cscb
Croydon Safeguarding Children Board

Serious Case Review Summary

Child Q

“Where were you when I was six?”

Charlie Spencer March 2019

The contribution made by family members to this report has been invaluable. The CSCB are extremely grateful for their courage in coming forward to share their experiences of the services provided so that other children and families may benefit from the lessons learnt by this review.

The CSCB offer sincere condolences to Child Q's family for the tragic loss of their child who was loved by all family members.

Contents

Section	**Subject**	**Page no:**
Chapter 1	Introduction	4
Chapter 2	Background to this SCR	6
Chapter 3	Methodology	6
Chapter 4	Family Perspectives	9
Chapter 5	Practitioner Perspectives	10
Chapter 6	Case History, Analysis, Findings & Recommendations	12
Chapter 7	Conclusion	22
Appendix 1	Bibliography & References	24- 25

CHAPTER 1 - Introduction

This Serious Case Review concerns Child Q, who was aged 16 years when he died following a moped crash. When this SCR took place, the Vulnerable Adolescent Thematic Review [1] was underway in Croydon. This Thematic Review involved a comprehensive analysis of multi-agency involvement with 60 children who were known to be vulnerable, Child Q was included in this review. The Vulnerable Adolescent Thematic Review should be read in conjunction with this Serious Case Review (SCR).

At the time of Child Q's death, he was a looked after child (LAC) with Croydon Children's Services and was living in the Midlands with members of his extended family. On the day of the collision, Child Q had been released on conditional bail from a remand court for breach of his court order. Family members and professionals requested that Child Q should be made the subject of a curfew and tagging, but this was not put in place and he returned to London where the fatal accident occurred.

Child Q was described by his family as a bright intelligent young man who loved his family. He was a talented young footballer and he aspired to be a professional footballer. Child Q's first conviction ended his aspirations and motivation to play football. Throughout his life, he lived with various family members and foster carers. He was often missing, was both a victim and perpetrator of various offences, was involved in high risk behaviour and believed to be a gang member.[2]

Child Q seemed to understand the concerns of professionals and family members that his high-risk behaviour could end very badly, but he appeared resigned to this being almost inevitable and the role of the gang in his life was very important to him. During the latter stages of professional involvement, Child Q asked a professional **"where were you when I was six?"** Although it is unclear exactly what he meant by this, it was understood it may have been a recognition of the help his family needed when he was young. This question has been used as the title for this report and is used as the basis for questions posed about service delivery within the Vulnerable Adolescent Thematic Review.

National and Local Context

The Vulnerable Adolescent Thematic Review details the national and local context in relation to children who are vulnerable to exploitation, serious youth violence and gang activity and refers to the Ending Gangs and Serious Youth Violence[3] strategy (EGYV). This strategy report identifies that a high proportion of males from Black and Minority Ethnic (BME) backgrounds were disproportionally involved in gangs or serious youth violence. The EGYV strategy illustrates the 'journey of a gang member' and suggests that children and young people who are involved in this behaviour came to

---

[1] Croydon Safeguarding Children Board: Vulnerable Adolescent Thematic Review. C. Spencer, B. Griffin, M. Floyd. February 2019

[2] In order to determine whether or not a child is a member of a gang, police, the gangs' team and YOS gather relevant intelligence and conduct specific assessments in order to make this decision

[3] Ending Gang and Youth Violence. A Cross-Government Report including further evidence and good practice case studies. HMG 2011

the notice of key agencies from an early years setting, throughout primary and secondary education and were known to key agencies such as police, youth offending, Children's Services and health (including CAMHS).

Alongside the increase in gang membership, serious youth violence and knife crime, moped enabled robberies have significantly increased in recent years. London has seen more than 22,000 moped-related crimes in the last year, more than double the number in the previous year.[4]

Children's Services are increasingly expected to respond to safeguard children via child protection or child in need (CIN) approaches. However, in isolation, these responses are not effective in dealing with the complexity, risk and vulnerability of a child with behaviours like Child Q.[5] The blurred line between vulnerability and risk, in the home or in the community or both, creates an uncertainty amongst professionals as to how best to respond. Should children at risk be taken into care, made the subject of child protection plans or receive services as children in need? If not, what are the viable alternatives? This Serious Case Review suggests that where preventative services are not available, where there is narrow focus on the risks inside the home and restricted multi-agency working, there are few viable alternatives. This SCR will explore some of these key issues for the wider children's safeguarding partnership.

Could this happen again?

The Vulnerable Adolescent Thematic Review identifies several practice, policy and procedural issues that need to be addressed locally and nationally in order for services to have the desired impact on children and young people to prevent further incidents of serious youth violence, and to curb the pull for young people to gang allegiance, these issues are relevant to this SCR.

The prevalence of knife crime, or other gang-linked behaviours such as moped robberies, and the complexities of providing services to children affected by gangs and serious youth violence presents significant challenges for services. The lack of a comprehensive understanding of the risks and vulnerabilities in the home and community is exacerbated by reducing resources to constructively engage young people to divert or prevent involvement in gang related activity.

Given the size of London and how transient some young people involved in this lifestyle can be, especially when placed in various locations for their own well-being (requiring handovers, transfers and complex information sharing), the challenge for multi-agency services are acute. The reduction of preventative services for young people often results in a reactive, rather than a pro-active, response. As children's high-risk behaviour escalates so does the service response and the statutory mechanisms used to safeguard a child reach the highest possible levels.

[4] https://news.sky.com/story/why-moped-crime-is-rising-and-how-you-can-avoid-being-a-victim-11399439
[5] That Difficult Age - Developing a more effective response to risks in adolescence. ADCS Research in Practice 2014

CHAPTER 2 - Background to this SCR

Croydon Safeguarding Children Board Serious Case Review Subgroup reviewed the circumstances of Child Q's case and agreed that the statutory[6] criteria had been met for a Serious Case Review.

This guidance specifies the following:

> *a serious case is one where: (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.*

Serious Case Review should be conducted in a way which:

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

The purpose of the SCR is to:

- Look at what happened in the case and why and what action will be taken to learn from the review findings
- Identify actions that result in lasting improvements to those services working to safeguard and promote the welfare of children.
- Provide a useful insight into the way organisations are working together to safeguard and protect the welfare of children. [7]

CHAPTER 3 - Methodology

Two independent consultants were commissioned to undertake this Serious Case Review. Exemplary co-ordination and administrative support was provided by the CSCB Business Manager and team.

[6] *Working Together to Safeguard Children- A guide to inter-agency working to safeguard and promote the welfare of children.* HMG 2015

[7] *Working Together to Safeguard Children- A guide to inter-agency working to safeguard and promote the welfare of children.* HMG 2015

Bridget Griffin, Independent Consultant, was appointed as Chair of the Serious Case Review Panel. Bridget has extensive experience in statutory safeguarding children work with specialist knowledge of being a chair and author in Serious Case Reviews.

Charlie Spencer, Independent Consultant, was appointed as the Lead Reviewer and author of this SCR report. Charlie has extensive experience in Youth Offending, young people services, and has led and participated in numerous multi-disciplinary peer reviews on behalf of the Home Office, in ending gangs and serious youth violence.

A serious case review (SCR) panel was established, chaired by the Independent Chair, and attended by the lead reviewer/ report author and senior professionals from all agencies to manage and oversee the review. A key role of the panel members was to facilitate the completion of independent management reports (IMRs) and chronologies relating to their agency's involvement. Five SCR panel meetings were convened, where members were able to analyse, explore and challenge the information gathered to identify learning across all agency involvement with the family.

The membership of the panel is set out below:

Bridget Griffin	Independent Safeguarding Consultant – Independent Chair
Charlie Spencer	Independent Consultant – Lead reviewer/ author
Manager	Croydon Safeguarding Children Board
Head of Targeted Services	Croydon Children's Social Care and Early Help, People Department
Service Leader Head of Youth Offending Team	Croydon Youth Offending and Gangs Service (YOS)
Head of School Place Planning Admissions and learning Access	Croydon Education
Detective Sergeant	Police Specialist Crime Review Group (SCRG)
Head of Safeguarding, Designated Nurse Children	Croydon Clinical Commissioning Group (CCG)
Designated Doctor Safeguarding	Croydon Clinical Commissioning Group (CCG)
Associate Director Nursing	Adults and Children's Safeguarding Croydon Health Service (CHS)
Contracts & Partnership Manager	Community Rehabilitation Company
Team Leader	Redthread, St Georges Hospital
Director of Projects	Safer London
Young Person Team Manager	Drugs & Alcohol, Croydon Recovery Network, Turning Point
Head of Family Safeguarding	Hertfordshire County Council
Service Manager	Cafcass (Children and Family Court Advisory & Support Service
Deputy Director, Quality	South London and Maudsley NHS Foundation Trust (SLAM) including CAMHS
Head of Safeguarding	Wolverhampton City Council

Deputy Designated Nurse, Safeguarding Children	Wolverhampton Clinical Commissioning Group
Head of Quality Assurance	Children's Social Care, London Borough of Southwark

Terms of reference

The Terms of Reference (TOR) agreed by the Panel included learning outcomes and the SCR timeline.

It was agreed that the period under review would be from Child Q's birth to his death, with the proviso that agencies would summarise any other relevant information pre-dating this period to add context and background to their report.

The review had several key strands including:

- Individual agency chronologies
- Individual management reports (IMRs)
- Composite chronology of all agency events
- Practitioner learning event and interviews with key professionals
- Family member contact
- Completion of overview report
- Review of various key documentation, including reports, minutes and assessments

Learning outcomes

- To gain an understanding of the factors that might be present in the child's life that would make him vulnerable to a life-ending result.
- To gain an understanding of what services or provision has been made to this child and family in order to inform what might work for others in the future to prevent the same outcomes.
- To influence commissioning of timely and appropriate services to address these issues.
- To ensure the learning from this SCR is disseminated across partner agencies, in order to inform future practice.

Practitioner Learning Event (PLE)

Key professionals from a number of agencies, who were involved in providing services to Child Q and his family, came together for a one-day event to contribute to the review and case analysis. Child Q's case summary was utilised to enable participants to reflect on their agency's involvement with the family in a supportive, non-judgemental environment. This enabled practitioners to express their views of the challenges, responses and actions taken, whilst being able to think about service improvements that could reduce the likelihood of other families experiencing such a devastating outcome.

Family composition

The family included Child Q and his mother (Ms R), his father (Mr S) lived separately from the family but continued to be an important part of Child Q's life. Child Q had a close relationship with his

mother and with his paternal aunt and paternal grandmother, with whom he lived on a number of occasions throughout his life.

Identifier	Family Member	Ethnicity
Child Q	Subject	Black British Caribbean
Ms R	Mother	Black British Caribbean
Mr S	Father	Black British Caribbean
Mrs T	Paternal Grandmother	Black British Caribbean
Ms T1	Paternal Aunt	Black British Caribbean

CHAPTER 4 - Family Perspectives

The perspectives of the family has been gained by two meetings each with Ms R and Mr S individually, plus two joint meetings with Child Q's paternal aunt and grandmother.

The death of Child Q has been an enormous loss for his mother, father, aunt, grandmother and extended family members. Understandably, their grief remains acute. It took great courage for family members to speak to the Lead Reviewer and the Independent Chair and for some family members there remains some understandable anger and frustration about the lack of assistance provided by services to support the family to care for Child Q and keep him safe.

Ms R and Mr S were very open and reflective in their views that they shared with the Independent Chair and Lead Reviewer. Ms R loved her son deeply and wanted the best for him, she says that the combination of own ill health and her worries for Child Q's safety were extremely challenging for her, especially as she had few support networks of her own. Mr S reflected on the fact that he was not there for his son as much as he should have been due to his criminal activity, for which he received custodial sentences, he regrets that he was not consistently available to be a positive father figure to Child Q.

Whilst both agreed there were some behavioural issues in primary school and secondary school, they were taken aback by his first offence. This proved to be a very difficult time for all family members. As Child Q's behaviour became more concerning Ms R sought assistance from various agencies and from Mr S, who would visit the home to physically chastise his son in an attempt to control his behaviour. Nevertheless, Mr S fully accepts that physical punishment is not acceptable and does not work.

Both parents recognised the influence of Child Q's peers, he was consistently drawn to these peers, despite how his parents felt. Young people would congregate at Child Q's home address and Ms R had the dilemma to ask them to leave (if she did Child Q would leave with them) or allow them in the property where she knew he was safe. Ms R highlighted that she tried to work with professionals, but often felt judged by them. She said that, at times, she was confused as different workers from different agencies would give her contradictory messages of what she should do for the best.

Paternal aunt and grandmother are angry, they felt they did everything they could to keep Child Q safe including moving to a place where they had no family and placed themselves in financial hardship as a result. They were very open with practitioners about their fears about Child Q returning to London and disclosed conversations they overheard between Child Q and his friends on the telephone that indicated his intention to return to London but feel that it made no difference. Mother, aunt and grandmother are extremely angry and upset that an electronically monitored curfew was not requested at his final court appearance and strongly believe that if the curfew had been reinstated on that day Child Q would not have travelled to London and therefore would not have lost his life.

All family members believe that services did not assist Child Q as they had hoped. They recognise that he had some emotional and behavioural challenges that went unaddressed. He was strong-minded and strong-willed but was very loving towards his siblings and his family members. His loss has left a great void in their lives, they have found it difficult to move on and to leave behind their experiences of working with various agencies, and the anger they feel.

After Child Q's death, mother, aunt and grandmother were disappointed by the limited support and sympathy demonstrated by agencies that worked with Child Q. Aunt and grandmother acknowledge that a few individual workers contacted them to send condolences and offer support, but their overwhelming feeling was that they were no longer important. The financial support was withdrawn almost immediately creating financial challenges.

Ms R, who had already suffered the devastating loss of her mother and father, was left in a state of deep grief without a supportive practitioner who could assist her to access bereavement counselling. The Independent Chair and Lead Reviewer referred Ms S to counselling after our interview, some seven months after Child Q's death.

Gang membership

Ms R does not accept that Chid Q was a gang member. She advised that she saw no evidence of this and did not think this should be included in the report. Where this has remained in the report, Ms R requested that a clear statement be made as to the basis for the view regarding gang membership is included.

Mr S advised during his two interviews that he believed Child Q was an influential member of a local gang.

CHAPTER 5 - Practitioner Perspectives

This section is informed via a practitioner learning event attended by over 30 practitioners from the various areas that held responsibility for providing service to Child Q and his family, the majority of whom had direct experience of working with Child Q.

Several practitioners had a great affection for Child Q and were evidently still coming to terms with his death. When asked to describe Child Q, they used words such as: 'strong minded, intelligent, well spoken, popular, well liked, engaging and endearing'. He was a good footballer, who wanted to do well in life and look after his family.

He was described as ‘loyal, a good friend, ‘he had an amazing smile’, but some felt he often seemed lost and they felt he was let down from the beginning. There was a general belief amongst some practitioners that services did not take the right actions at the right times, allowing behaviours to become more entrenched and riskier and responses were often characterised by ‘crisis management’ mode.

There were significant parts of Child Q’s life that they were not aware of, this was reinforced by the schools in attendance who said they had not received any background information on Child Q which did not enable an intelligence led approach to his education. School’s also highlighted they did not feel they had the skills, expertise or resources to work effectively with children who have needs as complex as Child Q.

Going forward, if another child with such needs was currently on their caseload, practitioners were not confident that the outcomes would be more positive. They pointed out that gaps in service provision, or current practice arrangements, must change to better assist children like Child Q. The areas highlighted included:

- Improved emotional wellbeing support for parents and carers delivered in the context of a whole family plan in partnership with Children’s Services, early help, health and adult services, to include parenting support.
- Strengthened information sharing at an earlier stage and throughout. School staff commented that they are often unaware of a child’s early years and this is important to understand to inform the support provided.
- Many practitioners highlighted the need for workforce development to improve the knowledge and skills needed to work with children who have complex needs and vulnerabilities such as Child Q (to include teaching staff, police and the wider children’s workforce).
- Better resourced, and better-defined preventative services in early years so all parents who need it can be supported.
- Improved targeted prevention for those children who display concerning or risky behaviours so that they can be supported or be subject to intervention and so that behaviours can be addressed far earlier, before they become entrenched.
- Improved collaborative working between agencies and inter-agency departments. An example of this was joining up gangs’ work, with YOS and Children’s Service interventions.
- An improved understanding of roles, responsibilities, and tools agencies have at their disposal that can be synchronised with other multi-agency interventions to make them more successful.
- Increased practitioner skills to build multi-agency ways of working - far too often staff said they had to learn on the job through experience of working with other agencies : ‘*if you do not hold a case that requires this level of collaboration, then you will not develop the skills and knowledge required to work effectively as a multi-agency partnership’.*
- Timely decision making at senior management level, complemented by trust in the practitioner’s judgements and assessments. On the flip side, some decisions were hasty, ill-advised or unsupported by the professional network. Such as stepping down the case to a lower level of service intervention, or repeatedly trying the same options when they had

already proven to have not worked. For example; '*continually identifying foster placements for Child Q that he was never to going to stay in.*'

- Management oversight applied more rigorously, with decision makers better sighted and informed to make more timely decisions. This was felt to be important as it was said that the time taken to convince managers of actions required to address behaviours led to important delays in securing a service that a child needed.
- Explicit contingency plans to promote proactivity rather than reactive interventions and crisis management.
- More responsive child and adolescent mental health services that are flexible and creative to meet the needs of children. It was felt this may require an adjustment to CAMHS thresholds to enable more children to meet the criteria at an earlier point in their lives and/or CAMHS delivering more universal work across the range of children's settings, such as schools.
- Police and other agency safeguarding approaches should be joined for children missing, absent and/or children on the gang's matrix, at risk of criminal or sexual exploitation.
- Families should be more involved in supporting their children and treated as a part of the solution, rather than 'the problem'. There should be a clearer, agreed collaborative approach to family engagement to avoid mixed messages, confusion and labelling of children and their parents/carers.
- Practitioners felt they needed to be better trusted by their organisations and better supported so the risks associated with a case like Child Q are recognised and held by the organisation, not by the individual practitioner. Too often practitioners said they experienced holding the risks alone and went home worrying about the safety of a child they are working with.

CHAPTER 6 - Case History, Analysis, Findings and Recommendations

The Vulnerable Adolescent (VA) Thematic Review identified five key findings, all of which are relevant to Child Q, the detail of these findings and recommendations will not be repeated. Only findings and recommendations specific to Child Q are included.

Finding 1. Early help and prevention

The Vulnerable Adolescent Thematic Review identified the need to provide help to families as early as possible, in this SCR the following was highlighted:

- Provide support to parents at the earliest possible point in a child's life paying particular attention to attachment in early years and experiences of separation and loss.
- Equip the children's workforce to provide a trauma informed response to adults and children and to work together across children and adult services to meet the needs of children and parents.

Recommendations

Finding 1 in The Vulnerable Adolescent Thematic Review is relevant to Child Q : *Early help and prevention is critical* as are the corresponding recommendations. An additional recommendation is made in respect to Child Q's specific circumstances.

SCR Child Q: Recommendation 1.

Working protocols between Adult Mental Health and Children's Services to be strengthened to facilitate the development of integrated whole family health care pathway so that a holistic multi agency treatment and support model can be provided, complemented by consistent timely information sharing and progress reviews.

Finding 2: Education, transitional points, managed moves and alternative education

Child Q displayed concerning behaviours in primary and secondary school resulting in numerous managed school moves, and ultimately to permanent exclusion and attendance at alternative education establishments such as a Pupil Referral Unit. It is unclear what level of information was exchanged during the various points of Child Q's transition to different schools or education establishments, but it was clear that his behaviours were not adequately addressed in school. After Child Q's first exclusion, it was difficult to maintain stability for Child Q and his multiple placement moves compounded the disruption to his education and impacted on the ability of services to provide the care and treatment he required.

Why is this important?

The prevalence of children of school age being involved in violence, or who display high risk behaviours as victims or offenders, is increasing. This creates a dilemma for schools on how they continue to educate these young people, and to keep other pupils safe. It is recognised that schools have a duty to keep all pupils safe, but it is the view of the panel that ideally a more productive approach would be to create alternative provision for some pupils within the mainstream school environment.

School staff were very clear in the Practice Learning Event that they did not feel they had the information, skills, knowledge or expertise to work effectively with children like Child Q. The development of staff, underpinned by consistent resources, will be required in order to enable schools to undertake the tasks required.

How widespread and prevalent is this?

This issue is not specific to Croydon, there is a plethora of information evidencing that children educated in a PRU achieve far less academically than children in mainstream education and are a greater risk of forming an association with a negative peer group.

The latest statistics on exclusions show that following a downward trend, the rates of permanent and fixed-period exclusions have risen since 2013/14.[8] A significant number of children attend alternative education settings due to behaviour and/or special educational needs. In addition, some BAME groups such as African Caribbean, White and Black Caribbean are over-represented in alternative education. It is understood that the Government are in the process of reviewing

[8] Creating opportunity for all Our vision for alternative provision DFE March 2018

alternative provision. It is suggested that this review should include the experiences of children like Child Q.

Recommendations

The Vulnerable Adolescent Thematic Review identified two relevant findings. Finding 2: *Schools should be at the heart of multi-agency intervention* and Finding 5. *Disproportionality, linked to ethnicity, gender and deprivation, requires attention and action.* These findings are relevant to Child Q, as are the corresponding recommendations. An additional recommendation is made in respect to Child Q's specific circumstances.

SCR Child Q: Recommendation 2.

CSCB to utilise the learning from this serious case review to influence the outcome of the Department for Education (DFE) review of alternative education and work with school leadership locally to agree a consistent methodology of working with high-risk pupils in a multi-agency context.

Finding 3: Dealing with fast paced risky behaviour, vulnerabilities and needs

During Child Q's adolescence he spent more time in the community engaging in serious risky behaviours and crime. He frequently came to the notice of the Police, there were numerous missing episodes and behaviours that led to frequent moves from one carer to another. During the latter period, incidents were being noted almost on a weekly basis that resulted in agencies responding to the presenting issue and not being able to address one incident, before another was highlighted. Various placements were tried, but stability of placement could not be achieved and much-needed treatment to address his mental health needs could not start. Agencies were aware of Child Q's illegal use of mopeds but did not put in measures to address this risk. Overall, multi-agency services struggled to grip his case and put long-term solutions in place.

The SCR panel recognises the unprecedented challenge presented to agencies attempting to provide services, and the need to address the immediate risk presented. Nevertheless, in cases such as Child Q it is crucial for agencies to reflect on the collective tools they have available and deploy them in a consistent coherent single multi-agency plan supported by impact measures and a contingency plan.

The assessment completed by the Consultant Social Worker in July 2017 determined that Child Q's anti-social identity, purpose and strength were intrinsic to his sense of self and suggested that to make himself available to change would have meant he would have needed to totally re-construct who he was happy to be. This assessment demonstrates how challenging it would have been to try and help Child Q overcome the traits and behaviours he had developed as coping mechanisms.

Why is this important?

Throughout Child Q's life, his initial vulnerabilities progressed to significant risk to himself and others. These continued to escalate up to his death, with the multitude of agencies having little or no impact. Agencies continued to work informed by traditional ways of working; they held regular multi-agency meetings and briefings and tried whatever tactics available to them, to no avail. Risks were identified early but went unaddressed and were not appropriately prioritised until Child Q started offending. There were many multi-agency meetings where multi-agency plans were developed, but these did not adequately keep Child Q safe or create the stability needed for the necessary treatment to take place. The longer treatment was not delivered, the less likely it was that treatment would meet Child Q's needs or reduce the risks he posed to himself and others.

The multi-agency partnership need to reconsider what is required in order to mitigate the fast-moving dynamic risks some young people present and consider ways of working that directly focus on the long-term outcome, as opposed to a single focus on the presenting issue.

Child Q had a good understanding of criminal justice processes and was able to position himself in the service gaps, and to navigate the systems in such a way that enabled him to do as he chose, challenging agencies to keep up with him. Joining up actions from across the multi-agency partnership was of great importance. Child Q was reported as missing on 28 occasions, but his missing episodes were managed separately to his gang membership.[9]

Inevitably, children who display high risk behaviours are known to services and, dependent on the behaviour, will normally be subject to monitoring via a multi-agency forum. For example, gangs managed via a gangs' partnership, missing via a missing panel, and children at risk of sexual exploitation are managed via multi-agency sexual exploitation (MASE) meetings; offenders managed via YOS risk or compliance panels etc. It is understood there are significant overlaps between cohorts of high-risk children that could be better managed via a single multi-agency forum, with sub strands of such a forum to deal with specific issues or develop integrated management plans to incorporate all these risks, including criminal exploitation of young people.

In addition, further evidence suggests that there is a link between experiences of victimisation and becoming a perpetrator of violent crime. Child Q informed his family (long after the incident) that he had been a victim of a similar offence to his first serious conviction and he was the victim of a knife point robbery and had been stabbed. This suggests a need for an effective preventative response to include work with young people who have been the victims of violence to help them overcome the experience without recourse to violence.[10]

How prevalent and widespread is this?

It is estimated by The Centre for Social Justice that gang membership has increased by approximately 20,000 to 70,000 in the past 10 years.[11]

---

[9] Gang membership is determined by an assessment of relevant intelligence held by police, gangs' team and YOS

[10] Teenagers at risk. The safeguarding needs of young people in gangs and violent peer groups. NSPCC 2009

[11] IT CAN BE STOPPED A proven blueprint to stop violence and tackle gang and related offending in London and beyond. Centre for Social Justice August 2018

Child Q's case is not predominantly about gang membership, however the risk Child Q presented to himself and/or others was exacerbated by his gang membership.[12] We know more and more about children from a younger age who are affected by serious youth violence and research suggests that the multi-agency response to children with high risk behaviour has been problematic for some time.

> *'Because young people are particularly sensitive to social threat, social status and their identity (compared to those older or younger than them), they may be at risk of gang involvement if they live in a neighbourhood where gangs operate, and they have few other means to feel safe, develop their sense of self, and connect to peers. The (often gradual) choice to join a gang can be adaptive, but over time, gang culture, demands and warfare drive young people into blind alleys of risk (Palmer, 2009)'*[13]

Recommendations

Finding 3, in The Vulnerable Adolescent Thematic Review, identified that: *An integrated, whole systems approach, is needed across agencies, communities and families.* This finding, and the corresponding recommendations, are relevant to Child Q. An additional recommendation is made in respect to Child Q's specific circumstances.

SCR Child Q: Recommendation 3.

Croydon Children's Services have recognised the need to join up multi-agency risk and safety planning forums to improve services for children at high risk in the community (such as gangs, serious youth violence, missing, all forms of exploitation – including county lines), multi-agency partners are encouraged to review current operational arrangements to support this new approach.

Finding 4: Transition and transfer arrangements between localities and services

Child Q's chaotic lifestyle, behaviour and needs resulted in numerous changes to his living arrangements which required his case to be 'care taken' by another local authority area or transferred in full. Effective transfer between agencies and locations is dependent upon early exchange of information (including key documentation such as reports or assessments that are further explained via dialogue between professionals) to enable the receiving area to continue working with the child as seamlessly as possible. It is incumbent on services to ensure transfer or transition arrangements are as robust as possible, especially given that these children are likely to be leaving their school, friendship groups and possibly family.,

Why is this important?

In Child Q's case, there was an urgency and necessity for specific intervention and treatment to be delivered to address his conduct disorder (and possible ADD), his missing episodes and offending

[12] Gang membership is determined by an assessment of relevant intelligence held by police, gangs' team and YOS
[13] That Difficult Age: Developing a more effective response to risks in adolescence. Research in Practise November 2014

behaviour. Child Q moved to and from various locations often within a short space of time and for short periods. Sometimes these moves happened at short notice (such as after Child Q was bailed unexpectedly), leading to transfer arrangements not happening until after his move, but there were many occasions when there was time to plan for his transfer of care. Overall, there were delays in information transfer to different services across three different localities.

The implication of this was that professionals spent more time than was necessary to chase up information, this led to agencies playing 'catch up', crisis management, poor continuity of service, and delays in putting in place the required interventions.

In other instances, as Child Q was placed in foster care as a 'red rated gang nominal'[14], police practice was to transfer his offender management to police in the local area. As his placements broke down quite quickly it resulted in gaps in his management that allowed behaviours to persist and get worse, without being gripped by police.

The logistics of managing cases such as Child Q present resource and geographical challenges. This was starkly illustrated when bail conditions were requested by one youth offending team to include a curfew, but this was not requested by the other youth offending team (in the area where Child Q was living at the time) in Child Q's final court appearance. It is important that current practice is reviewed to improve the continuity of case management and intervention. Where possible, consideration should be given to the case holding local authority, or local police offender managers, maintaining day to day responsibility to avoid unnecessary transfer (and to maintain an existing relationship the child or young person may have with professionals), supported by professionals from the host authority and/or host borough command unit. Some children will require bespoke tailored arrangements that fall outside of existing protocols.

How widespread and prevalent is this?

As described in: Pathways to harm, pathways to protection: a triennial analysis of serious case reviews (2011 to 2014), cross border working remains difficult to co-ordinate.

> *'Working across regional borders within England can present hurdles for agency operation and information transfer between area centres is potentially problematic. Work between geographical areas can cause logistical issues as well as differences in professional opinion with regards to how to proceed with cases'*[15]

Further anecdotal information gleaned from practitioners, and from the Lead Reviewer's experience on conducting gangs and serious youth violence peer reviews on behalf of the Home Office, highlights that case transfers (including young people moving from one geographical area to another) continues to present challenges to multi-agency services as transferring local authorities do not provide sufficient, timely information, supported by a transfer-in meeting. This makes it difficult for the receiving borough/county council to effectively pick up the case and can have a knock-on effect to the safety and well-being of the children who are being transferred.

---

[14] There is a RAG (red, amber, green) rating which is a grading system devised to manage risk and define level of response, activity or engagement by police

[15] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report. DFE May 2016 p187

SCR Child Q: Recommendation 4

Multi-agency partners to review and reinforce transfer or care taking arrangements to ensure timely information sharing takes place and consistent practice is adhered to, prior to and during these arrangements.

Finding 5: Provision of Child and Adolescent Mental Health Services

Child Q was referred to CAMHS when he was at primary school. The school stated their referral was urgent and noted various concerns. After attempts were made by CAMHS to contact the family, the case was closed. Later, Child Q was the subject of a psychiatric assessment when it was identified that he had various disorders that urgently required treatment. CAMHS practitioners attended several meetings and were an active part of Child Q's professional network. There are 3 key issues to reflect upon:

- CAMHS were aware of Ms R's ill health and Child Q's behaviour, but stuck rigidly to their model of engagement that did not engage the family, had they been more creative and more flexible, Child Q may have been assessed at an earlier point
- CAMHS could not or would not provide treatment due to the lack of stability in Child Q's life
- CAMHS understood all agencies were working exceptionally hard to achieve stability without success. Child Q's risk increased, and his lifestyle became more chaotic, but CAMHS insisted on what appeared to be unattainable stability before treatment would be initiated.

Whilst the SCR panel agree optimal conditions promote better outcomes and recognise the difficulties CAMHS had in attaining the family's full engagement to support the necessary treatment. However, Child Q's treatment was urgent. What would have made it possible for other creative, possibly non-perfect options, to have been tried by CAMHS? How could other agencies have assisted to ensure Child Q benefitted from the necessary treatment?

Why is this important?

All professionals agreed that Child Q required intervention and treatment for his various emotional and mental health issues, but treatment was unacceptably delayed and his risk taking, impulsive behaviour continued to escalate. Had Child Q been engaged at aged nine, when he was first referred to CAMHS, the deterioration of his emotional well-being and mental health may have been prevented.

How prevalent and widespread is this?

There have been extensive reports, representations and evidence, submitted to Government in the past few years calling for change in the delivery of Child and Adolescent Mental Health Services and an increase in resources. It is suggested that far more children from all backgrounds need support with their mental health and emotional well-being.

Research identifies that 20% of adolescents may experience a mental health problem in any given year,[16] 50% of mental health problems are established by age 14 and 75% by age 24,[17]

10% of children and young people (aged 5-16 years) have a clinically diagnosable mental problem,[18] yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age.[19]

Recommendations

Finding 2, in The Vulnerable Adolescent Thematic Review identified: *Greater recognition of, and response to, children's emotional health and wellbeing is needed.* This finding and the corresponding recommendations are relevant to Child Q. The following recommendation is made in respect to Child Q's specific circumstances

SCR Child Q: Recommendation 5

CAMHS to review current models of service delivery and consider how they may be adjusted to provide treatment to children with mental health needs who exhibit high risk behaviour and have limited stability, and further consider how preventative services for children in their early years can be provided.

Finding 6: The availability of appropriate accommodation

Agencies attempted to mitigate the risks to Child Q and create stability of residence to enable treatment work to be initiated, as a result Child Q experienced numerous placements moves and was placed with foster carers across London. Child Q frequently went missing from these placements and they all broke down. Children's Services reported searching 160 different providers to secure a suitable placement, without success.

When Child Q attended court for his index offence, a secure placement was authorised. However, there was 'considerable difficulty' in identifying a placement. If a secure placement had been available, it may have been possible for Child Q to receive the treatment he needed which could have had a significant impact on the behaviour he displayed thereafter. When it became apparent that a secure accommodation order was to be made (given Child Q's progressive offending, risk taking behaviour, vulnerability and need for treatment) a national search for secure

---

[16] Caring for children and adolescents with mental disorders: Setting WHO directions. [online] Geneva: World Health Organization. 2003

[17] Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Archives of General Psychiatry, (2005). 62 (6) pp. 593-602.

[18] Mental Health of Children and Young People in Great Britain: 2004. Green, H., Mcginnity, A., Meltzer, Ford, T., Goodman, R. Office for National Statistics. 2005

[19] The Good Childhood Inquiry: health research evidence. London: Children's Society 2008

accommodation was made. Only one secure unit were willing to take Child Q, but this did not provide the treatment he required.

Evidence submitted to this review highlights the lack of suitable, open or secure, placements for children who display complex risky behaviours (especially if they have diagnosed mental health needs and have previously been violent). There appears to be a lack of options available to children's services to provide security and containment for these children, to enable interventions and treatment to be delivered.

Why is this important?

It took 18 months for Child Q to be placed in secure accommodation from the initial agreement for a secure placement. At the time of his placement, the risks and challenges of working effectively with Child Q had become more difficult, more entrenched and more complex and he was now participating in increasingly high-risk behaviours**.** The delay in decision making and the lack of available placements to meet Child Q's needs compromised decision making by agencies and in the judiciary, and ultimately compromised Child Q's safety. More suitable secure, and other, accommodation is needed to mitigate risk, provide treatment and safeguard children.

How prevalent or widespread is it?

Data from Cafcass,[20] shows that there has been a year on year increase in the number of Secure Assessment Order applications in England since 2011/12 (apart from in 2014/15 when there was a slight decrease).

- 2011/12 - 10.4% increase
- 2012/13 – 15.8% increase
- 2013/14 – 35.4% increase
- 2014/15 – 2.9% decrease
- 2015/16 – 4.4% increase
- 2016/17 – 10.5% increase
- 2017/18 - 9.7% increase

In London, throughout the same timeframe, secure order applications have increased by 68%.

It is apparent that the judiciary are extremely concerned about the lack of available secure beds in the country, as detailed in a recent summary local judgement below:

> *This case represents yet another sorry example of the state failing a child in need, and highlights the impact of there being far too few secure accommodation unit places for children like O. In summary, I have been driven not to grant a secure accommodation order for a child who needs one due to the unavailability of appropriate placements. That is clearly a wholly unacceptable situation. He is a child in local authority care who is at risk from his disordered background and the depredations of gang life. This is the opportunity to help him and make him safe, and it is being lost. Like my colleagues before me, whose published judgments increasingly feel like heads banging against brick walls, I am dismayed, frustrated*

[20] Data supplied by CAFCASS: Child and Family Court Services. November 2018

and outraged; and to quote the former President of the Family Division from last year's case of Re X, I am deeply worried about the risk that 'we will have blood on our hands' (#39). I have directed that this judgment be sent by O's solicitor to the Secretary of State for Education, the Secretary of State for Communities and Local Government, and to the Children's Commissioner for England.[21]

SCR Child Q: Recommendation 6.

Children's Services to utilise available data and intelligence to complete a report for Croydon Safeguarding Children Board to evidence the challenges in identifying suitable placements for young people with high risk behaviours and make national representation on the issue.

Finding 7: The impact of parental criminality

Child Q's main male role model was his father, but as a recidivist offender, he had numerous convictions and cautions over many years. He was in and out of prison throughout Child Q's life. Child Q was said to have respected his father and responded to him when he was not in custody. His use of physical punishment has been previously mentioned. Mr S recognised during interview that he was not there for his son as much as he should have been, due to his offending. He said he would try to instil messages and discipline into Child Q to get him to change his lifestyle, but at the same time Child Q witnessed some of the behaviours that his father was asking him to refrain from, Mr S says he was committed to be a good father but is aware that he was not a good role model for his son.

Why is this important?

Professionals shared their concerns about Mr S, and the criminal activity to which Child Q would be further exposed. There was no specific plan of how agencies could minimise the impact of Mr S's criminal activity on Child Q. Joint work could have been completed between the probation officers, members of the YOS and social workers with father and son but this is not routine or expected practice. Mr S's behaviour was entrenched, and Child Q's behaviour was of increasing concern therefore whilst it may have been very difficult to achieve work with father and son, it was not a strategy that was actively considered. That said, joint work with father and son might have had the potential to make a significant difference to Child Q.

If agencies are to effectively prevent and tackle gangs, crime and the associated lifestyle, agencies should consider how they can effectively work with parents of children like Child Q to have a more positive constructive influence over their child's behaviour, health and wellbeing.

---

[21] LONDON BOROUGH OF BROMLEY - Applicant -and- MRS. O -and- O [4\10\18] Summary secure accommodation order judgement.

How widespread and prevalent is this?

The Ministry of Justice estimates there are approximately 200,000 children who are affected by parental imprisonment.[22] At present, there is no legislation or policies that recognise these children as a distinct group who require additional support. As a result, Local Safeguarding Children Boards often do not have a targeted work plan to support this specific group of children.

Research suggest that the impact of parental criminality can lead to negative outcomes for these children. For example, in comparison to their peers, children affected by parental imprisonment are twice as likely to experience mental health problems, and three times as likely to have had a history of poor living conditions and a poor employment record. Studies have also consistently found psycho-social problems including depression, hyperactivity, aggressive behaviour, withdrawal, regression, clinging behaviour, sleep problems, eating disorders, running away, truancy, low academic achievement, low self-esteem, delinquency and anti-social behaviour.[23] Given the findings of this SCR, the work undertaken by Local Safeguarding Children Boards[24] should be further explored to consider how these children could be better identified and their needs met.

SCR Child Q: Recommendation 7.

CSCB to investigate the prevalence of this issue in Croydon and learn from Local Safeguarding Boards who have implemented service changes to meet the needs of children effected by parental criminality and imprisonment.

CHAPTER 7 - Conclusion

Despite the love of his family, and the commitment and expertise of professionals, making any significant alteration to Child Q's trajectory proved completely unsuccessful. The influence of his peers, criminal associates and gang[25] members was significant, and he held a deep-rooted attachment to these peers. His anti-social behaviour, lack of remorse or emotional recognition, were defining factors in Child Q's life. He was a respected member of a gang that afforded him an identity and a niche, and he was perpetually drawn to this gang. He was involved in risky criminal behaviour which included extreme violence of which he was both a victim and perpetrator.

For professionals, Child Q's case was unprecedented. Whilst the professional network had a wealth of experience, skills, knowledge and expertise, they did not always have the tools they required at the time they required them.

A gang lifestyle provides groups of like-minded children and young people, a forum where they apply their own rules, concepts and understanding of what acceptable behaviour is and what is not.

[22] http://www.barnardos.org.uk/what_we_do/our_work/children_of_prisoners.htm
[23] Children Affected By Parental Imprisonment: Needs, Solutions and Rights – the Evidence from Across Europe. Lucy Gampell OBE, President of Children of Prisoners Europe. NIACRO
[24] This work requires evaluation
[25] Gang membership is determined by an assessment of relevant intelligence held by police, gangs' team and YOS

This is partly due to children and young people not believing they can either trust or depend on adults, professionals, teachers or parents to keep them safe or to support them to be successful members of their communities; they create networks they believe they can depend on, with peers they believe they can trust.

Whilst the media impression is that serious youth violence and gang related activity is significantly affecting communities across the country, current data suggest there has been some recent improvements in Croydon. This momentum needs to be built upon, with parents, carers, communities, professionals, politicians, and most importantly young people, coming together to collectively find ways to make a difference to children such as Child Q.

Appendix 1: Bibliography & References

This list of references are sequenced in the order they appear in the report.

Dying to Belong: An In-depth Review of Street Gangs in Britain. Centre for Social Justice 2009 www.centreforsocialjustice.org.uk/library/dying-belong-depth

IT CAN BE STOPPED - A proven blueprint to stop violence and tackle gang and related offending in London and beyond. Centre for Social Justice. August 2018 p5

Ending Gang and Youth Violence -A Cross-Government Report including further evidence and good practice case studies. HM Government 2011

https://news.sky.com/story/why-moped-crime-is-rising-and-how-you-can-avoid-being-a-victim-11399439

That Difficult Age - Developing a more effective response to risks in adolescence. ADCS Research in Practice 2014

Croydon Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. OFSTED September 2017

Contextual Safeguarding: An overview of the operational, strategic and conceptual framework. (Firmin November 2017)

Working Together to Safeguard Children- A guide to inter-agency working to safeguard and promote the welfare of children. HMG 2018.

Offenders as victims of crime? An investigation into the relationship between criminal behaviour and victimisation. Derek Deadman and Ziggy MacDonald, Public Sector Economics Research Centre Department of Economics University of Leicester. October 2001

Serious Violence Strategy. HMG April 2018

'now all I care about is my future' Beyond youth custody 2017

Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report. DFE May 2016 p187

Teenagers at risk. The safeguarding needs of young people in gangs and violent peer groups. NSPCC 2009 Caring for children and adolescents with mental disorders: Setting WHO directions. [online] Geneva: World Health Organization. 2003

Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Archives of General Psychiatry, (2005). 62 (6) pp. 593-602.

Mental Health of Children and Young People in Great Britain: 2004. Green, H., Mcginnity, A., Meltzer, Ford, T., Goodman, R. Office for National Statistics. 2005

The Good Childhood Inquiry: health research evidence. London: Children's Society 2008

LONDON BOROUGH OF BROMLEY - Applicant -and- MRS. O -and- O [4\10\18] Summary secure accommodation order judgement.

Forgotten children: alternative provision and the scandal of ever-increasing exclusions. Fifth Report of Session House of Commons Education Committee 2017–19 p3

Creating opportunity for all Our vision for alternative provision DFE March 2018

http://www.barnardos.org.uk/what_we_do/our_work/children_of_prisoners.htm

Children Affected by Parental Imprisonment: Needs, Solutions and Rights – the Evidence from Across Europe. Lucy Gampell OBE, President of Children of Prisoners Europe. NIACRO

Child Welfare Information Gateway, 2009

ACES: a Blackburn and Darwen study

http://www.blackburn.gov.uk/Pages/aces.aspx

Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Bellis, M.A et al. Journal of Public Health, Volume 36, Issue 1, 1 March 2014, Pages 81–91.

https://www.independent.co.uk/news/uk/politics/cuts-to-youth-services-will-lead-to-poverty-and-crime-say-unions-9659504.html

https://www.cypnow.co.uk/cyp/news/1158579/youth-services-cut-by-gbp387m-in-six-years

The Foundation Years: preventing poor children becoming poor adults. Frank Field 2010.Murdoch Children's research institute

Early intervention: the next steps, An Independent Report to Her Majesty's Government Graham Allen. HMG 2011 p20