Serious Case Review: Child K and services to reduce serious youth violence

Convenor - Brent Safeguarding Children Forum **Mike Howard**

Independent Reviewer **Keith Ibbetson**

Serious Case Review: Child K and services to reduce serious youth violence

1. INTRODUCTION

Reasons for conducting the review

1.1. Between October 2019 and August 2020, Brent Safeguarding Children Board (the LSCB) carried out a review of the services provided for a 16 year old boy and his family. He is referred to in this report as Child K. He was murdered in 2019 in an attack which is believed to have been part of a series of connected violent assaults and deaths involving young people associated with rival criminal groups.

1.2. The review was carried out under the statutory guidance *Working Together to Safeguard Children 2015*. Its purpose is to undertake a '*rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'*. The LSCB is required to *'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.*[1] This document sets out the review findings.

1.3. The death of Child K was brought to the attention of the LSCB which undertook the rapid review required by statutory guidance.[2] The LSCB Independent Chair decided that a serious case review (SCR) was required, noting that concerns about serious youth violence fall within the definition of contextual safeguarding in the statutory guidance. [3] [4]

1.4. Child K's murder has been the subject of a criminal investigation. One man has been convicted of his murder and another of offences linked to it. The report contains no further detail of the circumstances of Child K's death. The SCR is aware of the highly-charged atmosphere that often exists around the killing of a young person, the risk of retribution and further serious violence. Only essential information about Child K, his family and his contact with professionals is included in this report where it supports the review findings. Sufficient detail is provided of the risk to Child K, the risk that he had posed to others and the services that had been provided, in order to learn lessons that can be applied to other young people.

---

[1] *Working Together to Safeguard Children* (2015), 4.1 and 4.6. In September 2019 the statutory partners responsible for safeguarding children in Brent introduced new partnership arrangements, in line with the Children and Social Work Act 2017 and *Working Together to Safeguard Children 2018*. The LSCB is responsible for completing this work and publishing the finding and recommendations. Brent Safeguarding Children Forum will monitor the implementation of the recommendations https://brentsafeguardingpartnerships.uk/children/article.php?id=643&menu=0&sub_menu=2

[2] *Working Together to Safeguard Children* (2018) Sections 4.20 – 4.21

[3] In September 2019 the Independent Chair assumed the role of Independent Convenor of the Brent Safeguarding Children Forum,

The scope of the review and the information considered

1.5. Child K and his family had been well-known to a number of services in Islington, Camden and Brent (where he was living at the time of his death). Initial review of the history suggested concerns about the way in which agencies had worked together to safeguard his welfare, noting that there may have been shortcomings in service provision because of the involvement of agencies in different London boroughs.

1.6. At the time of his death, Child K was the main suspect in the police investigation of the killing of another young person. The review has been told by the police that, had he not been killed, Child K would have been charged with the murder. The police were also investigating his involvement in other serious alleged offences. This made it important for the review to consider how the risk that he posed to other young people and the public more widely was understood and addressed, as well as considering questions about how he was being safeguarded. By the end of Child K's life, there was a significant disparity between these risks and the interventions that professionals were able to make. This was recognised as a common challenge to families and professionals which the review could usefully explore.

1.7. Members of the LSCB, senior managers and the independent reviewer appointed to lead and undertake the review agreed initial terms of reference. These are set out in an anonymised form in Appendix 2. The original intention was to complete the review by the Spring of 2020. The Covid 19 lockdown caused the unavoidable postponement of interviews and meetings and delay in the agreement and publication of this report.

1.8. The review does not examine every episode in Child K's life and contact with services in the same detail. Most attention is given to the issues which are believed to be of most value to agencies working with children affected by serious youth violence.

Agencies involved and information obtained

1.9. The review has sought to obtain information from all of the agencies and contracted professionals that are known to have worked with Child K and his family including the following:

- Local authority services (social care, housing, education services, and targeted youth support services)
- Youth Offending Services
- Metropolitan Police Service
- Acute and community health services, including intensive care services

[4] *Working Together to Safeguard Children* (2018) Sections 1.30 – 33. Contextual safeguarding refers to children and young people '*vulnerable to abuse or exploitation from outside their families*'.

- Child and Adolescent Mental Health Services
- Schools
- General Practice

1.10. Agencies provided the review with chronologies that give factual accounts of their involvement with the family and other professionals as well as a brief commentary on the involvement. In addition groups of staff and managers who worked with the family have spoken directly to the independent reviewer in order to provide more detailed information about their work with Child K, reflect more widely on their experience of work with young people and their families, and suggest ways in which services might be improved. More senior or specialist staff have advised the review on relevant policies and procedures.

Family involvement

1.11. Serious case reviews must involve family members. During the preparation of this report, the independent reviewer held a number of substantial discussions with Child K's mother about the services that her son and the family had received. She later read a draft report and provided feedback. Unfortunately only phone conversations were possible because of the Covid 19 lockdown. The review has also taken account of feedback given by Child K's mother directly to some of the agencies that worked with the family. The independent reviewer had a number of short phone discussions with Child K's father via brief telephone call discussions.

1.12. The enormous pain caused to Child K's mother and father by the loss of their son was apparent throughout these conversations. The reviewer is grateful for their contributions and has tried to reflect their knowledge and views in Sections 2 and 3 of the report. The SCR recognises that discussions with the family, and the other formal processes that follow from a violent death, such as criminal investigation, court hearings and the preparation and publication of reports, intrude on the ordinary process of grieving, bringing events to mind afresh.

1.13. Appendix 1 is a full summary of the parents' contributions, but Child K's mother wished that a number of points should be given particular emphasis. She wanted readers to understand that parents need to be informed about the challenges and the potential risks of knife crime, gang activity and criminal exploitation much sooner. Then, if their children are exposed to these issues as they become teenagers, they will be more prepared to deal with them. She believes that there is an urgent need for improvement in the relationships between the police and young people. This would increase the trust of young people in the police and enable police to investigate crimes and protect the public more successfully. This does not mean that young people who have committed serious criminal offences should not be held to account. One of her great

frustrations was in the delay in action taken by the police over a number of incidents involving her son which all remained unresolved at the time of his death. The review has considered these further in Sections 3.5 and 3.8.

1.14. Child K's mother cannot understand the need for families to be repeatedly assessed by different services, and struggles to understand why there are so often delays between assessment and action. She wants practical solutions to the problems that young people face. Reading the review, she said that Child K sometimes came across in a negative way. She wanted it to be understood that in the family he was 'a loving boy with a big heart'. However she described him as 'unhappy' and reported that he 'couldn't find a way out of the situation he had put himself in'.

1.15. At some points the findings of the review and the views of the parents coincide. For example, the review agrees that the arrangements made to relocate the family in the months leading up to Child K's death did not protect him and added new pressures on his mother. Elsewhere the review has reached different conclusions, reflecting the fact that they draw on different sources of information, experience and perspective. For example, the review is much less critical of the decision made by Child K's school to permanently exclude him in 2018 than is his mother. This should not be a surprise. These are complex problems that are not amenable to simple solutions. It is inevitable that different views will be held and it is essential that they should be discussed in a constructive way.

How can this learning review assist in improving services to reduce violent youth crime?

1.16. The review took place at a time when there was a considerable and understandable public and political concern about the large number of young people being killed or seriously injured, often by other young people or young adults. It therefore considered the services provided to Child K in this wider context, taking into account a growing recent body of research evidence and policy discussion about serious youth violence.

1.17. 23 teenagers were stabbed to death in London during 2019; the largest number of fatal stabbings since comparable records began in 2008.[5] There were 14,590 recorded crimes involving the use of a knife in London in 2019-20, the highest figure since current records began in 2010-11.[6] In England and Wales just under 4,500 knife and offensive weapon

[5] https://www.bbc.co.uk/news/uk-england-london-50507433 one more was shot and there was one other recorded violent death

[6] https://www.statista.com/statistics/864736/knife-crime-in-london/ These do not all involve young people and this includes domestic knife crime.

offences were committed by 10-17 year olds in 2018-19. The number of these offences is lower than its previous peak which was in the years ending March 2009 and 2010. However until 2018-19, when there was a 1% fall, there have been year-on-year increases in these offences since the year ending March 2014, amounting to an increase of 64% compared with five years ago.[7] Although the number of violent deaths of young people fell substantially during the first Covid 19 lockdown, levels of violence began to increase as it was relaxed.

1.18. In the year ending March 2018, 51% of children received a community sentence following conviction for a knife or offensive weapon offence. Although the number of children in custody has fallen consistently over recent years, the number of custodial sentences given to children for a knife or offensive weapon offence has been increasing, because the number of such crimes has been increasing. In the year ending March 2018, nearly 600 knife and offensive weapon offences resulted in immediate custody, which is nearly double the volume in the year ending March 2013.

1.19. The wider picture has prompted government, charities and 'think tanks' to publish large amounts of research as well as consultation papers and policy recommendations, identifying causes and advocating solutions. As would be expected when attempting to understand a social problem that has such devastating consequences, there are varying and strongly-held positions. Some thinking is highly critical of current policies. 'Experts' often disagree. Within the time available, this review has taken account of as much of this literature as possible.

1.20. Reports by two other safeguarding children boards in London that sought to build on a detailed knowledge of individual cases in order to reach wider thematic findings are relevant and have been referred to.[8] The author of this report has conducted a number of reviews in relation to the death or serious injury of young people in similar circumstances and has drawn on this experience.[9]

---

[7] Youth Justice Board Statistical Bulletin. These are offences resulting in a conviction or caution. The overall figure is 31% lower than 2009

[8] Alex Chard (2015) Troubled Lives Tragic Consequences – a thematic review, Tower Hamlets Safeguarding Children Board, reviews the services provided to five young people convicted or victims of serious violence; Charlie Spencer, Bridget Griffin & Maureen Floyd (February 2019) Vulnerable Adolescents Thematic Review, Croydon Safeguarding Children Board, looks at the backgrounds and services provided to 40 adolescents deemed to be 'vulnerable' by locally determined criteria. Many, though by no means all, had been involved in youth crime. Reference to these reports should not be taken as an indication that either the author or the commissioner of this report endorses their thinking or findings.

[9] For example: Hounslow Safeguarding Children Partnership (2020) Serious Youth Violence Systemic Review, Buckinghamshire Safeguarding Children Partnership (2019) Serious Youth Violence: Thematic Serious Case Review

1.21. Whilst this review was in progress, the Child Safeguarding Practice Review Panel published a thematic review of services provided to young people at risk of criminal exploitation, focusing on 21 adolescents from 17 localities (in England) referred to the panel in the 9 months between July 2018 and March 2019. These young people had died or were seriously harmed *'within a context of criminal exploitation'*.[10] The thematic review was supported by a summary of relevant research.[11]

1.22. The national review covers some of the same areas of practice and this report refers to its findings at a number of points. Recommendations of the national review that appear directly relevant to Child K's case are reproduced in Appendix 3 of this report. This is an important document that should be read by all those working in this difficult area of practice.

1.23. Taking the huge amount of information into account, one policy commentary summarises the position as follows:
'The public debate about knife crime has intensified over the last two years but continues to generate single cause explanations, often overlooking the potential complexity and interconnectivity of the problem.' [12]

1.24. There is a consensus that there should be a collaborative approach to serious youth violence and for some time it has been government policy that a 'public health approach' is needed. However politicians and others contest what this means, how it should be implemented and how long it could take to succeed. The Association of Directors of Children's Services believes that *'at the most basic level we do not have a shared understanding and / or a clear definition of what constitutes a "public health" approach to reducing serious youth violence and knife crime'.*[13]

1.25. To be successful, any collaborative approach must be developed and put into operation at a local level, informed by young people, families, communities and the professionals who are working with children. This includes understanding the services that have been provided for children and their families, what worked well, gaps and weaknesses in existing

---

[10] The Child Safeguarding Practice Review Panel (2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government. page 12

[11] N Maxwell et al (October 2019) A systematic map and synthesis review of Child Criminal Exploitation, Cardiff University.

[12] Crest Advisory (2019) Serious violence in context: Understanding the scale and nature of serious violence, https://static.wixstatic.com/ugd/b9cf6c_654f5b6fab914780bd3f895df353e231.pdf?utm_source=Website&utm_medium=PDF&utm_campaign=Serious-Violence

[13] The Association of Directors of Children's Services Ltd (July 2019) Serious Youth Violence and Knife Crime, https://adcs.org.uk/assets/documentation/ADCS_Discussion_Paper_on_Serious_Youth_Violence_and_Knife_Crime_FINAL.pdf

services and ideas about what might have been done differently. The purpose of a case review is to try to make sense of the experience of one young person and his family in a way that can contribute to that discussion.

The focus on wider issues in the system

1.26. In keeping with the statutory guidance the purpose of this report is not to criticise the actions of individual professionals.[14] It is likely that any group of professionals working with Child K would have struggled to respond effectively to his difficulties, not least of which was that for long periods of time, particularly towards the end of his life, he refused to cooperate with the efforts of his family and professionals to help him. Inevitably specific decisions and gaps in activity are highlighted, but at each point the intention of the report is that the focus of the reader should be on two questions:

- What do these events tell us about the strengths and weaknesses of the multi-agency systems that are in place to address the problems of serious youth violence?
- Are commonly-used practice approaches as effective as they need to be?

1.27. In any retrospective review of a child's life and the services provided by agencies with welfare and safeguarding responsibilities, there is a danger of misusing the benefit of hindsight. This is particularly so when the review involves the life of a young person who was well-known to many professionals has been violently cut short. Because we know how Child K's story ends, it is easy to be drawn to aspects of the narrative that seem to have pointed to its inevitability and asked why no one acted decisively to prevent the tragedy. This is referred to as 'outcome bias' and the review seeks to avoid it.[15]

1.28. In general, the review has sought to avoid this by focusing its attention on the choices that professionals faced and the information that they had at the time. It is only by understanding the real context in which professionals were working that the review can offer positive suggestions. There are however a number of points when the report consciously makes use of a degree of hindsight, because it would be foolish not to take advantage of the overview of events that is now available. Where this approach is being taken, it is made clear.

Review of cases when a child has been killed or severely injured as a result of serious youth violence

[14] HM Government, (2018) Working Together to Safeguard Children, Section 4.1 – 4.5

[15] For a fuller account see, for example, James Reason (1997) Managing the risks of Organisational Accidents, page 38

1.29. This report is one of only a small number of locally-published serious case reviews or child safeguarding practice reviews in relation to the safeguarding of children from serious youth violence.[16] Local safeguarding children partnerships respond differently to very similar incidents and often do not undertake or publish a detailed review. Case reviews are unlikely to be initiated by the statutory youth justice sector as there is currently no requirement for Youth Offending Services to review the provision made to those who have been convicted of serious and violent offences while under their supervision.[17]

1.30. The national child safeguarding practice review (Section 1.21 above) had a particular focus. All of the young people featured in the national study were male. While accurately reflecting the profile of the young people most likely to have been killed or to have seriously harmed another child, the review does not deal with the sexual and physical harm of young women linked to criminal exploitation. Nor does it address the role of young women as perpetrators of violence. While highlighting the disproportionate number of black and minority ethnic young people in its sample, neither the child safeguarding practice review nor the linked research summary offered specific insight into the factors that have influenced the lives of those children and their families, or the services they received.

1.31. Having conducted one national review on the topic of serious youth violence the Child Safeguarding Practice Review Panel is unlikely to do so again. Further local reviews will be needed to shed light on different aspects of this problem and to stimulate further debate and service innovation. It will therefore fall to local safeguarding children partnerships to judge the value of conducting a local child safeguarding practice review when a young person dies as a result of serious youth violence. Partnerships have considerable latitude to determine whether there will be useful local learning. Without further guidance they may not appreciate the possible contribution to further national learning and there is unlikely to be consistency in approach.

1.32. The Child Safeguarding Practice Review Panel is aware of the range of

[16] A research summary found 4 SCRs published on youth homicides in London between 2016 and 2019, during which time 124 young people aged 16-24 had been killed. SCIE (2020) Analysis of statutory reviews of homicides and violent incidents: A report commissioned by the Mayor of London's Violence Reduction Unit. Two more are known to have been published in 2020. See Waltham Forest Safeguarding Children Partnership https://www.walthamforest.gov.uk/sites/default/files/WFSCB%20-%20SCR%20Child%20C%20May%20final_.pdf and City and Hackney Safeguarding Children Partnership, http://www.chscb.org.uk/case-reviews/

[17] HM Prison and Probation Service guidance previously covered young offenders but since 2018 there has been no requirement to notify serious incident or reoffending to the Youth Justice Board, https://www.justice.gov.uk/downloads/offenders/psipso/psi-2018/pi-06-2018-sfo-procedures.doc.pdf

incidents being reported, the number of reviews being initiated and the reasons for decisions about the need for a review. It is therefore well-placed to give more detailed guidance on the approach that it would prefer local partnerships to take when considering the need for reviews of practice in relation to children who are killed or badly injured as a result of serious youth violence. It might also usefully consider how it thinks the sector should learn lessons in relation to perpetrators of serious youth violence who are under the age of 18.

1.33. This report makes a recommendation on this. All recommendations are set out in Section 4 below.

2. BRIEF NARRATIVE

Introduction

2.1. This section of the report provides an account of key events and the services provided to Child K and his family. This account is deliberately shortened in order to reduce the risk of compromising the privacy of family members.

2.2. It therefore does not set out the detail of every incident, all of the services provided or the reasons for decisions. Section 3 of the report evaluates the services provided by agencies in the areas that are judged to hold the most potential for learning.

Family background

2.3. Child K was born in the UK. He had an older brother. The children's father is black. Records provided to the review do not say anything more about the father's history. He was noted to be unemployed in 2015 and reported to be frustrated about not being able to provide for his family.

2.4. Child K's mother is from a Mediterranean country and came to the UK some years before the birth of her eldest son. The family lived in Islington until August 2019 when they were found temporary accommodation in Brent because of risks to Child K. Child K's mother has always worked. When the family moved out of the borough, she had to pay the rent for two properties, and says that she barely qualified for housing benefit.

2.5. The parents separated in 2015, though they remain in contact. Child K's father was involved with professionals during 2015, but subsequently there are only a small number of contacts with him recorded.

2.6. Some years before any significant professional contact in Islington, a teenage member of the father's extended family was the victim of a fatal knife attack. This is now understood to have been a significant event in the life of Child K's family, and might have influenced the response of family members to events in his life. Despite the extensive contact with

professionals scrutinised for this case review, there is no record that this tragic event came to light in any professional involvement with the family until after Child K's death.

Child protection plan 2015

2.7. For 9 months in 2015 (when he was aged 12-13) Child K was subject to a child protection plan. This began because his father beat him with a belt when he learnt that his son had made offensive remarks to a female teacher. His father admitted the assault and accepted a police caution. Social care records note that Child K's mother told professionals that she had already decided to separate from the father when this happened. She reported that the father had been verbally abusive to her, and there is one account in 2015 of the couple '*pushing one another around'*. It has been widely assumed by professionals involved that this was a family in which there had been domestic abuse, but there has been no allegation or record of any other incident. For professionals the focus of the child protection plan was:

- protecting Child K from further physical assault
- perceived risks of domestic abuse and
- mother's concern to understand the reasons that Child K was having difficulties and to be able to parent him in a more authoritative way.

2.8. In late 2015 Child K's mother was rehoused with her two sons, allowing the child protection plan to cease. The mother received some advice about parenting. She told the review that it was of limited use and at that stage she would have benefitted from the kind of advice she received later, which was more focused on specific problems of gangs and exploitation. The social worker recorded a number of individual discussions with Child K where he discussed his feelings about his school problems and his views of the family.

2.9. Although from a professional perspective this seemed to have been a successful intervention, and there is no doubt that it was in line with procedures and established approaches, both parents viewed it very negatively. Child K's mother told the independent reviewer that she would never have considered voluntary involvement with social care after the child protection plan. His father said that the intervention had broken up the family and that the social worker had '*undermined*' any authority that the parents had in relation to Child K.

Transfer to Camden secondary school

2.10. At the beginning of 2016 (school year 8), Child K left the Islington school he had attended since secondary transfer. His mother said she had been unhappy with the school. He had not been permanently excluded but during 2015 he had been given a number of brief, fixed-term exclusions. Child K temporarily transferred to an alternative educational setting and

then to a secondary school in Camden. The new school received very little information about Child K, except that he had been on a child protection plan and had been 'aggressive' in school on a number of occasions.

2.11. The school immediately recognised that Child K had a strong motivation to learn and considerable potential, but also the risk that his inability to contain his anger would harm his education. Over the next two years the school put a number of supports in place. These included:

- individual and small group teaching and mentoring
- regular contact with pastoral care workers
- motivational talks and leadership activities and
- help with strategies to manage his emotional reactions to events at school.

Child K was allocated a sought-after place on a scheme run by a local football club and received good reports from his tutors and mentors.

2.12. A referral was made to Islington Child and Adolescent Mental Health Service (CAMHS) but Child K did not meet their criteria and passed the referral to the Youth Offending Service (YOS). The school believe he had mentoring sessions at the YOS but that organisation has no record of this. It therefore seems unlikely. In January 2017 the school referred Child K to the CAMHS outreach provided to Camden schools. The referral noted that Child K '*becomes incredibly abusive verbally and his non-verbal body language is intimidating'*. His mother's main concern was *'his inability to control his aggressive outbursts'*. The CAMHS service was provided by the Tavistock and Portman NHS Foundation Trust, a different provider to the Islington CAMHS.

2.13. The CAMHS intervention consisted of an assessment, individual sessions with Child K and joint sessions with his mother, led by an experienced mental health practitioner. The 11 sessions focused on triggers for Child K's behaviour at home and at school, the reasons for his responses and different ways of handling situations that were causing conflict and violence. Child K participated throughout and everyone involved believed that it had been a positive piece of work.

2.14. During 2017 Child K was involved in a series of violent assaults on school pupils. Child K was often in a leading role and it would be wrong to minimise the seriousness of these incidents. He also had a small number of contacts with the police, none of which were considered serious enough to merit a referral to the local authority.

<u>Murders of young people in Camden</u>

2.15. In February 2018 there were a series of connected violent assaults on young people in Camden, resulting in three deaths and other young people being injured. All three young people had associations with Child K's school and he is believed to have known one of them well.

2.16. Although there is no evidence that Child K was directly involved, and he did not feature in police briefings to other agencies at the time, these events had a significant impact on Child K (then aged 15½). In one incident (which the school reported to the police) he reported that he had been approached by a group of men and asked for information about the killings.

2.17. In April 2018 Child K started to attend evening sessions at a youth centre in Camden. He attended about once a month, engaged in lots of activities and caused staff no concern or difficulties. He stopped attending in January 2019, probably because of events in Islington (described below) and started to attend much more often in June 2019.

2.18. From this period his behaviour deteriorated and became marked by more violent episodes, a number of which occurred in and around the school. Positive sides to Child K's behaviour became less apparent and his aggression increased, with little respect for previously accepted limits. He responded far less well to individual staff members who had previously been able to calm and reason with him.

2.19. Further pressure was added when the school admitted another pupil who had a known history of violence, having made it clear to Camden Council and to the child's parents that the placement was unwise and risked harming the existing balance of relationships between a number of very difficult pupils in the school. Within a short time there was a violent conflict between Child K and the new pupil. Records show that the new pupil was permanently excluded.

2.20. Following an assault on a girl on a bus that the victim and her family did not want investigated by the police, Child K was referred via Islington MASH to the borough's Targeted Youth Support (TYS) highlighting concerns that he may be involved with youths with gang associations. TYS contacted Child K and his mother to offer support services with a specific proposal that he would be referred to a charity, the Safer London Foundation for a mentor. Child K declined the offer. His mother was also offered a service. Records say that she declined, saying that she felt supported by the school.

<u>Stabbing and permanent exclusion</u>

2.21. In May 2018 Child K was stabbed in Islington. He was admitted to hospital but his injuries were not serious. He gave no information about who was involved or the possible reasons for the attack. Islington social care convened a strategy meeting which resulted in a home visit at which all the family members were seen. Child K had returned to school and the social worker recorded being told that things were calmer at home.

His previous refusal to work with a mentor was noted. A further social work visit was planned but there is no record that it took place.

2.22. The school stepped up support for Child K, enrolling him in a six week 'intervention' run by a former gang member. His mother was referred to a further parenting group, which she told the review was helpful as it directly addressed the problem of gang influence on young people. Another offer of involvement was secured from the football club.

2.23. Child K was involved in further violent incidents in and around the school, leading to the decision to exclude him permanently in early July 2018. His mother approached schools in a neighbouring borough but none was prepared to offer Child K a place. He started to attend the Islington pupil referral unit (PRU) in September 2018 (the beginning of school year 9).

Social care and YOS assessment and intervention

2.24. In June 2018 Child K was arrested for committing a robbery. He was sentenced in July 2018 to a 9 month Referral Order, which is a community based penalty for young people who plead guilty to their first offence when appearing at Youth Court. Islington social care ceased its involvement, handing responsibility to the YOS to work with Child K under the order. The requirements placed on Child K were in keeping with the nature of the offence but did not reflect the concerns expressed about possible gang involvement or his previous violence and victimisation.

2.25. Child K largely complied with the requirements of the order. However it had little impact. The ability of the YOS to engage Child K, to judge the effectiveness of the order or to adjust its requirements was hampered by the fact that responsibility for oversight of the order was allocated to four different YOS workers during the first six months, in addition to other workers who were routinely involved in delivering different aspects of the programme.

2.26. In October 2018 Child K went missing for several days, the first time this had been reported. In interviews on his return, he gave no information as to his whereabouts. His YOS case manager referred him to social care but provided no other additional contact or involvement.

2.27. After a further assessment social care closed the case in early November 2018 on the basis that Child K had 'engaged well' with YOS and the mother's parenting was 'good enough'. There is reference in case records to a behaviour contract, presumably between Child K and his mother, but there is no evidence of its content or any work with the family to implement it. In late November 2018 Child K received a caution for assaulting a police officer and resisting arrest after objecting to a targeted stop and search which had been undertaken because the police had intelligence about a planned fight.

Further episodes of serious violence

2.28. In January 2019 Child K is believed to have fatally stabbed a young person. This incident is not thought to have been connected to Child K's stabbing in May 2018, the gang conflict in Camden referred to above, his subsequent stabbing in May 2019 or his murder in August 2019.

2.29. He was identified at a very early point as the most likely suspect and was arrested and questioned about this homicide. However the investigation was complex and the police took a considerable time to build their case. A large number of other young people were interviewed by the police as potential witnesses, or arrested and released under investigation. By August 2019 agreement was reached that Child K should be charged with the murder, but this did not happen before his death.

2.30. Child K was released on police bail for a month, later extended by two months. His bail conditions were specifically designed to keep him in the family home as much as possible in order to reduce the risk of retaliation or further conflict. They included a curfew. Professional concern focused on the risk of retaliation, as Child K had claimed responsibility for the killing on social media and was widely held to have been responsible. The YOS and social care developed a 'safety plan' with additional measures.

2.31. Continuing efforts were made to offer him education, though it was judged unsafe for Child K to attend the PRU and he was not motivated by online teaching. Efforts to make long term arrangements continued, taking into account his educational potential and previous enthusiasm to learn.

2.32. In March 2019 a Multi-Agency Risk Panel considered the safety plan and proposals to encourage the family to move. No application for rehousing was made at this point. Discussions continued as to how best to support Child K as YOS involvement would end once the Referral Order expired and there was no allocated social worker. The involvement of a mentor was suggested but at this point Child K continued to refuse help.

Second stabbing in Islington and move to Brent

2.33. In early May 2019 Child K was stabbed and very seriously wounded during a confrontation between groups of youths and men in Islington. Again Child K gave no information about the reasons for the attack, telling the police and other professionals that he did not know who was responsible. Subsequent information points to it having been triggered by rivalry between Child K and a group of older, more established gang associates in the area where he lived. Weapons were found near the scene of the altercation. Again it is possible that charges would have been brought against Child K had he not been murdered.

2.34. Child K received treatment in adult intensive care for several days before discharging himself. He was a very difficult patient, being aggressive to hospital staff and to his mother when she visited. He refused to accept guidance about his behaviour from health professionals. Despite the gravity of his injuries, he continued to make and receive numerous phone calls from the hospital.

2.35. Hospital staff believe that Child K's behaviour was due to a combination of his fear and uncertainty about what would now happen and the need to maintain a hard 'persona'. One member of staff told the review that when not being aggressive, he seemed '*sad and depressed… like a broken child'*.

2.36. On discharge, Islington TYS again proposed the involvement of a mentor who it was hoped would be able to form a relationship with Child K so that he could begin to recognise the level of risk to which he was exposing himself. The mentor began to meet with Child K and became the most important professional contact for Child K and his mother until Child K's death. The mentor told the review that when allocated responsibility for Child K he had little background knowledge about him or his family and was exclusively focused on protecting him from immediate harm. Islington social care assessed the case within the London child protection procedures and made plans to hold a child protection conference. Discussions about the about the allocation of a social worker began again, at this point both family and professionals believing that it should happen urgently.

2.37. Two weeks after his discharge Child K assaulted a teenage girl (in front of several witnesses). He is also known to have used indecent images to threaten her. This was investigated by the police, who ceased the inquiries when the alleged victim refused to give a statement. Social care managers made representations over this and a more senior police officer told the review that she had asked for the investigation to be reopened at the time of Child K's death, though no further action had been taken.

2.38. Child K's mother declined two offers of temporary accommodation (one was too far for her to continue to travel to work and the other was too small for the family) before accepting temporary accommodation in a three-bedroom house in Brent. The urgency with which this was approached meant that she accepted the offer without having the chance to see the accommodation or understand and work through all the practical and financial implications. The family moved at the end of May 2019. After extended discussions, social care case responsibility was transferred to Brent, which allocated Child K as a child in need case for assessment, believing that the level of risk was significantly lower now that Child K was living in Brent. This transfer took place in late June 2019 and Brent began a new social care child and family assessment.

2.39. The TYS arranged for a service to be commissioned by Brent from a charity working with young people affected by serious youth violence. A handover visit was made on 1 August 2019. Despite flexible offers of support being made, Child K refused any involvement.

Arrests in Camden and Essex, murder of Child K

2.40. Child K's mother had no effective authority over her son at this point. He continued to visit Camden and Islington regularly and did not hide this from either his Islington TYS worker or his Brent social worker. It is now known that in June and July 2019, after a break of five months, Child K regularly attended a Camden youth centre, more often than he had done during 2018. For as long as the TYS worker remained involved, Child K usually kept his appointments. They made positive agreements to work together, but Child K did not act on his advice.

2.41. In early July 2019 Child K was twice arrested in Camden on suspicion of possession with intent to supply Class A drugs, once in possession of a large amount of counterfeit money. He remained under investigation for these offences at the time of his death. The arresting officer completed a MERLIN (notification to the local authority) that flagged up the risk to Child K of involvement in a gang in Camden that had a history of serious violence. The officer appears to have been well enough informed to have had a specific gang in mind, but did not name it in the MERLIN.

2.42. This was the first event recorded connecting Child K to behaviour putting himself or others at risk in Camden since he had left his school there a year previously. Its significance was not appreciated or investigated further, in part because it had never been part of the professional narrative, developed in Islington and taken on by Brent, that contacts or risks to Child K in Camden would be significant.

2.43. The Brent social worker made two visits to the family in early July 2019, discussing this new information from the police with Child K and his mother on the second occasion. The child in need assessment and there was no subsequent change in the pattern of Child K's behaviour. The next visit was on 1 August 2019 in order to help the proposed handover from TYS to the charity worker, which proved to be unsuccessful. In the meanwhile the focus of social work was mainly in working with Islington's housing department to address the difficulties created for Child K's mother because she was being required to pay rent simultaneously on two properties. The child and family assessment remained unfinished at the time of Child K's death.

2.44. Although it is believed that he was regularly in Camden and Islington in July 2019, Child K did not come to police attention there again for another month. One professional told the review that Child K's brother took him there. This would have reduced the risk to him of travelling on public transport, coming into contact with local youths, or being stopped

by the police.

2.45. In early August 2019 Child K was arrested in Essex. He was reported by witnesses to have been part of a group of four young men who were trying to force entry to the home of a known local drug user. Child K's specific role in these events is unclear and his associates were not identified or arrested. The police took him to hospital for the treatment of unexplained cuts and the hospital referred him to the local social services.

2.46. Essex Police arrested Child K on suspicion of possession with intent to supply Class A drugs, possession of a large knife and criminal damage. His mother and a solicitor were contacted and after giving a 'no comment' interview Child K was released into the care of his mother and helped to return to London. Because of the circumstances the police had no alternative but to release Child K on police bail while further evidence was gathered and analysed. The bail conditions were very limited, aimed to minimise the chances of Child K returning to Essex and committing further offences there.

2.47. Child K's mother told the Essex police officers that he was well known to services in London. Neither she nor the solicitor raised concerns about Child K being at risk. Essex police did not contact social care about this episode and did not communicate with police colleagues in London until after Child K's death.

2.48. Two days later Child K was fatally stabbed in Camden, in the locality of the youth club he had regularly attended for many months without incident. The murder is believed to have linked to violent local gang conflicts going back over at least two years. None of the Islington or Brent agencies involved with Child K or his family had ever explored his connections or friendships in Camden or risks that might arise from them.

3. EVALUATION OF THE SERVICES PROVIDED AND LEARNING

3.1. Introduction

3.1.1. This section of the report evaluates the impact of the services provided to Child K and his family. The evaluation is thematic and does not focus on specific incidents in chronological order. The aim is to highlight learning about the effectiveness of services that is more widely applicable.

3.1.2. Section 3.2 explores the role of schools in responding to young people who are affected by serious youth violence. The impact of school exclusion is frequently mentioned in both popular and professional discussions of serious youth violence. The review considers in detail the steps taken by the Camden secondary school to respond to Child K's difficulties and to help him work within the reasonable expectations of a mainstream secondary school.

3.1.3. It also considers the wider role of schools, asking whether schools are sometimes being asked to accept an inappropriate level of responsibility for problems originating outside of the school that other agencies in the multi-agency safeguarding system are not responding to effectively.

3.1.4. Section 3.3 considers the response of agencies (individually and as part of the wider system) to murders and other very serious incidents of youth violence. Particular attention is paid to the impact of complex police investigations on a large number of young people, the time taken to complete enquiries and the working arrangements between agencies with different roles and responsibilities.

3.1.5. Section 3.4 explores the experience of Child K's family and the approach taken by agencies in his relocation from Islington to Brent, underlining the complexity of these situations for both family and professionals.

3.1.6. Both sections 3.3. and 3.4 question whether current multi-agency child protection procedures offer an adequate framework for the assessment and management of risk in cases of serious youth violence, recognising that – definitely in London and almost certainly elsewhere – local authorities are adopting a number of very different approaches. Agencies that work across London, such as hospitals and the police, adapt case by case. The evidence is that non-compliance with procedures in one of the most risky and complex areas of safeguarding practice has become widespread.

3.1.7. Taking Child K as an example, Section 3.5 considers the ability of agencies to safeguard young people and to protect the public (including other young people) when a young person has become deeply involved in criminal activity, often including county lines drug dealing. This section of the report draws on recent academic research on organised criminal activity and gang violence.

3.1.8. Section 3.6 looks specifically at the identification of young people whose lives are affected by gang involvement and associations, particularly the effectiveness of the Metropolitan Police Service Gangs Violence Matrix

(GVM). Considering the focus and limitations of the GVM, it asks whether wider multi-agency estimations of risk from gangs need to be considered in order to prioritise services from younger, more vulnerable children.

3.1.9. Section 3.7 discusses briefly the role of three key groups of professionals in working with serious youth violence:

- Social workers in children's social care roles
- Youth Offending Service professionals
- Youth-oriented workers in targeted youth support services (in both local authorities and charities)

It considers the strengths and limitations of approaches taken by staff in each of these services, drawing on Child K's case history but also referring to other case reviews.

3.1.10. Section 3.8 considers the approach taken to working with parents, including the timing and content of parenting support.

Examples of good practice

3.1.11. Inevitably a review of this nature focuses attention on areas in which improvement can be made. As much weight should be given to strengths in practice. The review briefly draws attention to the following:

- The sustained effort of Child K's secondary school to draw out his considerable intellectual and personal potential, while seeking to understand and challenging aspects of his behaviour that were self-destructive and harmful to the safety and education of other pupils (this is discussed in more detail in Section 3.2)
- The clinical medical and psycho-social care provided by the London Ambulance Service and at Imperial Healthcare Trust by the staff in its intensive care unit at St Mary's Hospital. It should be the cause of great sadness that colleagues in both of these services now have so much expertise in the management of seriously wounded young people. The practice is not discussed further in the review. It is assumed that the practice of this unit draws from and is disseminated among other ICUs and health safeguarding teams.
- The effort made by Islington TYS to continue to work with Child K and his mother after he had moved out of the borough to Brent

3.2. The position of schools in educating and safeguarding young people who are affected by serious youth violence

Introduction

3.2.1. This section of the report considers a range of factors that affect the ability of schools to make the most effective response to the problems of serious youth violence, both in relation to their educational responsibilities and as part of the multi-agency network of agencies with safeguarding responsibilities. It asks whether schools are being asked to shoulder inappropriate responsibilities.

The permanent exclusion of Child K from the Camden secondary school

3.2.2. Child K joined a Camden secondary school at the beginning of the second term of Year 8. Over the following two and a half years the school went to considerable lengths to develop his positive attributes, to help him reach his educational potential, and to help him deal with the ordinary demands and constraints of school life in a way that was not destructive or violent. These efforts drew continuously on resources from within the school (including mentors, teachers, senior members of staff, the safeguarding lead and the head teacher) and a variety of educational and specialist supports from outside the school, including an intervention from the CAMHS service. The school worked closely with Child K's mother throughout and involved Child K, making genuine and repeated efforts to find out from him what he thought would help.

3.2.3. The final decision to exclude Child K permanently is one that the school regrets but at the time believed was unavoidable. It came at a point when Child K posed a risk to other pupils (evidenced by a large number of violent incidents) and staff could no longer exert a consistent, meaningful influence over his behaviour. Child K's mother believes that the school should not have given up on her son and contrasts his behaviour at school unfavourably with his success at the project sponsored by a local football club. The reviewer believes that this comparison is not a fair one. In alternative settings many of the tensions that pupils need to deal with in mainstream school, in college, work and in ordinary life can be minimised. Disruptive behaviour is sometimes tolerated in a way that ordinary schools cannot. They may offer a temporary respite and a platform for reintegration and future progress but none of this is necessarily evidence of the failure of a mainstream school.

3.2.4. Child K's Camden school has reflected in detail on the way in which it worked with him throughout his time there, as any school should do when it has permanently excluded a pupil. The review does not criticise the approach taken by the school and does not believe there was a viable alternative to its final decision. The school continues to be committed to the inclusion of the most difficult pupils and believes it is better equipped to meet their needs now than it was in 2018.[18] It would be irresponsible of any school not to take account of the impact of disruptive and dangerous behaviour on all of its pupils. Not surprisingly the overwhelming majority of pupils support the use of exclusion for serious and repeated violation of school rules.[19]

[18] This is borne out by discussions with school leaders and supported by the most recent Ofsted inspection report

[19] HM Government (2019) Timpson Review of School Exclusion, CP 92. Research conducted by Coram cited in the review at Page 23. '*Children also considered exclusion as the best option when a pupil had ignored repeated warnings from staff and other discipline methods*

3.2.5. Public discussions about knife crime and serious youth violence often highlight concerns about exclusion, though research has identified a stronger association between weapon carrying and use by young people at the age of 14 and school truancy than with exclusion.[20]

3.2.6. It is recognised that permanent exclusion may be '*a trigger point for risk of serious harm'*, especially if there is a delay in making good alternative provision. Often it leads to a sense of rejection in the young person and their family and can seem to be a critical step in an irreversible exit from mainstream education. [21] [22] Great emphasis is therefore placed on finding a viable alternative educational setting without delay. Child K's mother approached a number of schools, but none was prepared to offer him a place. Islington Council made this arrangement for Child K, who attended the Islington PRU from the beginning of the next term and engaged well.

3.2.7. Child K's mother did not want him to attend the PRU, but it was unrealistic to think that any mainstream school would accept him at that point, taking account of his history of violence and deteriorating relationship with teaching staff. It is a great regret that Child K received no education after January 2019, other than online teaching. This was the result of his suspected involvement in violent offending rather than any shortcomings in the PRU.

The role of schools in the wider system to combat serious youth violence

3.2.8. Discussions about serious youth violence tend to focus on the role of schools for contributing to the problem by excluding pupils. An exclusive focus on internal school decisions draws attention away from wider factors that affect the ability of schools to work successfully with pupils affected by violence. It is equally important to explore the extent to which schools are currently being required to shoulder an inappropriate level of responsibility for managing the behaviour of young people who are involved in violence, because there is often no effective wider societal response. This is not what multi-agency partnerships would wish to happen, but it is what sometimes happens in practice.

3.2.9. Child K's history shows how often violent assaults or robberies occur in or around schools, and on children's journeys to and from school. As with

---

had failed to improve their behaviour. This included "when people are constantly unaffected by regular school sanctions" or "when someone gets constant chances to behave, but continues to disobey"

[20] Victoria Smith and Edward Wynne-McHardy (July 2019), An analysis of indicators of serious violence - Findings from the Millennium Cohort Study and the Environmental Risk (E-Risk) Longitudinal Twin Study (Home Office research report 110) page 9

[21] Croydon Safeguarding Children Board, Vulnerable Adolescents Thematic Review

[22] The Child Safeguarding Practice Review Panel (2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government

many other reported criminal offences the police are often unable to act because victims are unwilling to name assailants or there is insufficient evidence to pursue a prosecution. More widely the police and other agencies are required to avoid drawing young people into the criminal justice system (termed 'criminalising' them) because youth justice research supports the view that early contact with the criminal justice system is associated with poorer long-term outcomes. Consequently youth justice system performance indicators place a value on reducing the number of first-time entrants into the system.

3.2.10. In Child K's case, and in many instances known to the independent reviewer in other authorities, a violent incident led the school or the police to make a referral for diversionary activities to the YOS or to the local authority.[23] If there have been no previous significant violent incidents and there are no explicit safeguarding concerns, such referrals will often be passed to the early help service (either in a family support team, the YOS or a charity) which will offer a voluntary assessment and support package. The more difficult or challenging the young person or his family, the less likely it is that this will be taken up, often leading to case closure.

3.2.11. In practice the problem is then passed back to the school. Schools can provide additional support for the pupil or supervise behaviour more closely (which they may have done anyway) but are left with a limited range of supports and sanctions. If the violence is serious or part of a series of incidents that is badly affecting other pupils, over time the sanctions open to the school inevitably include temporary and then permanent exclusion. The situation is particularly challenging when the school is left to handle conflicts between groups of youths in school, or there is repeated violence in the proximity of the school involving pupils.

3.2.12. Agency responses in these circumstances are being dictated not by the needs of the child but by thresholds for social care assessment and allocation, and the requirement for parental agreement and the young person's engagement in early help. Child K's mother challenged the review to explain why in this situation so much weight is given to the young person's willingness to participate voluntarily.

Information sharing with schools

3.2.13. While being asked to share a disproportionate burden in the response to youth violence, schools sometimes lack information about the involvement of their pupils in violent incidents that occur in the community. There is for example no system comparable to the arrangement that exists for

[23] See for example Hounslow Safeguarding Children Partnership (2020) Serious Youth Violence Systemic Review

informing schools when a pupil is present when there is domestic violence in the household.

3.2.14. From their perspective, schools (including PRUs) often have a lot of useful information about young people, both individuals and cohorts of young people. Sometimes schools are very aware of the relationships between children within the school and those outside it. Such information is often not taken on board by agencies that work with young people and their families at the individual case level.

School admission criteria and 'exclusion in all but name'

3.2.15. The Timpson review of school exclusions documents in detail the way in which pupils are sometimes pressured to leave schools, without recourse to the use of permanent exclusion, a formal and time-consuming process that for a number of reasons both schools and parents sometimes wish to avoid.[24] The use of informal processes (managed moves to another school or a PRU, home education or short term moves overseas for pupils whose families have strong links in another country) creates a group of pupils whose educational arrangements are sometimes not being tracked by any school or by the local authority. This can make it very difficult for schools to obtain information about the child's background and likely needs when considering an admission or planning how best to educate the child.

3.2.16. Many of these factors are borne out by the educational journeys of Child K and that of a second pupil that his school agreed to admit in March 2018. The placement of this pupil proved to be extremely disruptive to Child K.

3.2.17. The Camden school received very little information about Child K when he joined the school in January 2016. In the experience of the independent reviewer this is a concern commonly cited by head teachers in secondary schools and pupil referral units when children have left another school as a result of behaviour problems. Child K's mother told the review that she was not happy with how he had been getting on at his previous secondary school. It is now known that he had been excluded for short periods, but there was no formal, permanent exclusion. It is not clear whether it would be right to categorise this as what the Timpson enquiry into school exclusions termed 'exclusion in all but name'.

3.2.18. The term can certainly be applied to the second very challenging pupil that the Camden secondary school agreed to admit in March 2018. His parents had been persuaded to remove him from his first secondary school, avoiding permanent exclusion. He was removed by his parents from a second school to be educated overseas before his permanent exclusion could be considered. He spent some months overseas, though it is unclear what happened to him while he was outside the UK or if he received any

[24] HM Government (2019) Timpson Review of School Exclusion, CP 92 (pages 10 – 11)

education. When his mother applied for a place at Child K's school, the head received very little other information about this pupil, despite making concerted attempts to obtain it.

3.2.19. The school advised the parent and the local authority that the admission of this pupil risked upsetting 'the precarious balance' that it was currently maintaining between a number of pupils. The school could have refused to accept the pupil and made a formal appeal. This is a time-consuming process which the school knew from experience was extremely unlikely to succeed. The pupil was permanently excluded after only a very brief stay. The outcome was that a school that is strongly committed to educating very difficult pupils felt that it had no alternative but to permanently exclude two such pupils within a short period of time.

3.2.20. Child K's school told the review that the current statutory arrangements for allocating places to children who have behaviour problems work against a school with its approach and philosophy. It has vacancies (because it is popular but not over-subscribed) and it is willing to work hard to integrate children with behaviour problems. Other schools, that are either over-subscribed or have a lower threshold for removing difficult pupils, shoulder less of the responsibility for educating the most challenging pupils.

Recommendations

3.2.21. The Timpson enquiry report was published in May 2019 and made a number of recommendations on this, which were largely welcomed by schools and local authorities. There is currently no indication that these will be implemented by government and it must therefore fall to local authorities and schools to consider what practical, local measures should be taken to act on the recommendations, or take other additional steps that are in keeping with them.

3.2.22. The review has been told that all of the local authorities involved have taken action in relation to the findings of the Timpson review. Camden Council should consider whether this has been effective and what further action could be taken in relation to the schools in its area. As there are a considerable number of pupils living in Islington who are being educated in Camden schools the local authorities should consider what joint steps can be taken. Although Child K was not educated in a Brent school, Brent Council should consider the relevance of this finding for its schools.

3.3. The multi-agency response to murders and other serious incidents of youth violence

3.3.1. This section evaluates the response of agencies to fatal stabbings and other major incidents of serious youth violence. It draws on information about the following episodes described in Section 2 of this report:

- The fatal stabbings in Camden in February 2018

- The stabbing of a young person in Islington in January 2019 and Child K's subsequent arrest
- The stabbing of Child K in May 2019
- The murder of Child K in August 2019
  It also takes account of the experience of the independent reviewer and participating agencies in dealing with other incidents.

Each event highlights different issues, but in some instances there was a lack of joined-up responses taking sufficient account of the full range of young people affected by these incidents.

3.3.2. Decisions about whether to move young people or families are considered separately in Section 3.4.

3.3.3. The response to a major incident is likely to affect a large number of young people who may be the victim (or victims), possible witnesses or suspects. Incidents often have unpredictable repercussions. Individuals may be identified on social media (sometimes accurately, sometimes not) as having been arrested or spoken to by the police. Retaliation may be targeted at more vulnerable individuals loosely associated with a suspect, such as family members, girlfriends, school friends and others believed to be linked to a gang or group, whether or not that link is real.

<u>The direct impact of police enquiries</u>

3.3.4. Investigations into the murders of young people are a priority for the police. There is an understandable and justified expectation to ensure that they lead to successful prosecutions. The police investigation into the murder in January 2019 (in which Child K was a suspect) was complex and necessarily involved the questioning of a large number of young people, a number of whom were released under investigation.[25] It remained open some two years later.

3.3.5. Such delays are often due to the need to interview large numbers of people and to undertake forensic examination of weapons, clothing, drugs, mobile phones and social media in order to determine their evidential value. Officers involved in these investigations told the review that delays could be reduced if resources were available to process this work more quickly. Decision making by the Crown Prosecution Service also often adds to delay because consideration often needs to be given to the legal basis for bringing a range of charges against a number of individuals.

3.3.6. The police major investigation teams (MITs) responsible for such investigations will understandably focus single-mindedly on that crime and may not pay attention to, or even be aware of, safeguarding or welfare

[25] Policing and Crime Act 2017. This places strict limits on the length of time for which police bail conditions can be applied but no limit on the length of time for which a person may be released under investigation

concerns about young people involved. Information about these concerns may be held in a number of police teams and forces as well as in the YOS or social care. Schools may be dealing with very anxious children in any of the categories in Section 3.3.3 above. These episodes highlight the need to promote better coordination between different police teams (for example Major Investigation Teams and police in Basic Command Units with responsibility for child protection, gangs and public protection) and welfare agencies. It would not be right to expect the police to adopt a less effective approach to a criminal investigation, but better liaison may bring benefits to the investigation and to the welfare of the young people affected. There is a sensitivity about releasing information from an uncompleted investigation, but trust between criminal justice and welfare agencies needs to be established, as has happened historically in family child protection cases.

3.3.7. It would be helpful if officers in the major investigation teams were given briefings on the range of safeguarding issues considered in this and other reviews, including the national child safeguarding practice review. As well as ensuring that basic information is shared with the local authority via the MERLIN system, the Metropolitan Police should consider the appointment of a liaison officer from within the investigating team of detectives who will act as point of contact for other agencies who have concerns about the impact on any young person who may have been caught up in the enquiry. Local authorities should agree who will receive and hold any particularly sensitive information and whether it may be shared further. A joint protocol may be necessary. The review makes recommendations on this.

Application of child protection procedures in cases of serious youth violence

3.3.8. These serious youth violence incidents reveal wide variation in the way local authorities are implementing (and sometimes not implementing) the pan-London child protection procedures, beginning with the organisation of strategy meetings and child protection investigations, but also later in the process, for example in relation to the thresholds for convening child protection conferences. No one in London would be able to provide an overview of the use of child protection plans for this group of children, or know whether other approaches are more effective.

3.3.9. This was highlighted by the major trauma unit that treated Child K in May 2019. The hospital deals with a number of badly-injured young people who are victims of youth violence and has developed good internal systems. Members of the hospital safeguarding team told the review that different local authorities adopt different approaches to basic safeguarding issues when children are admitted, despite there being an agreed set of procedures that were designed for intra-familial safeguarding. For example, this affects how quickly local authorities send staff to see young people and how strategy meetings are organised.

3.3.10. When a child is seriously injured local authorities have the responsibility to decide whether to convene a strategy meeting, make child protection enquiries under Section 47 to establish if a child is at risk of significant harm, and whether to convene child protection conferences.[26] Some authorities convene strategy meetings promptly and they are well attended, others delay them and some now hold what are referred to as 'contextual strategy meetings' in the local authority office rather than at the hospital. Hospital staff are sometimes unable to attend these, reducing the effectiveness of information sharing.[27] Usually agencies with cross-border safeguarding responsibilities (such as police and health providers) follow the local authority process, even if they find differences in approach confusing. This suggests that non-compliance with procedures in one of the highest risk areas of safeguarding activity has become common.

3.3.11. This should be addressed by the London Safeguarding Children Partnership. One way in which this could happen is through update of the London child protection procedures. These currently include practice guidance on safeguarding of children affected by serious youth violence. It is largely educational in nature and does not set clear parameters for multi-agency working.[28]

3.3.12. The term 'contextual safeguarding' is being used in different ways by different local partnerships, varying from an adherence to the particular model developed by the University of Bedfordshire, an approach loosely based on that model but given a specific interpretation by a local partnership, or as a term that is being used as a synonym for 'extra-familial harm'.[29] Both terms have been added to the definition of significant harm in the London child protection procedures (Core procedures - Section 1.3.13) without any indication that the detailed approaches set out in the core procedures may need to be varied. That however is what is widely happening.

3.3.13. Similar questions have been raised in Chapters 11 and 13 of the national child safeguarding practice review.[30] That report points to the need for revisions to national guidance in relation to assessments and child

---

[26] Section 47 Children Act 1989, Working Together to Safeguard Children 2018, Chapter 1 sections 43-53

[27] See for example, City and Hackney Safeguarding Children Partnership, http://www.chscb.org.uk/case-reviews/

[28] Safeguarding Children affected by Gang Activity / Serious Youth Violence https://www.londoncp.co.uk/chapters/gang_activity.html

[29] University of Bedfordshire Contextual Safeguarding, https://csnetwork.org.uk/

[30] The Child Safeguarding Practice Review Panel (2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government

protection plans, implying that assessments may take more time than is currently normally allowed.

3.3.14. Whether or not there is a need to revisit the application of core child protection procedures and set out a different procedural framework is a matter for the London Children's Safeguarding Partnership. The review will recommend that the London partnership discusses this as a matter of urgency.

Broader coordination of responses at a strategic level by senior police and local authority officers

3.3.15. The first marked deterioration in Child K's behaviour and emotional wellbeing occurred in the weeks after a series of violent incidents occurred in Camden in 2018. There was a coordinated strategic response to these events, but Child K's school believed that if it had been more fully involved, it would have been better placed to respond to the needs of Child K and a number of other pupils. Part of the longer-term response to the events was the creation of a task force on youth violence, in which the school played a full part.[31]

3.3.16. A large number of young people were affected by the January 2019 Islington murder (as described in Section 2.31 above). Although meetings were held to consider the potential impact of the killing on the local community, there was no continuing sharing of information between the police and the local authority about the other children, many of whom were considered vulnerable or were receiving services from the YOS, TYS or social care.

3.3.17. The review will recommend that the Metropolitan Police Service and all three of the local authorities involved with Child K review their recent experience of complex or serious youth violence incidents to consider whether more could be done at a senior level to mitigate the impact of complex investigations into incidents of serious youth violence on the welfare of the large numbers of young people who are sometimes caught up in these investigations (while not jeopardising criminal investigations).

3.4. The relocation of young people and their families

Introduction

3.4.1. This section of the report considers the decision to relocate Child K and his family after he had been badly wounded in a knife attack in May 2019. In hindsight it is clear that the move did not reduce the risks to Child K and that it created substantial, practical difficulties for his mother. It is clear

[31] Camden Council (2018) Youth Safety Taskforce Report 2018, https://www.camden.gov.uk/youth-safety-taskforce

from talking to the professionals involved that they were aware of the limitations of what might be achieved by the family moving. In hindsight more time should have been allowed to consider the implications more fully.

3.4.2. The difficulties associated with moving a young person who is at risk of serious youth violence (either alone or with his or her family) have been considered by the recent child safeguarding practice review.[32] This further evaluation is designed to add detail to the analysis in that report in the hope that it will assist families and professionals in discussing and making these very difficult decisions in future. This report considers the following:

- Evaluating the relative risks and practical difficulties of moving a family
- The impact on professional relationships and working arrangements when a family moves
- Housing policies and procedures.

3.4.3. The review makes suggestions about the type of assessment that may work best and the arrangements for case transfer that might facilitate this. The focus here is on moving the whole family, rather than individual young people. The latter have been rehearsed extensively and the dangers of moving children into care placements far from their homes are well documented. The review does not consider the steps taken sometimes by families to move children abroad, which is anecdotally becoming more common and merits a separate discussion.

Evaluating the relative risks and practical difficulties of moving

3.4.4. Discussions with the professionals involved with Child K confirm that they were aware of the potential negative aspects of the family relocating: as a key social care manager put it, there was *'nothing in our remit or power that would guarantee to keep (Child K) safe'.* However the circumstances in which the decision was taken made it less likely that alternatives would be fully explored. Initially moving was considered as a desirable, but not urgent, long-term plan. Later it came to be seen as a pressing emergency measure in which long-term arrangements were not the primary consideration.

3.4.5. The desirability of Child K and the family moving was first considered in February 2019, when Child K was arrested as a suspect in the murder of a young person. After arrest and interview the police gave Child K bail conditions designed to reduce the time he spent outside the family home, including a curfew. After his release from custody Child K told a YOS worker that he '*wouldn't mind* (moving) *as he doesn't feel safe'*. Encouraged by the YOS and social care, the family agreed to ensure that Child K was not alone

[32] Child Safeguarding Practice Review Panel (2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government (page 21)

away from the family home and he was told to reduce his social media presence. Alternative education arrangements were devised.

3.4.6. During March 2019 the level of concern increased as it was clear that Child K was continuing to claim responsibility for the murder on social media, bringing a high risk of violent retaliation. Records of professional meetings agreed the need to visit the family to help Child K's mother complete a housing transfer application and for the police to release information to provide evidence of the justification for the move. Housing records do not identify any application from Child K's mother at this point. Child K's mother told the review that she received '*no support'* about being rehoused during this period. Professional records suggest she did not believe that there was a threat and did not see the need to move. The review has not been able to explain these differences in expectations and understanding.

3.4.7. As there were no specific incidents or threats reported, the level of concern on all sides was reduced. Social care briefly closed the case assuming that an application would be made for the family to move out of the borough and that this work would be taken on by the Integrated Gangs Team once the YOS Referral Order had expired.

3.4.8. Everyone's view changed in early May 2019 when Child K was seriously wounded. There was now a consensus that the family needed to move urgently. TYS staff involved told the review that moving out of the borough '*was not a solution, but the family wanted it'*. The social care team manager told the review that '*at the time we felt we had to do something, even if the effect might be minimal'*. There is no evidence that these reservations were openly discussed at the time.

3.4.9. Child K's mother made a housing transfer application and Islington's housing services took steps to identify potential properties. After discussion about two properties, considered by the family to be too small or too far away to enable Child K's mother to travel to work, the family moved to temporary accommodation in Brent at the end of May 2019.

3.4.10. There is no evidence in these discussions of detailed consideration being given to the possible disadvantages of moving or of the specific additional risks that might come into play once the family had moved, for example the ease with which Child K could travel back to areas in which he might be at risk, or the prevalence of gang activity in the borough to which he was moving. Most professional discussion focused on the arrangements for the transfer of case responsibility between agencies in order to ensure some continuity of contact. Child K's mother told the review that it would have been better if the family could have moved to short-term hotel accommodation and had time to make better decisions. In general local authorities are discouraged from placing families with children in hotel accommodation, as it is often unsuitable or of poor quality, but in principle this approach will have much to commend it in some cases.

Case transfer – the impact of moving on professional involvement and relations

3.4.11. While conducting a child protection investigation into the risks arising from the May 2019 stabbing and the wider risks of violence, Islington decided to hold a child protection conference to which professionals from Brent would be invited. This was scheduled to take place in June 2019, roughly two weeks after the family had moved. This would evaluate the type and level of risk in detail, make a child protection plan if that was agreed to be necessary and secure the smooth transfer of the case between the local authorities. Islington's plan was that it would convene and chair the conference and that Brent would attend the conference and immediately take on responsibility for the work. The management decision on the Islington social care assessment was that the '*the only way forward is to try and manage his risks to self, others and wider community under a child protection plan'*.

3.4.12. The Brent social care team that would have held responsibility for the work after transfer declined to attend the conference, but asked to be informed of the outcome. The specific reasons were not recorded but are likely to have included uncertainty about whether the family's move to Brent would be a permanent one. This had been a difficulty in some previous, similar cases.

3.4.13. Actions taken by Brent social care staff suggest that they believed that having moved out of Islington the risks to Child K would be substantially reduced. This was reflected in the initial screening carried by the department which considered the risk to Child K as 5/10 while he was living in Brent (a score of one being the highest), consistent with classification as a child in need. Initially Islington challenged the Brent decision not to attend the proposed conference, citing the relevant sections of the London child protection procedures. Subsequently Islington agreed to cancel the conference and instead to transfer the family as a child in need case, in line with Brent's request. This was now viewed as the quickest way of arranging the transfer of the case since if Child K had been made the subject of a child protection plan without Brent's involvement, a further 'transfer in' conference would have been required, causing several weeks further delay.

3.4.14. After transfer as a child in need, Brent would undertake a reassessment of Child K's needs and any risks. Instead of all the involved professionals meeting at a child protection conference, separate transfer processes were arranged, including a joint meeting between social workers and a joint meeting between the TYS worker and a worker from a voluntary organisation commissioned by Brent with whom Child K refused to work.

3.4.15. A Brent social worker was allocated who made visits to Child K and his mother and an assessment continued for some weeks. The social worker discussed the continuing risks to Child K, being aware that he continued to

travel into Islington and Camden, but the main focus of the social worker's activity was the practical and financial difficulties that the housing move had created for Child K's mother. Child K's mother was understandably frustrated, seeing the further assessment as a waste of time when no additional services were being provided.

The national experience of moving young people and their families

3.4.16. The difficulties associated with moving a young person who is at risk of serious youth violence (either alone or with his or her family) were considered by the recent government child safeguarding practice review.[33] The national report considered information about 21 young people who had been killed or seriously wounded, eight of whom had been moved (six with other family members, two to local authority care placements). The review also studied a comparator group of children who had not been killed or seriously wounded. A similar number of the young people in both groups had also been moved to new homes, suggesting that the need to consider moving young people or their family is not uncommon.

3.4.17. The national review identifies a number of potential negative features of such moves, however well-organised. Although the intention in moving a young person is to break links with criminal associates or those who have threatened violence, communication between the young person and associates in the original location often remains easy and there will often be factors strongly pulling the young person back to their home area. Young people may become involved in criminal activity in the new area, for example dealing drugs to provide a basic income, which may prompt conflict with local groups. One recent study identified young people relocated from cities as one of the models used by criminal gangs in the establishment of new county lines.[34] There is no evidence that Child K made any local criminal connections or came into conflict with local young people. He remained in close contact with young people from Islington and Camden, as he had always said he would. According to one professional he was taken there regularly by his brother.

3.4.18. The national study also identifies the risk of placing new strains on the family, and weakening or breaking links between the family and the existing professional network. The professional network around Child K was weakened in a number of ways, the clearest indication of this being the widely differing perceptions of risk after the move. In Islington there was a clear understanding that Child K was the suspect in a murder investigation and had been stabbed twice. Consequently he would have been the subject

[33] The Child Safeguarding Practice Review Panel (2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government

[34] Simon Harding (2020) County Lines: Exploitation and Drug Dealing among Urban street Gangs, Bristol University Press

of a child protection conference and legal advice had been taken to explore whether there were legal steps that could have been taken to protect him. In Brent these issues were much less immediate. The screening score and the time taken to update the social care assessment indicate that the risks were believed to have been made considerably less significant by the move.

3.4.19. In Islington faith had been placed in the Islington TYS sessional worker allocated after Child K was stabbed. Despite making considerable efforts, he had never been able to establish the level of contact with Child K that had been planned. After May 2019 he had been the main and most regular contact with Child K and his mother, but his involvement came to an end because Islington TYS could not fund work with a young person living outside the borough for more than a short period of time. After the family moved the contacts with the TYS worker were infrequent and he had no significant influence over Child K's behaviour. Transfer to a similar service based in Brent failed because, after an initial meeting, Child K refused to have contact with the new organisation.

3.4.20. After Child K's move to Brent some police contacts continued to be routed via the Basic Command Unit covering Camden and Islington, causing delay in information sharing. Child K had been well known to the police in Islington but police teams in Brent do not seem to have had an awareness of his presence. His arrests in July 2019 triggered no specific action by the police in Brent or multi-agency consideration. The links to Camden presented an additional difficulty, though in this case they would also have been easier to handle from Islington because of the shared police BCU.

3.4.21. The national child safeguarding practice review advocates the relocation of young people and their families as an effective short-term strategy, '*providing an immediate reduction in risk and a breathing space*'. It suggests that this can only be successful as '*part of a clear and consistent strategy for protecting and supporting that child'*.[35] The emphasis on the use of relocation as a 'breathing space' suggests that attempts should be made to keep the professional network in place and that professionals who know the family should continue to be responsible for developing the long-term plan during this period. The ability of different agencies to do this will vary as they have different rules and guidance governing the retention of cases. Further difficulty may arise because this approach does not sit entirely comfortably with the requirement for the local authority in which the child is found or usually lives to take statutory action under the Children Act 1989.

3.4.22. This is an area that would benefit from agreed approaches at least between London authorities. The review has made a recommendation on this.

[35] Page 21

Housing

3.4.23. The national child safeguarding practice review also reports the views of practitioners that '*housing policies should be amended to include children at risk of criminal exploitation as a high priority group for rehousing or transfer'.* There are inherent difficulties for local authorities. They can support applications for mutual exchange or transfer, but are unlikely to be able to arrange a housing transfer sufficiently far from the original location to achieve the objectives of the move.

3.4.24. Islington identified short term accommodation for the family but Child K's mother was placed under considerable financial stress because, until an agreement for exceptional payment was reached with Islington Council, she remained responsible for paying the rent on two properties, or risked having to give up her original tenancy. The review has been told that this exceptional payment can only legally be made for a limited period and that, regardless of the intention of local policy to help families affected by serious violence, there are considerable practical difficulties in relocating a family without jeopardising their potential right to permanent housing.

3.4.25. The position of Child K's mother was unusual in that she had a reasonably high, stable income and received no housing benefit. Other families will be affected in different ways; but every family should understand exactly what its financial position will be when making decisions about whether or not to move. In genuine emergencies accommodation could be provided for a period of no more than a few weeks, while longer term plans can be developed.

Learning and recommendations

3.4.26. There is a growing recognition, shared by all the professionals who have contributed to this review, that relocating families because of the risk of serious youth violence is not always the best solution.

3.4.27. This being the case, an approach is needed that takes account of the relative and specific risks of a family moving or not moving, both in principle and in relation to specific locality. This should include the topics identified in this report and other case reviews, as well as the national child safeguarding practice review:

- Likelihood that the young person's behaviour does not change because their most important social connections will remain in place
- Risks in the locality to which the child is moving
- Risks of weakening professional networks so that there is less professional knowledge and oversight
- Practical difficulties (including financial difficulties) created for other family members.

It may not always be possible to be certain whether relocation is an emergency short-term measure (managed by the existing professional network) or part of a worked out long-term plan.

3.4.28. At the time professionals had no framework for undertaking the comparative assessment of risk in two localities. This may be a feature of the fact that safeguarding professionals dealing with families usually assess current risk and propose solutions that are assumed to be better. There is less experience of risk-assessing alternative plans.

3.4.29. Assessment of risk in these cases must be the assessment of risk in context and as such is very different from the assessment of clinical or medical risk (which is unlikely to vary greatly from one locality to another). This points to the value of professionals from two localities being involved simultaneously: those from the original location being fully aware of the history and the reasons for risk; those from the proposed relocation locality able to complement this assessment with their own local knowledge of the environment in which the child will be living, local criminal activity, school cultures and strengths etc.

3.4.30. Part of the more structured approach to assessing both sets of risks would be to understand the extent to which the young person and his family would accept and implement any measures. Efforts to reduce risks to Child K over several months had failed, in part due to his inability to change his behaviour. In this type of assessment that factor would strongly indicate against a plan that relied in a high level of cooperation.

3.4.31. The nature of the risk that exists when a young person is involved in youth violence severely tests the models of case handover and transfer that have been applied to intra-familial child protection work, favouring as they do transfer of cases at a specific point in time supported by written summaries of the history, sharing of records and a one-off transfer meeting. It is also not best resolved through the model, adopted in this case, of reassessment by the new professionals. This risks 'starting again' and losing sight of the seriousness of the original issues and risks delaying provision.

3.4.32. If part of the problem is that a young person will continue to return to their home locality, it suggests the need for some professionals in that area to continue to be involved for a longer period of time, even if case responsibility in some agencies sits elsewhere. It was always likely that Child K would continue to spend time in Islington (and as it turned out Camden) and that regardless of the move, steps would need to continue to be taken to safeguard him there. This was inevitably going to be much more difficult for professionals based in another borough to arrange. In this case for example Brent Council might have agreed to continue to fund the Islington TYS worker and to concentrate on meeting Child K in Islington or Camden, given that it was known that he would continue to go there. A framework is needed within which a flexible transfer can happen at different

points in different agencies but within which there is still clear accountability.

3.4.33. The review makes recommendations on these issues

3.5. The disparity between risk, the professional understanding of risk and action that could be taken to protect the young person and the public

3.5.1. This section of the report compares the evidence of risk to Child K during the last 12 months of his life with the action that professionals took to safeguard him and to protect the public. It considers both the actions possible within the criminal justice system and under children's safeguarding arrangements.

Information from the narrative

3.5.2. It is useful to summarise the key events. In June 2018 Child K committed a robbery and was sentenced to a nine month Referral Order. Although external inspectors have found Islington YOS assessments to be 'generally good', the assessment made in this case failed to take account of the depth of Child K's difficulties and possible gang influence on his life. This was because it took insufficient account of associations in Camden that had developed over time as he had attended a Camden secondary school. This gap in the assessment was never subsequently recognised or addressed.

3.5.3. In late 2018 the order was extended by three months because Child K was convicted of assaulting a police officer; however but no changes were made to the requirements of the order

3.5.4. Records show that Child K complied with the terms of the order but the likelihood that he would benefit from the activity or develop links with adults who might positively influence his behaviour was reduced because over the period of the order four different YOS case workers were allocated responsibility for the work with him.

3.5.5. Until January 2019 Child K attended and worked well at the pupil referral unit (PRU), though his reported interactions with others in the vicinity of the PRU point to tensions between groups of young people.

3.5.6. In late January 2019 Child K was suspected to have murdered a young person. He was questioned and released on police bail with conditions designed to protect him from reprisals and to restrict his contact with other young people. These were extended for a further two months, the maximum allowed without a charge being brought. He was then released under investigation as charges were not ready to be brought.[36] The murder

[36] https://www.cps.gov.uk/legal-guidance/bail

investigation continued and it is understood that Child K would have been charged with the murder had he not been killed.

3.5.7. Within days of the bail conditions expiring, Child K was stabbed and admitted to hospital with very serious wounds. There is no known connection between the January and May 2019 events, though it is likely that the ending of his bail conditions reduced pressure on Child K to comply with requests to stay at home. The circumstances of this incident remain unclear and a number of weapons were found near the scene of the incident, suggesting an armed affray. The incident remained the subject of a criminal investigation at the time of Child K's death.

3.5.8. Shortly after his release from hospital Child K physically assaulted a young woman and threatened to blackmail her with indecent images. Initially the police investigation was dropped due to lack of cooperation from the alleged victim, though a more senior officer told the review that she had asked for it to be re-opened following an approach from social care and given the gravity of the alleged events.

3.5.9. At the end of May 2019 Child K moved to Brent and from that point appears to have spent increasing amounts of time in Camden, avoiding the area in Islington where he had been stabbed.

3.5.10. In early July 2019 Child K was twice arrested for possession of drugs with intent to supply and the possession of counterfeit money in Camden. Again he was released under investigation. The police MERLIN noted that he was associating in Camden with known gang members who had a recent history of involvement in serious violence. The Brent social worker discussed this with the family and no other action was taken. Child K continued to travel to Camden but did not come to police attention in London again until his death.

3.5.11. In early August 2019 Essex Police arrested Child K for possession of a knife and for possession of drugs with intent to supply. Along with other youths he was suspected of attempting to break into the home of a known local drug user. The details of his involvement and relationship to the other youths or the drug user were never established and the investigation was closed when Child K was murdered. The circumstances bear the hallmarks of 'county line' criminal activity. Child K received minor injuries, though it was never clear how. The hospital emergency department referred him to the local authority emergency duty team, which noted the information.

3.5.12. Child K was released while enquiries were undertaken to establish if there was a forensic connection between Child K, the knife and the drugs. He was given bail conditions to 'live and sleep in London' and 'not to enter the county of Essex', the focus being on reducing the risk of further local offences rather than his general welfare. Prior to his release he denied being threatened or coerced in any way. When asked Child K, his mother and his solicitor raised no concerns about his welfare. Child K and his mother were

escorted to a station and put on a train to London. Neither his role in these events, nor the nature of his link with the other young people, was ever clear.

3.5.13. He was murdered shortly after this, a killing that was part of a continuing feud between gangs, one of which Child K was believed to be linked with, though the nature of that association is unclear.

Learning and recommendations

Situating Child K's behaviour in our current understanding of gang activity and organised criminal behaviour

3.5.14. Child K's behaviour put him at a high level of risk over this period. By the time of his death it is believed that he had been in conflict with:

- Youths from a gang in another part of Islington (because of the murder and his assault on a girl)
- Older Islington gang members from a locality near to his own neighbourhood
- Members of a gang in Camden who were in long term conflict with associates of Child K.

Any of these might have posed a serious threat.

3.5.15. As well as being a risk to himself, Child K posed a substantial risk to other young people and the wider public:

- He was suspected to have been responsible for a murder and involved in an armed affray
- He had assaulted and threatened a teenage girl
- He was suspected to have been involved in dealing drugs in London (and possibly Essex) and laundering counterfeit currency.

3.5.16. Discussions about the risk to young people often focus on the formal identification of gang involvement. However this may not be the sole or main determinant of risk. The way in which Child K would be viewed and treated by others depended on his reputation: what other young people believed he had done, or he could credibly claim to have done, and who his associates were believed to be. Research suggests that a rapid and serious acceleration in violent behaviour in some individuals is increasingly common and is a feature of the dramatic changes in drug markets and urban street gangs associated with the growth of county line drug dealing.[37]

3.5.17. In the past drug trading based on estates and defined localities gave rise to conflicts over market share and prestige that could be violent but were also usually self-limiting. In contrast, the rapid expansion of county lines drug dealing has created intense competition between groups and individuals to maximise markets and profits. Child criminal exploitation is a feature of this

[37] See for example the description in Simon Harding (2020) County Lines: Exploitation and Drug Dealing among Urban street Gangs, Bristol University Press.

activity, but there are also significant opportunities for young people who are prepared to be ruthless to operate across a number of groups and localities, with much more fluid loyalties to associates, sometimes seeking to outmanoeuvre more established older criminals. The short-term rewards in terms of money and standing can be substantial but the risks are extremely high.

3.5.18. These new patterns of criminality are a challenge both to the criminal justice system and to the ability of agencies to use safeguarding measures to protect young people who are considered vulnerable. We do not know what factors were motivating Child K, but there was a significant disparity between the risk posed by his behaviour and the response, particularly after he moved to Brent.

Response possible within safeguarding procedures and approaches

3.5.19. While he lived in Islington, after each major episode professionals took steps to establish what had happened and to understand the risk, including a discussion of Child K at the borough's High Risk Vulnerability Panel, strategy meetings, a proposed child protection conference and a legal planning meeting.

3.5.20. These efforts were not successful. For the reasons described in Section 3.4 the child protection conference did not take place. A legal planning meeting was held but could not identify steps within the family law that could protect Child K. The civil law framework includes measures that allow young people to be protected from adult exploitation or the consequences of their own behaviour (for example Secure Accommodation Orders, other types of abduction or retrieval orders) but they are often not relevant because they were not designed with this type of situation in mind.

3.5.21. After he moved to Brent, the risks described above (Section 3.5.14-15) were believed to have been mitigated by the family moving home. The child and family assessment that began in June 2019 was to be completed within the statutory timescale (35 working days) so it was not finished by the time of Child K's death in August 2019. It may not have provided a more detailed understanding of Child K's long-term risk level, or any additional plans to address it. At the time of his death Child K was receiving services as a child in need and the family were receiving periodic visits from a social worker. Despite new recent concerns and outstanding historical events, the support provided focused mainly on the financial problems caused to his mother by the relocation of the family, rather than on Child K's safety.

Responses possible within the criminal law

3.5.22. When a young person has been arrested because of suspicion that he has committed a crime (even a very serious, violent crime) the legal framework leans heavily towards release of the person under investigation (RUI) pending completion of the investigation and determination by the police or

the Crown Prosecution Service as to whether or not there is sufficient evidence to bring charges. Bail may still be granted even when serious charges are brought. In Child K's case, none of the other investigations merited his detention, even though the number of serious, alleged offences under investigation was large and growing. Child K's mother expressed her frustration to the review that it had taken so long for these suspected offences to be investigated and that in the meanwhile he remained living in the community with few (and sometimes no) measures that restricted his liberty or helped her to keep him safe.

3.5.23. Action by the police in relation to Child K was determined by the length of time taken to complete complex investigations and the requirement (beyond brief periods when it is possible to impose bail conditions) to release suspects under investigation. The police officers involved in investigating the January 2019 murder were focused exclusively on that case and had no specific additional interest in Child K's further alleged offences, except insofar as they might provide evidence in relation to the murder. Steps taken by them were dictated by the needs of their investigation and not influenced by the overall level of risk to any individual child. Had he been charged with the murder (which seems to have been very likely) Child K is likely to have been remanded in custody.[38]

3.5.24. The Essex police officers who arrested Child K were aware that the circumstances pointed to a possible county lines drug-selling operation and of the steps that can be taken under the National Referral Mechanism (NRM) to collate information about young people who are vulnerable to criminal exploitation.[39] The police officers had dealt with similar cases before and understood the pattern of risks. To demonstrate that such risks were present on this occasion would have taken considerable further multi-agency information gathering, which was not triggered by the episode.

3.5.25. Essex Police recognises that there were shortcomings in the action taken.

---

[38] The number of young people who are remanded in custody by the courts has fallen by more than half in the last decade from 5,663 to 2,370 between 2007/08 and 2017/18 (58%) Manon Roberts, Gemma Buckland and Harvey Redgrave (November 2019) Examining the youth justice system: What drove the falls in first time entrants and custody, and what should we do as a result?', Crest Advisory (page 27). In the introduction to Examining the youth justice system Anne Longfield, the Children's Commissioner writes that she has *'serious concerns about the number and treatment of children on custodial remand, 63 per cent of whom were not subsequently given a custodial sentence last year*'. (page 5). There is determined pressure on the part of policy advocates, researchers and academics to further substantially reduce or end altogether the use of custody for young people in almost all circumstances. See for example Tim Bateman (2020) The state of youth justice 2020 - An overview of trends and developments, National Association for Youth Justice (Chapter 8).

[39] The National Referral Mechanism allows those who are identified as victims of criminal exploitation (for example). Information about the NRM is available at: https://www.gov.uk/government/publications/humantrafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slaveryengland-and-wales

Sole reliance should not have been placed on reassurance from Child K and his mother that he was not acting under duress. Direct contact should have been made with social care services in Child K's home borough, though it is very unlikely that any alternative action would have been taken before Child K's death which occurred only days after the episode.

3.5.26. The recent review of the death of another child highlighted a similar response from a county police force.[40] This suggests that there is a need for greater awareness of the steps that can be taken under the NRM, and of the Rescue and Response system that has been commissioned by the Mayor of London.

3.5.27. There is also a need for a more thorough review of this legal device. Harding's research, citing National Crime Agency reports, is positive about the legislation. He reports police officers being keen to bring prosecutions for trafficking offences but realistic about the extent of evidence required. The child safeguarding practice review found that '*the NRM's original purpose does not always fit well with the circumstances of (criminally exploited) children and that understanding and use of the NRM was patchy'.*[41] Some police officers are sceptical about the widespread application of the NRM, believing that organised criminals understand the legislation and will organise their activities in a way that creates a class of young people who are immune to criminal investigation and sanctions and therefore even more vulnerable to exploitation. This is arguably only an extension of the factors that encouraged wide exploitation of young people in recent years because there is a large supply of young people available to involve in criminal activity who professionals seek to avoid bringing within the criminal justice system. There are other ways in which designation under the NRM can make young people more vulnerable, for example when the removal of a tag to enforce a curfew means that children cannot be traced and go missing more often.

3.5.28. No additional recommendation is made in relation to this, as both the national child safeguarding practice review and the Waltham Forest review of the death of Child C have already made recommendations on this issue. The case review assumes that the Mayor of London actively promotes information about the existence of the London Rescue and Response system with police forces outside London. The Metropolitan Police Service has introduced Operation Harbinger which provides for the rapid sharing of information about all children in custody.

---

[40] Waltham Forest Safeguarding Children Board (May 2020) Serious Case Review - Child C, a 14 year old boy

[41] Child Practice Safeguarding Review (op cit) page 9, discussed in more details at page 48

The gap between public expectations and the approaches favoured by professionals

3.5.29. As well as highlighting gaps and weaknesses in the current criminal and civil legal frameworks, Child K's history highlights gaps between public perceptions (including those of many parents) about what professionals should be able to do, what professionals are able to do, and what professionals and policy makers think should happen. Given the number of serious incidents in which Child K had been involved, members of the public might be surprised or disappointed that the police were not able to detain him and that local authorities were unable to safeguard him, especially as throughout the last 9 months of his life Child K was at risk of harm, his own behaviour put him in harm's way and he posed a risk to the wider public, including to other young people. He had consistently refused any offer of help and, to his mother's frustration, no effective restriction could be imposed on his movement or behaviour.

3.5.30. The wider context of this discussion is set out in Section 1 of this report:

- The growth in knife and offensive weapon crimes being committed by young people in the last five years
- The historically large numbers of young people who have been killed or seriously injured by other young people
- In addition, in London at least, black children and children from some minority ethnic backgrounds appear to be heavily over-represented among victims of knife crime.[42]

To this can be added recent evidence about dramatic differences in homicide victimisation rates for different ethnic groups, especially young people. [43]

3.5.31. Professionals also find the lack of effective powers extremely frustrating, adding to the sense of hopelessness that some already experience. At the same time, those who seek to influence the direction of policy in relation to serious youth violence focus almost exclusively on the need for more therapeutic and preventative responses to serious youth violence, focusing on young people's experience as victims. Youth Offending Services, youth and crown courts operate within a framework that strongly discourages the use of custody, either for remand or sentencing, as is evidenced by the

[42] Young black people and those of mixed backgrounds are significantly over-represented among victims of all crime. See Youth Justice Board presentation (August 2020), 'Exploring racial disparity - How it affects children in their early years and within the youth justice system', https://www.gov.uk/government/news/to-end-racial-disparity-we-require-your-absolute-focus

[43] S Kumar et al, (2020) 'Racial Disparities in Homicide Victimisation Rates: How to Improve Transparency by the Office of National Statistics in England and Wales, Cambridge Journal of Evidence-Based Policing, https://doi.org/10.1007/s41887-020-00055-y In the most extreme example, for young people aged 16 to 24, the 2018-19 homicide rate was 24 times higher for black people than for white people.

steep decline in the numbers of young people in youth custody in the last decade.[44]

3.5.32. Inconveniently, preventive services aimed at reducing risk factors associated with serious youth violence can only be successful in the medium to long term and there are already some young people who are beyond their reach. These young people are likely to be placing themselves at the most serious risk and causing the greatest harm to others (including to the most vulnerable young people). At the very least professionals need to be prepared to engage in an open-minded discussion with the wider public about the validity of current thinking and approaches.

3.6. Systems for identifying young people who are at risk because of gangs or serious criminality

3.6.1. This section of the report explores the way in which professionals make use of information about the influence of gangs or organised criminal groups on young people and how the impact of these is understood, taking the information that was known about Child K as an example.

3.6.2. There is continuing debate about whether it is useful to focus on the role of gangs. Some pundits and academics oppose this, almost as an article of faith, believing that it distracts from efforts to address the vulnerability of young people and illegitimately labels young black men. They argue that only a small percentage of knife crime is attributable to gangs and see the focus on gangs as a form of 'moral panic'. Others point to the evidence of young people themselves, significant academic research, high levels of retaliatory violence as well as social and cultural indicators of gang allegiance such as social media posts.

3.6.3. Any discussion about the significance of gangs and criminal groups must be prefaced by a recognition that professionals often do not have reliable information about gang involvement or influence because these matters are, by their nature, secretive and are discussed in terms that adults (including professionals) often struggle to understand. Research suggests that gang and organised criminal activity are rapidly changing. In some circumstances, beliefs about a person's criminal involvement and status are critical (particularly for other young people) but may not accurately reflect actual membership of a criminal group.

3.6.4. Using the broadest criteria, gang or organised criminal influences on Child K's life might have been identified at the following points:

[44] Gemma Buckland and Harvey Redgrave (November 2019) Examining the youth justice system: What drove the falls in first time entrants and custody, and what should we do as a result?', Crest Advisory

- February 2018 – events in Camden linked to killings were believed to be impacting on his life, behaviour and education
- May 2018 – victim of a stabbing in Islington, which is unlikely to have been a random event
- January 2019 - suspected murder of an associate of an Islington gang, although the trigger is believed to have been personal rather than linked to gang associations
- May 2019 – victim of a second stabbing in Islington
- Reported assault on young woman who had associations with a rival gang
- Involvement in county lines type criminal activity in Essex.

The Metropolitan Police Gangs Violence Matrix (GVM)

3.6.5. Given the circumstances of his death and knowledge of some of the events listed above, some professionals were surprised to hear that Child K had not been identified by the police as what is termed a 'gang nominal'. This is a result of the specific approach taken by the Metropolitan Police Service to the identification of gang members and associations, and the role of the Gangs Violence Matrix (GVM).

3.6.6. The GVM has a controversial history and has been modified after criticism of its failure to identify and include older, established gang members alongside the disproportionate inclusion of young people from black and some minority ethnic backgrounds.[45] It was also not clear to the public how names were added or removed and whether consistent criteria applied across London.

3.6.7. The police have responded to this criticism by making public much more information about the purpose of the GVM and the criteria for inclusion.[46] The police told the review that the purpose of the GVM is *'to reduce gang-related violence, safeguard those exploited or used by gangs and prevent young lives being lost'*. It aims to achieve this by identifying *'the most violent gang members who need enforcement action against them and gang members who have been repeat victims of violence and therefore need support to safeguard them from being further victims and to divert them away from gangs'.*[47]

---

[45] Amnesty, 'Trapped in the gangs matrix' https://www.amnesty.org.uk/trapped-gangs-matrix?utm_source=google&utm_medium=grant&utm_campaign=AWA_HRUK_gangs-matrix&utm_content=%2Bgang%20%2Bmatrix

[46] This and substantial amounts of other information can be found at https://www.met.police.uk/police-forces/metropolitan-police/areas/about-us/about-the-met/gangs-violence-matrix/ Information about the breakdown of people on the GVM is now regularly updated by borough.

[47] Submission to the review from the Metropolitan Police Service

3.6.8. In order to achieve consistency and greater reliability the police only include a person's name on the matrix when there are two pieces of verifiable intelligence to confirm membership of a known gang. The individual is then further assessed according to information about known use of violence and weapons, suspicion of involvement in crime and experiences as a victim of violence. The GVM is then used to target police activity at the most serious offenders and the most vulnerable victims. As a result, incidents involving young people who are on the GVM will automatically be checked. In some boroughs the police work as part of a multi-disciplinary gangs team so the review will involve members of the team from other agencies such as youth workers and social workers.

3.6.9. It is understandable that the MPS is required to use strict criteria that can be verified, can be applied consistently and focus on those who pose or are at the highest level of risk. At the same time this will not collate softer information (such as the examples set out in 3.6.4 above) which may build a cumulative picture of organised criminal influence on a vulnerable young person. According to the research supporting the child safeguarding practice review, for example, '*police services do not use a vulnerability flag for child criminal exploitation, meaning that children who are arrested for possession with intent to supply class A drugs may not be treated as vulnerable'*.[48]

3.6.10. This prevents the inclusion of many young people whose lives have been affected by organised criminal gangs, or perhaps have looser or more fluid affiliations, but do not meet the criteria. One effect of this is that when lists of the names of children considered to be vulnerable, based on police records, are searched, they are likely to focus on those on the GVM, rather than the larger number of young people who (while not having a proven association with an identified gang) may still be heavily influenced or affected by violent criminality. In some instances this will lead professionals to miss the involvement of young people in events that have taken place outside the child's home borough.

3.6.11. Some local authorities have already developed their own list of children about whom there are welfare concerns because of suspected gang influence to complement the GVM. If such a list were developed the inclusion of the child's name, details of information held and who has access to it should be known to the young person and his or her parents. The reasons for inclusion of a name might provide a useful focus for frank discussion about behaviour and risks. The review makes a recommendation in relation to this.

[48] N Maxwell et al (October 2019) A systematic map and synthesis review of Child Criminal Exploitation, Cardiff University

3.6.12. More broadly, much of the discussion about the GVM and other such lists has focused on their disadvantages and negative effects. If it is to have any positive impact for the young person or assist professionals, inclusion as a 'gang nominal' or on a vulnerability list or matrix should attract specific additional resources from agencies.

3.7. The role of social care professionals, Youth Offending Services and youth-oriented services

3.7.1. This section highlights areas of potential learning for social care professionals, Youth Offending Services and youth-oriented services (such as targeted youth support services). The evaluation takes account of the author's experience of conducting reviews in other local authority areas. In particular the findings have a substantial overlap with a review commissioned by Islington Safeguarding Children Board.[49]

3.7.2. Although these comments are organised by service, senior managers and leaders need to consider the way in which the three types of service respond together as a system to problems of serious youth violence, including the allocation of responsibility for work with young people between services and the way in which services coordinate their activity when more than one is involved.

Social care

3.7.3. Child K received an assessment or service from local authority social workers during the following periods:

- 2015 – 2016 – under a child protection plan focused on dealing with physical abuse by his father
- May 2018 – Child K's school made referral to the MASH, which was screened and passed to TYS and then closed because neither Child K nor his mother wanted to receive a service
- May 2018 - following an incident in which Child K was stabbed – a child and family social work assessment was undertaken and it was proposed to hand responsibility for work to be undertaken by the YOS which was beginning to work with Child K under the terms of a Referral Order
- January 2019 – following the incident in which Child K was suspected to have killed another young person –strategy meetings were held and the case was closed in March 2019 as the risk to Child K was believed to have diminished
- May 2019 – following the incident in which Child K was stabbed and very severely injured, strategy meetings were held and a child protection

[49] Islington Safeguarding Children Board (2021) Services Provided for Child P and his family (forthcoming)

conference was scheduled, a legal planning meeting was held, the family was encouraged to move and the case was transferred to Brent

- July – August 2019 – Child K was allocated as a child in need in Brent following transfer from Islington, the main focus of work was the financial difficulties created for the mother by the housing move.

3.7.4. After the most serious incidents (January and May 2019) social workers and their managers worked diligently to find ways to safeguard Child K. The key Islington social care manager told the review that Child K was '*the case with the highest profile, over and above all others in the team'*. But at the same time there was '*nothing in our remit or power that would guarantee to keep (Child K) safe'.* The decision to hold a legal planning meeting to ensure that every possible action had been considered on a case that was going to be transferred to another local authority, demonstrates this commitment.

3.7.5. At other points social workers struggled to know what to do. The pattern of brief assessment followed by referral to early help services, followed by case closure has been frequently observed by the author in work where the risk to young people arises because of serious youth violence. When a specific practical or procedural task has to be accomplished (such as moving a family, holding a strategy meeting or placing a child in accommodation) there is an obvious task for the social worker. Otherwise local authority social workers frequently say that they find it hard to define their role or to point to stories of successful interventions. Some believe that their training and skills are less relevant and that they have nothing to add to the work being undertaken by youth workers, relying on them and in some instances closing cases when high levels of risk remain. This is a reversal of the normal approach which allocates responsibility for lower risk cases to staff and managers without social work qualifications.

3.7.6. There may be genuine, practical reasons for this difficulty in finding a role. Social workers who have substantial and complex caseloads often spend considerable time in court or writing reports and inevitably have less time for direct work with young people. Sometimes the YOS is required to be involved, leading social workers to close cases because their participation can seem to be an unnecessary duplication. However there may be deeper reasons. Difficulties may also arise because there now is a tension between currently-favoured ways of working with young people and the fact that social workers and their managers who have roles, responsibilities and statutory duties requiring them to hold and exercise authority on behalf of the state and the wider community.

3.7.7. Relationships that acknowledge this authority recognise that one party has a status based on accumulated knowledge, greater life experience, a greater understanding of the consequences of young people's actions, and also holds statutory powers and duties. In contrast contemporary approaches now often strongly emphasise engaging with young people and pay little attention to the ownership and use of authority, despite this being

an ordinary and important part of relations between adults (including parents) and young people. For example, a highly influential report on working with adolescents focuses heavily on engagement, using the terms 'engage' or 'engagement' 43 times, almost always positively.[50] It makes no use of the term 'authority' or 'authoritative'.

3.7.8. This approach has implications. Relationships that rely exclusively on engagement will inevitably require repeated renegotiation of objectives in order to win trust; inevitably they place great store on not alienating the young person. Professionals focused on engagement will tend not to make judgements or set firm boundaries. Engagement is a legitimate and important objective but an exclusive reliance on engagement, if accompanied by a reluctance to make use of personal, professional and statutory authority, may not serve young people well. Social workers and others involved in safeguarding could usefully reflect on their approach, especially when the strategy of engagement is failing. The implications for work with parents are discussed further in Section 3.8.

Targeted Youth Support (TYS)

3.7.9. Child K was referred to the Islington TYS in early 2018 following a referral from Islington social care. TYS proposed to allocate a place on a voluntary organisation mentoring scheme, which Child K declined. The records note his mother's statement that she did not want any additional support at that time, as she was being helped by Child K's school.

3.7.10. As the end of Child K's Referral Order approached, the YOS and TYS identified the need for a worker to continue to meet regularly with Child K, either from TYS or the Integrated Gangs Team. It was not clear from the records what criteria pointed to one being the preferred option over the other. After some discussion a sessional worker was allocated from TYS who had had brief contact with Child K the year before, on the basis that he would be best placed to form a positive relationship with Child K. For about four months he became the most important member of the professional network and was able to meet with Child K (and his mother) about once a week. This was far less often than had been hoped and his influence on Child K's behaviour was limited. An attempt to hand over the work to a charity commissioned by Brent Council, which takes a similar approach to the work, was refused by Child K.

3.7.11. In contrast to the social work approach where – in theory at least – interventions are based on an assessment of need and risk and take a full

[50] E.Hanson and D.Holmes (2014) That Difficult Age: Developing a more effective response to risks in adolescence, Research in Practice / Association of Directors of Children's Services. The word 'authority' is found only when referring to 'the local authority'. https://www.researchinpractice.org.uk/children/publications/2014/november/that-difficult-age-developing-a-more-effective-response-to-risks-in-adolescence-evidence-scope-2014/

account of the history, the TYS worker was focused exclusively on the perceived current practical risk to Child K, i.e. that he had provoked at least one group of gang members and would be at risk if he visited Islington from his home in Brent. The stated objectives in May 2019 were to '*support the goals of recovery and safety'*. It is not certain what this meant. Critically, the TYS mentor told the review that he had not known that Child K had been to school in Camden or might have important connections there. He told the review that later he had not understood why Child K was visiting Camden, as well as Islington.

3.7.12. This episode illustrates the way in which TYS or similar voluntary services can be asked to play a leading role in this work, because their approach is viewed as more likely to lead to engagement, but do not undertake a detailed assessment on which to base the intervention and rely on others to provide important history. It suggests a lack of a structured and systematic approach to supervision and management oversight which makes the expectations that are sometimes placed on TYS and similar youth-oriented services too high. Arrangements for joint supervision and planning between social care, TYS and / or YOS need to be in place and operating effectively. These are issues that Islington Council has begun to address, but they may apply equally in any local authority where reliance is being placed on youth-oriented service commissioned from the voluntary services.

Youth Offending Services

3.7.13. Child K was made the subject of a Referral Order in July 2018 having pleaded guilty to committing a robbery. The supervision began in September because he was allowed to go on holiday to see his mother's family for a month in August. The order ended effectively in April 2019 when the work was handed over to TYS as described above.

3.7.14. Islington has recognised that the July 2018 assessment took insufficient account of the risks of exploitation and gang association that were already apparent at the time. The Referral Order intervention and plan which followed were appropriate to the specific offence and not to the whole picture and context in which Child K's offending was taking place. This was a missed opportunity for concerted multi-agency intervention with the family, particularly as there was a social care assessment at the same time.

3.7.15. It was easy for Child K to attend sessions and appear to comply with the terms of the Referral Order, in part because little was done to explore or challenge the difficulties in his history that contributed to his offending. But he also had four different YOS workers with responsibility for oversight of his order during a period of a few months, effectively spoiling any chance of effective, personal engagement. Islington has recognised that this level of staff turnover, in a service that seeks consistency and engagement, is

unacceptable and has made proposals to reduce changes in staff allocation in future.

Collaborative working between the three services

3.7.16. There were only brief periods when professionals from more than one of these services were actively working with Child K. Between February and April 2019 professionals from YOS and social care attended strategy and planning meetings and made separate visits to the family before it was agreed that the case would best be dealt with by the TYS worker. Had there been longer periods of case allocation to more than one service, joint supervision and planning of the work would have been of benefit.

3.7.17. The review has been told that Islington Council has begun to address this issue which may also equally apply in any local authority where reliance is being placed on youth-oriented service commissioned from the voluntary services.

3.8. The culture and practice of working with parents and young people

3.8.1. This section considers the work undertaken with Child K's parents, mainly his mother. Research commissioned by the safeguarding practice review confirms the importance of work with parents of young people affected by serious youth violence:

'*Parental engagement is nearly always a protective factor. Parents and extended family members need effective support in helping them manage risk from outside the home. This is skilled work and requires building good relationships with parents. A number of parents we spoke to felt blamed and therefore alienated from attempts by services to help.'* [51]

3.8.2. There were spasmodic attempts to work with the mother, but no coherent approach spanning the period under review. From 2017 the Camden secondary school engaged Child K's mother closely in its work to support Child K, involved her in the referral to the Camden CAMHS outreach service and referred her to a parenting programme in June 2018, shortly before Child K was permanently excluded. This and other parenting programmes are discussed below.

3.8.3. There was then a gap in work with the mother as there is no evidence of Islington YOS working with the mother under the terms of the Referral Order between August 2018 and February 2019. From then home visits were made to discuss safety planning for Child K and the family when he was suspected of killing another young person. From May 2019 the TYS

[51] N Maxwell et al (October 2019) A systematic map and synthesis review of Child Criminal Exploitation, Cardiff University

worker tried to work with her and it appears that his individual support was valued. After the case transfer in May 2019 the Brent social worker was in touch with Child K's mother but (according to her) made no positive or practical suggestions. At this point Child K's mother understandably resented the need for the family to be re-assessed and was disappointed that professionals had no other practical suggestions as to what she should do. Professionals were relying on Child K changing his behaviour and were encouraging him to take up an offer of education in September 2019.

3.8.4. The records suggest that professionals may have underestimated the extent of the pressure on Child K's mother. It is difficult to imagine any situation worse for a parent than to know that your son has been arrested as a suspect in the murder of another child and that (regardless of whether he committed the crime or not) there is a risk of violent retaliation. Shortly after this, Child K was nearly killed in an apparently unconnected attack. This must have had a devastating effect on Child K's mother and wider family, evidenced by comments recorded that *'I no longer know my son'* and an acknowledgement that she could not influence his behaviour. Such statements are found in the records over several months; however the records do not appear to show that the impact on her was fully appreciated and assessments do not draw any clear conclusions from this. Perhaps it was underestimated because Child K's mother was articulate and always willing to cooperate. It is noted that she had '*good enough'* parenting skills, though in the context of the problems she faced, this meant very little.

3.8.5. This may reflect a wider difficulty in relation to professional ownership and use of authority, referred to in Section 3.7. It is difficult to see how progress can be made in such cases unless parents (including members of the extended family however defined) develop the confidence to be able to relate to young people in a more authoritative way. It is hard to see how professionals can enable parents to be more authoritative if professionals do not feel comfortable responding in an authoritative way.

<u>Parenting support</u>

3.8.6. Child K's mother said that she valued the 2018 parenting programme as it focused attention on the stresses that she was facing at that point and dealt frankly with topics such as gangs and why children might choose to carry a knife. In contrast earlier programmes had been less specific in their focus, concentrating on the problems of younger children. Child K's mother told the review that it would have been helpful to have had this input sooner, so as to be able to anticipate the difficulties likely to be faced when looking after an adolescent. This echoes the views of other parents. The review makes a recommendation on this.

4. RECOMMENDATIONS

Guidance on the review by safeguarding partnerships of serious youth violence incidents

4.1.1. Brent Safeguarding Children Forum should ask the (national) Child Safeguarding Practice Review Panel to give guidance to local safeguarding children partnerships on the following:

- How the panel intends to undertake further enquiries into the areas of serious youth violence and child exploitation
- In what circumstances local child safeguarding practice reviews of practice in relation to children who are killed or badly injured as a result of serious youth violence should take place so that they can contribute to national as well as local learning.
- How it wishes the guidance to be interpreted in relation to perpetrators of serious youth violence who are under the age of 18.

Parenting and early intervention

4.1.2. Brent and Islington Councils should review their practice on the provision of parenting support, where there is a perceived risk of involvement in youth offending, to ensure that it covers issues that are likely to emerge in adolescence, such as risk from gangs and knife-crime, and to ensure that it is provided at an early point

School roles in safeguarding children at risk of serious youth violence

4.1.3. In the absence of central government action, Brent, Camden and Islington Councils should review the effectiveness of the steps already taken to act on the recommendations of the Timpson review of school exclusion and consider what further practical, local measures should be taken to and take additional relevant steps that are in keeping with the recommendations.

4.1.4. Brent, Camden and Islington Councils should consider what practical, local measures should be taken to improve information sharing with schools and colleges in relation to children who are at risk as a result of serious youth violence / child criminal exploitation.

Youth Offending Service assessments

4.1.5. Whilst recognising that Islington YOS assessments have been found by external inspectors to be 'generally good', the partnership should ensure that YOS assessments consistently seek to identify and take full account of the child's background and relevant contextual factors and are not focused narrowly on the circumstances of a specific offence. When a young person is known to have links with services in other boroughs, supervisors should ensure that assessments seek out and take full account of information from other localities.

Application of child protection procedures when children are at risk of significant harm as a result of serious youth violence

4.1.6. Brent Safeguarding Forum should ask the London Safeguarding Children Partnership to determine the suitability of existing core child protection procedures to this area of practice and, if necessary, set out a different procedural framework for children at risk of extra-familial harm, including serious youth violence.

4.1.7. Brent Safeguarding Forum should ask the London Safeguarding Children Partnership to consider the value of developing a common approach to the production of a list of young people who are considered to be at risk because of the influence of gangs or violent criminality. This would be used to supplement the police GVM in order to make regular checks of police records of incidents. The focus would be on evidence of risk of harm to the young person rather than gang membership or known criminal association.

Relocation of young people and their families because of the risk of serious youth violence

4.1.8. Brent Safeguarding Forum should ask the London Safeguarding Children Partnership to address the issue of relocation of families in its procedures so that there are shared expectations about practice across London boroughs.

4.1.9. Pending development of a cross-London approach, Islington Council should develop a template, capturing the issues set out in this report, to be used by professionals in their discussions with families and young people when considering the relocation of a family. The council should consider making decisions to support or enable the relocation of family the responsibility of a manager at director level who should be reassured that all alternatives and risks present in the proposed area of relocation have been considered.

4.1.10. Brent Council should review its internal procedures for the transfer in of serious youth violence cases. In future an invitation to attend a child protection conference on a child already living in the borough or where a plan is in place to move to the borough should only be declined by a senior manager.

4.1.11. Brent should carry out an audit to check that its initial screening of cases properly reflects the level of possible risk in youth violence cases. Screening and assessment should not assume that relocation has reduced risk.

The impact of complex and serious investigations on young people

4.1.12. The Metropolitan Police Service should confirm its commitment to providing a MERLIN report on all young people affected by incidents of serious youth violence. It should sample a range of incidents to assure itself and partners that the system is effective.

4.1.13. The Metropolitan Police Service should (in collaboration with local authority representatives) consider whether more should be done to safeguard the welfare of young people affected by complex criminal investigations into incidents of serious youth violence. In relevant cases the police should appoint a liaison officer from the Major Investigation Team to work closely with the relevant local authorities and youth offending services over the course of the investigation and taking into account all young people affected. The police should provide briefings on the range of safeguarding issues considered in case reviews, including the national child safeguarding practice review on child criminal exploitation to major investigation teams and to senior investigating officers as part of their training.

Collaboration between services

4.1.14. Brent Safeguarding Children Forum should promote arrangements for joint supervision and case planning in serious youth violence cases involving, as a minimum, social care, the Youth Offending Service and other commissioned interventions for high-risk young people.

4.1.15. Brent Safeguarding Children Forum should seek assurance from member agencies that staff working with young people affected by serious youth violence (including youth-oriented services) receive structured supervision to enable them to plan and review their work effectively.

Appendices

Appendix I	Views of Child K's parents
Appendix II	How the review was undertaken and Terms of Reference
Appendix III	Relevant findings and recommendations of the national Child Safeguarding Practice Review

Appendix I

Summary of discussions with Child K's parents

The following is a summary of the views of Child K's parents, transcribed from notes of discussions. The views expressed here do not necessarily coincide with those of the independent reviewer or the multi-agency safeguarding partnership.

Child K's father

1. The independent reviewer had two brief phone conversations with Child K's father during the lockdown. He sounded distressed during both. The focus of his attention was on the role of Islington social care during 2015 when Child K had been made the subject of a child protection plan. He felt that the social worker undermined the family's authority over Child K by asking him to report any further incidents of physical punishment to her. She should not have done this and after that Child K went downhill.

Child K's mother

2. Child K's mother spoke twice at length to the independent lead reviewer on the phone during the first Covid-19 lockdown. She had twice previously met Islington's Director of Social Care and a senior housing manager, and was informed that a letter summarising her views expressed in those discussions had been made available to the review. The views of the mother as expressed in these interviews overlap and are combined in Sections 3 – 27 below. After Child K's mother had seen a draft report, two further discussions were held, which are summarised in Sections 28 - 37 below. Points repeated in the second discussion are not all included in the second part of the summary.

Child protection interventions in 2015

3. The child protection and domestic abuse intervention (described in Sections 2.7 – 2.10 of this report) was negative and intrusive and Child K's mother said that she felt

judged all the time. This was why when the child protection plan ended, she would never have considered having further contact with social care Child in Need services

Educational difficulties

4. Child K's mother believes that his secondary school did not react when he started to go downhill (in early 2018). The school could have done more and been better trained to respond and have services in place.
5. Permanent exclusion was the key point that Child K's life changed for the worse. His mother believes that Child K's school got fed up with him, felt that they were not getting results. They should have kept trying. She asked why Child K was able to work and succeed in one environment (a specialist project) and not in other environments (the school). The problem must therefore be the school and not the child, and schools need to make more allowances.
6. Child K's mother did not want him to go to the Pupil Referral Unit. Child K lacked motivation there. There should be more resources for excluded children.
7. She believes that there aren't enough male role models in schools, among social work and Youth Offending Services for mixed-race kids.

Police interventions

8. Child K's mother believes that the police didn't investigate the stabbings properly. Young people don't trust the police so won't tell them anything. Police have to change and should police communities in a more sympathetic way. The police aren't visible in the community and they need to be.

Moving out of Islington

9. Child K's mother stated that it was her idea to move to Brent. She agreed it had been a good idea to move, but she expected more support. When professionals ask families to move urgently due to risks, and parents work, they are trapped in paying double rent (one for their permanent property which they can't give up otherwise they lose all rights) and one for their temporary accommodation. How can this realistically work paying for 2 properties?
10. If you are on benefits and have to move you do not have to pay two rents. If someone works it is impossible to survive financially having to pay two sets of rent. No one explained this. She could not afford this and the additional pressure this causes at an already very stressful time is not acceptable.
11. When a family is assessed as being at risk in their family home, the housing department and social care work together to offer solutions. Social care expecting a family to move immediately is a high-pressured situation and very stressful. Child K's mother felt that she was not offered any choice. Also she had not seen the place that the family were going to, which was in a very poor condition.

12. Asking a family to uproot is an overwhelming thing, even by itself, let alone with all the other factors and information that the family had to take in at that time. Child K's mother suggested that hotel accommodation should be provided even for a few days, somewhere you knew would have clean bedding, food and so that you are your family could be safe from harm. She had not been afforded this time by being told you needed to take Temporary Accommodation immediately.

13. Child K's mother expressed concern that moving away may actually increases risk to young people as they go missing for longer, not knowing the area and relationships with key professionals are broken.

Social work interventions

14. Child K's mother believed that when Child K was stabbed (in May 2019) social workers didn't know what to do. This was disappointing. Aren't they supposed to? Child K's mother said that they kept asking her what she thought should happen. Professionals are meant to make suggestions about the kind of things that will help.

15. Child K's mother said that the changeover between different groups of professionals was the cause of a lot of difficulties. Why if you have a perfectly good assessment in one borough and you go to live in another borough, they have to do a 4-6-week assessment? Why can't they just use the other borough's assessment and get on with the work?

16. To lose all the professional connections moving to a new area was very difficult for Child K and you as a family. Child K had told some professionals that he felt she had been bullied to take the temporary accommodation offer. You wondered whether social care services questioned whether you were able to protect your son and the implications of this. Whereas really you just needed time to think, rather than being hurried into a decision.

17. At one point professionals were repeatedly introducing new professionals to the family and this impacted negatively.

Youth Offending Services and support

18. Child K's mother said that he had had 4 workers from YOS in 9 months. Staff need to be more committed – they shouldn't keep leaving. The changes of workers don't help children talk to professionals or trust them. It is impossible for a child to think that professionals actually care if there is a constant change. You repeat your story again and again.

19. Child K had built a relationship with TYS worker but this had to change when the family moved to Brent and the service was no longer on offer.

Parenting support

20. Child K's mother said that the parenting support work who became involved in 2018 was good – but why was this not provided sooner? The parenting support work in 2015 was little use – it did not recognise how serious the issues were.

21. A charity worker spoke to Child K about the risk of carrying knives after he was first stabbed. Child K's mother said that she was in shock thinking why would a child who has just been stabbed carry a knife. The charity worker explained it to her. More education for parents is needed about knife crime.

22. Child K's mother said that more parenting work is needed. Parents don't know what is really going on in communities with young people and said that services needed to undertake prevention work very early on e.g. Year 5 with parents advising them about social media, community risks, grooming. She had done a parenting course but would have preferred this to be earlier on in Child K's life.

Local authority services for the young people who killed Child K

23. Child K's mother felt the system had failed the young people who had killed her son. She understood that one of them had been excluded at the age of 14 and that he had never had a job or education since but had 21 convictions. Child K's mother said the he must have been known by social services. How is this possible? There should be more openness about what services had been offered to young people such as him?

Response after the death of Child K

24. F Child K's mother said that following the death no one helped her. She was completely overwhelmed and in grief and without her brother and sister-in-law who had sadly lost their son many years earlier to knife crime she wouldn't have known what to do.

25. Child K's mother said that there were many aspects of the response to the death that made it more difficult. It was only the next day that she had confirmation of what had happened from a police Family Liaison Officer.

26. Child K's mother said that – with the exception of a worker from the YOS - she had received no contact from anyone in Islington that had worked with her son, not even a text sending their condolences or to ask how she was? Could they do anything for me or support me in any way? To her this was unacceptable. Some months later she had received a lot more empathy and support from a senior social care manager. Do all professionals know how to respond after a death of a young person?

Working with young people

27. Child K's mother questioned why young people have to consent to services and why parents can't override this when they know it will do their child good in the long run?

Summary of Child K's mother's comments on the report – February 2021

28. Child K's mother said that it was hard to read the report because it made the memories come flooding back. The report was quite dense and there was a lot of information. Sometimes it was hard to follow. There are some technical aspects to the report, which describe the procedures for the child protection system, which are hard to understand.

29. Child K sometimes comes across in a negative way, but his mother you would want everyone to understand that in the family he was a loving boy with a big heart. He was unhappy and couldn't find a way out of the situation he had put himself in.

30. Child K's mother believed that there are too many different services involved and there is not enough leadership provided by senior managers. These problems seem too difficult for people at the lower levels in organisations to solve, but they do not seem to involve more senior people. That is what you would do when you have a problem that you cannot solve in a business or a company and it is hard to understand why that does not happen in this work. As a result there is not enough leadership provided and no one has oversight of everything that is happening for a young person and their family.

31. As Child K's mother experienced it, there were sometimes three or four people dealing with the problems at the same time. When you face this as a family it takes too long to get anywhere and professionals don't seem to have any practical solutions. Why did the family have to be reassessed by Brent social care when there had already been assessments, and why this should take so long? You introduce a new person. Everyone becomes tired of telling the story. And this assessment did not result in anything happening.

32. A young person cannot deal with delays. The longer you leave it the less likely it would be that Child K would engage. Time is important and there is no time for lots of meetings. There was talk about finding an apprenticeship, or a college place. Three months after something has happened, a teenager will not be interested in what you are going to say.

33. There are three references to the police not taking action to prosecute Child K before his death, but saying that they intended to do so (i.e. the murder of another young person, the assault on a girl and the possession of drugs and a knife in Essex). Child K's mother said that this makes it sound as if they were all waiting for something to happen. It is very frustrating that there was such a long delay before any firm action was taken. If he had been dealt with sooner the outcome might have been different.

34. Child K's mother said that it was not good enough of Essex Police to say that she did not think her son as at risk. Was it not their role to look into that? She felt that generally the police did not deal with these issues well.

35. Child K's mother noted the time in hospital when a professional had said that he *'was sad and looked like a broken child*'. She agreed and she had been trying to make sure he had a mental health assessment, but with no success.

36. It is very frustrating that social workers are not able to make more practical suggestions. Really you wonder what the point is of social care being involved? It is intrusive if they come to your house and ask questions that are intrusive, write it in your record but don't do anything. There are too many meetings, which result in nothing. What is the point of workers who come – like admin workers making a list of problems – if they don't have any practical solutions? This is a difficult thing for

parents. You are somehow expected to open up about your problems to someone as if they are your friend. But they are not your friend.

37. Child K's mother would like to know about what happens to the recommendations and that some things at least will change.

Appendix II

Principles from statutory guidance informing the review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

Reviews should also:

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

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

Child K – REDACTED Terms of reference / lines of enquiry for the Serious Case Review

1. Purpose and scope of the review

1.1. The review is being carried out under the statutory guidance Working Together to Safeguard Children 2015. Its purpose is to undertake a '*rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children*'. The Brent Safeguarding Children Forum (now undertaking the review) is required to '*translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children*'. [52]

1.2. Brent's partnership will lead the review which will also consider provision made by services in Islington, Camden, Westminster and Essex.

1.3. There are too many separate incidents and actions – some taken by Child K and other family members and the decisions of a large number of professionals – for the review to be able to answer the question of whether this death could have been predicted or prevented. It is clear even from an outline of the history that during the last months of his life Child K was at a very high level of risk.

1.4. The review should consider services provided to Child K up to his death ……. Bearing in mind the need to undertake a proportionate piece of work and to focus the review on current / recent practice, the review will evaluate in detail services provided from January 2016. …The review should receive and consider summarised information about significant earlier events and service provision as this may point to antecedents and risk factors in Child K's earlier life.

2. The overall approach

2.1. In relation to the most important episodes and themes, the review will seek to understand both:

- the provision made in this specific case and the underpinning policies and procedures

[52] Legally Child P was a child throughout the period under review, although some aspects of the legal framework change as children become more mature or reach certain ages below 18. The review will use the terms 'child', 'young person' and 'young adult' flexibly so as to communicate its findings as clearly as possible.

- evidence of wider effectiveness / impact of these services so that recommendations do not rely just on the findings of one case history

2.2. The review will identify evidence of good practice and effective service provision so that this can be encouraged and promoted.

3. Episodes and themes emerging from the initial chronology and discussions that the review needs to understand

3.1. The child's educational 'journey', in particular

- change of secondary schools
- his move to the Islington Pupil Referral Unit

3.2. Engagement and continuity in support:

- the type of services that were offered
- actions taken by agencies when services were not taken up or children were not brought to appointments
- what happened at the end of a period of service provision?

3.3. Quality of assessments. For example:

- does assessment consider contextual risks?[53]
- does it consider the full history of attempts to provide services?
- does it take account of changes in circumstances?
- were the case closure decisions subject to a risk assessment?

3.4. Categorisation as a gang member or affiliate. For example:

- how was this done?
- what are the thresholds?
- is there one system or more than one system?
- how is it communicated to the professionals involved?
- how does it affect the way in which young people are seen and understood?

3.5. Management of the highest level of risk – including:

- evidence of a young person's involvement in organised criminal activity or serious crime
- taking discharge against medical and other professional advice
- decisions to facilitate relocation to a new area

[53] The term 'contextual safeguarding' is now commonly used. The review uses this to refer to the safeguarding of children when risks arise from their contacts in the community (including from gang affiliation) as well as, or rather than, from the family, and when the behaviour of the young person itself may pose a risk to others in the community. Whilst the term would not have been used during some of the period under review, these concerns are relevant.

- missing episodes or evidence of involvement in criminal activity outside of London (county lines)
- extent to which police intelligence is used to safeguard children.

3.6. Liaison between health providers (including acute hospital trusts that are major trauma centres) and local authorities in an emergency, both during 9-5 working hours and out of office hours.

3.7. Arrangements for inter-agency working across borough, including when agencies from two boroughs are involved or agencies have facilitated the relocation of a child or family to another area for his or her protection. This would include:

- continuity of provision (including health services) arrangements for the sharing of information
- case responsibility and transfer
- legal responsibilities and procedural aspects

3.8. The role and effectiveness of voluntary sector and commissioned services.

3.9. Response to incidents of domestic abuse involving intimate partners, both historically and in the recent case history.

Appendix III

Child Safeguarding Practice Review Panel (2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government

Section 16. Local learning points

16.3 We recognise that many safeguarding partnerships are already constructing their responses to the issues, although some are further ahead than others. Through this review, we have identified a series of questions and challenges in four key areas that we believe every partnership should be working on and be able to answer.

1 Problem identification

Do you know the size and nature of the problem in your area?

Do you know which are the most vulnerable neighbourhoods and community spaces?

Which children are predominantly affected in your area? Are they all boys? Are BAME children disproportionately affected? What is your response to your local dynamics?

2 Supporting your staff

Do you know the levels of risk your front-line staff are routinely managing?

Do you know how well they are supported and supervised in this work?

Have you articulated an approach to risk management that is shared across all agencies?

3 Service design and practice development

Are your services flexible enough to respond to the critical moments in children's lives?

Is there sufficient emphasis on relationship-based work and on the value of trusted relationships?

How are individual risk management plans for these children constructed? Are all local agencies contributing as needed?

Are risk management plans regularly monitored to respond to changing levels of risk?

How well are families being engaged in the joint protection of their children?

How is the balance between understanding these children as both victims and perpetrators understood locally?

Are adult and children's services working together where needed?

Are you satisfied with the approach in your local area to prioritising housing for families who face a serious threat as a result of criminal exploitation?

What is the pattern and trend in school exclusions? What is the nature of alternative provision available?

Is there a sufficient focus on disruption of criminal activity as well as support for victims?

How well co-ordinated are you with your neighbouring partnerships? If your police service covers more than one area, are you as integrated with those other areas as possible?

Are you confident that information follows children and families who are moved out of your area for their own safety and that there is continuity of support?

4 Quality assurance

How are your independent scrutiny arrangements focused in this area of work?

Have you developed a sense of what 'good' looks like in this work?

Are the voices of children and their families helping inform your responses and your quality assurance?

National recommendations

Recommendation 1: Trial a practice framework which can respond to children at risk of serious harm from criminal exploitation.

17.8 Key features of a practice model to respond to children at risk of serious harm from criminal exploitation

17.8.1 Identification of individual children who are at risk of serious harm through use of data, mapping exercises, local practitioners' knowledge and work with communities to get a detailed picture of those at risk. This group of children would be those who are identified as being at the most extreme risk, where criminal exploitation is known to be a feature and they are involved in county lines and gangs.

17.8.2 Intensive and dedicated work with individual children and their families to build good relationships. A specialist team (perhaps part of an existing service) comprising practitioners from a mix of disciplines and with significant experience of working with adolescents. The most important qualities are persistence, tenacity, creativity, flexibility and ability to respond quickly.

17.8.3 Team make-up will vary but could include both part-time and full-time staff from the following disciplines: police, youth offending, social work, clinical expertise, voluntary sector, youth work, teachers, family support workers.

17.8.4 Members of the team who can work closely with parents and provide dedicated support to help them manage the risk in a way which is perceived to be supportive and empowering. Family group conferences and group work with parents are a strong feature of this work.

17.8.5 Use of a shared practice model which is known to be effective, such as systemic practice. The seven features of practice described in the evaluation of the Innovation Programme outline the key factors which have been found to be associated with positive outcomes.