and

Gloucestershire Safeguarding Children Partnership

Child Safeguarding Practice Review

Ash

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1 INTRODUCTION

1.1 This case review was commissioned following the death of Ash who took his own life in 2021 at the age of 17[1]. At the time of his death Ash lived with his father and father's partner in Surrey and Ash had been found by his father unresponsive in the garden of the family home. Following Ash's death, a police search of his room found a quantity of unprescribed drugs, prescribed medication, his mobile phone, a "burner phone"[2] and a BB gun. This raised concerns that Ash was involved in criminal activity.

1.2 Ash's parents separated when he was age eight and until 2018 he lived with his mother in Gloucestershire. Gloucestershire children's social care and police had known Ash due to concerns about criminal exploitation and the local authority were also informed in 2018 that he was to be educated at home. After moving to Surrey, children's social care received three contacts due to concerns about exploitation, gang affiliation and possible county lines activity.

1.3 Surrey Safeguarding Children Partnership carried out a Rapid Review into Ash's death which identified the previous involvement of services in Gloucestershire. It was decided that, due to the concerns about criminal exploitation, a Local Child Safeguarding Practice Review should take place in order to explore and identify any potential improvements for the safeguarding system.

The Review Process

1.4 An independent reviewer worked with a review team comprising senior professionals from the organisations in Surrey and Gloucestershire who had been involved with Ash. The terms of reference[3] setting out key issues to be explored during the review were agreed. These stipulated that the period of the review would be from March 2018 until Ash's death in May 2021.

1.5 The independent reviewer met with members of Ash's family and reviewed documentation from all involved agencies. Chronologies and information reports were received from:

- Gloucestershire Youth Support Team
- Surrey Police
- GP (Gloucestershire)
- Named Doctor (Surrey Primary Care)
- Surrey Children's Services
- Gloucestershire Children's Services and Elective Home Education Team

[1] The cause of death as suicide was officially recorded at an inquest.
[2] A prepaid cell phone that can be discarded at any point in time, and often used to conceal a person's identity or purpose of use
[3] See Appendix Two

- School (Gloucestershire)
- Child Death Review Team (Surrey)

1.6 The lead reviewer also spoke to practitioners via a virtual learning event.

1.7 Following production of a draft report it was agreed by both partnerships that a second lead reviewer should be appointed to produce this final report.[4] This has resulted in delay in the review process.

1.8 Ash's parents were offered the opportunity to meet with the second lead reviewer but did not feel able to do so. This report has therefore relied on notes from the original discussions which inevitably cannot provide such a deep level of understanding as can be obtained from face to face discussions.

2 FAMILY BACKGROUND

2.1 Ash is the younger of two siblings and is described by his family as a happy young boy, loved by everyone and loving and caring towards others. He was able to do well at school, enjoyed sport and joined local rugby and football clubs. Although he lacked self-confidence, he would always "give things a go" with the right support behind him.

2.2 After his parent's separation Ash remained living with his mother and sibling in Gloucestershire. There are reports that the children had lived in an environment where there were significant arguments and acrimony between the adults. There were disagreements about the type of education (private or state) that the siblings should receive, and they changed school on at least five occasions. They also moved house seven times before their parents separated. The review has been told that Ash sent a text to his maternal grandmother asking how to make friends and she felt he became a lonely child who would latch onto people who showed him interest or friendship.

2.3 Father would see the children infrequently as he was often working and travelling abroad. From information provided to this review it is clear that significant parental acrimony continued after the separation, with Ash caught in the middle of parental disputes. The parents did try mediation but this failed with both believing the other did not follow recommendations to work together for the sake of the children. A decision to start divorce proceedings was made in 2018 and the parents finally divorced in 2020.

[4] See Appendix One for a short biography of the second lead reviewer.

3 ASH'S LIFE – A CASE SUMMARY

Ash's time in Gloucestershire up to the age of 14

3.1 Family information provided for this review identifies a significant event for Ash prior to the start of the timeframe for this review. Ash was in year six at primary school and told his mother that he had been sexually abused by one of his friends on an overnight stay. This incident was not reported to the police or children's social care but it prompted Mother to immediately remove him from the school and enrol him at the private school where she worked. He received counselling at the school and is reported to have settled in and done well.

3.2 Ash moved to the local secondary school in year eight. His mother was once more a member of staff. His alleged abuser was also a pupil, although no action could be taken by the school to keep them in separate classes as they were unaware of the allegation.

3.3 Mother was told by the head teacher in February 2017 that Ash had been found with cigarettes in his bag. She was then called in again by the headteacher to be informed that he had bought cannabis from another pupil and this incident prompted a referral to the police. There were additional concerns that he was beginning to associate with other young people known for anti-social behaviour as he had been referred by the police with two other young people for an out of court disposal (diversion work) following a theft from a motor vehicle.

3.4 A child exploitation screening tool was completed by the school which noted that he had contacts in London via social media as well as concerning local associates and he was found to be at mild risk of exploitation. This was followed by a brief social work assessment which concluded that Ash was remorseful and that his mother could meet his needs. Police information gathered after Ash's death notes that this assessment recorded a conversation with Mother where she commented on "historical sexual abuse" but without any specific details. Ash's father was not contacted and there is no evidence that this assessment explored in sufficient detail the risk of criminal exploitation and the root causes of his behaviour including consideration of the impact of parental separation.

3.5 Ash's mother describes him as responding to her positively after this episode and he joined the local army cadets. His behaviour later began to deteriorate and he became increasingly rude and argumentative. His mother did not know how to prevent him from meeting up with the young people he had become involved with and his father suggested that Ash should be removed from school, to be educated at home. According to Ash's mother she was opposed to home schooling but agreed with the plan as Ash had said that he would like to try living with his father. She did not understand this arrangement to be permanent.

The start of elective home education and Ash's move to Surrey

3.6 Ash's school received a letter from both parents in September 2018 to inform them that Ash was to be removed from school and educated at home. His father would be taking responsibility for Ash's education and that Ash may spend time abroad with his father whilst he worked. As far as the school were aware his father was still living in Gloucestershire. As would be expected practice the school informed Gloucestershire local authority that Ash was to be educated at home and included information about the previous incident involving drugs. A member of the Gloucestershire elective home education team spoke to Mother over the telephone as she explained that Ash's time would be split 50/50 between Mother and Father. There was no indication that Father had moved to Surrey although it now seems that he had moved and Ash would be staying with his father and his father's partner in the Surrey area.

3.7 Although there is no requirement for parents to engage with the local authority, there is an opportunity when the child is removed to consider any vulnerabilities, offer support and take steps to establish that the child is safe and receiving a suitable education. In this case the school did not raise any current concerns and contact with the parents indicated that Ash would be provided with a suitable education via a tutor. The issue of elective home education is discussed further in Finding Four.

3.8 Information from Ash's father and partner explains that the decision to electively home educate was based partly on the fact that Father would be travelling extensively for work and it would be best for Ash to travel with him and receive on line tutoring rather than go to boarding school. Ash had also told his father and father's partner that he had never had a positive experience at school and did not want to re-engage with schools. His preference was for an alternative education programme. A tutor was appointed and Ash travelled abroad with his father. Mother has told the review that she was not happy with this arrangement as she believed that Ash was spending a lot of time unsupervised in hotel rooms on his own.

3.9 There are differing views between the parents as to whether Ash was receiving an appropriate level of education during this time. Whilst Father believes Ash's education was sufficient, Mother has explained that she was very unhappy that he was only doing two GCSEs and she had no information about the tutor and felt powerless to do anything about it. Although Gloucestershire EHE team did make telephone contact with the parents they were not given the full facts about Ash's circumstances and the education being provided. Their belief was that Ash was residing in Gloucestershire.

Assessing accumulating concerns about criminal exploitation in Surrey and diagnosis of ADHD

3.10 In October 2019, Ash age 15 was the victim of what appeared to be a 'random attack' robbery in Surrey where the unidentified perpetrator punched him in the face and stole money. Ash was seen at a Surrey urgent treatment centre. The notes record a facial injury after being attacked by a stranger who punched him and demanded cash. His father is noted to have tried to report the crime via 101 but could not get through so planned to report via the website. Surrey police then investigated and

recorded no evidence that the incident was linked to any other criminal behaviour or activities on this occasion.

3.11 Father describes Ash as beginning to be out of control from this time onwards and that he believed that the incident which resulted in the attack related to a drug deal that had gone wrong; although Surrey police were not aware that this was father's concern at the time. The issue of how to work in situations where families do not wish to share information with statutory services is explored in Finding One.

3.12 Ash visited his mother in Gloucestershire from time to time. He had remained registered with a Gloucestershire GP and was seen by a GP in Gloucestershire in November 2019. The records note that his life was complicated, he had been involved in drug/alcohol use and spent time between his mother in Gloucestershire and father in Surrey. The GP discussed the possibility of local support. Ash did not attend a follow up GP appointment and returned to Surrey.

3.13 In February 2020, his father has described Ash as disappearing for three days but used someone else's mobile phone to report that he was safe. Father and his partner continued to struggle to cope with Ash and arranged an appointment with a private paediatrician specialising in neurodisability. He was seen in February 2020, diagnosed with ADHD with an added impairment in the domains of learning, academic, social skills and accessing leisure activities. ADHD assessments should be based on information from all significant people including parents and schools but Ash's mother was not spoken to and information was not gathered from his previous school or his current tutor or his GP.

3.14 Ash was prescribed medication privately by the paediatrician, who also dispensed the medication at the request of Father rather than entering into a shared care agreement with the GP[5]. Father's view was that it would allay Ash's fears that notifying his GP could have a detrimental effect when he tried to enter the Army. The paediatrician did discuss with Father the option of a shared care arrangement and offered to send the documentation to Ash's GP but did not receive the GP the details from Father and did not follow up with sufficient tenacity to ensure that the details were received. The lack of GP details also meant that no letter was sent to the GP informing them of the outcome of the assessment as would be expected practice.

3.15 The significance of this for Ash was that he was receiving a controlled drug which had known side effects with no effective follow up other than a request that the family make an appointment in three months.

3.16 In early March 2020, Father's partner contacted Surrey children's services via e-mail to relay concerns about Ash and his friends, saying that he was engaged with drug use, gangs and potentially county lines. There was reference to Ash's friends not being in education although no information as whether this applied to Ash. Father's partner was identified as a mental health professional working with young people and there

[5] There are enquiries outside this learning review to establish whether the paediatrician had dispensing rights.

seems to have been some uncertainty whether she was making contact in a professional or personal capacity. Whatever the basis for the contact this should not have detracted from the information and concerns. There was further follow up e-mail correspondence with father's partner asking for more information, family contact details and querying whether her concerns had been reported to the police.

3.17 Four days later a second contact was opened (in error) and there was a further e-mail to father's partner asking questions designed to understand the risks. The detailed response included several concerns about his behaviour including smoking 'weed' and using alcohol; staying out late; stealing; lying and being manipulative; conflict with potential rival gang members who were older which had resulted in Ash being physically assaulted. In addition, Ash was described as a vulnerable young person, who was influenced and "obsessed with obeying the boys in the gangs' demands."

3.18 The social worker appropriately identified that there was a need for targeted multi-agency help and statutory intervention might be required. However, the Surrey 'Levels of Need'[6] policy was then not followed as there was no multiagency partnership enquiry (MAPE) which would have included early information gathering and a decision as to whether Ash's situation should be referred to specialist services who could consider whether a strategy discussion should be convened. In fact, two telephone calls were made to Father and as he did not respond the contact was closed eight days after the original referral. This decision was agreed by the manager without any challenge as to whether more should be done to engage with Father, and there was no identification of the requirement to contact the police and convene a strategy discussion.

3.19 All of the information gathering at this point was carried out via e-mail and the impact of this on engaging with young people and their families through developing trusted relationships is explored in Findings One and Two of this report.

3.20 There were then two incidents within the space of nine days which raised concerns about the family. A 'dropped' 999 call from father's partner to the police was followed up as there had been sounds of an altercation in the background and someone demanding to know who she was calling. No further action was taken as father's partner explained this was as a result of her telling youths in a social club to stop smoking cannabis and when the police spoke to them there was no evidence of drug activity.

3.21 Three days after this incident father's partner again contacted Surrey police and raised concerns that Ash was being exploited by youths at the club. She described Ash as exhibiting 'suspicious behaviour' at home receiving text messages; immediately collecting 'items' from his bedroom; leaving the house, often without his father's permission for periods up to 24 hours. Ash was subsequently followed by two unknown males to his home address. They spoke to his father asking for Ash, stating

[6] https://www.surreyscp.org.uk/about-us/local-safeguarding-arrangements/effective-family-resilience-levels-of need/

he owed them £350 for 'clothes' sold by him on their behalf. Ash admitted to his father that he had been supplied 20 ounces of cannabis but had given it away, now owed the money and was frightened of the individuals concerned.

3.22 When the police followed up this call, Father told the police that Ash was staying with his mother in Gloucestershire where he had gone to after the incident and that the current arrangement would remain in place for the foreseeable future. Surrey Police suggested that a welfare check should be carried out by police in Gloucestershire but Father said he did not want police attendance as the relationship between Ash and his mother was fragile and he believed a visit would make matters worse. Father gave assurances that his son was safeguarded in Gloucestershire and had no concerns.

3.23 Father has told the review that he subsequently met the two individuals at a local railway station and paid them the money. He warned them that his son was no longer in the area and if they attempted to demand money again, he would go straight to the police. They never returned. After this incident Father, his partner and Ash moved to a different area within Surrey.

3.24 Following the referral by Father, Surrey police completed a SCARF/child come to notice form and shared this with Surrey children's services. The circumstances were also referred to Surrey's Child Exploitation & Missing Unit (CEMU) for specialist review. Their findings were that there was no evidence of exploitation. However the police officers making this assessment were not aware of the information relayed to Surrey children's services in the referral from Father's partner earlier in March. As a result the consequences of children's services not contacting the police at that point had a negative impact on this later police assessment.

Return to Gloucestershire and child and family assessment

3.25 The police notification was passed from Surrey to Gloucestershire children's social care. This prompted contact with Ash's mother who told the Gloucestershire social worker that she knew Ash had previously been in a fight and believed this may have been linked to criminal exploitation. Mother reported that Ash's behaviour deteriorated considerably when he moved to Surrey, his friendship group were all older than him; he was going to the pub and buying alcohol from local shops. She felt her concerns were ignored by Father and Ash.

3.26 A request for information was made from Gloucestershire children's social care to Surrey. A single assessment started in Gloucestershire and a social worker met with Ash on three occasions, twice in April and once in June 2020. This assessment took place during the early stages of the first Covid-19 lockdown and the first visit was at Mother's home and two further 'visits' to ASH were completed virtually. Ash was forthcoming and talkative with the social worker, with good evidence of his voice being recorded.

3.27 He spoke positively and said that he wanted to put the 'incident' behind him. He referred to his 'drug debt' and said that it was paid off and that he did not have any further contact from the two males who had previously come to his father's home. He

spoke about his future, his ambition to do an apprenticeship and join the military. He spoke openly about his cannabis use and described it as recreational and referenced having ADHD and described how cannabis helped him to sleep. Ash's mother spoke of her plans to move abroad for work in due course. Ash's mother has told the review that he admitted to her he had been dealing drugs and spent a lot of times at various houses in a drug induced state, to the point where he could not move.

3.28 Significantly this assessment did not gather any information about Ash's education and therefore Gloucestershire elective home education service remained unaware that Ash had been spending time living out of the county in Surrey

3.29 Prior to the completion of the assessment, the social worker found out that Ash had returned to his father's home in Surrey and the final meeting with ASH was held via video link. Ash seemed positive and happy at this time. The assessment focused on substance misuse risk rather than risk of criminal exploitation and the social worker signposted Ash's parents to a local young people's substance misuse service in Surrey. The recommendation was that there was no further action for Gloucestershire children's social care as Ash was no longer resident in the Gloucestershire area. As the assessment had not explored his involvement in elective home education the opportunity was missed to pass information from Gloucestershire elective home education service to Surrey

3.30 At the end of year 11, the Prospects NEET[7] team in Gloucestershire are responsible for contacting all young people to discuss their post 16 education plans. In September 2020, Prospects record a contact with Ash's mother stating that he was remaining electively home educated and was planning to attend college in Gloucestershire September 2021. As his parents did not consent to home visits all information was gathered through telephone and email contact. Gloucestershire Prospects record they were satisfied that Ash was receiving a suitable education, although there are no details as to what this involved.

Event's leading up to Ash's suicide

3.31 In early 2021 Ash's mother was planning to move to live abroad in the country of her birth. She has told this review that Ash was apparently very keen to visit her when she had settled into her new job as he suggested this in a card that he gave her just prior to when she left the UK. Both her sons could have obtained citizenship of the country she was moving to and the necessary documents for their application was completed before she left the country. This was not followed up. Once his mother had left, Ash refused to respond to any of her calls or texts.

3.32 In April 2021, as his mother had de-registered from the Gloucestershire GP due to her move abroad. Ash then registered with a Surrey GP although he did not access any GP services in Surrey prior to his death.

[7] Young People not in Education Employment or Training

3.33 On the 1st of May 2021, Ash was at his home address with his father and father's partner. The following morning Ash's father discovered Ash unresponsive in the garden and Father's partner attempted to give him CPR without success. South East Coast Ambulance Service attended at when the police arrived they commenced an investigation into Ash's death.

3.34 No suicide note was found but under Ash's bed inside a bag police located a silver-coloured handgun style firearm with black tape wrapped around the grip. This was confirmed to be a BB gun and not a viable firearm. Along with this, officers found a 'burner' mobile phone within the bag. A quantity of unlabelled unprescribed controlled medication was also located along with his prescribed ADHD medication.

3.35 An examination of Ash's mobile phone did not find any activity of note. There were two searches dated on the 21st of January 2021 asking, "Do opioids dissolve" and "Can you mix tramadol and codeine." These were not followed by any searches relating to suicide.

3.36 Later toxicology results received showed no drugs or drugs metabolites in Ash's system but detected a quantity of alcohol at a level consistent with drunkenness and possible impaired judgement, decision making skills and reduced inhibitions.

3.37 The Senior Investigating Officer (SIO) determined that the most likely cause of death appeared to be suicide and this was confirmed at a subsequent inquest.

4 SUMMARY OF FINDINGS

4.1 Reviews of suicide in young people have found an increased prevalence amongst young males who are likely to have a history of substance abuse alongside other cumulative risks that are present at the point that a young person takes their own life.[8] [9]

4.2 This picture chimes with thematic reviews of adolescent suicide by Surrey Safeguarding Children Partnership, with the notable difference that the Surrey reviews do not specify substance misuse as a factor. A local review of 12 suicides from 2014-20 did identify an increased prevalence in young males, a diagnosis of ADHD and a cluster of adverse childhood experiences alongside a recent stressful trigger – all of which are relevant to Ash. A similar picture emerged when this review was updated in 2021 to include a total of 17 young people. There is an ongoing action plan which includes a three year review of what has been achieved and this

[8] Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017. http://documents.manchester.ac.uk/display.aspx?DocID=37566

[9] Royal College of Paediatrics and Child Health (2020) *State of Child Health*. London: RCPCH. [Available at: stateofchildhealth.rcpch.ac.uk]

includes much proactive work within Surrey schools. Sadly this was not available to Ash as he was not in education in the months preceding his death.

4.3 The accumulation of risks identified in national and local research means that practitioners need to move beyond an incident focused approach to a holistic assessment of risks and protective factors. This will necessarily involve a multi-agency/multi professional approach to understanding what is happening and how best to respond.

4.4 The impression from all the information gathered for this review is that the number of stressors affecting Ash had stacked up at the time he took his own life. He had experienced trauma as a result of sexual abuse as a child, he had described being bullied at school and had been caught up in an extremely acrimonious parental separation. These risks were not mitigated by positive peer relationships, a good experience at school and it now seems that his needs associated with neurodiversity had not been known or addressed via the education system. His diagnosis of ADHD and prescribed medication was also not known to community health services including his GP. By the time he died he had few of the protective factors that help young people to cope with risk and adversity[10]. This left him vulnerable to exploitation and substance misuse.

4.5 Specific aspects of the safeguarding system are discussed in section five below and recommendations made for practice improvement:

- Much of Ash's day to day lived experience was not known or understood by statutory agencies. Families and young people may not choose to share details of their lives for a variety of reasons and practitioners need to be alert to this and consider how this may affect their day to day practice. This is explored in Finding One.
- Ash's known behaviours were not always understood in relation to past trauma and present challenges and risks. Assessments did not take account of all the information that was known about Ash's life, both in the past and present. This is explored in Finding Two.
- Children and young people may have medical or psychological assessments in the private sector. Where this occurs it is important that the information is available to practitioners who are required to carry out statutory assessments aimed at ensuring wellbeing and keeping a child safe from harm. This is explored in Finding Three.
- The safeguarding system as a whole did not understand Ash's experience of elective home education. Although the national legal framework limits the powers of the local authority, in this case there were opportunities to use local

[10] See for example: Rutter M. (2012) Resilience as a dynamic concept. Dev Psychopathol. 2 :335-44 and Dias, P and Cadime I (2017) "Protective factors and resilience in adolescents: the mediating role of self-regulation. Psicologia Educativa 23 1 pages 37-43

systems to integrate an understanding of Ash's experience of elective home education into assessments of need. This is explored in Finding Four.

- The potential for criminal exploitation was not given sufficient weight and action taken to understand what was happening from Ash's point of view. This is explored in Finding Five.

5 REVIEW FINDINGS AND RECOMMENDATIONS

5.1 The findings from the review are linked to agency specific recommendations aimed at improving the system responsible for the safety and wellbeing of children and young people. Safeguarding children partnerships have a responsibility to lead and co-ordinate safeguarding services and to implement local and national learning including from serious child safeguarding incidents. In this role Surrey and Gloucestershire children partnerships will be responsible for ensuring that learning is translated into action and that the impact of system change on work with children and families is evaluated. Partnership annual reports rarely refer to the impact of their work and measuring impact from review recommendations has been as a challenging aspect of their role.[11] The overarching recommendation below is designed to focus attention on the responsibility of the partnerships to work with local agencies over time to evaluate actions and the impact these actions are having on children and young people who may be experiencing similar issues to those described in this report.

Recommendation One
Surrey and Gloucestershire Safeguarding Children Partnerships should work with local agencies to support the implementation of the recommendations from this review and evaluate the impact of actions on the experience of children and families.

Finding One

There are many and varied reasons why parents may not wish to share information or work with statutory services. This presents a challenge for practitioners who have a responsibility to understand and identify those factors which might increase risk of harm for a child or young person.

5.2 It is not unusual for reviews following significant incidents to discover that important information was only known to family and friends. In this case the depth and extent of parental acrimony and the impact this must have had on Ash's wellbeing was not sufficiently well understood. Similarly it has been hard for the review to unravel exactly what happened at the point Ash was removed from the school roll and it is

[11] Child Safeguarding Practice Review Panel Annual report 2021

clear that there were misunderstandings as to where he was living. Throughout the records available for this review it has been hard to get a good picture of his lived experience.

5.3 Agencies are to a large extent dependent on the information they receive and the questions they then ask to gain a full picture of the life of the child. Where parents are reluctant to share information this challenges practitioners who need the skills to look beyond the surface and work with families to get the best possible information. An important aspect of this work is understanding the barriers that might prevent open and honest dialogue in the first place.

5.4 It has not been possible to get a full picture of why the information about Ash's life was not shared, or at times was confusing. It seems likely that the extreme level of acrimony between parents played a part in the lack of clarity as to where Ash was living. The lack of information sharing with the GP regarding the ADHD diagnosis appears to be linked to a distrust of statutory agencies and a fear that the response would not be helpful, and it is possible that this distrust also sat behind other situations where information was not shared or services not taken up.

5.5 It is important that practitioners are alert to these dynamics and beliefs and that this drives a tenacious response to information gathering. In this case for example gathering information in Surrey via e-mail would not have picked up on any nuances in the conversation that might have led to further exploration. Also, ensuring that both parents were always contacted even though the main referral may have been linked to one party.

Recommendation Two

Surrey and Gloucestershire Safeguarding Children Partnerships should work with parents to explore barriers to open honest dialogue with statutory agencies. These findings should be used to develop the skills of practitioners in exercising appropriate curiosity, understanding how biases might affect responses and reducing barriers to information sharing.

Finding Two

The death of Ash highlights the importance of assessments which identify the root cause of behaviours through understanding the child in the context of their history, (including the significance of parental conflict) and the influence of their current family and friend's network. Effective supervision is fundamental to this approach.

5.6 This finding is particularly important in situations where cumulative stresses in a young person's life need to be understood.

5.7 There were opportunities in school, during the two social work assessments in Gloucestershire and the contact with children's social care in Surrey to ask questions

that went beyond the immediate concerns to an understanding of Ash's life over time and the influences on his current behaviours. Specifically, more should have been asked about his experience of sexual abuse (mentioned during the first social work assessment) and the impact on his emotional wellbeing of the significant parental acrimony that persisted over time. A trauma informed approach to assessments might have prompted a stronger focus on these aspects of Ash's life rather than the incident led approach which resulted in early case closure before a robust multi-agency support plan could be developed. At the time practitioners were working with Ash an understanding of the importance of a trauma informed approach was in its infancy in Gloucestershire and Surrey and this is now being developed through staff development activities.

5.8 The significance of parental conflict is increasingly recognised and the Early Intervention Foundation had noted that that where conflict between parents is frequent, intense and poorly resolved, it can harm children's outcomes – regardless of whether parents are together or separated. This includes family contexts not usually regarded as 'high-risk', not just where parents have separated or divorced or where there is domestic violence.[12]

They go on to note that children who witness severe and ongoing parental conflict can display:

- externalising problems (such as behavioural difficulties, antisocial behaviour, conduct disorder)
- internalising problems (such as low self-esteem, depression and anxiety)
- cognitive and academic problems
- physical health problems
- behavioural problems.

5.9 There is also increasing knowledge that parental conflict may include coercive controlling behaviours and that practitioners need to be aware of the subtle forms that such behaviour can take. Where children are caught up in any parental acrimony the possibility that domestic abuse, including coercive control, should be part of routine enquiries in order to understand the extent to which this may be impacting on the children. This knowledge should help practitioners assess and work with children who have experienced acrimonious parental separation and might be presenting with a range of problems. There is little evidence that this aspect of Ash's life was explored with him in any depth and appears to be an area for practice knowledge and skill development.

5.10 Understanding the child and family as a whole will be most successful where there is the opportunity to communicate directly with all significant people in the child's life and to develop a positive helping relationship. The response to the referral from Father's partner within Surrey was solely via e-mail. Whilst this type of approach may be designed to manage workflow most efficiently, it is not compatible with a

[12] EIF Commissioner Guide: Reducing parental conflict EARLY INTERVENTION FOUNDATION UPDATED MARCH 2021)

relationship based approach to practice and was a missed opportunity to explore in any depth her significant concerns. The first contact with any agency is important, it may be at a time of heightened anxiety or crisis and will be at a time where there is a good opportunity gain trust and important information; this is less likely to be achieved electronically.

5.11 There is evidence that the social worker in Gloucestershire was successful in engaging with Ash and his mother, but Ash returned to Surrey before the end of the assessment and there was no engagement with his father and father's partner in order to work with them to agree any support that might be needed.

5.12 Where assessments have gaps in information or analysis, supervision should be a place where this can be identified and explored. The need for "professional curiosity" is frequently cited in reviews and in this case there are times when practitioners could have asked more detailed questions, reflected on the meaning of Ash's behaviour and whether they were making assumptions based on their own beliefs and values. For example how far were responses affected by Ash's professional family background? This is more likely to happen when practitioners have the time and space for critical reflection and challenging conversations. This is important in fast paced "front door" situations as well as in more long term work.

Recommendation Three

All agencies should review their staff development strategies to ensure that their practitioners understand the impact that parental acrimony and conflict may have on children and are able to use this to knowledge inform all assessments and responses.

Recommendation Four

All agencies should work with managers, supervisors and safeguarding practitioners to evaluate the quality of supervision and ensure that their approach to supervision:

- Promotes professional curiosity and critical reflection from the point of first contact with children and families so that all relevant information is captured and shared and risks are accurately evaluated.
- Is clear that practitioners should enquire about a child's education, including elective home education, and where a child is educated at home consideration is given as to whether the appropriate notifications have taken place.
- Establishes the expectation that where parents are separated and there are concerns about the wellbeing of a child, all adults with parental responsibility are consulted at the point of referral and during ongoing assessments and interventions.

Finding Three

Medical assessments of children and young people are an important aspect of multi-agency safeguarding work but a private consultation was not integrated into decision making in this case. Where medical and psychological assessments are carried out by private consultants it is vital that findings are communicated to GPs in local community services.

5.13 The private consultation with the paediatrician resulted in a diagnosis of ADHD and medication being prescribed. The problem was that this diagnosis took place in isolation, other professionals such as the GP were unaware of the diagnosis or prescriptions and the diagnosis was not taken into account in the light of other concerns known to children's social care and the police. NHS guidance [13] identifies that children and teenagers with ADHD may have signs of other problems or conditions alongside ADHD, such as anxiety disorder, oppositional defiant disorder (ODD), conduct disorder - this often involves a tendency towards highly antisocial behaviour, depression, sleep problems, learning difficulties such as dyslexia. The guidance gives advice that ADHD can be treated using medicine or therapy, but a combination of both is often best. The treatment is usually arranged by a specialist, such as a paediatrician or psychiatrist, although the condition may be monitored by a GP. NHS guidance gives 'Tips for parents' which include *be sure your GP or specialist helps you understand the difference between ADHD and any other problems your child may have* and *Find out the side effects of any medicine your child takes and what you need to look out for.*

5.14 NICE guidance on the use of medication for ADHD reiterates the need for monitoring and that the child should see them for regular check-ups to ensure the treatment is working effectively and to check for signs of any side effects or problems. [14].

5.15 Although the paediatrician did ask for GP information this was not pursued when it was not forthcoming and as a result there was no adequate follow up or monitoring of any side effects and the impact it was having on Ash.

Recommendation Five

The GMC, NHS England, RCPCH and Integrated Care Boards should work consider how to most effectively:-

- Remind private consultants and doctors o comply with GMC[15] best practice and NICE guidance, on who must contribute to the safe transfer of patients between healthcare providers and between health and social care providers, whether in private practice or when commissioned by a statutory agency.
- Review current national guidance and ensure that a patient's GP is copied into all private consultations for all children under 18 and to mandate this.

[13] https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/symptoms/

[14] NICE 2018 guidance refers to monitoring in section 1:8 https://www.nice.org.uk/guidance/ng87/chapter/recommendations#maintenance-and-monitoring

[15] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

Recommendation Six
Surrey Safeguarding Children Partnership should consider how to engage at a local level with private providers and families who use private provision, to encourage appropriate information sharing with NHS services.

Finding Four

The Elective Home Education system contributed to a situation whereby Ash's emotional, psychological and educational needs were not sufficiently well understood and he was not sufficiently visible to agencies who could have provided help and support. This is a local and a national issue.

5.16 This case occurred in the context of a significant increase in the numbers of children being educated at home with the Association of Directors of Children's Services (ADCS) survey of Local Authorities (November 2021) showing an increase of approximately 34% from the 2019/20 academic year. For many families this is a decision with the best interests of their child at heart but for some being educated at home will create an environment where they are at increased risk of harm. These harms can include various forms of abuse including gang affiliation and child exploitation. Surrey Safeguarding Children Partnership have been engaged with the debates concerning Elective Home Education at a national level and have made representations to central government regarding strengthening the safeguarding framework for children educated at home.

5.17 The decision that Ash should be educated at home was made in good faith and was a response to concerns about his behaviour and worries about the negative impact of his peer group. Also, according to father's partner, Ash was also affected by being in the same school as the pupil who had abused him, was bullied and commented that he had never had a positive experience at school and wanted to pursue an alternative programme. The complicating factor was that the decision to educate Ash at home coincided with a move to live with his father and a change of area.

5.18 Elective Home Education (EHE) is the term used by the Department for Education to describe the education provided by parents at home, rather than providing education for their children by sending them to school. Legislation regarding education in England and Wales sits within the Education Acts 1944 to 1996 and statutory guidance for local authorities is set out in Elective Home Education guidance for local authorities (2019)[16] which was due for review in December 2020 but has yet to be updated. Elective Home Education is also mentioned briefly in the updated Keeping Children Safe in Education (KCSIE) (2022)[17].

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/791527/Elective_home_education_gudiance_for_LAv2.0.pdf

[17] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1101454/Keeping_children_safe_in_education_2022.pdf

5.19 The legislation is clear that responsibility for a child's education rests with their parents who have a right to educate their children at home. There is currently no legal obligation for a parent to register or inform a local authority that their child is being educated at home and Department for Education guidance for parents (paragraph 4.2) advises them that when they remove their child from the school roll they are not required to inform the school that they are being withdrawn for the purposes of home education, although it is sensible to do so[18]. Schools are obliged to inform the local authority of children removed from its admission register and give home education as the reason, if the parent has notified them of this. In the case of Ash the parents did notify the school in Gloucestershire and the school also notified the local authority.

5.20 Local authorities have no formal powers or duty to monitor the provision of education at home. However, under section 436A of the Education Act 1996 they do have a duty to make arrangements to identify children in their area who are not receiving a suitable education. This duty applies equally to children being educated at home However, there are no detailed requirements as to how a system of oversight should work, and it is for each local authority to decide its approach. The guidance emphasises the importance of building positive relationships with parents who are home educating but equally makes it clear that that a proportional approach needs to be taken and local authorities should not exert more oversight than is actually needed. It recommends that an authority should ordinarily make contact with home educating parents on at least an annual basis so that it can reasonably inform itself of the suitability of the education provided.

5.21 The local authorities' duty to safeguard and promote the welfare of children allows a local authority to insist on seeing children in order to enquire about their welfare where there are reasonable grounds to suspect that they are suffering or likely to suffer significant harm (S47 Children Act /Working Together 18, EHE guidance (2019). It also states that local authorities should use their safeguarding powers if a lack of suitable education appears likely to impair a child's development. However, local authority powers do not extend to seeing all children who are educated at home or to take into account their wishes and feelings without parental consent.

5.22 The opportunity to establish whether Ash was receiving a suitable education and for the local authority to establish a working relationship with both his parents was at the point that the decision was made to withdraw him from school. The current EHE policy in Gloucestershire notes that although there is no requirement for parents to meet with the school *The local authority does, however, encourage schools to be professionally curious about the reason behind the decision and to meet with parents to identify if there are any school-based factors that can be addressed.* This review confirms the positive benefits of this approach as a meeting with both parents at the

18 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/791528/EHE_guidance_for_parentsafterconsultationv2.2.pdf

point he was withdrawn could have provided an opportunity to understand all of the reasons that lay behind the decision, and to explore whether additional support could be provided to enable Ash to remain in school. This was particularly important as he was known to have engaged in illegal activities, had been subject of a child and family assessment and could be at increased vulnerability to exploitation when not in school. The situation was however complicated by his last day in school being the end of the summer term and the notification by his parents that he was to be withdrawn from school did not happen until school had resumed in the autumn.

5.23 At a minimum, a meeting could have clarified his living arrangements, although the school had no reason to believe he had moved out of the area. Had it been established that he would primarily be living with his father in Surrey, Gloucestershire EHE team could have been notified of the forthcoming move and Surrey EHE services informed. With hindsight it can now be seen that there were assumptions and misunderstandings as to where he would be living which meant that Surrey elective home education service were not aware that his education arrangements were being organised by father who lived in their area.

5.24 Although there are persuasive arguments for the need for a national register of children educated at home, this may not have made a positive difference in this case without robust systems for gathering information at the point a child is withdrawn from school and clear information from parents to allow the transfer of information across local authorities when a child moves. Ash was not being deliberately hidden from view but equally the systems that are in place did not fully identify what was happening and enable dialogue with both parents to identify any concerns or risks.

5.25 Other opportunities to strengthen the EHE system could include ensuring GPs are notified of children who are electively home educated and requiring at least one home visit. These changes may have made a difference as they may have brought to the surface the change of area and triggered a proactive approach within Surrey, especially when concerns about criminal exploitation came to light. However, any positive difference would depend upon all practitioners across all agencies understanding the potential for increased vulnerability where a child is being home educated when there are coexisting concerns for their welfare.

Recommendation Seven

The National Child Safeguarding Practice Review Panel should ask the Department for Education to seriously consider the following as a result of this case.

- Whether a duty should be placed on parents to inform the local authority when a child is to be educated at home?
- Whether a duty should be placed on parents who electively home educate to inform the local authority if the child will be moving to another local authority area?
- Whether families should allow reasonable access to children by the local elective home education service during any period of elective home education?

Recommendation Eight

Surrey and Gloucestershire children's services, health and police should develop local multiagency EHE safeguarding procedures and staff development activities to ensure that:

- where there are safeguarding concerns, enquiries always include recording whether the child or young person is in education and where EHE is confirmed or suspected, there is liaison with the appropriate EHE team, clarification of roles and responsibilities and joint working to ensure the safety and wellbeing of the child.
- when there are any concerns that a child who is educated at home is at risk of criminal exploitation the required safeguarding action is taken and that this routinely involves children's social care, the local authority EHE services, police and any involved health agencies.
- GPs are routinely informed by the local authority (when appropriate consents have been provided) when children registered with their practice are taken off school roll to be educated at home.

Finding Five

Signs, indicators and the potential for criminal exploitation should be understood by all practitioners working with young people. This understanding should lead to routine enquiry when any indicators are present, an expectation that information will be shared between agencies and that shared information will inform decisions about child protection action.

5.26 The signs that Ash may be vulnerable to criminal exploitation began in Gloucestershire but intensified after his move to Surrey. To a large extent Ash fitted the profile of young people identified in the national child safeguarding panel review of criminal exploitation[19] as he had minimal previous involvement with children's social care and lived at home. Exclusion from school or not being in education is a risk factor which could have been taken into account. By the time he had moved to Surrey his isolation from any previous friends and his underlying vulnerabilities led him to be preyed upon and exploited by others. The extent to which this scared him and affected his emotional wellbeing appears not to have been fully understood by any professional.

5.27 There were accumulating concerns which taken together should have prompted a multi-agency strategy discussion in Surrey. But, primarily as a result of children's social care not sharing the significant concerns of father's partner with police

19 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf

colleagues, events were treated in isolation and the total picture was not understood by either agency.

5.28 Surrey children's social care too readily closed the case due to no response from Father, no attempt to contact Mother and after only e-mail correspondence with the referrer. As identified in Finding One, response to referrals via e-mail cannot possibly provide an opportunity to build trusting relationships where the full extent of information is shared, and all necessary follow up questions asked. In this instance for example there was no clarification as to whether Ash was in school.

5.29 There was positive follow up by Surrey police when it became clear that Ash was no longer in Surrey which led to the social work assessment in Gloucestershire. Although this assessment did engage with Ash the focus became substance misuse rather than possible criminal exploitation.

5.30 The sequence of events both in Surrey and Gloucestershire is indicative of a need for a greater awareness across the professional network of the signs of exploitation and the confidence to address it through safeguarding action. This much include good information sharing across agencies, must specifically across police and children's social care.

Recommendation Nine

Surrey and Gloucestershire children's social care and Surrey police should review and refresh procedures and staff development activities to ensure that:

- Practitioners can recognise signs and indicators of child criminal exploitation and risks outside the family.
- Where there are concerns risk assessments are based on the full facts of the case and the voice of the child is obtained.
- Multi agency communication takes place, including strategy discussions where there are concerns that a child is at risk of harm.
- Positive steps are always taken to work with family networks to reduce risk.

6 SUMMARY OF RECOMMENDATIONS

Recommendation One

Surrey and Gloucestershire Safeguarding Children Partnerships should work with local agencies to support the implementation of the recommendations from this review and evaluate the impact of actions on the experience of children and families.

Recommendation Two

Surrey and Gloucestershire Safeguarding Children Partnerships should work with parents to explore barriers to open honest dialogue with statutory agencies. These findings should be used to develop the skills of practitioners in exercising appropriate curiosity,

understanding how biases might affect responses and reducing barriers to information sharing.

Recommendation Three

All agencies should review their staff development strategies to ensure that their practitioners understand the impact that parental acrimony and conflict may have on children and are able to use this to knowledge inform all assessments and responses.

Recommendation Four

All agencies should work with managers, supervisors and safeguarding practitioners to evaluate the quality of supervision and ensure that their approach to supervision:

- Promotes professional curiosity and critical reflection from the point of first contact with children and families so that all relevant information is captured and shared and risks are accurately evaluated.
- Is clear that practitioners should enquire about a child's education, including elective home education, and where a child is educated at home consideration is given as to whether the appropriate notifications have taken place.
- Establishes the expectation that where parents are separated and there are concerns about the wellbeing of a child, all adults with parental responsibility are consulted at the point of referral and during ongoing assessments and interventions.

Recommendation Five

The GMC, NHS England, RCPCH and Integrated Care Boards should:-

- Remind private consultants and doctors o comply with GMC[20] best practice and NICE guidance, on who must contribute to the safe transfer of patients between healthcare providers and between health and social care providers, whether in private practice or when commissioned by a statutory agency.
- Review current national guidance and ensure that a patient's GP is copied into all private consultations for all children under 18 and to mandate this.

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- Positive steps are always taken to work with family networks to reduce risk.

7 APPENDIX ONE – LEAD REVIEWER

Jane Wonnacott qualified as a social worker in 1979 and has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed well in excess of 250 child safeguarding reviews, as well as Safeguarding Adult Reviews and Domestic Homicide Reviews. Jane has a strong interest in safeguarding practice and culture within organisations and has been the lead reviewer for two reviews into abuse in nurseries and complex and challenging reviews into non recent abuse in public schools. She has

contributed to the literature exploring effective safeguarding in education settings and has published books and training materials to support reflective practice and staff supervision. Jane has been a member of the National Child Safeguarding Practice Review Panel pool of reviewers and in this role has completed thematic reviews and was part of the team who completed the National Review into the deaths of Arthur Labinjo-Hughes and Star Hobson.

8 APPENDIX TWO – REVIEW SCOPE AND KEY ISSUES TO BE ADDRESSED

8.1 Time Period to be Considered by the Review:

The period just before Ash is excluded from school for the possession of drugs in March 2018 until the day of his death in May 2021.

8.2 Key Issues to be Addressed by the Review:

(These may evolve as more information becomes available during the review)

1. To what extent did the work by Gloucester County Council Children's Services assess the risks of criminal or other forms of exploitation? To what extent was the child exploitation screening tool completed by School in March 2018 explored in the initial assessment in April 2018.
2. In September 2018 when Ash's Mother took the decision to withdraw him from school, ostensibly to disrupt 'the pattern of risky behaviours', what information was shared with Children's Services?
3. What was the quality and effectiveness of the work carried out by the elective home education team in Gloucestershire? Did this accord with statutory guidance and good practice? Did this work identify any safeguarding concerns?
4. What was the quality and effectiveness of information sharing between Education, Children's Services and the Police?
5. To what extent does the current guidance and legislation regarding elective home education enable effective safeguarding and child protection activity?
6. What was the multi-agency understanding of the risks to Ash at the time of most recent referral in March 2020?
7. Was the cross border working between teams in both county councils effective?
8. What was the effectiveness of the response to the initial and subsequent referrals to Surrey County Council Children's Services in March 2020? What would need to be different?
9. What was the multi-agency understanding of Ash's daily life and lived experience? How did agencies seek to hear and understand his voice and his needs?
10. What was the multi-agency understanding of Ash's emotional well-being and mental health?

11. To what extent was Ash's Special Education Needs and Learning Disabilities understood? What was the understanding of the impact of these on his learning and day to day functioning?
12. How were issues of criminal exploitation and contextual/adolescent safeguarding understood and addressed in this case?
13. Were there wider-systemic issues across the multi-agency system that affected practice in this case?