Serious Case Review

Summary

Child Y

Charlie Spencer

May 2019

The contribution made by family members to this report has been invaluable. Croydon Safeguarding Children Board 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.

Croydon Safeguarding Children Board offer sincere condolences to Child Y's family for the tragic loss of their child who was dearly loved by all family members.

Contents

CHAPTER 1 - Introduction

This Serious Case Review (SCR) was commissioned by Croydon Safeguarding Children Board (CSCB) following the tragic death of Child Y, who was the victim of a fatal stabbing. This summary SCR report should be read in conjunction with the Croydon Thematic Vulnerable Adolescent Review Report.

Could this happen again?

The prevalence of knife crime has been detailed in the Croydon Thematic Vulnerable Adolescent Review. This Serious Case Review Summary illustrates the complexities involved for services and families when attempting to safeguard children who are affected by gangs and serious youth violence.

CHAPTER 2 - Background to the review

Croydon Safeguarding Children Board Serious Case Review Subgroup reviewed the circumstances of Child Y's case and agreed that the statutory[1] 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.

Purpose

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.

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

- Provide a useful insight into the way organisations are working together to safeguard and protect the welfare of children. [2]

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.

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:

Names/ designation	Organisation	Role
Bridget Griffin	Independent Safeguarding Consultant	Independent chair
Charlie Spencer	Independent Consultant	Lead reviewer/ overview report author
Manager	Croydon Safeguarding Children Board	Panel member
Head of Adolescent Services	Croydon Children's Social Care and Early Help, People Department	Panel member/ IMR author
Head of Youth Offending Service	Croydon Youth Offending and Gangs Service (YOS)	Panel member/IMR

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

Head of School Place Planning Admissions and Learning Access	Croydon Education.	Panel member/ IMR author
Detective Sergeant	Police Specialist Crime Review Group (SCRG) Met Police	Panel member/ IMR author
Head of Safeguarding, Designated Nurse Children	Croydon Clinical Commissioning Group (CCG)	Panel member
Designated Doctor for Child Protection	Croydon Clinical Commissioning Group (CCG)	Panel member
Associate Director Nursing, Adults and Children's Safeguarding	Croydon Health Service (CHS)	Panel member
SWL Community Involvement Officer	London Ambulance Service (LAS)	Panel member/ IMR author
Team Leader, St Georges Hospital	Redthread	Panel member
Director of Projects	Safer London	Panel member
Young Person Team Manager, Drugs & Alcohol	Croydon Recovery Network - Turning Point	Panel member
Safeguarding Manager and Prevent Lead	Camden and Islington NHS Foundation Trust	Panel member (from 12.06.18)
Child Protection Coordinator	Islington Children's Service	Panel member
Service Manager	Children and Family Court Advisory and Support Service (CAFCASS)	Panel member
Head of Safeguarding Children & Adults	St George's University Hospitals NHS Foundation Trust	Panel member/ IMR author (from 01.08.18)

Terms of reference

The Terms of Reference (TOR) agreed by the Panel included learning outcomes and the SCR timeline. The review had several key strands including:

- Individual agency chronologies
- Individual agency independent management reports (IMR's)
- Composite chronology of all agency events
- Author engagement with the SCR panel
- Practitioner learning event
- Family member contact
- Completion of Overview report

Learning outcomes:

- To gain an understanding of the factors that might be present in a child's life that would make them vulnerable to a life-ending result.
- To gain an understanding of what services were provided in order to inform what might work for others in the future, to prevent the same outcome.
- 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 had direct involvement, case holding responsibilities and knowledge of the case) came together for a one-day event to contribute to the review and case analysis. The event provided a supportive, non-judgemental environment that enabled professionals to clearly express their views about the challenges, responses and actions taken to safeguard Child Y, and to support his family. Professionals were encouraged to think about service improvements that could reduce the likelihood of other families experiencing such a devastating outcome.

One to one meetings

A number of one to one meetings were held with key practitioners, these interviews were invaluable in setting out the environment in which services were delivered, and for practitioners to be able to share their personal professional thoughts about their work including the key challenges.

Family involvement

Identifier	Role	Ethnicity
Child Y	Subject	Black Caribbean
Ms S	Sister	Black Caribbean
Ms M	Mother	Black Caribbean
Mr F	Father	Black Caribbean
Mrs A1	Paternal Aunt	Black Caribbean
Mrs A2	Paternal Aunt	Black Caribbean

The death of Child Y has been an enormous loss for his mother, father, his sister, his aunts and all of his extended family and kinship. It took great courage for family members to speak to the Lead Reviewer and the Independent Chair. The perspectives of family members has been gained by meeting with Mr F, Ms M and Ms S individually, plus a joint meeting with two of Child Y's paternal aunts (Mrs A1 & Mrs A2).

With the support of her treatment team, attempts were made to engage Ms M during the course of this SCR but Ms M was not deemed well enough to participate. However, Croydon Safeguarding Children Board persisted in their attempts to establish contact and during the final stages of this SCR Ms M's health improved and a meeting between the chair, Ms M and her support worker took place to discuss the report.

Croydon Safeguarding Children Board are extremely grateful for the contributions they have made. Where relevant, the family's views have been included throughout this SCR to provide an insight into how they felt or perceived actions that happened at the time.

CHAPTER 4 - Family perspectives

All family members are devastated at the loss of Child Y, who was a vital member of the family. Ms S and Child Y were exceptionally close siblings, he was very much loved by all family members.

Mr F was open in saying that he was 'learning on the job' as the father of a new-born premature child. He said he requested and received some financial support for 6 months to assist with childcare, but no other support was provided. He was hardworking, keen to provide for his children and said he was a strict father. He described Child Y as a fun loving, affectionate and charismatic child who enjoyed spending time with his family.

Mr F believes that things were going well until Child Y went to secondary school and his behaviour changed. He said that at this time, Child Y no longer followed his direction which he said was very frustrating. Mr F believes things got worse when Children's Services were involved and says that Child Y's exclusion from mainstream education, and his placement at the pupil referral unit (PRU) after he was stabbed, was pivotal. Thereafter, it is Mr F's view that Child Y's motivation and aspirations suffered; he was exposed to more risk at PRU and in the community and Mr F says that Child Y's behaviour deteriorated thereafter. He said that he was trying to instil discipline and respect into his son, who 'ran away' from discipline in the home. He said he resented being told he was a bad parent especially by young practitioners who he believed had no idea of what it was like to be a single parent, and he felt patronised by them. Mr F stated he would have preferred to work with a more experienced social worker, who engaged with him more sensitively. At times, Mr F believes that crucial information relating to his son (such as an incident where Child Y had been assaulted) was not shared with him by professionals.

From Ms M's perspective, she knew little about the various agencies involved in Child Y's life. Although she had contact with Child Y throughout his life, it seemed she was not consulted with about decisions made by multi-agency professionals. Ms M recalls receiving a large amount of papers through the post on one occasion and it seemed these papers related to the care proceedings. She said she was not

supported to read and understand the content of these documents. Ms M was clear that Child Y's exclusion from school and placement in a pupil referral unit was devastating for him, she said he missed his friends, missed his school and missed his relationships with teachers and adults from this school. She said that placement in a pupil referral unit should be a last resort. When speaking to Ms M about her relationship with her son, Ms M said she understood he would have found it difficult to understand her ill health and the impact this had on her relationship with him. She said both she and her son would have benefitted from receiving support to make this relationship the best it could be.

Mr F, Ms S, Mrs A1 and Mrs A2 were angry and upset with the response and involvement of Children's Services from different perspectives and were convinced that the 'system failed' Child Y. Ms S felt she and her brother were let down by services and that she was excluded from assessments and decision making. Mrs A1 and Mrs A2 stated they became aware of problems in Child Y's teenage years. They acknowledged that bringing up children as a single parent is challenging for any parent and they described Mr F as working very hard to provide a comfortable home. Mrs A1 and Mrs A2 had a good relationship with Child Y throughout his life. They recognised that Child Y was significantly affected by the loss of his grandmother, to whom he was very close, and enrolled Child Y in a project which supports children with bereavement counselling.

Both aunts feel that when Children's Services were initially involved, the wider family could have been supported in supporting Mr F to care for Child Y. Neither believed they were fully engaged, kept informed or supported by Children's Services. Mrs A1, Mrs A2, and Ms S were all very clear that they wanted to put in place a solution that provided support to both Child Y and Mr F but in their opinion, this was never explored or encouraged.

All family members were very clear that Child Y was not involved in a gang or gang activity. They spoke about Child Y having peers who were friends in the local area that he had known from a young age. Ms S said she had spoken with many of his friends after her brother had died who said that Child Y was not involved in a gang, this perspective was also shared by the professionals who knew Child Y well.

The family are all very concerned about the impact of social media and how this can fuel gang rivalry and pose risks to children in the community. They are keen that lessons are learnt from Child Y's tragic death so that children can be better safeguarded.

CHAPTER 5 - Practitioner perspectives

This section has been informed by a practitioner learning event attended by 19 practitioners, plus 4 one to one interviews with key case holding practitioners who worked directly with Child Y. This is a summary of their views.

Practitioners recollected the time they spent with Child Y with affection: when asked to describe Child Y they used words such as: 'lost, vulnerable, searching, huge potential, misunderstood, hopeful, charming, likeable, and a good friend'. He had a 'huge infectious smile', but they felt he was 'let down from the beginning'. There was a general belief amongst some practitioners that the pressures on Children's Services led to cases being closed too quickly before risks and vulnerabilities had been fully understood, and support services established.

Some practitioners were surprised by Child Y's case history, there was information shared throughout the practitioner learning event that many did not know. It was accepted that everybody will not know everything, but it seemed that practitioners predominantly worked on the presenting issue and did not reflect on the case history, which led to a collective response that was reactive rather than proactive.

During the event, it was clear that some agencies were engaging and learning about each other's roles, responsibilities, barriers and challenges for the first time. They agreed the best outcomes for children are supported by effective multi agency working, however no one could recall instances when they have been involved in any multi-agency training or workshops that sought to build relationships or a true sense of working collaboratively with each other. The lack of opportunity to forge these relationships created tensions and disagreements relating to an agreed way forward.

Resources, workloads and staff capacity were all highlighted as key issues across most agencies in attendance. It was said that resources previously available are no longer available; the reduction in available resources, the influx of new children and families that appear more complex (where risks seem more dynamic, behaviours more concerning and changes in circumstances are more frequent) means caseloads that were manageable are no longer manageable, and work continues in a context of heightened service and inspectorate expectations.

Practitioners were not confident that the current systems in place effectively responded to address the needs of Child Y. Practitioners spoke about services being constructed to address safeguarding risks in the home, not the community. Processes and decision making were described as slow and bureaucratic, with the general ethos being minimal incremental intervention, as opposed to using the right tool or response at the right time. Delays are therefore created whilst decisions are made, providing the time for behaviour to escalate and get worse.

CHAPTER 6 - Case History Analysis

Early Years

Croydon Vulnerable Adolescent Thematic Report articulates the importance of proving support to families at the earliest possible opportunity, the lessons learnt about providing support to parents to understand the impact of attachment in early years, and the need for adult and children services to work together to provide a whole family approach. This finding is relevant to Child Y and his family.

Through no fault of her own, Ms M's ill health prevented her from caring for Child Y throughout his childhood. As he grew up, it was clear that this relationship was a source of confusion and sadness for him. It was only when he spent some considerable time with a school counsellor in secondary school that he began to understand how his mother's ill health impacted on her ability to form a relationship with him. This was a significant relationship for Child Y that he and his mother needed support to understand, and for it to be the best it could be.

'You want your mum even when she's ill, especially when you're just a kid.'[3]

Recommendations

Finding 1, in the Croydon Vulnerable Adolescent Thematic Review, is relevant to Child Y: *Early help and prevention is critical,* as are the corresponding recommendations. Two additional recommendations are made in respect of Child Y's specific circumstances.

SCR Child Y: Recommendation 1.

Working arrangements between adult services and children's services to be reviewed to ascertain how effectively existing protocols are working to support the relationship between children and parents who are unwell.

SCR Child Y: Recommendation 2.

Adult Mental Health Commissioners to review service arrangements and, where appropriate, to introduce support for mental health patients to support a child's relationship with their parent and provide support to the care giving parent.

Primary years: 5 -11 years

> *'The range and coordination of early help provision for children and families are not fully established. Individual partner agencies are unclear about the early help offer and have not been involved in developing a shared approach to delivering services.'* [4]

As highlighted in the Croydon Vulnerable Adolescent Thematic Review, opportunities are often present in a child's primary years to identify that a child may need support in addition to their learning needs. This requires primary schools to recognise a child's needs and provide services, as they did for Child Y, but also to consider what more a child and family may need. Child Y was living with his father at the time and a referral was made to Children's Services, but this did not meet the

[3] Family Minded Supporting children in families affected by mental illness. J. Evans and R. Fowler Barnardo's 2006

[4] OFSTED London Borough of Croydon: Inspection of services for children in need of help and protection, children looked after and care leavers, The experiences and progress of children who need help and protection

threshold for service provision. It seems that no other referral was made, and it is unclear what early help services were available at the time.

Recommendation

Finding 2: *Schools should be at the heart of multi-agency intervention from the* Croydon Vulnerable Adolescent Thematic Review was also relevant to Child Y.

Secondary years: 11 years plus

School Life

Child Y's needs were highlighted when he transferred to secondary school and support for his learning and emotional needs was provided at his new school. However, at the end of Year 8 there was a gap in provision when his specialist teachers left, and they were not replaced for some time. He continued to see the school counsellor throughout his time at this school and this provided important emotional support to Child Y. The counsellor represented an adult Child Y could turn to, and trust. Schools need to be suitably equipped and resourced to respond to the additional needs of children so that their learning, emotional and behavioural needs can be responded to over time. The importance of meeting the emotional, social and behavioural needs of children at an early point in their lives is well evidenced in research. Croydon Vulnerable Adolescent Thematic Review identifies this as an important issue and makes relevant recommendations.

Preventative Services

Early help works best when all agencies take on and deliver on their responsibilities, with agencies and professionals having a clear understanding of what provision is on offer. Where robust early help services are not in place there is a natural knock on effect to Children's Services who inevitably experience higher caseloads and demand for services.

Historically, the availability of universal, targeted and outreach youth services, who could provide constructive activities and informal education to young people on issues that directly impacted their lives, was a key part of the local landscape. Numerous national reports have been published since 2008 detailing the level of cuts to youth services across the country.[5] [6] As local authority budgets have been cut, this has resulted in non-statutory youth services being cut, reduced or closed, in some areas. Without access to local community-based youth services many young people can be left with nothing to do outside school hours and this can result in young people spending more time on the streets, susceptible to the influences of

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

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

more negative peers. Croydon Vulnerable Adolescent Thematic Review identifies this as an important issue and makes relevant recommendations.

Exclusions, managed moves and pupil referral units.

'Mainstream schools should be bastions of inclusion'[7]

Child Y received a fixed term exclusion at the start of Y10 and two days later received another fixed term exclusion. The school responded by arranging a managed move of Child Y to another secondary school. Guidance from the Department for Education (DFE) and Association of Chief Police Officers (ACPO) advice to schools suggests that these incidents were not serious enough to warrant this response. Whilst it is the responsibility of schools to determine their own behaviour policy, it was a more robust approach than most Croydon schools. The school counsellor was not involved in this decision, nor were other professionals. During interview with Mr F, he expressed that Child Y was devastated to leave his school and was very keen to do what was required of him so he could return there. Child Y was not able to return, as a decision was taken to terminate his place. He was the subject of a managed move at his next school and was placed in a Pupil Referral Unit.

It was understood from family members that the structure, timetable and expectations of the Pupil Referral Unit were at odds with Child Y's wishes and feelings.

He was described as' desperate to go back to mainstream education' and felt he was given 'false hope' that if he did well enough, he could return after two weeks. In reality, mainstream schools in the area did not want to offer him a place. One of the issues the placement at the PRU was seeking to mitigate was the 'influence of negative peers', yet he was placed in a PRU that was populated with other more concerning young people who proved to have a greater capacity to have a negative influence on him. At this critical time in his life, Child Y did not have the structure or support a mainstream school offers, resulting in him having more time in the community exposed to serious risks and violence. Consequently, the placement at PRU did not appear to meet Child Y's needs, if anything, it seemed to increase his risk and make him more vulnerable as his situation deteriorated significantly thereafter.

Evidence suggests that children educated in a PRU achieve far less academically than children in mainstream education. In addition, these children are more likely to get involved in crime, anti-social behaviour and gang related activity. Research also evidences that alternative education for some pupils is highly effective in meeting their needs, but the quality of provision is variable as are the academic achievements of the pupils.

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

'Our vision is to ensure that all AP (Alternative Provision) settings provide high quality education and that the routes into and out of AP settings work in the best interests of children'[8]

The latest statistics on exclusions show that, following a downward trend, the rates of permanent and fixed-period exclusions have risen since 2013/14[9]. A significant number of children attend alternative education settings due to behaviour and/or special educational needs. In addition, some ethnic groups such as African, Caribbean, white and black Caribbean are over-represented in alternative education. It is understood that government are in the process of reviewing alternative provision, it is suggested that this review should include the experiences of children like Child Y, whose behaviour did not pose a direct risk to other children and who, with the right support, could have remained in mainstream education.

Recommendations

Croydon Vulnerable Adolescent Thematic Review identifies two relevant findings: Finding 4: *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 Y, as are the corresponding recommendations. An additional recommendation is made in respect to Child Y's specific circumstances.

SCR Child Y: Recommendation 3

CSCB and Croydon Learning Access to work with head teacher forums and the Fair Access Panel to; define pupils with safeguarding needs, the potential for increased risky behaviour of pupils if excluded or are the subject of a managed move and consider these vulnerabilities in decision making. In addition, an appropriate monitoring system should be in place to promote consistency of how behavioural policies are applied in practice.

Engaging and supporting families

Child Y was first reported missing when he was 14 years old, and over the following months there were a significant number of professionals involved with Child Y and family life.

Mr F was disappointed and frustrated by Child Y's behaviour and attempted to instil boundaries. This led to tensions at home, which on occasions resulted in physical confrontations. After one such confrontation, Child Y went to live with his aunt and Children's Services were involved. Whilst Children's Services regarded this as a positive move, despite requests from family members, no support was provided.

[8] Rt. Hon Damian Hinds MP Secretary of State for Education
[9] Creating opportunity for all Our vision for alternative provision March 2018

Throughout multi-agency involvement Ms S was available to her brother, and she was prepared to provide care to Child Y. The relationship between Child Y and his sister was close, he turned to her when needed and she provided love, guidance and care to him. Her presence in Child Y's life was not acknowledged by services, the value of her relationship with Child Y was not understood and the possibility of her providing alternative care to Child Y was never explored.

Family and kinship are a vital part of a child's life and if supported and engaged in decision making and planning they can provide the kind of support to children that professional intervention, in isolation, cannot.

Recommendations

Finding 3, in the Croydon Vulnerable Adolescent Thematic Review, identifies a relevant finding: *An integrated, whole systems approach, is needed across agencies, communities and families.* An additional recommendation is made in respect to Child Y's specific circumstances.

SCR Child Y: Recommendation 4.

Safeguarding children and providing alternatives to their care cannot be achieved through professional intervention alone. Children's Services to review what may be needed to achieve collaborative partnerships with families and kinship.

Responding to critical incidents

Child Y was the victim of a stabbing and was admitted to hospital. He was seen by hospital staff, and also a hospital based service which specialises in working with children who are the victims of serious youth violence. A sensitive piece of work was completed with Child Y. The London Child Protection Procedures state that in these circumstances a strategy meeting is needed, convened by the Local Authority. This did not happen and there was no challenge by involved professionals about this important oversight. These are critical points in a child's life and can provide an opportunity to effectively intervene to divert a child from behaviour that may pose a risk of future harm. There was no alternative planning forum put in place (such as a discharge planning meeting) and this meant there was no coherent multi-agency plan to respond to Child Y's needs.

It is understood that changes to multi-agency practice now results in a different response. Now when a young person is admitted to hospital with a knife injury it is understood that the hospital Safeguarding Team will follow up the referral to children's social care with a request for the local authority to convene a strategy meeting.

It is understood that the hospital trust has agreed a new process of escalation in the event that strategy meetings are not convened. These are welcome developments.

SCR Chid Y: Recommendation 5.

The newly agreed escalation process, established by the hospital trust, needs to be the subject of evaluation and review and CSCB informed of any future difficulties.

SCR Child Y: Recommendation 6.

CSCB to work with major trauma centres in London and the Association of London Directors of Children's services (ALDCS) to establish a good practice model of safeguarding children and young people who sustain serious injuries to ensure a consistency of approach and appropriate management oversight.

Trusted Adults

Child Y was allocated a support worker from the Safer London Gang Exit Service (SLGE) and the relationship formed was very supportive to Child Y. Again, the importance of trusted adults in the lives of vulnerable children was evidenced. This relationship ended when Child Y was transferred to another service (YOS), this was a significant loss for Child Y. There was a need to organise provision based on Child Y's needs, which was for this relationship to be maintained, the needs of a child should take precedence over decision making based on service boundaries.

Overall, Child Y's experience of engaging with professionals was short lived, and on occasions negative. This resulted in a lack of trust and confidence in the professional network. However, when key people had the time to build an honest, consistent, trusted relationship, he responded well. The school counsellor and the support worker from SLGE were trusted adults in Child Y's life, they acted as advocates who would make representations on his behalf. After his managed moved to another secondary school and after the transfer of his case to YOS, he lost these trusted adults.

There is a growing body of research evidencing that a trusted adult relationship, often outside the familial environment or statutory services, are essential for a child's well-being. The recent Early Intervention Foundation (EIG) rapid evidence assessment commissioned by the Home Office in 2017[10] establishes the value of trusted adults in children's lives.

SCR Child Y: Recommendation 7.

CSCB to reflect on how to promote the identification and engagement of trusted adults to support vulnerable children.

Multi-agency response to risk

Metropolitan Police Service (MPS) Gangs Matrix

Child Y's behaviour subsequently deteriorated in the community and he came to the notice of the police more often; for alleged offending behaviour, when reported as

[10] Building Trusted Relationships for Vulnerable Children and Young People with Public Services. February 2018

missing and when stopped and searched by the police. Police formally added Child Y's name to the gang's matrix[11] and was risk assessed to be 'an amber nominal'.[12]

He grew up in an area where there was gang activity and his friends were thought to be associated with a local gang, but to Child Y these were just friends from childhood. His minor offending history suggested that he was not immersed in criminal activity or high-risk behaviours that are characteristic of gang membership.

The label of a gang member is a serious matter for young people to carry and must be validated via detailed assessment of professionals and police before its application. The MPS gang matrix manager worked with the Gangs Team (who were not working with Child Y at the time) to inform this judgement using a range of intelligence sources. However, Child Y's gang membership was disputed by agencies working with him. Ideally, all agencies should pool their information to arrive at an agreed position in regard to the risk a young person poses, with the suspicion of gang membership being validated over time and regularly re-assessed to avoid stigmatising young people such as Child Y unnecessarily.

An assessment had been undertaken by Redthread and SLGE, based on their interaction with Child Y, both concluded that he had associates that were gang members, but he did not conduct or see himself in that way. Other professionals and family members were also clear that Child Y was not a gang member.

The office for the Mayor of London has established that young people from BME communities are disproportionately represented on the gangs' matrix[13] and young people from BME communities are over-represented as both victims and perpetrators of serious youth violence. More transparency to improve the community confidence in the application of the gang's matrix which will assist to reinforce the matrix as a non-racist tool**.**

Adding Child Y to this matrix did not change Child Y's predicament or change the multi-agency approach to Child Y's vulnerability or risky behaviours.

SCR Child Y: Recommendation 8.

Police to reflect on the wider learning articulated in this SCR and explore with multi-agency services how local safeguarding practices, and their understanding and involvement in informing the gangs matrix, can be improved.

[11] The MPS gangs' matrix is an intelligence tool used to identify and risk assess gang members across every London borough based on violent offences and intelligence

[12] 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

[13] Review of the MPS Gangs Matrix. Mayor of London December 2018

Multi-agency planning to mitigate risk

The view taken by the Local Authority was that the methods used by Mr F to attempt to curb Child Y's behaviour caused harm, and Child Y was made the subject of a child protection plan. There were differences in how physical chastisement was defined, viewed and responded to by the professional network.

Whilst Child Y was the subject of a child protection plan, an Interim Supervision Order (ISO) was made. In the view of the Guardian and the judge, Mr F was using physical chastisement to maintain boundaries at home in an attempt to curb Child Y's behaviour.

Whilst chastisement was not endorsed, it was the view of the court that Child Y's needs would be best met by continuing to be in the care of his father and for increased support to be provided, this was in line with Child Y's wishes.

English common law allows parents and others who have 'lawful control or charge of a child' to use moderate and reasonable chastisement or correction. The legal defence of reasonable punishment is detailed under Sc58 of the Children Act 2004. A review of relevant procedure and local guidance provides little assistance to practitioners in defining reasonable punishment. Therefore, it is perhaps understandable that different meanings and interpretations are applied. If professionals are unclear, it is perhaps unsurprising that parents are equally unclear. This is particularly relevant for parents who have been brought up in families where physical chastisement was commonly accepted as a part of family life, and something that was used in the belief that this would improve a child's behaviour and outcomes. This is an important issue that requires attention and is undoubtedly an issue that is not unique to Croydon.

SCR Child Y: Recommendation 9.

Information to be provided to families and practitioners to raise awareness about the definition and response to physical chastisement. Training and guidance to be provided to the children's workforce to assist in definition, assessment, plans and service provision.

Use of established child protection frameworks to mitigate risk

By now, the significant numbers of professionals involved was overwhelming for family members and a child protection plan and ISO seemed to make little difference to the risks or plans that were made. As a parent, Mr F felt criticised and undermined by professionals from Children's Services and understandably, this impacted on his engagement. The focus on home life, and the lack of a coherent plan to address the risks in all domains of Child Y's life, led to a fragmentation in service provision and

'professional paralysis'[14]. In the absence of a coherent multi-agency plan agreed by services and family members there was duplication and confusion.

Practitioners have knowledge of risk and protective factors that does not always translate into effective assessments or intervention.[15]

Multi-agency services are increasingly being challenged to effectively intervene with more adolescents who display riskier behaviours that progress rapidly and require a timelier response. The child protection system was established to protect children from abuse in the home and not in the community.[16] Recent statutory guidance[17] now emphasises the importance of taking a contextual safeguarding approach in order to recognise the risks and vulnerabilities for children across all domains of their life.

'*Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationship where the focus of safeguarding reflects the risks at home and in the community'.*[18]

There was no specific multi-agency model of working with adolescents, there was not a clear early help offer, youth service, or youth crime and gang prevention service. As part of service improvements, Croydon Children's Services have reorganised to create an Adolescent Service so that the Youth Offending Service, the Gangs' Team, Children Exploited and Missing Intelligence Team all sit under one Head of Service, along with two newly created Adolescent Support Teams. Croydon have taken this important step in recognising that this specialist integrated service provides a greater opportunity to improve outcomes for vulnerable children.

Recommendations

Finding 3, in Croydon 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 Y. Additional recommendations are made in respect to Child Y's specific circumstances.

[14] Children Social Care IMR : A term used to describe service input to manage risk
[15] Preventing gangs and youth violence. A review of risk and protective factors. Home office/ Early intervention Foundation 2015
[16] Teenagers at risk. The safeguarding needs of young people in gangs and violent peer groups. NSPCC March 2009
[17] Working Together to Safeguard Children HMG 2018
[18] Contextual safeguarding (Firmin November 2017)

SCR Child Y: Recommendation 10.

In light of the recent changes in service provision to young people in Croydon, CSCB are invited to consider the learning from this case and conclude whether these changes adequately address improvements required.

SCR Child Y: Recommendation 11.

CSCB to review provision of multi-agency training and/or workshops to enable better understanding of roles, responsibilities, remits and working practices.

SCR Child Y: Recommendation 12.

CSCB to review available evidence-based practice to revise and publish Croydon's model of intervention to effectively respond to vulnerable, risky, and gang-linked young people.

SCR Child Y: Recommendation 13.

Croydon Local Strategic Partnership to ensure adequate sustainable resources are in place to support the multi-agency response to address gangs and serious youth violence.

Working in partnership – Police

Throughout service involvement, police often notified Children's Services of any potential safeguarding concerns via PAC Merlin notifications. The Police IMR author identified that there were three occasions when a PAC Merlin was not documented and should have been. On four occasions, intelligence checks and/or risk grading's were inconsistently recorded.

The police use an integrated information system informed by six different operating and intelligence systems. The IMR author confirms that whilst all staff have access to use the intelligence system, the results can vary depending on a number of variables; including terms used to search, spellings, misspellings, and, in the case of Child Y, if information has not been recorded or sufficiently detailed. Police intelligence pictures are informed by various data strands, to include notifications from other agencies (e.g. when professionals are aware that an alleged crime has been committed). The Police records therefore did not evidence a full picture of all issues and concerns relating to Child Y.

A more detailed exploration to understand how the system worked for Child Y is needed to identify what could be improved in regard to; notification, risk assessment, expected actions and actions taken by Police, MASH and Children's Services, to ensure each agency discharges its responsibilities in accordance with the system, but more importantly to better safeguard children such as Child Y. Had the nature and frequency of call outs been viewed in their entirety, the pattern of similar reports and potential safeguarding concerns would have been clearer.

Throughout the summer months, Police, YOS and gangs' team were made aware of a violent feud between two of Croydon's rival gangs, resulting in a series of violent incidents in the community. Further threats had been made on social media and via gang related music videos. The individuals concerned were known to the gangs' team who visited parents to alert them to their concerns of further serious incidents occurring. Mr F and Child Y were not visited to warn them of any potential danger to him as it was believed that Child Y was not an intended target.

Towards the end of summer Child Y was the victim of a fatal stabbing in his local area, it was believed his murder was directly linked to the ongoing feud between rival local gangs.

Several questions arise: Could more have been done to prevent further escalation via police enforcement or other actions? Could an Osman warning[19] have been put in place? Should there have been an increase in high visibility policing in the areas they believed the gangs to be operating? Could action have been taken to stop the music videos being uploaded and promoting violence and revenge?

SCR Child Y: Recommendation 14.

MPS to consider the questions posed above and inform CSCB of any relevant service developments.

SCR Child Y: Recommendation 15.

MPS to review safeguarding advice and guidance to front line officers, to include the expectations of Merlin completion.

SCR Child Y: Recommendation 16.

MASH/ Children's Services to review actions taken on receipt of PAC Merlin and MIS Merlin to identify any areas of improvement to ensure risks are identified an appropriate action taken as a result.

CHAPTER 7 - Conclusion

Child Y was described by all without hesitation as a likeable fun-loving child who had an infectious smile and who enjoyed the company of family and friends. He was not a prolific offender nor was he an active gang member with related behaviours, but a boy who grew up around and associated with young people who were known to be in gangs.

The prevalence of gangs and serious youth violence is on the increase across London with more and more young people being affected by the issues as perpetrators, victims, or those that are dealing with the trauma having known somebody that has

[19] Police issue an "Osman warning" letter when there is intelligence of a threat to someone's life, but not enough evidence to justify the police arresting the possible offender

been killed or seriously assaulted. The Centre for Criminal Justice recent report 'It Can Be Stopped' August 2018 states that gang membership has increased by 20,000 to 70,000 in the past 10 years.[20] In this time over 700 young people have been fatally stabbed or shot.

In a time of reduced resources, the challenge for local authorities and partners is enormous, making it essential that staff are trained, and available resources are effectively deployed. But in the absence of a national intervention model, to address gangs and serious youth violence across the country, local partnerships will struggle to make a difference.

[20] 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

Appendix 1: References

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