Child W
Child Safeguarding Practice Review

2022/2023

Author: Nicola Brownjohn

CONTENTS

1 Introduction 2
2 Reason for commissioning the Local Child Safeguarding Practice Review 3
3 Child W's contribution to the review 6
4 Child W's Mother Views 6
5 Key circumstances of the case 9
6 Analysis of practice 12
7 Themes representing wider practice 21
8 Recommendations 28

1 INTRODUCTION

1.1 Islington Safeguarding Children Partnership (previously Board), in conjunction with the Youth Justice Services Management Board, has undertaken considerable work over the last six years to safeguard children and young people who have experience of serious youth violence.

1.2 The independent reviewer for this Local Safeguarding Child Practice Review would like to acknowledge the work previously done. There is evidence of some of the learning from previous reviews being embedded in current practice.

1.3 In 2016 there was a review into knife related harm[1]. Recommendations from the review included the need to '*Strive for better engagement and supporting protective relationships'* and to *'effectively support professionals across the public system'. It was evident in Child W's experience that there was a real effort by multiple agencies to engage and support him. This was achieved by professionals who were able to be flexible in their ways of working to ensure that Child W was not excluded.*

[1] Sterlitz, J. (2016) Multi-Agency Learning Review on Knife Related Harm, Islington LSCB & Islington Youth Justice Management Board

1.4 In 2020, Islington agencies were involved in two LSCPRs[2] that focused on adolescent boys who were murdered on the street by other young people. Of note, both of these reviews highlighted that Islington should review the provision of parenting support, at an early point, when there are risks of involvement in youth offending. In Child W's review, his mother was a key figure in the work achieved by agencies with Child W. This seems to have been significantly due to Child W's mother proactively seeking help but also due to professionals adapting their practice effectively in response to the family's needs.

1.5 There is considerable good practice in Islington and the aim of this current review is to support the ISCP and its partners to identify how they can build on the work to date to enable young people to feel safe in their communities.

2 REASON FOR COMMISSIONING THE LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

2.1 The Local Authority notified the partnership of a *serious child safeguarding incident* on 30.03.2022 by completing the LSCP's *case for consideration report* setting out basic demographic information and a brief synopsis of the serious incident. The Partnership sent a *Rapid Review Notification Letter* to the partnership and relevant agencies on 01.04.2022 with a request to check and secure records in relation to this child. If agencies had any contact with the family, they were asked to compile a brief report of their involvement evaluating the quality of their practice as well as areas for learning or improvement.

2.2 Additional representatives from organisations were invited to the rapid review panel meeting as required. The Rapid Review panel meeting on 03.05.2022 considered the reports, and what action needed to be taken. The attendees of the meeting discussed the circumstances surrounding Child W's knife injuries that occurred on the 24.03.2022. There were several key learning issues identified, they involve:

- Safeguarding children with additional needs (Child W had an EHCP),
- How the impact of the wraparound service he received from 2017 to 2020 was measured,

[2] Brent LSCP (2020) Child K
Islington LSCP (2020) Child P

- Holding and co-ordinating the contextual safeguarding risks using child protection procedures,
- How professionals identify 'harm' versus 'risk,
- Understanding Child W's voice and experiences,
- Non-compliance with the joint management and supervision policy between services.
- Addressing the issues of perpetrators, although Child W was involved in attacking another young person, the rapid review queried whether there were adults in control of young people leading them to acts of violence.
- Insufficient record keeping from the school Child W attended out of borough.

2.3 The Rapid Review concluded with a recommendation to the National Review Panel to not progress to a LCSPR on 17.5.2022. The panel did however recommend two courses of action:

- Drawing on a previous piece of work completed in 2018, to consider how the Partnership, in collaboration with agencies can address the issue of perpetrators.
- The Partnership also wish to consider leading on developing a framework of good practice, building on the recommendations from the work completed by the National Panel referenced earlier in the report.

The Chair of the Case Review Sub-group notified the ISCP Independent Chair of their decision. The National Panel responded on the 21.6.2022 recommending that there were compelling reasons for a LCSPR to be progressed. They cited that the rapid review *"could have been developed further to explore some key factors that may have been relevant to Child W's experience. These included issues related to equality, diversity, and inclusion, including the possible impact of 'adultification'. We also felt that the review would have benefited from further consideration of transitional safeguarding arrangements given Child W's age"*

2.4 Subsequently, the ISCP commissioned an independent reviewer to undertake the review. The terms of reference were agreed between the reviewer and the review panel.

2.5 Aims for the review

- Examine the background and circumstances leading to Child W's being harmed with a knife.
- Ascertain whether there are lessons to be learnt and identify improvements that can be made to better safeguard children and to prevent, or reduce the risk, of recurrence of similar incidents.
- Undertake a rigorous and objective analysis of what happened.
- Consider whether there are systematic issues, and whether and how policy and practice need to change.

2.6 Purpose and Scope of Review

2.6.1 It was agreed that the review would examine the period from 2020, when there was a decision to step down the wrap around work for Child W, until he was attacked on the 24.03.2022. The focus of the review is on the following key lines of enquiry:

a) Analysis of Child W's identity and his voice about the risks within the community, in terms of intersectionality i.e. equality, diversity, and inclusion, including the possible impact of 'adultification'.

b) Assessment of the decision to step down the wrap around service for Child W in 2020, which had been in place since 2017, to evaluate the impact of the intervention, especially from a contextual safeguarding perspective.

c) Exploration of the transitional safeguarding arrangements for Child W as he was nearing adulthood, in light of his care and support needs as a child with an education, health and care plan (EHCP).

2.7 The panel

- Independent Reviewer (Chair)
- Director of Safeguarding and Family Support, Local Authority
- Principal Officer - Safeguarding in Education (Interim)
- Assistant Director Safeguarding and Quality Assurance, Local Authority
- Director Youth Islington
- Head of Brightstart 0-5
- Director of Early Intervention and Prevention
- Designated Nurse for Safeguarding
- Designated Doctor for Safeguarding
- Head of Safeguarding and LAC, Whittington Health
- Metropolitan Police Service Specialist Crime Review Group
- Metropolitan Police Service DCI

- Metropolitan Police Service DSI

3 CHILD W'S CONTRIBUTION TO THE REVIEW

3.1 By the time of this review, Child W had reached adulthood. He was approached by a professional currently working with him to inform him about the review and offer him to opportunity to speak to the reviewer. Child W expressed the view that he did not feel able to talk about his experience as it would be traumatic for him. Therefore, he was asked for his consent for the reviewer to speak to his mother, which he gave.

3.2 The reviewer would like to express her thanks to Child W for giving consent to speak to his mother.

3.3 The reviewer conducted a practitioner event and other conversations with professionals who worked with Child W. Several of these professionals were able to represent Child W's voice through the trusting relationships they had with him.

4 CHILD W'S MOTHER VIEWS

4.1 In November 2022, the reviewer, and LSCP Manager, met with Child W's mother. This was an opportunity to hear about Child W's experience and his mother's view of the professional responses to her son.

4.2 The reviewer would like to thank Child W's mother for her valuable contribution to the review.

4.3 Child W is the youngest of four children. The family are of black Caribbean heritage. They live in an area in Islington on the border with Hackney. This is an area where there are parts that are known for rival gang activity. Child W's mother described how this meant that Child W would usually avoid certain roads to stay clear of the risks from the gangs.

4.4 Child W's mother described how issues started with Child W when he was permanently excluded from his Islington Primary School at the age of 6 years due to the school not

being able to manage his behaviour, which included attacking staff. He was then placed in a Pupil Referral Unit (PRU) for four months. His mother did challenge the permanent exclusion decision and was successful in overturning the record of exclusion as the school had not considered Child W's needs appropriately.

4.5 Child W's mother removed him from the PRU, and he was home tutored for 18 months until a place was found at a Hackney Primary school. Subsequently he attended a Hackney Secondary school, by which time he had been diagnosed with Obsessive Compulsive Disorder (OCD) and anxiety.[3]

4.6 Child W's mother described how she had to push for a statement (of educational needs) for her son. Initially, there was a delay due to waiting for an Educational Psychologist to assess Child W. This delayed any referral to CAMHS, which led to Child W's mother asking for help from the GP. At Primary school Child W's mother explained that the professional view was that her son was boisterous. The CAMHS referral did not result in help for Child W, and so his mother returned to the GP who made a referral to Great Ormond Street Hospital (GOSH). His mother said that GOSH worked with Child W for a year and completed a 12-page report on how the school could help him as his issues were complex and not just due to autism. The GP noted that the diagnosis from GOSH and CAMHS was Obsessive-Compulsive Disorder, limitations in executive functioning and processing speed.[4]

4.7 Child W's mother said that she had difficulties in getting Child W to primary school because of his OCD in needing to be immaculate before being able to leave the house. Once the statement/ Education, Health and Care Plan (EHCP) was implemented, the

[3] Local context regarding referral routes into Islington services over 5,000 CYP attend school outside of Islington predominantly at secondary level and yet this is significant route for delivery of SEMH services via primary and secondary CAMHS in schools and Schools Well Being Service offer.

[4] Within the new SEMH Partnership a YP would come via the Central Point of Access (CPA) and there would be a conversation with the family about a range of services that may feel more accessible than the traditional CAMHS clinic based services – for example Targeted Youth Services , Barnardo's

primary school, in Hackney, supported the family by sending work home for him when he was unable to get to school.

4.8 When Child W transitioned to Secondary school, the EHCP continued. His mother described how the EHCP was reviewed 6 monthly which helped the school to make allowances for Child W, e.g., allowing him to wear a Do-rag when he was not comfortable with his hairstyle, or coming in late due to him needing to feel immaculate before leaving the house.

4.9 When Child W started at secondary school, his mother emailed every teacher to ensure that they knew about his EHCP and particular behaviour. His mother described how Child W had some good Learning Support Assistants (LSA) who were able to give teachers a list of triggers for his behaviour. Child W's LSA at the end of Secondary school, followed him to the 6th form, where he was successful in completing his education.

4.10 During Child W's school years, his mother described how she struggled with his behaviour at home. She described how Child W would have outbursts when he would smash up the house. She described how his processing ability was below his age, e.g., at the age of 11 his processing was at the level of an 8 or 9 year old.

4.11 From the age of 4 years old, agencies had knowledge of Child W and his family at various points, either due to concerns about him or his brother. In 2016, there were professional concerns about the impact of his brother's behaviour on Child W, but it was reported that the family declined a child and family assessment.

4.12 Child W's mother did seek help from Children's Social Care (CSC) on numerous occasions during Child W's childhood. She agreed, on two occasions, to him being placed in foster care. These placements ended due to Child W going missing and returning home. This led to his mother asking CSC to help her keep him at home. Due to his behaviour becoming violent, Child W's mother made calls to the police. Although this resulted in no further action by the police, it brought Child W to the attention of the YJS.

4.13 By 2018, Child W was difficult to manage at home, which led to him sometimes living with his father or his sister. There were concerns that he was involved in youth violence and gang activity, and he was not always attending school. Child W was subject to a Child Protection Plan during this year.

4.14 In 2019, one of Child W's best friends was killed. Child W would have been with his friend but had gone home as he was not allowed to be out in his school uniform. Following this his mother said that Child W changed. He started smoking cannabis, displayed angry behaviour and did not want to spend time with his family. However, he was then charged with robbery, phone snatches, and caught by the police, carrying a knife. Had he been caught a third time he might have been given a custodial sentence. His mother bought him a stab vest as she thought this would stop him from carrying a knife, and Child W agreed to this. Then, Child W was charged with Grievous Bodily Harm (GBH).

4.15 Child W's mother said that her son has continued to be stopped by the police and questioned as to why he wore a stab vest. On one occasion, his mother described how the police returned him home, which she viewed as good practice to reassure her but also to calm her son. She said that Child W has not been involved in gangs and tends to be alone when out, although will arrange to meet with friends. She was not clear on why Child W had committed the robberies or whether someone had shown him what to do.

5 KEY CIRCUMSTANCES OF THE CASE

There are five key episodes identified during the period in focus for the review.

5.1 Key Episode 1: 2020: Step down decision making

5.1.1 By December 2020, the services involved with Child W since 2017 had all stepped back from him. This was considered to be successful multi-agency collaboration with good engagement from Child W's mother.

5.1.2 This success was in supported by Child W's mother who described how the YJS workers read Child W's EHCP and so arranged to come to the home to see him and he engaged with the work. Additionally, at one point, Child W was found carrying cannabis in his

school bag. The school wanted to exclude him, but his mother contacted his social worker and YJS workers who all went to the school to discuss Child W. This resulted in the school agreeing not to exclude him.

5.1.3 Criminal activity timeline

2017: Home criminal damage and assault: no further police action, YJS triage.
Dec 2018: • Criminal damage offence at home: Youth Conditional Caution • Theft of a moped: no further police action • Common assault of mum: NFA by police
Jan-Aug 2019: • Robbery: 10 months Referral Order • Possession for cannabis: NFA by police • Arrested in relation to a murder: Bailed for one year and then NFA
Feb-May 2020: • Possession of offensive weapon: Youth Rehabilitation Order with Supervision for 10/12 • GBH with intent and possession of offensive weapon: 18 month suspended sentence and 6 months tag (not sentenced until July 2022)

5.2 Key Episode 2: March 2021: 'Criminal activity'

5.2.1 At this point, Child W had been arrested for four knifepoint robberies, possession of an offensive weapon and cannabis. He received a 12-month Youth Rehabilitation Order with supervision and surveillance.

5.2.2 There was a referral to CSC which resulted in a referral to IGT without further action for CSC.

5.3 Key Episode 3: December 2021: Child W is assaulted

5.3.1 Child W's mother said that he told her that he had been on his way home, about 7.30 pm, but saw a police car where he would normally walk. As his experience was that the police would always stop and search him, he decided to avoid them by walking a different way.

5.3.2 Child W was stopped by two young white men who chased him and stabbed him 5 times. He managed to get home and his mother took him to hospital.[5]

5.3.3 Hackney police led the investigation into the attack. Child W refused to give a statement and would not allow his mother to sign a statement regarding what he had told her.

5.3.4 The investigation led to no charge due to a lack of any corroborative evidence, despite intelligence leading to two people being apprehended and interviewed.

5.4 Key episode 4: January -March 2022: Mental Health Crisis

5.4.1 In January 2022, Child W's mother contacted the GP requesting urgent mental health support for her son. CAMHS support was established with the clinical psychologist working within the IGT. Child W was diagnosed as suffering from severe PTSD, in conjunction with a very low mood and his already existing OCD.

5.4.2 There was also a referral to CSC. It was concluded that there was an extensive professional network around Child W, from the YJS, school, victim support and Islington/Camden Violence Reduction Unit (VRU) service. The social work assessment rated the risk of Child W being hurt again as 5/10. Subsequently, CSC closed the case.

5.5 Key episode 5: March 2022: Child W is left with serious injuries following an assault

5.5.1 On this occasion, Child W was on his electric scooter. He was approached by two young white men who took his scooter. They had a sword like blade which fell to the ground. Child W tried to grab it so that it could not be used to stab him. However, he grabbed the blade and severed his hands. He was also stabbed.

5.5.2 Once the assailants had left the scene, Child W told his mother he asked passers-by for help, but no one stopped. He then asked the driver of a vehicle, who noticed police

[5] There was no information received in the review regarding Social Emotional and Mental Health (SEMH) support offered to Child W in ED or beyond, at this point. The hospital he attended had Redthread involved in ED.

nearby and asked them for help. His mother was contacted, and she went to the hospital where Child W had been taken. She said that she was not allowed to see him as he was under arrest. It was reported that a witness saw Child W discard the knife.

5.5.3 Child W spent 5 days in hospital. His hands were severely injured. Due to his OCD, he would not allow the nurses to undertake his personal care and so his mother had to do it. Whilst in hospital he was watched by the police. On discharge, the police took him into custody.

5.5.4 Since the incident, Child W has made a gradual physical recovery to the point that he is able to work. He continues to be supported by the IGT education and employment worker and its Clinical Psychologist and is working well with them. For work he is collected and returned by his father. Otherwise, he does not go out. The family were offered the option to move away but, as their lives and connections are in the local area, they declined.

6 ANALYSIS OF PRACTICE

6.1 Analysis of Child W's identity and his voice about the risks within the community, in terms of intersectionality i.e. equality, diversity, and inclusion, including the possible impact of 'adultification'.

6.1.1 Child W is a young man of black Caribbean heritage. During his childhood he was assessed as having additional needs and mental health issues. His brother, 6 years older than him, is well known to the criminal justice system, and had also been stabbed on the streets. Child W has also been known to multiple services through his teenage years. He is well known to the Police and Youth Justice Service.

6.1.2 As his brother was involved in gangs, agencies have suspected that Child W has also been involved or known by gangs due to his brother.

6.1.3 By the time the wrap around services ceased their work with Child W in 2020, it was known that he had continued to come to the attention of the police to the point that he was a suspect in a murder for a period of time and was awaiting trial for GBH. He had been caught carrying knives and his mother brought him a stab vest. She stated

that the reason for this was to stop Child W from carrying a knife. According to his mother that worked. It seemed to provoke suspicion from the police when he was stopped and searched.

6.1.4 At the age of 15, Child W had experienced the death of a close friend who was murdered. He was not present at the time but, his mother explained that he could have been with his friend. The locality of Child W's home included an area where there is known gang activity. This has led to Child W avoiding certain areas when he is out.

6.1.5 In the documentation and conversations, there was good evidence of the IGT workers considering the impact of his friend's death on Child W. However, this does not appear to have been looked at from a multi-agency perspective. It appears to have been missed by the school as the victim was not a pupil there. Had Child W not been known to the IGT, his bereavement would have been totally invisible. Yet, the police and other services would have been involved in looking at the death and supporting the victim's family. There should have been recognition that there were peers who knew the victim from the youth centre.

6.1.6 The youth centre was situated in Hackney rather than in Islington. The review panel discussed how there has been joint contextual safeguarding work undertaken with Hackney. Additionally, when there is a murder then there is involvement across the two boroughs in the gold meetings which are held to coordinate multi-agency action. This would include mapping of young people who would be at a high risk due to the situation surrounding a murder. Child W was involved in the work carried out there following the incident.

6.1.7 Child W was faced with the early experience of violence and death on the streets where he lived and played. Given that lived experience, it can be understood why a young person is prepared to act illegally, by carrying a knife, to protect himself. Once he started wearing the stab vest, this gave him a feeling of some safety. This was viewed differently across the professional network. The police view was that it might indicate that he was involved in the perpetration of violence. Whereas the YJS and IGT

recognised that it made Child W feel safe. However, there were concerns about the vest being visible and placing him at an increased risk of harm by others, or by being more likely to be stopped and searched by the police.

6.1.8 The review panel discussed the use of a stab vest by Child W. The police explained how their experience of stab vests would generally be sight of the vests in adult households where there are knives kept, for violent attacks. Therefore, to see a child wearing a stab vest would elicit a police response of either viewing the child as needing to be safeguarded, or as that child being associated with gang activity.

6.1.9 The panel did not consider the use of stab vests to be a usual response for children or young people, although it was recognised that Child W's mother had bought the vest for him so that he would agree not to carry a knife. His mother was convinced that it had saved his life.

6.1.10 The review panel discussed how the wearing of a stab vest would indicate that a child was at risk on the street and likely to suffer significant harm, therefore meeting the criteria for a S47 child protection strategy discussion. That this did not happen for Child W may demonstrate that he was subject to adultification, in being viewed with suspicion.[6]

6.1.11 Following the murder of MP Sir David Amess, it is reported that some MPs, and their staff are wearing stab vests when seeing constituents, due to fear for their safety.[7] Therefore, it is understandable that members of the public who have a heightened fear for their safety would also wear a stab vest.

6.1.12 The family had declined the offer for a move out of the area as that was where their connections were, yet both Child W and his brother had been stabbed in the local area. This must have been a difficult decision for the family to make.

[6] Davis, J. Marsh, N. (2020) Boys to men: the cost of 'adultification' in safeguarding responses to Black boys. Critical and Radical Social Work, vol 8, no 2, 255–259, DOI: 10.1332/204986020X15945756023543

[7] https://news.sky.com/story/reports-mps-are-wearing-stab-vests-to-meet-constituents-concerning-no-10-says-12779058 : accessed 04 January 2023.

6.1.13 His mother commented that Child W's perception was that he was discriminated against, by the police, because of his colour. This view was in relation to general stop and search. In addition, Child W held the view that he was treated differently by the police when he was seen as perpetrator, whereby the police pursued the case despite not having a victim statement. In contrast, in Child W's view, when he was a victim of alleged white perpetrators, the police would not progress the investigation because he refused to give a statement. Child W's feelings about this were explored in interventions with the YJS and IGT. They undertook work to highlight this issue with the stop and search community monitoring group. The review panel recognises that this was Child W's perception of his personal experience. The ISCP is scrutinising the data on stop and search to evaluate the impact on the lived experience of the wider child population.

6.1.14 In March 2022, when Child W had been assaulted, he was taken to hospital. Whilst there he was arrested as a witness had reported seeing him discard a knife. The police had been called due to a reported fight between multiple people. When Child W was found, injured, he was wearing ski goggles and a balaclava. The police were not sure whether there were any other victims. It is known that some young people cover their faces to either avoid being picked up by the police or challenged by groups of other youths. The review panel considered that his clothing might have raised concerns and led to him being searched for a weapon. Child W stood out and it was not clear to the police that he was a child, at this point.

6.1.15 He was under police supervision whilst in hospital and, on discharge, was taken into custody. Within the conversations held during this review, there are differing professional views of whether this was appropriate action to take, considering that Child W was under 18 at this time. If the clinical opinion was that he needed to recover from his injuries, then this should have taken priority. That this did not take priority could be viewed as adultification as defined by Davis and Marsh (2020)[8].

[8] Davis, J. Marsh, N. (2020) Boys to men: the cost of 'adultification' in safeguarding responses to Black boys. Critical and Radical Social Work, vol 8, no 2, 255–259, DOI: 10.1332/204986020X15945756023543

6.1.16 The strategy discussion held with during this time. This showed that Child W had been treated under the adult plastic surgeon and was being cared for in a side room. There were police officers in uniform at his bedside as he was under arrest. Both police and the hospital staff were reminded that he was a child. It was confirmed that the police officers appeared supportive in their manner towards Child W. During this meeting, the police confirmed that Child W would be taken straight to the police station from hospital, when ready for discharge, in relation to the offence. This was due to the police view that Child W was both a risk to others and himself. At the meeting professionals highlighted Child W's needs regarding his physical injuries and the police clarified that whilst in police custody his needs would be met.

6.1.17Child W's mother described how, at 7.30 pm, Child W was taken into custody. She had to remain with him to provide his personal care. She said that Child W had been given codeine prior to discharge and was given more at the police station following a nurse assessment. Then, Child W gave an account of the incident. He was released on bail. His mother reported that her son was only interviewed as an alleged perpetrator rather than as a victim.

6.1.18 The reviewer recognises that Child W did receive a clinical assessment at the police station, prior to the interview. However, the reviewer concludes that this, again did not uphold Child W's rights as a child. Given the knowledge that he struggled in difficult situations anyway, but now had been traumatised by an assault, he should have been given the opportunity to recover and have a holistic assessment of his needs. Other professionals did challenge the police view, but no one escalated this when the police continued with their decision to take Child W into custody. As within the Child Q case review[9], other agencies did not escalate and Child W was viewed by the police as being 'the risk' rather than being 'at risk', apart from himself. There were risk assessments undertaken by the police when he was taken into custody. Although he was assessed as

[9] CHSCP (2022) *Local Child Safeguarding Practice Review: Child Q*

being fit to be interviewed, this did not take into account that Child W was in pain and was unable to undertake his personal care.

6.1.19 Later, the police concluded that there was no further action as, according to his mother, they believed Child W's explanation. Subsequently, he was asked to provide a victim statement, but he refused to speak to the police.

6.1.20 At this point Child W was 17 years old, legally still a child. He had suffered a serious injury, yet his rights and needs, as a child who was known to struggle in difficult circumstances, were not fully recognised by the police.

6.1.21 The police involvement in 2018 noted the need for Child W to attend school consistently and on time, to not have exclusions and to show more insight into his behaviours. This is despite it being noted in the police record that Child W had mental health issues, OCD, and autism. This was noted prior to the period of focus of the review, nevertheless, this did happen during the multi-agency intervention that ended in 2020. When this, 2018 record, is aligned with the police response during the period under review, there does not appear to have been a change in the police view. Therefore, whereas other agencies were cognisant of Child W's EHCP, and his actual diagnoses, the police were not as there is no system in place to enable this to happen. This meant that Child W had an inconsistent experience of having his voice heard by professionals.

6.2 Assessment of the decision to step down the wrap around service for Child W in 2020, which had been in place since 2017, to evaluate the impact of the intervention, especially from a contextual safeguarding perspective.

6.2.1 There was intensive work undertaken to divert Child W away from criminal activity and also to support him to continue his education. This was viewed as being a wraparound service. However, at the practitioner event it was established that each service stepped down at different times during 2020. There does not appear to have been a coming together of all of the services to assess Child W's needs going forward. He had continued to be involved in some recent criminal activity, but this was limited due to the Covid-19 pandemic lockdown periods.

6.2.2 The intervention was positive and had led to good engagement with Child W's mother to support him. However, his mother's view was that it was she who needed to instigate the agencies to work together to support her son. For example, when he was found with cannabis in school, his mother said that it was she who had to approach each professional for support. This was successful in keeping him in school and it was positive that the professionals were able to get into school to discuss the plan for Child W to remain in school.

6.2.3 The review panel reported that usually there would be a CiN closure meeting, but during Covid, this had led to the services stepping down at different points in time.

6.2.4 In the Child P review (2020) one of the recommendations was to that :

'*Islington Safeguarding Children Partnership should seek assurance from the local authority that when any two of the following services are working on a case, arrangements to promote joint supervision and planning are in place and operating effectively (the child in need service, YOS, TYS).*'

6.2.5 Child W's CiN plan would have been prior to the completion of the Child P review, nevertheless, it is important to consider the benefit that joint supervision might have made in Child W's case. It might have helped the professionals to reflect on the impact of the lockdown and the potential risks to Child W once lifted, and to link to the EHCP. It was reported that there were regular meetings between the IGT/YJS and CSC, but it would have been helpful to have extended this to the school. Crucially, joint supervision could have facilitated a focus on the trauma Child W had faced in his life and how he could be supported to navigate society as he transitioned into adulthood. This might have enabled more considered action, by a wider professional network, in recognition of the community in which Child W lived being affected by gang activity and youth violence. It is positive to note that, since this time, the IGT is now part of a formal joint supervision policy with the YJS and CSC.

6.2.6 As it was, Child W's mother seemed to be the co-ordinator for his care. When she raised concerns, agencies would act. Therefore, the agencies themselves did not appear to inform the rest of the network about changes, instead going via Child W's mother.

6.2.7 The impression that the reviewer gained from the information provided that there the focus of some of the professionals was on Child W's behaviour, the impact of his brother's criminal activity on him, and how the services could support his mother to keep him at home. This is based on the knowledge of Child W's history of being violent towards his mother and difficulties at school.

6.2.8 The reviewer concludes that, although there was understanding by the YJS and IGT of the contextual risks for Child W, this was not recognised sufficiently by the whole professional network. Therefore, the contextual safeguarding risks were not fully understood in terms of his lived experience, i.e., of him being able to navigate areas known for gang activity to move from his home to school or youth centre activities. The focus was on his behaviour and, with the notion that he was involved in gang activity, how to divert him from that life course.

6.2.9 The widely held view of professionals was that Child W was in the 'wrong place, at the wrong time' on both occasions he was assaulted. It was known that he was at high risk in the community, yet the network had completed their work to address his own behaviour. This left a gap for what further work could be achieved to maintain his safety on the streets, or that of any young person in a high risk locality.

6.2.10 In the Child P review (2020), there was a recommendation that:

'Islington Council and the Metropolitan Police Service Central North Basic Command Unit should ensure that information from all sources is informing the tactical policing of estates and other localities so that it is focused on creating a safer environment for young people and reduces the influence of gangs and organised crime groups on the day-to-day experience of children.'

6.2.11 By December 2021 and March 2022, the day-to-day experience of a 17-year-old Black Caribbean boy with additional needs was that he had to protect himself and avoid the police as he would be stopped, searched and suspected of criminal activity.

6.3 Exploration of the transitional safeguarding arrangements for Child W as he was nearing adulthood, in light of his care and support needs as a child with an education, health and care plan (EHCP).

6.3.1 Throughout Child W's childhood there were differing views regarding a possible autism diagnosis. At secondary school it was considered that Child W had high functioning autism, but he was assessed by CAMHS and was considered to have borderline autistic characteristics and did not meet the criteria for a diagnosis. In 2022, when he was assessed for court that there was a question whether he could be on the autistic spectrum, but this has never been confirmed in by a professional assessment. In fact, the Clinical Psychologist currently working with him, and who knows him extremely well is of the view that the potential 'autistic traits' can also be explained by trauma which affects how he initially relates to people, and by OCD, which can manifest as a degree of rigidity and significant anxiety around change.

6.3.2 Given that Child W had an EHCP, it is of concern that there were assumptions made, by some professionals, that Child W's presentation was one of an autistic individual. It has been confirmed that, his current diagnoses are OCD and Post Traumatic Stress Disorder (PTSD).

6.3.3 To ensure that any unsubstantiated diagnosis is not promoted or used as a label, it is crucial that the EHCP needed to be in place to support Child W through his transition to adulthood. With care and support needs which he cannot always manage himself, this places him at risk. Once he had been severely injured, this became even more of a priority for services to assess how his needs could be supported, and to be trauma informed. From the information received, the positive transitional support has been via the IGT. Had Child W not been known to youth justice services, it is not clear whether he would have had any transitional support. He had succeeded in his education and the continued support seems to have been lost outside of the IGT.

6.3.4 There was exemplary practice in the YJS, IGT and Social Workers going into the school to work with Child W and to meet with the school staff. This made a significant difference to Child W being able to complete his education successfully.

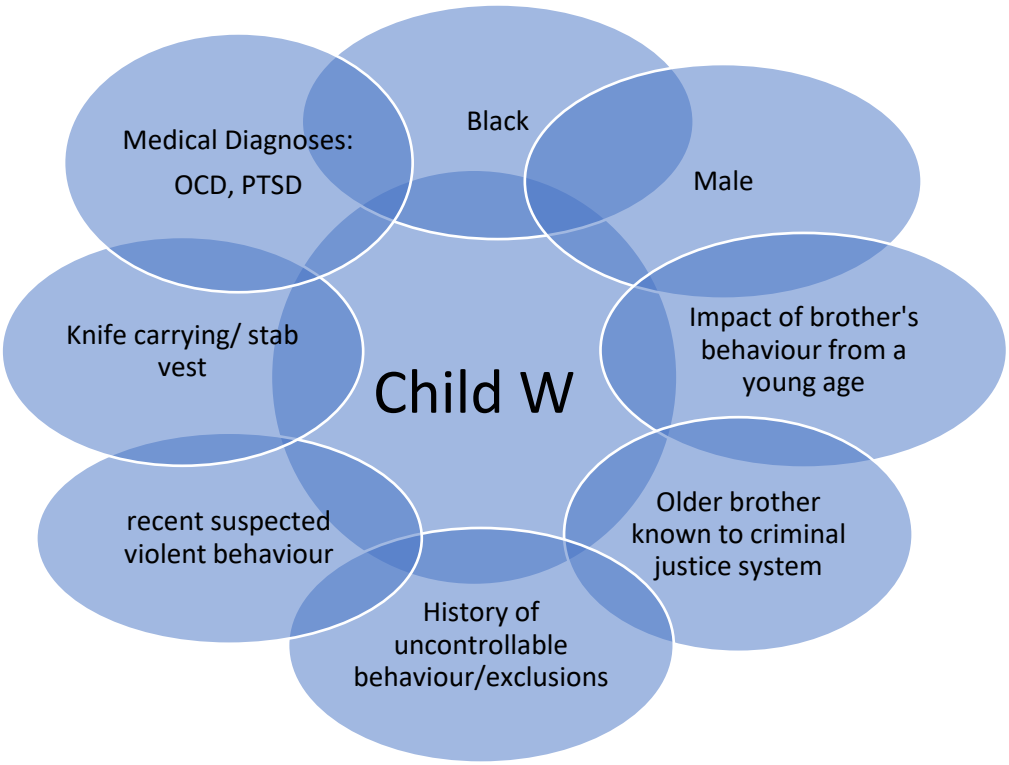
6.3.5 However, in 2020, as Child W had reached the age of 16, agencies stepped down. This was at a crucial time for plans to be put into place to support Child W to transition to adulthood in terms of his EHCP. Given the good multi-agency working between 2017 and 2020, there should have been formal recognition by the network about Child W's continuing needs. He was known to be unpredictable in his behaviour and to get him on track at school had required substantial work by professionals and Child W's mother to ensure that his needs were accommodated. There should have been a clear plan for him to transition to adulthood, in terms of the EHCP, and not solely the IGT work.

7 THEMES REPRESENTING WIDER PRACTICE

There are aspects of Child W's story that reflect the wider experience of children and young people in Islington, and beyond.

7.1 Theme 1: intersectionality of Black boys

7.1.1 Child W could be viewed through the following lenses which show the labels used for him and the inequalities:



7.1.2 However, these could be seen as negative labels. In contrast, there were the positive aspects of a young man who has reached adulthood having achieved good outcomes at school; worked well with the IGT interventions which were taken into consideration by the court when he was convicted for GBH; has been supported by the IGT to gain employment; is engaged with a psychologist; and he is able to live at home with his mother.

7.1.3 Firmin et al. (2021)[10] undertook research with Black boys and young men to gain an understanding of whether multi-agency safeguarding responses to their experiences of extra-familial harm actually contributed to the risks they faced.

7.1.4 The researchers found that, although Black boys and young men were highly visible their voices were not heard to enable services to meet their needs. There were examples of how the Metropolitan Police Gangs matrix discriminated against Black boys. Strikingly there was the view that, in contrast to the gated communities of the

[10] Firmin, C. et al. (2021) *Building Safety Safeguarding black young men and boys in Lambeth*

middle-class white population, Black children were having to live in *'violent gated communities*.'[11]

7.1.5 This is reflective of Child W's experience, how he had to navigate the roads in his community to reach home without harm. In March 2022, he had made the choice between avoiding the police or gangs. He chose to avoid the police and then faced the assault by two young White men, leading to life changing injuries. As a child, about to reach adulthood, he should not have had to make such a decision about how to move around his community. As a child, he definitely should not have had to make the decision to avoid the police for fear of being stopped and searched.

Finding

Child W's experience of the multi-agency safeguarding response to extra-familial harm reflects the Contextual Safeguarding research.[12] This means that Black adolescent boys are at risk of being viewed as being potential perpetrators who need to be diverted away from crime, rather than potential victims who need to be provided with safe environments in which to enjoy their transition from childhood to adulthood.

There are committed professionals who adapt their practice to meet the needs of an individual, but this is not consistent across the multi-agency workforce.

Firmin et al (2021) recommended that Lambeth LSCP *'Develop, and make explicit, a shared value base upon which they respond to extrafamilial harm and build safety for black young men in general'.*

7.2 Theme 2: Transitional Safeguarding: EHCPs

7.2.1 As in other parts of London, children in Islington do not necessarily attend school in that borough. This can provide a challenge for maintaining good oversight and planning for children who have EHCPS.

[11] Firmin, C. et al. (2021) *Building Safety Safeguarding black young men and boys in Lambeth*

[12] Firmin, C. et al. (2021) *Building Safety Safeguarding black young men and boys in Lambeth*

7.2.2 Evidence shows that a high percentage of those in the Criminal Justice System have a history of learning difficulties, mental health issues or childhood abuse. It is crucial that children who are known to have complex needs, including educational and mental health needs, and have been known to the youth justice system, are supported through a transitional plan into adulthood. This needs to be achieved through a multi-agency approach which includes the police.

7.2.3 Brandon et al. (2020) placed a vital importance on the need for professionals to develop good relationships with families to enable good understanding of the family context and effectively manage the complex risks over a period of time, which are not impeded by staff changes.[13] This includes the need to have a workforce capable of developing an empathetic relationship with parents. This was in evidence in Child W's situation. His mother had a relationship with key professionals who she was able to contact to get the help she and her son needed. This mother had to be proactive in making contact with professionals and developing relationships. However, not all parents are capable of taking a proactive approach, for varying reasons. Therefore, it is important that professionals recognise the benefits of a good relationship and the need to be proactive themselves. If the parents are not willing to engage, there should be continued efforts to find a way to support the child.

7.2.4 In Islington, following the Young Black Men's Mental Health Project, there is an increased offer of SEMH provision in the community, which is viewed as less formalised than CAMHS, by the young men. There is currently an ICB review in progress of the local SEMH service. This has a key focus on Equality Diversity and Inclusion with a strong theme running throughout the review to understand what 'Access to SEMH' really means for all communities in the borough.

Finding
Child W was not comfortable with meeting new professionals. Initially, he had declined mental health support, but the IGT Psychologist and the Youth

[13] Brandon et al (2020) *Complexity and challenge: a triennial analysis of SCRs 2014-2017 Final report.* DFE.p18.

Justice Service Educational Psychologist have been able to work with him flexibly and on his timetable. This needs to be replicated in mental health provision for a child who might not have reached the remit of the IGT or YJS.

7.3 Theme 3: Contextual Safeguarding: Survival on the Streets

7.3.1 The Serious Youth Violence Strategy[14] highlighted the need to change the attitudes and behaviour of young people towards the carrying of knives. The strategy considered that:

'a number of young people carry knives because they are worried that other people carry knives and think that they should do so too. Other young people carry a knife to portray themselves as fearless and to convey a 'hard' image.'

7.3.2 For Child W, the risk of a custodial sentence due to carrying a knife, according to his mother, led to him no longer carrying a knife, although this was particularly due to his mother providing him with a stab vest which saved his life in the incidents where he was a victim.

7.3.3 However, it is simplistic to consider that there just needs to be a change of attitude of young people and the threat of a criminal record to stop them carrying a knife. Firstly, there needs to be more consideration of the environmental factors, to not place the responsibility on children to have to have a safety plan in place for their routes home, to avoid gangs. If the community leaders are not going to ensure that the locality is safe, then young people will identify ways of protecting themselves; secondly, young people need to be able to trust those in authority to keep them safe, without being viewed as a potential perpetrator; thirdly, there needs to be greater consideration of the impact on a young person when they hear of a peer being killed.

7.3.4 When reviewing Child W's experience, it was striking that agencies did come together, apart from the police. In the practitioner and manager events, there were contrasting

[14] Home Office (2018) serious Youth Violence Strategy pp32-43 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf

views from those who worked closely with Child W and the police about the risks Child W posed to others.

7.3.5 Of course, the Metropolitan Police have a responsibility to maintain the safety of the community and, in so doing, have the powers to stop and search[15]. It is important to note that:

'Powers to stop and search must be used fairly, responsibly, with respect for people being searched and without unlawful discrimination.'

7.3.6 PACE emphasises that the need for police officers to adhere to the Equality Act 2010. This means that Black adolescent boys should not be subject to stop and search statistically more than their White counterparts, as that would be racial discrimination.

7.3.7 However, the police officers who spoke to the reviewer did explain that Child W's clothing, such as goggles and balaclava, would be reasonable indicators for them to stop and search.

7.3.8 PACE emphasises that the need for police officers to adhere to the Children Act 2004. When carrying out their work, police officers must have regard to the need to safeguard and promote the welfare of all persons under the age of 18. This includes a child of 17 years who has been seriously assaulted but who is also suspected of carrying a knife.

Finding

The Child P review (2020) recommended that

'Islington Council and the Metropolitan Police Service Central North Basic Command Unit should ensure that information from all sources is informing the tactical policing of estates and other localities so that it is focused on creating a safer environment for young people and reduces the influence of gangs and organised crime groups on the day-to-day experience of children.'

[15] HM Govt. Police and Criminal evidence Act 1984 https://www.legislation.gov.uk/ukpga/1984/60/

In 2022, there are streets on the boundary of Islington and Hackney which are not safe for some young people. This leads to children needing to navigate 'safe' routes if they are to gain access to the community opportunities offered to them. Meanwhile they are also being wary of coming to the attention of the police due to the 'stop and search'.

7.4 Theme 4: Impact of bereavement on adolescent boys

7.4.1 Child W's experience shows the impact the death of a friend can have on an adolescent boy. It is expected that when a school age child dies, there is wrap around support for the children within the school. This might include a celebration of the life of the child, a memorial, bereavement support offered to the children. Yet, when a child dies who did not attend school, or where friends attended different schools, the grief of those who knew him is not acknowledged.

7.4.2 Within the national research on adolescent behaviour and the carrying of knives, there is limited sense of the recognition of the grief that many of these children will be dealing with. In Child W's case, he wore a stab vest, which led to the police considering it to be suspicious behaviour. Whereas, it should have been viewed as a measure of trying to keep himself safe, and this could have led to checking on how he felt, i.e., a trauma-informed response.[16] Given that he had a diagnosis of PTSD, this demonstrates a need for services to be more alert to the trauma experienced by young people who have faced street violence, and the murder of a peer.

Findings

There is a gap in the bereavement support for children whose peers have been murdered due to serious youth violence situations.

The response of police officers to an adolescent wearing a stab vest should be in line with trauma-informed practice.

[16] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

8 Recommendations

Review Finding	Recommendations
Child W's experience of the multi-agency safeguarding response to extra-familial harm reflects the Contextual Safeguarding research.[17] This means that Black adolescent boys are at risk of being viewed as being potential perpetrators who need to be diverted away from crime, rather than potential victims who need to be provided with safe environments in which to enjoy their transition from childhood to adulthood. There are committed professionals who adapt their practice to meet the needs of an individual, but this is not consistent across the multi-agency workforce. Firmin et al (2021) recommended that Lambeth LSCP *'Develop, and make explicit, a shared value base upon which they respond to extrafamilial harm and build safety for black young men in general'.*	1. The ISCP should develop a shared agreement of how black boys will be safeguarded from extra-familial harm. This should include how partners will challenge each other when the agreement is not enacted, e.g., when a child is admitted to hospital with serious injuries but suspected of carrying a knife. This should also include how agencies have assessed the risk factors for the child, currently, and the whole childhood experience that might have made an impact on them.
Child W was not comfortable with meeting new professionals. Initially, he had declined mental health support, but the IGT Psychologist and the Youth Justice Service Educational Psychologist have been able to work with him flexibly and on his timetable. This needs to be replicated in mental health provision for a child who might	2. The ISCP should seek evidence from agencies, working with children and young people with mental health needs, as to how they enable flexible access to their service. 3. The ICB should provide updates on the SEMH review to the ISCP at regular intervals during its progress to promote a shared understanding of the needs of children and young people.

[17] Firmin, C. et al. (2021) *Building Safety Safeguarding black young men and boys in Lambeth*

not have reached the remit of the IGT or YJS.	
The Child P review (2020) recommended that *'Islington Council and the Metropolitan Police Service Central North Basic Command Unit should ensure that information from all sources is informing the tactical policing of estates and other localities so that it is focused on creating a safer environment for young people and reduces the influence of gangs and organised crime groups on the day to day experience of children.'* In 2022, there are streets on the boundary of Islington and Hackney which are not safe for adolescent boys. This leads to black boys needing to navigate 'safe' routes if they are to gain access to the community opportunities offered to children. Meanwhile they are also being wary of coming to the attention of the police due to the 'stop and search'.	4. Islington Council and the Metropolitan Police Service Central North Basic Command Unit should ensure that there is evidence of shared intelligence with their Hackney counterparts to ensure that there is a focus on how children have safe access between the two boroughs, without fear of harm from gangs and organised crime groups. The ISCP should share this learning with the Hackney SCP. 5. The Metropolitan Police Service Central North Basic Command Unit should ensure that all police officers are prioritising the safeguarding of children, including Black adolescent boys, when carrying out their duties. 6. The Metropolitan Police Service Central North Basic Command Unit should demonstrate to the ISCP how it is working with the local Black community to address the perceived discrimination of Black boys. 7. The Safer Islington Partnership should demonstrate to the ISCP what action has been taken to work with the local Black community to provide safer streets for their children.
There is a gap in the bereavement support for children whose peers have been murdered due to serious youth violence situations.	8. ISCP should ask the NCL Child Death Overview Panel to scope out and provide information for agencies on how bereavement support can be accessible for adolescents who experience the death of peers due to serious youth violence.

	9. The Metropolitan Police BCU should ensure that all officers are 'grief aware' and trained in trauma informed practice, especially in relation to serious youth violence, as set out by the Government 'Working Definition of Trauma Informed Practice'