



# **Serious Case Review**

## **Child C**

**December 2020**

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# 1. Executive Summary

- 1.1 On 1 May 2019, Child C, a 15 year old male, died as a result of being stabbed whilst in the street. Child C had been permanently excluded from school and three months before his death, he had been seriously injured in another stabbing incident. There had been a noticeable increase in police contacts and concerns about deteriorating behaviour and escalating risk. Child C was going missing and local intelligence suggested he was being criminally exploited and possibly involved in county lines.
- 1.2 On 19 December 2019, a 15-year-old boy was found guilty of his murder at the Old Bailey. A 16-year-old boy and an 18-year-old male were both convicted of manslaughter. A fourth suspect, a boy aged 16, died in custody prior to trial after becoming unwell.
- 1.3 The Serious Case Review (SCR) of Child C makes nine findings and fifteen recommendations for practice improvement. A summary of findings is set out below

## **Exclusion from mainstream school can heighten risk**

- 1.4 As identified in the Child Safeguarding Practice Review Panel's report on criminal exploitation<sup>1</sup>, '*exclusion from mainstream school is seen as a trigger point for risk of serious harm*' and permanent exclusion can be '*a trigger for a significant escalation of risk*'. Both statements resonate with the lived experience of Child C. **Recommendations 1, 2, 3 and 4.**

## **Education settings need access to local intelligence**

- 1.5 Pupil Referral Units (PRU) and Alternative Education Provision (AP) have minimal influence over which children are placed in their facilities. This can result in young people who live in rival gang areas being in the same classroom. Whilst staff had a good understanding of the needs of individual pupils, the risk

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<sup>1</sup> [It Was Hard to Escape - Safeguarding children at risk from criminal exploitation 2020](#)

dynamic created by the cohort of pupils was less understood.

**Recommendation 5.**

**A focus on the individual child is important**

- 1.6 When working with children who are victims of serious youth violence, emphasis needs to be placed on their individual needs. For young people from black and minority ethnic backgrounds, practitioners should explore what their racial and cultural identity means for them in the context of where they are growing up and how they live their lives on a daily basis. It is essential that practitioners are confident to explore these issues, have a good understanding of the implications and can tailor plans appropriately. **Recommendations 6 and 7.**

**Clarity is needed about interventions to mitigate extra-familial risk**

- 1.7 Whilst local procedures were followed, the difference this made to Child C's outcomes is less tangible. The review recognises that at the time of Child C's death, multi-agency contextual safeguarding practice in response to extra-familial risk was new and developing. It is also important to recognise that the circumstances involving Child C were complex and extremely challenging. There were no easy solutions. **Recommendation 8.**

**Developing positive relationships with young people is important**

- 1.8 As with many children in need or at risk, Child C is likely to have benefitted from a strong relationship with a trusted adult with whom he could build a relationship. There is a firm evidence base showing how this can make a significant difference in the lives of children, but it is acknowledged that Child C became progressively harder and harder to engage. **Recommendation 9.**

**Involving and supporting parents is essential to effective safety planning**

- 1.9 As noted by the Child Safeguarding Practice Review Panel's report on criminal exploitation: *'When parents are active in safety planning and implementation there appears to be a greater chance of success.'* Whilst it was good practice to engage Child C's family, the review found that there was an over-reliance placed upon them. A curfew, increased adult supervision and adult escorts

were agreed, but were all contingent on the family to action.  
**Recommendations 10, 11 and 12.**

### **Inconsistent judgements about risk creates uncertainty**

- 1.10 There was a lack of consistency in how different agencies defined risk, its implications and the responses to it. In the opinion of the lead reviewer, there was adequate information to conclude that the risk to Child C was imminent after the stabbing incident in February 2019. The collective judgement arrived at by agencies, did not equate to the actual risks facing Child C.  
**Recommendation 13.**

### **The use of child protection procedures**

- 1.11 There was ambiguity about the 'status' of intervention with Child C. This led to a lack of structure and confusion about multi-agency action. The overall consequence of this lack of clarity was that planning and management oversight was weak and opportunities to intervene were missed. No agency had a sufficient grip or a true appreciation of the risks facing Child C, his interactions with other young people in his community, or where and how he socialised.  
**Recommendation 14.**

### **Poor case recording can directly impact on practice**

- 1.12 Poor recording features as an issue in many reviews, although it can sometimes be difficult to see how this directly impacts on children. In Child C's case, inaccurate recording by the hospital (that Child C was going to live with his father) resulted in no onward referrals being made for community-based services. Opportunities to meaningfully engage with Child C at a critical moment after being injured were lost. **Recommendation 15.**

## **2. Introduction**

- 2.1 On 1 May 2019, the police notified Hackney Children & Families Service (HCFS) that Child C, a 15-year-old male, had died as a result of being stabbed whilst in the street.
- 2.2 Child C was known to a number of local agencies, including youth services, education, health, children's social care and the police. In the months preceding his death, there was a noticeable increase in police reported incidents and Child C had been considered at an Extra Familial Risk Panel (EFRP); a multi-agency meeting developed as part of the contextual safeguarding project<sup>2</sup> in Hackney.
- 2.3 Child C did not suffer with any chronic health conditions or take any regular medications. Following exclusion from mainstream school, Child C was attending independent alternative provision.

## **3. Key Circumstances, Background and Context**

- 3.1 Child C was born on 12 August 2003 and initially lived with his mother, father and sister. Throughout his early and primary years, there were no indicators of any significant needs or reported safeguarding concerns, and there were no health issues of note other than his weight. Following a breakdown in the relationship between Child C's parents, his biological father subsequently moved out of the family home and London. Child C had very little contact with him thereafter. Mother entered a new relationship with step-father, whom Child C is believed to have had a good relationship with throughout the rest of his life.

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<sup>2</sup> <https://hackney.gov.uk/contextual-safeguarding>

## **First referral to Hackney Children & Families Service**

- 3.2 HCFS first became involved in 2012 due to reports of disagreements and strained relationships within the family home. An assessment was completed by HCFS and family therapy was provided. This concluded after a few months. No safeguarding concerns were identified in respect of either Child C or his sister as part of this intervention.

## **Exclusion from Secondary School**

- 3.3 There was no further agency contact of any significance until 2017, when Hackney Learning Trust (HLT)<sup>3</sup> was notified of two incidents where Child C had received fixed term exclusions (May and June 2017). Soon afterwards, Child C received another fixed term exclusion for 12 days after he allegedly damaged the property of a schoolteacher. Despite reports of Child C responding positively to this sanction, he was permanently excluded (PEX) by the school a few weeks before the summer holidays in July 2017.
- 3.4 The school subsequently notified HLT of the PEX, albeit this was almost two weeks later than expected and a clear breach of the statutory exclusion guidance<sup>4</sup> that requires notification be made '*without delay*'. HLT made representations to the school, challenging the PEX and noting a number of procedural flaws. Other solutions were suggested, such as a managed move to another school or alternative provision, but this advice was ignored and the school proceeded with the PEX.
- 3.5 In December 2017, after an appeal by the family, the exclusion was quashed by the Independent Review Panel (IRP) and the school was directed to reconsider the PEX. Despite this finding, a Pupil Disciplinary Committee subsequently convened by the school's governing body upheld the PEX on re-hearing the case. In an interview for this review, the family commented that the

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<sup>3</sup> Now known as Hackney Education

<sup>4</sup> Para 40 - Exclusion from maintained schools, academies and pupil referral units in England Statutory guidance for those with legal responsibilities in relation to exclusion Sept 2017

school had made it clear that Child C would not be reinstated. They had no other option but to commit to building on the good start that Child C had made at his alternative education provision (AP). Whilst the secondary school was unable to support the review with an analysis of this episode (as record keeping at the time was poor), the testimony of a former teacher highlighted concerns with regards to the school's leadership and decision making in this case.

- 3.6 This teacher told the review that the matter was not so serious that it warranted a PEX. The teacher further suggested that the PEX was instigated by lobbying from other teaching staff who wanted to see Child C excluded.

**Critique of Practice:** The PEX of Child C was a significant incident. It was a catalyst to the deterioration in his behaviour, and a decision that exposed Child C to a new, more challenging environment that he realistically did not need. As a consequence, Child C was subsequently educated with a cohort of other excluded pupils who had displayed more entrenched behavioural issues, complex needs linked to special educational needs, significant safeguarding needs and issues relating to gangs, criminality and anti-social behaviour. It is the view of the lead reviewer that the school failed to exhaust all available opportunities to maintain Child C at his secondary school. Several serious concerns about the PEX were noted by HLT, which were all ignored by the school. The school governors had a duty to re-consider their decision, which they did and upheld the decision to PEX, despite the PEX being judged to be unlawful. It appeared that the school was determined to PEX Child C, without consideration of the wider implications to his safety, well-being or his education.

The family did not pursue a legal challenge to this decision via court. In saying that, no evidence has been presented to this review to confirm if the family were or were not advised of their legal rights.

- 3.7 At the start of the Autumn term, Child C spent a short period of time in a re-engagement group at a Pupil Referral Unit (PRU). He was then placed by the PRU at the AP in October 2017. The overall effectiveness of both the PRU and



the AP had been judged by Ofsted as being Good in June 2016 and June 2018 respectively. In December 2017, Child C received a good end of year report, which concluded that he had settled reasonably well into the AP.

### **Second Referral to Hackney Children & Families Service**

- 3.8 In January 2018, at age 14, Child C told a teacher at the AP about a domestic incident between his mother and stepfather and that he had attempted to intervene by placing himself between them. This was reported to have resulted in a brief physical fight between Child C and his stepfather. The case was appropriately referred to HCFS and allocated on the same day to a consultant social worker (CSW).
- 3.9 Not long after the CSW began their assessment, Child C threatened and punched another boy, with whom he was having an on-going dispute. Child C was given advice by the police and issued with a harassment warning. He was said to be genuinely remorseful for his actions and the matter was closed with the appropriate submission of a police notification to HCFS.
- 3.10 The CSW's assessment identified no safeguarding risks for Child C in his family and the case was closed. During this intervention, mother did take the opportunity to raise concerns about changes in Child C's behaviour. She stated she believed he was smoking cannabis, was finding it hard to adapt to the AP and that he was being bullied.

**Critique of Practice:** The AP and HCFS responded quickly in response to Child C's concerns and in line with expected standards of practice. This episode, however, had a detrimental impact on the relationships between professionals, parents and Child C. The disclosure of other concerns by mother was the first alert that Child C was becoming involved in new behaviours that were not apparent prior to his PEX and placement in the AP.

- 3.11 As a result of mother's concerns, Child C was referred by the CSW to the Substance Misuse Team to provide support and intervention to address his

cannabis use. This was felt to be contributing to his low level offending and anti-social behaviour. After some brief engagement, Child C was referred to and participated in seven out of ten sessions delivered by the Prevention and Diversion Team. These included an analysis of his offence (not a conviction), negative peer influence, consequential thinking, victim awareness, anger and conflict management.

**Critique of Practice:** The response from agencies in light of the alleged assault on another young person was consistent with expected practice. A productive relationship was formed between Child C and practitioners in the Substance Misuse Team and the Prevention and Diversion Team. Child C participated in the majority of interventions offered, supported by good communication and engagement with the family.

- 3.12 After the referral to HCFS, professionals noted that Child C's behaviour had become more defiant, and his engagement with them declined. He appeared to lose trust and confidence in professionals and was being more influenced by his peers.

### **Concerns about Alternative Provision**

- 3.13 The initial positive relationship between the AP and the family also deteriorated after a change in leadership and amid numerous discussions where the family had complained about the AP being chaotic and in a state of disrepair.
- 3.14 The parents told the review that they had also questioned the ability of the AP to properly address the behaviours of the young people attending. One example shared involved mother intervening to calm down a volatile situation, in which a teacher was failing to deal with a pupil threatening to assault staff. Similar concerns were also recorded in the case notes of the Prevention and Diversion Team practitioner, who described it as being impossible to deliver intervention in the AP due to its chaotic environment.

**Critique of Practice:** The review recognises the exceptional challenges that PRUs and APs often experience when educating, keeping safe and meeting the needs of a range of children with complex behaviours. Such challenges are often compounded by the fact that pupils reside in different postcode areas, amidst local gang tensions and postcode rivalries. All of these issues can contribute to (but not justify) the chaotic environment described by the family and a professional. It is essential that PRUs and APs establish and maintain disciplined environments to promote the learning and safety of pupils. The relationship between the AP and parents unfortunately broke down, and the expected collaborative approach between pupil, parents and school was undermined. This is likely to have contributed to the continued decline in Child's C behaviour.

- 3.15 Between February 2018 and January 2019, Child C received four additional fixed term exclusions from the AP for various breaches of school rules. A progression mentor from the PRU spent a lot of time with Child C and his family in an attempt to understand why his engagement in education was deteriorating and the perceived risks he faced. In January 2019, after an incident of violence towards a staff member, Child C received a 2 day fixed term exclusion. At the beginning of February 2019, the family met with the PRU and agreed a plan of support designed to get Child C's education back on track through the rest of year 11. Within days, Child C had been stabbed for the first time resulting in the agreed plan not being actioned as Child C did not return to the AP thereafter.
- 3.16 Over this period of time, Child C also repeatedly came to the notice of the police. He was either stopped and searched or questioned about various offences. It is understood that when challenged by the police, Child C was often in the company of other pupils who attended his AP. Child C was never charged or convicted of any offences.

**Critique of Practice:** Professionals had less influence on Child C's behaviour after his PEX from mainstream education. The 'un-structured' environment at the AP combined with new peer relationships were likely to have been

significant contributory factors in Child's C escalating risky behaviour. There is good evidence that the PRU and AP staff attempted to engage with Child C and the family to improve their understanding of Child C's change in motivation towards his education, to understand the risks he faced and to get him back on track. However, despite all of the warning signs, the professional network did not collectively mitigate the risks, curb his behaviour and keep him safe. Child C did not have an adult he trusted enough to 'open up' to, and who could also assist to co-ordinate the multi-agency support required. The support plan agreed between the family, the PRU and AP came too late to prevent the first serious assault on Child C and was never implemented as he did not return to the AP thereafter.

### **Stabbing Incident in February 2019**

- 3.17 At the beginning of February 2019, the police attended a youth club in response to a report that Child C had been stabbed in both thighs. He was taken to hospital by paramedics of the London Ambulance Service (LAS). He had suffered three stab wounds which were serious and required surgery.
- 3.18 Information obtained by the review details that on the way back to the AP (after attending off-site lessons at a youth club), Child C was warned by one of his peers that he feared something bad was going to happen. Child C made an excuse that he needed to return to the youth club. The teacher accompanying Child C allowed him to do so without supervision<sup>5</sup>. Child C was stabbed on the way back to the youth club. He was found by a peer who administered emergency first-aid and raised the alarm to initiate calls to the emergency services.

**Critique of Practice:** When Child C was stabbed, he was not under the supervision of a member of staff. Despite the teacher being unaware of any imminent threat to Child C, this is a serious concern. It is also of concern that the family believe that Child C was not supervised as the teacher had been

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<sup>5</sup> The family question this account of events as it is their understanding that the supervising teacher was not present as he had been summoned to return to the AP, leaving Child C and other pupils in the group to make their way back to the AP without adult supervision.

summoned back to the AP prior to the incident. All children who are taken off site for education should be escorted back to the school's location to be discharged. The review has not had sight any offsite risk assessment completed by the AP to ensure that appropriate control measures were in place to mitigate any potential risk. This is in accordance with expectations set out in the health and safety: roles and responsibilities of schools guidance.<sup>6</sup> The review is there unable to comment further or establish whether any control measures were adhered to at the time of Child C's stabbing.

## **The Immediate Multi-Agency Response**

- 3.19 Whilst in hospital, Child C was seen by medical staff and a worker from a charity specialising in working with young people involved in serious youth violence (Charity 1). This contact intended to establish his wishes and feelings and to ascertain any support that he might require. Given the time of day, the charity worker decided to return to see Child C and talk with him further when it was more convenient. However, due to an influx of new patients, Child C was discharged from hospital without further engagement.
- 3.20 Child C had also disclosed to the attending social worker that he was afraid and feared for his safety. This was taken seriously and the possibility explored of Child C moving to live with his biological father outside of London. Child C explained to his social worker that whilst he was prepared to go, he did not want to upset his mother (who did not agree to this course of action).
- 3.21 The hospital arranged for two meetings to be held concurrently. One was arranged as a 'strategy meeting' and the other, 'a discharge planning meeting'. The governance of these meetings was ambiguous and as no minutes were ever taken, the agreed actions were unclear. If the strategy meeting was intended to be held as part of enquiries under Section 47 of the Children Act, this was neither convened by the Local Authority nor chaired by a manager from

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<sup>6</sup> <https://www.gov.uk/government/publications/health-and-safety-advice-for-schools/responsibilities-and-duties-for-schools>

HCFS. The worker from Charity 1 was also not in attendance and hence, the information gathered during their brief engagement with Child C was unavailable. Overall, there was insufficient rigour in the management of these meetings to ensure timely actions were taken, with information and decisions being recorded and shared across agencies as appropriate.

- 3.22 Although it was believed by agencies that Charity 1 would follow up its engagement with Child C, a breakdown in communication meant that this didn't happen. Hospital notes recorded that Child C was going to live with his father outside of London, when in reality this had not been agreed. As a result, no support was provided in the community by Charity 1. This would have provided an independent practitioner for Child C who was experienced in working with victims of serious youth violence.

**Critique of Practice:** The initial engagement of Child C by medical staff and the trauma informed practitioners from Charity 1 (at what is described as a 'teachable reachable' moment for victims of serious youth violence) was good practice and could have been pivotal in preventing further harm or reprisals. After briefly engaging with Child C, the charity worker committed to return to speak with him again when his mother was present. This opportunity was lost as Child C was discharged before they could speak with him again.

Neither the strategy meeting nor discharge planning meeting were attended by Charity 1. The strategy meetings was not chaired by a manager from HCFS, in accordance with the Pan London Child Protection Procedures and no minutes were taken. This contributed to a breakdown in communication and a miss-interpretation of the ongoing plan.

Inaccurate case recording resulted in key services not engaging with Child C. Involved social workers did not recognise this void and whilst an independent practitioner (experienced in working with victims of serious youth violence) could have been allocated, this did not happen either. This was a significant missed opportunity to provide community support during a very traumatic time

for Child C. An opportunity to glean a more informed understanding of any future risks to Child C, and to better appreciate his lived experience was lost.

### **Discharge Home and the Multi-Agency Response**

- 3.23 Child C returned home with an agreed plan for increased family supervision, supported by home tuition (as it was deemed unsafe for him to return to school). It was also agreed that Child C would be escorted by an adult whenever he was out in the community. Within two days, Child C was reported missing and was found to be with a friend close nearby. Four days after his discharge, Child C spoke to his social worker again and stated that he now felt safe to remain in the area. This was explored further by the social worker, but no conclusive reason or evidence to support this significant change of heart was clarified with him. Throughout February 2019, further information and intelligence came to light that was appropriately responded to by the social worker.
- 3.24 Mother disclosed that Child C was increasingly becoming beyond her parental control. A suspect was arrested by the police for his stabbing, but the investigation stalled as Child C refused to cooperate. The investigation was closed a few weeks later. By now Child C's position had changed and he was categorically unwilling to relocate out of London. Child C and his peers were discussed at the EFRP where it was heard the stabbing could be linked to a music video Child C had shared online, and that a new video appearing to mock Child C had recently been posted.

**Critique of Practice:** There is good evidence that HCFS attempted to keep Child C safe, and designed a safety plan with him, which was reviewed and amended as further intelligence came to light. The social worker was persistent in their attempts to persuade mother that Child C should be relocated for his safety. Nevertheless, this review finds that when this course of action was declined, there was an over-reliance on the family to keep Child C safe and his immediate needs were neither recognised nor effectively responded to.

Child C had suffered a significant injury and trauma that had an emotional and physical impact upon him. It is reasonable to expect agencies to have recognised these needs, but no specific support was put in place to assist Child C to rehabilitate from such a life-changing event.

The fact that Child C's perception of his personal safety had shifted so far in the space of a few days is a cause for concern that was insufficiently explored by professionals. Was this due to the trauma he was experiencing, further threats or was he was planning his own retribution? Knowing the answer to these questions would have helped inform risk and safety planning for Child C and his family. Child C's sister told the review that from conversations with her brother, he did not want to look 'weak' to his peers, or to be seen to be running away. Professionals were unaware of Child C's motivation to remain at home and it appears he did not have a professional that he trusted enough with whom he could share this information.

The review accepts that Child C refused to cooperate with the police investigation, which is a significant gap in available intelligence. Again, could it be that Child C was still being threatened and was therefore scared to share further information with the police, or was he thinking about planning revenge? There is no evidence to suggest agencies fully appreciated the reason for his non-cooperation with the investigation and accepted Child C's position without exploring the matter further or planning to engage him at a later date.

- 3.25 On 13 February 2019, Child C was accompanied by his mother and stepfather to the local Emergency Department (ED) due to concerns around a new onset lump which had appeared on Child C's thigh, which corresponded with his stabbing injury. The ED appropriately viewed his health records and agreed a plan of ongoing treatment, that included the removal of Child C's sutures on 15 February 2019. Child C failed to attend his appointment and his non-attendance was not followed up in accordance with expected practice. A referral was, however, made to Charity 2 that has workers located in the hospital to engage young people at risk of violence. Charity 2 confirmed receipt, but



clarified that it was their understanding that Child C was due to receive support from Charity 1.

- 3.26 A timely referral was sent to the hospital Safeguarding Children Team (SCT) for consideration. Child C's case was discussed at the weekly paediatric psychosocial meeting that was reassured information had been appropriately shared with key agencies. In addition, the allocated social worker also confirmed that a community-based plan to support Child C was in place. It was not picked up at the meeting that Child C was not receiving support from either Charity 1 or Charity 2.

**Critique of Practice:** Health staff responded appropriately and addressed Child C's needs. Referrals were made to the SCT demonstrating a clear commitment to keeping Child C safe within the community and to reassure themselves that there was a multi-agency plan in place to compliment the medical care being provided. This was good practice.

- 3.27 Throughout the remainder of February 2019 and March 2019, further missing episodes were recorded and noted with HCFS via police notifications. There is no evidence that return home interviews were offered or completed. This was a missed opportunity to gather insight into Child C's lived experience, and to understand what the drivers were behind him going missing.
- 3.28 Child C continued to be seen by his social worker who noticed bruising to his face in a visit in early April 2019. He refused to explain this to the social worker, but did confirm to his mother that he had been assaulted by a group of males who also brandished a knife. This assault was not reported to the police. Following his stabbing, mother informed the social worker that Child C continued to repeat to her that '*they are going to kill me*'.
- 3.29 Child C's case was reviewed again by the EFRP, where police intelligence indicated that Child C and his peers were being exploited. Child C was reported as being exploited by a local gang. He was believed to be involved in county lines and had been seen locally riding mopeds.

**Critique of Practice:** When confronted with concerns relating to extra familial risks, both at school and in the community, social workers appear to have been less confident about what they could do to keep Child C safe and to curb the deterioration in his behaviour.

In accordance with recently established local procedure, the social worker demonstrated their concern for Child C's well-being by referring him to the EFRP. The EFRP is designed to support the creation of a more responsive, multi-agency contingency and safety plan. However, at the time, the EFRP was in its infancy, and whilst several actions were identified relating to Child C and his peer group, there was insufficient focus on Child C as an individual and what he might have needed.

3.30 At this point, Child C's biological father was contacted by the social worker to explore the possibility of his son moving out of London to live with him. Child C's father was supportive of the arrangement, as long as Child C adhered to his house rules. Mother agreed that whilst the safest options was for Child C to move out of London to reside with extended family, she was adamant that Child C should not live with his biological father. This was due to her previous experiences of domestic abuse. Mother wrote a letter to Child C to explain how she felt about him and why she wanted him to move away for his own safety. Child C was not in agreement and stated, for his own reasons, that he preferred to remain the community.

3.31 At the end of April 2019, further information was shared by Child C with a member of staff at the AP, explaining that his missing episodes were due the fact he was unhappy at home. It is not clear whether this meant he was unhappy living in his family home, or in his area.

**Critique of Practice:** The opportunity to move Child C out of the area for his own safety remained unresolved. Alternative accommodation does not appear to have been fully explored with the extended family, other than with Child C's biological father. The delay in finding a suitable resolution between

the family and involved professionals provided the opportunity for Child C to be exposed to greater risks in the community, particularly in the context of his apparent links to county lines. This information came to light in the days before the fatal incident that resulted in Child C losing his life, meaning agencies had limited time to react to this new intelligence. A family engagement meeting or family group conference could have provided a suitable framework for meeting with the extended family and to agree solutions to mitigate the risks to Child C.

Conducting return home interview for children who have gone missing is an important component of multi-agency practice designed to keep children safe. Despite Child C being reported as missing on numerous occasions, return home interviews were inconsistent, and appear to have been purely administrative. When a telephone interview was initiated by the police, vital intelligence was shared that Child C had been the victim of a further assault in the community, but this was not acted upon and did not instigate a revision of Child C's risk assessment.

### **Fatal stabbing Incident in May 2019**

- 3.32 On 1 May 2019 Child C was stabbed multiple times close to his home address and died from his injuries.
- 3.33 On 19 December 2019, a 15-year-old boy was found guilty of his murder at the Old Bailey. A 16-year-old boy and an 18-year-old male were both convicted of manslaughter. A fourth suspect, a boy aged 16, died in custody prior to trial after becoming unwell.

## **4. Views of the Family**

- 4.1 The family's views have been captured via a face to face meeting with mother and stepfather. Child C's sister was unable to attend the initial meeting, although shared her views at a later date. Child C's biological father could not be contacted. It is believed that he now resides in the Caribbean.
- 4.2 Child C was described by his family as a loving caring boy who was a talented artist and musician. He had natural ability to draw, could produce music, rap, and play various instruments such as the keyboards and drums. He was very family orientated, and displayed a strong sense of kindness, humility and respect. He would often offer support to older residents who lived within his community. He was generally very polite to the people he met. He had a strong sense of caring, often displaying his compassion by always wanting to help homeless people that he encountered from a very young age. He valued and maintained a strong and loving bond with all of his family and had an especially close relationship with his sister.
- 4.3 His parents confirmed that he had a 'normal' upbringing, and there were no concerns throughout his early and primary years, with some behavioural issues only coming to light from year 8/9 in secondary school. There were no concerns concerning health issues, although the family did seek support with his diet and managing his weight.
- 4.4 Both mother and stepfather were open and frank about their perceptions of the services received and were infuriated by the provision of education to their son. They are adamant that in their opinion, he was targeted after they complained about an incident when Child C was reportedly detained on his own and was being shouted at by a teacher in a locked classroom. Mother described how she listened to the incident over the phone as one of Child C's concerned friends called her and put their phone on loudspeaker. After this, Child C's parents believed he was continually targeted by the school, causing them to frequently challenge how he was being treated. The parents made formal

complaints, none of which were investigated or resolved to the family's satisfaction. Whilst the parents could not confirm the actual date of the alleged incident, they recall it was just prior to Child C becoming subject to fixed term exclusions. They remain certain that the exclusions were directly linked to their complaints and an unwillingness by the secondary school to address their concerns.

- 4.5 Both parents confirmed they met with at least three members of the senior leadership team to discuss Child C and their concerns relating to his treatment in school. This did not improve Child C's situation, and the parents believe their escalation of this matter was the catalyst for his PEX. Child C's mother told the lead reviewer, '*They got rid of me, not [Child C]*'. Mother clarified her statement by saying that she believed the school's decision to exclude Child C was borne out of a desire to stop further complaints from her about the school's approach to her son.
- 4.6 Once Child C had been placed at the AP; stepfather highlighted how surprised he was by the staff's apparent lack of knowledge about the area in which they worked. In his opinion, staff were ignorant to the volatility of areas where the AP was located and postcode gang rivalries between various groups of young people who attended the AP. It appeared that this valuable local knowledge was not utilised to inform risk assessment, safety or supervision planning for students.
- 4.7 Child C was not, however, involved in a 'gang lifestyle' nor did he have rivalries with boys from other areas. The family believe that placing Child C in the PRU automatically made him vulnerable and placed him at risk. This was exaggerated by the family's experience of security at the PRU, where they highlighted that despite robust checks for visitors entering the building, there was an apparent blasé attitude to student supervision witnessed by the parents.
- 4.8 The family described the environment they witnessed as a very unstructured, un-welcoming, chaotic and in a state of disrepair. They questioned the professionalism of staff, telling the lead reviewer that they had witnessed them

smoking outside the provision with pupils. On another occasion, they recounted receiving their usual text message from the AP confirming Child C's arrival at school, only to be contacted by a teacher almost simultaneously asking where Child C was as he had not arrived. The concern of the parents was heightened by the fact that Child C's mobile phone was at school, as it was handed in at reception every morning in line with the AP's protocol. This was an experience they found very worrying as they had no way of contacting Child C and the AP did not know where he was.

- 4.9 Three days before Child C was stabbed for the first time, his stepfather challenged members of staff at the AP about the apparent lack of supervision for pupils. The family also questioned why Child C was allowed to return to the youth club without supervision and why no staff member was immediately available to either prevent the assault or to respond to it.
- 4.10 Both mother and stepfather confirmed that Child C did not want to attend the PRU/AP and preferred to return to mainstream education. He did not like the lack of structure; he was being bullied and felt intimidated by other pupils.
- 4.11 The family state that when the school were instructed to reconsider their decision to PEX Child C after their successful appeal, they believed that they had very little option but for Child C to remain at the AP. Subsequently they confirmed to the AP that they wished for Child C to remain a pupil at the AP. Both parents were very clear that they were not surprised by the decision of the school's pupil discipline committee not to over-turn Child C's PEX.
- 4.12 Given the concerns raised by the family the progression mentor met the family to mediate and seek to repair their relationship which appeared to improve.
- 4.13 The family welcomed the involvement of the Prevention and Diversion Team, with whom mother maintained a good relationship. She believed they were making a difference to her son, although she would have welcomed better communication and organisation of the scheduled interventions sessions offered.

- 4.14 After Child C' stabbing, it was an exceptionally traumatic time for the family, and mother did not believe that she was in a position to make a decision about her son moving away. When it was brought up again by the social worker, mother states that she explained that Child C did not know his father and had no relationship with him. Whilst he appeared willing to leave in front of professionals, behind the scenes he would apparently beg his mother not to send him to live with somebody he didn't know or care about him. Mother confirmed that other kinship opportunities where Child C could be relocated were never explored by professionals.
- 4.15 Mother and stepfather described the changes they witnessed in Child C after his stabbing. He became withdrawn, anxious, and started to neglect his own personal hygiene. He had to learn to walk again as he had serious injuries to both of his thighs. He was fearful of being out in the community, and when he did go out, he decided to stay with friends rather than to try to return home.
- 4.16 The impact of the trauma on Child C was explained further by his sister. She stated that her brother had confided in her on more than one occasion, noting that he was suffering with flashbacks from the stabbing incident. When questioned why Child C changed his mind when he stated to professionals that he no longer wanted to leave the area, she highlighted that he told her that he did not want to appear weak or lose face with his peers
- 4.17 The situation at home then started to deteriorate as Child C's behaviour and attitude was increasingly becoming beyond his mother's control.
- 4.18 Overall, mother and stepfather were dissatisfied with the support they received. They felt that they were left alone to deal with the most traumatic experience of their lives without support, other than from each other. The situation at home became more and more challenging, although despite mother's concerns being shared and her 'cries for help', no additional support was forthcoming. On the contrary, agencies kept trying to persuade the family to re-locate Child C with his father, which appeared to them to represent the multi-agency plan.

- 4.19 After believing that her son was running county lines, Child C's mother made the difficult decision that the only viable alternative was to ask other family members who lived in another part of London to care for him. Unfortunately, Child C was killed before this plan could be actioned.

## 5. Findings and Recommendations

### Exclusion from mainstream school can heighten risk

- 5.1 During Child C's time at secondary school, safeguarding practice was poor in several different areas. Amongst a range of issues, this included the lack of any substantial record keeping of safeguarding incidents, risky behaviours, breaches of school rules and sanctions.
- 5.2 Numerous concerns and complaints were also made by Child C's mother, stepfather and sister about his treatment, although most were never resolved from the family's perspective.
- 5.3 The overwhelming impression of the review is that the school's leadership was ineffective and problems endemic; a position similarly reflected by Ofsted following its inspection of the school in July 2019. Grading the school as inadequate across all four inspection domains, Ofsted concluded:
- *Leaders and governors have failed to arrest the school's decline. None of the issues raised by Ofsted during the short inspection in June 2018 have been tackled effectively.*
  - *The school does not have an effective safeguarding culture. Record-keeping is weak, and concerns are not dealt with in a timely way. Staff have insufficient understanding of how to manage difficult behaviour.*
- 5.4 In respect of Child C, these deficits were evident in the context of his PEX, with the school failing to properly take account of statutory guidance and seemingly lacking any focus on Child C's overall wellbeing.



- 5.5 As part of the PEX process, there was neither sufficient consideration of Child C's progress nor evidence that the school was aware of and sensitive to his safeguarding needs. Furthermore, despite clear alternatives being recommended by HLT, these failed to gain traction. Child C's vulnerability and the likelihood of any potential risks arising as a consequence of his PEX should have received greater priority in any decision making. The review found no evidence that they were.
- 5.6 As identified in the Child Safeguarding Practice Review Panel's report on criminal exploitation<sup>7</sup>, '*exclusion from mainstream school is seen as a trigger point for risk of serious harm*' and permanent exclusion can be '*a trigger for a significant escalation of risk*'. Both statements resonate with the lived experience of Child C.
- 5.7 However, acknowledging that these findings are not new, there remains a disconnect between the known exacerbation of risk by exclusion and the Department for Education's (DfE) statutory guidance<sup>8</sup> on what head teachers need to consider when making such a decision. Indeed, despite the clear imperative for safeguarding risk to be an active component of decision making, the statutory guidance falls short in emphasising this with sufficient clarity.

### **What needs to be done differently?**

- 5.8 Children excluded from mainstream education achieve poorer outcomes and risks can increase through the potential to be exposed to greater risk from gangs, exploitation and involvement in youth crime. Every effort should be made by schools to keep children in mainstream education where possible.
- 5.9 Practice also needs to accord with statutory guidance. However, the statutory guidance concerning exclusions needs to better emphasise the inclusion of potential safeguarding risks when making such a decision. As presently written,

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<sup>7</sup> [It Was Hard to Escape - Safeguarding children at risk from criminal exploitation 2020](#)

<sup>8</sup> [Exclusion from maintained schools, academies and pupil referral units in England Statutory guidance for those with legal responsibilities in relation to exclusion September 2017](#)

whilst there is emphasis on avoiding the permanent exclusion of ‘*any pupil with an EHC plan or a looked after child*’, the guidance could also specify avoiding exclusions for those children where a risk of harm is likely to increase consequently. This is a matter for the DfE.

**Recommendation 1:** The secondary school should meet with the family to provide some closure to their unresolved issues.

**Recommendation 2:** Safeguarding Partners should reassure themselves that all schools within their jurisdiction abide by national and local exclusion policy and promote the use of other interventions designed to address disruptive behaviour as an alternative to PEX.

**Recommendations 3:** Schools should ensure they have a detailed understanding of the potential safeguarding needs of any child who is at risk of PEX. This should be informed by a robust assessment that includes a clear focus on extra-familial risks and the contextual safeguarding implications for the child.

**Recommendation 4:** The DfE should review the statutory guidance and non-statutory guidance covering exclusions to ensure safeguarding risks are sufficiently considered as part of the decision making process for exclusions.

## **Education settings need access to local intelligence**

5.10 Whilst at the PRU and his subsequent placement at the AP, there is good evidence that adequate assessments were completed with Child C and numerous referrals were made in an attempt to secure his engagement in a wide range of programmes.

5.11 However, both the PRU and AP had, and still have, minimal influence over which children are placed in their facilities. This could result in young people who live in rival gang areas or where there are other community tensions to be in the same classroom. Whilst the review concludes that staff in the PRU/AP

had a good understanding of the needs of individual pupils, the risk dynamic created by the makeup of pupils was less understood. In this context, PRUs and APs are likely to benefit from the support of other agencies and the sharing of contemporary intelligence on local themes, patterns and trends relating to youth violence and gangs.

### **What needs to be done differently?**

- 5.12 To help PRUs / APs develop a better understanding of risk and the context of the cohort of pupils attending their provision, information & intelligence needs to be shared with them to inform plans for individual children and the geographic locations in which the provision or its activities might be located.

**Recommendation 5:** To help PRUs / APs manage the potential risk arising from different cohorts of young people placed in their facilities, the CHSCP should make available to all educational settings, regular briefings that include intelligence on youth violence, local gang conflicts and other areas of community tension.

### **A focus on the individual child is important**

- 5.13 Due to poor record keeping by the secondary school, the review has been unable to draw any firm conclusions as to whether Child C's lived experience ever formed part of the thinking in respect of the decisions it made. The context in which Child C was PEX suggests that a focus on his individual needs was lacking.
- 5.14 With regards to the PRU / AP, a robust approach was adopted to both assessment and planning, that included face to face meetings with Child C to understand his wishes and feelings. There is evidence that Child C's experiences influenced the PRU / AP to make relevant referrals to other agencies, initiate interventions and provide training to meet his needs. It is recognised that following the APs referral to HCFS in January 2018, the change in Child C's behaviour, attitude and relationships with professionals made it difficult to gain a full appreciation of his experiences after this event.

- 5.15 After Child C was stabbed in February 2019, practitioners were clear in their assessment that Child C needed to be kept safe, although there was less certainty about how they would seek to manage the extra familial risks that he was exposed to. These were now significantly impacting on Child C's safety and well-being.
- 5.16 After being stabbed in February 2019, the practice of medical staff and the worker from Charity 1 demonstrated positive attempts to understand life from Child C's perspective. Social workers were subsequently persistent in their attempts to engage Child C to appreciate his experiences, risks, fears and his needs.
- 5.17 When HCFS social workers became involved, they escalated their concerns to senior management, and subsequently to the EFRP panel. This multi-agency panel should have facilitated a focus on how to mitigate both the potential risk that Child C was presenting to others and the risks that he was facing directly.
- 5.18 However, not enough focus was placed upon Child C as an individual during this process, and he was only discussed in the context of the wider group of peers that he was known to be associating with. Subsequently, when safety planning was initiated by social workers, this lacked the benefit of the view of partners and this was reflected in the quality of the plan. This omitted what should have been the cornerstone of action going forward; which was to seek to counsel Child C in respect of his personal safety and in order to come to terms with the significant trauma he had experienced.
- 5.19 Child C's mother and stepfather expressed during interview that in their opinion, Child C was suffering post-traumatic stress and mobility issues as he recovered from his physical and emotional injuries. Neither of these points were reflected in the safety plan devised for Child C.
- 5.20 Another relevant practice issue relating to individual needs links to the fact that boys from black and minority ethnic backgrounds, such as Child C, are more

likely to be vulnerable to extra familial risk, serious youth violence and criminal exploitation.

- 5.21 As part of the multi-agency response to Child C, whilst there is no evidence to suggest that racial bias influenced decision making in any of the agencies involved, there was little evidence that either his cultural or racial identity formed a central part of practitioner thinking. Indeed, practice was not insensitive to Child C's cultural and racial identity, but equally it cannot be said that practice was sensitive to these needs either. The review saw no evidence of any specific adjustments or proactive consideration of these issues.

#### **What needs to be done differently?**

- 5.22 When working with children who are victims of serious youth violence, emphasis needs to be placed on their individual recovery and that this aspect should be reflected in a plan that addresses their individual needs and fully engages the family.
- 5.23 When engaging with young people from black and minority ethnic backgrounds, practitioners should explore what their racial and cultural identity means for them in the context of where they are growing up and how they live their lives on a daily basis. It is essential that practitioners allocated to work with young people at risk of serious youth violence are confident to explore these issues, have a good understanding of the implications and can ensure that plans are tailored appropriately.

**Recommendation 6:** The CHSCP should ensure that local guidance covering risk, safety and contingency planning for victims of serious youth violence considers the trauma a young person has experienced, with the plan focussing on both the individual physical and emotional recovery.

**Recommendation 7:** The CHSCP should ensure that policy, procedure and guidance is sufficient to ensure the active consideration of racial and cultural identity as part of the safety planning process involving extra familial risks.

## **Clarity is needed about interventions to mitigate extra-familial risk**

- 5.24 At the time of Child C's death, multi-agency contextual safeguarding practice in response to extra-familial risk was new and developing. The partnership did not have extensive experience or a developed suite of interventions that could be deployed to keep Child C safe. It is also important to recognise that the circumstances involving Child C were complex and extremely challenging. There were no easy solutions.
- 5.25 Whilst local procedures were broadly followed as expected, the difference this made to Child C's outcomes is less tangible. Whilst perhaps sounding obvious, following procedures, or developing a better understanding of needs, are not actions in themselves that keep children safe. Key is a clear focus on the individual child and robust multi-agency assessment, planning and effective intervention.

### **What needs to be done differently?**

- 5.26 The multi-agency partnership needs to be supported to use a range of evidence-based approaches that are well placed to impact upon extra familial risk. The Child Safeguarding Practice Review Panel's recommendation for the DfE to trial a practice framework for the response to criminal exploitation may help in this regard, although the CHSCP should rapidly seek to ensure there is sufficient clarity about locally available interventions.

**Recommendation 8:** The CHSCP should ensure the available interventions for responding to extra familial risk, including young people at risk of serious youth violence and/or exposed to criminal exploitation are sufficiently defined within local guidance to promote consistency of best practice.

## **Developing positive relationships with young people is important**

- 5.27 As with many children in need or at risk, Child C is likely to have benefitted from a strong relationship with an adult or professional with whom he felt he could build a trusted relationship. There is a firm evidence base showing how this can make a significant difference in the lives of children, but it must also be recognised that Child C became progressively harder and harder to reach.
- 5.28 Indeed, a trusted relationship is likely to have been difficult to establish by any professional. However, had a trained community-based mentor or youth professional engaged Child C at an early stage (as had been initially planned), this could have made a difference. As Child C had previously benefited from good relationships with professionals from the Prevention and Development team, this could have been explored to provide support to Child C.

### **What needs to be done differently?**

- 5.29 Practitioners need to be persistent in creating opportunities to build confidence in both children and their families that professionals can keep them safe. At the earliest possible stage, the multi-agency network should identify a named professional who either has or can begin to develop a trusting relationship with a young person.

**Recommendation 9:** The multi-agency partnership should nominate a named professional or adult who has (or who can develop) a trusted relationship with children who are assessed to be of risk of serious youth violence. This named professional should focus on developing the child to adult relationship and coordinating multi-agency interventions.

## **Involving and supporting parents is essential to effective safety planning**

- 5.30 There was identified good practice from social workers engaging the family as part of the work with Child C. As noted by the Child Safeguarding Practice Review Panel's report on criminal exploitation: *'When parents are active in safety planning and implementation there appears to be a greater chance of success.'*
- 5.31 However, there is a balance to be achieved. In respect of Child C's family, the review identified an over-reliance on the family for the safety plan that had been developed at the discharge planning meeting. A curfew increased adult supervision and adult escorts for Child C were agreed, but all were reliant on the family to action. Agency responsibilities appeared to mainly focus on the provision of home schooling. Both mother and stepfather relied upon each other, and other family members to wrap around Child C to the best of their ability. The family told the review they had created a rota of family members who could supervise Child C in the home, or escort him to go to the local shops.
- 5.32 In the context of the challenges that the family were experiencing after Child C's stabbing, this plan would have benefitted from multi-agency resources and support, particularly in the context of someone developing a trusted relationship with Child C.
- 5.33 Other aspects of intervention involving the family included discussions about Child C going to live with his father. At the time, this plan was not supported by Child C's mother. This was reported as being due to the magnitude and implications of such a decision, with the need to make it quickly adding further pressure. Child C's mother did not feel able to agree given the trauma the family were experiencing.
- 5.34 This critical engagement with the family appears to have been rushed and narrow in focus. HCFS did not meaningfully engage with wider kinship or extended family to establish a more collaborative approach to safety planning,



and to explore much needed alternatives to Child C being relocated to live with his estranged father.

- 5.35 It is essential that parents are enabled and supported to make difficult decisions that are life changing in nature (like agreeing for your child to live with his estranged father) by engaging them in a way that establishes a collaborative footing between the family and professionals.
- 5.36 A family network meeting or family group conference could have brought key family members together with Child C and professionals to devise a family informed safety plan. This could have generated other placement options for Child C that mother is likely to have agreed. Instead, professionals repeatedly tried to convince Child C's mother to implement their preferred solution to relocate him with his estranged father.
- 5.37 Mother agrees that at times, she was indecisive, and on occasion changed her mind with regards to what was best for her son, and her family. This reinforced the need for professionals to be authoritative in seeking solutions to address the escalating risks and safety concerns for Child C. Had a placement with an extended family member been made, this is only ever likely to have provided a temporary solution for Child C in the short term.

**What needs to be done differently?**

- 5.38 Practitioners should make use of established forums such as family network meetings or family group conferences to bring together relevant extended family members and identify other alternatives to safety planning that might not be visible to professionals at the time.

**Recommendation 10:** HCFS should ensure that it follows the Pan London Safeguarding guidance for children who have been victims of serious youth violence, with an emphasis on the need to ensure that managers chair any relevant meetings as defined.

**Recommendation 11:** HCFS should ensure it exhaust all kinship options as part of a safety or contingency plan for children who are at risk of serious youth violence to help keep them safe.

**Recommendation 12:** To help families contribute to safety and contingency planning, HCFS should ensure the different methods of family engagement that can be deployed are promoted within HCFS and that relevant practice guidance is sufficient.

### **Inconsistent judgements about risk creates uncertainty**

- 5.39 Following Child C being stabbed in February 2019, risk was recognised and taken seriously by HCFS. There were ongoing concerns borne out of Child C going missing in the community, his diminishing engagement with professionals, plus mother's declarations about further substance misuse, confrontations in home and her increasing inability to control Child C's movements or behaviour. Together, all the highlighted issues were sufficient for HCSF to take decisive and robust action, especially in the context of the ongoing failure to agree an alternative address for Child C away from the community.
- 5.40 Although HCFS concluded that Child C was not safe in the community, the assessment by MPS judged that Child C faced a '*standard risk*' (both in terms of his missing episodes and his overall safety) and that there was limited intelligence to suggest otherwise. Child C remained in the same area following his serious stabbing in February 2019 until his murder in May 2019.
- 5.41 The actions taken by the multi-agency partnership over this period appear to have been insufficient in the context of Child C's experiences and known risk factors.
- 5.42 It was known that Child C had been coming to the notice of the police soon after his placement at the PRU/ AP. He had been stabbed and had refused to cooperate with the investigation to bring the perpetrator to justice. He stated he

feared for his safety and he was overheard on a telephone call discussing retribution with one of his peers. After his discharge from hospital, he started to go missing (even though usually let a family member know where he was) and was increasingly becoming beyond parental control. It is alleged that he was assaulted in March 2019. He had been seen in the community riding a moped, and just prior to his death, intelligence came to light that he may have been involved in county lines. There was also intelligence suggesting he was being mocked online and that his stabbing was linked to a music video involving Child C that could have been seen as disrespectful to particular gang members.

- 5.43 In the opinion of the lead reviewer, there was adequate information to conclude that the imminent risk to Child C was higher than that perceived by agencies at the time. Whilst the review found no clear evidence that the risk category assigned by the police swayed the view of risk in other agencies, it is hard to see how this didn't impact on the level of urgency with which Child C's case was being viewed.

#### **What needs to be done differently?**

- 5.44 When working with young people at risk of serious youth violence, it is important that individual agencies and the multi-agency partnership have a consistent understanding and process for determining perceived risk. This will help ensure that practice is commensurate with the potential for harm. The EFRP seems best placed as a forum in which risk can be discussed and graded in this context.

**Recommendation 13:** The CHSCP should review partnership and individual agency processes that involve the application of risk gradings for young people at risk of serious youth violence. Where required, these should be changed to ensure consistency and a clear understanding as to what the judgement means in the context of practice.

## **The use of child protection procedures**

- 5.45 In recognising the national debate on the use of the child protection framework to respond to the issue of safeguarding adolescents, there is known variance of practice across the UK. Many areas use established child protection procedures to provide a structure to their planning. Others are taking a different approach. Hackney's response revolves around the Extra Familial Risk Panel.
- 5.46 Regardless, the result should broadly be the same in that a coherent multi-agency plan is developed. This plan provides the structure to help mitigate risk in what are ordinarily complex circumstances. A gap in this context is the absence of any clear practice guidance in *Working Together to Safeguarding Children 2018*. The review understands that this is being addressed as part of a wider review into this statutory guidance and contextual safeguarding.
- 5.47 With regards to the multi-agency response to Child C, there is evident ambiguity about the 'status' of intervention. This led to a lack of structure and confusion supporting multi-agency intervention. For example, despite a strategy meeting being held, this did not appear to be a strategy meeting as defined in child protection procedures. Had it been, then there is likely to have been much greater emphasis placed on how this was managed, including who was chairing, who was attending, what needed to be considered and the partners involved.
- 5.48 Furthermore, the missed opportunity to focus on Child C's individual needs at the EFRP, meant that the one multi-agency forum where risk was being considered, did not have the remit or focus to develop an individual plan for him. This is likely to have been different if, for example, Child C was being considered as part of a Child Protection Conference.
- 5.49 The overall consequence of this lack of clarity was that planning and management oversight was weak and opportunities to intervene were missed. No agency was found to have developed a sufficient grip or a true appreciation

of the risks facing Child C, his interactions with other young people in his community, or where and how he socialised.

### **What needs to be done differently?**

- 5.50 When responding to extra familial risk, policy, procedures and practice guidance need to be explicit for practitioners. These need to ensure that established practice standards for safeguarding and protecting children are not diluted, regardless of the framework in which practice is being delivered.

**Recommendation 14:** The CHSCP should review the current guidance relating to the local response to extra familial risk and ensure that this provides sufficient clarity on the 'status' of a case, management oversight and the thresholds for intervention. This should enable practitioners to clearly differentiate when a response is required as part of an early help, child in need or child protection response or one that involves the engagement of contextual safeguarding procedure.

### **Poor case recording can directly impact on practice**

- 5.51 Case recording features in many SCRs, although other than noting it as being poor, it can often be difficult to see the actual impact on children. The circumstances involving some of the case recording in Child C's case are different and show how inaccurate recording resulted in Child C not receiving services. These could have helped him at a critical stage following his stabbing in February 2019.
- 5.52 As part of the strategy and discharge planning meetings held at the hospital, the disclosures made by Child C were shared and actions agreed. However, these meetings were not formally minuted and the hospital records were updated with inaccurate details, wrongly noting that it had been agreed Child C would live with his biological father outside of London.
- 5.53 Consequently, the hospital concluded there was no further role for them or a need to refer on to community-based services, that could continue to support

Child C post discharge. The worker from Charity 1 read the notes and came to a similar conclusion. The opportunity to meaningfully engage Child C at a critical moment after being injured was lost.

### **What needs to be done differently?**

- 5.54 Consistent with established standards of good practice, formal meetings as set out in the Pan-London Child Protection procedures should always be minuted, with a copy of the discussion and agreed actions circulated to attendees.

**Recommendation 15:** The CHSCP should reassure itself that clear minutes, including agreed actions from strategy and/or discharge planning meetings for victims of serious youth violence are accurately recorded, with copies circulated in a timely way to participant agencies and where appropriate, the family.

## **6. Conclusion**

- 6.1 Child C's PEX had a significant and life changing impact upon him. This event contributed to his exposure to a range of extra familial risks related to both school and the community. The PEX decision signalled a decline in Child C's behaviour and attitude, and a continual incline in associated risks.
- 6.2 Where possible children should remain in mainstream education. In instances where PEX is being considered, a fair and transparent process must be adhered to, and that the child's needs and any extra familial risks are fully considered and influence the decision-making process.
- 6.3 Child C's placement at the PRU, and then AP, was initially positive and he settled well. However, his exposure to challenging pupils from different post code areas, at a time where there was relevance of gang violence, made him more vulnerable. He went from being involved in a minor altercation with a peer to the victim of a serious assault. With risks and concerns mounting, agencies did not rapidly exploit previously established professional relationships that

existed with the family or find a way to 'grip' and agree solutions that immediately provided safety for Child C.

- 6.4 The relationship between parents and educational establishments is crucial. Mother initially had good relationships with his secondary school and AP, but both deteriorated when mother started to challenge how her son was being educated and treated. If constructive relationships could have been maintained, Child C's parents and school could have agreed a joint home – school strategy.
- 6.5 The multi-agency partnership met on various occasions to discuss Child C, and believed they had a good understanding of his lived experience. This is questionable. Professionals need to be mindful not confuse either presenting or alleged behaviour with a child's lived experience. These are not the same. Whilst lived experience can contribute to behaviour, it is not defined by those behaviours. Child C's ethnicity cannot be evidenced as a factor that meant he was treated differently, Child C's identity, how he perceived himself, his community and his peers was not known, and therefore could not inform his safety planning.
- 6.6 Communication channels were opened between agencies, but a consistent approach to information sharing, or a common understanding of what the information means in reality can be improved. All of the main involved agencies possessed key information, but it is not clear what difference having or sharing the information meant to Child C.
- 6.7 The review acknowledges the impact that Child C's tragic death has had upon those who knew him; his family and friends, his community and the many professionals who genuinely tried their best to help him. The opportunities presented by the introduction of the EFRP in Hackney provide a vehicle to improve the response to children like Child C who are victims of serious incidents. It is important that this partnership explores and clearly defines its roles, responsibilities, expectations and multi-agency methodology to extra familial risk management.