Publication date: 21.11.2024

Kent Safeguarding Children multi-agency partnership

Local Child Safeguarding Practice Review

Jasper Red [1]

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Introduction

1. The Kent Safeguarding Children Multi-Agency Partnership (the Partnership) agreed to undertake a Local Child Safeguarding Practice Review (LCSPR) to consider the learning identified from considering the professional involvement with a 17-year-old young person, to be referred to as Jasper Red, and their family. Jasper Red was reported missing in 2023 and was subsequently found deceased. An inquest found that the child died by suicide[2] with no third-party involvement. There were two known occasions where Jasper Red had taken overdoses prior to his death, and at other times he shared suicidal ideation with professionals. Jasper Red had lived in three different areas of England and was care experienced.
2. It was agreed that a focused LCSPR would be undertaken, using details of the professional involvement with Jasper Red and his family. This was to provide an insight into systems and practice in respect of children and young people who are struggling with their mental health due to their lifelong experience of abuse and neglect, and to consider the difficulties in working with children who are new to an area and where there is a history of acrimonious private childcare proceedings. Jasper Red was white British and lived with his father, who began following the Muslim religion whilst Jasper Red was growing up. It is also of note that Jasper Red had shared he was gay prior to his move to Kent to live with his mother.
3. Learning has been identified in the following areas:
    - Information sharing and communication when a child moves between areas
    - Consideration of a parent's history, on-going issues, and ability to meet a child's emotional needs
    - Assessment and support when a child is struggling with their mental health and has suicidal ideation
    - Impact of a child's learning needs and sexuality on their vulnerability and mental health
    - The need for those working with adults to consider the wider family context[3]

Process

4. An independent lead reviewer was commissioned[4] to work alongside a panel of local professionals. The process of the LCSPR was outlined in a Terms of Reference which agreed the review should focus on

[1] This is the name chosen for the review by the child's mother and one of his siblings.
[2] The inquest stated the cause of death was 'suspension'.
[3] Also referred to as 'Think Family' https://sway.cloud.microsoft/DpbpAhUKvidzkCAh?ref=Link
[4] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and has undertaken many Local CSPRs. She is entirely independent of the Kent Partnership

the most recent professional involvement with the family, while ensuring there was an awareness of the significant history, including in other local authority areas. The panel met on a regular basis while the review was in progress.

5. The detailed information provided for the Rapid Review process, along with single agency review reports completed for this LCSPR, provided the single agency information, reflection, and learning. Single agency recommendations were also made with action plans that were being completed as the LCSPR was undertaken.
6. A face-to-face meeting was held with the Kent professionals involved directly with the family prior to the Jasper Red's death. This was well attended and provided the review with the opportunity to reflect on both the case and wider systems and practice in Kent. A further meeting was held with professionals in West Sussex who either knew Jasper Red or who are in roles with relevance to the issues emerging. The child had lived in Middlesbrough until 2013. While the school, health agencies and the police in Middlesbrough provided written information to the LCSPR, children's social care provided no information despite numerous requests. No professionals attended the reflective event they were invited to, but this is understandable, as there was apparently no one left working in the area that was involved with Jasper Red in the less than two years that he lived there.
7. The lead reviewer hoped to speak to both of Jasper Red's parents. His father has not yet responded positively to the request. Mother met with the lead reviewer and a representative from the Partnership and provided information about her son and shared her views of where there is potential learning for partner agencies. Her views are included in this report. One of his younger siblings also met with the lead reviewer and spoke about their memories of their brother. We thank them for their contribution.
8. It was hoped that this report could reflect the conclusions of the parallel North East London NHS Foundation Trust (NELFT) Patient Safety Incident Investigation being undertaken, however there has been no response to requests for updates prior to the consideration of this report by the partnership.

The child[5]

9. Jasper Red was described by his family and by the professionals who knew him as funny, sociable and confident. Despite his early experiences and resulting sadness he made friends easily and had ambitions for the future. He embraced his sexuality and despite reportedly hating rainbows was a proud young gay man. His mother told the review that he was 'spiritual' and in May 2022 he told a Child and Adolescent Mental Health Service (CAMHS[6]) professional that his belief in crystals and spirituality helped him manage his emotions. Jasper Red experienced neglect and abuse as a young child. He spent time on a care order and in the care of West Sussex local authority from the age of three. Initially the plan had been for permanency via a long-term foster placement, because of Jasper Red's 'complex and significant needs'. Long and difficult contested care proceedings followed, however, with detailed assessments of both parents, and resulted in the Judge deciding the child should live with his father.
10. Over the course of his three years in care, Jasper Red had five different foster care placements. He went to live with his father and his then partner in Middlesbrough in 2011, when he was aged five. A Residence

[5] This report has been written with the intention that it will be published and only contains information about the child and their family that is required to identify learning.
[6] In this report CAMHS will be referred to, although there has been a change of title in Kent to Children and Young People's Mental Health Services (CYPMHS).

Order was made along with a 12-month Supervision Order to Middlesborough Council. Father's relationship broke down and he returned to West Sussex with his son in 2013. This was another change for Jasper Red, and it was known he had witnessed domestic abuse between his father and partner prior to them separating. Mother told the review that her relationship with Father had been violent, although it appears that agencies had not been aware of this at the time.

11. Jasper Red lived with his father in West Sussex for around nine years. In August 2021, just before he was due to start in Year 11, he decided not to return to his father's care after having contact with his mother in Kent. This was the first time he had seen her in just over a year. This was against his father's wishes. Jasper Red claimed that he had been a victim of non-recent physical abuse and ongoing emotional abuse while in his father's care. Jasper Red was spoken to by professionals, and he was clear that he would not return to his father's care and that he did not wish to have any contact with him. His wishes were noted by professionals, and it was agreed that he would be supported in his move.
12. While he initially appeared to settle, Jasper Red's life in Kent was not without issues, with his mental health noticeably deteriorating. He had an Education Health and Care Plan (EHCP) for a mild to moderate learning difficulty, which had been in place since he was in care in West Sussex. He was also thought to have a degree of disordered eating. He was gay, and while he appeared to embrace his sexuality, it made him more vulnerable in a community where homophobia, stigma, and discrimination is an issue. He told professionals that it had been difficult when living with his father, as he had been concerned that his father would not support him as a gay man.
13. In summary, Jasper Red's known/knowable history and life experience included neglect, sexual abuse, physical harm, domestic abuse, and extreme parental conflict and alienation. He was care experienced and had many different placements between the ages of three and six years old. By the age of 17 the impact was showing, with him having mental health issues which were exacerbated by a continued lack of stability, due to him choosing to live between his family and with a friend, and him not being in education, employment, or training (NEET.)
14. **Analysis and identification of learning**

    Learning: When a vulnerable child moves between local authority areas, there is a need to ensure the timely and detailed sharing of information.
15. Jasper Red was born in West Sussex and lived there for around six years, before moving to Middlesbrough. He lived in Middlesbrough with his father and partner and their children for less than two years before returning to West Sussex with his father. He was aged seven and a half at the time. Jasper Red then remained in West Sussex until he went to live with his mother, her husband, and their children, in Kent when he was aged 15. This LCSPR recognises that it is important to particularly consider the later learning, due to systems and practice changing in the years that Jasper Red was known to services. The focus of this section is therefore largely on the move to Kent from West Sussex in 2021.
16. It is significant to understand that Jasper Red experienced many moves of home and carer during his early years, which is likely to have had a profound emotional effect on him. Those working with him in Kent from 2021 needed to know this history to ensure that he received the support he needed, and that he had the reassurance that he was seen and understood. Frequent moves and disruptions in early childhood are known to lead to difficulty in forming secure attachments. For a child who had previously

lived in a home with parents where domestic abuse and substance misuse had featured, and who had early experiences of trauma and loss, the added instability of multiple foster placements would have had an impact on his emotions and behaviour. By the time he went to live with his father in Middlesbrough, he had an EHCP and a place at a special school for children with SEMH (social emotional mental health) difficulties, as he as he needed help with managing and regulating his emotions due to his lived experiences. Those working with 15 – 17-year-old Jasper Red needed to know this.

17. The anxiety and depression that emerged when Jasper Red was in Kent is likely to have been due to the experiences of his early years, compounded by difficulties in managing his feelings living with the acrimonious relationship between his parents, his stated unhappiness when living with his father, and his potential disappointment about the reality of living with his mother. Jasper Red's childhood was further impacted by the loss of two 'stepmothers' and his half siblings when his father's relationships broke down. The events held for this LCSPR found that a lot of those working with him knew some or even much of the historical information, but that most did not know it all. There was good practice identified, including by West Sussex children's social care and health services when the previously 'looked after' Jasper Red moved to Middlesbrough.
18. As well as changes of placement, home and area, Jasper Red also attended several different schools. There were two primary schools in West Sussex and a special needs primary school for 22 months in Middlesbrough. (There is no record of why the decision was made for Jasper Red to attend a mainstream primary school on his return to West Sussex.) He attended a secondary school in West Sussex, and another secondary school from year 11 in Kent. He then attended a college for vocational training at age 16. While some information was shared between schools, and with the college, there were gaps. Particularly, there were significant delays in information being shared between the two secondary schools when Jasper Red moved to Kent in the summer of 2021.
19. When Jasper Red decided that he wished to remain living with his mother and her side of the family rather than returning to his father's care, it was during the school summer holidays. He had completed year 10 and therefore half of the content for his GCSE courses, in West Sussex. He was well known and popular with staff and peers in his school there, and they were concerned when he left them early. His mother started the process of enrolling him at a school local to her home in Kent at the start of September, but there was some delay in Jasper Red being given a place. The school Mother chose did not accept the application, stating that they did not believe they could meet Jasper Red's particular learning needs (as outlined in his EHCP). No contact was made with the previous school in West Sussex, who had not had any issues or difficulties with Jasper Red. They told the review that he had made progress commensurate with his ability and that his behaviour and attendance were never a concern. Mother formally appealed the decision of the Kent school and in November Jasper Red was offered a place. The new school told the review that they spoke to Jasper Red about what he had previously learned from the GCSE syllabus and tried to compensate for the change of schools and two months of missed teaching. However, they did not request or receive any information from the previous school until April of the following year.
20. Meanwhile, the previous school had been informed by Jasper Red's father that Jasper Red had moved to live with his mother in Kent. They were also informed that the EHCP plan had transferred to Kent. The team responsible for administering and reviewing the EHCP in West Sussex reflected during the review

that it would have been better practice to share information at the stage of transferring the EHCP with the previous school and will now be adding this to their processes. The old school asked Father for details of Mother's contact details, address and the new school Jasper Red was attending, but Father did not know these details. The West Sussex school tried to contact Mother to ask for information, but it appears there was an issue with the two email addresses they had. Mother told the review she often changed her contact details to ensure that her ex-partner could not contact her, due to a history of abusive communications. The West Sussex school also made a referral to West Sussex Pupil Entitlement as Jasper Red was a 'child missing from education'. They did not seek information about where the EHCP had transferred to or whether CSC had information about where the child had moved to however, which has been identified as learning by them.

21. While it is the responsibly of the old school to transfer the child's records[7], it is good practice for the new school to request them if they do not do so. In this case the new school did not ask Mother or Jasper Red the name of his previous school and did not contact them to discuss Jasper Red, despite him being a vulnerable child. They did not request his records/file until April 2022. The review has found that there was limited and ineffective linking of knowable information at the time and learning for all agencies involved.
22. There was some liaison between children's services and police forces around the time of Jasper Red's move in August/September 2021. The Kent Front Door Service (FDS) made enquiries of both West Sussex and Middlesborough Children's Services to seek information about their non-recent involvement, which is good practice. However, it was acknowledged during the review by those working with the family at the time that that the extent of Jasper Red's history was not fully shared or appreciated. Jasper Red's mother had told the FDS that she would appreciate support and the Early Help service became involved with the family in a timely way in September 2021. Early Help were aware of Jasper Red's past trauma and exposure to emotional and physical abuse, the alleged reports of sexual abuse, and his learning needs. They would have benefited from timely updates from CAMHS about their involvement with Jasper Red to inform their intervention, however. The focus was on the more immediate issues such as the practicalities of him moving to live with his mother and her family, then later his unstable mental health and his disengagement with education at various times and his uncertain living arrangements. The Early Help support included direct work with the whole family, including work with Jasper Red about his newly disclosed but long-term self-harm by scratching. The Early Help worker also tried to engage with Father in West Sussex, but he reportedly became hostile and aggressive and refused to engage once he was told Jasper Red wished to remain in Kent. It was good practice to attempt to engage him. Shortly after the first Early Help episode ended in December 2021, Jasper Red took an overdose of co-codamol. The FDS was informed but a decision was made to take no further action due to the recent positive involvement with Early Help and him being referred for mental health support. The opinion was that taking no further action at the time was proportional.
23. The response to Jasper Red's mental health is considered further below. In respect of information sharing and knowledge of his significant history with and from mental health services, the following is noted: Jasper Red and his paternal family were offered significant support from CAMHS in Middlesbrough, but

[7]https://assets.publishing.service.gov.uk/media/64f0a68ea78c5f000dc6f3b2/Keeping_children_safe_in_education_2023.pdf

there does not appear to have been any involvement in respect of emotional or behavioural issues in West Sussex. When he initially moved there at age seven, there was a referral to CAMHS with details of the child's known history and the support provided by CAMHS in Middlesbrough. The need identified was for play therapy which CAMHS did not provide, and it was agreed that the school could coordinate this work. While at secondary school, Jasper Red made regular use of support available from a school-based learning mentor, who he appears to have had a good relationship with. As there was no on-going support with his mental health, there was no need or requirement to transfer information or services when he moved to live with his maternal family in Kent in August 2021.

Learning: There is a need for professionals to consider the impact of parent's history on their ability to parent their child safely. This should include consideration of their ability to meet a child's emotional needs, including when the matter is within private law proceedings.

24. Both of Jasper Red's parents had traumatic childhoods themselves, and a recorded and reported history of abuse and neglect. Mother's father was a heroin user and both parents died young, resulting in her spending time in care. She was also a victim of sexual abuse in the family environment. As an adult she had used heroin and other substances herself, had abusive relationships, and has suffered with her mental health. Father experienced physical abuse and neglect as a child and has mental health issues and problems with alcohol as an adult. He has been accused of being domestically abusive in his relationships and has recently also accused his partners of being abusive to him. He is also known to the police for other types of criminality.
25. Jasper Red's parents' relationship was short-lived but there has been long term acrimony in respect of residence and contact for their son. The court decided in December 2011 that Jasper Red could live with his father and partner in Middlesbrough, after care proceedings that lasted for three years. A contact order was given to his mother for contact six times a year, and she has maintained and then increased family time with her son. There were occasions however where the father stopped contact, which Jasper Red told his school made him very sad. By the time that Jasper Red moved to Kent in 2021 he had not seen his mother in over a year, though prior to that had been staying with her every other weekend and in school holidays. She told the review that he had a good relationship with his stepfather and siblings. In 2016 Mother had applied to the court for residence, stating that Jasper Red had been the victim of physical abuse from his father. A section 7 report was completed by CAFCASS and although Mother's contact was increased, it was agreed that Jasper Red should remain in Father's care. Jasper Red then refused to return to Father in 2021, which was around the same time as CAFCASS were involved in private family court proceedings between Father and his most recent partner in respect of their children, with allegations of domestic abuse in those proceedings. The court made a Child Arrangements Order for Jasper Red to live with Mother in March 2022. CAFCASS has identified single agency learning about recognising the impact of domestic abuse in private law proceedings, including across different cases within a family if relevant.
26. While it is impossible to ask Jasper Red now about his experience of the incredibly difficult relationship between his parents, it is likely that he was negatively impacted by alienating behaviours and implacable hostility in the ongoing disputes about residence and contact. The term 'alienating behaviours' is often used to describe 'circumstances where there is an ongoing pattern of negative attitudes, beliefs, and

behaviours of one parent (or carer) that have the potential or expressed intent to undermine or obstruct the child's relationship with the other parent.' This can include 'negative attitudes, behaviours and beliefs that denigrate, demean, vilify, malign, ridicule or dismiss the child's other parent.'[8] It is important that professionals are aware of the potential existence of alienating behaviours or implacable hostility[9] in a case where there is a dispute about residence or contact. CAFCASS workers and those involved in decision making in courts are aware of this and it is recognised as emotionally abusive for children where there is evidence that one parent is attempting to turn the child/ren against the other, often with the misplaced belief that this will protect their child from a parent who they despise or wish to exclude from their life. Jasper Red's father was aware of the abuse and neglect his son suffered while in his mother's care as an infant, and this was often spoken about with the child himself and with professionals involved with the family, By the time that Jasper Red had decided he would not return to his father's care at age 15, his father was stating that Jasper Red had been sexually abused by his mother. This had never been alleged by the child or by the father previously and was denied by Jasper Red who had stated that he had been abused as a very young child by a partner of his mother and by an associate of his fathers' more recently.

27. On the CAFCASS website there is recognition that 'when a child's resistance or hostility towards one parent is not justified and is the result of psychological manipulation by the other parent' this needs to be considered by the court and the child's needs must then be given precedence. CAFCASS have a Child Impact Assessment Framework which Family Court Advisers can use to help them assess the impact of factors such as domestic abuse and harmful conflict. The framework acknowledges the complexity of such cases and aims to keep the child's needs, wishes and feelings central to the recommendations they make to the court, with the final decision being made by the court, as was the case when Jasper Red was clear in 2021 that he wished to live with his mother and his family in Kent. This was not the case in the previous proceedings when Jasper Red was a younger child, as a framework to comprehensively assess such behaviours was not available to family court advisors at the time.
28. The complexity for professionals when working with Jasper Red was evident. The review found he was a child who had experienced poor care both in-utero and post birth. He had previously withdrawn from drugs after birth. He had spent his first few years living with his mother while she was misusing substances and had an abusive relationship with her then partner. Mother clarified that she was free from drugs and alcohol during pregnancy and that Jasper Red withdrew from the anti-depressant medication she was on at the time. She shared that during Jasper Red's early childhood, she fluctuated between maintaining a drug free life and relapse into substance use. It is known that the children of those who have chronic substance misuse issues are likely to have limited parental stimulation, which can lead to developmental issues, problems at school, and potentially learning difficulties[10]. This was Jasper Red's early experience.
29. The harm to Jasper Red cumulated as he had several moves of home, foster carers, and schools, which would have further impacted on his development. Information available from his arrival in Middlesbrough at age six shows that he was already subject to a EHCP for SEMH and required a referral to community CAMHS (by his social worker in West Sussex) requesting support to his father and partner to manage his

[8] Parental Alienation: In Search of Common Ground for a more Differentiated Theory. FCR April 2020. Johnston & Sullivan.
[9] 'Implacable Hostility: Parental Alienation' Dr Ludwig Lowenstein (2008)
[10]Cleaver et al. Children's Needs, Parenting Capacity. 2001

'complex needs' which included 'delayed development and emotional delay with inappropriate attachment' and a referral to occupational therapy to work on his fine motor skills and gait. However, there was evidence of a further deterioration of Jasper Red's behaviour while in Middlesbrough, and concerns about the impact on him and on the other children of the family dynamics. Family therapy had been identified but appointments were missed. Soon after, Father's relationship broke down, and he moved back to West Sussex with Jasper Red. This added more disruption and changes for a child who was already struggling with his experiences.

30. There were limited concerns for Jasper Red following his return to West Sussex. However, it appears that he disclosed sexual abuse from his mother's partner that had happened when he was age three, and domestic abuse, although not known at the time, was later alleged by Father's latest partner in West Sussex. Jasper Red also disclosed physical abuse from his father in 2015. An assessment was completed with no further action taken. In 2019 the Police were contacted by a younger sibling living in Middlesbrough. They said that they had overheard an argument while on the phone to Jasper Red and that they were worried that their father was being physically abusive to him. There were also concerns at this time that Jasper Red was self-harming when he was upset or stressed. An Early Help request was made for services in West Sussex, but there is no evidence that any work was undertaken.

31. In August 2021, both parents contacted CSC in West Sussex and the front door in Kent about Jasper Red's refusal to return to his father's care. Both were advised that this was a private legal matter, and that legal advice should be sought. This was a repeat of a pattern for Jasper, as his mother contacted West Sussex CSC on several occasions to share concerns about Father's care of their son, and she was advised to seek legal advice without robust consideration of the allegations made. This, and other LCSPRs, show that there can be a preconception amongst professionals that a child's situation should remain in the private law setting when there have been previous private law proceedings. There is a need, however, for any allegations and safeguarding concerns to also be considered by statutory agencies whether private proceedings are ongoing or likely. Both Kent and West Sussex have recognised this as an issue in other cases and are undertaking pieces of work to ensure improved practice in this area[11], so no further recommendation has been made in this review. In Kent there is another ongoing LCSPR where there is significant learning about professional understanding of private law and relevant recommendations will be made in that case. It is also important that the national CSPR panel recognises this as a significant national issue.

Learning: The response to Jasper Red's mental health and overdoses

32. It is important for the review to consider what services Jasper Red received in respect of his mental health. While there had been involvement of CAMHS in Middlesbrough, Jasper Red had not received specific mental health support while living in West Sussex. Although he reportedly had a good relationship with his head of year and with a learning mentor while attending secondary school there, it was not until he arrived in Kent that he shared his previous challenges in this area. He said that he had been self-harming for around six months prior to the move to Kent. He received support from a Kent Early Help Worker, and they made a referral to CAMHS as well as to the Mind and Body service, for support with his

[11] Including guidance and training.

mental wellbeing and self-harming. He was assessed and offered a place on a group work programme. He did not attend however, as in the meantime he had taken an overdose and Mind and Body was informed by Mother that he was waiting for support from CAMHS.

33. Prior to Jasper Red moving to live with his mother, she had been struggling with her own mental health. Reflection during the review has found that those supporting Mother at the time, including the Mother and Infant Mental Health Service (MIMHS), the community mental health team (CMHT), and her GP, while undertaking good assessments and providing medication and significant caring support, did not sufficiently consider the impact of her fluctuating mental health on her children. There was some exploration of her interaction with the youngest child but not the older children, and no evidence of consideration being given to how her worsening mental health and reported issues at home could impact on her ability to be emotionally available and safely parent her children. The role played by her husband in the family and impact on her relationship also needed to be considered, beyond Mother's self-report. There was one occasion where Mother spoke to her mental health worker, following Jasper Red moving to Kent, and she received advice on how to support him with his own mental health issues. There was no evidence of any information seeking or sharing in respect of Mother's own poor mental health when considering the support that Jasper Red required.
34. The report provided for this review from mental health services notes that the children and Mother's partner were recorded as and seen as 'protective factors' for Mother. While this terminology and thinking is common to those working in adult mental health services, it is now recognised as unhelpful and concerning when considering the children of those with mental health concerns. It does not consider their vulnerability or any potential risks to them due to their parent's mental health difficulties and the pressure of them of feeling they need to be a 'protective factor'. This issue has been identified in a number of CSPRs both locally and nationally. As pointed out by mental health services during this review, a meeting with the Early Help workers providing family support at the time could have allowed for the triangulation of information, recognition of the children's vulnerabilities, and the potential need for support to avoid emotional harm and neglect due to their mother's worsening mental health. It is of note that at the time there were also concerns about the mental wellbeing of another of mother's children.
35. The younger children had been referred to the Young Carers project just prior to Jasper Red moving in. CAMHS made the referral as they had identified that the younger siblings (one of whom they had been involved with) required support due to their parents' mental health needs. Learning has been identified about the need for the project to always ask and consider who lives in the family home and may be impacted by issues in the home, as they had little awareness of Jasper Red's presence and impact. This reflects a wider issue that the review found in respect of agencies needing to make sure that professionals always think about other family members beyond the individual they are assessing or supporting.
36. On New Years Eve 2021/2 Jasper Red took an overdose of prescribed pain medication belonging to his mother. Triage notes from A&E state that he had '*suicide ideation'* and a '*plan to end his own life'*. He told the Crisis Assessment Intervention Team (CAIT) clinicians that he was worried about the stress his mother was under and had a fear he would have to return to his father. He said he wanted help to overcome the voices in his head. Appropriate referrals were made to local CAMHS following the mental health pathway, and to the Front Door Service. There was no record of liaison with Early Help although they were aware

of their recent involvement. Jasper Red was seen by his local CAMHS team two weeks later for an initial assessment. He was placed on the Mood and Anxiety pathway; a safety plan was put in place, and it was recommended that he receive CBT[12]. He was also encouraged to download self-help apps; WYSA (for managing anxiety); and Kooth (an online platform for children and young people to explore their mental health needs). In January he was referred to his schools' Wellbeing and Learning Mentor for weekly sessions. The school also instated a safety plan, where Jasper Red had a welfare check upon arrival at school and a bag search.

37. This review has identified learning in relation to information sharing about safety plans and ensuring they are 'joined up' and potentially standardised. For example, A&E were not aware of the safety plans that were in place when Jasper Red presented there. They have limited access to the Kent and Medway Care Record, that can contain GP records if they have been uploaded to the system by primary care. CAMHS and Mind and Body made safety plans that were shared with the GP and with the family and recognise that it would have been helpful to share them more widely. There was evidence of some discussion with the school, but the safety plans were not shared specifically, with the school making their own separate plan. West Sussex reported that they have similar issues. NELFT are currently undertaking a piece of work in Kent, linked to another review, which it is hoped will make a difference in respect of sharing known and knowable mental health information. A recommendation has been made.
38. In the meantime, Jasper Red was seen by a consultant paediatrician, having been referred by the GP, about his physical health. His disordered eating, including purging after eating, was discussed. There was no clinical reason found for his physical symptoms, and it was agreed that no further paediatrician review was needed. There was no communication noted with CAMHS who had agreed Jasper Red required support but had not yet contacted him. The review was told that at the time CAMHS had extensive post pandemic waiting lists, staff shortages and that the team was in 'business continuity'. This means that it was difficult to ensure children were seen within the expected timescales. Nationally, CAMHS services have been under increasing pressure in recent years. The mental health charity, Young Minds, published an analysis of NHS data in 2023. They concluded that the number of children in mental health crisis has reached record levels in England, with the number of urgent referrals in May 2023 three times higher than in May 2019, and almost double the 2022 levels. The NHS data also shows that the number of children receiving mental health care or on waiting lists also reached new high levels. It was acknowledged that the likely wait should have led to an exploration with the family of what other support they were receiving and consideration of what signposting or referral would be helpful.
39. There was a delay in Jasper Red receiving any support from mental health services. (It was July 2023 before he received a CAMHS therapeutic intervention.) Mother contacted CAMHS two months after the overdose (March 2022) reporting concerns that Jasper Red's mental health was deteriorating. This included concerns around his eating. He was not seen or spoken to and there was no further contact with or from CAMHS until he was taken to A&E at the end of April having disclosed in school that he had active suicidal plans to end his life by taking an overdose. A mental health core assessment and risk assessment were completed by the Crisis Assessment and Intervention Team (CAIT) team. During the assessment Jasper Red reported that his risks of self-harming escalated due to arguments in the home.

[12] Cognitive Behavioural Therapy

There was nothing further recorded about the arguments and no evidence that this was shared with any other professionals or a referral for additional support from other services considered, including school health or Early Help, who had previously been involved.

40. It was also noted that Jasper Red was restricting his food intake to lose weight and because of his low mood. It was agreed that, despite this, generic CAMHS should offer the appropriate support. The Intensive Home Treatment Team (IHT) saw Jasper Red at school several times over the next few weeks. There is evidence of the child's voice in the recordings and that the practitioners tried to get to know him and to explore his state of mind. Learning has been identified about the need to find out more about life at home, and to explore with Jasper Red what his lived experience had really been like following his reunification back to his mother's care. There were times when Jasper Red was not spoken to directly, or when he was spoken to, it was in his mother's presence. For a child who had so much at stake, having left his father's care and invested in the idea of living with his mother and that part of his family, this would not have allowed professionals to explore any difficulties and disappointments about his current living situation.
41. While it appears that Jasper Red made use of the IHT sessions, he voiced his disquiet that he had no consistency of IHT worker, and how he preferred not to be seen by different practitioners each time. He requested the same worker, although he does not appear to have said, or have been asked, which of the workers he wanted. This was noted and efforts were made by the IHT to plan around this. However, it is noted that Jasper Red also shared that he was gay and that he had struggled with other males. It does not appear this was explored if he felt like this with male clinicians. At this time, he was requesting antidepressant medication. IHT therefore requested a medical review, and committed to continue seeing him until a joint review was arranged to transfer care to local CAMHS service.
42. The school also provided good 'voice of the child' to the LCSPR from this time, as Jasper Red shared with his mentor at school that he was struggling at home, was not sleeping well and had a complex relationship with his mother and stepfather. He also spoke of his ongoing issues with food and self-harming which did not require medical attention. While Jasper Red was seen in school by IHT, there was no record of any communication with the school. There is little evidence of communication with any other professionals about him at the time. Around this time, one of the younger primary school age siblings was also requiring mental health support. There is no evidence that the connection between the two children was made. They were not linked on the electronic data base and there is no evidence that professionals made enquiries about whether any of the other children in the home were receiving mental health support, which limited the ability of professionals to think about and consider the wider family contact and to be curious about what was happening for other family members beyond those they were working with.
43. IHT and the local CAMHS agreed with Jasper Red and his mother that he would remain on the waiting list for Guided Self-Help[13] and that he could be seen by a psychiatrist to discuss his request for medication. He then missed a face-to-face CAMHS review. Processes were followed as CAMHS rang Mother, who confirmed that Jasper Red had an exam that day. It was agreed that it would be followed up with a new appointment, but due to a missed call to Mother, this appears to have been missed, with a gap of around 6 months before the records were reviewed. There had been no contact with or from the

[13] Guided self-help is where you work through a self-help workbook or computer course with the support of a therapist.

family, or any other agencies, during that time. When a telephone appointment was made followed by a face-to-face meeting, CAMHS were made aware that Jasper Red was not living at home and that he was smoking cannabis. His mother voiced her concern that he was vulnerable as he had recently been chased by someone, that he was 'easily led', that he had jumped off a bridge into the river, and that he was 'partying' a lot. He was prescribed Melatonin for sleep, but there is no record of any exploration of or consideration of his vulnerability to exploitation or around referral to drug and alcohol services, although CAMHS unsuccessfully tried to contact the college to discuss Jasper Red.

44. Jasper Red missed some CAMHS appointments during the spring/early summer of 2023, and in July 2023 he took an overdose of pain killers and prescribed medication of unknown origin. The crisis practitioner who saw him assessed that he did not present with symptoms of an acute mental health disorder or a level of risk of harm to self, or other people, and that local CAMHS were the most appropriate service to manage his care. It was further recorded that a medication review should be undertaken in conjunction with long-term therapy, and that the transition process to adult services should start. It is recorded that he made a complaint at the time that he didn't get enough time within his CAMHS sessions to discuss his concerns, and he requested a new psychiatrist. CAMHS staff told the review that at the time it was thought this might be because the psychiatrist was reluctant to make a diagnosis or prescribe medication, which is something Jasper Red wanted. Early Help advocated on behalf of Jasper Red to share his views with CAMHS in June 2023 and August 2023, which was good practice. Early Help attempted to gain updates about Jasper Red's mental health to inform their interventions, and received some limited information. It would be helpful if letters written by CAMHS to GPs outlining their involvement with a child were also copied to other professionals involved with the child. In this case, Early Help.
45. Those in CAMHS who knew Jasper Red and assessed him are clear that at no time did he meet the threshold for tier 4 provision or require a bed in a mental health unit. He started CBT therapy 18 months after he was placed on the waiting list and had four sessions before he was reported missing. The previous face to face session had been five days before this and during that session Jasper Red showed no suicidal ideation. Jasper Red had previously said however that he was impulsive and would potentially carry out suicide without a plan and when feeling very low. During the session, psychoeducation was introduced, and they reflected on how past trauma that is linked to how he had been feeling. Jasper Red did not see another professional before he died.

Learning: The need to consider the different and potentially cumulative vulnerabilities for Jasper Red.

46. Jasper Red believed his father to hold negative views about gay people, and he spoke about how difficult this was for him. Despite this, Jasper Red was a young person who was proudly gay. While he reportedly felt empowered by being himself, consideration of his vulnerability as a young gay man with mental health problems and learning needs was required. It is important to ensure intersectionality is considered and explore what this means to a child and family in terms of their lived experiences. While those involved with Jasper Red were aware of his vulnerabilities, it would have been good practice to speak with him about this and consider what bespoke support he may need.
47. The Independent Inquiry into Child Sexual Abuse published findings in May 2022, that LGBTQ+ children experienced specific challenges which can increase vulnerability to child sexual abuse, with 'additional barriers making it difficult to disclose, access support or form adult relationships.' The inquiry quoted

survivors who said they 'experienced confusion, frustration, or difficulty with understanding their own sexual orientation or gender identity because of sexual abuse. For many this was made much more difficult because of the myths, stereotypes, and attitudes in society.' Children questioning their sexuality can also be vulnerable to abuse on-line, and before he lived in Kent there had been some concerns in respect of this. Jasper Red was asked about relationships, those he spent time with, in person and on-line, and there was sensitive practice in this area.

48. In his earlier years there had been concerns about Jasper Red's sexualized behaviour and touching. This was appropriately identified as him being a victim of sexual abuse. When in Middlesbrough a referral was made to Bridgeway, a Barnardo's project supporting children around inappropriate touching. When living in West Sussex Jasper Red made an allegation of non-recent abuse from his mother's partner, who had lived with them until he was aged three. This increased his vulnerability for further abuse, and of having mental health issues as he grew up. Those working with him needed to be aware of this.
49. Early Help became involved with Jasper Red again around eight months after they closed the case. The main concern at the time was him going to stay/live with a friend and no longer wishing to live at home. He was 16. He was not formally reported as missing as it was known he was at a friend's house, despite his vulnerabilities and little being known about the friend and his home life. His Mother was told that she must report him missing if he did not provide details of where he is staying, even if she saw him on occasion, as she stated she did. However, the review found some difficulties in respect of this plan, as when the police were called, they stated he was not missing if his mother had seen him.
50. A child going missing is a common and frequent indicator of child exploitation, and whether Jasper Red was at risk was considered at the time. The Kent Children Missing From Home and Care Procedures were updated in August 2023, just before Jasper Red went missing. They state the importance of understanding why a child goes missing, including considering the 'push and pull' factors. This is understanding that 'a child can be 'pushed' from something, including (but not limited to) abuse, neglect, family conflict, and bullying. Alternatively, a child can be 'pulled' towards something, for example those who wish to groom children or young people for the purpose of sexual or criminal exploitation.' In the case of Jasper Red there was some understanding that he was struggling living at home, however the pull factors were acknowledged to an extent but not well understood. Kent Police have recently rewritten their missing procedures and organised training for key staff, which will lead to improved responses.
51. Early Help visited Jasper Red at his friend's home in June 2023, due to increasing concerns about him being NEET and a reported decline in his mental health. They felt it was important to consider where he was staying as well as ensuring they saw him as he was not actively engaged in any services at the time. This showed some awareness of the need to consider the wellbeing of a child who was effectively 'sofa-surfing' and the need to ensure his basic care needs were being met, along with considering if he was at risk of any contextual harm[14]. Jasper Red said he did not want to engage with Early Help at the time, but their concern that he might 'drop off the radar' led to them visiting him anyway, which was good and child centred practice. Having met with Jasper Red and those he was staying with, it was felt that the biggest concerns were his mental health needs and education. There was good liaison with the college by the Early Help unit lead, who was actively supporting the Early Help worker due to the complexity of the case.

[14] It is noted that the Exploitation Assessment and Toolkit was not completed for Jasper Red.

They told the review that it was more difficult to establish lines of communication with children and young people's mental health services, which is a wider system challenge for early help.

52. Learning was identified about the potential additional benefit at this time of having a multi-agency/disciplinary meeting, which was not identified at the time. It is noted that at no point since Jasper Red arrived in Kent was a multi-agency meeting held. It is clear from considering Jasper Red's case that there is a need for children and young people with mental health difficulties, who are being supported by a mental health services and other agencies, to have regular information sharing meetings to include others involved with the children. In the case of Jasper Red this would have included CAMHS, Early Help, and his school then college. Guidance for Early Help Review Meetings was issued in June 2023 and included the minimum requirement for multi-agency professionals to be included in the first and last review. This guidance had not been embedded at the time of involvement with Jasper Red.
53. Early Help closed their involvement in June 2023 but reopened Jasper Red's case a month later, after he took his second overdose. The focus of the new episode of Early Help was on housing and benefits, as they were told by Mother that she was going to have to ask Jasper Red to leave as relationships at home were increasingly difficult. Advice was offered about homelessness, benefits and applying for Personal Independence Payments. Early Help did maintain their child centred practice with Jasper Red however, and listened to his views, which was challenging, as he often stated that he did not wish to work with them. They continued to try and address this, in recognition that life was not going well for him, which was good practice. They were reassured that he was in receipt of support for his mental health, and they looked at other things that Early Help could do to support him and build independence.
54. Consideration was given to a transfer from Early Help to the ICS Adolescent Support Team, for a Joint Housing Assessment, and advice was taken from them. It was agreed that the focus should be on supporting him to remain as part of his family, however. Jasper Red and his mother were told and offered ongoing support with his mental health and living together as a family. No concerns were shared at the meeting, but Mother told the review that Jasper Red wanted to live independently and was very disappointed he would not have the opportunity to be assessed for this. Jasper Red was open to Early Help at the time of his death.
55. It is known that Jasper Red, his family and some of his peers had beliefs in spiritualism, and it is possible that this had an impact on what happened. However, there was very little known by professionals about this prior to Jasper Red's death, so it has not been pursued as part of this review. However, it is still important to highlight that professionals need to explore a child or family's beliefs holistically, (when considering diversity and exploring lived experiences) including who or what might be influential in their life and the impact this has.
56. Mother told the review that she felt that additional reflection was needed about the response to Jasper Red going missing, with the potential for learning to be identified. She was concerned about the robustness of the search for her son and has questions about why the area where he was found had not been searched more extensively earlier. The Rapid Review considered the initial response and were satisfied that the response was managed as expected, however it is acknowledged that the time it took to find Jasper Red was traumatic and difficult for the family.

57. Discussions as part of the review also recognised that there is a need to consider how information is managed when a child is missing. Procedurally the police have the responsibility for advising the media regarding children and young people who are missing, to assist in locating them swiftly. A child's friends and family members also often share information on social media, as was the case with Jasper Red. This means that other agencies and professionals may not be aware of the missing episode until later, particularly if it occurs out of hours, and feel they have to catch up. The Kent Partnership are looking to understand this in more detail by undertaking a separate LCSPR in respect of a different child.

Conclusions and recommendations

58. Jasper Red died when he was 17 years old, after a lifetime of living with the impact of abuse, neglect, inconsistency of care, and worrying about the needs and vulnerabilities of his parents and their extremely acrimonious relationship. There is clear evidence of cumulative harm which exacerbated the risk to him. His mental health was impacted by his past as well as his uncertain present, and he required timely mental health assessment, support and treatment. Learning has been identified about safety planning and support for children who have attempted suicide, the need to consider an individual's wider family context, information sharing when a child moves area, the impact of parental mental health, and the impact of intersectionality and discrimination.
59. There has been relevant learning in other reviews being undertaken in Kent, in respect of parental mental health and children who are the subject of private law proceedings. It is recognised that actions have already been taken in relation to some of the multi-agency and individual agency learning, and that changes have been made. For example, Mind and Body and CAMHS have undertaken work to ensure improved transitions to support young people. Mind and Body now have a process of contacting CAMHS two weeks after they share information or make a referral, to check the status of support and to advocate for the child if appropriate.
60. Having considered further learning identified during the review, and recognising the need to check that the reported changes are effective, the following recommendations are made.

Recommendation 1:

NELFT to provide an update to the Kent Safeguarding Children Multi-Agency Partnership on the work being undertaken to ensure improvements in safety planning for children who are known to be a suicide risk. This should include the forming of next steps within the plans and more effective sharing and communicating of the safety plan[15].

Recommendation 2:

KMPT to inform the Kent Safeguarding Children Multi-Agency Partnership of the actions being taken to ensure that the need to consider the wider family context is embedded in practice and making a difference in their service to vulnerable families. This should include the fact that children should not be seen as a protective factor.

Recommendation 3:

[15] Including providing directions on where any safety plan is held.

That the Kent Safeguarding Children Multi-Agency Partnership considers how they can ensure optimum learning across agencies about cumulative harm, starting with a multiagency learning event which includes Jasper Red as an example of the impact of this.

Recommendation 4:

That NELFT, Kent and Medway ICB and other relevant health agencies consider how they can improve practice in respect of appropriate access to information and information sharing about mental health, including access by health services/practitioners to the Kent and Medway Care Record. They should then make clear recommendations for improvements and provide feedback the to the Kent Safeguarding Children Multi-Agency Partnership Learning and Improvement sub-group.