Three below.

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 and 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 Boards 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.

Finding Three

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.

- 4.38 Lack of sufficient placements is a national issue. There has been an increase in young people coming into care who have a range of vulnerabilities that cannot always be managed within foster care, with the number of children in residential care doubling since 2011.

- 4.39 A report on safeguarding pressures published by the Association of Directors of Children's Services²⁵ comments that: The acute insufficiency of placement options, and the related use of unregistered provision is an area of intense public, political and judicial attention. The prevalence of complex mental health concerns has increased and yet the number of inpatient child mental health beds has fallen by a fifth since 2017 and 16 secure children's homes have closed since 2002 (Nagalro, 2024). The severe shortage of places in secure children's homes leaves around 50 children waiting for such placements on any given day (Ofsted, 2024a). This report also notes that providers tend to "cherry pick" children with lower levels of need and that this was due to concerns about a negative Ofsted judgement if the child's issues of risk and harm rapidly escalate. There were repeated references to care providers giving 'immediate notice' when a child's behavioural issues intensified, contributing to the perspective that an increasingly outdated regulatory framework may be creating or exacerbating barriers to meeting the best interests of children and young people.
- 4.40 For JJ this meant that although the local authority made every effort to find a placement, he was looked after in unsuitable settings and ultimately returned home to his father who had been acknowledged through parenting assessments as also unable to care safely for him.
- 4.41 JJ was also deprived of his liberty via a Deprivation of Liberty Order on two occasions. At time of writing, the evidence was that these orders were being imposed at a rate of over 1,000 per year on children who were not within a secure setting such as a mental health unit or secure children's home but were deemed to be at exceptionally high risk of harm to themselves, from others or towards others. Research by the Office of the Children's Commissioner notes that: *restricting liberty is one of the most significant interventions the state can make into a child's life and* has clearly set out the link between lack of suitable placements and the increase in Deprivation of Liberty Orders²⁶.
- 4.42 Although the local authority tried hard to find a placement for JJ after his first suicide attempt, they could not find a suitable placement. This led to a situation where he was placed on a children's ward. This was highly unsuitable for both JJ and the other children on the ward and resulted in an escalation of his dysregulated behaviours. The hospital staff did their best to meet his needs, but it was an impossible situation for all concerned. Although not subject to a Deprivation of Liberty Order, JJ's freedom of movement was curtailed by the very nature of the placement causing him considerable distress. By the time a placement was found JJ was unable to cope and quickly ended up back in Accident and Emergency and on a children's ward at another hospital. He was placed on a ward closed to other admissions and there were security guards in attendance at all times. It was during his time on the second ward that the first Deprivation of Liberty order was made. The nursing staff worked hard to develop a relationship with him, the

²⁵ https://www.adcs.org.uk/wp-content/uploads/2025/01/ADCS_Safeguarding_Pressures_Phase9_FINALv1.pdf

²⁶ <https://assets.childrenscommissioner.gov.uk/wpuploads/2024/11/cc-deprivation-of-liberty.pdf>

local authority provided daily support via a care agency and EOP and there were daily visits from the CAMHS crisis team, but ultimately this was a totally unsuitable environment for JJ.

- 4.43 The Deprivation of Liberty Order was in place until JJ moved to his next (Ofsted registered) placement. The challenges associated with placement finding and quality assurance of this placement are explored in Finding Four below, but ultimately this was a setting unable to provide the safe secure care that JJ needed. The end result was an allegation of sexual assault against JJ and a move to an unregulated placement. This resulted in the granting of a second Deprivation of Liberty Order. Although there were some reports of JJ being more settled there were other aspects of this placement that were detrimental to his wellbeing and the children’s guardian was unable to recommend to the Judge in care proceedings that he remain there whilst the local authority continued to pursue other placement options. It was therefore the lack of placement options and the unsuitability of this unregulated placement that led to the final decision by the Judge that JJ should return to his father.
- 4.44 The local authority had made every possible effort to find a placement for JJ with numerous approaches to fostering agencies and residential homes both in Essex and elsewhere. When JJ was in the unregulated placement his social worker had begun to approach placements directly but felt helpless in the face of no one willing or able to offer him a place. It felt increasingly to the social worker that “this placement does not exist”. In the end, although the local authority did not support JJ’s move back to his father there was also a sense of relief and hope that it might be positive for him.
- 4.45 JJ’s death serves as a reminder of the urgency to improve both the quantity and quality of placement provision. This is recognised as a national issue with provisions within the forthcoming legislation (Children and Wellbeing Schools Bill) aimed at increasing access to suitable placements for young people such as JJ.

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.

Finding Four

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 multiagency escalation processes.

- 4.46 There are two aspects to this issue which affected JJ. Firstly, 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. Secondly, 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.

- 4.47 The daily escalation meetings, when JJ was in Hospital Two have been described as “extremely uncomfortable”, and a “battleground” where the focus on JJ and his needs became lost. Numerous people attended the meetings from executives in the acute trust to front line practitioners in health and social care and there seems to have been no rationale for who should attend or how the meeting could make a positive difference. Senior leaders from the Integrated Care Board in JJ’s home area for example were not invited to attend, and the focus was on immediate firefighting rather than longer term planning. There seems to have been little purpose to the discussion other than health executives stressing the negative impact of closing a ward to look after JJ, and managers in children’s social care stressing that they were doing all they could to find a suitable placement. Both had valid points to make but these meetings did little to bring a resolution for JJ forward.
- 4.48 It is undoubtedly the case that each time JJ was looked after on an acute ward it had a negative impact both on JJ and the other children, many of whom were very sick and have spoken of having been extremely upset by JJ’s behaviours. Paediatric nurses also felt ill equipped to manage JJ’s behaviour and it is sad that several have been reported to have left the profession as a result. One improvement, already implemented, has been the appointment of paediatric mental health nurses to work alongside staff and the young people concerned. This is reported to have already made a positive difference and is to be welcomed.
- 4.49 In respect of JJ, somebody commented to this review, nobody “pressed the pause button”. It should have been the role of senior leaders to take a step back and consider how to best work across health and children’s services to support practitioners and manage an impossible situation whilst keeping a strong focus on JJ. There seems have been little mutual respect for the efforts each were making, and a more positive approach would have been to separate daily planning to support JJ from strategic planning at a senior leader level with careful consideration of who should be involved.
- 4.50 Throughout JJ’s time as a child in care, Essex placement finding team worked hard to source a placement for him through numerous approaches to various care providers. A referral form was completed by the placements team and signed off by the social worker which outlined JJ’s needs; although it does lack some detail about the extent of his dysregulated behaviours and status as a child who was subject of a Deprivation of Liberty Order. This issue has been raised by the manager of Home 2 who believes they had insufficient understanding of JJ’s needs at the point of placement. Moving forward, consideration needs to be given to whether the placements team are best placed to complete this document or whether it would be more appropriately fully completed by the social worker.

- 4.51 Alongside the work of the placement team, Essex was also aiming to increase the sufficiency of local placements through proactive links with local care providers. This included visits to local Ofsted registered homes to develop relationships and to assure the local authority of the quality of the placement. It was within this context that JJ moved to Home 2 from Hospital 2.
- 4.52 Home 2 was well known to the placement team and the LADO service and there had been concerns about staff turnover and quality of management. These concerns had contributed to an Ofsted judgement as “requires improvement”. JJ’s social work team were also worried as they knew the home were struggling with another Essex young person when JJ needed a placement. The original recommendation from the social work team that the placement offer should be declined changed after the service manager responsible for quality assuring placements in Essex provided reassurance that there were no problems in the home that should prevent a placement. Although the service manager is clear that they did not become involved in placement matching, their intervention is noted in the records that the social work team were “directed” to agree to the move. The social worker has explained that although they had many reservations and had put these in e-mails, when the final decision was made at a meeting with senior managers, they did not feel able to voice their concerns as this might be the only chance that JJ had of a placement. This sequence of events is significant for JJ as poor practice within the home led to him being placed in a situation where he was accused of a sexual assault.
- 4.53 There are other instances within the chronology when practitioners working with JJ raised concerns with social workers about practice in placements but no evidence that this prompted any action to check on placement quality. This may have been considered beyond an individual social workers remit but there must be absolute clarity about how any concerns that sit outside a safeguarding alert should be responded to, especially in an environment where finding an alternative placement would be almost impossible. There is an imperative to make sure that the highest standards are maintained for extremely vulnerable children and roles and responsibilities are clear.

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.

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.

Finding Five

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.

- 4.54 This is an issue that has been explored nationally and in other local Essex reviews, but sadly this case is another example of the limitations of supervision orders when they are not accompanied by an outcome focused plan.
- 4.55 For a supervision order to be made, the court must have been satisfied that the grounds for a care or supervision order contained in section 31 Children Act 1989 exist²⁷. Currently there is no legislative requirement for a support plan to be agreed at the time a supervision order is made. Additionally, the wording of the legislation that the order requires the local authority to "advise, assist and befriend" does not always reflect the complexity of the child's situation including managing risk of harm.
- 4.56 Although the duty of the local authority to safeguard children remains in place, working with parents without the additional weight associated with child protection planning may lack clarity for all concerned. From a parent's perspective the court has determined that the child is safe in their care, yet a supervision order is made after a child has reached the threshold of being at risk of significant harm. This is why practice guidance in Essex came into force in January 2023, stating that a child should be subject of a child protection plan for at least three months after a supervision order is made. However, the review has heard that this guidance needs to be revisited as it is not always complied with. This is because some supervision orders are made when the child is not returned to their original family situation but are placed with alternative carers. There may be insufficient distinction between this situation and where a child is returning to a home situation where risks may remain.
- 4.57 The local authority's plan presented to the court had been for JJ to remain in the care of the local authority as parenting assessments found that neither parent could meet

²⁷ The s31 criteria are: 'the child concerned is suffering, or is likely to suffer, significant harm; and that the harm, or likelihood of harm, is attributable to (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give him; or (ii) the child's being beyond parental control

JJ's needs. It was the decision of the court that, in the absence of a suitable placement, the least detrimental alternative was for JJ to move to his father's care under a supervision order. The children's guardian proposed the move to Father and stipulated the need for a tight transition plan to mitigate any risk. This plan was successful for a short period of time and JJ remained a child in need rather than a child in need of protection and subject of a child protection plan. But Father disengaged, worries about JJ's behaviour increased and JJ was not seen for several weeks prior to his death. The view of professionals was that nothing could be done as "threshold was not met" for a return to court and the plan was still to move towards case closure by children's social care.

- 4.58 The impact of a supervision order was long lasting. From Mother's perspective she no longer had any power or influence and told this review that she was very worried about Father's continued alcohol and drug use and did not believe that she was taken seriously when she raised this with children's social care. It seems that JJ was initially excited to be back with his father and extended family, but he had moved from a very intense relationship with his mother to minimal contact. This must have been confusing for him.
- 4.59 The supervision order also seems to have disempowered practitioners from reassessing risks and challenging father when he declined their help. The order meant that father did not have to engage with any agency, and unless there were grounds to believe that JJ was at risk of significant harm he could not be compelled to do so.
- 4.60 There is an argument that an analysis using a matrix to explore the balance of adversity experienced by JJ during his life against protective factors in place in the weeks before his death could have concluded that he was increasingly vulnerable and lacked the resilience to cope with the situation he was in. This was compounded by the fact that the one consistent relationship he had with EOP was not in place over the summer holiday or at the start of term immediately preceding his death.

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.

Finding Six

Child to parent violence and abuse was not recognised as a specific issue that needed to be assessed in order to plan a coordinated multi agency response.

- 4.61 Throughout the time that JJ was in his mother's care she reported instances of JJ assaulting or threatening her and there were also allegations of assaults of a sexual nature. On at least five occasions police were called either by Mother or other family who were concerned for her safety. What seemed to be missing was a coordinated multi- agency response based on an understanding of the dynamics of child and adolescent-to-parent violence and abuse (CAPVA). 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.
- 4.1 Child and adolescent-to-parent violence and abuse is known to be an under-researched area of practice, but there is consistency across the literature in understanding this form of abuse as linked to a complex layering of factors. A literature review for the Domestic Abuse Commissioners Office²⁸ noted that no one explanation could account for child and adolescent- to-parent violence and abuse in its entirety, but ecological approaches are increasingly used as a framework to understand the interconnecting factors that may underpin violence towards a parent by a child. These move away from simplistic labels of "perpetrator" and "victim" and effective responses will need to involve a coordinated response across a wide range of agencies.
- 4.2 Parents have described feelings of guilt, shame and helplessness when they are abused by their own child, making it hard to disclose what is happening. It would have taken courage for Mother to call the police or talk to practitioners but too often her subsequent minimisation and/or retraction meant that the issue was not understood in this light and the issue properly named and addressed. This is an important aspect of the ongoing understanding of Mother's relationship with JJ, the support she needed and the eventual assessment of her capacity to parent.

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.

²⁸ <https://domesticabusecommissioner.uk/wp-content/uploads/2021/11/CAPVA-Rapid-Literature-Review-Exec-Summary-November-2021-Baker-and-Bonnick.pdf>

Finding Seven

Working with young people where problems seem intractable and there are no “right” solutions is emotionally draining. There is evidence from this review of the link between the emotional impact of this work, multi-agency relationships and staff wellbeing and retention.

- 4.3 The emotional impact on practitioners of working with JJ should not be underestimated and this was particularly significant during the period when he was in the care of the local authority, but no suitable placement could be found. The description of one practitioner that it felt like “sailing a ship that is full of holes” is an apt description of a situation where practitioners felt helpless to meet the needs of a young person whose experience of trauma had resulted in severe distress.
- 4.4 The review was told of practitioners, from more than one agency, who resigned from their jobs as a direct result of working in what they perceived to be an impossible situation. The implications for the system to retain staff who could continue to care for JJ and other similar young people is significant. The potential for vicarious trauma and the need for a trauma- informed approach to staff support when working with traumatised young people is well documented²⁹ as is the need for reflective supervision which addresses the emotional impact of the work³⁰. There is evidence that supervision systems were generally in place, but JJ’s situation moved beyond the need support for individuals when practitioners and their managers felt helpless in the face of a system which could not even meet JJ’s basic needs.
- 4.5 Effective safeguarding needs strong multi agency relationships and discussions with practitioners revealed the way in which these were often fractured as everyone tried their best within their own sphere to care for JJ. At times the system became focused on blaming others with the danger that a focus on JJ’s day to day needs became lost.
- 4.6 Although in-house individual supervision systems were mainly in place (testing the quality and effectiveness is beyond the scope of this review), what was not apparent was the opportunity for multi-agency reflective discussions. The need for multi-agency discussions at a strategic level has been highlighted at specific points during this review, most notably during the time JJ was in local hospital 2 and during the response to the sexual assault allegation. However, there is also the potential for these to be supplemented in complex cases by facilitated reflective discussions which can bring the network together. Sharing the emotional load, as well as understanding the part that everyone can play in supporting young people such as JJ may improve relationships, retention and ultimately decision making and consistency of care.

²⁹ https://www.researchinpractice.org.uk/media/p0lpho0w/trauma_informed_approach_sb_web.pdf

³⁰ Wonnacott, J (2014) *Developing and Supporting Effective Staff Supervision Brighton*. Pavilion.

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.

5 SUMMARY OF 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 and 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.

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.

6 APPENDIX ONE KEY LINES OF ENQUIRY

- 6.1 How well did assessments in all agencies consider the interface between JJ's developmental needs, possible mental ill health and behaviours stemming from relational trauma and how do we provide effective help for young people with multiple needs.
- 6.2 How well does the system listen to families and work with them to explain agency decisions and actions.
- 6.3 How well did the system hear JJ's voice especially when he was reluctant to engage or not present.
- 6.4 Do we have effective strategies for working together with families to support neurodivergent young people and how well do we recognise and use expertise within the system?
- 6.5 Was there a coherent multi agency strategy and plan aimed at providing JJ with a nurturing, containing environment, boundaries and with appropriate boundaries and consistent parenting.
- 6.6 What was the impact of placement insufficiency on JJ's wellbeing? Including:
- How was the quality of care in hospital and unregulated placements monitored and were concerns from family and professionals followed up appropriately?
 - were LADO processes used when concerns about care practices in hospital and unregulated settings were identified?
- 6.7 Were escalation processes (to senior leaders) used appropriately and how were risks managed at a senior level across the partnership?
- 6.8 How effective were assessments at identifying JJ's risk to others in the context of child to parent abuse, peer abuse and sexual violence.
- Was there an understanding of how best to respond in situations of child to parent violence including services in place to support practitioners?
 - Were risk assessments in relation to the potential for peer abuse shared with those caring for JJ?
- 6.9 Were there any barriers for any agency, to working with JJ when subject of a Supervision Order?