‘Jake’ – post inquest addendum

Jake a 17-year-old child, jumped in front of a fast-moving train and died immediately from his injuries. Jake was subject to a Care Order, living in supported accommodation and was awaiting an alcohol rehabilitation placement. Jake was described as ‘complex’.

The Croydon Safeguarding Children Partnership (CSCP) commissioned a Safeguarding Practice Review. The review was completed in July 2022 but was unable to be published until the inquest had been concluded. However, the 12 recommendations were progressed, and several learning events took place which highlighted the learning in this case.

The jury led inquest found Jake had died by suicide. His poor mental health and use of drugs/alcohol probably contributed to his death.

They also found the following factors possibly contributed to his death:

- The inadequate response of Mental Health & Social Care services, in relation to Jake’s dependency on alcohol and the possibility of a rehabilitative placement
- The failure to share risk information by Social Services and or Mental Health Services with each other, and with the Police (BPT & MPS)
- The sharing of risk information by the MPS and or BPT with partner agencies
- Steps taken by the MPS to seek an assessment of Jake’s mental health whilst in custody shortly before his death
- The inadequate approach of staff and the safeguarding processes within Croydon Police custody suite.
- Failures by multiple agencies and the inadequate response to the missing persons investigation conducted by the MPS
- The interactions with Jake’s girlfriends

The coroner issued a Report To Prevent Future Deaths (Reg 28) requiring a response from The Department of Health & Social Care and NHS England to detail action taken or proposed. The CSCP Executives will consider this response and direct action as appropriate.

The CSCP Executives agreed to wait until the jury’s findings were published before publishing the SPR. It was important to consider the jury’s findings and ensure they were appropriately referenced in the SPR. Post inquest they met with Jakes family and have agreed not to amend the body of the report, and an additional recommendation (see 13) would be included.

The CSCP Executives acknowledged the work that has been done since the SPR was completed and agreed to publish this addendum alongside the SPR to summarise the activity and impact of the work undertaken. Work is continuing. This is held in an action plan overseen by the CSCP Safeguarding Practice Review Group. This includes the recommendations which relate to national issues.

No. key - **Complete**, **In Progress**, **Outstanding**

No.	Recommendation	Evidence of progress / completion
1.	CSCP to consider how multi-agency reflective forums will be built into multi-agency meetings/panels and other current established processes. The outcome of these changes should be reviewed and measured through use of practitioner feedback and incorporated into multi-agency audits.	▪ A number of multi-agency forums have been observed, there is ongoing CSCP member engagement with those meetings. ▪ New multi-agency forums have been set up to offer multi-agency case reflection. This work is regularly reviewed at CSCP Meetings. ▪ The quality of partnership work is a mandatory theme in CSCP audits. ▪ For continuity and oversight of health needs, Croydon Child Looked After (CLA) health team now allocate a specific nurse to each CLA including those placed out of area. Part of the health assessment focuses on identity and offers referral pathways to relevant agencies.
2	A new directory of all statutory and voluntary services in Croydon is being developed. CSCP to promote the directory of statutory and voluntary services to achieve awareness of this directory so that services and referral pathways are visible and known to all agencies.	▪ Directory went live in Oct 2023. It will also be accessible via new CSCP website/newsletters. ▪ For some services or pathways, the relevant agency presents at a CSCP multi-agency meeting to ensure all agencies can understand the offer and associated pathways as well as offer advice on how services can be improved.

No.	Recommendation	Evidence of progress / completion
3	CSCP to promote Substance Misuse Training this training across multi-agency partners and have oversight of evaluation and impact. In addition, CSCP to liaise with public health and commissioners to consider what can be provided in terms of a local campaign regarding drug education.	▪ Current training is available via CSCP website, via the Public Health commissioned provider. ▪ Training is evaluated and the impact assessed as part of CSCP usual process.
4	The CSCP to raise awareness of intersectionality and the use of an appropriate framework or tools to consider a child's presenting needs and service response. Panels also need to provide an opportunity to assess the number of services involved with a child, their engagement and impact.	▪ Challenging Disproportionality training covers these topics. Training dates have been secured until Feb 2024. ▪ Specific sessions for various social work teams have been delivered by in house trainers on Adultification & Intersectionality ▪ The multi-agency Complex Adolescent Panel has continually developed to respond to the evolving area of extra familial harm, the impact of each agency is part of the panel discussions and outcomes.
5	CSCP to seek assurances that robust systems are in place to review care planning informed by the Nuffield Foundation research (October 2021). .	▪ Assurance is derived from scrutiny of data. ▪ The CSCP is working alongside the Housing Directorate to ensure Safeguarding is appropriately featured in their transformation work.
6	CSCP to continue to have oversight of local developments to reduce exclusions which includes intervention at the earliest possible point and to raise at a national level the need for strengthened guidance, with less opportunity for variation as identified in 2019 the Timpson report.	▪ CSCP receive regular data on children missing education and children out of education (excluded) ▪ The 'Team Around the School' and other campaigns are in place to reduce exclusions. Early data indicates this is having a positive effect (currently no children excluded in primary school and several successful challenges to keep older children in school). ▪ Two care experienced adults (CEA) nurse specialist have recently commenced and are collocated with 16 plus local Authority team. They will provide CEA in the borough with a universal and targeted health offer, to ensure there are no sudden gaps in services for young people leaving care once they turn 18 years of age.
7	CSCP to consider how current training and awareness raising forums can be used to facilitate an understanding Youth Culture and the findings in this CSPR.	▪ Community stakeholders have delivered sessions and other events are planned. ▪ Young Ambassadors – currently being recruited, will also support this work.
8	CSCP are encouraged to continue to learn from what works well when working with families and consider examples of innovative practice set out in the recently published guidance from Coram/BAAF and UCL.	▪ Examples of what works well, including examples from this review have been shared at learning events. ▪
9	CSCP to review which services/support are offered to families and for this to be revisited at the Rapid Review meetings and at Safeguarding reviews.	▪ Reports from all known services/agencies involved in a child's life are routinely requested at both Rapid Review and Safeguarding Practice Review meetings. Practitioners and their managers are invited to attend the Rapid Review meeting alongside panel members.
10	CSCP to oversee the development of multi-agency plans for children where contextual risks exist and, as in this case, when risks do not fit into the usual categories of gang affiliation and sexual exploitation there is also an urgency to ensure a timely response. This plan should include all emergency services who are likely to be involved and this should be shared with placement providers. These agreements must include detailed safety plans particularly when a child has known risks e.g., missing episodes, aggressive behaviour, drug use.	▪ A "Vulnerability Panel" is held within the 16+ Young People's Service to provide a holistic approach to considering and managing risk for some of the children we are most worried about. This panel welcomes multi-agency partners and care providers. ▪ CSCP promote/provide Trauma Informed training to all professionals working with children and vulnerable people in Croydon. ▪ Unconscious bias/social status considered in learning events. ▪ There is a newly created extra-familiar harm Child Protection Chair post to support the development of a more effective approach to developing appropriate plans with this cohort of young people. ▪

No.	Recommendation	Evidence of progress / completion
11	CSCP to encourage relevant bodies to provide national strategic guidance and resources for integration of CAMHS, substance use and social care services, so a more robust offer is available to children and their families and access to specialists' substance use services as needed.	▪ This is referenced in the Care Review which the CSCP are currently aligning with their 2023/24 Business Plan. ▪ It has been raised at London Level (LSCP Managers meetings). ▪ The CSCP are meeting with Mental Health Providers to scrutinise the Croydon offer and waiting times. (QIG) ▪ Croydon has a 'single front door' approach to emotional health and mental wellbeing referrals where one referral point ensures each referral is triaged and then directed to the most appropriate service. ▪ New pilot via SWL ICS to provide in/outreach community-based trauma informed emotional wellbeing and support to children and young people that arrive at the Croydon Custody suite. ▪ The CSCP Executive Partners will write to the Government in support of the Childrens Mental Health Services Report and review how recommendations from that report are implemented. ▪ Croydon is contributing to the SWL Audit for complex needs (Expected to conclude Mar 2024)
12	Agree at local director and senior management level in CSC, CAMHS, Health (including ED), Education, Police (BTP & MPS), LAS and commissioning the main principles (when are there enough 'red flags') for in-patient admission, welfare secure or some other response reflecting a shared commitment to medium and long-term plans for these children. This must include clarification about who is the lead agency in the child's care to ensure multi-agency ownership of care for children who are known to be at high risk.	▪ Currently part of transitional safeguarding work with CSCP / CSAB / Public Health. CSCP are influencing the revised suicide and self-harm strategy for Croydon. ▪ Croydon Children's Social Care has a dedicated clinical social care team. ▪ The Joint Working Protocol is being amended to include pathways and escalation.
13	When a child who is looked after dies, the process for informing the family and offering support should be reviewed to ensure that the co-parenting role of the Local Authority is continued until post inquest. Where possible the child's parents, the local authority and the lead agency responsible for the care of the child at the time of their death should work together to ensure practicalities such as funerals & inquest planning are co-produced.	▪ Children's Social Care will update their process accordingly. ▪ The CSCP will amend their Rapid Reviews process to include an action to ensure this is in place.