JACK

CHILD SAFEGUARDING PRACTICE REVIEW REPORT

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Introduction

1.1 Succinct summary of the case

This Local Child Safeguarding Practice Review (LSPR) concerns teenager Jack who sadly died by suicide in 2020.

In the two months immediately prior to Jack's death the UK was in lockdown due to the Covid 19 pandemic. Just prior to the lockdown the process had begun for Jack to move to a new school under stage 2 of the Warwickshire Partnership Managed Move Protocol following a number of fixed term exclusions. Jack's parents were divorced, and he had recently moved from living with his father and his two younger brothers to living with his mother.

There was minimal multi-agency involvement with Jack in the year preceding his death, although there were four referrals for the family to children's social care and one single assessment, none of which resulted in intervention or support.

Apart from school there were no other agencies involved with Jack at the time of his death. No school staff had any contact with Jack during the lockdown period prior to his death and there is no recorded information about him during this period. Jack's mother was a key worker working night shifts at a local hospital and it appears that Jack was spending a lot of time on his own. At 7.30 am, having returned home from a night shift, she discovered Jack had taken his own life. After his death information came to light (from Jack's mother to the Police) that he was using cannabis, he had experienced some difficulty with a friendship and there had been some conflict with his mother over his cannabis use.

1.2 Family Composition

Jack

Until January 2020 Jack was living with:

- Father
- Jack's brother 1
- Jack's brother 2

Jack's step-mother moved out of the family home in 2019 with her children:

- Jack's step-brother
- Jack's half-brother
- Jack's half-sister

Jack's mother was living locally, and Jack moved in with her at some point in January 2020 (exact date not known).

1.3 Scope of the review

The period of time chosen for this review is the year leading up to when Jack took his own life. The Review Panel considered that a timeframe of a year prior to Jack's death would provide sufficient information about involvement of services with him prior to his death to contribute to learning about current systems issues.

1.4 Organisational learning and improvement

A Rapid Review[1] concluded that this case met the criteria for a LSPR as it presented a number of issues in terms of the way in which agencies worked together, the management of information sharing between partner agencies and the quality of assessments. The case was referred to the National Child Safeguarding Practice Review Panel who deemed that the case did not fit the criteria for a national review but agreed that a local review could be undertaken.[2]

This case presented as having minimal multi-agency involvement and no preceding risk factors identified by agencies at the time. The Review Panel agreed that it could shed light on particular areas of practice including addressing the following questions:

- How well do safeguarding services and schools in Warwickshire identify and support teenagers with immerging vulnerabilities and risk-taking behaviour?

- How did the Covid 19 pandemic impact on support to teenagers with immerging vulnerabilities and risk-taking behaviour?

- What can we learn from this case about support to key workers and their children during the Covid 19 pandemic and lockdown?

- How effective is the transfer of information about children when they move between schools in Warwickshire?

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[1] When a possible serious case is identified 'the safeguarding partners should promptly undertake a **rapid review** of the case, in line with any guidance published by the Panel. The aim of this rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review ' (Working Together 2018)

[2] Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed (Working Together 2018)

1.5 Methodology

An independent lead reviewer[3] was appointed to undertake the review. She worked closely with a review panel comprised of the following:

Agency	Role
Independent Safeguarding Consultant	LSPR Author and Lead Reviewer
Education	Strategic Lead for Alternative Provision
Warwickshire Police	Police and Staff Manager (Statutory and Major Crime Review Unit)
NHS Coventry and Rugby and NHS Warwickshire North Clinical Commissioning Groups	Head of Safeguarding
Warwickshire County Council	Legal Services
Warwickshire Children's Services	Practice Improvement Manager
Warwickshire Safeguarding Partnership Board	Quality, Learning and Improvement Officer

In the context of the Covid 19 pandemic the review needed to be proportionate taking into account other demands on agencies and the imperative to identify learning from Jack's tragic death that took place in the new pandemic context. All meetings including the practitioner reflective workshop were conducted virtually using Microsoft Teams.

The review drew on information and analysis provided by each agency in individual information reports and chronologies. These reports are designed for an agency to analyse their involvement with the child and family. The information was followed up at a Reflective Learning Event. Agencies also provided additional data including assessments and case records where appropriate. Data from reports to the rapid review was also available.

Agencies that provided Information Reports and chronologies
Secondary School 1
Secondary School 2
Children's Services
Hospital 1
Hospital 2
Warwickshire Police

[3] Lucy Young is an independent safeguarding consultant with an extensive background in children's social care and safeguarding and undertaking serious case reviews.

Warwickshire and West Mercia Community Rehabilitation Company (Probation)

This review has used a systems approach drawing on the Social Care Institute of Excellence (SCIE) Learning Together Systems model[4]. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families, and make it more or less likely that the quality of practice will be good or poor[5].

1.9 Involvement of the family

Jack's mother and father were offered the opportunity to contribute to the review but at the time they chose not to be involved. After the review was completed, they met together with the Lead Reviewer and Partnership Board representatives to share their perspectives. This is set out in paragraph 3.6. This means that the data and information for the appraisal of practice has been taken from agency accounts and case records.

After Jack died information came to light that provided some insights into his circumstances at the time in terms of friendships and family relationships which were not known to any professionals prior to his death. Whilst recognising the value of taking them into account, the review is aware of introducing bias due to hindsight and has sought to avoid this.

2 Appraisal of professional practice

The appraisal of practice provides an overview of 'what' happened in the year preceding Jack's death, looking at professional responses and systems learning. It sets out the view of the review team of how effective agencies were in their contact with Jack and his family. It aims to outline what got in the way of professionals being as effective as they wanted to be and, where possible, to provide explanations for practice.

The review tries to avoid hindsight bias in appraising the practice, no one at the time knew that Jack would take his life and the practice is seen in the context of what is expected good practice in terms of what was known or what was knowable if information had been shared.

Jack's death by suicide at such a young age is an absolute tragedy and the professionals who took part in this review felt a deep sadness for him and his

[4] https://www.scie.org.uk/children/learningtogether/

[5] 'The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy-makers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.' (Working Together 2018)

family. Jack's behaviour is documented by school, hospital and to some extent by social care but there is little sense of his wishes and feelings or of his lived experience and no one involved in the review appears to have known Jack or his circumstances well.

Learning from previous Serious Case Reviews[6] where young people have committed suicide found that: 'Suicide (in teenagers) is rarely a response to a single event. It is usually the result of a build-up of problems over time. Professionals should consider the cumulative impact of adversities on children, regardless of whether or not they appear to be coping well. Parents' problems should not be allowed to overshadow the needs of their children.'

At the heart of this case lies a series of missed opportunities for professionals to understand Jack's lived experience when there was evidence of a number of adverse childhood experiences. It is not possible to know whether a multi-agency approach and more robust assessment of Jack's well-being would have made a difference to the outcome, but the review has identified a number of missed opportunities to assess the impact of adverse experiences on him. The review found that individual agencies that became involved with the family were focussed on the adult relationships rather than the impact parental conflict might be having on the children. When Jack was directly involved with agencies (hospital, school) they tended to focus on the symptoms (Jack's behaviour) rather than the causes.

2.1 Family separation, conflict and domestic abuse

In the year preceding his death Jack experienced the breakup of his family and the loss of his stepmother and three younger siblings who moved to a refuge as a result of domestic abuse by Jack's father. The professional involvement with the family focused on the safety of the younger three children living with their mother and not on the safety and well-being of the three older children who remained in the care of their father. The Police have systems in place and operational requirements to risk assess the safety of children living with domestic abuse however these proved to be inadequate in being able to include the children left behind.

A child risk assessment completed by a detective refers to the domestic abuse incident taking place "in front of the three children" without specifying which three children or how many children were living at the family home. Subsequently a DASH[7] was completed with the stepmother where she shared information about Jack and his brothers, there was reference to some concerns about the fathers 'heavy handed' parenting of Jack but it was not explored further. This was hindered by a 'glitch' in the Police Athena database that day which resulted in officers being unable to input the names of the

[6] Suicide: Learning from case reviews NSPCC 2014

[7] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009. It is a common tool for both police and non-police agencies when identifying and assessing victims of domestic abuse, stalking and harassment and honour based violence.

three children remaining in the home and to record any information on them. DASH and child risk assessments are the tools used by the Police to determine whether to inform the MASH and the Harm Assessment Unit of children who may require additional support from other agencies. The Police were aware of the correct action to take and submitted accurate risk assessments for the stepmother's three children.

There can be a tendency for tools such as risk assessments to shape the practice and the existence of three other children who were not the victim's dependents did not fit easily within the format of the tools. Research by the College of Policing found: 'Overall, and in accordance with HMIC's recent inspections, we observed an often process-driven approach to domestic abuse, which was of variable and inconsistent quality and often not fully understood or properly implemented by the officers involved'[8].

There was no cross checking of Jack and his brothers at a MARAC meeting that concluded that the stepmother's three children were being adequately protected because they were no longer in the family home. A number of offender triggers identified at the MARAC would have raised sufficient concerns about the children who remained in the care of their father to raise concerns about their welfare. This was a missed opportunity to initiate a multi-agency safeguarding approach to Jack and his siblings and to gain an insight into Jack's lived experience at home and share information with his school.

When Jack's father was arrested for breach of a non-molestation order Police once again undertook a risk assessment of the stepmother's children but not of Jack and his siblings living with their father at the time. With this family the Police had a narrow focus on the victim and her dependent children and did not look at a wider picture that included the children who remained in the care of the alleged perpetrator.

Finding 1
The Police did not take into account all the children in the family, including those who remained with the perpetrator, when risk assessing domestic abuse which meant that opportunities were lost for a multi-agency approach to assess their needs.

A referral by housing to the MASH resulted in an early help assessment referral for the stepmother and her children as social care was confident that she was not allowing the father contact with her children due to the risks he posed. However, Jack and his brothers were not considered in this decision making despite the serious allegations by their stepmother about their father.

[8] Risk Led Policing of Domestic Abuse and the DASH Risk Model. Robinson et al 2016 College of Policing

Consent for lateral checks with other agencies either could have been obtained from Jack's mother or dispensed with and consideration given to initiate section 47 inquires that do not require consent.

Finding 2
There is a lack of clarity in the MASH about the threshold for dispensing with parental consent for lateral multi agency checks on children resulting in missed opportunities to assess children who may be at risk of harm.

2.2 Jack's misuse of alcohol and referrals to children's services

There were three known occasions when Jack (a young teenager at the time) misused alcohol to a possibly dangerous level resulting in his admission to hospital overnight on one occasion. There was evidence from the hospital that this was associated with emotional distress at home and Jack's presentation at hospital was extremely concerning. He was self-harming to an extent that security was required to watch him, and this led to him being admitted overnight. Hospital 1 lacks a paediatric unit, so he was transferred to hospital 2 for an overnight stay. Hospital 1 made a referral to the MASH that gave a very clear picture of Jack's presentation on that night however by the time Jack got to hospital 2 he was much calmer and hospital 2 did not have the same level of concern.

Hospital 2 made a referral to a drug and alcohol support agency, but this somehow got lost and in the event the service was an adult only service so not an appropriate referral. This was another missed opportunity for agencies to assess and support Jack. Research has found that 'beginning to drink before age 14 is associated with increased health risks, including alcohol-related injuries, involvement in violence, and suicidal thoughts and attempts. Drinking at an early age is also associated with having more sexual partners, pregnancy, using drugs, employment problems, and risky driving behaviours.'[9] Reponses to Jack's alcohol misuse tended to see it as a one off and that he was partying with friends and the underlying causes were not explored. School assigned a learning mentor for Jack specifically to work with him on the alcohol issue. There was no record of the sessions with the mentor or any information available to the review about these sessions and Jack's response. School 1 did not monitor or evaluate the outcome of specialist (learning mentor) intervention with Jack.

Finding 3

[9] Chief Medical Officer Report. Guidance on the Consumption of Alcohol by Children and Young People 2009

In Warwickshire excessive drinking by teenagers aged under 14 is generally not considered as an indicator of vulnerability which means that signs of adverse childhood experience are missed, and some children do not get the support that they need

2.3 Single assessment

Further referrals to the MASH in 2019 concerning the conflict in parents' relationships and Jack's misuse of alcohol led to a decision to undertake a single assessment in relation to Jack and his brothers. The single assessment focused solely on the conflict and relationships between all the parents. This narrow focus meant that there was no capacity for a more in-depth assessment of Jack and his brothers. Under pressure people may narrow down their focus leading to a tendency for 'tunnel vision' where practitioners tend to make the task manageable by seeing an increasing narrow portion of their environment. This has the benefit of allowing them to stay well focused on one thread in the case but has the weakness of making them slow to notice issues arising outside the narrow focus[10].

The information from hospital 1 about Jack's alcohol misuse, extreme distress and self-harming behaviour was not considered in any depth or viewed as a possible safeguarding issue. The social worker spoke to each child but there is no accompanying analysis of each child's view in the context of what was known about the family. Speaking to each child individually was good practice but each child's view was taken at face value and not analysed in the context of the family history, their relationships with school, the community, peers and family so there was no sense of real understanding of Jack's lived experience.

There was no information in the assessment of which agencies, if any, were contacted for lateral checks. The social worker did speak to Jack's school, but this was not done in the context of the information from the hospital referral and no concerns were raised about him. The assessment concluded that Jack's parents' relationship was positive. By contrast a more in-depth assessment of the stepmother's children did focus on the impact of parental conflict on the children.

2.4 Concerns about Jack's behaviour at school leading to a managed school move

Jack's school describe him as 'a likeable boy, confident, popular with his peers and easily led; he often made the wrong choices. His attendance was below expectations and his progress at school and attainment continued to be below his ability.' During year 8 Jack's behaviour continued to be of concern, he was 'silly' compared to others, sometimes rude, defiant and cheeky, and disruptive to others. Jack rarely completed homework, was disorganised and

[10] Dekker S. (2002) The Field Guide to Human Error Investigation

frequently received detentions. Jack received his first fixed term exclusion for drinking alcohol in school brought in by another student. A reintegration meeting was supported by Jack's father and he was put on report to his Head of Year.

There was a change of leadership at school 1 in November 2019 when the then head teacher was replaced by two joint head teachers. At this point there was a deliberate shift in policy for behaviour management from a 'warm strict approach' to a more 'student focused approach'. This aimed to move from using sanctions as punishment (e.g. seclusion) to a pastoral system that was more about building relationships and involving families. In Jack's case there was no evidence that the new approach had an impact on this behaviour at school or on their understanding of its causes.

The school do not seem to have had an accurate knowledge of Jack's home situation, either of the history of domestic abuse historically with his mother and more recently with his father and stepmother. They were not aware of the impact of this on him or on his position in the family as the oldest child. There was no evidence of consideration of the underlying reasons for his behaviour and insufficient curiosity about his life outside school at home and in the community. Despite regular tutor and learning mentor involvement information about Jack's lived experience was not known or analysed in the context of his behaviour.

The school did not record the date he moved to live with his mother or why this happened. Nor did they have a clear understanding of how Jack's time was shared between his mother and father. Jack's mother was involved and supportive with the school and they did not have any concerns about her care of Jack.

School 1 were holding weekly meetings about Jack's behaviour although the detail and Jack's own voice are not recorded and there is no record of strategies for supporting Jack with the situation at home. Interventions from staff were aimed at supporting him in developing insight and making changes to his behaviour. Research into positive responses to support children with adverse childhood experiences identifies the involvement of a trusted adult who a child can talk to and gain support from as being pivotal to supporting these children. Schools can provide protective factors for children with adverse childhood experiences when they: create a climate that enhances belonging and connectedness, have clear policies on behaviour and bullying, an 'open door' policy for children to raise problems and a whole school approach to promoting good mental health throughout the school.[11] This, of course, can only have an effect if a school looks beneath the behaviour to identify the causes.

Jack's views were not consistently recorded in the notes of reintegration meetings following fixed term exclusions. It is not known whether this is

[11] Addressing Adversity: Prioritising adversity and trauma – informed care for children and young people in England. Young Minds NHS England 2017

because the template for the meeting was not completed or his views were either not sought or he did not give them.

School 1 believed that the family was not receptive to support because they had declined offers of early help and the social care assessment had been closed. The lack of a coordinated early help response to Jacks father was a missed opportunity to develop a team around the child. Statutory Guidance[12] states that 'All staff should be prepared to identify children who may benefit from early help. Early help means providing support as soon as a problem emerges at any point in a child's life.' The review found that offers of early help to Jack's father were not presented to him in a such a way that he was willing to accept. The lack of a coordinated early help response to Jack was a missed opportunity to develop a 'team around the child' to support him.

School 1 identified several areas for improvement from their own review of this case:

- Greater curiosity about the students lived experience, including their history, parenting and adverse childhood experiences will help staff to understand whether there are underlying reasons for the behaviours presented and thus the evidence-based interventions that may support change.

- Formal systems for supporting and challenging Heads of Year and Tutors will assist them in reflecting and making sense of the information that they are receiving so that they can consider the broader context of the child's lived experience and the impact of this. In some professions this is called supervision'.

- Improved record keeping, and report writing, with templates that include prompts to ensure that consideration is given to underlying factors that may be indicators of significant harm.

- A strengthened pastoral support system, using an assess, plan, do, review, approach to pastoral support plans is likely to be more effective in recognizing underlying issues for behaviour and thus the most effective intervention.

Finding 4
The school and other agencies missed possible signs of trauma resulting from adverse childhood experiences and did not work together to develop plans to address these and support Jack.

[12] Keeping Children Safe in Education DfE 2020

Operation Encompass[13] is a police and education early information sharing partnership that enables schools to offer immediate support for children and young people experiencing domestic abuse. It was launched by Warwickshire Police in September 2019. Operation Encompass was designed to give schools a notification that a domestic incident has occurred within the child's household. The notification is sent to the school's Designated Safeguarding Lead (DSL) before the start of the next school day and allows the school to monitor the child, provide pastoral support if required, speak directly to the parents or liaise with other agencies. Due to the requirements of GDPR[14] no detailed information is shared. If there is a significant risk to the child then the notification to the school would also be accompanied by a referral to Children's Services via the MASH if the child is not allocated or if the child is allocated then the referral will be sent direct to the social worker.

Although school 1 was not aware of previous domestic abuse incidents at Jack's home as a result of the launch of Operation Encompass they received an alert about Jack's family. However, in this case the information was sent several days after the incident. School 1 felt that the information was insufficient for them to act on it and it was noted on Jack's safeguarding record. Schools 1 and 2 told the review that they were unclear as to how they should respond to information shared by Operation Encompass. In Jack's case this information was not used by school 1 to add to the sum of information about his life at home in order to learn more about the context of his behaviour and develop plans to support him.

Finding 5
Schools involved in the case did not consider the information they receive about incidents of domestic abuse from Operation Encompass to be sufficient for them to meaningfully act to support students.

In 2020 Jack was living with his mother, school 1 was unable to tell the review what date he moved or why. This lack of detail reflects a pattern where school 1 did not appear to know or at least record detail of significant events or issues in Jack's life. After five fixed term exclusions school 1 obtained mother's agreement for Jack to move to a school nearer to her house with the aim of offering him a 'fresh start'. This was against Jack's wishes. School 1's belief that Jack's parents were supportive of the school's approach to Jack's behaviour may have prevented them from being more curious about Jack's lived experience and the issues underlying his behaviour. There was no attempt to consider what the impact of the move may have had on Jack.

The Warwickshire Area Behaviour Partnership sets out the protocol for a managed move which usually lasts 10 weeks and during that time the student

[13] https://www.operationencompass.org/

[14] General Data Protection Regulation 2016

remains on the roll of the original school. School 1's information sharing with school 2 was poor and they did not document any concerns or safeguarding issues about Jack on the Learner Information Form. If Jack had started at the school this lack of information would have prevented school 2 from developing a pastoral support plan for Jack to support his move. The lack of information sharing by school 1 was concerning and led the review to question whether schools have a clear understanding of what information can or should be shared.

The Local Authority asks schools to share information about students whose behaviour is resulting in fixed term exclusions and who are being considered for a stage 2 managed move so they can be flagged and discussed at Area Behaviour Partnership meetings. Schools are also asked to share the Learner Information Form. In Jacks case this did not happen, the local authority was unaware of the planned move.

Finding 6
The schools which Jack attended during this period did not consistently collate and share safeguarding and other relevant information both internally within their own organisations and externally when students move schools which means that students safeguarding, and welfare needs are not always met

2.5 Covid 19 pandemic and lockdown

Schools in Warwickshire closed on 18th March 2020 for the lockdown due to the Covid 19 pandemic. The Learning Partnership clarified that any children on a managed move to another school would remain the responsibility of their original school. School 1 placed Jack on their 'vulnerable students list' because of the managed move and he was therefore a priority for the school for maintaining contact. Guidance issued by Warwickshire Council to school was: 'Any child on the school's register/database of vulnerable children who it has been decided does not need to attend school; cannot attend school due to a risk to their own health or another member of their household; or whose parents/carers are unwilling to send them to school will have an identified plan of support that will be overseen by a named Designated Safeguarding Lead and recorded on the child's safeguarding file.'[15] There was no such plan for Jack in his school file.

As a vulnerable student and child of a key worker Jack would have been entitled to attend school however it is not clear whether school 1 encouraged Jack's mother to send him to school. In the event Jack did not attend school and school 1 provided his mother with meal vouchers. His situation was different from most students because of the arrangements that were already

[15] Safeguarding Children during coronavirus (Covid 19) Warwickshire Council 2020 taken from DoE guidance

in place for the managed move to school 2. School contact with parents was done to check that student's had access to the internet and were able to access home learning and if there were any safeguarding concerns. School 1 was aware that Jack's mother worked nights, the Head of Year spoke to her once in the two-month period before Jack died and she told them everything was ok. They also spoke to Jack's father twice. It is unclear whether there was any curiosity about the care arrangements for Jack.

School 2 maintained daily direct contact with all their vulnerable students by obtaining parental permission early in the lockdown to contact students directly on their own phones. Students like Jack who were on the vulnerable list were contacted directly each day. School 1 did not have Jack's phone number and he did not reply to emails that they sent him. If there had not been any contact with parents, they would have visited the home eventually.

Since the first lockdown school 1 are now using video calls to make contact with students and there is an expectation that every student (including all vulnerable students) has an online face to face tutorial once a week.

Research has found that 'Suicide by young people was rarely caused by one thing. It usually followed (sic) a combination of previous vulnerability, with traumatic experiences in early life, a build-up of adversity and high-risk behaviours in adolescence and early adulthood, and recent stressful events. Each aspect is open to prevention in different ways, such as support for young children and their families, access to CAMHS including self-harm and substance misuse services, and crisis support.'[16] Early research into the effects on children of the lockdown highlights the need for schools to be extremely vigilant of vulnerable students and the effects the isolation and issues at home may have on them during lockdown:' There is a concerning signal that child suicide deaths may have increased during the first 56 days of lockdown, but risk remains low and numbers are too small to reach definitive conclusions. Amongst the likely suicide deaths reported after lockdown, restriction to education and other activities, disruption to care and support services, tensions at home and isolation appeared to be contributing factors.'[17]

Finding 7
Schools that obtained students' phone numbers and consent from parents were able to keep in daily direct contact with vulnerable students during lockdown which meant that they could provide support and monitor their wellbeing more effectively than if they only contacted parents

[16] Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester (2016).

[17] Child suicide rates during the Covid-19 Pandemic in England: Real time surveillance July 2020 National Child Mortality Database

In terms of Jack's mother's key worker role, the ward staff were aware that Jack was living with her, but they did not know how much time he was spending alone. Hospital 1 have acknowledged that there was more support and information available to day staff when management was also available, and that night staff might have missed out.

2.6 Perspectives of Jack's parents

Pen picture of Jack

Jack's parents provided this information about Jack to be shared as part of the review.

Jack was a very good-looking boy, who seemed grown up and would appear older than his years. He used to take great care of his appearance and enjoyed wearing the latest designer clothes. He liked sports and physical activity and had enjoyed boxing, martial arts and running and was creative and talented. He was very popular and had lots of friends. He was a "larger than life character", "head strong" and a "risk taker". He was adored and loved by his family, was very popular and had lots of friends.

Domestic Abuse

Jack's father said that he was not violent towards Jack's stepmother and that she had made false accusations against him. He did acknowledge, however, that the children would have been exposed to conflict between the adults in the household when their relationship broke down. He also recognised that Jack was very anxious about the potential outcome of court proceedings for his father about the allegations made by his stepmother. Jack's mother and father did not consider that he was ever heavy handed with the Jack or his siblings.

Lockdown

Jack's mother was not aware that Jack could attend school 1 during lockdown and said that if she had known she would have sent him. She said school 1 did not give Jack any work and there were difficulties with Jack being able to log onto the school portal. This problem occurred before lockdown and she made the school aware, but this was never resolved.

Jack's mother said she really wasn't clear which school should be providing Jack with work following lockdown but thought it would be school 2 because of the managed move. She had no recollection of school 1 trying to contact her during the lockdown. Jack did not stay at his fathers during this period because his father was shielding due to his health condition and his mother worked on a Covid ward. Jack did spend a lot of the time on his own, but his

parents felt that he was socialising with his friends and girlfriend using social media much as he would have done normally.

Mental health

Jack's mother hopes there can be more access to mental health awareness and support in schools. She also felt that more needs to be done to raise awareness amongst young people in schools about the support available to them if they experience anything that makes them feel uncomfortable/vulnerable/abused. This was specifically in relation to how Jack felt after a distressing incident with his friend (services were not aware of this until after Jack died).

3 Findings

3.1 Finding 1

The Police did not take into account all the children in the family, including those who remained with the perpetrator, when risk assessing domestic abuse which meant that opportunities were lost for a multi-agency approach to assess their needs.

Recommendation

Warwickshire Police to ensure that when attending domestic abuse incidents, the details of all children living in the household or living with the alleged perpetrator are recorded, risk assessed and considered for referrals rather than only those present at the time of the incident

3.2 Finding 2

There is a lack of clarity in the MASH about the threshold for dispensing with parental consent for lateral checks with other agencies for children resulting in missed opportunities to assess children who may be at risk of harm.

Recommendation

Warwickshire Children's Services to clarify for staff and set guidance about the need to undertake lateral checks with other agencies on children and the threshold for dispensing with parental consent to do so

3.3 Finding 3

In Warwickshire excessive drinking by teenagers aged under 14 is generally not considered as an indicator of vulnerability which means that signs of adverse childhood experience are missed, and some children do not get the support that they need.

Recommendation

Warwickshire Safeguarding Partnership to develop guidance for staff to help them consider the potential significance of underage drinking for vulnerable

children under 14 years and provide information of appropriate ways to respond.

3.4 Finding 4

School and other agencies missed possible signs of trauma resulting from adverse childhood experiences and did not work together to develop plans to address these and support Jack.

Recommendation

Warwickshire Safeguarding Partnership to support staff in all settings including schools to recognise the signs and symptoms of adverse childhood experience and to develop the skills to increase resilience and address the causes as well as the symptoms.

Recommendation

The Safeguarding Partnership Board to request that the Board of Trustees of School 1 monitor and evaluate the implementation and outcomes of their improvement plan to address Finding 4 and the areas for improvement identified in the school's Information Report for this review.

3.5 Finding 5

Schools involved in the case did not consider the information they receive about incidents of domestic abuse from Operation Encompass to be sufficient for them to meaningfully act to support students.

Recommendation

Police to refresh Operation Encompass in Warwickshire Schools and the guidance that the notification to the school allows the school to monitor the child, provide pastoral support if required, speak directly to the parents or liaise with other agencies.

3.6 Finding 6

The schools which Jack attended during this period did not consistently collate and share safeguarding and other relevant information both internally within their own organisations and externally when students move schools which means that students safeguarding, and welfare needs are not always met

Recommendations

Schools should follow the Local Authority agreed protocols when transferring students to a new school/provider.

Ensure that when students transfer to a new school the Learner Information Form contains all necessary information relating to a child's welfare and that a timely transfer of safeguarding files takes place.

The Local Authority to develop clear guidance for schools about information sharing (including safeguarding and welfare information) between schools and with other agencies.

3.7 Finding 7

Schools that obtained students' phone numbers and consent from parents were able to keep in daily direct contact with vulnerable students during lockdown which meant that they could provide support and monitor their wellbeing more effectively than if their only contact was with parents.

Recommendations

During lockdown schools should encourage vulnerable pupils to attend school and where they do not attend school they should be spoken to daily and seen virtually in line with government guidance.

If a student is transitioning into another provision the school where they are on roll has sole responsibility to ensure all aspects of their safeguarding and welfare needs are taken care of.

Vulnerable students who have had adverse childhood experiences will benefit from the support and involvement of a trusted adult who they can talk to, this is especially important to support them with the isolation they may experience during lockdown

4 Single agency recommendations reported to the review in the information reports

4.1 Children's Social care

- Staff in the MASH and Initial Response Service to ensure that the voice of the child is obtained and listened to.

- Staff are able to determine the key information by robustly challenging the referrer to be specific and address any anomalies or conflicting information

- When undertaking a statutory assessment, we need to ensure staff are addressing the specific concerns raised and any new concerns during the course of the assessment.

- We need to ensure we have fully considered who has PR before deciding on thresholds.

- Where details of anonymous referrers have been shared with practitioners it is important that contact is made to verify the information and assess validity of the information shared.

- We need to ensure that staff are fully aware of the appropriate Early Help, and specialist services available for appropriate sign posting. In this case alcohol and substance misuse agencies.

4.2 Police

- Ensure officers have a full understanding of who lives in a family home when arresting a suspect, and that officers make referrals for any child dependents if additional support is required from other services following the arrest of a parent/carer.

4.3 School 1

- The Local Governing Board to ensure that student records evidence that the Positive Learning Policy is being securely embedded and that templates act as prompts to evidence this e.g. identifying underlying reasons for behaviour and possible indicators of significant harm

- The Head of School to ensure that the approach to Pastoral Care includes a formal assess, plan, do, review approach to identified vulnerable students' needs and that evidence-based interventions are used

- DSL to ensure that Heads of Year and Tutors receive regular support and challenge (supervision) and that they analyse and reflect on the meaning of behaviour, this should be consistently evidenced on the students file

- The Head of School provides written guidance to staff on effective record keeping so that accountability for actions can be evidenced