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# Serious Case Review – Chris

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Overview Report – August 2018

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A Serious Case Review (SCR) commissioned and completed for Newham Safeguarding Children Board (NSCB) in order to establish whether any lessons can be learned and to promote and develop good practice following the death of 'Chris'.

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## Chapter 1

### 1. Introduction

- 1.1. This Serious Case Review (SCR) was commissioned by Newham Safeguarding Children Board (NSCB) following a notification of the death of Chris, a fourteen year old boy who identified as being of Caribbean heritage. Chris was shot at close range in Newham and was transported to the Royal London Hospital. Chris died later in hospital, with his family around him, after his life support was turned off.
- 1.2. At the time of writing, there is an ongoing murder enquiry but as yet, no arrests have been made in relation to Chris's death. Exploration and analysis of the murder itself is not within the scope of this Serious Case Review.
- 1.3. This Serious Case Review provides an opportunity to address the specific questions set out in the terms of reference (see page 6) but to, more broadly, gain an understanding of Chris's life, his identity, the relationships he had with family, friends and professionals and how these may have shaped his world. The SCR allows for exploration, analysis and reflection on the journey of Chris's life, identifying opportunities to learn from the tragic death of Chris and reduce the likelihood of this happening to others.
- 1.4. The Lead Reviewer, Newham Safeguarding Children Board and all agencies and professionals involved in this process, express their sincere condolences to Chris's family.

### 2. Background Chronological Summary

- Chris grew up with his mum and older sister. The relationship between his parents had broken down in his early years as a result of ongoing domestic violence. He ceased all contact with his dad in 2012, often reporting to professionals that his dad had died.
- Chris spent his early years living at various addresses, all temporary accommodation secured by the London Borough of Newham. This included addresses in the London Borough of Havering, where the family report they experienced racially motivated harassment from neighbours. The family lived for some time in the London Borough of Waltham Forest, again in temporary accommodation provided by Newham, where Chris attended Woodside Primary School from 2007 to 2014.
- Chris had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder and was prescribed Ritalin to manage this, supported by East London Foundation Trust (ELFT). It is the family view that Chris struggled to integrate this diagnosis into his identity, feeling that it made him different and so he was reluctant to take the medication.
- ADHD diagnosis followed the emergence of challenging behaviour at primary school, including serious and significant incidents such as threats to self-harm with scissors and a ligature. These should have triggered a safeguarding referral but it is unclear if this took place as records from Waltham Forest Children's Social Care were not accessed as part of the review process.
- Extensive support plans, centred on relational, therapeutic, trauma informed practice were in place throughout Chris's time at Woodside Primary School, which both school staff and

his family report he responded well to, and which, overall, had a positive impact on his behaviour and development.

- The family secured a tenancy in Newham in 2011 where Chris then lived with his mum, in housing provided by East Thames Housing. His maternal grandfather, with whom he had a strong and positive relationship, also lives in Newham with his own tenancy. At the time of his death, Chris was living at his maternal grandfather's address.
- There are strong family links to the London Borough of Lewisham where Chris's maternal uncles live and where he also lived for short periods as part of the risk management plan implemented by the family.
- Between November 2013 to March 2014 Chris was an open case to Newham's Children's Social Care due to concerns that his mother had physically chastised him. This resulted in no further action following an assessment period. Supervision records state that there was no immediate identifiable risk to Chris at home.
- As the family moved to settled accommodation in Newham in 2011, Chris did not follow his classmates and friends from Woodside Primary School into Waltham Forest secondary schools and instead, in September 2014, started at Forest Gate Community School in Newham. This transition, particularly without a trusted peer group, was difficult for Chris. There is little evidence that his SEND (special educational needs and/or disabilities) needs were fully understood or met in this new setting although a pastoral support plan including 1:1 support sessions was in place.
- Chris's behaviour became increasingly unmanageable in this context, as he struggled to regulate himself without the support and trusted relationships available at primary school. He received regular punishment in the form of internal and fixed term exclusions (totalling at least ten days) between September 2014 and January 2016. He was referred to the Tunmarsh School, a Pupil Referral Unit in Newham, in January 2016, aged 13.
- Chris had regular appointments with the Clinical Psychologist from the Child and Family Consultation Service ADHD Clinic who made multiple referrals to other specialist services including substance misuse services and to talking therapy for other family members.
- From April 2016, concerns began to escalate about Chris's behaviour and for his safety. Information was shared, by the Police, with Newham Triage (MASH) in April, indicating concerns regarding gang activity and association with older, pro-criminal peers. The decision was made not to progress to Initial Child Protection Conference (ICPC) and instead to refer to the Youth Offending Team.
- Police reports from April 2016 state that Chris was 'associating with troublemakers'. The officer believed that he may be a target for gangs as he was easily influenced and was associating with gang members.
- Chris was arrested for a serious sexual assault on 6th July 2016 but was not charged, with no further action being taken. School records also highlight concerns about sexualised behaviour at school, which were referred by the Designated Safeguarding Lead to Newham Triage (MASH) in July 2016.

- In July 2016, the case was allocated for assessment by Newham Children's Social Care and opened to Families First<sup>1</sup>, however, after one home visit the case was closed due to 'non-engagement'.
- In July 2016, a direct referral was made by the Tunmarsh School to Newham Youth Offending Team for voluntary support delivered by a Disruption offer. This referral includes information about Chris buying a Rambo style knife and being observed looking at knives online. The disruption offer included targeted assessment and intervention for those at risk of youth violence, anti-social behaviour, possession with intent to supply matters and where sexually inappropriate behaviour may be a concern. The family are reported not to have engaged in this offer of support and so the case was closed.
- Further reports at this time make reference to Chris using his maternal grandfather's address to order the Rambo knife online, along with a bullet proof vest.
- On 6th November 2016, Chris was reported missing from home by his mother and did not return for a week. When he returned home he was debriefed by police but refused to answer any questions as to where he had been.
- On the 14<sup>th</sup> November 2016, a single assessment by Newham Children's Social Care was initiated following a referral from the police after his mum reported Chris missing.
- On 20<sup>th</sup> November 2016, Chris was reported to have assaulted his mum after she tried to prevent him leaving the home. In police interview, Chris claimed self-defence and that he had sustained injuries himself. No further action was taken by either police or Children's Social Care and he was returned to the pre-arranged care of his uncles.
- On 12<sup>th</sup> December 2016, Children's Social Care notified police that Chris had disclosed to his mum that he been pressured into selling drugs. His mum had found him to be in possession of a quantity of drugs and she subsequently disposed of £600 of Class A drugs that belonged to dealers. Information on record by Children's Social Care quotes Chris as saying he was in fear for his life.
- Two days later, on 14th December 2016, a search warrant was executed at Chris's home address in Newham. Officers were looking for numerous items of property, clothing, and weapons used in robberies. A mobile phone stolen in a knifepoint robbery on 18/07/16 was recovered. Chris was not at home as he was staying at his uncle's home in Lewisham following a break down in the relationship between Chris and mum after the alleged assault.
- Children's Social Care records at this time note that evidence pointed strongly to Chris being groomed by older young people for the purposes of selling drugs and being involved in gang related activities.
- Chris's mum is recorded as saying she was concerned for their safety. She made a direct approach to the family's housing provider, East Thames Housing, requesting urgent relocation for the family on the basis of risk.
- In December 2016, Chris was added to Newham Gang Matrix as a green nominal. Also in December 2016, Chris joined Forest Gate Youth Centre where he attended casual sessions rather than structured or group activities.

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<sup>1</sup> <https://www.newham.gov.uk/Documents/Health%20and%20social%20care/Support-and-protection-for-children-and-young-people-in-Newham-practice-guidance.pdf>

- At the end of January 2017, Chris's mum arranged for him to live with her brothers in south London as a temporary risk management strategy; at this time she continues to report, in writing to Children's Social Care, being in fear for her son's life and welfare.
- As Chris was no longer residing in Newham, despite remaining on school roll in Newham, voluntary engagement services such as the Youth Offending Team disruption offer were no longer available to the family. Support services local to the temporary address, including Lewisham Youth Offending Service, were not notified that Chris was living locally and so no direct support was in place at this time.
- During his time in Lewisham, Chris was provided with access to virtual learning via the Tunmarsh School.
- The case was not transferred to Lewisham Children's Social Care.
- In April 2017, Chris was arrested and subsequently convicted for carrying a knife in south east London. Records show that Chris explained that he had received threats via social media and was in fear for his safety. He reported, during his AssetPlus assessment, that he took the knife out with him for his own protection, with no intention to use it. However, during his police interview Chris stated that he was carrying the knife for someone else. It does not appear that details of others involved in either scenario were disclosed by Chris to professionals.
- Chris received a Referral Order from the court, and was initially assessed and supervised by Lewisham Youth Offending Team who worked with him until June 2017.
- In June 2017, the relationship broke down between Chris and his uncles, with whom he was residing and, with no other accommodation available, Chris went to stay with his maternal grandfather back in Newham.
- The case was formally transferred from Lewisham to Newham Youth Offending Team (YOT) in June 2017, where Chris was supervised at an enhanced level and required to attend twice weekly meetings. The YOT co-ordinated regular multi-agency professional meetings attended by the Tunmarsh School and Child and Adolescent Mental Health Services (CAMHS).
- On his return to Newham, Chris was raised to an amber nominal on Newham Gang Matrix.
- In July 2017, Chris reported that he had been chased by a group of youths and felt unsafe travelling to the Youth Offending Team given its location in the south of the borough (an area in conflict with the gang(s) with which Chris was allegedly affiliated) and so taxis were arranged to transport him to and from his appointments to manage potential risk following a safety planning meeting with Youth Offending Team police.
- In August 2017, Chris was arrested in Newham in possession of a corrosive substance (acid) and was due to be prosecuted for this offence. Children's Social Care records again state that Chris had explored the incident with the assessing social worker and stated that he had no intention of proactively using this but obtained it for his own protection.
- On 4th September 2017, Chris was in Newham in a group of four young people. An unknown assailant passed by in a stolen vehicle and fired multiple shots into the crowd of young people; it is not possible to be sure if Chris was the intended victim of the attack. Chris received a bullet wound to his head and was taken to hospital but died as a result of his injuries the following day.



## Chapter 2

### Initiation of the Serious Case Review (SCR)

Working Together 2015<sup>2</sup> sets out the SCR criteria where:

*(a) abuse or neglect of a child is known or suspected; and*

*(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.*

The legal advice to the SCR Consideration Panel was not to undertake a learning review. This advice and the information provided to the panel were carefully considered by the Independent Chair of the Newham LSCB who made the decision that a Serious Case Review would be conducted and Ofsted were notified of this decision on 17<sup>th</sup> September 2017.

### Purpose of Review

In this tragic instance, Chris has died and there are multiple indicators that he was subjected to gang violence, or threats of, and criminal exploitation linked to the illegal supply of drugs.

It was known to statutory partners that Chris was at risk of harm and the serious case review will analyse the effectiveness of multi-agency risk assessment, intervention and planning. The purpose of the SCR is for agencies and individuals to learn lessons that improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children.

### Terms of Reference

The focus of the review was originally agreed to be from April 2016, when information from the police was shared with Children's Triage which raised concerns about potential criminal exploitation linked to gangs and the illegal supply of drugs. This was amended, at the request of the Lead Reviewer, and extended to cover the fourteen years of Chris life in order to fully explore the longer term trajectories of offending, risk and responses.

The specific lines of enquiry identified to focus the Serious Case Review are:

1. To gain an overview of Chris's childhood that describes his care arrangements, family dynamics, significant events and relationships and the impact of these on his identity and development.
2. To analyse how well Chris's individual needs and vulnerability factors were recognised and addressed in the assessments, interventions and plans that were made to support him.
3. To analyse critical incidents in the 12 months prior to Chris's death and comment on the quality and effectiveness of intervention and service delivery at these points and the impact for Chris.

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<sup>2</sup> Working Together to Safeguard Children, Department of Education, 2015

4. To analyse the quality, effectiveness and impact of work to protect Chris from criminal exploitation. Did those working with Chris view him primarily as a gang member or 'gang affected' or did they recognise that he was a victim of grooming and criminal exploitation?
5. How well did Chris respond to the services that were offered to him? What was the quality of individual professional interaction with him and how well did he engage with individual professionals? Were Chris's voice, views, wishes and feelings sought and captured in their work with him?
6. To evaluate whether the risk assessment and safety plans for Chris following his return to Newham were sufficiently prompt and robust.
7. To review the response to mother's request to be moved and whether this followed the protocol for urgent rehousing
8. How well was the police intelligence about the involvement of Chris in drug supply used to inform protective plans for Chris; and how thoroughly was the information that mother provided in November 2016 investigated by the police?
9. Are locally agreed pathways for support, protection and case management for young people sufficiently clear and were these followed between 2016-17? Are any changes to these arrangements required as a result of this SCR?
10. What do Chris's mother and other key family members say about the effectiveness of agency involvement? Which services made a positive difference to him and what could have been better?
11. To consider whether the outcome of Chris's death could have been predicted by any individual or organisation involved at the time and were there any missed opportunities that could have led to a different outcome
12. To be cognisant of the rise in serious youth violence in Newham and make recommendation from this review for the Community Safety Partnership and LSCB to ensure that a proactive and effective approach to preventing the criminal exploitation of young people in Newham is underway.

## Participation and Scoping

The following agencies had contact with Chris during the original period of focus of the SCR.

- Barts Health NHS Trust
- East London NHS Foundation Trust (ELFT)
- Child and Adolescent Mental Health Services (CAMHS)
- East Thames Housing
- GP
- Housing (London Borough of Newham)
- Lewisham Youth Offending Team
- Newham Youth Offending Team
- Metropolitan Police
- Newham Children's Social Care
- Newham School Nursing Service

- Tunmarsh School (Pupil Referral Unit)
- Newham Youth Service

All agencies above were asked to complete an Individual Agency Management Report (IMR), which includes a chronology of key events, agency response, the recorded views of the young person and analysis of the agency response.

The extension of the period of focus, brought contact with the following agencies into scope and so their engagement with Chris was also reviewed within the SCR process.

- Woodside Primary School
- Forest Gate Community School

## Methodology

Guidance from the Department of Education, Working Together 2015<sup>3</sup>, requires that Serious Case Reviews are conducted in such a way which:

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

The Newham Adult Social Care Director of Operations was originally appointed to chair the Review, and was later replaced by the London Borough of Newham Director of Commissioning Support Unit following their departure from the London Borough of Newham. A Lead Reviewer with extensive experience in undertaking reviews and in gangs, serious youth violence and child criminal exploitation, and not connected to any local agencies, was commissioned to support the learning and write an Overview Report.

A Review Panel of senior officers from agencies who had worked with Chris and the family was established. This included:

- London Borough of Newham - Youth Zones Service Manager
- East London NHS Foundation Trust – Safeguarding Children’s Team
- Metropolitan Police Specialist Crime Review Group

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<sup>3</sup> Working Together to Safeguard Children, Department of Education, Chapter 4: 2015

- London Borough of Newham - Head of Youth Offending Team and Strategic Lead for Youth Violence
- London Borough of Newham – Children’s Social Care Service Manager INW East
- CCG Designated Doctor for Safeguarding Children
- London Borough of Newham Safeguarding Education Lead
- London Borough of Newham Housing Options
- London Borough of Newham Learning & Development Manager
- Tunmarsh School - Safeguarding Welfare & Attendance Manager
- Newham Pupil Referral Unit Head Teacher
- Newham CAMHS - Care Coordination

The panel was supported by the Local Safeguarding Children Business Unit. In order to mitigate against the potential problems involved in amending the Terms of Reference, panel members were, overall, communicative and supportive in assisting the Author between meetings.

The Review Panel members coordinated their agency engagement with the Review; this included providing a written timeline of significant actions, undertaking an analysis of their actions and interventions, coordinating the gathering of information, and identifying and supporting the professionals involved with the family who could contribute directly to the Review.

Newham Safeguarding Children Board agreed a mixed methodology to understand professional practice in context; the approach used is well aligned with the SCIE ‘Learning Together’ approach<sup>4</sup>. This encourages exploration of the factors that impacted individual and agency responses and approaches to working with Chris and his family and considering the wider issues of identified increases in youth violence and child criminal exploitation across the London Borough of Newham and London as a whole. This was to ensure consideration of the submission of information from various sources and used different activities to ensure a collaborative, engaging, systemic and transparent approach centred on developing shared learning and not attributing blame. This included:

- Individual Agency Management Reports (IMRs),
- Integrated chronologies
- Family interviews
- A practitioner learning event that used an approach centred on Chris, incorporating key family quotes creating a visual timeline, pictures of Chris and creative activities to bring Chris ‘into the room’ and to create a safe space for honest and reflective discussion
- Case recording system reviews
- Assessment reviews
- Video testimony from friends
- SCR Panel Meetings
- Additional agency specific information requests
- Policy, best practice and evidence review

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<sup>4</sup> <https://www.scie.org.uk/children/learningtogether/>

The Lead Reviewer identified, early in the SCR process, that there was extensive additional and clarifying information required to complete the review to an adequate standard. This included accessing case management systems, electronic assessments, meeting minutes, case transfer records and action plans. Every effort has been made to ensure accuracy, openness, transparency, comprehensiveness and challenge of the information provided; this was well supported by the Newham Safeguarding Children Board Business Manager and the SCR Independent Chair.

## Inhibitors

The following inhibiting factors have impacted on the timescales for this review:

- A number of original IMR submissions were found to be incomplete records of key events and with insufficient analysis of agency responses. Commissioners actively requested amendments to be made on several occasions before IMRs were shared with the Lead Reviewer, delaying the start of the Lead Reviewer.
- In order to adequately contextualise the information presented, the Lead Reviewer requested that the original Terms of Reference (ToR) be amended and expanded to include both primary and secondary education rather than just focusing on the twelve months preceding the death. This meant additional IMRs were requested and incorporated into the review process. This significantly extended the timescales of the report due to unavailability of key professionals over the Easter period.
- As a result of the amended ToR, further lines of enquiry were identified, necessitating further analysis and highlighting additional gaps in information provided by the original IMRs.
- Requests for additional or clarifying information, from some agencies, were slow to be shared and required follow up from the NSCB Business Manager, the Independent LSCB Chair and the Lead Reviewer.
- Several staff members left the employment of London Borough of Newham, or other involved agencies, during the SCR process including the original SCR Panel Chair. This created a range of challenges when attempting to clarify the details of chronologies and actions and in ensuring timely responses to requests for information.

## Ethnic, Cultural and Other Equalities Issues

### Disproportionality

There is ample, and growing, evidence highlighting that young black males, such as Chris, are disproportionately represented in the criminal justice system<sup>5</sup>, are more likely to be identified as both perpetrators and victims of gang related violence and are disproportionately represented on Gangs Matrices as recently released data from the Mayor of London (June 2018) shows<sup>6</sup>

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<sup>5</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/643001/lammy-review-final-report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf)

<sup>6</sup> [http://questions.london.gov.uk/QuestionSearch/searchclient/questions/question\\_298645](http://questions.london.gov.uk/QuestionSearch/searchclient/questions/question_298645)

There is also extensive evidence<sup>7 8</sup>that:

- Black children and young people appear to be over-represented in the child welfare statistics both in the primary and secondary school years.
- However, they are less likely to be subject to being placed on Child Protection Plans.

Whilst Chris's ethnicity was not a specific feature in any of the IMRs it is important that any strategy, or practice recommendations, to address safeguarding concerns linked to gang related harm, violence and exploitation includes an equality impact assessment to consider this disproportionality and other equality issues.

Ethical and legal issues associated with the labelling of children as gang affected or as gang members are acknowledged<sup>9</sup>, and it is to be noted that the use of this label throughout this report is aligned to how Chris was viewed and assessed by professionals involved in his life. It is not the intention of the Lead Reviewer to apply this label.

### **Safeguarding and Cultural Understanding**

The original referral to Children's Social Care followed a self-disclosure from Chris of physical abuse in the home. Whilst there was found to be no substantiating evidence of abuse, during the interview undertaken with Chris's mum, the cultural aspects of discipline were explored with particular reference to the emerging behavioural issues associated with the ADHD diagnosis. She explained that this was a challenging time for the family as, culturally, ADHD is often misunderstood as children 'just being naughty' and requiring a firm parenting style, often including physical punishment. This was addressed by her, and is noted as an example of good professional and parenting practice, by inviting extended family members to appointments to improve and enhance understanding of the diagnosis and treatment plans.

This review recognises the harm that can be caused by physical punishment of children and the need to consider excessive physical chastisement as a safeguarding concern. However, it is important to highlight the potential perception of assessments and interventions being culturally insensitive and contributing to mistrust in professionals.

This statement is made to draw attention to the requirement for culturally competent and anti-oppressive practice in safeguarding children from Caribbean families, as well as other Black, Asian and Minority Ethnic backgrounds, and this should be noted. It is acknowledged and understood that culture, and safeguarding concerns, exist in all communities; specific reference is made to the need for cultural competency when safeguarding children of Caribbean heritage as this is how Chris, and his family, identify and during the review process they themselves made reference to some of the cultural and value differences that existed between the family and professional approaches. Best practice acknowledges, explores, reflects on, understands and responds sensitively to these differences.

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<sup>7</sup> [http://bucks.collections.crest.ac.uk/9702/1/Schaubfinal\\_bme\\_bucks\\_review\\_-\\_25-5-10.pdf](http://bucks.collections.crest.ac.uk/9702/1/Schaubfinal_bme_bucks_review_-_25-5-10.pdf)

<sup>8</sup> <http://dera.ioe.ac.uk/11152/1/DCSF-RR124.pdf>

<sup>9</sup> Fraser, A. and Atkinson, C. (2014) Making up gangs: looping, labelling and the new politics of intelligence-led policing. *Youth Justice*, 14(2), pp. 154-170.

## Chapter 3

### Analysis of Key Events and Professional Practice

Examples of good practice and single agency recommendations are included here, using the following format.

Good Practice Example

Single Agency Recommendation

#### Children's Social Care

Concerns regarding Chris's wellbeing and welfare emerged early in his life, with clear indicators of distress in his early years and primary education. Whilst the family have a long history in Newham, there were periods when the family were placed in temporary accommodation in neighbouring boroughs and so Chris attended primary school in the neighbouring London Borough of Waltham Forest. The involvement of Waltham Forest Children's Social Care is not within the scope of this Serious Case Review and so it is unclear what information was known to this agency and what any subsequent responses were. There is no indication that any information relating to concerns about Chris at primary school was shared with Newham Children's Social Care at the time or as part of any transfer when Chris relocated to Newham. It does not appear that Chris's early years and primary education were ever fully explored as part of later assessments completed by Social Workers in Newham or that contact was made with Waltham Forest Children's Social Care to establish the case history during his time living there.

Once Chris was living in Newham, professional concerns relating to Chris were formally shared on seven separate occasions with Newham Children's Social Care, resulting in three periods of involvement. There was a history of no further action outcomes by the police in relation to allegations against Chris, which were shared with Children's Social Care. Whilst Chris was not charged with offences, the emerging pattern of offending and risk taking behaviour should have been of concern to professionals in Children's Social Care and seen as part of a pattern contributing to the safeguarding response to youth violence and which, in this case, were not factored into assessments or responses from a safeguarding perspective.

Children's Social Care did not respond to or review assessments as new risk emerged, and specifically following a Merlin report that Chris had seen and handled a gun at school. This is not in line with guidance outlined in Working Together to Safeguard Children<sup>10</sup> which makes clear that good assessments should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family.

A review of 56 published studies<sup>11</sup> confirms that the mere sight of weapons increases aggression and risk, the wording of the Merlin report also could have been interpreted as suggesting that Chris was potentially an intended target of violence using the weapon although on further exploration by the

<sup>10</sup> [http://www.workingtogetheronline.co.uk/chapters/chapter\\_one.html](http://www.workingtogetheronline.co.uk/chapters/chapter_one.html)

<sup>11</sup> Bushman, B. J.(2013). The weapons effect. JAMA Pediatrics, 167(12), 1094-1095. DOI:10.1001/jamapediatrics.2013.3824

Lead Reviewer, this was never the intended inference. This incident, even without the possibility of Chris being a possible target of a shooting, should have warranted further exploration and intervention from a welfare perspective but does not appear to have been acknowledged as a significant episode.

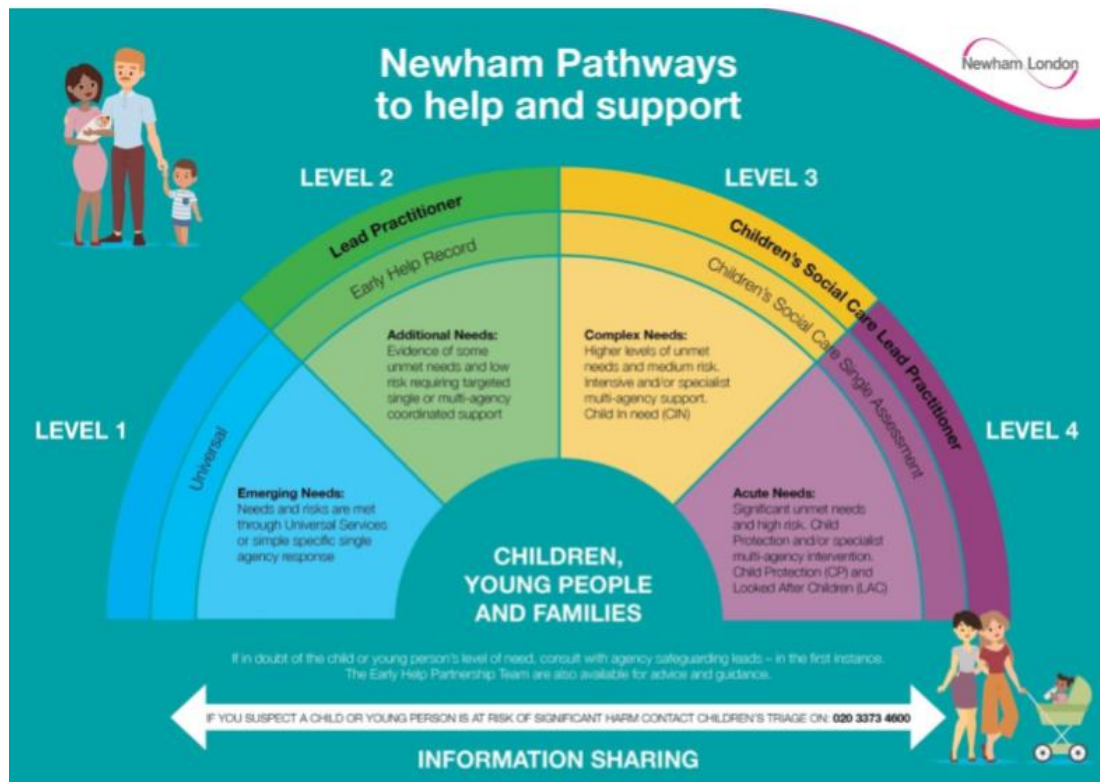
This indicates a pattern of observing risk associated with alleged gang affiliation solely through the lens of offending behaviour, without adequate analysis or understanding of the complexities of the victim/perpetrator overlap, the nature of child criminal exploitation and the need for robust and timely safeguarding responses to reduce the risk of significant harm. This in turn increases the likelihood of young people being fast tracked into the criminal justice system with automatic referrals to youth offending services, where other services may be more appropriate to holistically assess, plan, intervene and review. However, this needs to be understood in the context of the borough's strategic approach to youth violence which centres assessment, intervention and review of case work with gang affected and at risk young people within the community safety partnership, and where the Youth Offending Service and the Police Gangs Unit are the most actively engaged partners and lead on the two multiagency forums to explore risk and vulnerability (Multiagency Risk and Vulnerability Panel and the Gangs Tactical Meeting).

1. Between November 2013 to March 2014 Chris was an open case to Newham's Children's Social Care due to concerns that his mother had physically chastised him. This resulted in no further action following an assessment period.

It is clear from case records that Chris was presenting with a range of emerging, yet complex needs at this time. This was a key opportunity for assessment beyond the single dimension of physical chastisement and which could have explored the multifaceted aspects of Chris's young life. The assessment states that Chris fabricated the reported incidents to 'take the heat off him' but his thought processes and motivation for this were not further explored, nor were the incidents that it is inferred he tried to deflect attention from. This assessment period was in Chris's last year of primary education, with an upcoming transition to secondary education. This is widely recognised as a challenging time for many children, particularly those with additional needs such as an ADHD diagnosis.

Co-ordinated support, through a Team around the Family (TAF) approach and an early help record, could have been a key opportunity for early intervention at this point. In the absence of a more holistic and robust assessment, opportunities for intervention were missed, after which issues are evidenced to have escalated.





2. July 2016 when Families First unsuccessfully tried to support the family following referrals about his behaviour at the Tunmarsh School and the young people he was associating with.

Records suggest that a single home visit was made to engage the family in support through Families First, but given the limited scope of the previous assessment and the focus of contacts with Triage being on Chris's problematic behaviour, the family chose not to engage in the support offered. It was the reported view of the family that this offer was not felt to adequately understand or respond to the context of Chris's behaviour and the underlying and complex risk factors at play within the community as well as within the home.

It is apparent that by 2016 there were multiple complex and long standing difficulties that required support services to meet Chris needs. A full assessment of family dynamics was necessary in this case in order to have put in place diversionary and early prevention when Chris's problematic, and potentially exploitative, peer associations were beginning to develop. This did not happen.

3. November 2016 onwards

Chris's case was allocated for assessment, during which a number of multiagency meetings and communications occurred. Following the departure of Chris's allocated social worker, who was agency staff, at the end of February 2017, activity to support the family waned off as Newham Children's Social Care attempted to transfer case responsibility to Southwark. This was despite the family only temporarily living in Lewisham (there was no Southwark connection – this was an assumption made in error due to the area in which Chris was living and its proximity to Southwark) and Chris remaining on educational roll in Newham.

Multiple referrals between agencies in Newham demonstrated that Chris had a range of clearly identified, high level, unmet needs, with some professional insight into the type of interventions required. However, there is limited evidence of this work being delivered in any meaningful way or the impact of interventions reviewed. This, to some extent, can be attributed to the challenges of cross border working but it should also be noted that there was an absence of a Lead Professional with the role of co-ordinating this support, promoting engagement, and ensuring that the multidisciplinary, multiagency intervention (including family work, substance misuse work, mentoring and direct therapeutic intervention) required to meet Chris's needs was on track with regular review.

Another key event was a missing episode, where Chris was reported missing from the family home for a week and returned home with a number of high value possessions. The Police schools officer was reported to have undertaken a 'safe and well' interview when Chris returned to school; although Chris refused to disclose his whereabouts and how he had purchased the clothing he was wearing. A missing person and debrief Merlin was shared with Children's Social Care; although no independent return interview took place.

The key benefits of return interviews are to identify people at risk; understand the risks and issues faced whilst missing; reduce the risks of future episodes of missing or running away; and equip people with the resources and knowledge of how to stay safe if they do choose to run away again<sup>12</sup>. Whilst both are conducted when the missing person is found or returns, it is important to note that a return interview is distinct from a safe and well check. A safe and well check<sup>13</sup> is undertaken by the police as soon as possible after a child is found, and is intended to check for harm against the child or young person, which promptly took place in this case and was well communicated to key agencies.

The Children's Society research<sup>14</sup> suggests that return interviews are 'an effective way of identifying children at risk of significant harm' and help to 'reduce, and even prevent, further episodes of running away by helping children understand the risks of being away from their families and carers.' Additionally, in cases of child sexual exploitation, return interviews can help disrupt the 'exploitation or abuse and provide evidence for prosecution', the same is now evidenced as true in cases of child

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<sup>12</sup> DfE. (2014) Statutory guidance on children who run away and go missing from home or care (London: The Department for Education)

<sup>13</sup> NPIA. (2010) Guidance on the Management, Recording and Investigation of Missing Persons

<sup>14</sup> The Children's Society. (2013) Here to Listen? Return interviews provision for young runaways (London: The Children's Society)

criminal exploitation and the absence of a return interview would indicate that there is still some work to do shifting professional perception from offender to potentially exploited child.

Information was shared, by Chris's mum to a professional providing direct support to her, regarding Chris's self-disclosure that he had been pressured into selling class A drugs for older gang members, and that a high value bag of drugs was found and destroyed by his mum. This information was then shared with Triage in Newham but did not trigger a Children's Social Care strategy meeting or assessment despite clear indicators of risk for both Chris and his family. The information was shared with the police, by Triage, but this was some time after the drugs were disclosed. As the incident was not directly reported to the police, there was limited action that could be taken from an enforcement perspective at this point. Professionals did not appear to consider the safeguarding implications of the family's decision not to report to police that a large amount of drugs had been confiscated from Chris, despite the police visiting the family home in relation to the alleged assault, by Chris, on his mum whilst the drugs were in the house.

There is no evidence that any agency fully explored this incident with Chris. He was not spoken to and so was not supported to understand the risks associated with this incident or to develop his own safety plans. This could have been a significant opportunity to intervene at a time where Chris was potentially reachable and teachable, having taken the step to tell an adult about the coercion and exploitation. The absence of any safeguarding response presents a significant missed opportunity to engage, assess and intervene at a crisis point for Chris and his family.

Despite the absence of strategy meetings at key junctures, at least three multiagency meetings did take place, which were intended to consider Chris's presenting risks and vulnerabilities. These meetings were the Multiagency Risk and Vulnerability Panel (MRVP) chaired by the Head of Youth Offending Service. A named Children's Social Care manager was invited to all three meetings but did not attend. The consistent non-attendance of key agencies at these meetings significantly limit the ability of the panel to effectively consider and respond to risk in a multidisciplinary, multiagency and holistic way and this is explored further on pages 39 and 52.

As highlighted in the Children's Social Care IMR, the record shows a limited understanding of what was happening to Chris as a vulnerable child, within the context of his family and the local community, and the need to take appropriate action. The risks increased over time and in 2017 escalated exponentially on his return to Newham. The assessment process did not keep pace with these events, with action and services not being commensurate with the emerging risks. Immediate and practical needs should have been addressed alongside more complex and longer-term interventions which in this case was the need for rehousing out of area as a family.

The social care assessments, whilst not informed by information from across the partnership due to non-attendance at meetings, did identify both strengths and difficulties within the family and the context in which they were living. Consideration was given, to some extent, as to how these factors impacted on Chris health and development although with minimal analysis and limited evidence of any professional curiosity. His mum's attempts to keep Chris safe and requests for support were well documented although there was minimal evidence of professional insight into the complex reasons

why the family did not always engage in additional voluntary engagement support offers or consideration given to the capacity and capability across the extended family to effectively safeguard Chris without support.

The family's self-identified risk management strategy was for relocation outside of Newham and beyond the reach of those who the family felt were exploiting Chris and putting him at risk. This plan was supported by the family's housing provider, East Thames Housing, who requested risk information to support a move and inform decision making in relation to safe areas for relocation. This was requested via the allocated social worker, rather than as a direct request to agencies. The IMR from East Thames Housing states that the supporting statement from the Police remained outstanding. However, it was evidenced that the Police had in fact written a supporting statement in December 2016 and had sent this, as requested, to the allocated social worker. However, there is no evidence that this was forwarded onto East Thames Housing as the agency social worker left the employment of Newham Children's Social Care at this point. There is no indication that their inbox was monitored or that an alternative, named contact was communicated to partners.

The inability to secure timely and appropriate housing out of borough for the family, required the family to implement alternative living arrangements as the interim measure, staying with extended family in Lewisham had broken down. This meant that maternal grandfather was the only option available to accommodate Chris at that point.

Despite a close and loving relationship between Chris and his grandfather, this was inappropriate and inadequate to manage the presenting risks. The address was within Newham and as care was being provided by an elderly man with dementia, there were insufficient safeguards and boundaries in place to mitigate the identified risks and so impacting on all dimensions of welfare and wellbeing. This is evidenced by the purchase of weapons and a bullet proof vest purchased online using grandfather's details and delivered to the house.

At the point that Chris returned to Newham, there was sufficient evidence available to review the case and escalate to child protection as it was the view of the multi-agency partnership that he was at significant risk of harm. This did not happen.

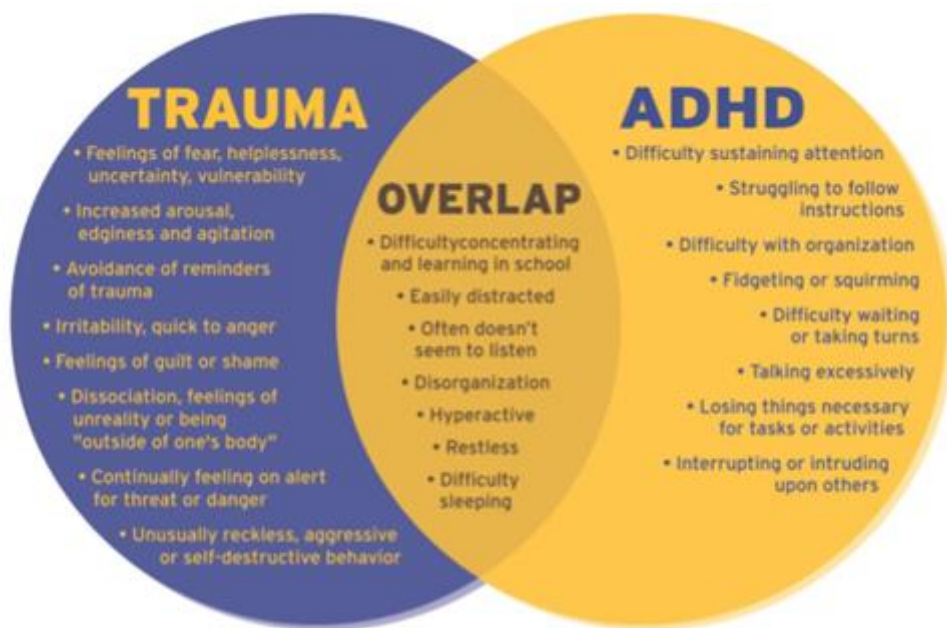
An email shared with the Lead Reviewer, but not included in case notes or the IMR, was sent to the allocated social worker in February 2017 and went unanswered.

*"In follow on to our telephone conversation today I would like to just make some clear pointers. I understand you have just taken on my son's case and have not had to full understanding of the situation however today conversation felt as if was fighting for my son's situation rather than us working together.....I am solely interested in safeguarding my son, and hope that you are too....I would really appreciate if you looked at all the factors when speaking to housing so they understand the greatness of this case. To me this is a life and death situation, to you; it came across like it was just like any other case, no passion to understanding my family's needs. Every day my son is not with me pains me as a mother"*

## Health

Chris was initially seen by Child and Adolescent Mental Health Services (CAMHS) in Waltham Forest in relation to his behaviour and subsequent diagnosis of ADHD, prior to his transition to secondary school. This period was not initially within the scope of this SCR and so no IMR was requested from that service, making it impossible to comment on with any certainty.

However, it should be noted that there is no evidence, as recalled by the family, that Chris's childhood was explored or that the impacts of childhood trauma and toxic stress<sup>15</sup> were considered as an alternative or additional way of understanding the presenting behaviour. It is not for this SCR to in any way challenge the diagnosis but given the significant overlap between ADHD and trauma presentations<sup>16</sup>, additional information provided by Woodside Primary School, and the indicators of up to four Adverse Childhood Experiences<sup>17</sup>, the impact of trauma and attachment difficulties seem pertinent to this case and yet does not appear to have been explored or considered by any professional.



Once the case was transferred to Newham in 2016, there are a number of areas of good practice highlighted:

- The Clinical Psychologist made extensive efforts to support the patient and family despite variable attendance and significant unexpected changes in his location and accommodation
- The Clinical Psychologist supported the family's attempts to relocate and maintained good contact with Chris's mum
- The service continued to see Chris even when out of borough
- The service referred Chris to Substance Misuse services and his mum to Talking Therapies
- The service responded to Chris's mums urgent request for an appointment very promptly
- The Clinical Psychologist and Consultant completed very detailed and complete clinical records.

Positive intervention around his ADHD diagnosis also took place in the family home. Chris's mum shared a book which had been made by the art therapist at Woodside Primary School, and which she read and explored with him to encourage him to see his ADHD as a unique trait rather than a character flaw (how he is reported to view the diagnosis) that didn't need to hold him back.

The records of the discussions with Chris indicate that he talked extensively about his family and lifestyle, including friends, and the associated challenges with moving regularly, during his sessions with the Clinical Psychologist. Whilst these conversations are entirely appropriate, it is noted that they replicate the conversations that other professionals from the Tunmarsh School, Youth Offending Team and Children's Social Care were having with him and so it can be concluded that during the period of 2016/2017, Chris has repeated his story to at least four agencies all to be included in single assessments and intervention/care plans without any central coordination.

Chris was also referred to Speech and Language Therapy (SALT) services following a meeting at school with his mum where it was discussed whether there had been any previous assessment for Speech, Language Communication needs. This assessment was arranged to take place through Tunmarsh School and the report concluded that there were no additional speech, language communication needs which would be considered to be impeding his ability to learn. No further intervention by the School Speech and Language therapist was reported to be required.

## **Education**

### **Primary Education – Woodside Primary School**

Chris attended Woodside Primary School in Waltham Forest from 06/09/2007- 23/07/2014. Chris had excellent attendance throughout his time at Woodside, averaging 99%, with no concerns in that area.

The family reported that this was a safe, supportive, nurturing place for Chris despite his emerging challenging behaviour in the classroom. Chris was initially supported through School Early Years Action in 2007, School Early Years Action Plus in 2008 and a Statement of Special Educational Needs in 2010, relating to his diagnosis of ADHD and Conduct Disorder.

Staff from Woodside Primary School, approached as part of the SCR process, were able to immediately recall Chris and gave both personal and professional accounts of his time with them and provided key insights into his earlier years.

A comprehensive support plan was in place for Chris incorporating a range of calming and grounding techniques into classroom behaviour management. This included having accessible textiles and multisensory experiences available for Chris to use to self-soothe when he became agitated and overwhelmed, Chris also had access to safe and quiet places in the school and there were staff available who were able to support Chris with co-regulation when he struggled to soothe and calm himself. Chris's mum was given regular updates and attended meetings at the school regularly to review plans and contribute to what worked for him.

Information from Woodside Primary School indicates that Chris's ADHD diagnosis had a significant impact on his emotional wellbeing, identity formation and peer group relationship. Academically he achieved well in Year 6 – his writing had personal style and he was above national average, reading and maths were at national level.

Chris took medication for his ADHD which supported him to focus in class for learning. In the latter years in Year 6, he was very aware of how he was feeling if he had not taken his medication – he would require 30 min with an allocated person to wait for the medication to begin to work so that he could settle. If he had not taken his medication – he became easily distracted and agitated both mentally and physically. The medication had a very big impact with regards to his behaviour and learning. It was noted that there were periods of time when medication was not being taken due to none being brought to the school, although it is unclear if this was addressed with the family or whether it was seen as potential safeguarding concern. There is no indication that this information was shared with Children's Social Care in Newham.

He was allocated one –to –one support: This was both on a regular and needs basis. This person in addition supported in the afternoon if necessary, when classes were more varied with a range of outside specialist teachers.

He was also able to express if he was able to work independently – or in group situation – he would mention that he needed to work separately himself to the teacher so he didn't disturb others. Chris's success was assessed by Woodside staff as being dependent on him having consistent boundaries and high work and behaviour expectations- alongside this was the fact that staff knew Chris very well and responded well to meet his needs. For example, he would work at the desk kneeling and writing rather than use a chair and this was fully supported by staff. To support Chris's ability to self-soothe when agitated, he was allocated and chose calming and safe places across the school to calm down and would usually go to these in these instances.

Additionally, Chris had access to art therapy at Woodside Primary School, which he is reported as responding well to. Comments from the art therapist include:

*Chris is reported as presenting as confused and at times depressed about his diagnosis of ADHD and found it difficult to understand. It impacted on his self-esteem; he could express this openly.*

*Chris was such a well-liked individual; he had a personality that members of staff warmed to, a little boy who sometimes struggled to contain his vitality and energy but a little boy with great charm. He was a real joy to work with and a character that will always be remembered with fondness in our school*

He was allocated Learning Mentors throughout his schooling – however he also formed many relationships with adults who he could talk to and who were all able to support him.

Chris was particularly interested in being part of school productions and performances. He was known by staff and pupils as being a talented dancer and performer, and was encouraged to showcase this in school assemblies.

Chris was a pupil who went through the school with his class and same year group from the age of Nursery. He therefore had developed good relationships with pupils and his peers also understood his behaviours. This is seen as key to both understanding and responding effectively to his behaviour in this classroom and playground. It is noted that even within this primary education setting, Chris was sometimes negatively influenced by other children as he could be easily led. Woodside Primary staff assessed that despite the ‘bravado’ in situations, Chris was extremely vulnerable and young.

In year 5 there was a recorded serious incident whereby Chris was in a class and refused to eat lunch in order to take medication. He was allocated a staff member to calm in a quiet room and whilst talking to this adult he was reported to have jumped up and grabbed scissors, which he held to his neck saying ‘tell these voices in my head to stop’. Chris is recorded as reporting that the voices were telling him to kill himself. The adult calmly talked to him and removed the scissors at which point Chris then went under the tables which had all the computer cords trailing from it and wrapped these around him saying that voices were telling him to kill himself. He remained under a table, crying uncontrollably wanting the voices to go away until he calmed in the head of school’s office lying on a beanbag.

There is no record of this event in Children’s Social Care case files in Newham and it does not appear to have factored into any assessments of his risks or vulnerabilities.

Successful strategies used at Woodside Primary School also do not appear to have been factored into later planning and were not continued during his secondary education. The clear presenting issues, recorded in a statement of special educational needs, would suggest that at a minimum, Chris required an enhanced package of support to enable him to successfully and safely transition to secondary school and a personalised support plan to ensure his needs were met once at secondary school. There is no indication that this happened.

### **Secondary Education – Forest Gate Community School**

There was limited information provided to the Lead Reviewer from his secondary school, Forest Gate Community School and nearly all entries in the IMR relate to poor behaviour and subsequent punishments which included detentions, internal exclusions and fixed term exclusions.



There is reference to a pastoral support plan being in place but this being unsuccessful, a view shared by the family who requested a review to the plan, but which resulted in the referral to the Tunmarsh School (an Alternative Education setting)

One significant entry describes Chris drawing a picture of a gun on the board during a lesson and when challenged, stating that he felt that *“abuse is the way to live”*. There is no indication that the reasons why he felt this, or drew the picture, were explored in any depth or shared with other agencies.

It is believed, based on the family reports of Chris’s time at Forest Gate Community School and the absence of any information to the contrary, that there was inadequate support for Chris as he made the difficult transition from primary to secondary education. However, without the full facts as to what support was in place, it is impossible for the Lead Reviewer to make meaningful recommendations as to what should have happened to support the transition.

In light of this, the single agency recommendation, whilst crucial, is limited to Forest Gate Community School considering the processes in place for effectively supporting the transition of pupils with SEND<sup>1</sup> and ensuring that individual needs are assessed and responded to building on evidence of what worked in primary education.

## **Secondary Education – Tunmarsh School**

The Tunmarsh School quickly recognised the complex needs that Chris was presenting with, and made a series of timely and robust referrals to other agencies for support on a number of occasions as well as implementing internal strategies to manage risk. Staff convened and attended a range of multiagency meetings and high quality records were kept, and shared.

However, it was clear that information known to both police and Children’s Social Care, including the incident where Chris disclosed his involvement in dealing Class A drugs, was not always shared with the Tunmarsh School and so limiting their ability to respond appropriately and put necessary safeguards in place at the school. It is recognised that the standard and expected method of communication relating to risk between the police and Children’s Social Care, is via Merlin reports and these were completed and shared in a consistently timely and often thorough way. It is also noted that following several incidents, there was direct verbal communication between the school and the police. However, information contained in Police Merlin reports was not always disseminated to partners such as Tunmarsh School by Children’s Social Care, who also did not attend a number of the multiagency meetings convened to discuss Chris’s welfare.

Staff at the Tunmarsh School collated information on concerning sexualised behaviour that was observed at the school, including a game that Chris initiated with a member of staff that made her

feel deeply uncomfortable. This was shared with Children's Social Care but no further action was taken.

- Immediate referrals made to external agencies for advice and support for the child and family.
- Effective information sharing between partner agencies and liaison with parent.
- Ensuring regular searches at the start of the day and sporadic searches during the school day.
- Risk assessment updated and information cascaded to staff regarding potential knife concern.

Once it was established that Chris was to move temporarily to his uncle's address in south London, the Tunmarsh School explored options for ensuring that disruption to his education was kept to a minimum. An initial offer of home tuition was made, and several successful sessions took place at the south London address. Chris engaged well in these, excited about getting back to learning and enjoying topics such as Spanish. Unfortunately, this was not a sustainable offer due to pressure on resources and so Chris was enrolled onto Academy21 (Virtual Learning Programme).

It is reported that he logged on regularly, completing work online even when in Jamaica on a trip with his family and remained on roll at the time of his death.

Information shared through the practitioner learning event and the SCR panel meetings highlighted the frustration of staff at the Tunmarsh School, who reported an exponential rise in the intake of pupils with unmet, and often unassessed Special Educational Needs and Disabilities (SEND). It was reported that whilst there is real expertise within the Tunmarsh School for responding to challenging behaviour and complex needs, they do not receive adequate funding to be able to provide learning that meets the multiple needs of this growing cohort, particularly when combined with gang related risk, exploitation and offending.

It was Chris's mum's view that the Tunmarsh School, whilst meeting their educational obligations, was not the right environment for Chris as it meant that he was surrounded by other young people with high levels of need and gang affiliations and so increased his exposure to peer pressure and exploitation rather than reducing risk.

### **Youth Offending Team (YOT)**

Newham Youth Offending Team were first aware of Chris when he was referred to the Multiagency Risk and Vulnerability Panel (MRVP), chaired by the Head of Youth Offending in May 2016, when Chris was just 13. This meeting flagged a range of concerns and made explicit reference to conflict with gang elders, accessing knives and noxious substances and disengaging from education. A number of actions were identified including diversionary activities and referral to the Youth Offending Team Disruption Team, which were both sensible and appropriate given the presenting issues. It is acknowledged that a key aspect of the disruption offer is to address criminal exploitation and the associated risk factors. However, there did not seem to have been any consideration of Chris's complex vulnerabilities and potential risks of criminal exploitation beyond this voluntary offer

of support, and there is no indication that concerns were shared with Children's Social Care, who were not present at the meeting.

The referral to the Disruption Team was completed but not until July 2016 and was not responded to within the locally agreed standards of five working days. Contact was made within ten days, although attempts to engage the family were unsuccessful and no alternative intervention was put in place to address the risks identified at the MRVP meeting that took place in May 2016. Improvement in YOT practice has seen the implementation of an Out of Court Disposal spreadsheet that provides target dates for first contact and the Out of Court Disposal process has been reviewed to accommodate the volume of Disruption referrals, to ensure there is robust management oversight

There are processes in place to ensure that a Team Around the Family (TAF) meeting is convened as part of the referral to the Disruption Offer so that the young person and their parent/carer can be made aware of the service, their consent and engagement is elicited and they are at the centre of the assessment, action plan, intervention offer and review of progress. However there is no indication that this process was followed in this instance.

Chris was again discussed at the MRVP in January 2017, at which point Chris's family had implemented their own risk management plan and relocated Chris to his uncle's property in Lewisham as a temporary measure. Again there were a number of actions agreed at this meeting, with several relating to information sharing which did not happen. Other actions included referral back to Newham Youth Offending Team Disruption Offer, which was later established to not be an option as Chris was residing out of borough. Newham YOT acknowledge that they did not make contact with Lewisham YOT as part of a preventative approach to advise that Chris had moved to their area and to ascertain whether Lewisham YOT or Lewisham Children's Social Care were able to provide a voluntary support intervention to Chris and his family or refer onto an organisation within that borough.

Chris was later arrested and convicted of possession of a knife in April 2017, whilst still residing in Lewisham to manage risk in Newham. He received an eight-month Referral Order to be supervised by Lewisham Youth Offending; his AssetPlus assessment was therefore completed by Lewisham YOT rather than Newham, in line with Youth Justice Board guidance and practice standards.

The assessment completed by Lewisham YOT was well informed by Chris's views and those of his family, however, it did not include key information relating to risk and vulnerability, known to professionals in Newham, and the role of Children's Social Care in responding to these risks.

An Initial Referral Order Panel Meeting took place at Lewisham YOT where a contract was agreed between Chris and the Panel to include:

- 20 hours of indirect reparation to the wider community
- Work with his allocated case manager to improve/enhance his decision making skill
- Complete a weapons awareness programme

- Work within supervision sessions around peer influence/peer association
- Voluntary component to continue on-going sessions with CAMHS in Newham

This contract appears entirely appropriate based on the presenting information, although it is questionable whether the YOT should have supported return to Newham for CAMHS appointments. Further discussion at the Newham MRVP meeting does make reference to the exploration of securing taxi transportation to ensure these sessions were safe to attend.

When it was identified that Chris had returned to Newham and was residing with his maternal grandfather, the transfer process was instigated between Lewisham and Newham Youth Offending Teams.

The Lewisham Case Manager forwarded the transfer request document along with assessment completed for the production of a Referral Order Panel Report to the Newham secure mailbox. The documents were reviewed by a Team Manager from Newham who started liaison between Newham and Lewisham YOT to enable the request to be dealt with within four days and a handover meeting convened to coincide with a planned Professionals Meeting in Newham within five days.

Once the case was accepted by Newham YOT, it was allocated and the assessment was reviewed. The assessment was updated with some information and it did reflect a range of concerns regarding his safety and wellbeing. However, there was limited analysis beyond the offence and the assessment failed to really explore indicators of exploitation. Chris was assessed, by Lewisham YOT, at the following levels.

- Risk of Harm – Low
- Risk of Reoffending – Low
- Safety & Wellbeing – High

Whilst the AssetPlus<sup>18</sup> assessment is designed to be more holistic and strengths based than previous assessment frameworks, it is not designed to be the primary assessment and planning framework in complex adolescent safeguarding and exploitation cases. It therefore did not capture the full range of information that was relevant to understanding Chris, his development, his life and his vulnerabilities. This was compounded by a lack of analysis and professional curiosity in a number of areas of assessments, although it is also noted that in some areas there is crucial information that was not known to other services and which indicates that there was a strong working relationship between Chris and his Case Manager, and that some areas were explored with interest and probing questioning.

The AssetPlus was the fourth single agency assessment to have been completed, with much overlapping information but significant gaps in history and presentation beyond offending. There is no indication that any single agency assessment was shared across the partnership and so no one practitioner or agency had full oversight of the presenting issues.

<sup>18</sup> <https://www.gov.uk/government/publications/assetplus-assessment-and-planning-in-the-youth-justice-system>

Chris had his first appointment with Newham YOT in June 2017 when a home visit was conducted, by his Case Manager and co-working Disruption Officer, to meet his grandfather and mum. At the time of the visit, Chris was residing with his grandfather in Newham, despite the risks associated with returning to the borough with no additional risk management plans in place. There are also questions of the suitability of Chris living with an elderly man with dementia, and where he was previously known to have accessed weapons and a bullet proof vest. It had been agreed at an information sharing meeting, two days prior, that the case would be escalated to Children's Social Care. However, there does not appear to have been any action to escalate the case and request a further strategy meeting. It is the view of the Lead Reviewer, that this information absolutely should have been shared with Children's Social Care in order to trigger an Initial Child Protection Conference and ensure a robust multiagency risk management plan with regular review to ensure this happened.

An integral part of YOT interventions are that a home visit is to be conducted at least once a month to ensure that parents/carers are aware of the intervention the young person is attending with the YOT, to elicit their 'buy-in' and to ensure the living environment of the young person is suitable and meets their basic needs with regards to the Children's Act 2004.

It was identified that it was unsafe for Chris to be in several areas of Newham and so taxis were arranged to transport him to the YOT, which is located in a risk area. A safety meeting was convened with the YOT police staff, and a YOT team manager was present. The risk concerns were explored and as an outcome, the YOT venue was assessed as suitable with appropriate safeguarding measures adopted, which all parties agreed to. Appointment times were also agreed to limit interaction with known young people who may present a risk.

Whilst these adaptations could be seen as good practice, it is questionable whether this was a helpful approach as it presents a very mixed message regarding risk management and safety planning for young people. It also conveys that taking clearly identified risks are acceptable when adults tell you they are, a potentially dangerous message for young people at risk of exploitation. The Youth Offending Team has acknowledged that a different approach could have been taken with appointments arranged in safe places such as local youth zones.

The intervention plan for Chris was in its early stages of delivery in June –September 2017 and was still focussed on engagement and rapport building. Referrals had been made for a specialist substance misuse intervention to address his cannabis use but again was in the early stages of delivery. Whilst there was no indication that the intervention plan in place as part of the Referral Order was adequate to meet Chris's wider needs, risks or vulnerabilities as these were not sufficiently understood in the assessment, it is impossible to accurately predict the potential outcomes of this work.

What was clear throughout this SCR process, is that there was a strong, positive relationship between Chris and both his Case Manager and the Disruption Officer from the Youth Offending

Team. It was also clear that both staff members were personally and professionally affected by Chris's death and more generally by the rise in youth violence in Newham. It is noted that these roles involve an almost relentless risk management function with a large volume of young people who are at risk, who pose risk and who have experienced significant trauma. This is emotionally draining and leaves staff at high risk of burn out and secondary (vicarious) trauma.

Research tells us that there needs to be a culture within the department or service that recognises the seriousness of vicarious trauma and that it is not just "part of the job" so that professionals have an outlet through which they can raise concerns and get help<sup>19</sup>.

It is noted that the response of the Head of Youth Offending to Chris's death was compassionate and timely, ensuring that the wellbeing of staff was a priority in short term service planning. This included access to group support and 1:1 therapeutic intervention, which again is noted as good practice.

There is a need to ensure that there is an organisational culture of self-care with access to high quality management and clinical supervision. It is important this exists across the organisation and not just within the Youth Offending Team and is considered an integral element of delivery with traumatised young people. This is further explored in the recommendations.

## **Metropolitan Police**

The following is an overview of significant contacts made with Newham and Lewisham police and relating to Chris.

- July 2016 - Chris was arrested after an allegation of serious sexual assault was made against him. The case resulted in no further action (NFA).
- July 2016 - Chris was questioned under caution for a robbery matter. The case resulted in no further action (NFA).
- November 2016 – Chris's mum made an allegation of assault against her by Chris and he was arrested. In police interview Chris claimed self-defence and stated that he had sustained injuries. No further action was taken by either police or Children's Social Care.
- On 01/12/2016 Chris was added to the gangs' matrix as a green nominal.
- December 2016 – Chris was identified as a suspect for robbery that occurred in August within Newham and questioned under caution. The case resulted in no further action (NFA).
- Chris was discussed at the Gangs Tactical meeting which took place on the 16/12/2016. Chris was then discussed at a Multi-agency Risk Vulnerability Panel (MRVP meeting)
- On 22/02/2017 a crime report was created following the information Chris's mother provided to a social worker regarding Possession with Intent to Supply (PWITS) which resulted in no further action (NFA). Chris was never spoken to regarding this alleged

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<sup>19</sup> Hoff, L. A., et al (2009) Violence and abuse issues: cross-cultural perspectives for health and social services. London: Routledge.

offence as it was not reported to police and a significant amount of time had passed between the incident and police being notified by other professionals.

- April 2017 – Chris was stopped, searched and arrested for possession of a knife for which he was convicted, resulting in a Referral Order.
- July 2017 – Chris was stopped and spoken to by police.
- August 2017 – Home visit by Newham gangs unit.
- September 2017 – Murder investigation launched.

In April 2016, a Police schools officer completed a comprehensive Merlin outlining concerns regarding Chris's escalating behaviour. This collated incidents going back to 2014 and so highlighted a pattern of increased risk taking behaviour and offending. This Merlin was assessed and 'RAG' rated as Red, indicating immediate concerns regarding Chris's welfare.

The Merlin was shared with Children's Social Care via Triage (MASH) and police highlighted their concerns stating that *"although this report was submitted in relation to the subjects ongoing behaviour which has raised concerns, my main focus is on his apparent involvement with (and vulnerability to exploitation by) gang members with whom he associates at Tunmarsh. Although he has not been linked to gang activity on police reports and he is not on the gangs' matrix, I believe the risk assessment should remain red - intervention is required ASAP to keep him away from gang members and reduce the risk of offending and or exposure to gang culture"*.

Newham Police were recorded as attending four multiagency meetings to discuss risks associated with Chris. Firstly, the Gangs Tactical meeting which took place in December 2016 and three presentations at the Multi-Agency Risk Vulnerability Panel (MRVP). Discussion at these meetings focussed on the information previously shared in Merlin reports and did not include all professionals who could have usefully contributed, including Children's Social Care despite being invited. Across all four meetings there were just three actions that were police related.

Feedback on the MRVP meeting, from Police and other agencies, is that the minutes do not accurately reflect the discussions that took place or the actions agreed and cannot be relied upon as an accurate reflection. The minutes reviewed within the SCR process did not include any detail on the sign off process or whether they were ever agreed as an accurate reflection of what was discussed and agreed. In terms of actions, one related to updating the police CRIS (crime record information system) which was recorded as completed. The two further actions, which relate to involving the school based police officer in discussions and sharing information across boroughs, were both recorded as 'delayed, not on track, not in control' suggesting they were never completed. However, it has been explained that actions are reviewed at subsequent meetings and if someone else or another agency has dealt with it or there is crossover it may be deemed as no longer required. The action is then closed but it will still be highlighted as red/incomplete against the original owner in the original minutes. It is therefore impossible, from the minutes, to conclude whether actions were in fact completed or what the outcome was.

Much of the concern for Chris's welfare and risk stemmed from the self-disclosure, to his mum and subsequently his social worker, that he had been coerced into selling drugs on behalf of 'gang elders'.

This information was verified by his mum, who also disclosed to professionals, although not directly to police, that she had intervened and disposed of the drugs, estimated to have a street value of approximately £600, including both crack cocaine and heroin. This prevented police from taking action including evidence gathering that could have supported investigation into those who supplied Chris with the drugs. Subsequently, Chris's mum stated that she was not prepared to share the names of the gang members involved until there were adequate risk management plans in place to safeguard Chris. Once the police were notified of the incident, the justified concern over the family's safety was noted and discussed with Chris's mum by police who offered reassurance that any disclosure of information would be handled sensitively; however, no action appears to have been taken by other key agencies, including Children's Social Care to develop or implement such a plan or to include Chris in this process.

Chris was first added to the Newham Gang Matrix in December 2016 as a Green nominal. His position on the matrix was determined by the available information and intelligence related to his offending and risk profile. In June 2017, new offences and the return to Newham from Lewisham, raised Chris to an Amber nominal.

The MPS Gang Operating Model prescribes that there are a range of actions that should be the response to those deemed to be an Amber nominal. Due to the restricted nature of this model, they will not be shared in full within this SCR.

Most action relates to enforcement activity but with offers of diversion from offending activity, including monthly home visits by an officer (where there is a specific and lawful basis to do so). In this case, one home visit is noted as having taken place, in addition to flagging on the Police National Computer and discussing tools such as anti-social behaviour agreements at the multiagency meetings that took place.



The family did recall and share with the Lead Reviewer another interaction with the police where Chris was spoken to with the aim of engaging and diverting him from offending, although this is not substantiated by other records. This meeting involved the police officer pointing to the chair that Chris was sitting in and informing him that another child to have sat there was now dead, an approach the family felt was unhelpful and insensitive. This is backed by evidence that approaches intended to shock or scare young people into reducing criminality, not only are ineffective but can increase risk and be more harmful than doing nothing<sup>20</sup>

One tactic now operational in Newham to respond to child criminal exploitation is Operation Anzen. This was in its infancy at the time of Chris's death, having been launched in July 2017. Operation Anzen seeks to support those who were identified as potentially being criminally exploited by a specific Newham based gang. Chris was not considered to meet these referral criteria and so was not referred. This is later referenced as an example of promising, emerging practice.

The Police are recorded as stating that 'it was felt that the most proportionate and established method of engagement with Chris and his family in order to deter Chris from further criminality was to adopt tactics in-line with the MPS Gangs Operating Model'.

Police are noted to have completed a Merlin in April 2016 outlining their concern prior to Chris being added to the gangs matrix, requesting support from other agencies that does not appear to have been delivered.

*It read "although this report was submitted in relation to the subject's ongoing behaviour which has raised concerns. My main focus is on his apparent Involvement with (and vulnerability to exploitation by/ gang members with whom he associates at Tunmarsh. Although he has not been linked to gang activity on police reports and he is not on the gangs matrix I believe that the risk assessment should remain red – intervention is required ASAP to keep him away from gang members and reduce the risk of offending and exposure to gang culture"*

## **Housing**

Newham Housing Options and Allocations were identified as a key agency in this SCR, although had had no contact with the family since 2011. As previously stated, Newham had provided the family with a number of temporary accommodation placements whilst they submitted bids through the Choice Based Letting (CBL) system. In 2011, the family were successful in their bid for a property and started their tenancy with East Thames Housing. The case was closed, in terms of housing, to Newham at that point.

During 2016 and 2017, when the risks of exploitation and gang association were escalating, Chris's mum approached her housing officer, at East Thames Housing, to explore options for an out of borough move. In December 2016, the Housing Manager (HM) was formally informed by the

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<sup>20</sup> Aos, S., Phillips, P., Barnoski, R., & Lieb, R. (2001). *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia: Wash. State Inst. Public Policy.

allocated social worker that a household member was at risk and wanted to explore moving options.

Supporting evidence was requested, from the social worker, on the same day to support East Thames Housing Review Panel (HRP) application. The HRP is a body of senior managers who review and approve applications for priority moves and management transfers. Children's Social Care requested evidence from the Police, Tunmarsh School and the Youth Offending Service on 22nd December. A supporting statement was received from Tunmarsh School on the 4th January but records held by East Thames Housing state that additional evidence was still outstanding from all other agencies.

A professionals meeting took place at Tunmarsh School on 6th February 2017 and agency updates provided. It was agreed that East Thames was to progress the HRP application and consider including Chris's maternal grandfather as a household member so that care could be provided to him by the family as his health declined.

It took a further seven working days for supporting evidence to be shared by Children's Social Care, and several weeks for the application to be made to the Housing Review Panel as evidence was still being sought from the police and Youth Offending Team. However, detailed police records make clear that written support for the move was provided, within days of the request, by the police to Children's Social Care.

On 7th March 2017 the East Thames Housing Review Panel (HRP) meeting took place and it was agreed that a direct offer of permanent alternative accommodation outside of Newham would be made. The next day an offer of temporary accommodation out of London (Harlow) was made to Chris's mum by telephone as no suitable permanent property was immediately available. This offer was refused as Chris was now living with his uncle in south London and it was felt another short term move would not be in his best interests. East Thames therefore agreed to continue to look for a suitable permanent offer of accommodation.

The Housing Manager attended all professional's meetings scheduled in the following months, keeping in touch with Chris's mum.

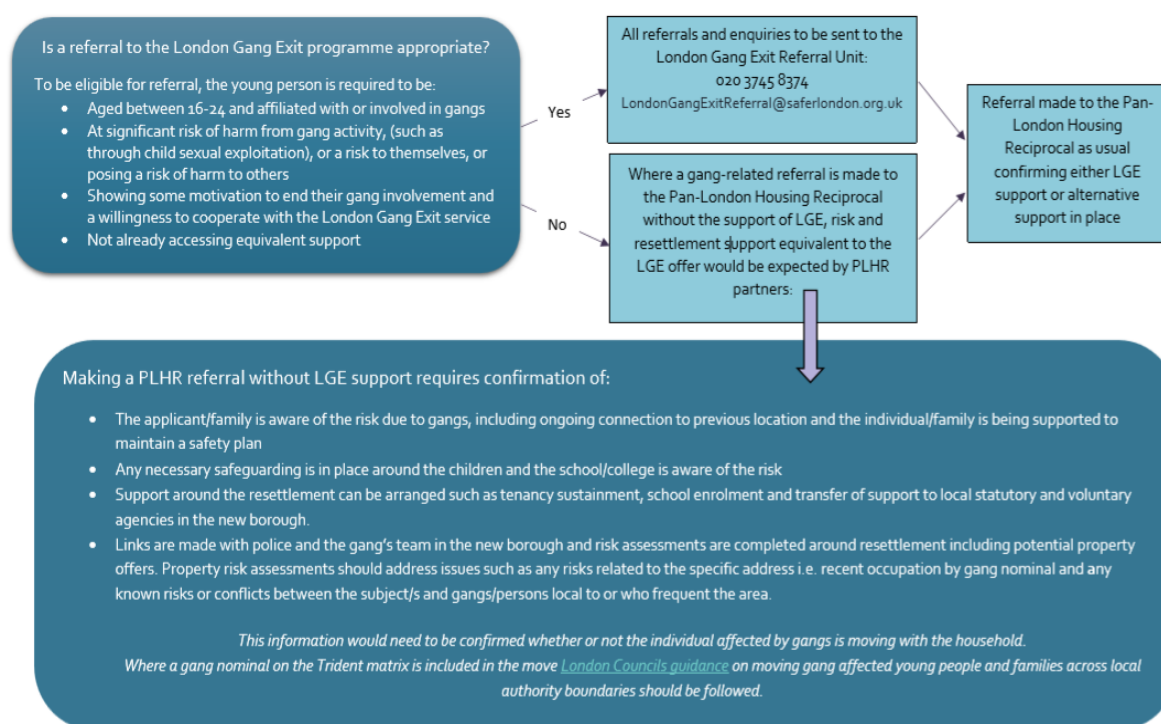
In June 2017, East Thames reported that a potential new property had been identified although this was then withdrawn as it was not, in fact available. Reasons for withdrawal are not clear. In a professionals meeting in July 2017, the Housing Manager states that they were informed that Chris was still residing in south London.

It wasn't until a subsequent meeting, on 24th August 2017, that the Housing Manager was informed that Chris was in fact back in Newham and at high risk. The Housing Manager requested supporting evidence from the Youth Offending Team at this meeting to take back to the East Thames Housing Review Panel (HRP) to update the case and review the action required. East Thames report that they never received the supporting statement from the police, despite communication between the Gangs Unit and Children's Social Care having taken place.

There are a number of possible reasons why an offer of a suitable property took so long, including the absence of timely and effective information sharing by professionals, the short supply of social housing stock and the proximity of East Thames Housing stock to both Newham and areas of identified risk based on the volume of relocations of gang affected young people out of Newham into Essex and surrounding areas and established County Lines drug markets in these areas.

One option available to East Thames, although it doesn't appear to have been taken up, was for referral to the Pan-London Housing Reciprocal, managed by Safer London.

This agreement allows social housing providers, such as East Thames Housing, to access stock owned by other providers on a reciprocal basis. It was specifically designed for cases such as these, where urgent moves are required to manage the risk of gang related harm and violence and where stock available to the original provider may not be available in a safe location.



Use of this process is clearly included in East Thames' policies and procedures, but does not seem to have been utilised in this case. Again, it is recognised that without up to date information, the Housing Manager was not in position to request this action as part of a reviewed risk management plan. It does not appear that anyone in the professional network supporting Chris was aware of this option and it was not discussed at any of the minuted multiagency meetings.

To ensure that use of the Pan-London Reciprocal Agreement is considered in cases of gang related harm or exploitation and where relocation is required beyond the borough borders or the areas where stock is concentrated.

## Youth Services

Chris attended local youth zone provision and was reported to be a well-liked and popular young person. Whilst he didn't attend any formal or structured provision, he was reported to enjoy socialising and supporting other young people. This was echoed in video interviews with his peers made after his death, with youth zone staff. Chris was a relatively new member, and it was hoped that he could have been supported and encouraged to get involved in more activities as he became more comfortable in the space and with staff and volunteers.

Frontline staff from youth services, who had direct knowledge and ongoing involvement with Chris, had not been invited to any multiagency meetings and were unaware of the escalating risks and vulnerabilities, nor was the information shared at the meeting cascaded down to youth workers by the senior staff that regularly attend these meetings.

Exploration of this with senior youth services staff highlighted a number of issues that contributed to this not happening including a variation of Chris's name being used in the MRVP meetings, and the variation being wrongly recorded in minutes. This meant that cross-referencing with youth zone records did not flag up that he was a user of local provision and so prevented those with direct contact with him being invited to meetings or information being shared as those in attendance did not realise that the case being discussed was in fact a young person they were engaging well with. Referrals to, and discussions at MRVP are also not recorded as standard on Azeus (the local Children's Social Care Case Management System). This means that when concerned professionals from the wider partnership are concerned about a child or young person, and review records on Azeus to inform next steps, they are not aware that risks are being managed through MRVP allowing for duplication and risking children falling through the cracks as partnership concerns are not recorded.

High quality youth work provides young people with safe spaces to explore themselves, the world they live in and their place in it and it appears that this work was positively underway with Chris. There was potentially a missed opportunity to enable youth work staff to work with Chris to address existing and emerging issues in an informal setting in which he felt safe, supported and engaged well. Had the full extent of the presenting risks been known to youth zone staff, a range of interventions and activities could have been scheduled to reduce risk and support Chris to make positive choices.

It was noted, both at the practitioners learning event and through information review, that the impression of Chris by youth work staff differed from that of other professionals. Staff were visibly shocked when they learned of the full extent of Chris's offending behaviour and described it as at complete odds with the young man they knew. This is stated to draw attention to the fact that young people can be loving, caring, well-liked children, commit dangerous and harmful offences and take part in harmful risk taking behaviour. These are not always mutually exclusive and work with young people must seek to understand these behaviours as symptomatic of underlying challenges

and difficulties, often linked to traumatic experiences and the complex and difficult worlds that young people are living in.

### Responding to Questions in the SCR Terms of Reference

- *To gain an overview of Chris's childhood that describes his care arrangements, family dynamics, significant events and relationships and the impact of these on his identity and development.*

It is clear that no assessment effectively explored Chris's childhood, family dynamics, significant events and relationships and the impact of these on his identity and development. Assessments were characterised with assumptions, false information and information with no context or analysis and so did not provide a realistic image of Chris. The opening and closing of his case, agency staff moving on and referrals from one agency to another also impacted on the potential for Chris to form meaningful, trusting relationships with those making decisions about his life. Chris is reported as being open and keen to engage, however, it is reasonable to assume (although cannot be guaranteed) that Chris may not have shared all of his worries, concerns and wishes with those involved in safeguarding him as they regularly changed and often started the assessment process over again rather than developing a deeper understanding of what life was like for Chris.

Childhood experiences, both positive and negative, can have a tremendous impact on future violence victimisation, perpetration and lifelong health and opportunity; it is noted that these experiences are by no means deterministic as there are multiple, and highly individualised, factors that impact on outcomes for children including wider family dynamics and relationships within and beyond the family. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences (ACEs)<sup>21</sup>.

Chris was observed by professionals to have low self-esteem, an insecure identity and sense of self but with no evidence as to insight regarding underlying reasons for this or an awareness of the potential impact of his early years, adversity, trauma and toxic stress on his development and how

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<sup>21</sup> <https://www.cdc.gov/violenceprevention/acestudy/index.html>

this presented in the context of his ADHD diagnosis. Key episodes from his primary education were not included in later assessments, nor were successful strategies built upon in later action plans.

Case files did not indicate that any genogram or ecomap work took place to explore relationships or connections in the community. This was a significant and crucial omission in the approach to understanding Chris's world.

- *To analyse how well Chris's individual needs and vulnerability factors were recognised and addressed in the assessments, interventions and plans that were made to support him.*

The intervention at Woodside Primary School was clearly highly personalised and tailored to meet Chris's needs and is noted as an example of good practice. Specialist intervention was also in place through health services to respond to his ADHD, with opportunity for additional therapeutic support which unfortunately wasn't accessed.

Violence prevention research undertaken by the Centre for Disease Control<sup>22</sup> identifies a range of individual, family and community risk factors for both violence victimisation and perpetration, many of which were present in Chris's life but did not feature in any significant way in assessments, planning or intervention beyond primary school and this was missed opportunity to deliver targeted work as part of a co-ordinated early help offer.

There was a theme of Children's Social Care and Youth Offending Team assessments taking a snapshot of Chris's life as it linked to the reported concern, rather than taking a more holistic and longitudinal approach to understanding and analysing underlying risk and vulnerability factors. As his holistic needs were never adequately assessed, there was limited opportunity to develop planned interventions that effectively responded to these needs.

- *To analyse critical incidents prior to Chris's death and comment on the quality and effectiveness of intervention and service delivery at these points and the impact for Chris.*

Analysis of key events are explored in detail throughout Chapter 3 and so are not further explored here. However, it is to be noted by way of an overview, that there is limited evidence of any intervention being effective beyond the single agency interventions to address single and isolated issues such as the medication prescription to address the symptoms of his ADHD, as part of a range of interventions by ELFT, which are noted as good practice.

The exception is the intervention and support in place at Woodside Primary School, that enabled Chris to excel in this setting in a way not observed after he transitioned to secondary education.

- *To analyse the quality, effectiveness and impact of work to protect Chris from criminal exploitation. Did those working with Chris view him primarily as a gang member or 'gang affected' or did they recognise that he was a victim of grooming and criminal exploitation?*

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<sup>22</sup> <https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>

There are reports in case files that do indicate that Chris was seen as highly vulnerable and was being groomed, most notably in the report shared by the Police schools officer with Children's Social Care. However, this wasn't consistently reflected in assessments or discussions and there is no evidence of any targeted work being undertaken with Chris to protect him from this potential exploitation making it impossible to analyse the quality, effectiveness or impact of such work.

Chris had self-disclosed that he was selling drugs on behalf of 'his elders' and indicated that he didn't want to and didn't know how to stop. He went missing for a week, returning with new clothes and expensive trainers but did not have an independent return interview and it remains unclear exactly where he was or what he did to acquire these possessions. There were clear indicators that Chris was being exploited, as well as making some risky decisions, not mutually exclusive concepts if the victim/perpetrator overlap is understood. There is significant police led activity, appropriately responding to emerging and escalating offending through enforcement action, as well as identification and sharing of information relating to his vulnerability to exploitation by older gang members. However, there seems to be little evidence that agencies effectively responded to Chris's experiences as a victim.

The missing episode should have triggered exploration of referral to the National Referral Mechanism<sup>23</sup> but didn't, suggesting that he wasn't seen through the lens of exploitation but as an offender.

The National Referral Mechanism (NRM) is a framework for identifying victims of human trafficking or modern slavery and ensuring they receive the appropriate support.

The NRM is also the mechanism through which the Modern Slavery Human Trafficking Unit (MSHTU) collect data about victims. This information contributes to building a clearer picture about the scope of human trafficking and modern slavery in the UK. The NRM was introduced in 2009 to meet the UK's obligations under the Council of European Convention on Action against Trafficking in Human Beings. At the core of every country's NRM is the process of locating and identifying "potential victims of trafficking". From 31 July 2015 the NRM was extended to all victims of modern slavery in England and Wales following the implementation of the Modern Slavery Act 2015, and so now incorporates child criminal exploitation.

It is clear that despite the concerns, across agencies, relating to Chris's vulnerability that the systems in place at the time of his death and ways of working in Newham did not effectively respond to Chris as an at risk child. Information from multiple sources, including the police and the Youth Offending Service, highlight the escalating risks and vulnerabilities for Chris and were shared with both Triage and Children's Social Care Social Workers. However, despite clear indicators of significant harm, social workers did not recognise that he was a victim of grooming and criminal exploitation and therefore did not respond to him as such by instigating strategy meetings to consider the emerging risks and put appropriate safeguards in place.

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<sup>23</sup> <http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism>

- *How well did Chris respond to the services that were offered to him? What was the quality of individual professional interaction with him and how well did he engage with individual professionals? Were Chris's voice, views, wishes and feelings sought and captured in their work with him?*

Chris was described at the practitioner learning event as an easy to engage, likeable, chatty, funny young man. He had a particularly positive relationship with staff from the Youth Offending Team and Youth Zone; staff reported that sessions would often overrun as Chris was so keen to talk and that he was open and forthcoming in these conversations. The film made by Youth Zone staff and youth people to remember Chris highlights the strong and positive relationships he had there despite the relatively short period of engagement. Again it is highlighted, that if those staff members had known the full extent of the risks facing Chris, they could have used these strong relationships to support Chris's understanding of risk, offer a range of positive activities to divert him, supported risk management strategies and better contributed to reviews.

A key element of effective practice is ensuring that the child's view of their situation is understood, acknowledged and effectively and compassionately responded to. Children do not always find it easy to articulate all of their worries and fears, particularly when closely linked to their family, friends, sense of self and identity. Despite Chris being described as a chatty young man, Chris's "voice" was rarely truly heard and even more rarely adequately responded to. It took real courage for Chris to tell his mum how scared he was of his 'elders' and how little choice he felt he had. It also took courage to subsequently explore this with professionals. Chris told professionals where he felt unsafe and still he was asked to attend those areas for professional appointments, albeit with additional safety measures in place. The courage that it took Chris to confide these things to adults cannot be underestimated.

Chris is often reported to have shared concerns to trusted, friendly and familiar adults, sometimes sharing information about other young people which could have in fact exacerbated and increased risk for him. Whilst steps were taken to keep him safe through referrals and meetings, he was not part of these referral process and nor was he invited to meetings. For Chris, he told adults he wasn't safe and then saw nothing happen. In the longer term, little changed for Chris and the risk grew rather than being reduced as he was excluded from mainstream education and became more entrenched in 'friendships' with older children and adults involved in gang related offending.

Chris is reported as being devastated when the offer of alternative accommodation was withdrawn. He had started planning where he would park his bike, how he would get to his new school and he was making plans with his family to start again when they were all safe. A child inevitably becomes dispirited when effort made to get adults to change something he cannot, ultimately makes no difference. This needs to be understood in the context of engagement with intervention in the latter months of his short life.

- *To evaluate whether the risk assessment and safety plans for Chris following his return to Newham were sufficiently prompt and robust.*



There are clear gaps in risk assessments and risk management plans for Chris, including the failure to update the Housing Manager of the need to expedite relocation as Chris has returned to the area. The Youth Offending Team is noted as developing a multidisciplinary safety plan and providing transport. Whilst this addressed the risks associated with attendance at his YOT appointments, it was not sufficient as an overarching risk management strategy to ensure his safety and wellbeing

A new approach to safety planning has since been developed by the Youth Offending Team, based on the Signs of Safety principles, with positive emerging feedback from young people who have used this new approach. However, this new planning document has yet to be reviewed or evaluated and so no conclusions as to its effectiveness can be reached.

- *To review the response to mother's request to be moved and whether this followed the protocol for urgent rehousing*

This is explored in depth earlier in this report and so will not be explored again here. To summarise, the response from East Thames Housing was appropriate, and in line with protocol, in relation to the referral to the Housing Review Panel. However, there was a significant missed opportunity in the absence of a referral to access the Pan-London Reciprocal Housing Agreement. There were also significant gaps in information sharing between Children's Social Care, the Police and the Youth Offending Team in relation to risk information that could have triggered such a referral. This prevented additional risk management strategies being explored or implemented and was not in line with the guidance on information sharing outlined in Working Together to Safeguard Children.

- *How well was the police intelligence about the involvement of Chris in drug supply used to inform protective plans for Chris; and how thoroughly was the information that mother provided in November 2016 investigated by the police?*

There was regular and high quality information sharing between the Police and Children's Social Care in the form of Merlins throughout Chris's life. However, there is no evidence that this information informed protective plans for Chris or his family beyond the enforcement led approach associated with his position on the Gang Matrix, which is likely to have included this intelligence in the scoring. Chris was not spoken to directly after the self-disclosure of drug supply, and his mum's need for safety before disclosing names was recorded as non-cooperation rather than a justified and appropriate safeguarding approach, particularly in light of the £600 drug debt Chris now owed. As information was not shared directly with police, they were unable to investigate and so, subsequently, no outcomes of investigation could be shared across the partnership or used to inform any intervention or planning beyond discussion at the Gangs Tactical Meeting and Multiagency Risk and Vulnerability Panel.

- *Are locally agreed pathways for support, protection and case management for young people sufficiently clear and were these followed between 2016-17? Are any changes to these arrangements required as a result of this SCR?*

It is in no way unique to Newham, but the pathways for support appear complicated and convoluted particularly for the uninitiated and those without expert local knowledge. Widely understood terms such as MASH (multiagency safeguarding hubs) are replaced with local terminology (Triage) and a multitude of acronyms and complex terminology describe other services making it very difficult for families to understand what is on offer and the focus of agency's attempts to engage them. It is noted by the Lead Reviewer that within the written submissions that informed this SCR, a variety of names were used to describe services and agencies which differ from their official names. This adds another layer of confusion, in an already complicated and confusing landscape that it is believed most families would struggle to comprehend.

For professionals, there also appears to be a degree of confusion, compounded by the widespread tendency to view risk taking adolescent behaviour primarily through the lens of offending and harmful peer groups through the lens of gangs, distorting understanding and responses. This resulted in several reports of concerns shared with Triage, being automatically signposted to the Youth Offending Team rather than allocated for assessment, which could have resulted in an earlier and more holistic response to emerging and escalating risks and vulnerabilities.

Generally, there appeared to be a sense of everyone trying to safeguard appropriately but with no overarching strategy or local guidance to follow in these multifaceted, but not unusual, adolescent cases where there is a complex interface between community and family risk.

It does appear that good use was made of the Multiagency Risk and Vulnerability Panel, with three referrals for consideration and discussion. However, it is questionable whether this panel is fit for purpose given that actions agreed are not evidenced to have made any discernible impact to Chris or his family. The terms of reference of this panel are aligned to that of Multiagency Public Protection Arrangements (MAPPA) and do reference safeguarding and safety planning, but still remain focused on offending rather than exploitation and associated vulnerability. Many actions did not seem to correlate to presenting issues or to take wider safeguarding concerns into consideration and there also appeared to be significant slippage in the completion of agreed actions, although this cannot be concluded with certainty given the poor quality minutes. As previously stated, there does not seem to be continuity or accuracy in the use of names of young people being discussed and Azeus (or other database) case reference numbers were not included to avoid confusion and ensure accuracy.

A full review of this panel is included as a recommendation.

- *What do Chris's mother and other key family members say about the effectiveness of agency involvement? Which services made a positive difference to him and what could have been better?*

The family view is that Chris required support from an early age. It was the absence of this support during his transition to secondary school, and the ineffectiveness of pastoral support in his secondary education that led him to a place where he struggled to regulate his own feelings and behaviour, subsequently leading to exclusion. The referral to the Tunmarsh School is seen, by the family, as a negative and unhelpful decision as it exposed Chris to a concentrated pool of young

people with complex needs and involvement in violent and drug related offending at a time when he was highly susceptible to peer pressure and exploitation. A view also held by professionals.

The family talk of positive engagement with professionals, including at the Tunmarsh School, but a lack of co-ordinated support. Chris's mum reported that she felt she was trying to hold it all together and was asking for help that never materialised despite lots of conversations and lots of meetings.

The family cite the support available at Woodside Primary School as excellent, and were disappointed this was not the blueprint for later support. The overall view of the family is that whilst they hold no agency or individual to blame for Chris's death, they do feel let down that support was not better coordinated and that they felt they had to battle services rather than being supported by them.

- *To consider whether the outcome of Chris's death have been predicted by any individual or organisation involved at the time and were there any missed opportunities that could have led to a different outcome*

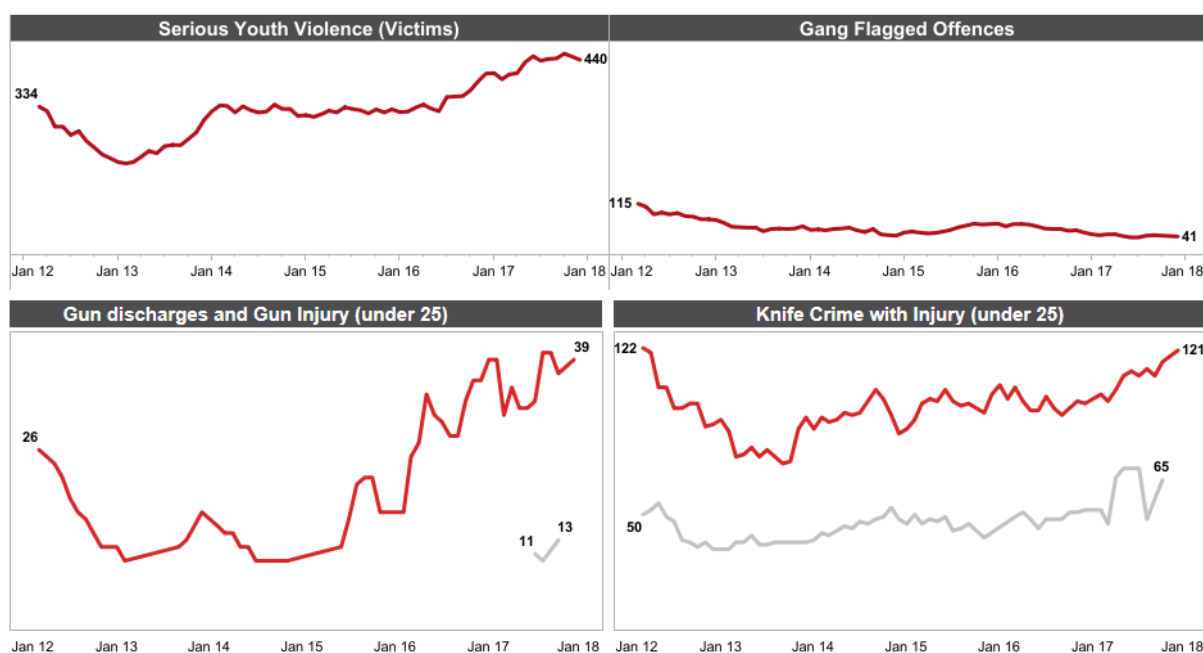
Whilst it is evident that there were complex risks, and there was multiagency agreement that Chris should have been relocated out of Newham, it is not believed there were any indications that Chris was at risk of being a victim of an assault with a firearm at the time of his murder, as such it is not felt there were key opportunities to have predicted or prevented this specific incident. It could be argued that if the family had been relocated he would not have been at the location of the murder; however, it is impossible to predict whether the move would have prevented him returning to Newham.

- *To be cognisant of the rise in serious youth violence in Newham and make recommendation from this review for the Community Safety Partnership and LSCB to ensure that a proactive and effective approach to preventing the criminal exploitation of young people in Newham is underway.*

Youth violence is a considerable issue in Newham as shown by the data collated by the Mayor's Office for Police and Crime (MOPAC)<sup>24</sup>

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<sup>24</sup> <https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/crime%20gangs-dashboard>



It was clear throughout the review process that responses to Chris's needs were consistently reactive, with little evidence of positive impact. Recommendations relating to a more proactive approach are detailed in Chapter 4.

## Issues on the fringes of the Serious Case Review

### Social Media

Social media was reviewed in relation to indirect threats to Chris made via Snapchat and WhatsApp and a Malicious Communications crime allegation was made and recorded in December 2016. This matter relates to Chris being arrested for theft of a phone from a person from another school and subsequently receiving indirect online threats.

There were also reports of aggressive and threatening language used in YouTube videos and in the comments fields linked to these videos. It is believed that these YouTube videos were posted after Chris's murder but a number of media outlets have referenced the ongoing use of social media, such as YouTube, as platforms to communicate threats and intended acts of violence in Newham. This has been linked to rising tensions between groups of young people believed to be gang affiliated.

A 2017 report by Catch 22<sup>25</sup> explores 'Social Media as a Catalyst and Trigger for Youth Violence' and makes a series of recommendations. These recommendations are included in full below as they are directly relevant to intervention to reduce violence and exploitation in Newham.

### Resources and training on social media

<sup>25</sup> <https://www.catch-22.org.uk/wp-content/uploads/2017/01/Social-Media-as-a-Catalyst-and-Trigger-for-Youth-Violence.pdf>

For adults with no knowledge or experience of social media apps, the task of getting to grips with young people's online behaviour must appear daunting. Yet providing professionals with a basic understanding of what social media apps are and what they do is not a particularly difficult task. These apps are expressly designed for ease of use: with a limited amount of instruction they can be downloaded with only a few clicks of a button and the basic functions are relatively simple to navigate. Training workshops that provide a basic yet comprehensive overview of the main social media applications should take no longer than half a day to deliver. The content, however, will require updating on a regular basis to keep pace with the development of online platforms

### ***Intervention***

Based on the current research, there seems to be a significant gap around the use of social media by parents, carers and professionals to engage with young people and pre-empt violent conflict. Policy and practice in the UK around social media intervention strategies appear to be lagging behind countries such as the USA. Recent research in Chicago, for example, provides evidence of how the effective use of social media by outreach youth workers is pre-empting and preventing serious incidents of face-to-face violence between young people. In short, youth workers in Chicago are using social media platforms as a way of picking up on early warning signs of increased tension between high-risk individuals and groups. Youth workers then act on this information by attempting to reduce the heat between young people and groups whenever real-life violence appears imminent. The frontline professionals participating in this research, however, reported being highly reluctant to use social media content to inform their frontline practice because they lack clear guidance on what is and what is not acceptable from an organisational and legal perspective.

### ***Suppression***

It is right that social media providers should remove content that violates their own community guidelines, for example, content that is violent or contains threats. However, it is equally important that young people do not feel that they are being unfairly targeted by those in positions of power and authority, for example, social media providers and the police. This is particularly important given the pressing need to protect and enhance the legitimacy of the police in the eyes of young people. If professionals can proactively engage with young people to prevent them from uploading inappropriate content (as defined by the community guidelines provided by each social media platform), then this should be seen as preferable to simply responding reactively by removing such content. Some decisions concerning whether or not to remove the type of content described in this report may be relatively straightforward. Others, however, may fall into a grey area. To enhance the legitimacy of a platform's decision to remove or allow certain content, platforms may benefit from some form of consultation with young people themselves to establish relevant criteria for making such judgements. As and when certain content is removed by social media platforms, the relevant user should be provided with a clear and specific rationale as to why the content breached the relevant guidelines.

Parents, carers and a wide range of professionals should encourage young people themselves to report online content that displays or incites serious violence. The major social media platforms

already have processes in place for users to report inappropriate material. However, in the case of some platforms, the guidance given to young people is to contact the police to report any concerns about illegal activity or violent threats. Inevitably, many young people will be reluctant to contact the police about activity that they view online, both because of the time and effort required to do so and because of concerns around their own anonymity and fear of any potential repercussions around being labelled a 'snitch' by their peers. With this in mind, young people ought to be able to report this type of content anonymously and directly to the social media provider, who should then be under a duty to engage with the police when appropriate.

Newham do already have Social Media Single Points of Contacts (SPOCs) who monitor social media closely. This is managed through specially trained officers within Newham Gangs Unit. The Gang Unit work closely with Operation Domain and where possible they attempt to remove the post, download and transcribe relevant inappropriate social media posts. Operation Domain is an ongoing successful Metropolitan Police Service project taking action against gang-related activity online, working with social media companies to remove relevant content.

## **Harmful Sexual Behaviour**

Whilst Harmful Sexual Behaviour (HSB) was not included in the Terms of Reference for this SCR, it did feature in IMRs and in decision making relating to the case.

Harmful sexual behaviour includes:

- using sexually explicit words and phrases
- inappropriate touching (of themselves or others)
- using sexual violence, threats or intimidation
- penetrative sex with other children or adults.

Sexual behaviour between children is also considered harmful if one of the children is older – particularly if there is more than two years' difference in age or if one of the children is pre-pubescent and the other isn't<sup>26</sup>.

A study by Hackett et al (2013) of children and young people with harmful sexual behaviour suggests that two-thirds had experienced some kind of abuse or trauma including family breakdown and parental rejection<sup>27</sup>, both experiences are recorded as having an impact on Chris in relation to his father.

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<sup>26</sup> Davies, J. (2012) Working with sexually harmful behaviour. *Counselling Children and Young People*, March 2012: 20-23.

<sup>27</sup> Hackett, S., Phillips, J., Masson, H. and Balfe, M. (2013) Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review*, 22(4): 232–245

Whilst there was a clear referral made, by the Tunmarsh School to Children's Social Care, outlining several examples of harmful sexual behaviour, it does not appear that any assessment or planning took place to respond to this which is deeply concerning. It did not feature in the AssetPlus assessment completed by the Youth Offending Team and was not referenced on any action plan, despite the YOT case worker being trained in HSB (AIM model<sup>28</sup>). It is recognised that work with Newham Youth Offending Team had only begun three months prior to Chris's death and that this may have been a feature of future work once a relationship with Chris was established and other risks had been addressed.

Chris is noted in case files as struggling with his transition from boyhood to manhood, and his perception that his mum didn't always understand this transition and the impact of his hormones and sexual development on his identity and choices. His self-identification of this as an issue would suggest he may have been open to some sensitive and gendered intervention around masculinity, healthy relationships, consent and other issues around sexual behaviour.

The Good Lives Model, is recognised as a model of best practice and is grounded in positive psychology and strengths based approaches. This is used by several specialist support programmes that could be commissioned in Newham and could create a bespoke pathway to support for young men.

One example is the Safer London<sup>29</sup> Young Men's Project, which provides assessment and intervention as well as case management for young men aged 11-18. Dedicated case workers are able to build rapport with young men based on a support offer that addresses holistic and gendered needs rather than as a response to offending. Intervention is then incorporated into multiagency action plans rather than being delivered in silo (although issues of confidentiality limit information sharing beyond safeguarding and risk). Caseworkers, who are co-located within local services, are also able to build professional networks and to be fully integrated into support structures including attending strategy and other professional meetings.

## **Confidentiality and the Security of Information**

It came to light, during the SCR process, that there was a significant issue concerning a data protection breach relating to Chris and other young people in Newham. A copy of the Gangs Matrix, which is shared across the local partnership to support multiagency working, was mislaid by an unknown professional and was acquired by an unknown member of the public. It was subsequently photographed and shared on social media, accessed by unknown individuals but is believed to have been accessed by a number of young people. The Gangs Matrix included information including names and gang affiliations.

It is believed that this data protection breach occurred prior to Chris's murder but was not known to professionals at that point. Whilst there is no evidence to suggest there is causal link between the

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<sup>28</sup> <http://aimproject.org.uk/>

<sup>29</sup> <https://saferlondon.org.uk/services/young-mens-service/>

data breach and Chris's murder, it is acknowledged that are lessons to be learned and so a full enquiry into how this occurred has taken place across agencies in Newham. A criminal investigation commenced in relation to the circumstances surrounding the data breach with the aim to identifying how the breach occurred and if any offences had been committed. The breach was referred to the information commissioner.

A number of changes in practice and protocol have since been implemented including changes made to the information shared relating to the Gangs Matrix.

## Chapter 4

### Conclusions

The antecedents to this tragic event include a complex constellation of risk factors requiring an analysis of the interaction between community risk factors, family functioning, protective factors and professional intervention. There is limited evidence that this analysis took place or that any intervention was put in place to effectively reduce the risks to Chris.

Despite hundreds of professional hours provided by a multitude of people, discussion at dozens of meetings over several years and provision of multiple forms of support (albeit with limited intervention), little changed for Chris and risk was not effectively managed as evidenced by an upwards trajectory of risk and offending. Poor quality assessments and reviews were regularly confused with intervention and activity with progress. It does not appear that professionals paused to consider fundamental questions such as 'what are the underlying risk factors here?' 'What needs to change and why?' 'What does good practice look like and are we seeing it?' 'Is what we are doing working and if not, why not?' 'What do we need to do differently?'

It seems that review processes, often not even named as such, were actually discussion and activity planning sessions and did not address the quality or effectiveness of the few interventions in place, this is not in line with the guidance in *Working Together to Safeguard Children*<sup>30</sup> which states that a good assessment will monitor and record the impact of any services delivered to the child and family and review the help being delivered. They did not effectively consider whether Chris was developing increased resilience, improved engagement in positive activities including education, a sense of safety, positive and healthy relationships, positive sense of self, improved family dynamics and a positive outlook for the future.

Review of assessments, plans and meeting minutes show that when one agreed action was unsuccessful, or not agreed to by the family, it tended to be replaced with another solution without the underlying issues that it was intended to address having been fully identified and quantified. Often these were simply professional actions and not interventions; there was, therefore, no

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<sup>30</sup> [http://www.workingtogetheronline.co.uk/chapters/chapter\\_one.html](http://www.workingtogetheronline.co.uk/chapters/chapter_one.html)



objective way of monitoring the effectiveness of any plan and no sense of coherence, integration, or clear purpose focused on Chris's welfare and wellbeing. In this case, there is no evidence that any of the resources being committed to the case were improving Chris's situation.

## Emerging and Promising Practice

The process of reviewing and revising local approaches to supporting young people at risk of criminal exploitation is already underway across the London Borough of Newham with a number of examples of emerging and promising practice.

### Newham Safeguarding Children Board – Professional Development

The Newham Safeguarding Children Board has reviewed its training offer and ensured there is access to specialist training in a number of areas explored within this SCR. This offer is available to staff and volunteers across the Local Authority and the Voluntary and Community Sector (VCS).

Training that has been delivered, often by external specialist providers, includes:

Session	Aims and Objectives
<b>Child Death Overview and Serious Case Review</b>	<p>The death of a child is a tragedy. It is vital that all child deaths are carefully reviewed. This is so that we may learn as much as possible from them, in order to better support families and to try to prevent future deaths' (The Lullaby Trust 2016)</p> <p>Training Level: 2</p> <p>Learning Outcomes:</p> <p>By the end of the session participants will:</p> <ul style="list-style-type: none"> <li>• Have increased knowledge around Health and Safety and keeping children safe.</li> <li>• Be aware of the numbers of child deaths in Newham and have an understanding of current trends identified.</li> <li>• Have an understanding of the Child Death Review Process, the role of the CDOP, the role of staff involved with a child death and its value to Public Health and Improving Child Safety through Prevention</li> <li>• Understand the difference between Serious Case Reviews and the child death overview process</li> <li>• Have an improved understanding of risks and the possible pitfalls in multi-agency working to protecting children and young people</li> <li>• Explore the lessons learned from SCR's and local Learning reviews to reflect upon what they mean for their agency and their own practice</li> </ul>
<b>Working with Children and Young people who display sexually harmful behaviour</b> - 2 sessions	<p>The training was designed to enable delegates to have a better understanding of what is normal sexual behaviour from potentially abusive sexual behaviour. It provides information around the prevalence and possible onset of the behaviour with regard to young people who abuse</p> <p>The session provides an understanding of legislation, policy and procedures which govern this area which supported staff in managing risk and promoting positive behaviour</p> <ul style="list-style-type: none"> <li>• Greater confidence to engage positively with young people with sexually harmful</li> </ul>

	<p>behaviour</p> <ul style="list-style-type: none"> <li>• Critically reflecting on attitudes and beliefs</li> </ul>
<p><b>Introduction to CSE</b> – 2 sessions</p>	<p>This half a day training session enables participants to develop a greater awareness of CSE, equipping professionals with tools to develop effective responses. Throughout the training you will be encouraged and supported to consider how your own practice can best address and support children and young people at risk or experiencing CSE.</p> <p>As a result of the training, you will:</p> <ul style="list-style-type: none"> <li>• Identify risks and indicators for young people experiencing or at risk of CSE</li> <li>• Analyse roles of young women linked to gangs and relate to experiences of CSE</li> <li>• Recognise opportunities for early intervention</li> <li>• Demonstrate an effective response to disclosure of CSE</li> </ul> <p>Contextualise responses to CSE within your local referral process</p>
<p><b>CSE for professionals and safeguarding leads</b> – 3 sessions</p>	<ul style="list-style-type: none"> <li>• Identify risks and indicators for young people experiencing or at risk of CSE</li> <li>• Analyse roles of young women linked to gangs and relate to experiences of CSE</li> <li>• Recognise opportunities for early intervention</li> <li>• Investigate safety planning tools</li> <li>• Demonstrate an effective response to disclosure of CSE</li> <li>• Contextualise responses to CSE within your local referral process</li> </ul> <p>This one day training session enables participants to develop a greater awareness of CSE, equipping professionals with tools to develop effective responses. Throughout the training you will be encouraged and supported to consider how your own practice can best address and support children and young people at risk or experiencing CSE.</p>
<p><b>Criminal Exploitation</b> – 6 sessions</p>	<p>In 2017, the Government introduced national guidance to help identify and protect those exploited through criminal exploitation. This guidance is part of the cross-government approach to ending gang violence and exploitation.</p> <ul style="list-style-type: none"> <li>• How young people are targeted to join groups.</li> <li>• The business model of county lines and how this operates.</li> <li>• The safeguarding response to Criminal Exploitation</li> <li>• The signs and triggers to be aware of with regards to those who are involved and/or at risk of county lines.</li> <li>• The strategic and tactical plan to address Criminal exploitation.</li> <li>• How Youth violence and exploitation is evolving;</li> </ul> <p>A key outcome of the workshop, will be to identify individuals to be champions, and act as a point of reference to signpost colleagues for further information, advice and guidance. This workshop is delivered by Newham Youth Offending Team.</p>
<p><b>Effective Engagement with Families</b> – 3 sessions</p>	<p>The critical role played by practitioners in engaging and communicating with families has been highlighted in findings from serious case reviews and is at the heart of many Early Help strategies. Engaging families with high levels of need can be challenging though and the way we communicate with parents is often critical. This course aims to support practitioners to feel more confident in this task. It</p>

	<p>provides an opportunity to stand back from the detail of the work and reflect on how we engage in these relationships and what gets in the way of successful engagement.</p> <p>By the end of the course the learners should be able to:</p> <ul style="list-style-type: none"> <li>• Describe what is meant by engagement and, therefore, what is meant by “effective engagement with families”</li> <li>• Describe the variety of ways in which families do not engage and co-operate and why families may exhibit difficulties in engaging</li> <li>• Recognise the barriers that working with difficult to engage families causes in keeping the child at the centre of the work</li> <li>• How to progress risk assessments whilst working to facilitate change and improve engagement</li> <li>• Develop the skills to manage and diffuse highly charged and difficult situations</li> <li>• Ensure that practitioners have a further insight into disguised compliance</li> </ul>
<b>Understanding Gangs and Youth Violence and County Lines</b> - 4 sessions	<p>The aim of this course is to raise awareness of the issues involving young people and serious youth violence and gangs in Newham. This course will help attendees to identify and develop the key skills and techniques required to work with those involved in the aforementioned activity.</p> <ul style="list-style-type: none"> <li>• Be aware of the historical background to Serious Youth Violence</li> <li>• Be able to identify Grooming and Initiation – Female exploitation</li> <li>• Identify appropriate Intervention programmes</li> <li>• Understand what processes and interventions are in place to support practitioners</li> <li>• Identify at the earliest stages possible whether a young person is involved in gangs, serious violence and County Lines</li> <li>• Understand the reality of youth violence locally, whilst debunking media hype</li> <li>• Increase awareness of the involvement of Newham gangs in county lines and the resulting risk for young people</li> <li>•</li> </ul>

### Alternative Provision

Significant development has been underway at Tunmarsh School with a wide range of strategies and approaches now in place to better respond to criminal exploitation and serious youth violence (SYV)

- A new additional PRU provision (APPLE) has been developed and piloted over the past year aimed at ensuring those pupils who are identified as high risk and not able to attend onsite group provision at either of the Newham PRUs sites, are able to access a 25 hour supervised education provision at a location out of Newham in Essex. Pupils are securely transported there and back by minibus every day by staff and 25 hour education provision has been developed to ensure that bespoke, personalised curriculum which meets needs of individual pupils is in place. One year of data is available from this programme which commenced on 4th October 2017. This provision has been developed in response specifically to the safeguarding concerns of those pupils not able to attend onsite group provisions due to the perceived risks to self or others. This was the case for Chris. No additional funding has been

available for this provision so it has been funded by making cuts to other PRU provisions and through PPG (Pupil Premium Grant). PPG funding is neither secure nor adequate to sustain this provision as the PRUs do not receive any PPG for the majority of our eligible pupils as they are dual registered. PPG for those pupils remains with their mainstream school.

- In response to serious concerns raised by the PRU relating to risk for increasing number of PRU Pupils, the Local Authority proposed a second education hub at Shipman Centre which was then managed by Newham PRUs. This Hub provided additional offsite education provision capacity for those pupils identified as being associated with serious safeguarding SYV risks. The hub provided 25 hours supervised education provision and pupils were transported by minibus to and from the provision with pick up points around Newham. This hub provision ran for 10 weeks until funding was withdrawn.
- The Head Teacher of Newham PRUs together with 'EduKit' has established and chaired a working group to address issues around PRUs and SYV, gang and knife crime, and to share / develop improved practice in responding to these issues within PRUs and education. Representation in this working group includes Metropolitan Police (Trident), Greater London Authority, Mayor's Office for Police and Crime, OFSTED, London PRU Head Teachers and Designated Safeguarding Leads, Newham Schools Police. Outcomes to date from this working group include a pupil-led PRU Safeguarding Conference in July, held in central London to promote and raise the profile of PRU pupil voice specifically around the key issues related to SYV, gang and knife crime. Pupils from PRUs across London are now working together to organise a conference to be held in central London Google Headquarters with the aim to enable direct dialogue between themselves and those in authority in relation to these matters including the London Mayor, Police, Government Ministers etc. There is also further exploration taking place about how the APPLE provision could be replicated to support additional capacity for PRU Pupils across London.
- Intensive targeted intervention courses based on the main referral reasons to PRUs have been developed by Newham PRUs multi-disciplinary team (Educational Psychologist, Clinical Psychologist and Speech and Language Therapist), and are delivered as a rolling cycle of therapeutic interventions to all pupils attending Newham PRUs. This suite of courses is referred to as STIC (Short Targeted Intervention Courses). They run on top of the academic curriculum and include courses on:
  - Resilience - all pupils attend this programme - managing emotions including anger and responding to ACEs
  - Choices and Consequences (looking at offending behaviours)
  - Relationships - with focus on healthy relationships and issues around harmful sexual behaviours and child sexual exploitation
  - Self-Management - responding to internal emotions, impulses and responses including anger, aggression, defiance etc.
  - Social Communication - issues around speech and language learning needs and effective communication

### **Metropolitan Police Service – Op Anzen**

The delivery of specialist police diversionary intervention is now well established in Newham, as part of Operation Anzen.

Operation Anzen was set up to identify, tackle and safeguard young people affected by 'County Lines' drug dealing and try to implement diversion strategies for them. So far, this approach has been deployed in three boroughs Enfield, Newham and Lambeth, with further roll out planned. A Vulnerability Assessment Tracker has been introduced in each of the three boroughs that identifies subjects and enables any officer to input relevant information around their engagement and ensures they are dealt with effectively. It does not operate off the 'Gangs Matrix' as people are identified when they come to police notice, generally from Merlin reports rather than waiting for offending to escalate.

Early indicators are that this seems to be a particularly effective piece of work and is locally assessed as contributing to the reductions of missing persons.

### **Children's Social Care - Exploitation Response**

Additional development is also underway relating to new guidance as set out in Working Together to Safeguard Children, which was revised and issued during the course of this SCR. This is outlined in Appendix 2 alongside an overview of proposed work to respond to contextual safeguarding concerns. Analysis of proposed changes is not within the scope of this SCR.

At the time of writing this report the author has been informed that social workers in Children's Social Care are now provided with access to reflective supervision when working with young people who are at risk of exploitation. This is provided by an independent, experienced and suitably qualified professional. This is considered an example of good practice that could be built on, as it relies on the identification of cases as having features of Child Criminal Exploitation and is a key opportunity to improve practice across Social Care.

## Recommendations

### **1. The board should explore, through discussion, debate and professional development initiatives, ways of improving professional competence in assessment across services.**

Options to be considered include the regular sharing of good practice as well as peer led audits undertaken using a bespoke audit tool developed by the NSCB. Recent professional development activities, under the title of 'Obsession with Assessment', in the neighbouring London Borough of Havering, have shown promising early indications of improvement in the approach to and quality of assessments and is a useful starting point for building on what works.

Specific emphasis will be on:

- The importance of understanding early years and development in adolescent safeguarding
- Engaging young people and families in assessment and decision making, ensuring their voice is heard
- Assessment of contextual safeguarding concerns and understanding the impact of environmental/community factors on young people's welfare and wellbeing
- The offending/welfare overlap, including deepening understanding of patterns of offending such a multiple no further action (NFA) outcomes in the context of risk and vulnerability
- Professional curiosity and analytical skills
- Understanding and exploring risky or challenging behaviour through the lens of trauma

### **2. To undertake a full review of the Multiagency Risk and Vulnerability Panel (MRVP)**

A review should be undertaken at the earliest opportunity to analyse the effectiveness of the MRVP. This should include an audit of independently selected cases and the outcomes achieved through MRVP actions as well as consultation with existing panel members and referrers to explore the effectiveness of the process. Learning from this must inform any development of new or additional panels, forums or processes for multiagency consideration of risks and vulnerabilities.

### **3. To strategically and operationally realign work with young people at risk of child criminal exploitation (CCE) with CSE, and to consider the creation of a contextual safeguarding hub.**

Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships

that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships. Therefore children's social care practitioners need to engage with individuals and sectors who do have influence over/within extra-familial contexts, and recognise that assessment of, and intervention with, these spaces are a critical part of safeguarding practices. Contextual Safeguarding, therefore, expands the objectives of child protection systems in recognition that young people are vulnerable to abuse in a range of social contexts<sup>31</sup>.

Such a hub could perform the following functions:

- To coordinate Newham's response to Child Criminal Exploitation and the overlap with missing children, trafficking and serious youth violence, acting as a central point for information collation and sharing as well as for expertise and information.
- To support the Local Authority and Local Safeguarding Children Board in achieving a consistent and effective multi-agency response to CCE, including the prevention, identification and disruption of criminal exploitation as well as supporting, where appropriate, the prosecution of perpetrators.
- To act as point of contact for the children's workforce in Newham on matters of CCE.
- To raise awareness regarding CCE across organisations and to contribute to basic and advanced multi-agency training. To contribute to the training and awareness strategy including development of the CCE Champions Network (see later recommendation).
- To ensure effective implementation of a CCE strategy and associated procedures across Newham. Identifying any barriers, establishing, proposing and implementing solutions to ensure children and young people receive the best response.
- To develop and implement improved support to foster carers and parents to understand and manage complex areas of risk with children who have experienced or are at risk of CCE, Missing & Trafficking.
- To maintain datasets on CCE and to contribute to the promotion of better understanding of the nature of CCE in Newham analysing local data and trends.
- Using data ensuring effective preventative action is taken to avoid escalation of concerns and protect children and young people from being exploited. To identify unmet need and provide analysis and potential solutions to Operations Managers, Service Managers and the LSCB.
- To contribute to complex strategy meetings for child criminal exploitation. Coordinating the response of all agencies to exploitation and ensuring the individual child or young person is safeguarded as well as addressing the development of effective disruption plans. This includes taking the lead implementing victim plans and risk assessments along with partner agencies.

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<sup>31</sup> <https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding>

- To ensure all agencies response to CCE is coordinated in a clear, concise, efficient and effective manner. Ensuring the right children, get the right service, at the right time, with a focus on early identification and intervention.
  - To monitor individual children's cases where child criminal exploitation, frequent missing episodes and trafficking has been confirmed as a concern.
  - To coordinate support to victims of CCE through the criminal and family court process. Ensuring the voice and experience of children is listened to, heard and understood.
  - To debrief and complete an analysis of complex operations to ensure the experiences of children, young people, parents/carers and practitioners are captured. To ensure learning from complex operations is communicated and practice improves for children.
  - To oversee the effective use of the National Referral Mechanism (NRM) in relation to child criminal exploitation; ensuring the outcome of NRM is recorded, communicated and understood.
  - To represent Newham at regional forums
  - To explore best practice and national research to inform local responses to CCE, Missing & Trafficking.
- 4. To ensure that there are appropriate policies, procedures and pathways in place for children and young people at risk of gang affiliation and criminal exploitation, recognising that there is often an overlap.**

It is essential that there is an overarching strategy in place that recognises the complexity of child criminal exploitation, the need for effective and evidence based intervention at the earliest opportunity and the need for well-coordinated joined up working. Young people affected by crime, violence and criminal exploitation should be consulted on this strategy and their voice included in its development.

This strategy should be accompanied by clear policies, procedures and pathways that are easily accessible and understood using plain English. These should include information on evidence based intervention and risk management options aligned to points of critical decision making and with a focus on early opportunities for intervention. Where existing processes are to be replaced, there should be a clear rationale and a thorough understanding of why they were not effective. This is to ensure that ineffective systems are not replicated or duplicated.

- 5. To ensure that there is access to independent return interviews after young people return from missing episodes linked to child criminal exploitation.**

It is important that professionals from across the partnership understand the difference between safe and well checks and independent return interviews and that best practice in working with children who go missing is understood locally. Much of this draws from work with sexually exploited children and young people, presenting a key opportunity to learn from this area of work and apply it in other contextual safeguarding contexts.



**6. To consider the current capacity of specialist case work in Newham that offers flexible and culturally competent engagement opportunities for gang affected and exploited young people using established and evidence based practice models.**

Whilst it is essential that messaging consistently reinforces that safeguarding criminally exploited children is everyone's role, there is an acknowledgement that engagement and intervention is often best delivered by those with particular skills and expertise in working with this cohort of young people. It is important that the partnership understands where this expertise currently sits and to ensure that there is sufficient capacity to keep pace with the need for case work as awareness is raised across agencies. This should include the Voluntary and Community Sector, with additional support offered to ensure local capacity and capability working with this group of young people.

There may be a need to consider the commissioning of additional case work support and to ensure access to support through initiatives commissioned at a regional government level such as the recently announced 'Out There Response and Rescue'<sup>32</sup> service. This project will deliver a pan-London 'county lines' service to support vulnerable young Londoners exploited by criminal gangs. This project will be the first large scale county lines service that brings together police intelligence analysis, London boroughs and specialist voluntary and community organisation to tackle this complex issue. It is essential that clear referral pathways are locally established and accessible to staff across the children and young people's workforce, not just within Community Safety Partnership.

It is recognised that there is a paucity of evidence based best practice in working effectively with criminally exploited children and young people as this is a relatively recently acknowledged issue. However, there is strong evidence for practice approaches that address the complex needs of adolescents living with adversity and multiple, contextual and community based risks.

It was not within the scope of this Serious Case Review to fully explore all existing and emerging practice approaches; however, there are key (and overlapping) approaches to be considered by the partnership and consideration given to how they could be best implemented across the Children's workforce in Newham to achieve improved outcomes for criminally exploited children and young people.

Contextual Safeguarding (as previously explored)

Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.

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<sup>32</sup> <https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/community-safety/crime-prevention/london-crime-prevention-fund>

Therefore children's social care practitioners need to engage with individuals and sectors who do have influence over/within extrafamilial contexts, and recognise that assessment of, and intervention with, these spaces are a critical part of safeguarding practices. Contextual Safeguarding, therefore, expands the objectives of child protection systems in recognition that young people are vulnerable to abuse in a range of social contexts.<sup>33</sup>

### Relational Social Work

Relational social work engages with existing networks to enhance their resilience and capacity to resolve difficulties. It does this by addressing the identified problem, and by engaging, mobilising and developing both supportive and problem-solving networks.<sup>34</sup> This is not a new model, and underpins much existing social work practice but could be better used to support complex adolescent safeguarding.

### Family Group Conferencing

A family group conference is a process led by family members to plan and make decisions for a child who is at risk. Children and young people are normally involved in their own family group conference, although often with support from an advocate. Conferences could be better used to empower families to explore risk and put appropriate plans in place to respond to emerging risk.

### Trauma Informed/Responsive Practice

Trauma-informed practice is well described by Pippa Goodfellow<sup>35</sup>, in relation to how it can support young people involved in risky and harmful behaviour and offending. She explains that implementing trauma informed practice involves awareness raising and training, the provision of safe environments, reducing the scope for re-traumatisation and the coordination of provision designed to increase resilience and support. Trauma-informed approaches can be thought of as incorporating three key elements: an understanding of the prevalence of trauma; recognition of the effects of trauma both on those affected and on those who work with them; and the design of services which are informed by this knowledge.

She goes on to explain that by addressing the emotional and psychological needs of young people, services can enable them to better manage their emotions and behaviour as a first step towards making other long-lasting positive changes in their lives. Trauma-informed approaches that seek to build young people's strengths and attachments can help to minimise the impact of their traumatic experiences, reducing the likelihood that they will continue to engage in high-risk and anti-social behaviour. With more insight into how traumatised young people behave, staff can work more effectively with them, thereby helping them to gain an understanding of their behaviour, take responsibility for themselves and develop negotiated, positive relationships.

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<sup>33</sup> <https://www.beds.ac.uk/ic/current-projects/contextual-safeguarding-programme>

<sup>34</sup> <https://www.cambridge.org/core/journals/social-policy-and-society/article/relational-social-work-principles-and-practices/B04E89F2198581797B1692CC4A80B2E1>

<sup>35</sup> <http://www.beyondyouthcustody.net/blog/childhood-trauma-offending/>

Work is currently underway with the Youth Justice Board to improve understanding of trauma across Youth Offending Services and to ensure that trauma is considered when assessing young people's needs. However, to be effective trauma informed practice needs to be considered at an organisational level and embedded in practice across agencies and disciplines.

Research is currently underway, by specialist clinical psychologist Dr Karen Treisman, on best practice in trauma-informed practice at an organisational level and it is recommended that the outcomes of this research are reviewed by the partnership when published<sup>36</sup>.

### AMBIT Model

Adaptive mentalisation-based integrative treatment (AMBIT)<sup>37</sup> incorporates practices of mentalisation-based treatment to address the needs of chaotic, complex and multiply comorbid young people, such as those in gangs, via team-based (predominantly outreach) multimodal practices. Mentalisation refers to a form of imaginative mental activity about others or oneself, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons). Mentalisation offers an integrative theoretical framework that is easy to train and can be applied with positive outcomes across individual, family, social-ecological and inter-professional domains. Mentalisation is primarily relational, placing great emphasis on the therapeutic relationship between worker and young person.

AMBIT is a team-based approach, adopting an alternative position to the conventional notion of the "team around the family" – instead creating a "team around the worker". In most cases a single keyworker works with the young person, the family and the wider network, so as to reduce the opportunities for families to feel overwhelmed by the multiplication or duplication of workers, or to be distracted by the different emphases, or frank disagreements, of different workers.

### **7. Where multiple risk indicators exist, consider additional transitional support between primary and secondary education with a focus on reducing the risk of Child Criminal Exploitation (CCE) and gang affiliation.**

There is a wealth of guidance on best practice supporting transition and this should be considered by a time limited task and finish group. The group's purpose is to collate and consider best practice and how this could most usefully be disseminated locally. The group should also look at the particular issues involved in the transition from mainstream to alternative provision, particularly through managed moves and how these impact on risk across the cohort of students attending alternative provision. The outcomes from this group should inform strategic planning for meeting the needs of children at risk of exploitation, including advocacy for resources as required.

### **8. Consider the need for a full review of PRU provision in the borough to ensure it meets the local need**

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<sup>36</sup> <https://www.wcmt.org.uk/users/karentreisman2018>

<sup>37</sup> [http://discovery.ucl.ac.uk/1385449/2/Fonagy\\_AMBIT\\_for\\_CAMH\\_finalSubmission.pdf](http://discovery.ucl.ac.uk/1385449/2/Fonagy_AMBIT_for_CAMH_finalSubmission.pdf)

Impact data should inform a full review of PRU provision for those children at high risk, ensuring there is continued access to a safe learning environment for those young people identified as being unable to safely remain in mainstream or existing PRU provision.

#### **9. Ensure there is a comprehensive professional development offer on Child Criminal Exploitation (CCE)**

This offer should go beyond one off training provision and ensure that professionals from across Newham are supported to understand this issue from a policy perspective and, crucially, to adapt their practice to better meet the needs of criminally exploited children and young people.

Training offers should aim to improve the quality of early identification of risk and vulnerability, assessment, referral, intervention and risk management including use of the National Referral Mechanism (NRM). Training for practitioners should be supplemented with advance practice workshops for managers and team leaders, these should focus on ensuring that those with management oversight of cases are able to critically evaluate and analyse both presenting risks and professional responses.

#### **10. Review local processes for the relocation of young people and families out of Newham, ensuring that best practice underpins all decisions to relocate and the process of relocation**

Specific consideration should be given to:

- Identifying key leads to oversee and collate information on relocations for high risk young people to ensure effective and informed risk management
- Consider, at a strategic level, the relocation of young people from Newham and how this might impact on the development of County Lines and other criminal and exploitative enterprises beyond borough borders
- Collating information on the processes for relocation across housing providers in Newham, utilising the learning and information from East London Housing Partnership and Safer London (who manage the Pan-London Reciprocal Agreement)
- Development of practice guidelines for relocation including timescales (i.e. for gathering supporting evidence and assessing risk), risk assessment, communication with receiving areas, transitional support planning and ongoing risk management strategies

#### **11. Identify Child Criminal Exploitation (CCE) Champions in key services across Newham**

This recommendation builds on the evidenced impact of Child Sexual Exploitation (CSE) Champions and ensures a similar approach is taken to child criminal exploitation (CCE). The purpose of having Champions within each organisation is to:

- Have a key contact for people within the organisation to go to for support and advice in relation to child criminal exploitation.
- Have a key contact for NSCB to share updates, resources and examples of good practice

The role of the CCE Champion could include:

- Keeping up to date with Newham CCE arrangements
- Disseminating and sharing relevant information and resources internally
- Keeping up to date with policy and procedures in relation to CCE
- Ensure that CCE remains on the agenda and is regularly visited in team and case discussions
- Providing advice and signposting in relation to individual cases

Newham Safeguarding Children Board (NSCB) will maintain the contact details for all Champions and will ensure that information, training and awareness is provided to enable them to fulfil their roles as a CCE Champion, including an annual event to bring Champions together with a focus on:

- Opportunities for further learning and development locally and nationally
- Sharing local practice, protocols and examples of good practice
- Feedback from multi-agency audits and how this can be applied to practice
- Best practice working with boys and young men

## **12. Increase awareness, across agencies, to the role social media plays in inter group (gang) tensions and violence**

Recommendations follow those made by Catch 22 in their report on social media as a catalyst for violence<sup>38</sup>.

### ***Resources and training on social media***

Training workshops should be developed that provide a basic yet comprehensive overview of the main social media applications and include a contemporary overview of how each platform is being used locally and how this has been assessed as linking to violence. The content will require updating on a regular basis to keep pace with the development of online platforms and the use of such platforms locally.

To support the professional use of social media to better understand conflict between young people, key professionals should be granted access to social media sites through the Councils IT system. A simple system for authorising and granting this access should be developed with full buy-in from IT and heads of service.

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<sup>38</sup> <https://www.catch-22.org.uk/social-media-as-a-catalyst-and-trigger-for-youth-violence/>

## ***Intervention***

Consideration should be given to how social media can inform targeted conflict resolution and restorative approaches between individuals and groups of young people. It is recommended that Newham consider the implementation of intervention that follows the Cure Violence<sup>39</sup> approach to violence reduction, where trusted members of the community take on the role of mediator when violence is predicted to erupt, often through social media identification.

## ***Suppression***

Work should continue to remove online content assessed as harmful, this is already happening in Newham should be promoted as good practice. Additionally, there should be awareness raising of the work to suppress online content shared through all training that explores gangs, youth violence and criminal exploitation.

### **13. Consider the commissioning of a specialist Young Men's Service, to include casework around harmful sexual behaviour (HSB) using evidence based approaches such as the Good Lives Model.**

This recommendation relates specifically to the need for non-statutory intervention that addresses emerging harmful sexual behaviour and so requires a gendered, non-stigmatising, evidence based approach. Models such as Good Lives use a range of approaches to intervention and include more general work exploring and supporting the development of positive, non-harmful masculinities and identities. There is significant evidence that this links to violence, particularly in a gang context<sup>40</sup>, and so is also considered to offer a useful model of intervention beyond sexual behaviour.

There should also be ongoing local training, through the NSCB, on harmful sexual behaviour that raises awareness of the issues, enables practitioners to identify early indicators of harmful behaviour and to respond appropriately in their own practice, as well as making safeguarding and specialist intervention referrals.

### **14. Ensure that there is access to flexible and responsive trauma-informed debriefing and clinical support available to staff and volunteers across the children's workforce and that self-care and staff wellbeing is embedded in policies, procedures and organisational culture.**

- Self-care strategies and support to be universally available to staff and volunteers across the workforce through access to tailored online resources
- Self-care and wellbeing focussed training to be made available to managers and case supervisors to inform practice with staff and volunteers

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<sup>39</sup> <http://cureviolence.org/the-model/essential-elements/>

<sup>40</sup> Adam Baird, (2012) "The violent gang and the construction of masculinity amongst socially excluded young men", *Safer Communities*, Vol. 11 Issue: 4, pp.179-190,

- Access to immediate and follow up debriefing by clinical staff following the death of a child or a serious incident to be made available to involved staff
- Access to regular high quality reflective supervision to be made available to all staff working with at risk children and young people and prioritised by managers
- Existing provision of reflective supervision to be reviewed to ensure that it supports trauma informed practice, and is itself trauma informed<sup>41</sup>

The implementation of all recommendations should be informed by Equality Impact Assessments and, where appropriate, should include the voice of young people and service users in their design, development and review.

## Appendix 1 - Glossary

ACE	Adverse Childhood Experience
ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Child and Adolescent Mental Health Service
CCE	Child Criminal Exploitation
CCG	Clinical Commissioning Group

<sup>41</sup> <http://www.safehandsthinkingminds.co.uk/wp-content/uploads/2016/03/trauma-informed-supervision.pdf>

CP	Child Protection
CSE	Child Sexual Exploitation
DSL	Designated Safeguarding Lead
ELFT	East London Foundation Trust
ETAC	Exploitation Team Around the Child
HSB	Harmful Sexual Behaviour
ICPC	Initial Child Protection Conference
IMR	Individual Management Review
LBN	London Borough of Newham
LBWF	London Borough of Waltham Forest
LSCB	Local Safeguarding Children Board
MASH	Multiagency Safeguarding Hub
MOPAC	Mayor's Office for Police and Crime
MRVP	Multiagency Risk and Vulnerability Panel
NFA	No Further Action
PPG	Pupil Premium Grant
PRU	Pupil Referral Unit
SALT	Speech and Language Therapy
SCR	Serious Case Review
SYV	Serious Youth Violence
ToR	Terms of Reference
YOS	Youth Offending Service
YOT	Youth Offending Team
ETAC	Exploitation Team Around the Family
IRH	Independent Return Home (Interview)
IRO	Independent Reviewing Officer

## Appendix 2 - Contextual Safeguarding Developments in London Borough of Newham

The following is an overview of current plans being developed in Newham as part of the response to local contextual safeguarding concerns.

### Introduction



**Working Together to Safeguard Children** – A guide to inter-agency working to safeguard and promote the welfare of children) has been revised and issued July 2018. For the first time the guidance recognises Contextualised safeguarding and children with complex safeguarding needs where the harm/abuse occurs outside of the family and not related to the care given to children by the parents or family. Although the Guidance does not provide any great details in regards to a framework of assessment and intervention, it does provide some useful clarify regarding statutory intervention for children where the abuse takes place outside of the family home. The following will outline the main points in regards to contextualised/complex safeguarding and LBN Children's Services Response

## **1. Section 47 – Child Protection enquires and investigation. .**

There has been some confusion over several years regarding current legislation and children with complex safeguarding needs when the abuse is not directly caused by the care given. The new Working Together has, to some extent provide clarify on the issue; *under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare. Such enquiries, supported by other organisations and agencies, as appropriate, should be initiated where there are concerns about all forms of abuse, neglect. This includes female genital mutilation and other honour-based violence, **and extra-familial threats including radicalisation and sexual or criminal exploitation***

Therefore children likely to suffer or suffering harm through exploitation should be subject to s47 if the existing and threshold is met. This will mean that strategy discussions and S47 investigations/assessment is as relevant to exploited children as those children who have suffered harm as a result of care given .We have introduced a new system and process for monitoring and tracking the use of s47 investigations and strategy meeting in regards to children who are either Missing from home or care and those who are at risk of exploitation. This function will also provide a quality assurance in regards to the timeliness of responses, intention and multi-agency working. This is a key performance indicator for children's services and has recently been included in the audit framework and programme.

## **2. Identification**

**Working Together has included complex safeguarding in a wider definition of need;**

*As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered*

**The guidance also references indicators and feature of exploitation-**

- *is showing signs of engaging in anti-social or criminal behaviour, including gang involvement and association with organised crime groups*
- *is frequently missing/goes missing from care or from home*
- *is misusing drugs or alcohol themselves*

- *is at risk of being radicalised*

LBN has developed an exploitation screening tool for practitioners where exploitation is suspected. This tool will help practitioners identify, at an early stage, indicators and features of all types of exploitation in order to inform decision making. The tool can be used to within MASH when children are not known to children's services to determine level of needs and risk. Furthermore during an assessment to identify areas of need and inform planning for children. The tool can be used at any point during a child journey by any agency and or professional. We are arranging practice sessions for managers and practitioners throughout July and August on the tools use.

### **3. Assessment**

#### **Working together also address exploitation within the section on assessment;**

*Assessments of children in such cases should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare. Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and welfare of a number of different children who may or may not be known to local authority children's social care. Assessments of children in such cases should consider the individual needs and vulnerabilities of each child. They should look at the parental capacity to support the child, including helping the parents and carers to understand any risks and support them to keep children safe and assess potential risk to child.*

LBN has developed a new process for assessment and intervention where a child is being or at risk of exploitation. The development of a multi-agency Team around the Child Approach along with a framework of planning, invention and disruption has been implemented.

The purpose of the ETAC is to;

- Ensure that all available information is shared and considered.
- Needs and vulnerability are identified and planned form.
- A trigger and disruption plan is completed.
- Roles and responsibilities are clearly defined.
- Timescales are agreed.

Members of the ETAC are;

- Social Worker.
- CSE/MISSING/ANZEN Police.
- Safeguarding Nurse.
- CSE/Missing coordinator
- Education Representative
- IRO (If child is looked after).

There is a 'live' ongoing Complex Abuse Investigation named . This Operation involves a number of children exploited through organised Gang Activity. We are using the above framework to assess risk and inform multi-agency planning/intervention for these children and their families

**Working together 2018 states that;**

*“Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including: sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take*

Furthermore LBN has introduced a system for monitoring and tracking our most vulnerable children and developed a distinct and bespoke response to complex safeguarding by-

- Creation of two interim full time posts dedicated resources to monitoring individual children with complex safeguarding needs, providing support and guidance to staff and partners when working with a child they believe or suspect is being exploited.

**The aim of the above is;**

- ❖ Devise and maintain a tracking system for all children missing/CS/E.
- ❖ Devise and maintain a system for allocating, tracking and monitoring IRH and process for allocation of IRH.
- ❖ Monitor and track 72 Hour Notification and plans.
- ❖ Support the implementation of a Missing from Home/Care Panels located within the Integrated Neighbourhood Team, chaired by Head of Service/Service lead for LAC and Safeguarding and support
- ❖ Identify children to be presented to the missing from Home/care panel and manage the tracking of these children
- ❖ Provide monthly reports on Missing/CS/E including the top ten.

**4. Work Force.**

**Working together 2018 states;**

*In order to carry out good assessments, social workers should have the relevant knowledge and skills set out in the Knowledge and Skills Statements for child and family social work.*

Over the past three months training high quality training courses have been commissioned. These included;

- Trauma based assessment and intervention for exploited children.
- Exploitation champions framework and training.
- Missing from home and Minimising risk (IRI) training

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Feedback and evaluation of the above training courses from practitioners has been excellent. Many staff has stated how beneficial the training has been in regards to learning and improvement in insight into the needs of exploited children

**Working Together states that's;**

*The social worker should receive insight and challenge to their emerging hypothesis from their practice supervisors and other relevant practitioners*

As a result of ongoing live 'Operation and complex investigation, we have commissioned independent reflective and clinical supervision for all staff involved including partners/police. This will commence in August and will be held every two weeks for groups of up to ten Social Workers and practitioners. This will create a space for social workers to access high quality case specific supervision and reflection.

#### **5. Medium-longer term plans .-Complex safeguarding Hub**

Children's Services is striving to develop a Multi-agency/Service Complex Safeguarding Hub which is responsive to the changing safeguarding landscape and the emergence of complex safeguarding needs within the community.

The complex safeguarding hub will bring together expertise, knowledge, and skills to deliver services in a co-ordinated way in relation to the following strands of Exploitation:

- Sexual Exploitation
- Modern Slavery and Human Trafficking (including County Lines)
- Violent Extremism
- Honour Based Abuse (Female Genital Mutilation)
- Organised Crime Groups/Serious Youth Violence (including Threats to Life)
- 

All key agencies and stakeholders will be represented in the HUB in order to develop a robust multi-agency response to individual children's needs.

We have held staff and key stakeholder engagement events and have presented an outline of our vision to the LBNSCB. There has been a positive response from all key agencies and staff as there is recognition that this approach and response is required to increasing complexities associated with exploitation. Lynn McIntosh - July 2018

