Thematic Study

'Patrick'

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1 Introduction

1.1 This Local Child Safeguarding Practice Review (the Review) is focused on the multi-agency arrangements that engaged Patrick during his years in the care and criminal justice systems. It evaluates Patrick's journey through these systems between 2016 and 2022.

1.2 The Review provides an analysis of practice in the context of Patrick's complex and often chaotic life. It makes eight findings and 14 recommendations for practice improvement, all of which have been substantially informed by the views of both Patrick and the practitioners / managers with whom he was engaged.

1.3 At the outset, it is important to acknowledge that whilst Patrick has the clear potential to rehabilitate, move forward and contribute positively to society, the Review has neither sought to minimise his past behaviour nor the impact this had upon many, not least his victims, Patrick himself and without doubt, his own family.

1.4 However, Patrick's experiences during this time-period are known to have been characterised by several issues of concern that cannot be ignored in terms of their correlation to Patrick's broader outcomes. These relate to the overall effectiveness of the help, care and protection provided to Patrick and the sufficiency of both single and multi-agency practice. More specifically:

- Patrick lacked stability. He experienced 17 placements in two years. He routinely went missing from home, care and education and his placements outside of Bromley contributed to the complexity of casework.
- The serious and repeated incidents of violence and confrontation involving Patrick are likely to have influenced some practitioners in their focus on Patrick's needs as a child.
- The support provided to Patrick in respect of his emotional wellbeing, including his attempts to self-harm (and his needs more generally), lacked a level of consistency and coordination.

1.5 However, without minimising the impact of these issues, the circumstances of Patrick's case were not that of a '*serious child safeguarding case*' and did not meet the criteria for notification to the national Child Safeguarding Practice Review

Panel (the Panel)[1]. In this respect, there was neither a formal requirement to trigger a rapid review nor submit one to the Panel itself.

1.6 That said, the Bromley Safeguarding Children Partnership (BSCP) was clear that there were opportunities to accrue learning. As a result, the Independent Chair of the BSCP made the decision to instigate a review to better understand what had happened in this case and why. The full Terms of Reference can be found in Appendix 1.

1.7 The decision to undertake a review was fully ratified by Bromley's safeguarding partners and the initial plan was for this work to be framed as a '*Thematic Learning Review*'. However, following more detailed guidance being published by the Panel in September 2022, the status of this report is now that of a Local Child Safeguarding Practice Review. To explain further, the Panel's guidance states:

> *'We know that sometimes safeguarding partnerships propose undertaking an 'alternative learning review' or use other terminology to describe different approaches to further review. We support and encourage different methodologies and approaches to review; however, any further review of a case should be referred to as an LCSP…'*[2]

1.8 The BSCP would like to express its gratitude to Patrick for his participation and the way in which he has reflected upon and shared his experiences. It would also like to thank the practitioners and managers who contributed to the Review with both openness and transparency.

[1] under 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1108887/Child_Safeguarding_Practice_Review_panel_guidance_for_safeguarding_partners.pdf Page 19

2 Key Circumstances, Background & Context

Early Life before Bromley

2.1 Patrick lived with his mother and four half-siblings during early childhood in two neighbouring boroughs. There were reports of sexual abuse of his older sister by a relative, but at that point, practitioners did not suspect that Patrick had been abused.

2.2 At the age of eight, Patrick and his siblings were placed on a Child Protection Plan (CPP) in Greenwich for emotional abuse (later the category was changed to neglect). Patrick's mother was unable to meet the needs of her children and the behaviour of Patrick's eldest sibling was causing significant concern. The children's fathers were largely absent, although once the CPP was in place, Patrick's father was known to spend more time at the family home providing support.

2.3 Despite the involvement of a range of agencies, Patrick's behaviour became more difficult to manage. At the age of nine, he was absconding from home and his relationship with his mother was tense. Patrick was excluded from primary school and was placed in a special school. Although he was reintegrated to a new mainstream school, Patrick was again permanently excluded after a couple of months and returned to the special school.

Early Life in Bromley

2.5 Patrick subsequently went to live with his father in Bromley at the age of ten years old. Greenwich Children's Social Care (CSC) removed Patrick from his CP Plan (assessing father as being protective) and recommended that Bromley CSC consider a Child in Need Plan (given Patrick's recent history). Bromley CSC decided that an early help response was more appropriate, and referrals to local Early Help services were advised. Father agreed with this approach. A Common Assessment Framework was put in place and Bromley Children's Project worked with the family for a short period.

2016

2.6 In 2016, Patrick started secondary school. He was excluded in year 7. It was reported that a large kitchen knife was found in Patrick's bag and that he had

threatened to bring a gun to school and '*shoot all of them'*. Patrick was arrested. There was also an allegation that Patrick had assaulted his mother. No assessment was triggered by Bromley CSC.

2.7 Patrick was also noted as bringing in a considerable amount of money into school. He expressed fear of physical chastisement if his father was told and was deemed to be at risk of self-harm.

2.8 Patrick's father could no longer manage his son's behaviour and there followed a period of Patrick staying with different family members. He regularly went missing and father reported that Patrick's behaviour had changed in a two-month period. He subsequently became a looked after child under section 20 of the Children's Act 1989 and placed with foster carers.

2.9 Whilst in care, concerns about Patrick's behaviour continued. He was alleged to be the leader of a group of around 25 young people that were behaving anti-socially in public. By this time, Patrick was well known to the police, breaching bail conditions and routinely going missing from his foster placement.

2.10 The police were also engaged following father reporting that Patrick was trying to kill himself. Patrick was detained under section 136 of the Mental Health Act and was taken to hospital for assessment. This concluded that Patrick did not have any risks to his mental health and whilst there was follow up by Bromley CAMHS, this was short-lived due to Patrick being placed outside of the borough.

2.11 During 2016, there were further incidents of Patrick trying to harm himself and he was placed in different foster placements. A Family Group Conference was convened, but no family member offered accommodation.

2.12 From an education perspective, it was agreed that Patrick needed to attend a Pupil Referral Unit as he was not manageable in a mainstream school. He attended one for a short time, until his father raised concerns about the influence of other pupils over his son.

2.13 Towards the end of 2016, there was an incident in which Patrick tried to kill himself. Bromley CSC recorded that Patrick appeared to be 'self-destructing' although the social worker was unclear why.

2.14 He was not following the rules of his placement (in Bedfordshire), stating that *he was Patrick, and he didn't have to*. This placement broke down soon afterwards due to a knife being found in Patrick's bedroom and his foster carer reporting that Patrick was aggressive and non-compliant. An urgent referral had been made to CAMHS, although he was moved to another area before intervention commenced.

2.15 By the end of 2016, Patrick had been living in a variety of placements, from relatives, to foster carers in Hertfordshire and Bedfordshire. He ended the year in Northampton.

2017

2.16 At the start of 2017, Patrick commenced a Referral Order under Northampton Youth Offending Service. He attended a local Pupil Referral Unit but was soon excluded due to violence towards a teacher.

2.17 In March 2017, he was assessed by a CAMHS Consultant Psychiatrist as part of care proceedings that had been initiated by Bromley CSC. The Psychiatrist concluded that Patrick showed behaviours that were in keeping with a diagnosis of Conduct Disorder and that his threats to kill himself had been in the context of adults trying to place boundaries around his behaviour. The Psychiatrist also confirmed that Patrick did not have any neurodevelopment difficulties such as ADHD.

2.18 During the first six months of 2017, Patrick continued to move placements due to him causing serious damage and aggression. He repeatedly went missing. On one occasion he was found staying with his cousin who was a known child sex offender. He was removed and later disclosed to his social worker that his cousin had sexually abused him. Despite this disclosure, Patrick refused to engage with the police investigation. As part of this Review, the police have confirmed that no information has been held regarding this disclosure.

2.19 In November 2017, Patrick was moved to a placement in Birmingham due to his high-risk behaviours. Patrick continued to abscond from this placement and display violent behaviour.

2018

2.20 In 2018, Bromley CSC made the decision to apply for a Secure Order on welfare grounds. At this point, Patrick was also on a 3-month Referral Order in Shropshire having assaulted a police officer. He was subsequently placed in a secure children's home in Wales, although he continued to abscond, and his behaviour escalated.

2.21 Whilst at this placement, there was a serious incident involving violence, aggression, Patrick making weapons, threatening female staff, and influencing the behaviour of other children. This resulted in the police being called. Patrick resisted arrest, was handcuffed and was subjected to a strip search.

2.22 Bromley CSC raised concerns about the secure accommodation not being therapeutic and that it was simply 'holding' Patrick. Whilst the provision explained their use of a trauma recovery model, Bromley CSC continued to try to address their concerns – particularly given the relationships between placement staff and Patrick had broken down to the extent where they would not enter his room unless he was sitting on his bed. In June 2018, Patrick was removed from the secure accommodation after seriously assaulting a member of staff.

2.23 He was placed back in Birmingham and Patrick was noted as expressing relief to be *'free'* of his secure placement. There were questions regarding the appropriateness of Patrick's care at the secure setting, with Patrick alleging that staff were pushing food into his room using their feet so as not to enter, removing his bed to make him sleep on the floor and taking all his clothes away so he had to ask for clothes to wear daily.

2.24 One of the key workers at Patrick's new placement expressed a view that being a black boy could have been a contributory factor to his treatment by staff in Wales.[3] There is no evidence that this was explored further by Bromley CSC.

2.25 In Birmingham, Patrick had a period of a few weeks in which he did not go missing or display any violent behaviour. However, this stability ended when Patrick was

[3] There was no information found in inspection reports and other documents about the secure provision to demonstrate any consideration of equality, diversity, and inclusion.

once again moved, this time to a Secure Training Centre (STC). This was due to Patrick being remanded on charges of robbery and two stabbings. Patrick also had a pending case of grievous bodily harm (GBH).

2.26 Whilst at the STC, Patrick reported to his SW that he had been restrained, but not hurt.

2.27 In November 2018, a brief CAMHS assessment was undertaken by a Consultant Clinical Psychologist as part of Patrick's pre-sentence report. This assessment described Patrick as looking '*older than 14-year-old'*. Patrick was noted to be *'quite defensive and resistant'* when asked about his childhood.

2.28 The purpose of the assessment was to explore any therapeutic and treatment needs for Patrick in relation to his mental health, conduct difficulties and anger. He was reported to have asked for anger management at the STC but had been told he could not have this until after his trial. Patrick described how he would not instigate physical aggression but would always hit back if someone else started it. He admitted that if provoked, he would react with aggression once in the community.

2.29 Patrick demonstrated that he did not know what Conduct Disorder meant and responded well to the Psychologist's explanation in terms of his offending behaviour. He was reported to be happier at the STC due to it being a *'better multicultural fit'* than the secure accommodation. Patrick reported seeing peers he had been to school with, whereas, at the secure setting, his first interaction with another child was to punch them due to a racist comment.

2.30 This assessment also supported Patrick's diagnosis of Conduct Disorder. He was not showing any signs of anxiety or depression, although the likelihood was acknowledged that he would have been affected by the separation from his family and being placed into custody at such a young age.

2.31 The assessment concluded Patrick to be a *'very angry young boy'* and that he had *'little ability to regulate his anger – this is to a clinically unusual degree and should be a focus of any intervention*.' It was also considered that he was minimising the extent of childhood maltreatment.

2.32 The Psychologist recommended that, as Patrick was asking for anger management support, intervention to address this should be a priority. Additionally, Patrick needed support to develop his emotional responses. It was recommended that the best outcome would be achieved through Patrick being in a wraparound therapeutic environment, with encouragement to take part in team sports to develop discipline and to use art therapy to help him to express his feelings.

2.33 The assessment did not identify any suicidal ideation from Patrick. However, during this time he was expressing threats to kill others and himself.

2019

2.34 In early in 2019 Patrick tried to hang himself, reportedly due to how he felt following an assault on a staff member at the STC. The STC did not report these events to Bromley CSC for two days. There was no immediate explanation provided for this delay, although Patrick's social worker challenged the STC Governor on what had taken place. This incident was subsequently reported to the local LADO covering the STC.

2.35 Additionally, there were reported incidents of Patrick threatening another young person, causing damage to furniture, and punching a member of staff in the face.

2.36 In April 2019, Patrick was transferred to another setting, a Youth Offending institution (YOI). It is not entirely clear why he was moved, but there were concerns about the care being provided by the STC.

2.37 However, Patrick found it hard to adjust to this new placement. When seen by his social worker, he reported that he was fearful of other children as they frequently threatened him.

2.38 Some of these children were on remand for the murder of someone known to Patrick. His social worker reported that he also made threats about others. Patrick expressed feeling low because he spent his time alone. At the YOI, Patrick was also given a meal containing nuts, despite it being known he had a severe nut allergy. He required urgent treatment from the health care team who reported that Patrick had not ingested the meal but had swelling around his face, eyes, and lips. This event was reported to the local LADO for investigation. However, the names

of prison staff involved were not forthcoming. The outcome of the LADO investigation was for no further action, although there were subsequent changes made at the YOI for those needing access to EpiPens.

2.39 In October 2019 there was a plan to transfer Patrick to a therapeutic unit within the current YOI, but he declined due to the distance from his family. He remained at the YOI and accessed CAMHS to help him manage his emotions and anger. This then changed to an anger management group rather than one-to-one sessions.

2020

2.40 In 2020, a new social worker was assigned to Patrick. At the time of writing, they are still his designated SW.

2.41 In August 2020, Patrick was released on licence with supervision and placed in semi-independent accommodation in Bexley. At this point there was supposed to be a therapeutic element to his care, and whilst undefined, there was a plan to refer to CAMHS.

2.42 Patrick consistently failed to comply with his licence conditions and went missing. When found, at his father's home, he refused to engage with the return home interview. He then breached his licence due to assaulting another young person at college. This was not reported to the police. He reported to his social worker and youth offending worker that he was the only black man in his class, and he felt there was a need to stand up for himself.[4]

2.43 Towards the end of 2020, Patrick was struggling to control his emotions and behaviour in the community. He was arrested for damaging a window at his girlfriend's house. By this time, he had received two written breach warnings and would be recalled if he had a third. He was not accessing any emotional support or counselling. He also started a motor mechanic course.

2021

[4] This was discussed with the Review Panel, and it was explained that there would be no role for the YJS worker or SW to risk assess the college environment, as this would be the responsibility of the college.

2.44 Patrick continued to have missing episodes and was recalled to the YOI. He attempted suicide once again, which led to another LADO referral. Following this incident, an event occurred in which Patrick was given (in error) a very detailed Asset Plus assessment relating to his recall. This contained details of his victims. Patrick was observed to be trying to make notes and allegedly needed to be restrained to remove the document from him. There were differing accounts from officers regarding the event, and they did not wear their body cameras. Due to the restraint, there was a referral to the LADO.

2.45 Shortly after this incident, a psychiatric assessment was commissioned as part of the parole recall. The assessment stated that Patrick met the criteria for Complex PTSD and, although not exhibiting a depressive disorder, it was recommended he should be monitored by specialist CAMHS. At this point, Patrick was noted to be in very low mood and losing weight. He then started to engage with the clinical psychologist at the YOI.

2.46 In June 2021, Patrick was released on licence and returned to the Bexley placement. He was successful in getting a job at a hotel but had several late returns to his placement.

2.47 In July 2021, he sent a photograph of himself covered in blood, accompanied by a "*goodbye*" message to his mother. A few hours later, the police were called by motorists reporting that Patrick was attempting to run into moving traffic on the M25. On the arrival of the police, Patrick is said to have attempted to run into the traffic again. He was detained under S.136 of the Mental Health Act and taken to hospital, before being discharged later that evening.

2.48 In August 2021, Patrick went missing after a domestic abuse incident with his girlfriend and after being arrested for six offences associated with this, he was recalled to a YOI. He disclosed domestic abuse by his girlfriend and childhood abuse and neglect.

2022

2.49 Patrick reached the age of 18 in 2022. At his final looked after review, it was agreed that Patrick's current social worker would continue to work with him until

19 to provide consistency and stability. There was also a plan for therapeutic intervention and speech and language therapy (SALT).

3 Child Patrick's Story: In his words

"Try to speak to staff, even if you don't get along, pretend, so you get support".

Overview of early problems

3.1 During interview, Patrick said he 'followed' his older brother who had learning difficulties and behaviour problems, not knowing what was right or wrong. He also struggled with his relationship with his mother, which led to involvement with CSC and Patrick subsequently moving to live with his father.

3.2 Patrick described his father as being old and not in good health. He felt he was doing well living with his dad and attending a new school. He played rugby, which he enjoyed. He reflected that he thought he was doing well in his life, although around this time he was arrested when he was showing off with a knife. From this point, things began to deteriorate rapidly.

Key episodes of Patrick's journey

3.3 Patrick spoke about what he considered to be the key episodes during his time in the care and criminal justice systems. Patrick was 12 years old when he was first taken into care and said that his placements were with older children. He felt he had been groomed to get into drugs and violence, stealing to make money to get a phone to ring home.

"It was a crazy time; I had no relationship with anyone".

3.4 During this time, Patrick kept his feelings to himself. He said he had so many changes of social worker (five). He reflected on the fact that he had no education and would just be in the placement all day, doing nothing.

"I should have been able to stay in one place. I didn't know how to deal with it. There was no one to help me."

Secure Children's Home (Wales)

3.5 Patrick was very vocal about his experience at the secure setting in Wales. He was there for about three months. He described it as being the worst experience. He said he suffered racism from peers and staff.

"I was the only black person there".

3.6 Patrick stated that he reported the racism to his social worker, however, he did not get on with this worker, and so nothing was done about it. He described how, on one occasion, he was restrained by staff as he would not go back to his room. This led to a member of staff being injured.

3.7 At this point, Patrick gave a vivid description of how he was made to stay in an empty cell, with no furniture and fed nothing other than finger food. He had no phone and even though he wanted to, he could not call home. He became angry, which he says led to an assault on a member of staff, for which he was arrested.

Deepening Problems

3.8 Patrick said that he was charged for an assault on a staff member and kept in a police station for three days as CSC had no placements available. He was then moved to Birmingham, to a semi-independent, unregulated, setting. He was 14 years old.

3.9 Bromley CSC tried to find another secure unit, but Patrick explained that nowhere would accept him due to the incident in Wales. He absconded and went to London where he was later arrested at his mother's home.

3.10 Patrick described how he was on the CAMHS list for years and that at some point he was diagnosed with a Conduct Disorder. [5]

[5] Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive, or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations. There are associations between conduct disorder diagnosis and poor educational performance, social isolation, and increased contact with the criminal justice system. The NICE guidelines set out the need for good assessment of the child's behaviour, followed by interventions involving parenting programmes, training for foster carers and child-focused social and cognitive problem-solving programmes. (NICE Guidance 158)

Trying to be Independent

3.11 Patrick described what happened when he was released from custody. He said he was released for six months, then recalled in 2021 for four months, out for two months, then recalled again in August 2021. These recalls were due to Patrick being arrested for further offences and him being assessed as too high risk to remain in the community.

3.12 Whilst out on release, Patrick had a job at a hotel and was also undertaking training as a motor engineer. He saved money and was living semi-independently. However, Patrick said he had no time for himself due to the licence, his work, and the course. Then his dad became unwell and Patrick was trying to look after him. This was a low time for Patrick. He attempted suicide. He said there was no support from CAMHS at this time.

"Everything became too much. I quit my job and stopped everything."

Youth Offending Institution

3.13 Whilst at the YOI, Patrick experienced a life-threatening event due to a severe nut allergy. He described how he had ordered a lamb burger but was told that there was only chicken satay left. He did not know this contained nuts.

3.14 He took the meal to his room. He had one mouthful and knew the signs of a reaction. He threw the meal away and got into bed. His throat was getting tight. He pressed the emergency buzzer. Patrick stated that staff are supposed to respond in two minutes, but no one came. He banged on the door, but no one responded. He said he managed to phone his mum and she phoned the YOI. Staff entered the room but did not get his EpiPen from the health care hub. An ambulance was called, and the paramedics treated him.

3.15 Patrick said there was an investigation, and the food arrangements were changed and that EpiPens are now allowed in the young person's room. He also received a formal apology.

Reflections as an Adult

3.16 Patrick was able to reflect on his childhood experience. He said that the last recall to prison really helped him[6]. He has been able to speak to staff for help and he feels he is building relationships.

> *"Last 3 years I have had the best social worker, no silly question. I am staying with her until I am 19."*

3.17 Patrick said he is working on his GCSEs and is still keen to do motor vehicle work. He feels he now has a support network around him for when he is released.

4 Analysis of Practice

4.1 The difference made when Patrick had consistent workers, identified support networks, and had access to education is noteworthy. The current social worker and youth offending worker particularly stand out for Patrick. Additionally, the access to therapy and education at his current YOI seems to have made a significant difference to Patrick.

4.2 Patrick feels he will be supported when released which will enable him to get used to being out in society. Whilst there are no guarantees, there is optimism for Patrick. This optimism is enhanced by what is seen as a strengthening in the continuity of care for Patrick and improved integrated working. These can be powerful tools in changing the prospects of the young and vulnerable.

Children Looked After

4.3 Until the final social worker took on her role with Patrick, there was little evidence of Bromley CSC providing a stable and consistent 'corporate parenting' role for Patrick. This was affected by the regular changes of social worker which meant that no one could establish a trusting relationship with Patrick. In this sense, the ability of practitioners to affect change was seriously hindered. This theme was discussed in depth by the Review Panel, with an acknowledgement that worker stability is a known issue on a national level, influenced by both systems and

[6] Patrick was recalled to custody in September 2021 due to having been arrested for six alleged offences against his girlfriend, including theft and violent behaviour. He was not recalled to the initial YOI due to the ongoing legal case regarding the inappropriate use of force and so he was recalled to another YOI instead.

workforce pressures. Whilst there are no easy answers in this respect, clear workforce strategies and a leadership focus on manageable caseloads and two areas that are known to improve staff turnover.

4.4 Whilst there were reviews of Patrick as a looked after child, he was noted as not engaging with some of the health reviews. Furthermore, there was limited evidence of attempts to understand Patrick's early childhood and his potential exposure to any adverse experiences. Given his siblings had disclosed abuse, this should have been considered in more depth. Indeed, this could have created opportunities for Patrick to disclose earlier and this may have facilitated an improved focus on Patrick's needs. As it was, a stubborn view of Patrick emerged and remained. He was viewed by the multi-agency network as an 'instigator of poor behaviour' and seen as a 'risk to others and himself' as opposed to being fundamentally vulnerable in his own right.

4.5 Patrick was placed around the country, but there seemed to be limited access to CAMHS to allow for an assessment of his emotional wellbeing, at least not until 2021. Had this happened earlier, then Patrick might have been able to gain some benefit from therapeutic intervention. Additionally, there was insufficient understanding of Patrick's institutionalised living and the impact of this on his ability to cope with living with the community.

4.6 When Patrick was at the secure children's home in Wales, he reported that he informed his social worker about racial abuse, but felt that he was not listened to, and that he had no one to help him.

4.7 Patrick was a looked after child and should have had his social worker to call on to hear his concerns in the same way a parent would listen to their child. Whilst Patrick's concerns about the care he received were eventually identified, they do not appear to have been escalated for any further exploration or considered in Patrick's care plan.

4.8 From a Bromley perspective, once Patrick had moved out of the borough it was a challenge for professionals to work together. This, alongside the frequent changes in worker, meant there were limited opportunities for local networking that is likely to have improved the understanding about Patrick's needs.

4.9 As a looked after child, Patrick was moved frequently. Every move reinforced the pervasive view of Patrick's risk towards others, his violent response towards workers and threats against others. The impact of these moves was likely compounded by the lack of any coordinated approach to gaining therapeutic intervention for Patrick. Such support could have helped Patrick learn how to better regulate his emotions and behaviour.

Secure Training Centre

4.10 At the age of 14, Patrick was placed at the STC. This was the first 'stable' setting since Patrick had been 10 years old. At the time, he seemed to be more settled as it was nearer to home. His family were able to visit, and he knew others there from his primary school. Nevertheless, there were still serious incidents involving Patrick and violence and he was considered to be a risk to others: staff, boys, and girls, as well as to himself.

4.11 In 2019, the STC's Local Safeguarding Children Board commissioned a Serious Case Review (SCR) in relation to the STC. This was following whistleblowing concerns about the safety of the children and how some staff were violent. Amongst a range of findings, the SCR identified the need to improve children's access to have their voices heard and greater oversight of practice.

4.12 The STC closed in March 2021. At the time of writing, there is a plan for the first ever Secure School to open at the same site. Secure schools are an alternative to youth offending institutions which place child-focused education, health, and resettlement at the very heart of the youth secure estate. The method of intervention will be underpinned by therapeutic principles designed to build on individual strengths and develop life and social skills that support children's transition back into the community. At the practitioner event for the current review, there was discussion about the increased options that will be available for a trauma informed approach.

Youth Offending Institution

4.13 Patrick was placed in the first YOI in 2019. He experienced a life-threatening episode due to his nut allergy. It is positive that this was investigated, changes made and Patrick received a formal apology. However, this was such a dangerous episode for a child with a history of not being able to trust the adults responsible for providing his care.

4.14 The LADO investigation into this incident noted that the YOI took the concerns seriously and concluded that no further action was needed. Whilst noting differences in the account provided by Patrick and the YOI, measures have since been put in place to prevent a recurrence.

4.15 With regards to the incident involving Patrick being mistakenly given a copy of his Asset and parole dossier, his restraint and the injuries he sustained resulted in a referral to the LADO and a child protection enquiry under section 47 of the Children Act 1989.

4.16 The local LADO service has developed strong links with the YOI to provide some independent scrutiny of the use of force by staff. This has meant that the LADO has been involved in restraint minimisation meetings and safeguarding meetings. The LADO service has worked with the YOI to encourage the activation of Body Worn Cameras, as whilst the cameras are mandatory, their activation is not. In terms of Patrick's experience, the cameras were not activated when he was restrained during the incident with the documents. Had they been it would have helped to analyse how the incident occurred.

4.17 It is understood that the Local Safeguarding Partnership relevant to the YOI raised this issue with the Secure Estate Quality Assurance Subgroup and received a response that a new model of body worn cameras is to be introduced to overcome the issue of short battery life, as cameras constantly record but the batteries do not always work.

4.18 In April 2022, the YOI was subject to a formal inspection by HM Inspectorate of Prisons for England and Wales (HMI Prisons). This was a year after Patrick had left this setting. The findings illustrate that several stubborn challenges remain.

- There was a lack of purposeful activity.
- Staff did not challenge poor standards on residential units.
- Staff had low expectations of the children.
- Levels of violence were high, with no plan for violence reduction.
- There was insufficient investigation of complaints about discrimination (28 complaints in the previous six months).
- Lack of access to mental health support and therapeutic intervention.

- There had been improvements in the level of education support for the children.

Access to Education

4.19 The timeline regarding Patrick's Education Health and Care Plan (EHCP) was not clear until September 2020 when the EHCP was finalised. However, there had been assessments recorded since 2015, when Patrick had an educational psychology assessment whilst at secondary school in Bromley. This assessment was to consider his learning, emotional and behavioural presentation. There does not appear to have been a handover from the previous local authority or schools, where his behavioural issues were known.

4.20 There were prior reports that Patrick was performing academically at a level of average to above average. Because of this and given early concerns were in relation to Patrick's emotional wellbeing and behaviour, his needs did not fit with the SEND categories. In this respect, schools would have been expected to manage Patrick's disruptive behaviour.[7]

4.21 By 2018, when the EHCP assessments commenced, Patrick was being placed around the country in various settings. This required engagement from the education providers at these placements. Patrick described how he received no education whilst in Wales. The Virtual School team described how difficult it was to find a good personal education plan (PEP) whilst he was in custody, due to the lack of engagement by placement education teams.

Interagency Working

4.22 At the Review Panel and practitioner event, there was good interaction between agencies. However, this was not evidenced in the chronologies viewed as part of the Review. Whilst the police, CSC and YOS were aware of the incidents during Patrick's journey, there was limited evidence of effective joint working and planning to consider why he was displaying such a high level of violence and what could be done, together, to help.

4.23 A key barrier to working together was that Patrick was not placed in Bromley. The responsibility for intervention was dispersed across a range of agencies local to

[7] DFE/DoH (2015) Special educational Needs and Disability Code of practice: 0-25 years.

his placements. Up until 2019, there were further complications caused by Patrick having changes in social workers. The challenges in cross-borough working manifested in several ways, most markedly seen in the accurate and timely sharing of information.

5 Findings and Recommendations

Finding 1: Preventing permanent school exclusions needs to be a key feature of Bromley's early help arrangements.

5.1 Behavioural issues, including persistent disruptive behaviour and those that are deemed to create a risk to others can lead to children being permanently excluded from school. Such action can ultimately expose children to pathways to harm, such as exploitation and criminalisation[8]. Numerous reviews and research have frequently identified the impact of school exclusions on the outcomes for adolescents, especially boys[9] [10] with 86% of children in YOIs having been excluded from school at some point.[11] [12]

5.2 Supporting the substantial evidence in this context, The Young Lives Commission recommended: *"That the exclusion from school of primary school age children is ended within the next four years, and that schools are supported with the necessary resources to achieve this. Local partnerships with youth services and youth organisations to engage and support young people at risk of crisis. We would like to see teams of youth and community workers in all schools to build relationships and support young people."*[13]

5.3 The experiences of Patrick reinforce the benefits of keeping children at school wherever possible, and for local safeguarding arrangements to maintain focus on the provision of effective early help to make this happen.

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf
[9] The National Child Safeguarding Practice Review Panel (2021) Annual Report for 2020.
[10] Sutton LSCP (2021) LCSPR: Child V
[11] Ministry of Justice (2014) Transforming Youth Custody
[12] Commission on Young lives (2022) *All Together Now: Inclusion not Exclusion: Supporting all young people to succeed in school.*
[13] Commission on Young lives (2022) *All Together Now: Inclusion not Exclusion: Supporting all young people to succeed in school.*

5.4 Notwithstanding the complex childhood that Patrick experienced (and whilst also recognising hindsight bias), it is not unreasonable to suggest that had early help been more effective in Patrick's younger years, then he may very well have followed a different pathway to protection.

5.5 Ideally, this early help should have been looking to address the root causes of Patrick's behavioural difficulties – as opposed to simply leaving the education system to deal with their consequences. In this respect, the importance of identifying and intervening with Adverse Childhood Experiences (ACEs)[14] is key.

5.6 Indeed, Patrick's story highlights similar themes as those found in the Croydon Vulnerable Adolescents Thematic Review (2019).[15] This also referenced the prevalence of ACEs and the need to intervene with these in mind. Whilst Patrick did not disclose the abuse he had suffered until relatively recently, services involved at the time were aware of the abuse suffered by his sibling and this should have triggered professional curiosity and a more forensic focus on what might have been causing his behaviour to deteriorate.

Recommendation 1

The BSCP should seek reassurance on the effectiveness of early help in the context of children being at risk of exclusion / permanent exclusion. The evaluation of sufficiency in this respect should include a focus on the ability of local practitioners to recognise and intervene when there are identified Adverse Childhood Experiences.

Recommendation 2

The Local Authority should review / develop a specific exclusions strategy that is formally adopted and embedded as part of the BSCP's written safeguarding arrangements. As relevant agencies, all schools and colleges will have a statutory duty to cooperate with these written arrangements.

Recommendation 3

The Local Authority should routinely report to the BSCP on exclusion rates, and reasons, by ethnic background, gender, age, and number of episodes.

14 Original ACE Study: Am J Prev Med(1998) - V.J. Felitti et al. https://www.ajpmonline.org/article/S0749-3797(98)00017-8/fulltext

[15] Spencer, Charlie, Griffin, Bridget, Floyd, Maureen and Croydon Safeguarding Children Board (2019) Vulnerable Adolescent Thematic Review.

Finding 2: The adultification of children masks their needs.

5.7 Within the CAMHS assessment completed in 2018, Patrick was described as looking older than his years. In the documentation seen by the Review and through conversations with practitioners, this was a view reinforced by others. Alongside the physical presentation of Patrick, it is not unreasonable to deduce that practitioners were also influenced by Patrick's behaviours. Indeed, the narrative about Patrick's violence towards others (whilst accurate) is also likely to have influenced how practitioners saw Patrick as being older than he was. The perception of Patrick as being older is, in the opinion of the Review, evidence of adultification. This ultimately meant that opportunities were missed to better intervene with Patrick as a child.

5.8 Explaining further, Davis[16] highlighted how the rights of Black children are often weakened due to them being viewed as perpetrators of crime, rather than being at risk of harm or exploitation. Black children who are subject to the criminal justice system are not always being safeguarded or treated with compassion and support. This leads to the amplification of racism, the application of social stereotypes and insufficient curiosity regarding the lived experience of Black children in secure settings. The result is that Black children can be *'categorised as undeserving when in need of safeguarding and protection.'* [17]

5.9 The impact of this 'undeserving label' can perhaps best be seen through Patrick's experiences in the secure children's home in Wales. Here, Patrick was the only black person and spoke of the racism he experienced. Whilst not excusing his behaviour, there was no attempt to find out the catalyst for his violent acts, rather the label of a violent young man became prevalent. From conversations with both practitioners and the Review Panel, there was agreement that this perception largely prevented Patrick from being placed in a wraparound therapeutic environment to give him the best chance for a positive outcome in his future.

5.10 The understanding and application of 'intersectionality' by practitioners could also have helped facilitate a better understanding of the support that Patrick required.

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[16] Davis, J. (2022) *Adultification bias within child protection and safeguarding.* HMIP

[17] Davis, J. (2022) *Adultification bias within child protection and safeguarding.* HMIP

Intersectionality[18][19] enables an individual to be viewed through multiple lenses, e.g. gender, ethnicity, physical or mental ability, employment. Whilst there was evidence of numerous assessment and planning activity, there is little evidence these were sufficiently focused on the full range of factors that needed to be understood in the context of Patrick's lived experience.

Recommendation 4:

The BSCP should ensure that policy, guidance and training is developed and launched on both adultification and intersectionality.

Recommendation 5:

Bromley CSC should undertake a review of the plans for all children placed in YOIs, STCs and Secure Children's Homes and provide reassurance to the BSCP that these are appropriate. The plans should be evaluated to test whether they consider the full range of factors impacting upon a child (intersectionality) and that intervention in these contexts is not being influenced by adultification bias.

Finding 3: Strong oversight is needed for children in secure settings.

5.11 Patrick's experiences highlight the significant number of placements that children can experience when they are looked after and / or in need of a secure settings. This is far from ideal, with research and practice experience reinforcing that good placement stability often leads to improved outcomes. For Patrick, a child with a disrupted and unstable childhood, his frequent moves will have done little for his sense of belonging, his self-esteem and his ability to visualise a positive future.

5.12 Beyond the existing placement challenges for children requiring care, the extreme challenges in finding secure placements for young offenders in England are well recognised. Such pressures have been highlighted in other reviews which emphasise the urgency for solutions.[20] This is undoubtedly easier said than done.

[18] UN Gender and racial discrimination: Report of the Expert Group Meeting) https://www.un.org/womenwatch/daw/csw/genrac/report.htm

[19] Dhamoon, R. K. (2011). Considerations on mainstreaming intersectionality. *Political Research Quarterly*, *64*(1), 230–243.

[20] Croydon SCP (2019) Child Q Overview

5.13 However, the sourcing of secure placements is not the only issue of concern in this regard. When placements are identified, they can be high cost and poor quality. Indeed, the Independent Review of Children's Social Care concluded that YOIs and STCs *"are wholly unsuitable for children"*[21]*.* It recommended that the system is redesigned to be managed regionally under the national oversight of the Department for Education to ensure that there is a greater focus on children.[22]

5.14 In terms of Patrick, his lived experience is marked with trauma and a professional response that was insufficiently attuned to what life was like for him in these settings. Of relevance to how Bromley can deliver improvements in this area, Walters (2019) recommended that: *"All Local Authorities who have children placed in the secure estate or host the secure estate to ensure that they engage with a high level of professional curiosity and ensure they ask and understand the child's lived experience"*[23] The Review makes the following recommendation in this regard.

> **Recommendation 6:**
> Bromley YJS should ensure that they have access to inspection / monitoring reports for any secure settings in use, as well as reports from advocacy services. This will enable them to raise any concerns with the relevant Youth Custody Service. If there continue to be concerns about a secure setting where a Bromley child is placed, the Bromley YJS should escalate through the YJS Executive Board and LSCP.
>
> **Recommendation 7:** As part of ongoing engagement with children placed in secure settings, their wishes, feelings and experiences of the placement should be routinely established, with any concerns being transparently addressed with the provider and/or through the escalation routes defined in recommendation 6.

[21] MacAlister, J. (2022) *The Independent Review of Children's Social Care* https://childrenssocialcare.independent-review.uk/wp-content/uploads/2022/05/The-independent-review-of-childrens-social-care-Final-report.pdf
[22] MacAlister, J. (2022) *The Independent Review of Children's Social Care*
[23] Medway Safeguarding Children Board /Walters, A. (2019) Serious Case Review *'Learning for organisations arising from incidents at Medway Secure Training Centre'*

Finding 4: Practitioners need to routinely use opportunities to understand the reasons for a child's behaviour.

5.15 Despite escalating violence, spiralling criminal activity and regular missing episodes, the professional network did not use all available opportunities to come together and think through the reasons for Patrick's behaviour.

5.16 Of importance in this respect is the information that can be gleaned from children themselves. Their voices can help practitioners better understand those reasons and plan how to mitigate risk. Several defined mechanisms are already in place to help facilitate talking with children, such as through the return from missing interview process. Looking at Patrick's journey, there was limited evidence that this process was used to best effect.

Recommendation 8:
Bromley CSC and Bromley Police should provide reassurance to the BSCP about the quality and effectiveness of return home / return from missing interviews for children placed both in and outside of the borough.

Finding 5: Children in semi-independent living need ongoing support.

5.17 Patrick was provided with semi-independent accommodation without the support of a trusted adult. The benefits of such support should not be underestimated. Much in the same way that most parents continue to help their 16/17-year-old children, it would be unusual for those in semi-independent living not to have the same needs – if not more. This was a large gap in Patrick's care plan that should have been filled. Notwithstanding his age, Patrick's previous offending and violent behaviour should have made it obvious that he required enhanced support not less. As it was, Patrick was left to his own devices and was relatively alone in having to regulate his behaviour. The challenges he subsequently experienced were predictable.

5.18 Reflected as a theme in other local reviews, the learning from 'Leo'[24] illustrated the need for Bromley SCP to satisfy itself that the network of preventative services is making effective provision for young people who have risk factors that have an association with violent offending. An enhanced focus should be applied on those in semi-independent living arrangements.

> **Recommendation 9:**
> The BSCP should revisit the recommendations from the 'Leo' case and seek reassurance that improvements have been made and are being sustained in respect of the provision of support for young people who have risk factors that have an association with violent offending.
>
> **Recommendation 10:**
> Bromley CSC should dip sample a range of cases of children living in semi-independent living to ensure they all have access to a trusted adult and that support plans are sufficiently robust.

Finding 6: The importance of escalation about education

5.19 Patrick's experiences illustrate the barriers that some children can face in accessing a good education whilst in secure accommodation. They also demonstrate the positive impact that effective education arrangements can have on children's outcomes when support is in place and that this is individualised and focused. For example, when Patrick did receive an education, it was noted that he did well, both in academic subjects and in sports. The power of good education should never be underestimated.

5.20 In terms of Patrick's journey, whilst acknowledging the challenges of placement stability, there were some obvious deficits at Patrick's secure settings with his educational needs neither being prioritised nor met. There was less focus (and perhaps urgency) about Patrick's education within the overall plans for his care, and an absence of challenge to those settings that were insufficient in engaging with Patrick's personal education plan.

[24] Bromley SAB (2020) Learning Review: Leo.

Recommendation 11:
Bromley Local Authority (Education) should review the standards expected for personal education plans for children placed in secure settings. A defined escalation process should be developed that is triggered if secure settings fail to properly engage and implement such plans

Finding 7: Practitioners need to 'reach out' with mental health support, particularly for those in secure settings.

5.21 Patrick's experiences illustrate the challenges that exist for some children in swiftly accessing child and adolescent mental health services when in care or criminal justice settings. For those children needing this support, a lack of timely intervention is likely to negatively impact on their ability to address previous trauma and move on in their development.

5.22 Whilst efforts were made to provide a therapeutic environment for Patrick, this was relatively late in his journey. Ideally, this should have been made available when he was first taken into care. Whilst the Review acknowledges both the historic pressures facing CAMHS, alongside the more recent and exceptional surge in demand (following the Covid-19 pandemic), it is hard to think of any cohort of children more in need of support than those placed in secure settings.

5.23 As a collective of 'corporate parents' (in its widest sense), the multi-agency network in Bromley needs to ensure that the therapeutic needs of this group are being routinely and effectively met.

5.24 To support this priority group, there is also a need to reflect upon the sufficiency of pathways into key services. For example, whilst recognising the practical requirement for CAMHS to manage demand, an existing approach that closes cases where there is no clear willingness to engage seems limited in terms of 'reaching out' to help children and families[25].

[25] Croydon SCP (2019) Child Q Overview

5.24 Indeed, for some children, and perhaps for those with similar issues to Patrick, they might not recognise their need for support. This does not make their needs go away, and even if the first answer to the offer of support is 'no', this should prompt the system to be more proactive, not less. In such circumstances, the wider partnership, including CAMHS, needs to default to using creative means to encourage engagement, particularly for those in secure settings and for those who are hesitant or reluctant.[26]

Recommendation 12:
The South East London ICB should provide reassurance to the BSCP regarding how CAMHS support is appropriately prioritised for children who are in care and/or in secure settings and how those hesitant / reluctant to engage are encouraged to do so.

Finding 8: The child's voice was, is and always will be central to effective help and protection.

5.25 Patrick was extremely articulate in describing his experiences. He was able to explain how both his workers and placements frequently changed and how he saw a difference in those practitioners with whom he is now involved. They have clearly made a positive impact on Patrick. Trusted adults make a difference.

5.26 However, in reflecting on his journey, the multi-agency system seems to have been either disinterested or ineffective in routinely hearing Patrick's voice. This would have been an important omission for any child, but for one living in settings that were less open to the 'public eye', the failure to focus on Patrick's voice was a significant deficit. Hearing children's voices is established good practice and the rationale for why this should happen does not need to be repeated here. That said, in the context of children involved in criminal activity (or on the periphery of it), listening to them can help practitioners respond effectively and avoid further criminalisation.[27]

[26] Sutton SCP (2020) Child T.
[27] Mayor of London (20210) *Protocol for reducing Criminalisation of looked after children and care leavers.* https://www.london.gov.uk/sites/default/files/reducing_criminalisation_of_looked_after_children_and_care_leavers-_a_protocol_for_london.pdf

5.27 Despite some of the historical issues, the Review recognises the positive changes made locally since Patrick's experiences. For example, practitioners from Bromley YJS were noted as more regularly visiting children placed out of borough. This is likely to help them develop consistent, trusted adult relationships and enable them to talk about their experiences. It will similarly allow practitioners to identify and respond to any concerns.

Recommendation 13:
Bromley YJS should provide reassurance to the BSCP about how it provides a trusted adult role for children in secure settings and when they are released.

Recommendation 14:
The BSCP should consider how it can hear the voices of children placed in secure settings by way of its direct engagement with them (i.e. surveys / interviews, health assessments). This activity should be developed and undertaken as a defined part of Bromley's Learning and Improvement Framework.

6 Appendix 1: Term of Reference

Decision to Conduct a Review

This case was considered at a meeting of the Safeguarding Practice Review Subgroup in March 2021. The Independent Chair concluded that there was a pattern of being moved around to different youth offending services (YOS)/ youth justice services (YJS) and institutions, with lack of consistent support, frequent confrontations and attempts to self-harm. The Chair agreed to a Thematic Review which aims to provide a contextual view of a young person in custody.

Period under Review

A detailed chronology should be provided by relevant agencies from 01/06/2016 until February 2022 and a summary of any significant events prior to this.

Methodology

The agencies identified in Section 6 are required to prepare a chronology of the agency's contact with Patrick.

Professionals involved with the family were invited to an **Engagement and Reflection Session with the Investigative Author** after the chronologies have been reviewed. A further meeting for professionals will be held after the first draft of the Overview Report has been completed.

The Independent Reviewer will lead the review and produce an Overview report. The Case Review Group will support the Reviewer, contribute expertise, consider learning from the review and will be responsible for developing an action plan in response to any recommendations.

Scope of Thematic Review

1. Establish the context of Patrick's life prior to his engagement and involvement with social care and the criminal justice system - focusing on timescale of 2016, with background information of earlier life.
2. Develop an understanding of Patrick's journey through the system from his perspective (via his voice).
3. Establish whether the system made the situation better or worse. In doing so address the following issues:
    - How does the system reflect a parenting/corporate parenting approach?

- What are the systems for identifying adverse childhood experiences of children involved in serious offending?
- What is the role of professionals in working together (e.g., YJS and CSC) to safeguard the child and how have agencies responded to meeting his needs overtime?
- Why does a young person enter the youth justice system? Use this young person's voice and story to consider how Bromley can prevent this pathway for other children.
- What is the experience of a young person in secure estate/custody? - general care, keeping safe, use of restraint, rehabilitation?
- How is a young person's health and wellbeing managed in a secure estate? i.e. what is the healthcare plan within secure estate (mental and physical health)?
- How can the LSCP gain assurance about the safeguarding of the local young people placed out of borough in secure estates - research from LSCPRs, NHSEI commissioning of health in justice, Youth Justice Board, YOT etc
- What work was undertaken on the reduction of risk for Patrick? Was this considered before moving him to other placements?
- Whether the frequent moves between placements is common for young people in custody and how this impacts the young person.

4. Identify the challenges that services face and deal with in protecting and safeguarding children with complex needs that are further exacerbated by being remanded. This should include consideration of:
    - Confrontations with staff and other young people in custody. How well was safeguarding policy understood by the YOI staff? (To include Restraint Policy, safe environment, de-escalation techniques and conflict centred strategy). Were policies adhered to and what can be learned?
    - The provision of medical assistance, access to medical equipment and access to advocates (including family) at times of crisis. Was access to medical equipment/assistance readily available and did it follow the YOI policy?

Agencies Involved

Chronologies were requested from the following agencies:

- Children's Social Care
- Youth Justice Service (YJS)

- CAMHS
- Bromley Healthcare
- Early Intervention and Family Services
- Metropolitan Police
- LBB Placements Team (CPT)
- Virtual School
- LBB Education (SEN)
- GP
- Prison Services including Oxleas Prison Healthcare Services

Independent Chair and Author

The Independent Chair of the SPR Review Group will be Jim Gamble, the BSCP Independent Chair. The Independent Reviewer will adopt an investigative approach. They will be independent of BSCP, and the organisations involved in the case.

Family Involvement

Consent is not being requested in order to carry out this Thematic Review. The young person will be informed and invited to contribute to the review.