Josef

Local Child Safeguarding Practice Review

August 2021

Contents

Introduction

Josef[1] was a looked after young person from January 2019 and was 17 when he died in February 2020.

Josef was known to various agencies at the time of his death, and the last few months of his life were particularly troubled, however those who worked with him remember him as being good fun, witty, funny with a great smile.

Initiation of the Safeguarding Practice Review

After Josef's death a notification was sent to the National Panel on 27th February 2020, with a Rapid Review taking place on 9th March 2020. The feedback from the National Panel was that local Child Death Overview Panel arrangements were sufficient and agreed with the Enfield Safeguarding Children Partnership (SCP) that a practice review was not necessary. The Panel found some shortcomings with the initial Rapid Review minutes lacking depth and analysis. The case stayed on the Enfield SCP agenda, through the Practice Improvement Group, while awaiting the outcome of the post-mortem. The case was discussed at a Practice Improvement Review Meeting in January 2021. On the 9th February 2021, the Enfield SCP advised the National Panel that a Local Child Safeguarding Practice Review would be appropriate to generate learning and the National Panel agreed.

The SCP agreed that this Local Child Safeguarding Practice Review would be undertaken engaging frontline staff and their managers and conforming to the expectations as set out in statutory guidance, Working Together 2018 (Appendix 1). The review was conducted by an independent reviewer, Thomas Savory, who is fully independent of the SCP and its partner agencies.

Following the submission of agency chronologies, a multi-agency workshop was held involving practitioners, managers and the agency chronology authors (contributors), and the perspectives and opinions of all those involved at the time were discussed. This group then reconvened to examine the first draft of the report and further help shape the learning.

The engagement of family members has been an important consideration for this review and would have been helpful in shaping the learning. The independent author invited Josef's father to meet however, the invitation was not responded to. No agency involved with Josef has contact details for his mother or extended family.

Terms of Reference

This review primarily covers the period from January 2019 when Josef became looked after to the time of his death in February 2020.

[1] The names used in this report are pseudonyms

Participating agencies were asked to provide a detailed chronology setting out how each organisation had been involved with Josef, supported by analysis of the Key Areas to Consider.

Chronology and Analysis questions:

Chronology

- This should cover the agreed time period of the LCSPR
- It should detail significant events, contacts and agency knowledge in relation to Josef and information about family members and significant others where relevant
- It should include any pertinent historical information that precedes the LCSPR's timeframe.

Analysis questions

- Responses should be completed as part of the LCSPR chronology template
- Responses should be proportionate to the circumstances of Josef's case and should focus upon addressing the key questions posed. This does not prevent the authors or the independent reviewer identifying additional lines of enquiry
- Authors should consider the question of why events occurred, why decisions were made and why actions were taken as opposed to merely identifying events.

Key Issues to Consider

The following areas set out what the LCSPR is seeking the review to consider. This allows for the review to maintain a clear focus. This does not exclude others being identified for the Enfield Safeguarding Children Partnership to consider and additional lines of enquiry being developed.

- Review Risk - How do agencies review risk both as individual agencies and across the involved organisations?
- Exploitation – look at the relationship between Josef and his friends/ acquaintances.
- Placement concerns including missing notifications
- Adolescent mental health and suicide attempts, crisis management follow up
- Drugs and alcohol use
- Communication between agencies

Agencies Participation

The following agencies contributed to the LCSPR:

- LB Enfield Children and Family Service (includes Leaving Care, Child Protection & Family Support Team, Independent Reviewing Service and Virtual School for Looked After Children)
- Semi-independent Housing provider
- Specialist Nurse – Looked After Children
- General Practitioner (via the CCG)
- Whipps Cross Hospital
- North Middlesex University Hospital
- Compass – Drugs & Alcohol service
- Barnet Enfield & Haringey Mental Health Trust (BEHMHT)
- Barts Health NHS Trust
- North East London Foundation Trust (NELFT)
- Education – Secondary School including School Counsellor
- The Metropolitan Police Service
- British Transport Police

Josef's death

Josef was 17 when he died in the early hours of a mid-week morning in February 2020 after climbing on top of a train as it arrived at the destination station.

Josef was electrocuted by overhead cables after the train had stopped. There is only limited information about his final hours and his state of mind during those hours. At the time of writing, it is understood that the Coroner's Inquest is set for Autumn 2021, so there has yet to be a finding of fact in relation to Josef's death.

Little is known about Josef's movements on the evening that he died, after he left the placement where he was staying late that afternoon. He had a text exchange with his social worker arranging to meet the next day, and Josef said he was going to be back late to his placement. At some point that night he ended up on the train from London Liverpool Street. As the train pulled into the destination station sometime around 01.30 am Josef was seen by another passenger, he was reportedly standing by the door, and he was smiling, he did not appear to be upset. As the train arrived at the platform, he was seen pulling down the window and using the window frame to climb out of the train and up onto the roof of the train. The windows of the train are not centrally locked in the same way as the train doors. When the train finally came to a stop at the platform and the centrally controlled door lock was released, passengers began to disembark from the train, the passenger who had seen Josef as he climbed out of the window heard a loud bang from the electricity cables overhead.

The British Transport Police were called to the station and found his mobile phone, a paint spray can and tube of toothpaste amongst Josef's possessions. It is not possible to know what his intentions were when he decided to climb through the train window.

His mobile phone was too severely damaged for the police to fully examine the contents although it was established that he had been in contact with his father by text earlier that day. Josef's father later told a member of staff at his placement that he had spoken to his son at around 21.30 on the night he died.

A brief overview of relevant background in relation to Josef's contact with agencies

Josef was living with his father and aged 8 years in August 2011 when a referral was received by Children's Services from the NSPCC, after concerns had been reported that Josef's father had a very demanding work schedule which resulted in Josef being left home alone for periods of time.

An initial Assessment was undertaken by a Social Worker from the LB Enfield Referral & Assessment Team. Josef's father said that he always made arrangements for Josef's care when he was at work and denied that Josef was ever left at home alone. However, Josef was subsequently seen at school by the assessing social worker accompanied by a Polish speaking colleague and confirmed that his father did leave him for up to an hour at a time, but during daylight and that he never felt unsafe. Josef had joined the school on 7th December 2010 after moving to London to live with his father. The school reported that it had taken him some time to make friends, he was described as initially being solitary and withdrawn and he would go missing around the school, however he had begun to settle by the end of the school year in the Summer of 2011.

Josef talked to the social worker about his experiences in Poland, although he was described as being vague about the detail, he said he had attended school and he had lived with his mother and younger half-sister, that his mother drank beer and vodka. He said that he missed his mother "a little" but he'd had no contact with her since moving to live with his father. He was in contact with his maternal grandmother and paternal grandparents via Skype. He said he was happy to move to live with his father and described the different things he enjoyed doing with his father.

It was observed that Josef had a stammer when speaking in both Polish and English. The father had a letter from Josef's GP dated 24th August 2011 asking the school to refer to a Speech and Language Therapist for assessment. The social worker concluded that Josef had experienced significant changes and losses in his life and had experienced a difficult home life with his mother which was likely to have impacted on his emotional wellbeing, which might account for his speech difficulties. It was agreed that the school would refer for a Speech and Language assessment and refer to Place2Be to support Josef with his emotional needs.

The social worker concluded that Josef's father was like many single working parents, doing the best he could to manage work and life balance, and that if he was leaving Josef home alone it was only occasionally and for short periods and during daylight. However, because of Josef's father's complete denial of this the social worker felt it

was not possible to discuss the referral concerns openly and discuss safety issues with him in more detail. The outcome of this assessment was no further action by Children's social care, a letter was sent to Josef's father advising him that Josef should not be left home alone, while the school would refer for a speech and language assessment and make a referral to Place2Be. The case was closed to Children's Services late in September 2011.

In October 2011, the GP records refer to Josef moving to London to be with his father, at the time his father said he had been in the country for the last 18 months. His father said he had custody of Josef who he said was receiving counselling due to trauma in Poland when he lived with his mother. His father also indicated a history of speech concerns due to anxiety as a result of his adverse early years experiences however this was not explored further by the GP as Josef was present.

In September 2012 Josef was taken to see his GP by his father who had noticed swelling around his chest. In October, a chest x-ray showed deformity of Josef's chest wall and possible healing rib fractures. In January 2013, a clinic letter was sent to the GP from Homerton hospital who reviewed the chest x-ray and confirmed it was possibly the result of old healed fractures. There is nothing to indicate that the implications of this information resulted in a consideration of Josef's wellbeing in the context of traumatic early childhood experiences.

In August 2017 Josef attended the GP with his father after experiencing a period of 'low mood'. The low mood had lasted 2 weeks. Josef said he had smoked weed in the past. Josef said he was feeling well and did not want any further help at that time. Josef and father did not feel a CAMHS referral was needed. The GP advised Josef to speak to the school counsellor. This was advice was not followed up at that time.

Towards the end of Year 9, Josef's attendance at school began to drop, as well as days when he was absent, he would also arrive to school late or leave early. This marked the start of an escalation in concerns for Josef, and over Year 10 and 11 his attendance was recorded as being around 75%. The school managed this without referring to the Attendance Team.

The first concerns about Josef's drug misuse in school emerged in January 2018 and were discussed with his father. In May 2018 school contacted Josef's father concerned that Josef was smelling of cannabis. In October 2018 Josef was excluded from school for three days for bringing smoking paraphernalia into school and passing a lighter to younger pupils, swearing at members of staff, and leaving the school grounds twice.

Key Practice Episode 1

The period leading up to Josef becoming looked after: October 2018 – January 2019

- On 29 October 2018 Josef was referred by school to the School Counsellor, and to the CAMHS team SAFE, and COMPASS, for a comprehensive assessment.

Josef reported using MDMA, Cannabis, Alcohol, Lean and Xanax. Concerns identified included dangerous substance misuse, high risk behaviours when intoxicated, witnessing domestic violence against his mother, thrill seeking, physical abuse, emotional abuse, neglect, peer violence and social care involvement, self-harming, self-neglect, suicidal ideation and attempts as well as mental health concerns

- The resulting Self Harm Risk Assessment established a rating of 'high' for overall risk
- On 9th November – CAMHS advised Josef's father to stop threatening Josef that he would send him to live with his paternal grandmother in Poland, as this was a potential trigger for his suicidality
- Concerns for Josef increased over December and by 17th January 2019 professionals were very concerned that his basic needs were not being met. During a key worker visit to his home, the only food reportedly seen was shreddies cereal and teabags. Josef said his father had not been home recently to drop food off and it was observed that he has lost significant weight
- 22nd January Josef presented himself to Children's Services, saying he could not return home due to the abuse and neglect by his father. Josef said that his father was working and often left him unsupervised at home for days at a time with no money or food. Josef said that his father would often shout and be verbally aggressive and abusive towards him and would often call him names and tell him that he did not care about his self-harming or drug misuse. Josef said that he had self-harmed a lot in the past, and he showed the assessing social worker his arm with multiple scars
- When spoken to after Josef has become looked after, his father told the social worker that Josef could return home, his only condition was that he stop smoking cannabis. He said Josef was angry because he would not let him bring his friends home to smoke drugs. He denied threatening to take Josef to Poland but did say he had discussed this with Josef as a way of taking him away from the influences of his friends who use drugs. His father denied that Josef was being left for so long and that he always made arrangements with a neighbour to pop in and see him. He said he would leave him food rather than money as he was worried he would spend the money on drugs.

Key Practice Episode 2

The period when Josef first became looked after: January – July 2019

- Josef was accommodated under Section 20 of the Children Act, 1989, on 24th January 2019, 2 days before his 16th birthday. This was in the context of escalating concerns about his drug and alcohol misuse and his mental health
- At the time Josef became looked after the Virtual School for Looked After Children became involved. Josef did not have an Education Health and Care Plan

- In March an allegation was received by the police that Josef had been allowing access to family home to drug dealers/drug gangs where they had been 'cutting' cocaine & heroin & dealing from the address. Whilst recorded by police as 'intelligence' it is not evident that any action was taken in response to this allegation
- During this period Josef's foster carer shared concerns about Josef's misuse of drugs, alcohol, and self-harming. Concerns were raised about Josef's suicidal ideation and self-harming assistance was sought from CAMHS requesting a full mental health assessment.
- Josef said he had self-harmed recently cutting his body, and "You would lock me up if you saw them". Josef said he had an "expiry date of age 21"
- The subsequent CAMHS Self Harm Risk Assessment in April 2019 assessed the risk as high
- Josef didn't return to placement on occasions, on two occasions he said he was staying 'with friends', and on another occasion said he was staying at his father's
- In May Josef withdrew from attending appointments with CAMHS and COMPASS and he left school, with no academic qualifications, despite his academic ability, no Education Health and Care Plan, and no plan in place for further education, employment or training in September
- In June Josef sent text messages to CAMHS and COMPASS withdrawing himself from their support.

Key Practice Episode 3

The period following Josef's return from Poland to his transfer to Leaving Care: August 2019 – January 2020

- Josef returned from 3 weeks in Poland at the end of July and soon began to go missing from placement on an almost continuous basis
- Josef was not returning to his foster placement
- When not at his placement Josef was believed to be staying with an older young person aged 18 called Alun who was known to LB Barnet Leaving Care and who was living in semi-independent accommodation
- There is no education provision in place for Josef from September, although it is reported that he went to enrol with friends at 6th Form on 3rd September. It is known that his Secondary School refused his request to join 6th Form as he did not have the required qualifications
- There was a plan to hold a Strategy Meeting on 23rd September in response to Josef being missing however when his whereabouts were established this meeting did not go ahead
- Children's Social Care Placement Panel were informed that Josef was not willing to return to his foster placement and on 10th October agreement was given to move Josef to semi-independent placement out of Borough
- A semi-independent placement was identified but Josef refused to move as he does not want to live with other young people

- On 23rd October Josef's social worker attended a meeting with Alun's social worker in LB Barnet to discuss concerns about Josef's contact with Alun, this meeting was described as a Vulnerable Adolescent Sexual Exploitation and Missing Meeting
- Josef reluctantly moved to semi-independent accommodation on 18th November. Josef told staff about his illegal drug use encouraged by one of his friends
- Josef was seen by his social worker once in September and once in October he was seen twice in the social workers office in November, the last time on the day that he moved placement on 18th November. Although subsequently there were 4 social work visits to see Josef at his placement, he was not present on any of these visits, and Josef was not seen again by a social worker until 11th February 2020
- Another young person in placement also looked after by LB Enfield later alleged that on the day Josef had moved into the placement Josef had raped and then made a threat to kill after they had smoked cannabis together. This was reported on 22nd November and Josef was arrested and interviewed. He denied the allegation and was released under investigation. This was not well communicated by the police as both Children's Social Care and Josef's placement believed that there was to be no further action. It was only after his death that it emerged the allegation was still under investigation, although the investigation hadn't progressed
- After his police interview on 22nd November Josef later attended Whipps Cross A&E for an overdose of LSD and Acid
- A Child Protection Strategy Meeting was to be convened on 26th November because of the allegation of rape, however this didn't go ahead for reasons not recorded
- On 26th November, Josef attended Whipps Cross for a second time as he was distressed and talking about suicide. He alleged he had been physically assaulted by another resident in the placement on the 22nd November and that some of his property had been stolen. The Doctor noted a red eye injury. The initial plan was for inpatient treatment, but no Tier 4 bed was available, and Josef did not want hospital admission. He was discharged back to his placement on 27th November with a plan for follow up from the CAMHS SAFE Team within 7 days. It is not clear how well understood either at this time or subsequently, the impact of the allegation of rape and the police investigation was having on Josef's psychological state, and there is no evidence that he was receiving ongoing support with this
- Josef said he did not want to remain in the placement and started going missing repeatedly saying he did not feel safe there
- Josef continued to spend a lot of time with Alun and reported staying at the houses of others but did not give any more information
- A Child Protection Strategy Meeting was to be convened on 3rd December, however this didn't go ahead, for reasons not recorded

- The CAMHS SAFE Team made contact with Josef's placement on 13th December more than the planned 7 days after his discharge from hospital on 27th November
- Josef attended A&E at NMUH on 8th January 2020 brought by police and subsequently placed under Section 136 of the Mental Health Act when he became agitated and tried to run away
- On 9th January a Mental Health Act assessment was undertaken by his CAMHS psychiatrist, an independent psychiatrist and approved mental health professional and Josef was assessed as not being detainable under the Mental Health Act, he was assessed as having mental capacity, the Section 136 was rescinded, and he was discharged back to his placement. He was seen the following day in the community by his CAMHS psychiatrist
- Josef was taken by ambulance to NMUH A&E again on 18th January having been found on the platform at White Hart Lane train station. He was confused and had dry blood on the neck and left side of the forehead. He said he had been sleeping in the park for 2 days and at hospital he tested positive for various drugs, and he said he felt paranoid due to his drug misuse
- Josef attended Whipps Cross A&E on 20th January saying he fell downstairs 2 days previously and reported numbness in saddle and been incontinent of urine. He was discharged following examination. He later reported he had sustained the injuries when he was begging in the street and had been kicked.

Key Practice Area 4

The period from Josef's transfer to the Leaving Care Team and his death: 21st January – 26th February 2020

- Josef was allocated to a Leaving Care Social Worker on 21st January 2020 – however early attempts to establish contact with Josef were unsuccessful and the case was reallocated within Leaving Care in early February
- During this period Josef's GP notes were with Primary Care Support England (PCSE) as he was not registered with a GP practice. This process and time frame coincided with the escalation of his attendances to different hospitals. Therefore any information regarding these attendances will not be directed to a specific GP surgery. He was registered with a local GP on 26th January. As a result the new GP held very little information about Josef
- Josef continued to go missing from placement, he repeatedly told professionals that he was unhappy in the placement and felt unsafe there
- Josef attended Homerton Hospital on 30th January with a head injury, under the influence of alcohol and agitated. The initial plan was to detain him. Josef said that he was concerned about being attacked by gangs, he said they knew where he lived. He was discharged back to his placement
- Josef said he spent a lot of time traveling on public transport, and hiding, as he became increasingly paranoid about people watching him, and listening to him

- On 2nd February a police officer visited Josef in his placement to conduct a Criminal Exploitation prevention interview with him. This was conducted face to face due to the concerns around exploitation. Josef said he was not being exploited and provided Alun's name and address. This did not result in targeted disruption intervention with Alun to safeguard Josef
- On 5th February Josef attended Whipps Cross A&E with his placement support worker. Josef had stated he was going to kill himself he was going to stab himself with a knife. Police had searched Josef and no knife was found. He was discharged back to placement
- On 6th February Josef was picked up by police at Stansted Airport. He stated that everything had got too much for him, and he just wanted to get away, as he was not in education, he did not have a job, and had no money or a travel card. He did not resist going back to his placement. The police officer recorded concern that Josef was getting involved in drug dealing and that Police Operation Anzen were 'aware' of Josef. No further information is available in relation to this
- On 8th February Josef approached his Secondary School Headteacher on a train, he was described as, "looking starving, confused, and very vulnerable". He talked about people watching him and following him, and also watching and possibly having kidnapped his father. He said he was often too frightened to go back to his placement and spent his time on the rail and underground evading fares. When asked about gangs and grooming he said the 'people' were different but alluded to owing money. The Headteacher sent through his concerns to Josef's social worker on the 10th of February
- On 10th February Josef called the ambulance himself from his placement. He reported that he had taken an overdose of 16 aspirin, taken in the morning plus a couple of blue pills he had bought on the street. He said he had taken a further 24 aspirin tablets that evening because he 'wanted to put myself in coma'. He was taken to Whipps Cross Hospital. The Psychiatrist on call refused to assess Josef because had been verbally, racially abusive the previous day. It was agreed that Josef would be assessed by the day team the next morning. He left the hospital before he could be seen by the day team. The police were called by the hospital after he had left, and he was visited by the police at his placement. The officer who saw him reported that he appeared safe and well and the decision was taken to leave him at the placement for follow-up by the CAMHS team
- Josef was also seen by his new social worker in his placement on 11th February, this was a Statutory Visit with Josef and the session covered Josef's relationships with Alun, staff, friends and family. Although Josef expressed being happy in the placement, the social worker was concerned that a clear plan of intervention needed to be agreed by the professionals working with Josef
- Later that day police attended the placement because of concerns that Josef had taken another overdose of aspirin, he was taken to Whipps Cross A&E by ambulance and subsequently discharged back to his placement

- On 13th February Josef's CAMHS psychiatrist visited him at his placement and asked him if he would consider agreeing to a period of inpatient treatment. Josef refused
- On the same day Children's Social Care reviewed Josef's accommodation at the internal Placement Panel. Actions were agreed to support Josef in the placement including funding extended key working
- On 19th February a Professionals Meeting was attended by staff from social care, CAMHS SAFE team, COMPASS and the placement. At the meeting risk, care plan and placement support plan were discussed and areas of risks requiring action were discussed. These include his non-compliance with medication which he would spit out, his ongoing substance misuse, concerns around Josef's relationship with his friend Alun and the risks associated with this, his ongoing self-harm and suicidal ideation, his challenging behaviours and the frequency of missing incidents. The meeting agreed a plan intended to address these issues
- On 20th February Josef told his COMPASS key worker that he had borrowed a couple of hundred pounds from Alun and he was trying to pay him back, and that so far, he had paid back £800, he said he also owed two girls £340. He also said that he had been begging in the street and had been he had been harassed by some boys and kicked
- Josef was picked up by police for the second time at Stansted Airport on 24th February, he said he had missed his bus stop, he was returned back to his placement in the early hours of 25th February
- Later in the afternoon of 25th February Josef woke up and left the placement. He was angry that he had missed a visit from his COMPASS worker and sent her a message to let her know. He also had a text exchange with his social worker saying he would see him the following day.
- 26th February, Josef died.

What needs to happen to ensure that agencies learn from this case

Key Issues to Consider

The following sections examine the issues arising from the questions posed by the Safeguarding Partnership and seek to understand the quality and effectiveness of the multi-agency safeguarding response to Josef, and key Learning Points for improving practice have been set out.

The following areas set out what the Enfield Safeguarding Partnership is wanting the LCSPR to consider:

1) **Review Risk - How do agencies review risk both as individual agencies and across the involved organisations?**

Although little is known about his early years, from what is known it is likely that Josef experienced significant abuse and neglect in his earlier childhood whilst living in Poland with his mother. When he moved to live with his father in England information about Josef's history was not effectively understood or subsequently shared. Although this is unlikely to have altered Josef's behaviours, it disadvantaged agencies attempts to support him at the times when he began to need help. When adolescent mental health services became involved, he was diagnosed with complex post-traumatic stress disorder related to his childhood experiences. This could have triggered an assessment for an Education Health and Care Plan, but it did not for Josef.

Earlier work with Josef was not fully informed by knowledge about the trauma Josef had experienced as a younger child and the extent of the impact of his earlier adverse childhood experiences, had they been, they might have then informed safety planning and family work. "Wellbeing in adolescence is influenced by early childhood experiences and can in turn determine adult behaviour, health and wellbeing (WHO, 2016). Understanding adolescents' experiences, including their family lives, local community and wider social networks, is necessary for understanding adolescent harm". (Firmin, 2018, cited in Brandon, et al (2020: 113)[2].

Children's Services undertook a single agency assessment in 2011 in response to an allegation that Josef was being left home alone in the care of his father. On the basis of the presenting information and following a visit to meet with Josef's father the decision was taken that this did not require further action from Children's Services. No history was gathered at this stage and so the extent of Josef's troubled past was not understood. The outcome of the assessment undertaken was not shared with partner agencies and during the same period Josef was presented by his father to his GP, again information was shared about Josef's early experiences and later concerns were raised about an historic injury.

The opportunities to discuss early help need to be placed in context. At the time of the referral in 2011 Josef had only recently moved to live with his father, and the level of parenting required of his father to support Josef would have been significant given his traumatic experiences whilst living with his mother, added to the inevitable feelings of loss in the act of moving to another country, away from everyone he had known. Whilst Josef was referred for speech and language therapy and emotional support, there was insufficient joined up working at that time to help inform a conversation with the family about help.

When Josef asked to become looked after in 2019, he said that he was left home alone for long periods when his father worked away and he gave this as his reason for not

[2] Brandon, M. et all (2020), Complexity and Challenge: a triennial analysis of SCRs 2014-2017, Final Report, Department for Education

wanting to live with others, and however unrealistic it might have been, he insisted that he wanted a place of his own. It is still not known how long Josef had been spending prolonged periods of time alone at home before he became looked after, it had been a cause for concern in 2011 and school reportedly became concerned about his non-attendance and poor punctuality from Year 9 when Josef was 14 years old. Josef later talked about his smoking skunk cannabis from the age of 13, and the impact he believed that this had on his mental health.

Around the time that Josef became looked after, work was not undertaken with his father and the wider family, in particular Josef's aunt who lived in London and reportedly had a good relationship with him, to explore all available options for Josef to be supported to remain within his extended family. Subsequently there is little evidence of engagement with Josef's father, or other members of the family, even though Josef was known to be in contact with his father.

When Josef became looked after in 2019 risks were identified, but the analysis and response to changing risk is less evident as Josef's behaviour became more concerning, and the risk assessment was not updated as risks escalated.

Following the referral to CAMHS and COMPASS in October 2018, two risk assessments of self-harm were completed in November 2018 and April 2019 and the overall risk rating was high in both risk assessments, however as time moved on it is not clear how these assessments translated into actions that helped reduce risk and by May 2019 Josef was withdrawing from CAMHS and COMPASS. This coincided with his leaving school without qualifications and without a plan in place for September, his school refusing him a place in the Sixth Form because he did not meet the required qualification criteria.

There were 3 Professionals Meetings during the time that Josef was in care: in February and April 2019 and in February 2020, however no Strategy Meetings were held in relation to either his escalating and extended periods of missing from care, the allegation of rape, his self-harming behaviours and multiple attendances to different A&E Departments, or the circumstances he was describing to different professionals e.g. debts owed; begging on the street; and being physically assaulted.

Planning for Josef would have benefitted from a risk assessment that incorporated information from all agencies involved that would have provided an overall view of the current risks. Until the Professionals Meeting on the 19th February 2020 there was no collective thinking to look at how best to support Josef who was presenting with multiple complexities.

The multi-agency Professionals Meeting on 19th February 2020 had initially been arranged as a Strategy Meeting, but the police did not attend and so the meeting went ahead with the professionals present. The plan agreed was to increase visits from the social worker and Compass keyworker to weekly visits, with increased support hours for Josef in the placement. This planned increase in support reflected the concerns of those attending the meeting but it came just a week before his death.

The non-attendance of the police Missing Team to the Strategy Meeting arranged for the 19th February reflected a local issue in relation to that team's management of missing young people in the area at that time, only attending Strategy Meetings when there was an open missing episode. This created a gap in the multi-agency safeguarding arrangements. This was particularly evident in Josef's case as he was not being treated as a potential victim of criminal exploitation by the Police Exploitation Team, who might otherwise have attended the Strategy Meeting.

The decision for Josef's case to be transferred to Leaving Care occurred a long time after Josef came into local authority care. According to the local case transfer policy this would ordinarily have taken place around 13 weeks after his admission to care (in May 2019), however the plan to explore the possibility of his moving to live with his grandmother in Poland delayed the transfer. In any event this was not a realistic long-term option, in November 2018 the CAMHS team had identified that the prospect of moving to live in Poland increased Josef's suicidal ideation. After his return from visiting family in Poland in 2019 Josef become much more unsettled and stopped staying at his foster placement. Had Josef transferred to the Leaving Care Team in May 2019 in line with local policy, the direct work undertaken with him which began in February 2020 would have been in place much earlier.

Decision and review points are important to ensure case management is effective in meeting the safety needs of a child. In this case as concerns for Josef escalated there were no Strategy Meetings, although the relevant Statutory Guidance is clear that, "Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion…Local authority children's social care should convene a strategy discussion to determine the child's welfare and plan rapid future action…"[3].

The Independent Reviewing Officer asked to be notified at the time that Josef moved into semi-independent placement, this didn't happen so the opportunity to arrange a Statutory Review as concerns for Josef escalated was also missed.

2) Exploitation – look at the relationship between Josef, his friends, and acquaintances.

Very little is known about Josef's friends and acquaintances outside of his group of friends in Enfield. There are mixed professional views about his friendship group in Enfield with whom he was reportedly very close, in fact he had told a professional that they were the ones 'keeping him here' when discussing suicide. There is no evidence that work was undertaken with Josef to explore his peer group, and their significance to him, until the first session with his new social worker on 11th February. This is

[3] Working Together to Safeguard Children, July 2018, Department for Education

increasingly recognised as being an important aspect of contextual safeguarding work with young people[4].

Contextual Safeguarding is a conceptual framework for understanding, assessing, and reducing the risk of harm originating beyond the family home. This approach recognises the importance of the transitional phase and the growing importance of social relationships outside the family. It has a specific focus on risks to young people who may be at risk of harm in the community from sexual and/or criminal exploitation, radicalisation, serious youth violence and gang membership or affiliation.

While he was living at home his father referred to Josef's Enfield friendship group as his 'druggy friends' and he was concerned to remove Josef from their influence. Later when Josef was in care the move to the semi-independent placement in Waltham Forest was intended to create distance between Josef and his Enfield friends.

Josef had wanted to progress to the school Sixth Form with his friends but was refused because he didn't have the necessary qualifications. He left school with no plans in place for September. Had Josef had an Education Health and Care Plan the Virtual Headteacher could have intervened on Josef's behalf to require the school to adjust their entry requirements in order to secure educational continuity for him.

There were indicators that Josef was vulnerable to exploitation[5], and this should have resulted in a discussion at the Enfield Multi-Agency Child Exploitation Panel, however there is no evidence of analysis of potential exploitation risks

At the time that Josef had become looked after his father had said that he had received complaints from neighbours about the smell of marijuana from his address and he had told Josef that he could not have his friends at their home smoking drugs. In March 2019, an allegation was received by police that Josef was allowing access to his father's address to drug dealers who were cutting and selling drugs from the property. This report was recorded as 'intelligence' by the police but not investigated.

When Josef returned from being missing, he often refused to say where he had been or who he had been with, when he did speak about this, he referred to staying with people but refused to give any more information. His contact with Alun was well known and a cause of significant concern.

[4] Latimer, K., Adams Elias, C., with Firmin, C., (2020), Opportunities for peer safeguarding intervention, A briefing following fieldwork with Safer London, Contextual Safeguarding Network and Safer London

[5] Firmin, C. Wroe, L. Lloyd, J. (2019) Safeguarding and exploitation – complex, contextual and holistic approaches, Research in Practice

Alun was aged 18 and a care leaver to another London Borough, he was reportedly very volatile and referred to Josef as one of his 'disciples'. It was known that Josef was staying with him at his placement. Alun was reportedly controlling of Josef encouraging his substance misuse by supplying him with drugs and in this way, Josef later talked about owing a debt to Alun and it is possible that Alun made him sell drugs and possibly street beg to repay this debt. Alun was contributing to Josef's paranoia by telling him people at his placement, and other people in the community were keeping him under surveillance.

There was a meeting held with the social worker from Barnet about Josef's contact with Alun, and the workers at Josef's placement made several attempts to work with him around identifying positive friendships, but he was always reluctant to engage and receive advice. Josef gave Alun's details to the police, however, there is no evidence of any professional discussions about disrupting this relationship.

Josef denied he was being put under any pressure for debts when police spoke to him in February 2020 about whether he was being exploited. Although he did give the officer Alun's name and address, this did not result in any targeted disruption of Alun's contact with Josef or any concentrated effort to safeguard Josef from Alun. Josef subsequently told his Compass key worker about debts he owed Alun and two other people.

By the end of 2019 going into 2020 Josef was known to travel extensively on trains and the underground, he repeatedly said he felt unsafe in his placement, the extent of his paranoia was such that he believed the people at the placement were reporting back to Alun, because this is what Alun had told him. On 10th February a police officer recorded that Josef had huge anxieties about "people" watching him, and that Josef spent his time trying to get away from "people" by travelling the rail and underground network.

3) Placement concerns including missing notifications

Published Government data of children and young people missing from care in 2019-2020[6] indicate that 11 per cent had a missing incident, most of these were older young people with 56 per cent of those being reported missing from secure units, children's homes and semi-independent arrangements. Most missing incidents were for between 1 and 2 days, very few were for more than 7 days, with an average of 6.5 missing incidents per child who went missing.

Josef was regularly missing from his placements and some of these episodes were for extended periods of time.

[6] Children looked after in England including adoption: 2019 to 2020, (December 2020), Department for Education

The Metropolitan Police report that he was missing on 21 occasions from 2019-2020 with various lengths of time before he either returned of his own accord or was taken back to his placement by the police.

In 2019 the police report that there were 7 police missing person reports, and 14 in 2020, although some of these were recorded as absences by Children's Social Care after Josef's whereabouts had been established.

Missing notifications were sent every time Josef was reported missing from his placements however, there were no Child Protection Strategy Meetings held in 2019 or 2020 in relation to these repeated episodes to explore risk of exploitation. The Enfield Missing Protocol requires that a Need to Know is completed to alert the Director of Children Services to the fact a young person has been missing from care for a 24-hour period. After a looked after child has been missing for 3 days a Strategy Meeting is convened. Although professional judgment can be exercised and a strategy meeting can be convened when there are several shorter episodes of missing or 'unauthorised absences' and there are known vulnerabilities as in Josef's case, the protocol does not specifically stipulate this.

"When children go missing, they are demonstrating that things are not right for them and while they are missing, they are at increased risk of harm. Communication and information sharing can support practitioners to see a developing and more holistic picture when adolescents repeatedly go missing". (Brandon et al, 2020: 117)

When a child is found or returns, they should have a prevention interview by police and the local authority should offer an independent return home interview within 72 hours[7]. In this case statutory guidance in relation to missing from care was not always followed as independent return interviews were not routinely undertaken. When a child goes missing, and there is concern s/he is at risk of significant harm, a Section 47 enquiry should be initiated, and a strategy meeting held, and this didn't happen.

Placement and local authority staff were concerned that some of their reports to the police were not taken seriously due to the frequency of Josef being missing and eventually returning to the placement. Staff at the care placement were frustrated on occasions when police did not follow up on their concerns and out carry out a welfare check to ascertain Josef's safety even though they had expressed concern that he was with an adult who was believed to pose a risk to him. On these occasions it is reported that the police view was that because his whereabouts were known he was not missing, even though his absence was unauthorised.

[7] Statutory Guidance on children who run away or go missing from home or care, 2014, Department for Education

Whilst the police did frequently try to speak to Josef on his return from being missing, he would either refuse to speak with them or he would just say he was OK and refuse to provide any more information about where he had been or who he was with. The arrangement of independent return interviews during this period was a significant gap, these may have provided more information about Josef's lived experiences during the multiple missing episodes.

Need to Know missing from care reports were being completed in Children's Services, and throughout the period under review his placement needs were being considered by Placement Panel. Statutory Reviews were held in February and April 2019, Josef attended them both. Josef did not attend the final Statutory Review in October 2019, by that time he had been away from his foster placement since August. His Independent Reviewing Officer was not made aware of his move to the semi-independent placement until January 2020, otherwise it is likely that a further Statutory Review would have been arranged.

4) Adolescent mental health and suicide attempts, crisis management follow up

CAMHS were treating Josef for complex Post-Traumatic Stress Disorder (CPTSD) in the background of a very difficult childhood that was affected by many adverse childhood experiences and trauma affecting his emotions, behaviour and relationships, impacting on his emerging personality**.** There were periods when he was completely unable to manage his emotions resulting in extremes of mood, anxiety, anger and depression. The impact of early trauma on the developing personality is well understood[8].

There were two self-harm risk assessments in November 2018 and April 2019, and both assessed Josef as being at high risk with a plan for treatment in the community. Despite Josef's wish for CAMHS and COMPASS to cease in the Summer of 2019, both services responded immediately and proactively when he re-presented in January 2020.

From November 2019 to February 2020 Josef presented with very concerning mental health needs, and physical injuries, to different hospitals on several occasions (see Appendix 2) however it is reported that he did not have an acute mental illness diagnosis but had presented with complex behavioural and emotional problems in relation to his very vulnerable psychosocial circumstances.

Josef was assessed by different psychiatrists between November 2019 and February 2020 and was assessed as having mental capacity and was not detainable under the Mental Health Act. However, it is not clear from the submissions to this review what

[8] Howe, D., Child Abuse and Neglect, Attachment, Development and Intervention ((2005), Palgrave Macmillan

weight was given to the wider issues impacting on his capacity and competency, most significantly his persistent non-engagement in the community treatment plan alongside the escalating concerns about his presenting behaviours.

Whilst it is accepted that treatment in the community is the least restrictive treatment option when patients are compliant with the treatment programme, the community-based treatment Josef was receiving was not having the intended impact, mainly due to Josef's noncompliance, whether it was because he was spitting out the medication he had been prescribed or not attending appointments.

Securing Josef an appropriate placement in a specialist mental health provision may have had an impact on safety planning and care management. By February Josef's admission to inpatient treatment was being pursued by his Consultant Psychiatrist on a voluntary basis, however he told his psychiatrist, "You're never going to lock me up, I am going to be free. You can't take away my freedom".

At the same time, CAMHS professionals were having conversations about the possibility of Children's Services seeking to place Josef in secure accommodation on welfare grounds. However secure accommodation was not under consideration by Children's Services due to their interpretation of the law given Josef's age and legal status[9].

Many of the professionals working with Josef were so concerned about his mental state certainly by the time of his attendance to A&E on the 8th of January, that they believed he should have been detained and admitted to hospital, and still do not understand why this did not happen. There was no forum where these dilemmas or professional disagreements could be shared and discussed and the range of intervention options explored, with management of risk shared.

5) Drug and alcohol use

Despite evidence of complex post-traumatic stress disorder, severe depression and anxiety, paranoia, and his misuse of drugs and alcohol, Josef was repeatedly assessed as having capacity. The plan was community-based treatment, however Josef did not consistently engage with this.

Josef was often very open in talking about his use of alcohol and drugs and at times presented to be under the influence. At other times he said he had stopped using drugs and alcohol. Josef was known to use drugs and on one occasion stated that cannabis did not affect him in anyway whatsoever, because he had smoked so much, he was immune to its effects. On other occasions he acknowledged that the way he was feeling was as a result of his drug misuse. He said he believed that his use of skunk cannabis from the age of 13 had contributed to his mental health difficulties.

[9] Re P (application for Secure Accommodation Order) (2015) EWHC 2971 (Fam) (2015)

6) Communication between agencies

Over the period under review, what was known about Josef was disjointed and incomplete, and is only now coming together as part of this review process. Information was not always shared in a way that joined up what was known.

Had information sharing been timelier and more comprehensive, this might have contributed to a better understanding of the risks, and a review of whether the interventions were achieving the right outcomes for Josef.

There continue to be gaps in what is known about Josef, however this does not mean that these gaps were not knowable at the time, and it is possible that working in a different way with Josef may have helped to develop a broader understanding of Josef's history and presenting needs.

Josef came into contact with many different professionals, and it is clear that different teams were discussing their concerns for him and referring them on, but it is less clear how these were co-ordinated to create an overview of risk and to inform risk management decisions when the interventions aimed at reducing risk were not having the intended impact.

At the multiagency Professionals Meeting on 19th February 2020, professionals working with Josef shared concerns and agreed a plan of support in the community, although the high level of on-going risks to Josef in the community were acknowledged.

Changes to safeguarding vulnerable young people in Enfield since February 2020

Since February 2020 changes have been introduced within Children's Services to the management of young people who go missing, there is a Missing Persons Co-ordinator in post who is very proactive in following up reports of young people missing and offering return interviews, with daily missing notifications followed up and established escalation arrangements in place.

Since June 2020 the Metropolitan Police Service (MPS) no longer uses the 'absent' category, all reports are now treated as 'missing'.

The new MPS Public Protection Senior Leadership Team in place since January 2021 have prioritised a clear commitment to bring local practice in line with the MPS standards, this includes the attendance of the Missing Team at Strategy Meetings and to the development of 'trigger plans' for people who are frequently missing under the oversight of a dedicated case officer. The new leadership team is actively promoting a joint approach to problem solving drawing on the expertise across the Public Protection Team and the wider partnership.

In June 2021 Children's Services launched a redesigned service to vulnerable young people in response to contextual safeguarding risks and created the Adolescent

Safeguarding Service which is multi-disciplinary and multi-agency. Local panel arrangements have been streamlined to create a greater focus on the range of risks to vulnerable young people.

The Named GP and Designated leads have established regular meetings with the heads of service in social care to raise their understanding on the role and scope of the GP, and there is a plan in place to deliver cross agency training to support cross agency working.

Local Learning Points for consideration by the Enfield Safeguarding Children Partnership (SCP)

These Learning Points have been identified through the review process and discussed at the SCP Executive Board. The Partnership will develop a detailed action plan that will be clear about what is required of relevant agencies and others collectively and individually, and by when.

Learning Point One

The SCP to review, and make amendments where necessary, to the guidance and procedures around the management of children and young people who are missing. Re-issue the guidance and procedures to all workers around how to respond to missing episodes and concerns around exploitation, and contextual safeguarding in order to achieve greater consistency in approach to managing risks in these areas.

Learning Point Two

The SCP to lead the opportunity for local agencies to consider ways to understand how to incorporate the concept of contextual safeguarding in the assessment of risk to children in the future and how to respond when the main safeguarding concerns are existent in the community. The development of the Adolescent Safeguarding Service to provide professional consultation, and the development of interventions to include working with peer groups.

Learning Point Three

It is important to ensure that practitioners are in a position to escalate their concerns when there are professional disagreements.

The newly revised SCP Escalation Policy to be launched across the borough which demonstrates a clear escalation pathway.

Learning Point Four

The existing Enfield Risk Management Panel is a multi-agency platform for discussing high risk cases where practitioners are stuck with no reduction of risk despite their

interventions. This panel has senior representation from partner agencies and can be used more widely as it offers the opportunity for professionals from across the partnership to present cases directly to senior management, and for practice dilemmas for young people with multiple complex needs to be considered.

When there are differences of professional opinion between agencies in relation to young people presenting with mental health and substance misuse issues these current arrangements could provide a positive forum for these differences to be considered, and ways forward agreed in partnership.

Learning Point Five

SCP to initiate a review whether the functionality of the hospital Child Protection Information System (CPIS) could be developed to flag when a young person is presenting at different Trusts in order to identify patterns, supporting the triangulation of episodes to inform risk assessments and interventions. This review to explore whether the system could be extended to flag children and young people who are reported as missing.

Learning Point Six

The SCP to consider who is best positioned to receive and review all health notifications for children and young people looked after, especially those placed outside of Enfield, so that there is an opportunity to identify emerging themes and patterns through a single health professional perspective.

Learning Point Seven

The SCP to explore the role of the Virtual Headteacher to intervene on behalf of young people in care to negotiate with schools in making adjustments to their entry requirements in order to secure a post 16 placement, where this would be in the young person's best interests, and also to initiate an Education Health and Care Plan when this has not been initiated by the school, but the Virtual Headteacher believes it would better support the child.

Appendix 1

Summary extract of what Working Together to Safeguard Children (July 2018) says about Local Child Safeguarding Practice Reviews

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed

Purpose of Reviews

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose.

Expectation of the Final Report

Safeguarding partners must ensure that the final report includes:

- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children
- an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report

Any recommendations should be clear on what is required of relevant agencies and others collectively and individually, and by when, and focused on improving outcomes for children.

Appendix 2

Josef A&E attendances

November 2019

Whipps Cross Hospital:

22/11/2019 – Taken by ambulance. Josef had taken LSD/Acid. Discharged back to placement.

26/11/2019 – Taken by police. Josef in distress, suicidal ideation (initial decision to seek Tier 4 bed subsequently changed). Discharged back to placement and referral made for psychiatric assessment.

8th January – 11th February 2020

North Middlesex University Hospital:

08/01/2020 – Taken by police concerned he was having a psychotic episode, subsequently placed under Section 136 by police, assessed by CAMHS psychiatrist and Mental Health Act team, assessed to be not detainable under the Mental Health Act. Discharged back to placement for follow up in community.

18/01/2020 – Taken by ambulance, Josef found at train station with head injuries.

Whipps Cross Hospital:

20/01/2020 – Josef presented himself with physical injury and said he had fallen downstairs.

Homerton Hospital:

30/01/2020 – Josef presented himself under the influence of alcohol and agitated, with a head injury (initial decision to seek Tier 4 bed subsequently changed). Josef discharged himself.

Whipps Cross Hospital:

05/02/2020 – Taken by police. Josef said he was going to stab himself, concern that he was psychotic

10/02/2020 – Taken by police. Josef had taken an overdose of aspirin and had taken 2 blue pills earlier in the day. The psychiatrist refused to assess in night as Josef had been verbally, racially abusive previously. Josef left the hospital on 11th before he could be seen by the day team. Police were contacted by the hospital, and he was seen by police at his placement and the decision was taken to leave him there for follow up in the community.

11/02/2020 – Taken by ambulance. Josef was taken from his placement by ambulance after he had been suspected of taking an overdose of aspirin. He was discharged back to his placement.