Cheshire East Safeguarding Children's Partnership

Local Child Safeguarding Practice Review

Jez and siblings

Jane Wiffin

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All the professionals involved in this review process would like to send their condolences to his family and all those who knew him. He is a much-missed young person.

1. Introduction

Reason for this Local Child Safeguarding Practice Review (LCSPR – known as the review from this point onwards).

1.1 This review is about Jez, a 17-year-old boy. He had been known to a range of services due to concerns about his history of trauma, including experiencing domestic abuse and being physically abused by a stepfather, his resulting poor mental health, and substances misuse, leading to self-harming behaviour including several intentional and unintentional overdoses of prescription, street drugs and alcohol. In early December 2022 he was reported missing by his mother, Kate, and he was found unconscious by police, having taken an overdose of drugs. He was taken to hospital and pronounced dead on arrival.

1.2 A serious incident notification was completed, and a Rapid Review[1] meeting convened. This agreed that an Independent led[2] Local Child Safeguarding Practice Review would be commissioned.

Process of the review

1.3 It was agreed that the review would be undertaken using the SILP (significant Incident Learning Process[3]) methodology, which engages frontline staff and their managers who were involved with Jez and his family. It seeks to avoid hindsight bias or individual blame, encourages critical thinking to focus on the why and opportunities for improvement. Engagement with family is a key part of the process.

1.4 A panel representing the safeguarding partnership was convened, with the aim of overseeing the LCSPR process, and to act as a critical friend to the independent reviewer in drawing together an analysis of the professional response to Jez and his family from December 2018 until the date of the critical incident. The independent reviewer is responsible for this report. Business support was efficiently provided by the business manager and support team.

1.5 The Rapid Review process provided comprehensive early timelines of each agency's involvement with Jez and his family and set early recommendations for immediate action and change. Further individual agency reports were

[1] A Rapid Review is a multiagency review of a case that is carried out in response to a serious child safeguarding incident. The purpose of a Rapid Review is to assemble the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety. The Child Safeguarding Practice Review Panel requires safeguarding partners to promptly undertake a 15 day rapid review on all cases that meet the criteria and are notified as serious incidents.

[2] Jane Wiffin was commissioned as the independent reviewer. She is an experienced reviewer who is trained in the SILP (and other) methodologies.

[3] Link to website

sought and focused on agreed key lines of enquiry which underpin the Findings in section 4.

1.6 Additional records, reports and assessments were sought where there were gaps in an understanding to guide the analysis and key points of learning.

1.7 The front-line practitioners and their managers who provided support to Jez and his family came together to help with the analysis and provide their reflections. It is always difficult to do this when a child who you have worked with had died, but all practitioners were committed to considering what lessons could be learned for future practice. The independent reviewer would like to thank them for their thoughtful contributions.

Involvement of Parents

1.8 Contact was made with both of Jez's parents, Kate and Sam. They both said they wanted to contribute to the review. Kate met with Jane Wiffin. She found the process distressing because she is still grieving the loss of Jez. She feels that Jez was not provided with the support and help he needed and that she was ultimately left on her own. She said she felt overwhelmed by the different professionals and services involved with the family, without one key point of contact to help her understand the concerns and the various services on offer. It is striking the extent to which Kate was described in records as having either refused services or cancelled appointments for herself and the children. Her view is it was not always clear when the appointments were, what they were for and there was often so much chaos, which she was left to deal with alone, it was impossible to make sense of what was happening.

1.9 Her specific views have been incorporated in more detail across the report. Jez's dad (Sam) was unable to meet with the reviewer.

Voice of the child

1.10 Jez wrote in his diary[4] in the months before he died that he felt very low in mood and that he did not know how he could go on with life. He expressed clearly how negatively he was feeling about himself. He ended the letter by telling both parents that he loved them very much.

[4] It is not known when this was written.

2. Jez's Family

The whole family is white/British		
Jez	Subject of the review	Aged 14 when the review period started (December 2018). He was 17 when he died.
Ciara	Sister to Jez	Aged 6 when the review period started.
Paul	Brother to Jez and Ciara	Aged 12 months when the review period started.
Kate	Mother of all the children	
John	Father of Paul	Kate's partner at the start of the review process.
Sam	Father of Jez	Living in a different area with his partner but remained close to all the family.
Ian	Father of Ciara	Separated and not in contact with the family.

3.Timeline and chronology of agency involvement with Jez and his family

Background Information:	
2013	Kate, Ian, Jez, and Ciara moved to East Cheshire.
2017	Ian was domestically abusive to Kate. The family were subject to MARAC and IDVA support. Kate was supported to separate from Ian in mid-2017. At some point in 2017 Kate met John and she was pregnant with Paul.
2018	Paul was born prematurely in early 2018. Kate had physical health needs and poor mental health/postnatal depression for which she received support. John became her full-time carer and was the primary carer for the children. Early help support was provided for a period. Jez was often distressed and self-harming.
Period Under Review: December 2018 to date of critical incident.	
November 2018	Ciara was referred by school to specialist domestic abuse service. Contact attempted, but not made.
December 2018	Allegation to police of non-recent concerns about possible sexual abuse by John of a child outside of the family. Police Investigation initiated. Safety plan in place for John to have no unsupervised contact with the children in this family.
2019	
January 2019	Child and Family assessment completed and child in need plan agreed.
February	Safety plan not adhered to, and a strategy discussion was held. Agreed that child protection enquiries (Section 47) would be initiated, and an Initial Child Protection Conference (ICPC) convened.
February	ICPC held. Children made subject to child protections plans under the category of sexual abuse. Safety plan remained in place. Jez's father moved into the family home to supervise the children's contact with John. He was there for 4 months.
April	Review Child Protection Conference.
April	Jez referred to community paediatrics for assessment of autistic spectrum needs.
May	Referral to domestic abuse support service for Ciara; she was not brought for any sessions.
June	Specialist domestic abuse service started an assessment of Jez, but led to no further action because Kate felt the school could complete this work.
July	First appointment with community paediatrics for Jez.

July	Ciara offered a place on domestic abuse group for children. Kate cancelled the first two appointments and this period of support ended.
September	Jez went into year 10 at school. His attendance had been very good up until this point, but now started to deteriorate.
October	Final Review Child Protection Conference. The conclusion of the police investigation in relation to John was no further action due to evidential difficulties. Children no longer subject to child protection plans. John remained living in the home.
October	School made a second referral to the specialist domestic abuse team for Jez. Kate said this work should happen at school so as not to overwhelm Jez and so this was not taken forward.
2020	
January	Kate made a self-referral to the specialist domestic abuse service for Ciara. Concern raised by Ciara led to referral to children's services involvement.
March	COVID public health requirements in place. Jez school attendance started to significantly decline.
2021	
January	Kate reported that John was domestically abusive to her. John was arrested. Kate then withdrew the allegations; it is reported that she said she needed John to be at home as her main carer. Lack of discussion about alternative arrangements. Police referral to children's services. Child and family assessment completed. Onward referral to early help.
February	MARAC meeting and IDVA allocated. IDVA referral to Domestic abuse services, which Kate declined. Referral to early help which led to a 5-month period of early help support.
March	Concerns from school that Jez and friends were being targeted by drug dealers. School proposed a referral to drugs support service which Jez declined.
April	The family support worker contacted youth support services to discuss alternative education options for Jez. These discussion would be ongoing.
April	Child and family assessment completed by children's services. This recommended that the children were subject to child in need planning. This was for a period of 5 months.
June	Appointment with Community Paediatrician. Kate spoke of Jez's poor mental health. Advised to visit GP for onward referral and mental health information provided.
October	Child in need support ended. Kate contacted CAMHS crisis line concerned about Jez. Appointment offered for November 2021.

October	Paediatrician confirmed diagnosis of autistic spectrum concerns for Jez and support options were discussed.
October	Jez stopped attending sixth form.
November	Jez did not attend the CAMHS appointment. Appointment offered for February 2021.
2022	
January	Concerns that Jez was involved with dealing drugs. Police visit in February and make referral to children's services. Early help support offered.
February	Jez was not brought to 2 further CAMHS appointments.
April	Jez seen by CAMHS for an assessment.
April	Jez took an overdose of drugs and went to A&E.
April	A referral to drug agency by early help for Jez. Support for Jez offered.
May	Jez took an overdose of prescription and street drugs and alcohol. Admitted briefly to hospital. Discharged home with impression of support in place. This was not quite as clear as it could be.
May	Kate cancelled Jez's CAMHS appointment; he said he did not want to go.
13th May	Jez attended A&E having self-harmed. He was seen by psychiatric liaison and considered safe to go home with what was perceived to be an ongoing package of support. Lack of review of how and if this was working.
8th June	The early help worker found additional drugs in Jez's possession. Early help made a referral to children's services. They felt more support for the whole family was needed.
9th June	Jez seen by CAMHS. Number of onward referrals made for CAMHS intensive support; Kate cancelled the first session of this because Jez did not want to attend.
July	Jez attended CAMHS appointment.
August	Child and family assessment was completed, and a period of child in need support proposed.
18th August	Kate reports that John physically abused Jez, had behaved in a scary way to Ciara, smacked Paul and been domestically abusive to her. John arrested with bail conditions to have no contact with the family. Strategy meeting agreed joint police/children's services child protection inquiries started.
September	Ciara completes ABE interview. She shares that John physically abused Jez. She said she was uncomfortable with John's behaviour to her and said there was something she was worried about but could not remember what it was.
2nd September	Jez took an overdose of prescription, street drugs and alcohol. He was taken to hospital and discharged after medical and psychiatric assessment. Lack of liaison with community services.
6th September	Jez was discussed at CAMHS; due to his lack of attendance at appointments it was concluded that CAMHS would cease their involvement. This was decided without consultation with other agencies.

9th September	Strategy meeting to discuss concerns about Jez's recent overdose. Decision for child protection enquiries and Initial Child protection Conference to be convened. Social worker visited the family and safety plan put in place. Kate Left to oversee this.
22nd September	Jez taken to A&E after taking drugs, using aerosols and self-harming. He was discharged home, and it was noted that he had support in place. There was no clarification of whether this was working or making a difference.
30th September	Initial Child Protection Case conference. All the children were made subject of plans for emotional abuse. Lack of a care plan or oversight form specialist services such as mental health.
16th September	IDVA allocated to Kate but said she did not need any support.
10th October	Jez taken to hospital due to taking a mixture of drugs and had self-harmed. Jez was discharged and went to stay with a family friend.
13th October	Jez was taken to hospital after another overdose and went to live with his father Sam.
15TH October	Jez admitted to hospital as an inpatient.
25th October	Jez discharged from hospital with comprehensive support package, building on the links with the practitioners he had seen in hospital including substance misuse support, inclusion of Intensive support and treatment service, CAMHS, and practical help to look at apprenticeships.
End of November	Sam asked Jez to leave due to Jez taking cannabis from the home belonging to Sam. Jez returned to live with Kate, Ciara, and Paul.
November	Jez had virtual contact with the specialist drugs team. He was seen again on the 5th December.
30th November	The key worker allocated when Jez was living with Sam visited.
7th December	CAMHS sought to make contact with Jez without success.
8th December	Jez found dead after an overdose of drugs.

4. Analysis, Findings, and recommendations.

4.1 The purpose of a Local Child Safeguarding Practice Review is for agencies and individuals to learn lessons to improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children. This review was initiated by the sad death of Jez, but also considers the professional response to his two siblings. All children lived traumatic, chaotic and at times scary lives. The findings of this review do not aim to suggest that there was one easy solution to responding particularly to Jez's needs or that any one action which could have changed the end outcome. These were circumstances of cumulative harm, which professionals were seeking to respond to.

4.2 **Finding 1** focusses on the response to concerns about child sexual abuse and the impact a lack of a robust response can have on children's lives. **Finding 2** is about support for children when they experience domestic abuse and **Finding 3** is about responding to allegations of physical abuse. **Finding 4** is about support to victims/survivors of domestic abuse and **Finding 5** explores what support could have been provided to Kate as a mother with care and support needs. **Finding 6** looks the professional response to Jez's deteriorating mental health, self-harm, and substance misuse in the context of a trauma informed approach.

4.3 There is not a separate finding about Jez's diagnosis as an autistic young person[5]. The process for diagnosis took longer than would have been helpful, impacted by the COVID public health requirements, and advice was given about avenues of support including links with the autism team. This subsequently got overshadowed by the pressing nature of Jez's distress characterised by poor mental health, substance misuse and self-harm. Those agencies that worked closely with Jez or spent time with him provided evidence to the review of action they took to make reasonable adjustments in recognition of the autism diagnosis. These were not successful because he was not attending those services.

Finding 1: There was insufficient attention focus on concerns about the risk of sexual abuse that John might pose to all three children.

4.4 Over the period being reviewed there were three separate indications that John might pose a risk of sexual harm to Jez, Ciara and Paul.

First incident of concern:

4.5 At the start of this review period, December 2019, a child out of this family made a non-recent allegation that John had sexually abused him. A criminal investigation was started, alongside child protection enquiries for that child and the children in the household with John. A safety plan was put in place. At this time there was agreement that John should remain in the home because

[5] This is identity first language – terminology preferred by the majority of the autistic community.

he was the main carer for Kate and the children and that all his contact with the children would be supervised by family members. This decision was flawed in a number of ways:

- There was insufficient discussion of the contradiction between the risk that John might sexually abuse the children and putting him in a position of trust power over Kate as her carer, and the children as the main parent responsible for their care.
- Little was known about family relationships and dynamics. Initially John's mother was asked to supervise John's care of the children, without an assessment of her capacity to do so. This broke down due to family conflict. The detail of this was not explored.
- The role of supervisor was taken over by Jez's father. There was no assessment of his capacity to do this, or any discussion of possible tensions or difficult family relationships that might impact on his ability to fulfil this role.
- There was little exploration of what 'supervision' looked like in practice and whether full supervision was possible. How was this to be managed with 3 children of different ages.
- The views of the children were not sought about this arrangement.
- Finally, Kate was tasked in the last few months to provide supervision. This was despite knowledge of her complex health needs and medication that meant she was often asleep because of the strength of this medication. It is hard to see how she could have supervised contact and what this looked like. She felt this was too much responsibility for her and would have welcomed some additional support. She says this was never offered.

4.6 In the course of the police investigation and the child protection process further information became available about John. There had been two previous allegations of the sexual abuse of a child; the first related to the son of a previous partner. There was information that the alleged victim found some legal papers which related to his being in the care of the local authority and suggested he had been sexually abused by John as a child. The second concern related to John's daughter. There was an anonymous referral in another area when she was a young child (she was now an adult|) which suggested that John had sexually abused her. This information was held in the minutes of the initial child protection conference. Kate says she does not think she received minutes, and she was not aware of these concerns. Going forward these further indicators of a possible risk of sexual abuse formed no further part of the ongoing analysis.

4.7 The initial child protection case conference took place in February 2020 and all three children became subject to child protection plans for sexual abuse. It was agreed that John would remain living in the family home because he was said to be mother's main carer and the primary parent for the children. There should have been much more discussion regarding whether John remaining in the home was a safe or appropriate response for either Kate or the children. There was an over-reliance on the use of a safety plan, with

supervision to be provided by family members without any assessment of family dynamics or relationships. The link between coercion and control in the known concerns about John's domestically abusive behaviour to adults and possible child sexual abuse were not made. There was no assessment of the risk John posed proposed, and no discussion about Kate's ability to protect, given her poor physical and mental health and the risks that John could be domestically abusive and coercive and controlling to her. She confirmed in the interview with the reviewer that John was coercive and controlling. He used his role as a carer to control her. She did not consider at this time that he might pose a risk of sexual harm, and this she said this was not discussed with her by the lead social worker or child protection chair. It is not clear form the records what conversations took place about this.

4.8 Jez and Ciara were provided with individual support, they were informed about the concerns regarding John, though very much in the context of these being likely false accusations. They were given opportunities to discuss any concerns they had. There was some very child focussed work completed with Ciara, which, however started from the premise that the concerns regarding John sexually abused a child were likely to be unsubstantiated and were untrue.

4.9 A word about keep safe work.

As part of the child protection plan, Jez and Ciara were provided with some brief sessions of appropriate relationships and keeping themselves safe. As a general preventative strategy for all children, it is helpful to know what appropriate and inappropriate behaviour by adults and their peers is. Helping them think about what they can do if they have concerns is also important.

Careful thought is needed in the context of concerns that a child may have been or has been sexually abused. In these situations, talking to children about recognising inappropriate behaviour and seeking help may suggest to these children that they should have recognised the signs and done something about it. There is a tendency for children to blame themselves for what has happened. Often part of the perpetrator strategy, but this work can reinforce this.

There is also a potential false reassurance that this work will per se keep children safe. Thus, communicating to them that it was and is their responsibility, not the responsibility of adults.

4.10 The police investigation took place over a nine-month period and due to evidential difficulties, a conviction could not be pursued. The professional network understood this to mean that John had not sexually abused a child and did not pose a risk of sexual harm to the children; this was not the intended message from the police. It is important that professionals are clear about police decisions in the context of child sexual abuse, where the threshold is about beyond reasonable doubt. The safeguarding system can still explore and address concerns.

4.11 Weight was given to the fact that that neither Jez nor Ciara had shared any concerns. This over reliance on children to be the ones responsible for evidencing concerns about child sexual abuse is out of step with how many barriers there are to them doing so. It is not also clear that they understood that this was the question being asked of them.

4.12 The reports to the final conference noted how glad John was that this was 'all over' and was sympathetic to his reports that the 'false allegations' had an impact on his mental health and Kate's wellbeing. This communicated to them both and the children that professionals believed that there were no concerns about the risk of sexual abuse. This was not an accurate picture. John remained the main carer for the children without any discussion of the appropriateness of this or whether this left the children at risk. He was not held responsible for the potential concerns about sexual abuse of children and there was no insufficient acknowledgement that he posed a risk to the three children.

Second incident of concern.

4.13 In May 2019 Ciara was seen for an assessment to provide support from the domestic abuse service. As part of the assessment, she said that John was 'naughty daddy' and that she had started a routine of checking the doors were locked so he 'could not get in'. There was no further discussion of this, either what it meant or what follow up was needed. Ciara was not brought to subsequent appointments, despite the service seeking to contact Kate. Ciara had been brought to this appointment by the family support worker, not Kate. There is no evidence that this information was shared with Kate or any professionals; Kate confirmed she was not told about this incident. The domestic abuse service were not aware of previous concerns about sexual abuse. This assessment had come from a self-referral by Kate and the period of child protection planning had ended. This should have led to a referral to children's services and at least a discussion with early help who had been present on the day.

Third incident of concern.

4.14 In January 2021 Kate made an allegation of domestic abuse against John. This was said to be in the context of an argument about John taking Jez, Ciara, and Paul to see his brother who was said to be 'a sex offender'. This was not explored further in the child in need process that followed but provided another glimpse of possible concerns about child sexual abuse that were not addressed. Kate withdrew the allegations of domestic abuse saying that she needed John to provide her care needs and to look after the children. There was no discussion about whether this was safe for anyone. Kate was not offered support at this time, and she reported during the interview with the reviewer that John forced her to withdraw the allegations, and no one asked her about this.

Fourth Incident of concern

4.15 In August 2022 Jez found John standing over Ciara on the floor. She was screaming, in distress. John said that he was tickling her, but Jez was clear that this was not what was happening. He confronted John, and this led to him being physically abused by John. The lead social worker supported Kate to go to the police and investigations of domestic abuse of Kate, physical abuse of Jez and Ciara started; concerns about possible sexual abuse were not identified.

4.16 Ciara attended an Achieving Best Evidence Interview in September 2022. This was police led, rather than a joint police/social work interview. Ciara confirmed that John had physically abused Jez. She reported that she had been uncomfortable with John's behaviour; she also said there was something else she had wanted to share but had 'forgotten it'. This interview has been watched by the police lead as part of the review process and there is a clear sense that Ciara had something she wanted to say. This was not shared with the lead social worker by the police and this interview was not followed up. An action from this review has been to follow this up with Ciara who did not report any sexual abuse by John. Ciara continues to be supported by her mother Kate, who has made it clear that she can share any concerns with her about John. This incident raised the importance of joint ABE interviewing between police officers and social workers and where this is not possible the sharing of the detail of the interview.

4.17 There was a lack of focus on whether the children had been sexual abused and what support they might need to talk about. The focus was on educational responses and helping the children to keep safe in the future.

Key Learning Points:

- There was insufficient recognition by professionals of the evidence that John could pose a risk of sexual abuse to Jez, Ciara and Paul based on the available evidence.
- There was no discussion with Kate about using Claire's Law to understand John's background and risks he posed.
- There was a lack of questioning of whether it was appropriate to leave John living in the house, as the main carer to Kate and primary care for the children, given recent concerns about sexual abuse, domestic abuse, and the position of power which he could easily have abused. We know this was the case with Kate.
- Kate was not asked about domestic abuse, coercion or control and a DASH[6] was not completed.
- There was professional confusion about what the decision by the police to take no further action meant. The police were clear that for the concerns raised in December 2018 and more historical concerns there were

[6] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009-2024) Risk Identification, Assessment and Management Model is a multi-agency tool used by most agencies with a focus on keeping victims and their children safe and ensuring perpetrators are proactively identified and managed. DASH Risk Checklist

evidential difficulties, which led to no further police action. This did not mean that John had not sexually abused a child and did not pose a risk in the future. That needed to be assessed. It was not.

- There was a lack of thoughtful consideration of the use of keep safe work with children where there are concerns that they might have already been sexually abused. Professionals saw their role as educational, the risk of sexual abuse was not identified, and keep safe work completed as a preventative response.
- The ABE interview was police led, rather than joint between police/social worker. The information from the interview was not shared, and so the sense that she had not been able to share all her concerns was not responded to.

Why does this matter?

4.18 Current evidence suggests that 15% of girls and 5 % of boys in the UK will experience child sexual abuse by the age of 16. To put this in context that is 500,00 children. Ony around 103,00 of these will be recorded as offences by the police, 50,00 will come to the attention of children's services for sexual abuse and 2,700 will become subject to child protection plans for sexual abuse[i]. The Children's Commissioner found that only one in eight children who have been sexually abused come to the attention of services[ii]. Despite rising number of offences of child sexual abuse being reported to the police, the charge rate has fallen from close to a third in 2014/15 to 12% in 2020/21 and conviction rates remain low. The national picture is that far more children are being sexually abused than are being safeguarding and supported by services.

4.19 Over the last ten years there has been growing national concern about how confident safeguarding professional feel to work with child sexual abuse; there has been an over reliance on waiting for children to tell professionals that they are being sexually abused, rather than making a professional judgment based on the available information[iii]. Children face many barriers to talking about sexual abuse, and when they do tell, or indicate through their behaviour or sharing concerns about adult behaviour, they are often not heard[iv][v]. There is not routine assessment of adults who are thought to pose a risk of sexual abuse or analysis of the non -abusing parents' ability to protect or understand the risk. These were all issues for Jez, Ciara, and Paul.

Recommendation 1: Cheshire East Partnership needs to consider the effectiveness of the multi-agency response to intrafamilial child sexual abuse. A Task and Finish group has been established and set priorities to improve the multi-agency response to child sexual abuse. This group is subject to Independent Scrutiny. The Task and Finish group will consider the findings of this LCSPR alongside those findings of a previous LCSPR. The Task and finish Group will report progress to the Quality and Impact Executive board.

Recommendation 2: The Safeguarding Children's Partnership to consider how it can strengthen practitioner skills that enable the child's voice and experiences to be listened and responded to whether there is a verbal or non-verbal disclosure. This needs to include child observations and understanding of behaviours that may reflect harm and distress.

Finding 2: Providing support to children who have experienced domestic abuse.

4.20 In 2017 Kate disclosed that she had been subject to domestic abuse by Ian, including violence, sexual assault, control, and isolation. It is recorded that Ciara and Jez witnessed the assaults and were traumatised by what they saw. Jez (aged 13) talked of flashbacks and raised anxiety and Ciara (aged 5) of struggling to sleep and having nightmares. Individual support was provided by specialist domestic abuse service to Ciara, but not to Jez. There were ongoing concerns about Jez, Ciara, and Paul (who was just a baby) experiencing domestic abuse across the timeline of this review. Despite many referrals to specialist domestic abuse support services, these did not lead to either child getting the help they needed:

- In 2017 Ciara's school made a referral to the specialist domestic abuse service. They responded but could not make contact with Kate, so this referral was not actioned. There was a lack of reflection about Kate's needs as an adult with emotional and long-term health needs.
- In 2019 when concerns were raised about John and sexual abuse, information emerged that John had been domestically abusive to his ex-wife over a 22-year period including violence, sexual assault, intimidation, and coercion/control. No action was agreed about the implications of this for the three children. Kate says this information was not shared with her. It was in the minutes of the case conference which Kate does not believe she received. There is no evidence that the implications of these historical allegations and likely domestic abuse were discussed with Kate. She was not explicitly asked if John was abusive to her. This would need to have ben done safely. The presence of john in the family home, taking on all caring roles would have made this difficult and required professional discussion.
- The child protection plan in place in 2019 recommended that Jez and Ciara receive specialist support to address the ongoing impact of the domestic abuse they had witnessed.
    - A referral for Ciara was made in April 2019 and she was seen for an assessment in May 2019, where she shared concerns about John's behaviour. Group work was offered and then cancelled by Kate. The service were unable to contact Kate and so there was no further action. Ther was a lack of liaison with other services to explore why this service had been cancelled, and what the implications were for Ciara not receiving the service.
    - Jez was seen for an assessment by the domestic abuse service for an assessment in June 2019. Kate said that Jez did not need

support because he had a mentor at school and because of his emotional needs would be overwhelmed by too many professionals. Kate was concerned about Jez and his likely neurodivergent status.

- The lack of progress of domestic support work as part of the child protection plan was not discussed in the final child protection conference in 2019. The referral for Jez was said to be outstanding, and there was a belief that Ciara was continuing with groupwork. School were asked to action a referral for Jez. There was a lack of exploration of why this work was not progressing, and what barriers existed.
- Jez's school made the referral in December 2019, and again Kate said that it would be confusing for Jez to have too many services in place given his social and emotional needs.
- Kate made a referral to the specialist domestic abuse team for Ciara in January 2020. Ciara was seen for an assessment and made disclosure of physical abuse by John. Kate said she did not want to have any further contact with the team because of this referral. This was not further explored.
- In January 2021 Kate told the police that John had been domestically abusive to her. This led to a referral and a child in need plan. Once again, the focus of this was the need for support for Jez and Ciara. This was not progressed; the connection to experiencing domestic abuse and Ciara's clingy behaviour was not made or Jez's self-harm and emerging substance misuse which he started to refer to as a 'self-medicating' activity to blot out sadness. John remained living in the home, and there was no discussion about what the impact of this might be on the children, who were likely to witness further abuse. It is hard to see how any of the children could recover from past experiences or present concerns.
- In May 2022 Jez told the GP that he was experiencing flashbacks about the domestic abuse he had experienced. There was no onward referral proposed.
- In September 2022 when there were further allegations that John had been domestically abusive the child and family assessment completed acknowledged the significant impact of the abuse on the children, noting that this would have been scary and unsettling. The connection to Jez's poor mental health, anxiety, self-harm and substance abuse was not made. The need for a trauma informed focus is picked up in Finding 6.

4.21 Over the time period for this review, professionals were aware that Jez and Ciara had experienced domestic abuse, the impact was evident, referrals were made, but did not progress. This lack of progress of a key area of concern was not discussed and the need would be lost when a period of support for the family ended. Without support the focus shifted to Jez's mental health and substance misuse, and the link to the trauma he had experienced got increasingly lost. There was some evidence of this also for Ciara, where the focus moved to her behaviour being described as problematic, and the link to previous trauma not made.

Key learning:

- There was a lack of follow through on the lack of progress of the planned support for these three children to address the known impact of domestic abuse on their emotional wellbeing and development. This left the trauma unaddressed, and the impact became internalised. There was something wrong with them as opposed to what had happened to them.
- There was no liaison between Domestic Abuse services, MARAC and the child protection processes leading to a disconnected plan to address these children's experience of domestic abuse.
- Routine processes such as early help support, child in need processes and child protection planning did not address the lack of progress.
- There was a lack of follow though of why appointments were cancelled or exploration of Kate's concern that the children would be overwhelmed by so many different services being involved in their lives. or reported that the children did not need services.
- There needed to be a focus on relationship-based practice. One key point of contact for Kate and the children to help them navigate the system of support and services. The scattergun approach of offering support meant that the family flat overwhelmed, did not understand what was being proposed and were therefore less likely to accept the services necessary.

Why does it matter?

4.22 Research suggests[vi] that one child in five in the UK has been exposed to domestic abuse. This exposure leads to short term and long term negative physical and emotional impact, including poor self-esteem and self-confidence, their ability to deal with change, adaptation and the ability to problem solve; all the attributes of resilience that enable children do deal with difficulties and developmental changes in their lives, such as adolescence. There is evidence[vii] that children who experience domestic abuse may have fractured attachments, delayed cognitive development, heightened anxiety and evidence of hyper-arousal, depression, eating disorders, self-harming behaviour, self-medication with drugs or alcohol and trust issues within relationships. Without the right support and the connection made between the trauma experienced, and the often unmanageable and unfathomable feelings, children can start to think there is something 'wrong with them', as opposed to understanding the connection with 'what has happened to them'.

Recommendation 3: The findings from this review should be incorporated into the development of the new Cheshire East Domestic & Sexual Abuse Strategy; specifically, the links between domestic abuse and suicide risk, the provision of support for children and young people who have experienced domestic abuse and the importance of a domestic abuse-informed response within child safeguarding responses. The progress of this work will be overseen by the Quality and Impact Executive board as part of the Action Plan.

Finding 3: The importance of an effective response to the physical abuse of children.

4.23 Over the period of this review there were two incidents of physical abuse by John, and one incident where Ciara raised concerns about his abusive behaviour.

4.24 In May 2019 Ciara was brought to an assessment appointment with the domestic abuse team, with the aim of providing her with support. At this meeting she spoke about John as 'a naughty Daddy' and that she had started to check the doors were locked (does not say which ones) so that he could not get in. Ciara did not attend any further appointments due to the team being unbale to contact Kate and no further action was taken and no professionals informed, and Kate was not aware of this incident. These were worrying concerns, already picked up in the finding on child sexual abuse.

4.25 In January 2020 Ciara was seen again by the domestic abuse team. She spoke about John dragging her up the stairs (at the age of 8) by her clothes. An appropriate referral was made to children's services. In response to this children's services contacted Kate who said that Ciara's behaviour had been of concern lately and that she had misinterpreted John's intention. It was concluded that there was no need for further action. The link to the recently closed child protection planning for sexual abuse, which highlighted concerns that John had been previously domestically abusive, was not made. The important known link between domestic abuse and physical abuse was not considered. John was not asked about this allegation. Meaning he was never held responsible for his behaviour, and any ongoing risks were not established or understood. It is unclear what Ciara thought had happened because of her disclosure of physical abuse. Ciara had sought help from professionals; this is one of the central goals of the child safeguarding system. Children should be able to share concerns about abuse, and for these to be responded to. She was not asked about what had happened, why she had spoken about it and what she wanted to happen as a consequence. This lack of child centred practice will have undermined her confidence in asking for help in the future.

4.26 In August 2022 Kate reported that John had 'assaulted' Jez, behaved inappropriately towards Ciara, physically harmed Paul (aged 5) and was domestically abusive to her (Kate). This led appropriately to a police investigation, a strategy discussion and child protection enquiries. John was arrested and bailed with the conditions that he was to have no further contact with Kate or the children. An Initial Child Protection case conference was held but focussed on issues related to Jez's self-harm and suicidal ideation, rather than physical abuse and its impact on the children. It was considered that the children were now safe because John had left and bail conditions were in place; however, there was no action agreed as part of the child protection plan

to address the trauma of physical abuse and to explore previous incidents of harm.

4.27 As part of the police investigation Ciara attended an ABE interview. She made clear that John had physically harmed/abused Jez. She spoke of being uncomfortable about John's behaviour. A date was agreed for Jez to be ABE interviewed. This had to be delayed because of his hospitalisation and was planned for a later date. Sadly, he died before the interview could take place.

Key Learning:

- John was described as being in a 'physical altercation' with Jez. This suggests an adultification[viii] of Jez. He was a child and John an adult. John was in a position of power, and this was physical abuse.
- There were at times a confusion about what was seen as 'physical disciplining' or 'physical chastisement' with the attendant sense that this was about helping children manage their behaviour, however inappropriately. Without exploration and assessment, assumptions cannot be made that the intentions of parents/carers is benign and intended to educate. There are times that it is intended to harm, humiliate, and impose power over a child. Professionals need to understand the difference between 'physical chastisement' and physical abuse. This was not always understood for these three children.
- The link between domestic abuse and physical abuse was not made. It is a clear research finding that where there is domestic violence there is a very real risk of physical abuse, either indirectly when children intervene to protect a parent, or directly as part of the use of coercion and control by the domestic abuse perpetrator.
- Each incident was treated in isolation, and there was no discussion with the three children about whether John had physically abused them in the past. The scale and pattern of his abusive behaviour was not known.
- Ciara's help seeking behaviour was not responded to; making it less likely that she would seek help from professionals or other adults in the future.
- There was no plan to address the impact of the physical abuse, which coexisted with other trauma.

Why does it matter?

4.28 There has been significant debate in England about whether it is legitimate for parents/carers/family members to use physical punishment in the context of disciplining their children; this is often described by professionals as "reasonable physical chastisement" This debate has focussed on the fact that "reasonable physical chastisement" is legal, that family history and culture influence this method of discipline and a belief that "physical chastisement" or physical punishment is used in the best interests of the child. There are several difficulties with this assertion.

4.29 Children view physical punishment as the most severe type of discipline and report that it hurts both physically and emotionally[ix]. Some describe feeling scared, sad, and unloved and say that it negatively affected their relationship with their parents[x].

4.30 Physical abuse (masquerading as punishment) compromises children's developmental outcomes leading to poor mental health, behaviour problems and increased violence and anti-social behaviour across childhood and into adulthood; physical abuse demonstrates to children that violent behaviour is a means of problem solving in childhood and adulthood[xi].

4.31 Although the legal framework currently in place in England suggests it is acceptable to physically punish children, safeguarding partnerships should have a child-centred view about its appropriateness and provide advice and guidance, and challenge where necessary.

4.32 A word about help seeking behaviour. It is the central ambition of the child safeguarding and support system that children and young people will ask practitioners for help when they have worries and are being harmed. Research, Serious Case Reviews, and the work of the Office for the Children's Commissioner suggest that there are many barriers to children talking to practitioners about their worries, concerns, and experiences of abuse. As such, more needs to be done to develop children and young people's help seeking behaviour by professionals. Research and reviews of safeguarding systems and processes also highlight that children and young people often receive little feedback about the action taken when they raise concerns about abuse with professionals. This can leave them feeling that their concerns were not heard, valued, or responded to. It can undermine their trust and confidence and prevent further help seeking behaviour. There is often too much focus on what cannot be achieved because of procedural and evidential barriers, as opposed to what could be done to acknowledge harm, and action that could be taken to increase safety and address wellbeing.

Recommendation 4: The findings of this review will inform the current quality assurance framework, which is focussed on:

- the quality of assessments,
- the use of analytical chronologies
- taking a holistic and trauma informed approach to children and their family's lives.
- Considering the effectiveness of assessment processes to distinguish between the misplaced use of physical chastisement as a way of responding to behavioural concerns and the use of physical abuse intended to humiliate and harm children, to help distinguish between what is lawful and proportionate and what is harmful and abusive.

This work will require all agencies should make every effort to understand a child's history, through discussion with the family and other agencies. This history should be analysed and shared with all agencies to prevent the 'start again' process, to understand the impact of history and therefore needs. Agencies need to give thought to how history and trauma impacts on the engagement of children and families and how to make reasonable adjustments which enabled engagement to take place.

Finding 4: Identifying and responding to the domestic abuse of women who are mothers.

4.33 Kate first reported domestic abuse, physical and sexual harm by Ian, Ciara's father in 2017. This was responded to by the police, Kate was provided with support from the Independent Domestic Violence Advocate (IDVA) service and a non-molestation order was put in place. This was all effective practice, creating safety for Kate and reassurance for Jez and Ciara; Paul had not been born.

4.34 In 2018 Kate was in a relationship with John. As part of the child protection inquiries started in February 2019, Information became available that John had been domestically abusive (including violence, financial control, sexual violence, and isolating behaviour) to his ex-wife throughout their 22-year marriage, and she reported a significant impact on her mental health and wellbeing. There were also concerns that John had been domestically abusive to another partner. This information was discussed as part of the child protection planning process, but the likelihood that John would be domestically abusive to Kate was not. Kate was not asked directly about whether John had been domestically abusive to her. This meant no action was taken to consider her safety. Indeed, it was agreed that John should remain in the home (concerns were focussed on child sexual abuse) and be her main carer. The likelihood of existing coercion and control, and grooming here was not considered, and there was no discussion of the impact of putting John in a position of some power over the family. An application under Claire's law should have ben discussed with Kate.

4.35 The child protection planning process also did not make a connection between Kate's experience of domestic abuse and her poor mental health, which was manifest in periods of depression and illnesses which left her chronically fatigued and in pain. It is critically important that women are supported to understand the impact on them as individuals and as parents of the domestic abuse so these issues can be addressed. Without this, feelings of low self-worth can make the task of everyday life more difficult and can have a significant impact on parenting and attachment relationships. At this time there were concerns about Kate's attachment to Paul, this is likely to in part be caused by past experiences of abuse. Perpetrators of domestic abuse can also use women's experiences of depression and low mood against them to justify their controlling behaviours, thus creating an unhelpful cycle. Women

need support to address the impact of domestic abuse. This was not offered to Kate at this time.

4.36 In January 2021 Kate reported to the police that John had been domestically abusive to her. He was arrested and bailed to have no contact with Kate or the children. A referral was made to children's services. Kate then withdrew the allegation because she said John was her full-time carer and the main parent for the children. This was accepted, leaving Kate and the children at further risk of harm. Kate reported that John forced her to withdraw the allegations. There was an assumption here that she had made a free choice rather than being controlled.

4.37 The child in need meetings minutes from April 2021 recorded concern that Kate had 'chosen' to withdraw the allegations; there was no reflection that John likely coerced her into dropping the allegations; this was confirmed by Kate. Professionals need to move their focus from exclusively thinking about the actions of the victims of domestic abuse to considering the coercive and controlling behaviour of perpetrators. The idea that women who are being coerced and controlled are actively making choices is entirely contradictory. The child in need plan also proposed that Kate and John were to complete joint work about domestic abuse. It is not clear what the rational for this was or what the expected outcomes were. This ran contrary to the professionals understanding if best practice, which recognises the need to hold the perpetrator responsible for the harm, and not allow them in joint sessions to exert control or use information that emerges from such session to control further. In the end this work did not take place, and the child in need plan ended without the domestic abuse being addressed, including the safety and wellbeing of Kate, the safety and wellbeing of the children and without a sense of the risk that John might pose.

4.38 In March/April 2021 there was also an early help assessment. Kate and John were said to be unhappy that this included information about domestic abuse; this was challenged, but the focus of the work became about parenting, not parenting that might have been compromised by domestic abuse and parenting that may have been undermined by John's control. This issue was discussed with them together, rather than individually, meaning Kate had no opportunity to discuss what was happening and to seek support.

4.39 Neither of these plans question the notion of John being Kate's main carer and being a perpetrator of domestic abuse, leaving Kate extremely vulnerable to ongoing harm.

4.40 In August 2022 Kate told the social worker that John had been domestically abusive to her throughout their time together. This included violence, rape, emotional abuse and coercion and control. The lead social worker supported Kate to go to the police station and make a statement; this was good practice. John was arrested and bailed to have no contact with the family; his attempts to further harass Kate after this, including threats of violence if she allowed

the children to have child protection medicals, were responded to swiftly by the police. This was also good practice.

4.41 A MARAC meeting was held in August 2022 where it was appropriately concluded that '*Kate has been the victim of domestic abuse for a long time; she has been controlled and coerced through threats and psychological violence*'.

4.42 At the Initial Child Protection Conference in October 2022 there remained a victim blaming narrative that '*Kate might resume her relationship with John'* due to her need for care and support. This statement did not take account of the known complexity of domestic abuse, the use of coercion and control by perpetrators, or the impact that the domestic abuse was having on Kate's emotional and physical health, which linked to her ongoing dependency on a carer. There was no discussion about how to address Kate's care and support needs, and by association the risk of harm to her and the children.

Key Learning:

- There was effective support and clear advice to Kate which enabled her to keep herself and the children safe in 2017 from domestic abuse agencies.
- John's history of domestic abuse was not taken seriously. This did not lead to any action or assessments.
- Kate was not asked directly if John was domestically abusive (in a safe and appropriate way). There was an assumption made that her assertion that he needed to be in the home to fulfil carer responsibilities meant she trusted him. This did not take account of either coercion and control or issues regarding constrained choices.
- All professionals need a good understanding of domestic abuse to inform early help plans, child in need plans and child protection plans. Concerns about domestic abuse became minimised and other actions such as parenting support became the focus with domestic abuse unaddressed and unacknowledged.
- There as evidence of victim blaming language and approaches. Kate was said to have 'chosen' to allow John back into the home, without consideration of his part in this.

Why does this matter.

4.43 The crime survey for England and Wales[xii] estimates that 5.5% of adults (8.1% of women and 4% of men experience domestic violence and abuse 2020). Most domestic violence is perpetrated by men against women, and pregnancy is often a trigger. In this review we are focussing on a woman who is a mother, who was domestically abused by her partner, who was in a co-parenting role. In the context of the child welfare and safeguarding system this is by far most common way in which this concern emerges.

4.44 There has been considerable concern about the way in which the child safeguarding system has focussed on women as mothers', holding them

responsible for the harm they have experienced at the hands of perpetrators and for the safety of their children, despite the risks being largely from the perpetrators of domestic abuse[xiii]. Those perpetrators are often invisible, absent from meetings, not required to change, and not offered services designed to understand and address their violence and abuse. In this review, and across many other serious case reviews (SCRs) and local child safeguarding practice reviews (LCSPR) it has been noted that language does not make clear what is the behaviour and responsibilities of perpetrators and does not make clear the harm experienced by the victim/survivor. This was notable in the records here. So, phrases used are 'there is domestic abuse in the family', there is 'domestic abuse between Ms A and Mr B' and this is a 'domestic abuse relationship'. All imply mutuality or collusions across a family group and hide both perpetrators behaviour and the impact on the victim and children. In this review, despite the evidence of coercion and control, Kate was seen to be making active choices.

4.45 What was also missing was a focus on the harm. Domestic abuse causes stress, depression, poor mental health, low self-esteem, exhaustion, powerlessness, humiliation, and shame. There is a strong link to drug and alcohol misuse as a form of 'self-medication'. This all impacts on a victims/survivor's sense of self, their ability to live an ordinary and fulfilling life, and on parenting. Many victims/survivors have little capacity left to care for themselves or their children[xiv].

Recommendation 5: The Cheshire East Safeguarding Partnership should work with Safer Cheshire East Partnership to review the findings from National Safeguarding Panel briefing paper on Domestic Abuse. The findings from this LCSPR should inform this work with an emphasis on developing a domestic abuse informed workforce and whole systems think family approach.

Finding 5: Supporting women who have disabilities/mental health needs to parent.

4.46 Kate told professionals in December 2018 that she had a diagnosis of a rare form of motor neurone disease which caused muscular spasms, and nerve pain so severe that this was agonising; she said that she was at risk of seizures, which increased at times of stress. She had experienced post-natal depression after the premature birth of Paul and had long term (unspecified) mental health needs. Kate was prescribed a range of medication, including pain killers which were opiates. A report was sought from the GP for the Initial Child Protection Conference. This reported that Kate had a psychosomatic illness, which caused significant pain and debilitation. Further information was provided to the review child protection conference that Kate's medication would cause extreme drowsiness and that she was likely unconscious for much of the day. This information was not responded to by any professionals, and the impact on Kate, the children, their safety and Kate's safety was not considered. The question about how she could fulfil her parenting role safely was not asked by anyone. She had previously received direct payments and

her ex- partner Sam (Jez's dad) was her main carer until she met John. She did not know why the direct payments ended.

4.47 In February 2019 Kate was reported to have declined a referral to adult services for an assessment of her care and support. Kate said during the interview with the reviewer that she was never offered an assessment. This meant that her need for care was unknown, and there were no services put in place to enable her to fulfil her parental role. This left her in a vulnerable position, dependent on John for her care needs. In the context of previous concern about his domestic abuse, this should have caused more concern. It also left the children in a vulnerable position, given both the domestic abuse concerns and the child sexual abuse concerns. The safety plan was dependent on those family members understanding coercion and control, possible grooming processes and feeling able to challenge John if needed. There was no assessment of their capacity to do this, and no understanding of family relationships or tensions which might impact. The decision to leave John as the main carer, without thought to alternative arrangements was not a safe one.

4.48 There was also no outline of what kind of care John provided. There are hints that Kate's medication left her unconscious for much of the day, Ciara and Jez described their mother being in her room for much of the day. It is hard to see how effective the plan could be without there being some clarity of what Kate's needs were, what her day to day looked like and what this meant for the children.

4.49 In 2021 Kate reported that John had been domestically abusive to her. She then withdrew the allegation through controlling behaviour by John (unacknowledged at the time) and John continued to be in the home fulfilling caring responsibilities for her and the children. It was suggested that Kate could seek an assessment of her care and support needs. She is said to have declined this, but she says she was not asked. John was keen that no assessment took place, and given they were always interviewed together (he was always at home) Kate wonders if this was his view that she went along with because she felt she had no choice. This decision not to have an assessment was viewed as her own choice, as opposed to a decision that once again left her vulnerable to domestic abuse, maintaining John in a position of power, and left the children at risk of witnessing abuse and being harmed themselves. In the context of the child and family assessment this should have been considered, been part of the analysis and an assessment for Kate could have been a requirement of the plan.

4.50 An assessment of care and support needs would have been an opportunity for Kate to be in control of how her care needs were met, including a likely personal budget. The acceptance of these arrangements sent the message that they were appropriate arrangements. This should have been more robustly challenged and Kate's perceived reluctance to have her needs assessed explored.

4.51 In January 2022 the police shared concerns with children's services that the needs of Jez, Ciara and Paul were being neglected. This included Ciara particularly being left to make her own meals and look after herself. This led to a period of early help support. This was a further opportunity to propose that Kate's care and support needs be assessed by adult services and more formal care arrangements put in place, in the context of the safety and wellbeing of the children. There should also have been some assessment of any caring roles the children were taking on; an early picture of Ciara taking on a young caring role emerged, but without any action to address this. This should have led to action to address his through increased support and an onward referral to young carers support.

4.52 In August 2022 there were further allegations of domestic abuse by John to Kate. He was arrested and bailed to live away from the home. Kate was left to parent three children alone and oversee a complex safety plan which required her to search Jez's bedroom, supervise him and ensure he was only in the community for short periods of time. Support was to be provided by friends and family and a family support worker. Given that in 2019 and 2021 it was noted that Kate was unable to meet her own needs without John as a live in carer, and she had not been the primary parent, it is hard to see how she would be able to manage. There was evidence over time that she was not managing, and there a lack of thought about whether these arrangements left all three children at risk of neglect and harm. It is notable that at this time Kate had a new partner. It is not known what his role in the family was, if he was taking on a caring role and whether he posed any risk to Kate or the children.

4.53 Overall, we do not have a picture of exactly how Kate's illnesses and mental health needs impacted on her day-to-day life or what this meant for the children, because no parenting assessments were completed to understand this and to put into place appropriate caring arrangements.

Key learning:

- There was a lack of clarity about what impact Kate's health and mental health needs had on her day-to-day life, wellbeing and parenting. It was accepted that John needed to fulfil the parenting role without questioning this. The impact for Kate and the children was not fully considered.
- The overwhelming nature of so many services and professionals on a family who were in crisis was not recognised. There was an absence of a key point of contact for Kate.
- There was insufficient concern about the level of medication that Kate was prescribed and what this meant for her wellbeing, the safety of the children and their emotional and attachment needs. Kate was vulnerable adult, with identified need for mental health and physical pain treatment. It is important that professionals Identify and support adults who are prescribed opiate pain management treatment in line with NICE guidance on safe prescribing. Recommendations | Chronic pain (primary and secondary) in

over 16s: assessment of all chronic pain and management of chronic primary pain | Guidance | NICE

- There was lack of exploration of what was perceived to be Kate's reluctance to accept an assessment of her care and support and so no action taken to enable her to be in control of her own care needs.

Why does it matter?

4.54 It is important that adults with complex needs, such as debilitating illnesses, disabilities, mental health needs are supported to fulfil their parenting role. This is the purpose of care and support assessments under the Care Act 2014[xv] and Child and Family assessments under the Children Act 1989. Without support, research suggests that adults' mental health can deteriorate, and the needs of children will be neglected. Many serious case reviews and local child safeguarding practice reviews have highlighted how adults who wish to exploit and harm children and coerce and control their partners, have sought to take on a caring role in the context of parents with vulnerabilities such as poor physical and mental health. A lack of formal support arrangements leave a parent with care and support needs at risk of harm, and children at risk of taking up inappropriate young caring responsibilities with the attendant impact on their development and wellbeing.

4.55 Finally, parenting is about relationships, attachment, emotional support as well as care. For Jez, Ciara and Paul, the acceptance of Kate not being able to fulfil a primary parental role, left the children with different adults taking on a parenting role. The impact of this, and Kate's unavailability to them, was not addressed as likely causing insecure attachments. Another trauma for them all.

See recommendation 5.

Finding 6: The interplay between Jez's emotional and mental health needs combined with neurodiversity was not fully understood – the system was fragmented and did not take a whole person approach.

4.56 Jez's records highlight a young person who was interested in people, caring and considerate, with a sense of humour. He was also a young person who had experienced significant trauma, which was manifest in anger, violence as well as self-harm and suicidal behaviour, fluctuating depression and anxiety as well as drug/alcohol use were responded to. He was also neurodivergent.

4.57 This is the last finding because, although this distressed behaviour led to the critical incident about which this review has been being commissioned, it is important to consider the context of Jez's life. He had experienced the domestic abuse of his mother, he had been subject to physical abuse, he may have lived in an environment of sexual harm, with the possibility that the adult designated as his primary parent had sexually abused children. He had different adults taking on a parental role in the context of Kate's poor health, which left her unavailable to the children for much of the time. He was aware

that Kate took pain killers and John anti-depressants; medication to address distress was very much part of family life. Jez spoke often about using drugs to self-medicate and address his anxiety and sadness.

4.58 There had been worries about Jez self-harming from 2017 and in school he often seemed low in mood. He was provided with a learning mentor and counselling which he said was helpful. His school attendance was good at this time, and it seems that school was a safe place for him. He stopped attending school during the COVID pandemic because of Kate's health vulnerabilities and from this time his attendance was sporadic. The impact on him of not having this safe space and support was apparent.

4.59 There was a child protection plan in place from February 2019 to October 2019. There were no plans within this to address Jez's low mood and self-harm, despite the known concerns of experiencing domestic abuse and possible sexual abuse.

4.60 In March 2021 Jez confirmed that he was buying street drugs to address his anxiety and low mood. School suggested a referral to a specialist drug agency, but Jez declined this help. There was a period of child in need planning as well as early help support in place. There were no plans to address Jez's anxiety and depression formulated, despite the fact that he was no longer attending school consistently and was missing out on counselling. The focus was not on the impact of trauma. This period of support ended in October 2021 without Jez's depression, self-harm, support needs and absence from school being addressed.

4.61 Kate felt that there was nothing in place for Jez and that his wellbeing was deteriorating. In June 2021 Kate spoke to the community paediatrician about her worries for Jez and his low mood, anxiety, and self-harming behaviour. She was advised to take Jez to the GP, but he refused to go. Advice and signposting support was provided by the paediatrician. The period of child in need and early help support was drawing to a close and there was no plan in place.

4.62 In October 2021 the period of child in need ended without Jez's needs having been addressed. Kate said she felt desperate at this time, and she contacted the CAMHS crisis line, and an appointment was offered by CAMHS for November 2021. Kate said she encouraged Jez to attend, but he refused to do so. The next appointment was booked for February 2022.

4.63 In January 2022 intelligence was shared with the police that Jez might be dealing drugs. This was investigated and found not to be substantiated. The police became aware at this time that Kate and John were sharing their medication with Jez to help him manage his anxiety and panic attacks. A picture of chaotic drug use within the household started to emerge. A referral to children's services was made by the police which led to a period of early help support and the involvement of a family support worker. Jez did talk with the family support worker about using street drugs to manage his anxiety and

to escape ‘unwanted thoughts and feelings’. The family support worker made a referral to the drug agency for Jez, an appropriate plan of action. It was thought that Jez was consistently attending CAMHS where these concerns would be addressed; he was not. There continued to be no overall plan focused on the multiplicity of Jez’s needs.

4.64 Kate said there was then confusion about the next two subsequent appointments in February and March 2022 which were not attended. His mental health needs remained unaddressed. CAHMS did not seek to clarify why Jez was not attending his appointments.

4.65 Jez was seen by CAMHS in April 2022 for an assessment appointment. Jez reported being in low mood, having feelings of suicide and self -harming. He said that he suffered from high anxiety and panic attacks and took street drugs to manage these. Enhanced support was offered, but once again Jez was not brought. There was no link between the early help plan and the CAMHS work, so not discussion about why appointments were not attended. CAMHS were aware of his neurodiversity status and planned to make reasonable adjustments in terms of consistency of appointments, worker and room. Jez would only be seen on two more occasions.

4.66 Jez first took an overdose of drugs in April 2022 which led to hospitalisation. This would be a regular occurrence over the next few months. This was an escalation of concerns. He was assessed by psychiatric liaison as safe to return home with the package of support in place. Kate was upset that he was sent home on his own without what she believed a clear plan to address his needs. On paper it seemed that there was family support to provide individual help to Jez and the family, CAMHS to address his mental health needs and the drugs agency to address drug use. There remained a lack of a coordinated response, with a focus on each agency addressing the impact of Jez’s distress. The family support worker helping Kate and John to manage Jez’s distress, and to ensure that there was no access to drugs or implements to self-harm. The drug service was helping Jez to think about his drug use needs, CAMHS were attempting to assess his mental health, the police keeping an eye on criminal exploitation/drug dealing and the hospital making sure he was safe to be discharged home. There needed to be a more coordinated approach at this stage. Children’s services became involved in April 2022.

4.67 In May 2022 Jez took a second intentional overdose of prescription drugs, street drugs and alcohol. He was medically treated, seen by psychiatric liaison, and discharged home for continued support from community CAMHS, early help and the drug agency. There was a continued lack of liaison between acute and community services, the early help team, and children’s services. Each agency was supporting Jez in isolation.

4.68 Jez took another overdose in May 2022 and was taken to A&E. He was discharged home with the ongoing package of support. Again, there was no significant liaison between the acute and community setting about Jez’s

needs or any planning processes with other agencies. Each incident of crisis was treated in isolation.

4.69 Jez was seen by the CAMHS community team at the beginning of June, and they suggested the involvement of the CAMHS intensive support team. An appointment was agreed but cancelled by Kate. Jez attended an appointment with CAMHS in July, but the appointment agreed for August 2022 was not attended because Jez was physically abused by John and the appointment was on the same day. CAMHS were not made aware of this. There was by now a child in need plan in place. This could have been the opportunity to bring all the agencies together and consider a plan for Jez. This did not happen, and each agency continued to work to address Jez's needs, but largely in isolation from each other. There was lacking a shared holistic plan.

4.70 At the beginning of September 2022 Jez took another overdose of prescription and street drugs and alcohol. He was assessed and discharged home with the oversight of the ongoing package of support; there remained a lack of sufficient liaison between acute services, those connected to the child in need plan, CAMHS and the drug agency.

4.71 There were continued concerns over the next few weeks, with drugs being found in Jez's bedroom, including packages with Kate and John's name on them. There were implements found to be used for self-harm. Child protection enquiries were initiated. A stringent safety plan was put in place. Jez was only allowed out for brief periods on his own. He was not allowed to have any money and access to the internet was limited. He started to talk about feeling trapped and feeling that the restrictions raised his anxiety further. There was no clear support plan in place.

4.72 In September 2022 the CAMHS therapist who had seen Jez on three occasions, was due to leave CAMHS. There was a discussion about Jez's poor attendance at appointments and the formulation was that Jez was not ready to engage with therapeutic support. This discussion happened in isolation from other concerns and did not take account of the lack of clarity about why Jez had not felt able to attend CAMHS. This should have linked in with the' did not attend framework', despite Jez now being 17. There was insufficient thought about what reasonable adjustments needed to be made to address Jez's needs as an autistic young person which would enable him to attend. There was discussion with the lead social worker who asked that CAMHS continue to work with Jez. There was to be an initial child protection conference and it would have been helpful to have CAHMS attend this. They didn't because they had ceased to work with Jez. This left him with no services to address his mental health needs. The focus was on his drug use and self-harm, not the causes of this in a trauma informed way.

4.73 Jez took another overdose towards the end of September 2022. He was found unconscious in a field and taken to A&E for the fourth time in 14 weeks. Her had taken a mixture of drugs, used aerosols and self-harmed. He was assessed and discharged home. There was no liaison with the lead

social worker who also made no contact with acute services or any other agencies. What was now required was a multi-disciplinary meeting to consider Jez's needs.

4.74 There was an initial child protection conference convened at the end of September. All the children were made subject of plans for emotional abuse. Concerns focussed on Jez's drug and alcohol use, his mental state and self-harm/suicidal ideation; he was said to be at high risk of overdosing. There was a lack of recognition that there was no care plan in place to address these concerns and the need for a care coordinator. Jez was becoming a frequent attender of A&E services in crisis. Where was the plan to respond to this. CAMHS did not attend this conference because they were no longer involved. This meant their specific expertise could not guide the plan. Although there was a safety plan in place, there was no care plan.

4.75 Kate was tasked with overseeing the safety plan. This required her to limit his access to the internet, his phone, he was only allowed out for short periods and Kate was required to search him and his room when he returned. She was extremely unhappy about this and felt it put her and Jez under pressure, and also meant she could not focus her attention on the other children. She said she needed more support. Kate also asked if there was any in-patient provision for Jez and was told that there was not. There was still no plan to address Jez emotional needs. Kate was frustrated but could not get anyone to listen.

4.76 At the beginning of October children's services proposed that Jez move to live with his father in another local authority area because they were concerned that he was linked with a known drug dealer locally and the younger children were becoming more distressed about Jez's self-harm. Kate was vehemently opposed to this.

4.77 When the move happened, Jez took another drug overdose was admitted to hospital. He would remain there for two weeks. There was a mental health assessment, and the conclusion was that Jez was a young person with an extensive trauma history, with repeated overdoses of drugs and alcohol, a clear outline of his needs. The initial plan was for Jez to be admitted to Tier 4 mental health services in-patient care and treatment. It was then agreed that he could be supported in the community with an intensive package of support, including drug and alcohol support, mental health support, intensive support, and treatment service to be involved and for apprenticeships to be pursued to address his not in education or training status. Crucially there was a care coordinator to oversee the response to Jez's This was to be overseen by a care coordinator. This was a comprehensive plan, bringing together substance misuse services and mental health services. The plan was put into place immediately.

4.78 Sadly, four weeks after leaving hospital Jez's father Sam asked him to leave because Jez had broken into a shed where cannabis was stored safely. The

effectiveness of the care plan and the holistic approach that had been developed was put in jeopardy.

4.79 Jez returned home to live with Kate and his siblings. There was no liaison with the team who had been overseeing his care plan. They had believed that it was unsafe for Jez to live back with his mother and were alarmed at the possible risks. It was good practice that the professionals involved in the care plan continued to visit Jez, despite the move. The safety plan remained the same. Sadly, a week later there was an argument at home, Jez left and was able to purchase drugs and took an overdose from which he died.

4.80 Although it was recognised that Jez was displaying trauma symptoms from his life experiences the approach taken to manage his behaviour was to separate his symptoms and looked at them in isolation. A trauma focused approach may have supported Jez and the agencies working with him and his family to establish clear roles and plan his care comprehensively in response to his life experiences as no one agency would have been able to support the family effectively.

4.81 Jez's move to out of area further highlighted the dis-connect between agencies as communication between them was poor and his plan of care did not include multi-agency input to cover the 'cross-border' working required, including a plan if he was return to his mother.

4.82 Overall the response to Jez was incident led, rather than being a coordinated and joined up approach to consider all his needs in a holistic trauma informed way.

Key Learning:

- This review highlights the importance of a having a multi-agency approach to the identification of poor mental health, self-harm and suicidality in children and families. All assessments include direct questions on mental health, self-harm, and suicidality and understanding of the make every contact count (MECC) model. Making Every Contact Count (MECC): practical resources - GOV.UK (www.gov.uk)
- There needs to be good liaison between acute services dealing with suicidal behaviour and the community resources which should be working to address the underlying factors. This did not happen here.
- There needed to be a clearer focus on Jez's neurodivergent status to understand his non-attendance at services. He was characterised as making a choice or being "unable to engage with therapeutic support". This was an assumption that needed clarifying with him, fulfilling the requirements to listen to the voice of the child, but also with the other services working with him.
- It would have been expected that professionals in the acute settings and community mental health would have made use of the CNEST assessment (complex needs escalation and support tool). This helps identify unmet needs including, social, emotional, neurodivergent, and mental health. It is vital that the child has a discharge plan, that is coordinated using a multiagency

approach. Introduction to the Complex Needs Escalation and Support Tool (CNEST); Cheshire and Wirral Partnership NHS Foundation Trust (levelupcm.nhs.uk)

- Overall Jez had many professionals involved in his life. We heard from his mother that instead of feeling supported, he flet initially overwhelmed. He had no single point of contact. A professional who was there for him, listening with intent and seeking to understand his world. This changed when he moved to live with his father and he had a care coordinator who was there for him alone.

Why does this matter?

4.83 Young people who are neurodivergent, with a history of childhood trauma and abuse, who have co-existing mental health needs and substance misuse difficulties have some of the worst health, wellbeing, and social outcomes with increased risk of suicide. They need integrated services, which are trauma informed and holistic, taking into account the needs of the whole family.

Recommendation 6: The Cheshire East Partnership needs to consider the multi-agency response to children's wellbeing. There is a current working group look at the integration of the i- THRIVE[7] approach to children's wellbeing and the findings of this review will inform that work.

Recommendation 7: The Cheshire East Safeguarding Children's Partnership will need to ensure that all partner agencies have awareness of self-harm NICE guidance and the key principles of safety planning, managing risk and suicide prevention and make professionals aware of this . Safeguarding Childrens The partnership to find support from the Cheshire East Self-Harm and Suicide Prevention Partnership.

Recommendation 8: The Cheshire East Safeguarding Children's Partnership to make partner agencies aware of the CNEST assessment (complex needs escalation and support tool) which should be used in secondary care provided by both the hospital trust and mental health provider. This helps identify unmet needs including, social, emotional, neurodivergent, and mental health. It is vital that the child has a discharge plan, that is coordinated using a multiagency approach. Introduction to the Complex Needs Escalation and Support Tool (CNEST); Cheshire and Wirral Partnership NHS Foundation Trust (levelupcm.nhs.uk)

[7] i-THRIVE is the implementation of the THRIVE Framework for system change (Wolpert et al., 2019),translating the principles of the THRIVE Framework into local models of care using an evidence based approach to implementation. i-THRIVE has been designed to enable a move towards delivery of a population health model for children and young people's mental health and promotes the use of Quality Improvement techniques.

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