ST HELENS SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW IN THE CASE OF CHILD JSH

OVERVIEW REPORT

MAY 2015

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CONTENTS

Note on the Structure and Content of the Overview Report

The report is in four sections and two appendices. A brief explanation of each section is provided below for ease of reading.

Section 1

This section is self-explanatory. It sets out the rationale and process for the serious case review, a brief overview of Systems Review Methodology, parameters of the Review and relevant timescales.

Section 2

This section provides a brief background to the case including significant people involved in the case and key locations, all of which are anonymised. This section also includes an introduction to the background to the case. **NB Systems reviews do not replicate the detail of the case within the report and readers are guided towards significant practice in sections 3 and 4. This is intended to avoid the reader becoming distracted by the minute detail of the case. The professional narrative included as an appendix provides the support background material upon which the key practice episodes and findings are built.**

Section 3

This section contains the Review Team's analysis of practice in the case, based on all the data reviewed. This section begins to identify the areas in which practice could be improved (and where good practice should be maintained and enhanced). This section also begins to highlight the important areas that support the findings set out in section 4 of the report.

This section also includes an overview of the key practice episodes that the Review Team judge to be most significant in shaping the case.

Section 4

This section contains the key findings from the Review. Each finding is summarised under a heading. Material is drawn out from the Review to support the finding and to illustrate why the Review Team consider this finding to be significant.

Each finding is followed by a series of related questions to the Board. These questions are intended to stimulate discussion and to assist in forming an action plan to assist the Board in (a) learning from the Review and (b) implementing learning at local level.

This section also contains reference to wider learning that has been derived from the Review – this wider learning may not be related to deeper issues within local systems – but is deemed by the Review Team to be significant enough for inclusion in the report.

This section also contains reference to effective practice.

Appendix 1

Genogram of Child JSH's family

Appendix 2

An abridged version of conversations with key professionals in the form of a narrative. The narrative sets out the case as it unfolded to professionals; it contains their perspective on what, how and why particular actions took place.

1. Purpose and Conduct of the Review

1.1 Principles and Methodology

This Serious Case Review was established in line with guidance set out in regulation 5(2)(a) and (b) (I) of Working Together to Safeguard Children. The case has been judged by the Critical Incident Panel of the Local Safeguarding Children Board to meet the criteria for the conduct of a Serious Case Review.

In line with the principles set out in Working Together to Safeguard Children (2013) this serious case review:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings

The Review has used Systems Methodology. The approach uses multi-agency professional practice to provide a window on the system. The goal is to move beyond the specifics of the case i.e. what happened and why to identify the underlying issues that influence practice. These generic patterns or findings from the case are presented as findings through which practice can be improved.

The approach uses qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis, data comes from semi-structured conversations with professionals who have been directly involved in the case, case files, and contextual documentation from key agencies.

1.2 Time Period Under Review

The period under review is from September 2007 when Child JSH joined High School 1 to the date of his death in January 2014. A multi-agency chronology was compiled detailing agency contacts in the review period; this did not include school records, which were provided as separate documents.

The Review also received information in the form of a short report from Child JSH's primary school, from which a managed transfer took place, although this is outside of the review period.

1.3 The Review Team

Membership of the Review Team was agreed with the Safeguarding Children Board Business Manager at the start of the process. A Review Team of senior professionals represented agencies from the multi-agency child protection system, as follows:

- Children's Social Care
- Merseyside Police
- Legal Services
- Designated Doctor
- Designated Nurse
- Education
- Lay Member
- Named GP for Safeguarding
- CAMHS

An Independent Lead Reviewer was appointed to lead the Review and guide the work of the Review Team. The Independent Lead Reviewer provided ongoing guidance in using the systems approach to professionals involved in the case throughout the process.

1.4 Structure of the Review Process

Using the systems methodology, gathering and making sense of information about the case is a gradual and cumulative process.

The Review Team held six meetings at which data from professional conversations and documents was presented, analysed and formulated into key practice episodes and findings. These meetings were used to continually analyse and refine findings to ensure that they were congruent with local experience and conditions.

The Case Group (professionals directly involved in the case) met with the Independent Lead Reviewer and members of the Review Team on two occasions at the start of the Review and at the end of the Review, prior to the final report being presented to the SHSCB.

A professional opinion was sought from a senior mental health professional who advised the panel on aspects of Child JSH's presenting behaviour.

1.5 Sources of Data

The systems approach requires the Review Team to understand how professionals and others saw the case at the time. It requires those involved in the case to play a major part in the review, analysing how and why practice unfolded as it did. The Review Team held conversations with key professionals and analysed records and written reports.

1.6 Conversations with key professionals

The Independent Lead Reviewer, together with a member of the Review Team, conducted face to face and telephone conversations with practitioners as set out below.

Pseudonym	Agency	Conversation Held
YW1, YW2, YW3, YM1, YM2	YOS	Yes
CS1, CS2	CAMHS	Yes
SW1, SWM1, SWM2, SW3	Social Care	Yes
SMW1, SMM1	Substance Misuse Service	Yes
HW1	Housing Worker	Yes
SPO1	School Police Officer	Yes
SSL1, SSL2	High School 1 and High School 2	Yes
CT1	College	Yes
SLWIC	Walk in Centre	Yes
CS1, CS2	Counselling Service	Yes
NN	Named Safeguarding Nurse	Yes
PML	Police MAPPA Lead	Yes - Telephone

1.7 Data from Documentation

The Review Team was provided with extensive documentation and records, short reports and a full integrated multi agency chronology. The chronology is not included as part of this report.

1.8 Data from Other Sources:

1.8.1. The Assistant Director of Children's Services conducted an internal audit of the case files relating to JSH to clarify Social Care involvement and adherence to standards. The findings from this audit are summarised in this report.

1.8.2. The Trust responsible for CAMHS services conducted a '72 hour incident review' the report and findings were made available to the Review Team, the findings of which are summarised in this report.

1.8.3. The Trust responsible for Accident and Emergency and Walk-In Centre Services conducted an internal review, the findings of which were made available to the Review Team and are summarised within this report.

1.8.4. The Head of Psychological Services reviewed all available information on the case and was invited to provide a professional opinion on Child JSH's displays of violence and

aggression, his controlling, manipulative and sexually aggressive behaviour, and his underlying vulnerabilities and risks.

1.9 Family Involvement in the Review

The panel offer their condolences to the family of Child JSH on their tragic loss.

The Review Team sought to involve Child JSH's family in the Review and contacted both his parents to inform them that the Review was taking place.

Following enquiries by Adult Mental Health Services, the panel was informed that Child JSH's father was engaged with Adult Mental Health Services and that an approach to participate in the Review would require him to have a psychiatric assessment to determine whether it would be detrimental to his mental health to be involved in the review. The panel discussed this and decided not to approach Child JSH's father to be involved in the Review based on his current mental health status.

In relation to Child JSH's mother, it was established that she did not have any current contact with services. Child JSH's mother met with a representative of the SHSCB prior to submission of this report to the Nation Panel. She did not ask for any amendments to be made to the report. The panel wishes to thank Child JSH's mother for her contribution to the review.

Section 2 – Background to the Case

2.1 Family Members

All people in this case are referred to using pseudonyms to protect the identity of Child JSH. Due to the nature of some of the events that took place in Child JSH's life the panel have not submitted a 'gender neutral' report.

Family Members

Child JSH	Subject	Address 1 and 2
JSHM	Mother of Child JSH	Address 1
JSHF	Father of Child JSH	Address 2
JSHS	Sibling of Child JSH	Address 1
JSHMGF	Maternal Grandfather of JSH	Not included
JSHMGM	Maternal Grandmother of JSH	Not included

Two girls who were involved in incidents that came to police attention are referred to in this report as Child 1 and Child 2.

2.2 Child JSH

Child JSH was 17 years and 10 months old at the time of his death in early January 2014. Child JSH was found deceased by his father at Address 2, he was hanging by his neck from scarves that were tied to an upstairs ceiling.

An inquest held in April 2014 found that Child JSH had intentionally taken his own life.

Child JSH was described by some of the professionals who met him to be an academically able, presentable young person who appeared to have very high self-esteem and self-confidence. He was often engaging, charming and polite. In contrast to this, some professionals also described another aspect to his personality, where he was described as being manipulative, physically and sexually aggressive and intimidating; these behaviours appeared to be more prevalent as he became older.

It was noted by professionals that Child JSH had few close friends or friendship groups and tended to be something of a 'loner'. He did however have a wide network of associates on social media and had a high profile in his local community, primarily in relation to his reputation for being involved in fights and anti-social behaviour. The police had intelligence to suggest that in the two or three weeks before his death, Child JSH was receiving threats via social media. These threats referred to 'revenge' being taken for incidents that he had allegedly been involved in.

Child JSH lived with his mother and father until they separated when he was around ten years old. Following their separation he lived with his mother for a period of time. During the two years before his death, Child JSH had moved between living with his mother and his father on more than one occasion, this appears to have been dependent on how well or otherwise he was 'getting on' with them at the time.

Child JSH has a younger sibling. During the period under review, neither Child JSH nor his sibling had been subject to any form of child protection planning. The family had been previously known to Children's Social Care; this was regarding an allegation of inappropriate sexual behaviour in 2008. This allegation referred to a member of the extended family and

did not relate to Child JSH, his sibling or either of his parents. No further action appears to have been taken in relation to this allegation. It is included in this report as context in relation to the wider family dynamic.

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Child JSH also told professionals that he had been subject to 'beatings' by his father, and that he had been in fear of his father as a younger child. He attributed his own inability to control his anger to these experiences.

It should be noted that these accounts have not been corroborated by either of Child JSH's parents or other family members because they have not participated in the review. There are no police records in relation to domestic abuse between Child JSH's father and mother, nor any record that either parent sought advice or support from services in relation to domestic abuse. Child JSH's mother did report domestic abuse incidents that involved herself and Child JSH.

Child JSH appears to have experienced emotional and behavioural difficulties from the age of around 9 or 10 years. These difficulties manifested in violent and aggressive outbursts and behaviours at school (he was moved on managed transfer in both primary and secondary education); sexual aggression and intimidation towards females (both peers and members of staff); physical violence and aggression towards his mother and, latterly he is alleged to have committed serious offences involving physical and sexual assaults.

Child JSH told professionals that he had thought about, and had inflicted physical harm upon himself. He presented to his GP in November 2011 saying that he had purposely cut his hand (this happened in the school setting, following the end of the relationship with Child 1). This resulted in the GP referring Child JSH to Child and Adolescent Mental Health Services (CAMHS). Child JSH also talked about self-harm in his contacts with YOS and to the Appropriate Adults who saw him in police custody.

Although he was assessed by Child and Adolescent Mental Health Services in 2011, Child JSH was never diagnosed with a mental illness under the International Diseases Classification 10 (ICD10)[1]. He was assessed by CAMHS as having no suicidal ideation and as having emotional and behavioural problems. He did not engage in the therapeutic services offered to manage these difficulties.

From the accounts given by professionals involved in the review, and according to information given to practitioners who had contact with Child JSH, he appears to have had a turbulent and difficult relationship with his father.

Child JSH and his father appear to have had physical altercations with each other and, on one occasion, Child JSH presented to the Walk-In Centre service with injuries (including a bite to his chest) that he and his mother said had been inflicted during an altercation with his father.

[1] ICD 10 – The diagnostic tool used by Child and Adolescent Mental Health Services.

Child JSH's mother provided ongoing support to Child JSH throughout his engagement with services, only withdrawing when Child JSH's violent outbursts became too much for her to cope with.

Child JSH's relationship with his mother became volatile and there were several reported incidents of him displaying verbal and physical aggression towards her. On three occasions these incidents were reported to police, however, Child JSH's mother was never referred to any service for safety planning, nor was she assessed for any indicators of risk presented by Child JSH.

Child JSH moved accommodation several times, living alternately with his father and his mother; this appeared to be dependent upon his behaviour and how able, or otherwise, they were to cope with his behaviours. He spent two short periods of time living in local authority accommodation as a homeless young person.

In the latter months of his life, Child JSH became more chaotic and reckless in his behaviours, particularly in relation to involvement in violent assaults, both as a perpetrator and a victim. Although there were increasing concerns from Police and YOS around the risks that Child JSH presented to others, there is little evidence in the case that Child JSH's vulnerabilities and safeguarding needs were discussed in a multi-agency context, until the strategy meeting that was held on 20th December 2013.

It was not until the YOS Manager escalated her concerns about Child JSH to the Director of Children's Services in January 2014 that multi-agency action was taken to discuss the safeguarding needs and risks to Child JSH.

Following this escalation the Director took action to instigate a multi-agency meeting to assess Child JSH's risks and vulnerabilities, and to take appropriate action. A professionals meeting, chaired by the Police was held on 10th January 2014. A MAPPA meeting was arranged for 31st January. Tragically, Child JSH's death precluded decisive multi-agency safeguarding measures being put in place.

2.3 Brief Synopsis of Key Agency Involvement

Child JSH's challenging behaviour at school resulted in him being subject to managed transfers, both at primary and secondary level. He was transferred in his final year at primary school from Primary School 1 to Primary School 2, following aggressive behaviour towards other pupils. On both occasions the Local Authority policy on Managed Transfers was used. A key finding of the Review relates to the use of managed transfers to manage physical violence and sexual misconduct.

His first year at High School 1 was relatively free of any incident; however, in his second year he began to display disruptive and aggressive behaviour towards pupils and staff.

2010

In March 2010 Child JSH was involved in a serious incident at High School 1, where he made a sustained and violent assault upon a fellow pupil. Although the injuries resulting from this assault were technically minor in nature, the loss of control and extreme response to a minor dispute on the part of Child M was considered to be of significant concern. The assault resulted in prosecution and a police caution, following which Child JSH was moved on a managed transfer to High School 2 in May 2010.

After the move to High School 2, Child JSH's behaviour continued to be of concern and he was subject to Behaviour Support measures and sporadic contact with the School Police

Officer. Whilst at High School 2 he began to display sexually intimidating behaviour towards female members of the school staff and towards female pupils.

In September 2010 the School Police Officer had occasion to speak to Child JSH in relation to an alleged assault upon his mother and brother whilst travelling to school in the car. Child JSH was reported to have shown no remorse about this alleged assault, and would not accept that being violent towards his mother was unacceptable behaviour.

A report was made to police in September 2010 regarding a dispute between Child JSH and his sibling there were no injuries or damage resulting from the incident.

2011

In or around October 2011 Child JSH began a relationship with a fellow pupil (Child 1) at High School 2. School staff were aware of the relationship and noted it to be 'obsessive' on the part of Child JSH. When Child 1 ended the relationship with him, Child JSH reacted very badly and began to stalk and threaten her, both in person and via social media.

Both Child JSH and Child 1 were below the age of consent at this time, although it later emerged in a witness statement made to police that this relationship was a sexual one. After approximately 12 months in the relationship, Child 1 decided she no longer wanted the relationship to continue. On being told this Child JSH became aggressive and intimidating towards her, this intimidation ultimately resulted in the Child 1's family referring the matter to the police. When interviewed by police Child 1 gave a statement making very serious allegations involving manipulation, intimidation, controlling behaviours and serious sexual assault. These allegations were investigated and submitted to the Crown Prosecution Service (CPS), who provided advice that there was insufficient evidence to proceed. The matter was therefore recorded as undetected.

Upon leaving High School 2, Child JSH secured a place at a local college that commenced in September 2012. Following Child JSH's admission to college, they became aware of rumours about Child JSH's previous behaviours at school and in the community. Within a short time of joining the college, Child JSH began to display aggressive and sexually intimidating behaviours. He was involved in a fight in college and was often disruptive in the classroom setting.

In October 2012 Child JSH presented to the local Walk-In Centre, accompanied by his mother. He reported that he had been involved in a fight with his father and had sustained a number of injuries including a bite to the side of his chest. Child JSH received a safeguarding assessment and information was shared with his GP and with Children's Social Care.

Following the break-up of their relationship, and in response to complaints of ongoing harassment, Child 1 gave a witness statement to police in November 2012 in which she alleged that, during their relationship there had been consensual intercourse but that on one occasion Child JSH had raped her. She described Child JSH as being manipulative, controlling and threatening. He also displayed physical and verbal aggression in her presence.

Following arrest and charge for an offence of possession of drugs and an offensive weapon Child JSH was made the subject of a Referral Order in October 2012. Child JSH complied with the Referral Order and developed a good relationship with his YOS caseworker. He was referred to a Counselling Service in November 2012 and engaged with them in January 2013

2013

Child JSH was living with his mother at this time, who reported to YOS that there were still issues in relation to Child JSH's attitude and behaviour towards her. YOS provided ongoing support to Child JSH's mother including advice on dealing with JSH's outbursts of aggression.

Child JSH appeared to engage well with the counselling service. He disclosed traumatic events in his early years relating to domestic abuse between his parents and physical violence towards him by his father. The Counsellor had hoped that she would be able to pursue these issues with Child JSH; however his behaviour became much more chaotic over the next few months and the counsellor found herself dealing with whatever incident was of concern to Child JSH at that time.

Although the counsellor and the YOS worker made strenuous efforts to see him at appointments (by moving the location of sessions and 'following him around'), the sessions tended to be dominated by the problems and difficulties that Child JSH was encountering in daily life.

In January 2013 following one incident of fighting and other disruptive behaviour, the college decided that they would terminate his course and that he could no longer attend. Child JSH left college in January 2013.

In February 2013, Child JSH was involved in a violent altercation at his mother's home (Address 1) involving two adult males aged 19 and 23 years. This had taken place due to messages on social media regarding a female associated with one of the males.

Following this altercation, Child JSH attended the local Accident and Emergency Department with facial injuries and a bite to his hand; he told the clinician in A&E that he had been in a fight with two youths. He was seen in Adult A&E rather than Paediatric A&E, no safeguarding concerns were noted. Information about this presentation was shared with Child JSH's GP.

On the 27th February 2013 an incident occurred at the family home, which resulted in Child JSH being arrested for breach of the peace. He had threatened his brother and his mother and had caused damage to the house. His mother said to police that she could no longer cope with his behaviour and that, although it 'broke her heart', she could not allow him back into the family home.

Child JSH's paternal grandfather died around this time. The counselling sessions ended in early March 2013.

Following the recent incident at Address 1, Child JSH presented as homeless and was accommodated in a local hostel. It was noted that there were a number of females resident at the hostel, which was a cause for concern given Child JSH's previous behaviours and reputation for inappropriate sexual conduct. Within a day of Child JSH entering the hostel it was reported that he had breached the rules of the hostel by allowing a female resident into his room, there were allegations that he had had sex with the female. He stayed at the hostel for only a few days after which it appears that Child JSH returned to live with his father.

The YOS Referral Order was due to end in February 2013, however the YOS worker remained involved with Child JSH until March 2013 as she was concerned for his safety.

In April 2013 Child JSH presented at Accident and Emergency once again after being involved in a fight with a gang. He said he had taken a small amount of alcohol, although no drug/alcohol screening tool was administered. Information about this presentation was again shared with his GP.

Child JSH was arrested on 27th July 2013 for Grievous Bodily Harm upon an adult male. Child JSH received conditional bail until 1st October 2013.

On the 17th October police received intelligence that Child JSH was carrying a weapon in the local area and on 23rd October he was 'stop checked'. He was said to be initially aggressive but then calmed down. He told the officer that he was living with his father. He said his father had no money and that he had not eaten for two days. A referral was made to the contact centre; however this did not take place until 3rd December 2013. There was no follow up to this referral from Children's Social Care.

Police arrested Child JSH on 26th November in connection with sexual offences and making indecent images of Child 2. Child 2 had been approached in a public open space, whilst incapacitated by alcohol, her lower garments had been removed, and photographs were taken of her bottom and genitalia. Her attackers, one of whom was Child JSH, then urinated on her. Child 2 became aware of what had happened to her when photographs were sent to her via Facebook by a concerned acquaintance who had seen the pictures published on closed groups on Facebook. Child JSH was given conditional bail until 3rd April 2014 in relation to this offence.

On 27th November two members of staff from the YOS acted as appropriate adult for Child JSH whilst he was in police custody in relation to the above offence. The first YOS worker was concerned about Child JSH saying that he had thoughts of harming himself and reported this to the custody sergeant. The second YOS worker discussed Child JSH's thoughts of self-harm with him and made an immediate referral to CAMHS. On that same day Merseyside Police made a call to Child JSH's GP informing them of Child JSH's thoughts of self-harm. The referral to CAMHS was discussed.

CAMHS received the referral on 28th November 2013 and processed it, offering Child JSH an appointment for 14th December 2013. Child JSH did not attend this appointment, which was at a Saturday clinic. CAMHS were unaware that Child JSH was in custody at the time of his appointment and therefore the appointment was not disclosed to police and no contact could therefore be made with the CAMHS service. The service did not follow up his failure to attend, nor did they notify any other services, including the referrer that Child JSH had failed to attend. A failure to attend letter should have been sent out on 16th December, however, this did not take place.

On the same day Child JSH was brought by the police to A&E, he was in custody, he mentioned that he had consumed some alcohol but this was not explored further, although the question had been asked and it was recorded that the use was not excessive. He received appropriate triage but safeguarding questions were not asked.

Children's Social Care attempted to contact Child JSH at his father's address on 17th December, as it was known that Child JSH had been 'missing' for a number of days. When CSC eventually spoke to Child JSH's father that afternoon he said that JSH was at his work placement and that he was not aware that he Child JSH was missing.

A multi-agency strategy meeting was held on 20th December, which was attended, by YOS, Children's Services and Police. CAMHS have no record of being invited to attend this meeting.

On 24th December police received a report from the parent of a ten-year-old child who had disclosed that Child JSH had shown her his penis. This incident was alleged to have taken place sometime between February and June 2012 when Child JSH had lived with a member of the alleged victim's family. On speaking to the alleged victim's mother, she said that she did not want the matter to be pursued and wanted it to be forgotten. No further action was taken due to a lack of evidence.

A member of YOS staff attended as Appropriate Adult on 30th December 2013 when Child JSH answered bail regarding the S47 assault charge. He informed the YOS worker that he was still living with his father and that they were getting on well. He said that he had seen his mother and likes her new boyfriend, that he is getting on with his brother, and that he has a job. The YOS worker was struck by Child JSH's dishevelled appearance. He was wearing uncharacteristic clothing and had a swollen eye and injuries to his face.

2014

On the 2nd January 2014, Child JSH was arrested in relation to a Section 18 wounding with intent to do grievous bodily harm, alleged to have occurred on 31st December 2013. Two members of YOS staff attended the Police Custody Suite to act as Appropriate Adult. At the end of this interview, prior to Child JSH being bailed from custody, he was re-arrested in relation to another Section 18 Wounding with Intent, also alleged to have occurred on 31st December 2013. The YOS worker attending recorded no threats of self-harm but was concerned about Child JSH's mental health, he informed the custody sergeant of his concerns and Child JSH was placed in a camera cell.

The YOS worker raised his concerns with a senior manager in the YOS who liaised with the Emergency Duty Team (EDT) and the Custody suite regarding the concerns. On 3rd January the YOS manager escalated her concerns in an email to the Director of Children's Services.

On 6th January CSC recorded a number of entries in relation to current concerns regarding Child JSH. A strategy meeting was arranged for 8th January 2014; however this did not take place. CSC asked YOS to enquire whether Child JSH met the criteria for MAPPA (Multi-Agency Public Protection Arrangements).

Between 6th and 8th January YOS made several phone calls in an attempt to arrange an urgent professionals meeting. This was arranged for 10th January and involved the MAPPA coordinator, to discuss whether Child JSH met the criteria for MAPPA. In the interim the Social Worker tried to contact Child JSH by phone at his workplace, however, his employer would not disclose a contact number without Child JSH's permission. He was asked to pass on a message to Child JSH to ask him to contact the Social Worker, Child JSH did not make contact.

A professionals meeting scheduled for 10th January went ahead and was chaired by the Police. The meeting was well attended; however CAMHS did not attend as they report that they were not informed of the venue or time of the meeting. CAMHS state they requested this information. A number of actions for professionals to establish current risks in relation to JSH were allocated. A MAPPA meeting was arranged to take place on 31st January and due to concerns about JSH's mental health a request was sent to CAMHs to attend the meeting.

On 17th January 2014 Child JSH was found dead at his father's address. He was hanging by the neck, suspended by two scarves.

Section 3

3.1 Significant Episodes and Analysis of Professional Practice

Child JSH had many contacts with services during the period of this review and the Review Team have considered detailed information from a range of services.

It is the view of the Review Team that there is no malpractice or practice that would lead to conduct or disciplinary action in this case. However, the Review Team has identified several missed opportunities where agencies could have acted differently to safeguard Child JSH and those around him.

It is true to say that Child JSH presented with very challenging behaviour that some professionals found difficult to understand. He was seen by some professionals to be a vulnerable young man who had experienced traumatic early life events, whilst to other professionals he was seen as a calculating and predatory adolescent who was without remorse or concern for the victims of his offences. This contrast between childhood and adulthood and victim-perpetrator appears to have been a significant factor in the way professionals responded to Child JSH.

It is the view of the Review Team that the following practice events are particularly significant in the case:

3.2 Significant Events

An important part of organising and analysing the data using a systems approach is to identify key practice episodes. These are a selection of practice episodes that were significant in the way the case developed and/or was handled. Some of these are identified by professionals in the individual conversations, others are identified by the Review Team, with the benefit of the overview perspective that they hold.

In identifying the key practice episodes the Review Team have:

- Clarified the way in which the episodes were significant
- Judged the quality of practice they contain
- Identified contributory factors that help to explain why the practice made sense at the time

The Review Team has identified twelve significant points in the case, referred to as key episodes of practice. Each of the key practice episodes is shown below with an explanation of why it is important as a KPE and what contributory factors were taken into account by the Review Team in deciding its importance to the case as a whole.

Date	Event
March 2007	Child JSH was transferred on a managed transfer from Primary School 1 to Primary School 2. Child JSH had begun to display disruptive and aggressive behaviours in the classroom and was involved in incidents with other pupils. He appears to have settled well at Primary School 2 who focused on his behaviours by diverting him into sports and other activities. This was perhaps the first opportunity to intervene with Child JSH when his aggressive and disruptive behaviours were

	forming.
May 2010	Child JSH was transferred from High School 1 to High School 2 on a managed transfer following a serious assault on a fellow pupil. The assault committed by Child JSH was of a serious nature, however, there appears to have been no safeguarding risk assessment and the incident was dealt with through criminal proceedings and managed transfer. This was a further opportunity to explore Child JSH's behavioural difficulties in a multi-agency context.
30th September 2010	The School Police Officer interviewed Child JSH in relation to an assault upon his mother and brother in the car. Child JSH did not accept that he should not have done this and responded 'if you can't take it you shouldn't give it'. He showed no concern for his mother or his younger brother. The School Police Officer referred her concerns to the School Safeguarding Officer. No further action appears to have been taken, and no domestic abuse risk assessment was undertaken.
12th December 2011	A CAHMS assessment was undertaken following referral by Child JSH's GP, where disclosures were made regarding violence by Child JSH toward his mother and brother and his self-harming behaviour. The Clinician judged that there were no safeguarding risks as both JSH and his brother are 'old enough' and his father was no longer living with them and was reported to have left the family home two years previously? No safeguarding referral was made despite historic indicators of domestic abuse and Child JSH's violence towards his mother.
25th October 2012	Child JSH presented to the Walk-In Centre accompanied by his mother. He had injuries inflicted upon him by his father, including a bite to his chest. A referral was made to CSC and notification to GP, no copy was sent to the Safeguarding Team. CSC did not feed back to the referrer nor did the referrer follow up the referral.
26th October 2012	CSC received the referral from Walk in Centre in relation to Child JSH having been assaulted by his father, however, this was not followed this up. The rationale for this decision is not clear from the records or professional conversations.
November 2012	Following allegations of harassment Child 1 gave a witness statement to police in which she alleged that Child JSH had raped her. The matter was investigated and referred to

	CPS, who advised that there was insufficient evidence to proceed. The matter was recorded by police as undetected but there appears to have been no safeguarding referral made, either in relation to Child 1 or JSH.
23rd November 2013	Child JSH was arrested for sexual assault and making indecent images of Child 2. He was bailed and a referral was made to CSC, this referral was logged by CSC on 16th December.
14th December 2013	Child JSH did not attend the appointment made for him with the CAMHS service. Child JSH was in police custody at the time the appointment should have taken place. CAMHS did not follow up with the referrer or send Child JSH a DNA (did not attend) letter.
16th December 2013	Children's Social Care received a referral from police relating to the arrest of Child JSH that took place on 23rd November. There was a delay in the referral being sent/received. Given the seriousness of the offence, Child JSH's background and recent events a S47 strategy meeting was called on 20th December. SW3 tried to contact JSH and father but this was fruitless.
20th December 2013	Multi agency strategy meeting took place. This meeting appears to have focussed heavily on Child JSH's criminal behaviour and did not appear to address his vulnerabilities and safeguarding needs.
3rd January 2013	The YOS manager sent an email to the Director/Assistant Director of Children's Services to raise concerns about Child JSH. Following this the Director instructed that an urgent meeting should be called to address Child JSH's safeguarding needs.
10th January 2013	A professionals meeting was held as a precursor to a MAPPA meeting, which was scheduled for 31st January.

3.3 Analysis of Professional Practice

During his school years, behaviour management strategies were put in place in both the primary and secondary school settings. When these did not result in any behaviour change Child JSH was subject to managed transfers to other schools. The policy for managed transfers is clear and was followed on both occasions; however, it is the view of the Review Team that behaviour management following managed transfer, particularly where this has resulted from violence and sexual misconduct, could be strengthened.

Following the serious assault at High School 1 the School Police Officer became involved, although there does not appear to have been any other multi-agency consultation regarding any triggers or underlying causes for Child JSH's behaviour. When Child JSH joined High School 2 he was perceived from the outset as a pupil who would be troublesome and immediate plans were made to put behaviour management and support in place.

Both the CAMHS service and the Hospital Trust responsible for Accident and Emergency Services have conducted internal serious incident reviews and have made and acted upon their own recommendations.

On the first occasion that JSH presented to CAMHS insufficient attention was given to safeguarding Child JSH and his sibling. The time taken to offer a therapeutic intervention to Child JSH and his family appears to have been unacceptably long, indeed Child JSH's mother reported that by the time the appointments were received things appeared to have calmed down without interventions.

On the second occasion that Child JSH was referred to CAMHS, two years later, he failed to attend; however, the service did not follow this up with an offer of a further appointment or a discharge letter. The service could not prioritise attendance at the Professionals meeting held on 10th January as they were not given time or venue although this was requested, where their attendance would have strengthened the multi agency discussion and response to the managing what had become a very serious situation for Child JSH.

The Walk-In Centre undertook a safeguarding assessment and made a referral to CSC, however, this was not followed up and a copy was not sent to the safeguarding lead, therefore opportunities to enquire about the outcome of the referral were missed.

With regard to Accident and Emergency Services, the service has identified that the safeguarding response to Child JSH on each occasion that he presented was inadequate. Child JSH was treated as an adult rather than as a child by this service. Whilst it is acknowledged by the Review that Child JSH was presenting in situations in which he may have been construed as a perpetrator, as well as a victim of violence, his vulnerabilities were not explored. The response provided to Child JSH in these settings was not child centred.

Practice in Children's Social Care was not in line with expected standards. The Review Team asked for an internal audit of practice in this case as the records provided to the Review were of poor quality. Practitioners and managers involved in the Review recognised that opportunities were missed that may have resulted in reducing the risks associated with Child JSH's harmful behaviour.

The quality of record keeping by Social Care was deemed to be extremely poor and requires improvement. Opportunities to conduct Initial Assessments were not taken and assertions about the capacity of Child JSH parents to look after him were not tested.

On the 26th October 2012 the case was allocated and on a positive note case allocation instructions were provided to the Social Worker. S47 enquiries commenced and a home visit was completed. There is no evidence of the write up of the visit or analysis of the outcome.

The Social Care Management of the case lacked cohesion and coordination and there is no evidence that at any point, until after the strategy meeting on 20th December 2013, that an attempt was made to understand the needs of Child JSH or the drivers behind his behaviour.

The family's GP had minimal contact with Child JSH in the period under review. When Child JSH attended with his mother saying that he had self-harmed, the locum GP made an appropriate referral to CAMHS.

The police response to Child JSH in relation to his offending was in line with expected practice and appropriate referrals were made to CSC, however, there is learning from this Review in relation to the multi-agency risk assessment process for young people who are offending and pose risk to themselves and to others.

The School Police Officer had considerable contact with Child JSH and raised concerns about his risks and vulnerabilities to colleagues in the school setting. However, the relationship between the role of the School Police Officer and other police activity is not clear in this case and would benefit from review.

It is the view of the Review Team that the response to the domestic violence risks presented by Child JSH to his mother was not sufficiently robust. Whilst all reports from Child JSH's mother were responded to, at no time was a Domestic Violence Risk Assessment (MERIT) undertaken. Because of this no formal risk management strategy or safety planning was put in place for Child JSH's mother.

The Youth Offending Service supervised Child JSH when he was subject to a referral order from. Two staff from the service also acted as Appropriate Adult for Child JSH on three separate occasions.

Despite the relatively short period of statutory involvement, YOS staff remained involved and concerned about Child JSH. They provided support to other professionals and escalated their concerns, which acted as a catalyst for multi-agency action.

Section 4 – Findings and Questions for the Board

The findings and wider learning set out below encompass the key learning emerging from the Review. Systems reviews do not make recommendations to LSCB's, rather they present findings and ask the Board to consider (a) whether the Board accepts the finding, (b) how the Board will respond to the finding, (c) who will take responsibility for actions in relation to the finding, (d) when the actions will be completed.

Each finding includes a brief rationale for inclusion drawn from the case material. Each finding also has associated questions for the Board. These are designed to assist the Board in testing the finding and improving safeguarding practice. Multi-agency ownership of these findings is critical to moving forward from the Review and the Review Team would recommend that an action plan be put in place to implement and monitor the Board's agreed actions in response to the Review.

The Review has concluded that there are four key findings in this case, covering the following areas:

- Improving safeguarding practice in relation to young people who are involved in criminal and sexually harmful behaviours
- Strengthening multi-agency support for schools in dealing with violent and sexually harmful behaviours
- Reviewing professional understanding and improving responses to children who have witnessed or experienced domestic abuse, and improving responses to parents who are subject to violence by their children
- The current system of mental health referral and triage does not meet the needs of children who experience severe behavioural difficulties.

4.1 Finding 1:

The local safeguarding system is not sufficiently robust in its response to identifying and understanding indicators of risk and vulnerability in young people involved in violence, offending and sexually harmful behaviours

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4.1.1. Background to the finding

Child JSH was involved in crime and anti-social behaviour from the age of 13 years. His behaviour and offending escalated over time and placed himself, his mother and his victims at increasing risk. However, for the most part these risks and vulnerabilities were not addressed in any multi agency context.

The actions of professionals in this case, other than YOS and the Counsellor, were not child centred and did not consider Child JSH's risk of harm to others and his own safeguarding needs and vulnerabilities in equal measure.

The Youth Offending Service recognised Child JSH's vulnerabilities and provided support to him. This support was also provided when he was not on any formal order to the service. The YOS were proactive in attempting to stimulate multi-agency involvement and action for Child JSH; however, this did not result in a strong multi-agency response to Child JSH until the YOS Manager escalated her concerns to the Director of Children's Services.

Throughout his contact with all services his age, physical stature, offending behaviour and demeanour appeared to determine the professional response, rather than his vulnerabilities.

Child JSH's risk to others was viewed disproportionately to the risks he himself was exposed to. This does not mean that Child JSH presented as being at high risk of self-harm. His self-reported self-harming behaviour was not apparent to any of the professionals who came into contact with him, although he did present at times with raised levels of anxiety and, on one occasion, appeared to be somewhat overly optimistic about the seriousness of his situation and potential consequences, when in police custody.

The Review Team has judged that the key issue in terms of professional interaction with Child JSH is that he was not afforded the opportunity to discuss his safeguarding needs, other than with the YOS. He did discuss his vulnerabilities with the Counsellor; however this was not a formal assessment and did not result in any contact with CSC.

It appears that Child JSH was assumed by those who met him in the school and police setting, and to some extent in the medical setting, to be a young man who could 'look after himself'.

4.1.2. Questions for the Board (for further discussion with Review Team and Case Group)

- Can the Board be confident that professionals across the agencies understand the need to respond to the safeguarding needs of older children and adolescents, despite the nature of their presentation (i.e. violent, criminal and aggressive behaviours) and that in these circumstances professionals remain child centred?

- What training/workforce development is required to assist professionals in understanding, assessing and providing interventions to young people who present risk to themselves and others, and have safeguarding needs and vulnerabilities.

4.2 Finding 2:

The multi-agency system for responding to serious violent and sexual incidents in schools is not well developed. The role of the School Police Officer is valuable but requires clarification in relation to links to police and other agencies

4.2.1. Background to the finding

Child JSH displayed violence and sexually intimidating behaviour in the school settings, this involved fellow pupils and members of staff. Each school attempted to manage Child JSH's behaviour with behaviour support strategies and by engaging Child JSH's mother. However, when these strategies did not result in behaviour change, managed transfers took place, until he moved to High School 2.

Whilst at High School 2 Child JSH was involved in numerous incidents that required the interventions of the School Police Officer and school safeguarding lead. These interventions were focused on the school setting rather than referrals to the wider safeguarding system.

Child JSH's mother was appropriately involved by school safeguarding however, known incidents of domestic abuse by Child JSH upon his mother were not reported or risk assessed in conjunction with other agencies.

High School 2 and the School Police Officer are to be commended for their attempts to keep Child JSH in school and engaged with his education, as this may have been a protective factor in managing his behaviour in the short term.

The Review Team concluded however that a stronger multi agency safeguarding approach would have strengthened support to the school in managing the challenging behaviour presented by Child JSH.

4.2.2. Questions for the Board

- Is there a robust and clearly understood policy for schools in relation to managing the risks and vulnerabilities of children such as Child JSH?
- Does the policy on managed transfers give sufficient guidance on managing pupils who have been moved because of violent or sexual misconduct post transfer?
- Is the wider multi-agency safeguarding system sufficiently focused on addressing issues of violence and sexually harmful behaviours in the school setting?
- Is the role of the School Police Officer understood and supported by all agencies?

4.3. Finding 3:

(a) Professional understanding and pathways for children who have experienced and witnessed domestic violence are underdeveloped

(b) Responses to children who perpetrate domestic violence, including the protection of the at risk adult, are underdeveloped

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4.3.1. Background to the Finding

Child JSH disclosed that he had witnessed domestic violence to practitioners in YOS, CAMHS, Counselling Services and Children's Social Care. He attributed his inability to control his temper, his feelings of rage, and his underlying anxiety to his experiences as a child. Although he did not directly attribute his violence towards his mother to having witnessed domestic abuse as a child, he did aspire to be 'like his father' whom he had witnessed assault his mother on a number of occasions.

He received emotional and practical support from the Counselling Service and from the YOS, with the latter agency offering structured interventions in relation to anger management. Neither CAMHS nor Children's Social Care properly assessed Child JSH's exposure to domestic abuse and its impact upon him. As his parents had separated, there was an assumption that any risks from domestic abuse had been removed, without taking into account the historical context.

Child JSH assaulted his mother physically and verbally on a number of occasions, which warranted her calling the police to the home address. Police did not initiate MERIT risk assessment or offer Child JSH's mother any safety advice or planning to help protect her from Child JSH's anger.

There are three other incidents of threatening and violent behaviour by Child JSH towards his mother. These incidents were reported to police and recorded as domestic violence incidents, however, no formal action was taken to assess the safety of Child JSH's mother or to offer interventions and support to her as a victim of domestic abuse.

4.3.2. Questions for the Board

- Does the local domestic abuse policy include clear guidelines and pathways for children who have witnessed and/or experienced domestic abuse?
- Is there clear guidance in relation to risk assessment indicators in situations where a child is perpetrating domestic abuse on a parent, and is this sufficiently linked to child and adult safeguarding practice?
- What training/workforce development is needed to assist professionals in dealing with these issues?

4.5. Finding 4:

The current system of mental health referral and triage does not meet the needs of children who experience severe behavioural difficulties

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4.5.1. Background to the finding

Child JSH was referred to CAMHS on two separate occasions because professionals from other agencies who were working with him believed he would benefit from specialist psychological support.

On the first occasion that Child JSH was assessed by a specialist in Mental Health and deemed not to have a mental illness. Despite Child JSH's disclosures regarding a troubled history and his displays of anger, aggression and violence, Child JSH and his family were offered 2 further appointments which they did not attend and were then placed on the waiting list. The service did not undertake any enquiries with Child JSH in relation to safeguarding issues, on the basis that when the matter came to light, the children were no longer at immediate risk of harm as their father had left the family home 2 years before, there was no suggestion that they were wishing to make a complaint.

The service did not feed back to the YOS worker who made the referral, however they did respond to Child JSH's GP saying that he had failed to attend and that he was being discharged from the service.

4.5.2. Questions for the Board

- What support is available for children and young people who experience severe behavioural difficulties but are not diagnosed with a mental illness?
- Do multi-agency professionals refer to CAMHS because of a lack of behavioural support services?
- Is the Board satisfied that the system of triage within CAMHS services across all levels / Tiers is responsive to the needs of young adolescents who present with challenging behaviours?
- Is the assessment and referral process within all CAMHS services robust?
- Are CAMHS sufficiently engaged and proactive in the local safeguarding system?

4.6 Wider Learning

4.6.1. The voice of the young person

There is no evidence in this case that the wishes and feelings of Child JSH were considered through formal assessment or exploration of his wishes and feelings. The panel have concluded that JSH was treated as an adult by services, rather than as a vulnerable child. The exception to this is in the YOS and the Counselling service who did seek his views.

4.6.2. Social Media

The risks presented by Social Media in relation to developing networks that promote and encourage sexually harmful behaviour were clear in this case. Professionals understand these risks but feel powerless to intervene. This is not only a local issue but is one that LSCB's need support in addressing, as the use of social media and its negative impact is an ever-present challenge.

4.6.3. Drugs and Alcohol

There were a number of incidents and contacts with Child JSH where drug and alcohol use was raised. This was not formally pursued or assessed by any agency, and there was no referral or communication with specialist substance misuse services.

Child JSH denied that he used drugs or alcohol (other than admitting on one occasion that he had used a small amount of alcohol). When asked about drugs by one professional he said that he would not use drugs and that he had an aversion to them. The Board should consider whether current assessment and referral in relation to substance misuse is fully explored with young people who present to a range of services.

4.6.4. Parental Mental Health Issues

Child JSH's father had experienced mental health problems and had contact with adult mental health services. The panel were unable to determine the nature and duration of the mental health problem and the impact that this may have had upon Child JSH.

What was clear to the Review Team is that the parenting capacity of Child JSH's father was never assessed by any professional. His ability or otherwise to safeguard Child JSH was not assessed. When Child JSH's father was eventually seen by a Social Worker in December 2014 she had concerns about his mental health and his ability to look after Child JSH.

Whilst the panel could not definitely point to deeper systems issues they felt it was important to raise the following questions with the Board in the context of safeguarding and parental mental health:

- Are the links between adult mental health, child mental health and child safeguarding sufficiently robust?
- Are professionals supported in making assessments of parenting capacity where parental mental health (particularly borderline mental health problems) may impact on safeguarding?
- Are adult mental health services sufficiently engaged in the local safeguarding children agenda?

4.6.5 Child Sexual Exploitation and Sexually Harmful Behaviour

The Review Team heard from professionals in the area their increasing concerns about the growing prevalence of sexually harmful behaviours amongst children and young people. The recently published Jay Report[2], the report by Ann Coffee MP[3] and the OFSTED[4] Report highlight the pressures and dangers for young people who become involved in CSE and sexually harmful behaviours.

All agencies involved in this Review are in contact with greater numbers of young more people who are involved in violent and sexually harmful behaviours.

The Review Team would encourage the SHSCB to incorporate learning from this Review into its approaches to tackling CSE, sexual violence and sexually harmful behaviours.

4.6.6 Record Keeping in Children's Social Care

The quality of recording and record keeping in Children's Social Care was found to be very poor. The Review Team were unable to accurately track contacts with the service, where records had been made they were often incomplete and inaccurate. An internal audit was conducted which recommends that high priority should be given to improving record keeping in the service, and that a further audit should be undertaken following this Review to ensure that standards have improved.

4.7 Good Practice

4.7.1. There is excellent practice in the local Youth Offending Service in relation to safeguarding at risk and vulnerable teenagers.

A generic health service offer to YOS is currently being developed and a school nurse is now placed within the team two days a week. Specialist mental health support provided to CSC as required.

4.7.2. There is a willingness amongst professionals in St Helens to address the complex issues presented by this case. The use of professionals meetings should be encouraged to enable professionals to discuss complex cases where they do not immediately appear to meet the threshold for child protection.

[2] Alexis Jay OBE, Independent Inquiry into Child Sexual Exploitation in Rotherham (1997-2013)

[3] Anne Coffee MP, Real Voices (2014)

[4] OFSTED, Child Sexual Exploitation – It Couldn't Happen Here, Could It? (2014)

5. Conclusions

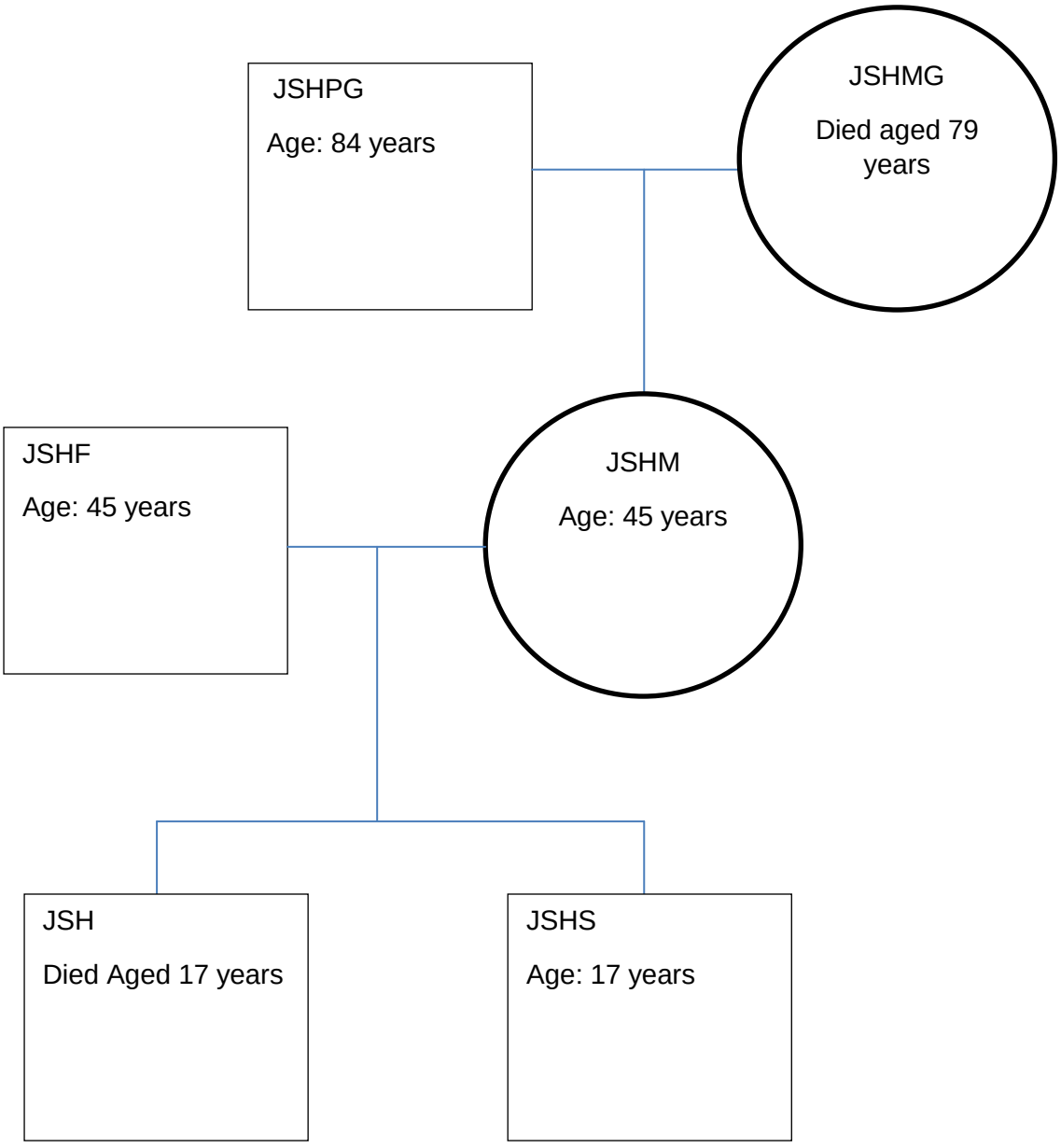
This Review was commissioned by the SHSCB to establish what learning could be gained from the way professionals and agencies worked with Child JSH and his family.

The Review has provided a window on the local Child Protection system through which the Review Team have been able to analyse practice and explore where systems work well and where improvements may be required.

Within the context of a Serious Case Review it is important to establish whether the child's death was predictable or preventable and whether there are modifiable factors in systems and practice that may help to prevent deaths such as this from occurring in the future. It is the view of the Review Panel in this case that the tragic death of Child JSH was neither predictable nor preventable.

APPENDIX 1

FAMILY GENOGRAM



APPENDIX 2 – ABRIDGED PROFESSIONAL NARRATIVE

Narrative of the Case as it unfolded to professionals

The narrative below is taken directly from conversations with professionals involved in the case. The narrative represents the understanding and actions of professionals at the time that they were working with the family.

It should be noted that the narrative may not be factually accurate in relation to policies and procedures i.e. it is the unedited interpretation, perspective and view of the professionals interviewed according to their understanding and actions at the time.

Background

The first known contact with Children's Services was in 2008 when JSHM contacted CSC with allegations of sexual abuse by JSHPG upon one of JSH's female cousins. The contact was closed as there were no disclosures by JSH or his brother, nor any substantiation of the allegations.

JSHF was previously known to police for a drug related offence and a drunk and disorderly offence, both of these were outside of the time-period covered by the review.

Child JSH appears to have had a relatively uneventful childhood. There is no evidence of agency contacts or disruptive behaviour until a managed transfer took place from Primary School 1 following an altercation with another child. The transfer was made to Primary School 2 in March 2007 and was led by the Pupil Support Officer. At this time the BEST (Behaviour Support Team now known as the Behaviour Improvement Team) had just started to engage with JSH.

He had achieved well at Key Stage 1 achieving at or above age related expectations and he was predicted to achieve at age related expectations in the end of Key Stage 2. There were concerns at the school about JSH's aggressive behaviour and his inability to control his temper. The Head teacher advised JSH's mother that he would be expected to behave and that aggressive behaviour would not be tolerated. It was acknowledged that JSH was a keen rugby player and that he would have the opportunity to develop this interest at Primary School 2. It was agreed that JSH would benefit from a 'fresh start' and that he should attend Primary School 2 with continued support from BEST.

The Deputy Head teacher at Primary School 2 noted that the transition was a success and JSH settled into life at the school. He responded well to the school's positive behaviour strategies. BEST soon closed and he enjoyed a very productive and positive end to his Primary education with no major incidents recorded. He developed a good relationship with senior leaders and his class teacher. He had received extra support for his SATs and achieved good results, all of which were above age-related expectations.

To manage his transition to secondary education, transition meetings were held between staff at Primary School 2 and the Learning Mentor at High School 1 during the Summer Term of 2007.

SSL1 recounted that JSH started at High School 1 in year 7. JSH was described as a happy-go-lucky, smart and intelligent lad, who was in the top sets. It felt that he should have gone to achieve at least 5 A-Cs. There were no recorded incidents of bad behaviour throughout year 7. The first incident was in term 3 of year 8. Things started going wrong in year 9 and from then on things gradually got worse.

JSH became known to the School Police Liaison Officer who had occasion to speak to him a number of times. The first significant involvement that she had with Child JSH was when she received a report that he was being bullied by children from another school out of the area. On investigation it appeared that this allegation 'went two ways' with all three children being involved in aggression towards each other.

Around this time Child JSH's maternal grandmother passed away, he had apparently been close to her and it was presumed that her death would have an impact upon him. SSL1 did speak to him after his return to school following grandmother's death to check whether he needed any support. Child JSH said that he was OK and that he was coping.

During Year 9 at High School 1 Child JSH was involved in a very serious assault on another pupil. This took place in the sports changing rooms and was filmed by another pupil on his mobile phone. The incident was described as one in which Child JSH escalated what was a relatively minor dispute, where Child JSH was trying to take a ball away from the other pupil, to a situation in which Child JSH quickly became extremely violent towards the other pupil, punching and kicking him to the ground and causing bodily harm. The pupil who had been filming this incident began shouting at Child JSH to stop and eventually dropped the mobile phone.

The School Police Liaison Officer spoke to JSH about the incident however, as the victim of the assault and his parents decided to press charges, this was handed over to the police as a criminal matter for which Child JSH was prosecuted.

SSL1 noted that Child JSH had begun to develop a very bad reputation in the local community and that he was becoming 'out of control'. He was unable to control his temper and had a reputation amongst his peers as someone to avoid. JSHM was very supportive of school, although she felt that more could have been done to deal with Child JSH's anger management.

Following the serious incident, it was agreed that it would be in JSH's interests to put in place a managed move to High School 2.

2010

JSH transferred to High School 2 on 12th May 2010, at this time he was just over 14 years of age. According to the Head of Safeguarding (SSL2) at High School 2, JSH came with a poor reputation and a known history of violence and aggression.

SSL2 had been told that, on joining the school JSH had been heard to say that if she (SSL2) was 'fit' that he would have sex with her. It was the view of SSL2 that JSH felt himself to be superior to women and that he 'could have anyone he wanted'. SSL2 said that JSH was obsessed with sex; it was all he thought about.

He was reported as being intimidating to some members of the Female staff at the school, but others engaged well with him. His behaviour towards his female peers led to fights with boys at school, JSH was said to not to care whether he 'flirted' with someone else's girlfriend which caused arguments that erupted at school and in the community.

It was felt by SSL2 that Child JSH had learned his attitude and behaviour towards women from his father (although this is not substantiated by direct reports). At this time there was no evidence of any violence towards women or girls, however, there were a number of references in school discussions to domestic abuse in the family home, however, again this is not substantiated by records.

Child JSH was observed by SSL2 not to be a part of any friendship group and he was described as something of a 'loner'. He did have friends, but no-one who seemed permanent or committed to him. SSL2 observed that, on the whole, other students tended to avoid him if they could. He had a reputation as being a fighter, however the School Police Officer observed that he would sometimes step away from fights so that he didn't get into trouble at school, however, in doing this, he made it clear that this was a choice and not because he was afraid or intimidated by others who wanted to fight him.

Within a short time of joining High School 2 Child JSH was put on a pastoral plan and received behaviour improvement support. He was first placed in the inclusion base, which separated him from his class. However, he was then successfully integrated into class. There continued to be incidents of inappropriate behaviour and he was reported to be intimidating and aggressive towards some female staff.

SSL2 said, 'he did what his dad did, he idolised dad'. He said dad was good looking and could have any woman he wanted. Mum was considered a lesser being; he was violent with mum and smashed the house up. He did not create the best first impression.

SSL2 recalled, 'he did settle in a bit, he was with us until year 11. I was on maternity leave. Then High School 1 closed and High School 2 started. He could not make friends or relationships; we offered him a lot of support. We offered him counselling and other support, but he manipulated those sessions. He would claim bullying but when we looked into this it was usually because of arguments with other males. None of the lads wanted to be with him, he was very unpopular'.

On 30th September 2010 the School Police Officer received information that JSH had assaulted his mother and his younger brother in the car when they were on their way to school. The School Police Officer spoke to him about this, she recalls that he was unreasonable and refused to concede that this was unacceptable behaviour. The School Police Officer passed this on to the school safeguarding officer.

In October 2010 began a relationship with a fellow pupil. Child 1 appeared to be happy with JSH, although SSL2 recalls that she felt it to be an 'obsessive' relationship on the part of JSH.

The true nature of the relationship was not apparent until Child 1 decided to break off the relationship. (A later statement from Child 1, in which she said he had raped her when she was in Year 11 talked about him pretending to be overtaken by demons, he would stand and look vacantly at her, he would get onto all four and chase her, then when she cried he would stop and say he didn't remember).

2011

In October 2011, after a 12 month relationship, Child 1 decided she wanted to break up with him. He reacted badly to this and was known to be threatening and 'stalking' her both in person and via social media. He then began to threaten self-harm. Child 1's mother made the School Police Officer aware of this behaviour.

The School Police Officer reported that Child JSH kept harassing her, he approached her in school with a cut hand and said he had done it because of her, and that he had razor blades. Police came out to the incident. The officer attending the incident did not suspect any abuse of Child 1 and appeared to believe his convincing account of events.

School decided that a referral needed to be made in relation to Child JSH's behaviour but felt that it would not meet the threshold for CAMHS, therefore a referral was made to the family GP.

Child JSH attended an appointment with his GP and said that he was self-harming. The GP referred JSH to CAMHS in November 2011. CAMHS received the referral and on 2nd December tried to contact the family by phone, however JSHM was out of the house. CAMHS continued to try to contact JSHM contact was made again on 6th December, and an appointment was made for 12th December. JSH attended to see a clinician for initial assessment and background information. JSH said he had self-harmed on two occasions using a razor blade to cut his hands. He had no suicidal ideation but due to his behaviours, he was seen as an urgent referral.

The CAMHS assessment noted that Child JSH reported there had been significant domestic abuse in the family which JSH had witnessed. He also reported that his father was a heavy drinker, that his parents had separated and that his grandmother had recently died.

JSHM described two recent incidents when JSH had assaulted her and been aggressive toward his younger brother, on one occasion holding a knife to his brother's throat whilst he was under the influence of alcohol. JSHM said that JSH was beginning to take his father's place in terms of aggressive behaviour. JSH said that he used self-harming to control his feelings. He said that on one occasion his father had hit him with a belt.

The CAMHS clinician completing the assessment judged that there was no safeguarding risk to either Child JSH or his brother because of their ages (14 and 15 years).

CAMHS sent an outcome letter to the GP on 12th December, a risk assessment was completed and this would have been available to view by other clinicians. On 24th December Child JSH was discussed with the senior family therapist, documenting discussion and agreement that one to one sessions would be undertaken with Child JSH and his mother and JSHS. A comment was recorded that there was no evidence of risk to either Child JSH or JSHS.

2012

On 1st January 2012 CSC received a call from JSH's mother saying that he had smashed up the house It was recorded that JSH was going to move to his father's house, no further action was taken as father did not request support.

On 23rd April an appointment was made with CAMHS for JSH to see a second clinician, Child JSH did not attend and this was followed up with a non attendance letter. On 7th June another appointment was arranged but this was not attended. The GP was informed by letter of the non attendance. A clinician contacted JSHM to ascertain why they had not attended the appointments. JSHM's response was that the wait had been too long and that things had now settled down.

On 28th June another appointment was made which JSH did not attend. A letter was sent to JHSM asking her to contact the service within ten days and that if no contact was received then the case would be closed, a copy was sent to the GP. On 31st October a discharge letter was sent as there had been no contact.

High School 2 were continuing to manage JSH's disruptive behaviour via Behaviour Support Plans which involved the School Police Officer and school health, by that point JSH was at the end of year 11. They undertook a self esteem assessment which SSL2 described as being 'off the scale' i.e. very high. There was no offending behaviour at this time and JSHM

was coming into school regularly. There was no indication of any aggression towards JSHM.

We know the pathways, we know now that he was violent towards mum and Child 1 but Child 1 always presented as really happy at school, had we known maybe we could have intervened, but we didn't have the whole picture then. In terms of the community, CSO's would come into school but they didn't for JSH.

JSH left High School 2 in July 2012 having completed his schooling there.

On 25th July 2012 CSC were made aware that JSH was in police custody for an assault on his mother. JHSM had refused to pursue a complaint against JSH but would not allow him to return home. CSC referred the incident to Housing Options so that JSH could make an application as a homeless young person.

The YP Housing worker recalled that JSH came to the service on 25th July saying he was homeless she dealt with him and he was placed in a hostel. JSHF came in the following day; he was in a dispute with his partner who had told him that he had to make a choice between her and Child JSH. JSHF said he would be prepared to go into accommodation with JSH. A referral was made and they were accommodated in local housing, they were there for a month without any problems occurring and then JSHF got an offer of a house. They moved to the house together but things began to break down in the relationship. The YP housing worker noted that the relationship between JSH and his father was a very immature one; they presented more like friends, fooling around, his father behaving in an immature manner rather than taking any responsibility for the situation. She noted that JSH and JSHF were very alike in their behaviour.

In August 2012 Child JSH attended the Walk In Centre; he had reportedly had a fight in a park. He alleged he had been head-butted and his brace had cut his lip, he was advised to contact the orthodontist and he said he would pursue this. He said he had been fighting with a peer. Although JSH would have left school by this time, the school nurse was notified.

Child JSH started a course at a local College in September 2012, during the first half of the term he was living with JSHF. JSH went to the college with what was described as a fresh sheet. They had no information about his past. There was some hearsay with some parents asking 'what is he doing at a nice college like this'.

His personal tutor (CT1) described his first few months in college as being difficult. JSH was in court on 2nd October 2012 for Class C possession and possessing a hammer. Life did get very difficult for him. There was a serious fight with his dad and he was then back with his Mum.

On 2nd October JSH attended St Helens Youth Court and was made subject to a 3 month Referral Order for possession of an offensive weapon and possession of a Class C drug. The case was allocated to a student at YOS. YOS look in the file and then screen it for the interventions that are required. The main purpose of the screen is to identify vulnerability and risk of serious harm. So then the case manager takes over. JSH was re-allocated to YW1. A Platform 51 (counselling service) referral had been made whilst JSH was open to the YOS prevention team. He had completed some reparation as part of the triage and had done a letter of apology that the victim worker had processed. I enquired to find out who the victim was. On 15th October I rang our Police Officer to find out about the assault charges. Offence in 2011 was against mum but she had decided not to press charges.

The Probation Officer remembered Child JSH coming in for the first meeting which she said was a very tense interview. JSH attended with his father, the interview lasted for an hour and a half. The relationship was evidently tense, bickering between the two of them. When JSH said something his dad would chip in, it wasn't good. A lot of blame, a lot of threats about whose fault it was, a very tense, very awkward interview. It left me on edge, I felt uncomfortable being with them. On 31st October I rang Child JSH to see how things had been between them (I'd been on annual leave).

JSH informed YW1 that he and his dad had two fights and his dad had wished him dead. He was living with his mum again at this time. I asked him how they had been; he added that things turn nasty when they fought. I asked him how things were with his mum and he said great. I told him I wanted more info for his report to the community panel overseeing his Order; he was fine with this and that he and his mum would attend to see me before college tomorrow.

His behaviour in college had escalated during October, on the 12th October; he was inappropriate, challenging and agitated in a lesson. It was late in December by the time he got onto a contract (disciplinary). In class he squared up to a female student, according to CT1 'this girl was a feisty girl, very pretty, he was flirting, she was having none of it'. I had to pull them apart, he was very angry and so was she. This led to further tensions between JSH and his peers.

CT1 met JSHM in early November and she was doing her best to support her. JSH appeared 'meek' on that day and he said he would do better.

October 2012 appears to be a critical month for Child JSH – he was sentenced to a referral order, had his first contact with YOS, presented to the Walk In Centre with injuries sustained in an altercation with his father (which was also recorded on ICS and was discharged from CAMHS). At least five agencies were aware of JSH at this time but none of them thought to call a multi-agency meeting!

He came into walk in centre again in October with his mum; he had a hand injury and a bite to left side of his chest and soft tissue injury to his face. It was advised that he had had a fight with his father with whom he lives. They were advised the need for the nurse to speak to social services with whom they had previous contact but no input at present.

He was x-rayed and reviewed, the fight had taken place at 2.30 that day, he was cooking chicken when his dad kicked off, stated his dad grabbed him, punched him to the ground and bit him. He denied any alcohol involvement but said his dad smokes a lot of cannabis. No head injury or loss of consciousness, pain to right hand since. He spoke to his mum and 15 year old brother after the incident and will be staying there.

He had superficial wounds to his face and a superficial break to his skin on his chest, small superficial wounds to his hands. The notes say social services informed, Child JSH to go home with his mum, mum was not too concerned about further danger from his dad. Police were not informed, advise social services and contact them later for further information.

Spoke to the Social Worker at 7.20 and referral was sent across at that point. That episode of care was then concluded, the letter was sent to GP and there was no further involvement.

On 25th October 2012, CSC received an out of hours contact from Walk in Centre saying that Child JSH and had attended having had an altercation with his father. JSH presented with his mother, he had sustained a hand injury, swelling and pain and a bite to the right side of

his chest and soft tissue injury to the face, also an older bite mark from a previous altercation on 22nd October.

On 26th October 2012 undertook a home visit, according to the conversation with practitioners 'based on the contact 25th October 12 it progresses CP and there is a record of a strategy discussion which is when 'practitioner' would come in, and an initial assessment was completed by a practitioner'. There is a core assessment because it has been S47, so from 25th October, CP initiated, S47 and then closes on 28th January 2014.

During November 2012 JSH and his mother attended appointments with the YOS and a referral was completed by YW1 to the counselling service for counselling support for JSH. JSH informed YW1 that he and his dad had two fights and his dad had wished him dead. He was with his mum. I asked him how they had been; he added that things turn nasty when they fought. I asked him how things were with his mum and he said great. I told him I wanted more info for his report to panel, JSH was fine with this and that he and his mum would attend to see me before college the following day.

On 12th I phoned mum and she said everything was OK. They hadn't attended initial panel, she said she didn't know anything about it (a text message had been sent on the 1st).

On 10th December JSH attended the YOS for a rearranged health assessment at which no outstanding health needs were identified.

In general JSH was reflective, he complied with his order, his P51 worker and YW1 went to see him in Haydock to make sure he got to the office. They tried to make it easier for him to comply with the order which is something they would normally do.

2013

In January another incident occurred whilst JSH was at college, it happened off site, at the rugby club which is nearby. There was an incident like the one in the classroom but it escalated, he got hit over the head with a chair. He bit a girl and another student hit him. In the final exclusion meeting the senior tutor said she felt quite threatened and saying that staff were to be aware should he try to come back on site, there was a concern.

On 15th January JSH attended his first appointment with the counsellor at Changing Lives (previously Platform 51). Having received the referral the counsellor contacted JSH within the next 24 hours to see him.

It was mentioned in the referral from YOS that there had been some DV towards mum from CHILD JSH, he was assaulted by his father following an altercation and went to live with mum, he had received treatment for cuts and bruises. His relationship with mum was strained and he had been violent towards her, he had been subject to bullying at school.

The appointment was made to see him at college. He was very receptive, he engaged from day 1, from the first session he was very open and honest. Usually the first session is about getting to know each other but he disclosed from the first session. That may be because he wanted to get things off his chest. If he didn't want the service then we wouldn't see him, it has to be voluntary. He was on a referral order but he didn't have to receive the counselling. Very often referrers will say 'they have to engage' but it won't work if that's the case, so we would go back to referrers in that case and renegotiate. He needs to want to do it otherwise we wouldn't continue.

CS1 was quite struck by how groomed he was, very smart, affable and friendly, he appeared quite confident at first. He began engaging immediately, the relationship was formed right

away. He didn't appear to be in low mood, but as the session progressed, he disclosed things. It became clear that he was experiencing some difficulties; he started talking about DV (physical abuse) from his father in his childhood. CS1 believed that was a major issue; he said he had experienced exposure to quite severe violence from his father from an early age (around age 7). In the counsellor's view it is unusual for someone to start speaking about things at such an early stage in the counselling relationship.

At first CS1 thought they would only need six sessions, she then thought as we went on that they may need more. At that point it was mainly about his childhood and the DV which was a huge aspect of Child JSH's problems. CS1 saw him six or seven times and spoke to him on the phone when he couldn't attend. One was when his grandmother passed away and she spent some time on the phone with him.

On 6th February 2013 JSH presented at Accident and Emergency accompanied by his mother. He said he had been assaulted some by youths following an incident on Facebook. He was 16 years old at this time. He was asked about appropriate adult and about whether information was shared with the school nurse. JSH was treated more as an adult than a child and no safeguarding issues were raised.

Two months later JSH presented again to A&E on 1st April, so he was still technically at school then. He had been assaulted by a gang and said he had taken a small amount of alcohol. No safeguarding questions were asked and JSH was treated and discharged.

JSH was still attending counselling sessions, CS1 saw him about 9 times in all. According to CS1 he wanted to engage so much that the counsellor 'moved everywhere' to find him. YOS worked with Changing Lives on ensuring they saw him. He was seen in college, then in the YOS office, Haydock Library, then he moved to Sherdley House and the counsellor went there. This wouldn't normally happen but the counsellor felt he was so willing to engage and needed support because of what was happening in his life at the time.

On 23rd October JSH was arrested for S47 assault

On 16th November police stopped Child JSH on Blackbrook Road at 0030 hours; they were concerned for his welfare. An officer spoke to JSH who said that he lived with his father and that because there was no money he (JSH) had not eaten for two days.

On 23rd November JSH was arrested for sexual assault and offences relating to indecent images of a child alleged to have occurred on 23rd November. The victim, in a public open space, whilst incapacitated through drink, her lower garments had been pulled down and photographs taken of bottom and genitalia. The victim was then urinated on. She was made aware what had happened to her when photographs of herself were sent to her via Facebook by a concerned acquaintance who had seen the pictures published on closed groups in Facebook.

JSH was bailed until 3rd April 2014 with conditions. A referral was made to CSC.

YOS made a referral to CAMHS on 28th November. A YOS worker had acted as appropriate adult although JSH was not, at that time, an open case to YOS. The referral mentioned self harm and thoughts of hanging. The referral was picked up the same day and discussed with YOS. No current risks were identified a letter was sent on 12th December for an appointment on 14th December.

JSH did not attend for the appointment with CAMHS on 14th December (presumably because he was in custody), this was a Saturday clinic and other services do not work on Saturday so no-one could be contacted regarding the DNA. No numbers for family were on

the referrals, therefore no one was contacted. This was not handed over or followed up on the Monday. A DNA letter was requested but was never sent due to administrative workloads.

On 13th December JSH was arrested for affray and an appropriate adult was requested to attend the police station where he was held. The appropriate adult was a worker was from the EDT.

On 14th December JSH was brought to A&E by the police, he was in custody and he had been fighting in the street. There was another mention of alcohol but again this was not explored. He was properly triaged but safeguarding questions were not asked, he was not asked who he lived with for example. The staff may have assumed that he was being 'looked after' because he was with the police. JSH had an appointment with CAMHS on this day but he did not attend (this was probably due to him being in custody).

On 16th December CSC received a referral regarding the above incident. SW3 picked up the case but it is not clear from the ICS record what action was taken. CSC knew the girl who was the victim in the sexual assault; they commented that she had an alcohol problem. SW3 tried to contact JSH and his father. A number of home visits were conducted but nobody was home. SW3 also tried to speak to JSH at his work placement but they were reluctant to pass on any information about him. SW3 asked the work placement manager to leave her number with JSH and to ask him to call her.

Eventually SW3 found JSH's father at home. The house was freezing cold. They asked whether JSHF was aware of concerns about JSH but he didn't want to know, he was only concerned with himself he kept saying 'what about me, I'm depressed and down'. They wanted to discuss JSH; he said that the police had taken the computer and phones. He was told that JSH had been stopped and had no money and no food. He said there was no food in the house because friends had helped him out, but that there was no money for heating. JSHF complained that his benefits were messed up but he didn't have the motivation to sort things out. He said he didn't care about JSH, he didn't know where he was and then he became tearful (about his own situation rather than about JSH). He said he wanted to kill himself. SW3 phoned the doctor and asked for an emergency appointment but he did not attend. Further attempts were made to see JSH and CSC then received information that JSH had been arrested for an assault. Another home visit was made and JSHF said he hadn't seen JSH for a few days because he'd been in hospital after someone had hit him with a golf club. JSH had in fact been in custody, not in hospital.

A strategy meeting was called for 20th December. The meeting was chaired by SWM1. There was agreement that there were concerns and that the family are not engaging in efforts to conduct a core assessment. The sexual offences were being investigated and JSH was on bail until April.

On 24th December police were contacted regarding a disclosure from a child regarding JSH. The alleged Victim was 10yrs old but would have been slightly younger at the time of the alleged incident. The victim's mothers contacted the police after her daughter told her that JSH had shown her his penis. This was disclosed after the child heard a song on the radio which reminded her of the day it happened. This is historic and happened between February 2012 and June 2012. JSH used to live with mum's sister during this short period. He no longer lives there and the child has no contact with him. No further action was taken in regard to this allegation due to a lack of evidence and the child's mother not wanting to pursue the matter.

The police record says 'The offence is SX03043 - Engage in sexual activity child aged under 13, offender aged under 18 years. At this time, we have no evidence of what happened on this day. The child does not wish to speak to us and her mother is not co-operating with the police and will not allow a video interview to take place. There are no witnesses and details are very brief. This happened approximately two years ago. There is no forensic evidence'. This matter can be filed as undetected pending any further evidence coming to light. An email was sent to the contact centre to inform them of the incident.

On 31st December JSH was arrested and charged with S18 wounding. JSH had been at a house party and was involved in an altercation with another male who was struck in the face with a herb cutter receiving lacerations to his face.

2014

Police took JSH to Accident and Emergency on 2nd January he had a hand injury that he had sustained two days ago during an altercation. He was given an x-ray but no fracture was seen and he was discharged.

On 2nd January JSH was arrested YW1 attended as appropriate adult. JSH wasn't very responsive, he discussed self harm, he said he had continued to feel low in mood, he said he wanted to commit suicide, he said he had received a CAMHS appointment and that he wanted to engage with either CAMHS or the counselling service and said he would like YOS to follow this up.

The interview hadn't gone well as the evidence was stacked against him. His perception was that it had gone really well, but it clearly hadn't. He was re-arrested on another matter before he left the police station, S18 wounding, he was worried about that, he was put back into the cells – the YOS worker was anxious at that point and he was put in a camera cell to be monitored at the YOS worker's request.

That referral was based on the sexual offences and YOS had attended a strategy meeting that was called by social care (20th December). YOS have an agreement that we will be invited to all strategy meetings and would make a decision based on our knowledge even thought JSH was not an open case to YOS at this time.

YM1 I contacted the custody suite after the AA involvement but at that stage there were a number of offences stacking up in quick succession. YM1 then sent a lengthy email to the Director and Assistant Director saying things weren't looking good in relation to his vulnerability and his risk to others.

YM1 asked for another meeting to be pulled together, unfortunately, that was 3rd January which was very close to the incident. On 6th January YM1 had a discussion with the Director of Children's Social Care who agreed that a meeting should be put in place as soon as possible.

On 6th Jan SWM1 arranged a meeting to include a number of professionals, including the MAPPA coordinator. This was not a MAPPA meeting but was a precursor. As the Coordinator could not attend on *8th January the meeting was rearranged to 10th January.*

On 10th January a professionals meeting was held to discuss JSH, the meeting was attended by Police, Health, Children's Social Care, YPDAAT and YOS. CAMHS had been invited but did not attend.

The meeting heard that social care were in the process of completing a core assessment that a CAMHS referral had been made but JSH had not engaged. It was noted that JSH

may be drinking alcohol in connection with his offending. The relationship between JSH and his father was discussed, including the presentation at the walk in centre with bite marks.

A MAPPA meeting was arranged for 31st January.

On 17th January JSH was found at Address 1 by his father. He was suspended by a ligature and was lifeless. He was pronounced dead by paramedics at the scene.