

Southwark Safeguarding Children Board

Serious Case Review

Child U

Independent Reviewers:

Sally Trench

Kelly Wilson

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1. Circumstances that led to this Serious Case Review

- 1.1 U was a 16 year old boy, of black African (Sierra Leone) heritage, who was killed in a knife attack in south London on 14th September 2015. At present, the Police investigation is ongoing.¹
- 1.2 The case review: Southwark Safeguarding Children Board (SSCB) decided to undertake a Serious Case Review (SCR), as the following criteria had been met:

*The child has died, and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.*²

2. The Welsh Model and Terms of Reference

2.1 The Welsh Model

The SSCB chose to use the 'Welsh Model' for this SCR. This takes the form of guidance for multi-agency 'child practice reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected'.³ It is intended to be used in conjunction with *Working Together to Safeguard Children* (2015). The model is suitable for all levels of case reviews, including SCRs, and for cases with good outcomes, as well as more negative ones.

- 2.2 The emphasis is on promoting 'a positive culture of multi-agency child protection learning and reviewing in local areas, for which LSCBs and partner agencies hold responsibility'. The model is inclusive in a new way, involving agencies, staff and families 'in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability'. Other key features include:

- A more focused, streamlined process with a shorter time period to be reviewed
- Consideration of the context in which professionals work in agencies, including 'culture', policies and procedures, and resources
- A **Learning Event** for all those involved in the case
- Exploring not only **what** has happened, but **why**
- Recommendations and actions to improve future practice

¹ An alleged perpetrator was charged and was due to go to trial, but the case was discontinued on the advice of the Crown Prosecution Service.

² *Working Together* (2015), p75: Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) – as quoted here.

³ *Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews*, The Welsh Government, January 2013

2.3 Time frame for review

The Welsh Model recommends a review period of no longer than 2 years. This is so that the learning is about recent, rather than historical practice, procedures and agency circumstances. In this case, a period of just under 2 years was chosen:

1st February 2014 to 14th September 2015

This period has allowed us to review U's last few weeks in one secondary academy, and then his managed move to a fellow Ark academy. The end of the review is the date of U's death.

2.4 Individual Management Reviews (IMRs)

With the production of IMRs, the process adopted for this review added another element to the Welsh Model, taken from the previous 'Chapter 8' model of *Working Together to Safeguard Children* (before 2010). The agencies and services involved with U and his family were asked to complete a chronology of their activities during the time period, and to produce an IMR for their agency, which should respond to the areas of inquiry listed in the next paragraph. The integrated chronology and the IMRs added a clear sequence of events, useful details, and, in some instances, direct information from members of staff who were interviewed.

2.4.1 The authors of the IMRs were persons with expertise and understanding of the work of these agencies, but with no direct involvement in this case.

2.5 Learning areas

The Welsh guidance suggests a set of generic practice areas for exploration and analysis, and these have been adopted by the Board for this review:

- Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. How did that knowledge contribute to the outcome for the child?
- Were appropriate agencies involved with the family, and were the respective statutory duties of agencies working with the child and family fulfilled?
- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues)?

In addition, the following questions were added by the SSCB in relation to this case:

- Was information about risks from or to the young person shared in an effective way amongst the agencies involved?
- Was effective action taken to mitigate risk?

In relation to all these areas of inquiry, were actions guided by sufficient attention to the child and family's culture, ethnicity, religion, and language?

2.6 Learning Event

A full-day Learning Event was held on 18th March 2016, for front-line staff and managers who were involved with U and his family, and included the SSCB Chair, the Lead Reviewers and Board Manager. The 24 professionals who attended took part in multi-agency discussions about the themes emerging from the case review so far. The group was also addressed by the Police Detective Inspector (DI) regarding gangs and youth crime in Southwark.

This group will be reconvened at the end of the SCR process, to give feedback on the final report.

2.7 Involvement of family

U's mother, his younger sister, and an uncle met together with one of the Lead Reviewers, Sally Trench. They talked about U and his difficulties. They described the help of Police and others. This was a distressing meeting for them, and we are grateful that they were willing to participate in the review.

Written contact has been made inviting U's older brother to meet with the Lead Reviewers. No response has been received.

Similarly, U's father was invited by letter to make contact with the Board Manager, so that a meeting could be arranged with the Lead Reviewers. No response has been received.

2.8 Independence of Lead Reviewers

The review is being led by an independent social worker, Sally Trench, who has a background in local authority mental health social work and children's social care, principally child protection. She currently acts as Chair and author of SCRs. She completed the London Accreditation and Training Programme for SCR Chairs and Authors, run by the Tavistock Institute (2010), and is accredited to use 'Learning Together', the Social Care Institute for Excellence (SCIE) systems model for case reviews.

The second lead reviewer is Kelly Wilson, a member of Southwark Youth Offending Service. She had no involvement with this case. Kelly is an experienced Lead Analyst for both tactical and strategic analysis within the policing and public sector field. With a strong background in intelligence and

performance analysis, she is currently working as the Quality Assurance Lead for Southwark Youth Offending Service.

Please see **Appendix 1** for full details of the Terms of Reference and the process of this SCR.

3. Family composition and brief family history

Family member	Age (at February 2014)	Address
Mother	45	London
Father of U and his older brother	Not known	London
Father of U's half-sister	49	Not known
Subject U	15 (died 14.09.15, aged 16)	London, with mother
Brother	20	West London
Younger half-sister	11	London, with mother

- 3.1 All members of the family are Black African from Sierra Leone. Mother, and other older members of the family, speak both Krio and English; the children understand both languages, but generally speak English, including at home. The family's religion is Islam.

Mother's comment: *She has two brothers and one sister living in London, and receives support from them and their families. A larger number of her family members remain in Sierra Leone. Father and his second wife, who live nearby, are not currently involved with her or the children.*

- 3.2 U was born in the UK. However, he and his older brother were sent back to Sierra Leone in 2001, where they remained living in the care of their maternal grandmother and other family members, between U's age of 3 years to 10 years.

Mother's comment: *She decided to send the children home to her family because she was worried about the risks from drugs, violence, and gang culture in the area where she was living; in addition, she says, the boys wanted to go with their maternal grandmother back to her home and live with her there. In Sierra Leone, the two boys were sent to a private school*

and got on well there. Mother visited them during this period; after the boys returned to live in London, the family continued to travel for family visits to Sierra Leone in the summer holidays.

3.3 Mother and Father had separated in 1998, and in the following years, Mother had a new partner, with whom she had her third child, U's half-sister. This relationship broke down after U and his brother returned to London, around 2011.

3.4 Older brother A:

3.4.1 The South London and Maudesley (SLaM) Mental Health Foundation Trust IMR states that U's brother A was reported to have had serious behavioural difficulties as a primary school child. At age 7, his school recorded his violence towards another child and threatened violence against a teacher, destruction of property, verbal abuse, and an inability to work in class or group situations. He was designated SEN Stage 3 for 'behaviour problems and negative behaviour'. The school made a referral to Child and Adolescent Mental Health Services (CAMHS), which was delayed for several months. Although the records show that Mother welcomed this referral, she was apparently angry at the waiting time, and in the end was not happy to take this up for U's brother.

Mother's comment: *She does not agree with this description of A, and does not recall that a referral to CAMHS was made.*

3.4.2 When U's brother returned from Sierra Leone, aged 15, he continued to have episodes of violence and challenging behaviour, both at school and at home. U was sometimes the target of bullying or assault from his brother, and he and his younger sister would certainly have witnessed his brother's anger and aggression on occasions. Both father and mother, in their separate households, were 'not able to manage the boy's behaviour', and at age 16 U's brother A was accommodated by the local authority (March 2010), and then moved on to semi-independent accommodation. It was suspected that he was involved in gang violence and criminality.

Mother's comment: *She does not agree with this description of A, and denies that he had any involvement with a gang or gang activity. She says that A was affected by the bad feelings between their parents. She did not want her sons to come back to live in London, but it appears that their father insisted that they return.*

3.4.3 During this period, assessments were made of U's brother, which did not adequately take into account or describe the 'extent to which his needs and behaviour impacted on the other children in the household' (Para 6.6, Children's Social Care (CSC) IMR). The IMR author states that this was 'not consistent with agency expectations and it constitutes a missed opportunity

to have formed a fuller view of U's needs, family relationships and to have identified sources of support or potential harm in the community'.

3.4.3.1 CSC's new data recording system, Mosaic, now makes it easier to create family groups and it is less likely that the wider family would get overlooked. However, it remains important to underline the need for a 'whole family' approach.

3.4.4 Southwark Youth Offending Service (YOS) was involved with U's brother A from August 2010, when he received a Referral Order in relation to an assault on a young woman. The focus of their work was support for housing and education. In April 2011, he himself was the victim of a serious attack; he was hit over the head with a bottle by a group of young men on his local estate. Since that time, U's brother A has not lived with his mother, and is regarded as being potentially at risk of violence from others should he come to the Southwark area.

3.5 Child U

In early 2009, U returned to London and lived with his mother and half-sister. There was little contact with his father and his new family. He entered Surrey Square Primary School in March 2009, and remained there for his final Year 6.

3.6 Child U independently accessed a local community organisation, XLP⁴ in his last year of primary school. They continued to work with him in secondary school for a number of years, until he transferred to Globe Academy (see below). Walworth Academy commissioned XLP to work with U within school as mentors, supporting both his academic work and his behaviour in class. He also joined their weekly football sessions and other youth tournaments, and regularly attended their community 'bus', for a programme aimed at diverting young people from offending and placing themselves and others at risk. XLP staff knew the family well, and Mother considered them a positive factor in U's life.

3.7 Upon his transfer to Year 7 at Walworth Academy (September 2010), U was said to be approximately 4 years below the expected level of achievement for a child of this age. As a result, the school placed him in a small 'Nurture Group', where he remained for Years 7 through 9. U made good progress there, and 'had caught up significantly', so that he was deemed suitable to return to mainstream classes and to access GCSE courses. However, a concern was recorded in October of Year 9, when he reportedly 'brought a weapon into school'.

⁴ From the XLP website: 'XLP is about creating positive futures for young people growing up on deprived inner city estates, struggling daily with issues such as family breakdown, poverty, unemployment and educational failure, and living in areas that experience high levels of anti-social behaviour, criminality and gang activity... We believe positive, consistent relationships can restore a young person's trust in people, nurture the belief that things can change and encourage them to set positive goals and work hard to achieve them.'

Mother's comment: *She stated that this was a 'corkscrew'.*

- 3.7.1 The school stated that their working relationship with Mother in these years was good, and she attended meetings and other school events as required.
- 3.8 The move back into mainstream school in Year 10 was less successful. U was at times disruptive and increasingly defiant in school, resulting in a succession of exclusions, and at the same time, he began to go missing from home (staying with unspecified friends). In October 2013, U stabbed a fellow pupil with a pencil, and appeared before a Governor Behaviour Panel (25/10/13) where he was formally warned about his conduct. Suspicion about his carrying a weapon (a knife) and making threats to use this were of particular concern.

Mother's comment: *Mother was aware that U was at times frightened. She mentioned his involvement with XLP, which works with young people to reduce offending and knife crime.*

- 3.9 At the same time, U was a popular boy with a beaming smile, whom his teachers found charming, a young person who was willing to listen and try to change his behaviour, but who struggled to follow through on these changes, especially when around other pupils. His Principal at Walworth Academy described various efforts to support U, including daily mentoring, and one-to-one learning assistance in the classroom:

'The impact of having one-to-one support was the best intervention he could have but he could not transfer it to other situations when with his peers.'

Mother's comments: *U was initially happy and settled at Walworth Academy, and she attributes this to the influence of the Principal at the time. Both Mother and U admired and respected this man. Mother suggests that U was less happy after his departure.*

- 3.10 U's younger sister is half-sibling to U and his older brother. She is described as a well-behaved young girl who is doing well in school. She can be assumed to have witnessed a great deal of upset and conflict in her family home.

Mother's comments: *U and his sister were very close and spent a lot of time together.*

4. The Review Period (February 2014 to September 2015)

Please see **Appendix 2** for a **Key Dates Chronology** for this time period.

- 4.1 In February 2014, U's brother A was serving a 30-months prison sentence for robbery with a knife; he remained in custody until February 2015. U and his half-sister were living with their mother, and having no contact with their father(s).
- 4.2 Because of U's disruptive behaviour in school, and one serious assault on a fellow pupil, he had already been excluded 4 times during this academic year. The school were making extensive use of pastoral and mentoring services for U, whom they wished to support to succeed, both in terms of making academic progress and of reducing his anti-social behaviour.
- 4.3 At the beginning of the winter term, U had an unauthorised absence of two weeks, whilst on a trip with his mother to Sierra Leone. Upon their return, the school met with Mother and his absence was discussed, along with U's behaviour. A behaviour contract was signed, in the hope that there would be an improvement. However, U was unable to sustain this, and in fact was becoming more confrontational and defiant in his classes. As a result, the school saw little means of avoiding permanent exclusion, something which they wished to avoid. This triggered discussions, across the Vice Principals in the two academies, about a managed move from Walworth to Globe Academy. This was in order to give U a 'fresh start', whilst keeping him in mainstream schooling.
 - 4.3.1 The Assistant Principal of Globe Academy met with Mother and U, to explain the purpose of the managed move, and has reported that they were in agreement with this. U joined Globe Academy on 25th March. The local authority's Manager Pupil Inclusion was consulted regarding the schools' decision-making and the outcome of the move.
- 4.4 U initially settled into his new school, and 'passed' the 6-weeks trial period. He was monitored closely, and staff reported that at the end of the spring term and during the summer term, 'his behaviour and general demeanour were for the most part positive.'
 - 4.4.1 From the outset, Globe Academy provided high levels of monitoring and support to U. His Dean of Students took a particular interest in him, and at the end of Year 10 she made a referral to their Student Referral Group, which is designed to consider the needs of any pupil about whom staff are concerned and who needs 'some form of intervention'. The reasons for the referral were that U 'didn't seem to understand the consequences or implications of things he did and said'.
- 4.5 In April 2014, U presented to St. Thomas's Hospital ED on two occasions: once, unaccompanied, at 10pm, with a facial injury; second, unaccompanied, daytime, with a knee ('football') injury (April 2014). The IMR for GSTT commented that on his first visit, when he attended unaccompanied, 'no

concerns were evident and therefore did not trigger the need to undertake any network checks’.

- 4.6 On 6th June 2014, Police were involved with U and his mother, when he called Police to their home, saying his mother had thrown him out.
- 4.7 At the beginning of Year 11, after the summer school holidays, U arrived at school with a recognisably altered attitude – e.g., wearing a hoodie over his school blazer. He began to truant early on in the school year, and to revert to the disruptive/challenging behaviour which had led to his managed move from Walworth Academy. The school tried to work with U and his mother to improve his ability to participate in classes. Individual mentoring and intensive support continued to be provided.
- 4.8 Mother requested Police involvement again on 15th October, when she called them to assist her with U, whom she had found out of school, hanging out with a group of ‘gang members’ and smoking cannabis on a nearby estate. The Police took both U and Mother home, but were called again later the same day to deal with a further family dispute.
 - 4.8.1 The Globe Academy Safer Schools Officer met with both Mother and U a couple of days later, to discuss truanting and poor behaviour in school.
 - 4.8.2 Soon after this, in the last week of October, Mother reported U missing to the Police, and they visited for a ‘return interview’.
- 4.9 Academy staff made no referrals for U to Education Welfare in years 10 or 11, although his attendance levels at school were consistently below the level at which a referral might have been made. In September of Year 11, the Dean of Students for Key Stage 4 requested an educational psychologist assessment. She had observed how U was struggling with his academic work and wondered whether ‘the low level disruption [in classrooms] was because he was not accessing the work in school, so acted the clown.’
 - 4.9.1 The educational psychology assessment, which took place in November, showed that U was still significantly behind in reading skills and was not able to access much of the material presented in classes, or expected for homework.
 - 4.9.2 The Dean of Students noted in her interview for the Ark Academies’ IMR that ‘it was late for this assessment to have taken place, but once assessed by Globe he was supported quickly’.
- 4.10 U’s ongoing behavioural difficulties and the psychologist’s report suggested that he was unlikely to cope in a mainstream setting. A Student Referral Group meeting (20th November 2014) was held to discuss a way forward. At this point, U was referred to two specific programmes for young people

struggling to control their aggression (COVO⁵ and LEAP⁶). It was noted that after accessing the LEAP programme, U showed a greater awareness of his own responses, and a desire to avoid problems with his peers, and subsequently 'there were no exclusions for anything to do with conflict with other students'.

4.10.1 This meeting included all of U's teachers, and a representative from the LA Early Help Team, who (the school's IMR noted) did not suggest a referral onwards to CSC or any other agency.⁷ In response to the Educational Psychologist's report and U's ongoing difficult behaviour, the decision was made again to move him, in the winter term of Year 11, to a work-based programme, Building Lives. This programme was for 2/3 days a week, and allowed U to continue working towards his GCSE English and Maths exams at school, as well as to access the COVO counselling and LEAP workshops to which he had been referred.

4.11 During this same period, as noted above, U was coming to the notice of the Police, for family conflict/arguments, for going missing from home, and for involvement with other youths deemed unsuitable by his mother. At this point, and in relation to later periods of U being missing from home, there was inconsistent sharing of information by MASH Police with CSC. In relation to their own duties, the Police followed up each missing episode with a return interview, and U's and his mother's views were recorded. U's story was that he was staying with friends when away from home. (NB, the length of his missing periods increased to the point where he was away from home for **12 days** in July 2015, although he was not reported as missing until he had been away from home for 7 days.)

Comment: U explained to his mother, in a letter found by her after his death, that he was staying away from home because he was frightened of one particular young man (and possibly others) who had threatened to beat him up, or worse.

4.12 U's placement at Building Lives began in January 2015 and lasted for one term. The Manager of Building Lives commented that U was an able boy who picked up skills readily and was very keen to please. But he was also worried about U and the negative influence of older boys from a nearby estate. U seemed to be attracted to the 'gang culture lifestyle', which he was ready to adopt as 'his way of life'; he also regularly and openly talked about drugs and

⁵ A 'bespoke therapeutic intervention designed for individual students' – commissioned by Globe Academy. COVO made an assessment of U, followed by weekly counselling sessions, during which U spoke about his family situation, and feelings that he was not good enough, especially in comparison with his younger sister.

⁶ LEAP provided a series of workshops over 6 weeks that deal with conflict resolution and aggression, which M attended.

⁷ The Review Panel were told that a referral to CSC would have awaited the outcome of the plans which were made at this meeting. A referral would have been considered at a follow-up meeting, had there been no positive outcome from the planned interventions.

weapons. The Manager saw U as a 'tough boy who would not back down and I feared this might get him into trouble one day'.

- 4.13 U was asked to leave Building Lives (April 2015) after he assaulted another pupil, requiring him to have hospital treatment, as well as a second incident of threatening a pupil with a knife. These incidents resulted in his returning to Globe Academy just before his final term of statutory schooling. He was placed in the Internal Exclusion Centre, although it is unclear how much time he attended there. The school were keen not to exclude U at this very late stage, and wanted him to be able to sit his imminent GCSE exams. They also needed to manage the assessed risk posed by U to other pupils and staff. He was granted early Study Leave for the remaining period leading up to his GCSE exams. As a consequence, he was off school/at home for many weeks, and not under the direct supervision of any staff, apart from telephone contact.
- 4.14 In 2015, Police were frequently involved with the family, for a number of different reasons.
 - 4.14.1 U was reported missing in January (away 1 night). At every return interview with Police, which were consistently carried out, U stated that he had stayed with 'a friend', but would not give a name.
 - 4.14.2 February 2015: U's brother A was stabbed on the day he was released from prison. He went to his mother's flat, where only his younger sister was at home. A MERLIN was sent to Police in MASH, regarding the sister, who (aged 12) called an ambulance for her injured brother. However, it is noted that her age was recorded incorrectly as 16.
 - 4.14.3 March 2015: U was arrested as a suspect in a burglary at Walworth Academy; this resulted in NFA.
 - 4.14.4 April 2015: U was arrested, as a suspect in a group of young people who committed an assault on a 15-year old girl. This later resulted in NFA when the victim withdrew the allegation.
 - 4.14.5 April 2015: U's brother A was stabbed for the second time since his release from prison in February, and was returned to prison because he was found to be in possession of a blade and a baseball bat.
- 4.15 U was supported to attend his GCSE exams. Sadly, he did not attain any passes. He told school staff that he had signed up to attend college in September, but later no record was found of his application or acceptance.
- 4.16 June 2015: U was missing for 3 days. Later in June, he was arrested after his apparent involvement in the robbery (with others) of a pizza delivery man. While running away from the scene, he was seen to discard a 'long bayonet

type hunting knife'. He was charged with the offence in relation to carrying the knife, and bailed to appear at Camberwell Youth Court on 23/9/15 – shortly after his death. It was as a result of this episode that U's name was added to the Gangs Matrix and he was discussed at the HAMROW meeting on 25th June.

- 4.17 In July 2015, U was missing for 12 days, during which time his mother reported him to the Police, after he had been away for 7 days (and in which time his sister had seen him out and about). A return interview was carried out on 20th July, and U again stated that he had been staying with friends.
- 4.18 In September 2015, just before his death, there were two reports to police: one from a previous friend of U, who said he had been threatened by him, with a suggestion that U would use a knife; the second, an anonymous informant from Walworth Academy suggested that U was dealing drugs.
- 4.19 In these two years (Years 10 and 11), U's mother was fearful about his activities and the risks involved. She struggled to keep him safe, but her night-time job in a care home made this particularly difficult. She generally cooperated with school and Police in trying to do so. She frequently expressed her concerns about his associating with a dangerous peer group, including some 'older men'. The relevance of U's activities and associations for his death is not known.

5. Practice and Organisational Learning

- A. Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances? How did that knowledge contribute to the outcome for the child?**

Understanding family and childhood history

5.1 Introduction

The key to understanding a child lies not only in responding to him in the present (talking, doing things together, meeting his family and friends, etc.), but critically requires one to find out about his early experiences of care-giving and nurture, about his family relationships and friendships, and his overall physical, emotional and cognitive development.

- 5.2 Much of this information for U was missing because he had spent a significant period of his early childhood in Sierra Leone. He attended school there and only entered the English school system near the end of Year 5. In order to meet the requirement to provide him with an education, as a child entering the borough from elsewhere, the LA would need to place him in a

school as quickly as possible. The child may or may not, depending on the school, receive an assessment of his needs, including language, and his past educational experiences and attainment. This can be assumed to be a complex matter for a child whose first language and the medium of previous schooling were not English.

- 5.3 Upon his admission to Surrey Square Primary School at the end of year 5, all required academic assessments were completed. At the time of his admission, the parents shared limited information about background and context and as such the school were unaware of his previous educational and wider life experiences. There were no concerns about U's behaviour and no safeguarding concerns were raised. Due to the short time he was at primary school, there was limited information on his pupil file.

Recommendation 1:

Southwark Education and schools should consider how to make a consistent and appropriate assessment of the needs of children who move into the borough, especially where they have come from abroad under unknown and/or potentially traumatic circumstances.

Recommendation 2:

Southwark Education and schools should establish a consistent set of expected standards about the information passed from primary to secondary school, and from school to school under 'managed moves'.

For the Education Authority, in partnership with schools, to consider: What are the mechanisms for schools to get to know information about a child's family and community situation?

- 5.4 Both Walworth and Globe academies knew that U was a low achiever who was significantly (4 years) behind in his understanding and attainment at school. Walworth Academy had appropriately placed him in a protected 'Nurture Class' for three years, and this had worked well for him. But beyond this, we have found no specialist assessment of his communication needs (oral and written) relating to English as a second language, or any other problems. The educational psychologist's assessment was requested in September 2014, at the beginning of Year 11, and undertaken in November. Its conclusion was that his inability to read and understand material meant that he could not access the mainstream curriculum. Had this been known several years before, a different approach might have been taken, possibly as early as in primary school.

The interview with the manager of XLP, someone who had known U for 5 years, suggested that he continued to struggle with communication, because of his poor English, though this was not mentioned in other interviews.

- 5.5 The family did come to the notice of CSC in March 2010, when Mother asked for U's brother A to be accommodated because she could not manage his aggression and offending behaviour. He remained in foster care for only a short time, before going to stay with an aunt, and then returning to his mother. A Core Assessment was undertaken by CSC, which concluded that U's brother A 'was not considered to be a child in need.' The IMR for CSC questions this judgement, in light of the fact that the boy self-referred as homeless shortly after (June 2010), after using violence towards his siblings.
- 5.6 The 2010 Core Assessment focused 'almost exclusively on U's brother A and did not take into the account the needs of the siblings with whom he was sharing a family home'. (CSC IMR, para 6.3) It did not include an exploration of either boy's experiences of care while in Sierra Leone, so lacked vital information for assessing needs and risks. An Initial Assessment was carried out in June 2010, relating to a Police report that U's brother had 'either punched or pushed U and his sister', but it was not evident that the siblings were interviewed. In the following year (May 2011), Police sent a MERLIN to CSC about an incident of 'bullying' (U's brother against U, when U was playing football). This included the first mention of his brother having 'gang affiliations', but this again was not explored further in relation to the impact on U. This was a missed opportunity, given that the London Child Protection Procedures stipulate that 'the needs of siblings should be considered when this [gang affiliation] is identified in respect of a family member'. (Para 12.5.3)

Recommendation 3:

Assessments by Children's Social Care should capture as much as possible about a child's psycho-social history, including the experience of care by other relatives and in another country, and relationships with siblings.

Recommendation 4:

The partner agencies of the SSCB should consistently flag up and share information about siblings who are involved in serious youth violence or are known to have gang affiliations.

- 5.7 The point being made here is that, when U began to a) struggle at school and b) come to the notice of the police, the impact on him of his older brother's aggression within the family – over many years – and the brother's current offending and gang links were not known about and were not understood as risk factors for U (and his sister). This would have later implications for those involved with U. Only some agencies knew that his brother was suspected of gang activity or that he was in prison.
- 5.8 Could services have found out more about the family and U? Mother was an isolated single parent from a very different culture, struggling to keep her two sons and daughter safe, and with a poor relationship with their father(s). It is not clear that agencies had a good understanding of her sources of

support, within her family and her community. In meeting Mother for the purposes of this case review, she appeared to rely on the help of a close and trusted male relative, and also described how she asked an 'elder' from her own community (Sierra Leonean) to 'keep an eye' on U, and to assist in dealing with another young man who was 'harassing' U, trying to get him to deal drugs.

B. Were appropriate agencies involved with the child/family? Were the respective statutory duties of agencies working with the child and family fulfilled?

5.9 Introduction

One of the findings of this review is that services put a lot of effort into helping and supporting U, and trying to prevent the growing risks to him from his behaviour and associations. The agencies who were involved generally carried out their roles and responsibilities towards him and his family well. However, as we shall see below, all their efforts might have been more effective had they been able to establish a wider partnership, a fuller assessment of his needs, and better planning to share how these would be met.

5.10 Police:

5.10.1 Borough Police were involved throughout the period of this case review.

They responded to 5 incidents in 2014, and 7 incidents in 2015. These included several referrals by Mother and by U himself, regarding conflict between them, his going missing, and her worries about his using drugs, and associating with older boys/young men involved in violence and gang activity. There were also a number of separate incidents/allegations about U's offending, and one arrest leading to a charge against him.

5.10.2 With regard to the family matters, Police responded appropriately, in assisting both Mother and U to resolve conflicts, and, when U went missing, in carrying out the required 'return interviews'. Their recordings include Mother's views and concerns in detail, giving a powerful account of U's increasingly risky behaviour out in the community. Mother, in her interview, showed appreciation for the help that Police gave her. She had only one concern (reported in conversation with Sally Trench), which was that U was handled roughly when Police came to search the family home after an allegation of a break-in at Walworth Academy (3rd March 2015).

5.10.3 U was always seen and listened to, and what he said was captured and recorded. However, Mother suggests that he did not tell Police what was really happening for him. She shared a letter which U had written to her in summer 2015, after he had been missing for a long period of time. In this, U apologises to his mother for being away, and says that this was because of threats of violence from a [named] older male whom he was

trying to avoid. Mother felt that U would have been too frightened to tell the Police about the people in the area who were harassing him, and why he was trying to get away from them (e.g., when he was missing).

5.10.4 The Police IMR comments on particular good practice in relation to the incident of 2nd August 2014. 'Mother had rung Police seeking advice regarding U who she believed was *'associating with unsuitable older Somalian men...'*. It would not have been unusual for this to have been dealt with by way of advice on the phone and referring Mother to CSC. However, in the middle of the day, officers went to the home address and spoke to both separately, recording the actions and the advice given on a MERLIN record.' (Para 5.57).

5.10.5 MERLINS were created and sent to Police Officers in Southwark's Multi-Agency Safeguarding Hub (MASH) in all instances. These included two MERLINS for each missing incident: the pre-assessment check (PAC) and the Return Interview record.

5.10.6 The Police IMR makes criticisms and recommendations regarding how the MASH Police dealt with the MERLINS received by them. This will be discussed below in Section D, on information-sharing.

5.10.7 Safer Schools Officer

School and Police records show that the Safer Schools Officers in both academies met with U (and sometimes with both U and Mother) when they received information in some MERLINS (not all). Globe Academy staff say that they were only aware of three incidents regarding U, with the implication that there was not consistent and complete reporting by the Safer Schools Officer to the appropriate person in the school.

5.10.8 The Early Help IMR suggests that it would be helpful for the Safer Schools Officers to attend Student Referral Group meetings more regularly, so that key information, including criminal intelligence, could be readily shared about pupils coming to the attention of Police.

Recommendation 5:

Schools, Police and YOS representatives should consider how to enhance the effectiveness of the Safer Schools Officers, especially in how they record and share information and expertise with school staff and managers.

5.10.9 HAMROW in Southwark

The Metropolitan Police Service (MPS) routinely analyses data regarding all those (adults and young persons) involved in crimes and gang activity in London. These data, in the form of a list called the 'gangs' matrix, are provided to each borough on a daily basis. In Southwark, all members of the gang's matrix are discussed fortnightly within a HAMROW meeting: a multi-agency forum to identify risk and vulnerability, ensure prevention and

diversion work is taken along with enforcement action against individuals or groups involved in serious violence. The forum includes a number of Police teams, as well as YOS, Probation, Southwark schools and exclusion/safety officer, CSE and anti-social behaviour units.

5.10.10 A full assessment of the top 10 names on the Southwark gangs matrix are undertaken, to include welfare and family matters as well as offending ones. Police and YOS also carry out a joint visit to juveniles on the matrix where this has been agreed through HAMROW. Additionally, Police now refer relevant subjects directly to YOS, outside of the HAMROW process.

5.10.11 U's name was placed for the first time on the gangs matrix after being charged with carrying a knife (in connection with a robbery) in late June 2015. As a result, U came to the attention of the YOS at that point, but in fact there would be no involvement with that service until his court date in late September (which was after his death).

5.11 Ark Academies (Walworth and Globe)

5.11.1 U's first secondary school (Walworth) reflected the diversity of the area where he lived, including 30% Black African pupils, and was thus an environment which to a degree matched his ethnicity. The student body of Globe Academy was similarly diverse.

5.11.2 It has already been noted above that due to U not starting school until the end of year 5, he arrived at Walworth considerably behind in his learning, especially in literacy and maths. Based on his standard tests, such as SATs at Key Stage 2, U was placed in the school's 'Nurture Class' for three years. This provided a smaller group with a consistent teacher, similar to what happens in a primary school setting, with specialist subject teaching brought in as needed. It seems he did well in this environment, progressing to the point where he could be transferred into mainstream classes in Year 10.

5.11.3 As outlined in Section 4 above, U struggled from the outset in Year 10, and his behaviour was disruptive in a way that affected his own learning, and that of others. Teachers and pastoral staff responded with firm and clear measures about poor behaviour, as well as positive help to support and encourage U to improve. These measures often included communicating with Mother, and involving her in meetings about U. In Globe Academy, the Dean of Students for Key Stage 4 was a Sierra Leonean woman who was able to communicate well with Mother, speaking a shared dialect from their home country.

5.11.4 The IMR for Ark Academies includes a set of very full written interviews with staff, which describe the persistent and intensive efforts they made to help U at both Walworth and Globe. These included the following:

- One-to-one classroom support and mentoring for literacy and behaviour, from XLP and others
- 'high quality pastoral support, which was provided on an almost daily basis at Walworth Academy' (Para 7.10)
- Inclusion in targeted programmes for young people at risk from knife and gang crime and violence
- Extra help via commissioned programmes COVO and LEAP

The schools concluded that the most effective way to work with U was 'one-to-one', rather than in group settings. This meant that much of the work done with him was resource-intensive and costly.

- 5.11.5 The Ofsted inspection of Walworth (2014), in addressing the area of 'Behaviour and Safety', gave the following judgement: 'The academy's work to keep pupils safe and secure is outstanding. The quality of care for students' health and well-being is second to none.' Globe received a similar evaluation: 'The school's work to keep pupils safe and secure is outstanding. Students say they feel very safe in the academy and staff carry out regular checks of the site to make sure of this'.
- 5.11.5 All this suggests that in both academies, U was in an environment which gave the highest possible priority to his (and others') safety and wellbeing. This was a message to all pupils, and it may have been reassuring to him and his mother. The problem for U seems to have been the overriding lure of street culture among the groups of teenagers and young men in the local area where he spent a large amount of time. U was said to be attracted to the status of using weapons, dealing drugs, and even the 'badge of honour' of being sent to prison (where his brother was).
- 5.11.6 In the first two terms of Year 10, U had 4 exclusions, one of 5 days (October 2013) after a serious incident in which he stabbed a fellow pupil with a pencil. He then missed school for the first part of January 2014, having travelled to Sierra Leone with his mother, an unauthorised absence. Upon his return, his behaviour continued to be unacceptable. Thus, he was at serious risk of permanent exclusion from Walworth. The 'final' step taken to prevent this was a 'managed move' to Globe Academy (March 2014). This was explored between the two schools, at Assistant Principal level, and was also discussed with the local authority's Manager for Pupil Inclusion.

Recommendation 6:

Schools should consider 'at risk of permanent exclusion' as a trigger to convene a multi-agency meeting.

- 5.11.7 The Ark Academies have a rigorous framework for monitoring and enabling students to alter their behaviour. An important aim is to reduce the number of students being permanently excluded, and managed moves are an important tool in this strategy. These have contributed to a considerable

reduction in the numbers of permanent exclusions across the whole of Southwark. The local authority Manager for Pupil Inclusion has been working with Head Teachers and Principals in relation to using managed moves to support children at risk of permanent exclusion. (See reference at Para 5.18.2, about the information that was shared/not shared at the point of decision-making regarding U's managed move.)

5.11.8 Globe managed the 'trial period' of U's first 6 week with very close monitoring and support for him. This period is seen as important in establishing for a pupil what is expected of him/her in the new school setting. U responded reasonably well, and completed the final term of this school year with no major mishaps. (At home, there were still problems, and Police were involved in a family dispute in June 2014.)

5.11.9 U's return to school in Year 11 marked a noticeable downturn in his attitude and behaviour. Globe's Dean of Students Key Stage 4⁸ was increasingly concerned about his academic performance, and at the beginning of the new academic year, September 2014, she made a referral for him to be assessed by an educational psychologist. The referrer has commented in her interview that it was 'agreed it was late for this referral to have taken place'. The educational psychology assessment took place in November. The IMR author has raised the question of whether an earlier educational psychology assessment might have been helpful, in terms of understanding and dealing with M's 'spiralling poor behaviour'.

5.11.10 One important benefit of an earlier assessment would have been to gain a better understanding of U's learning needs. In fact, this is what the assessment did do, by demonstrating that his communication skills (reading, writing, speaking) were too poor for him to access the mainstream curriculum. This was unlikely to have been the only factor in U's disruptive behaviour and absences from school, but it may have been a significant one. For this reason, it would have been helpful to have this assessment at an earlier stage: at primary school or in the first year of secondary school.

5.11.10.1 One of the Senior Educational Psychologist's in Southwark was asked to describe how the system works, in terms of the timing of when an educational psychologist's assessment is needed/requested. She explained that not all academies choose to buy into the local authority service. At the time of U's entry into Walworth, there was no contract in place (though there is one now; there is not one with Globe). The contract with the LA Educational Psychologists team includes regular consulting meetings with staff, who can discuss pupils who may need an assessment or other type of service. Whatever service an academy uses, they are required to follow the national code of practice for children with special educational needs, in providing a 'graduated response to the child's needs'. She also commented

⁸ Non-teaching member of staff looking after the behaviour and welfare of KS4 students. The role can include some direct link with parents.

that a child who arrives in this country with little or no English (as U did, at age 10) may take several years to develop the language needed for academic cognitive skills.

5.11.10.2 This is not to diminish the extensive efforts made by both academies to support U and the progress they enabled him to make. But it is also possible, as the IMR author suggests, that an earlier educational psychologist assessment might have been helpful 'in terms of accessing wider support through external agencies, including possibly social care'. (para 7.38)

Recommendation 7:

Children arriving in the borough and requiring an education place should, under the following circumstances, have an assessment of their needs so that appropriate services can be offered:

- **Arrival from another country**
- **English as a second language**
- **Evidence of trauma/separation and loss**

5.11.11 The Ark Academies' IMR and the participation by their staff at the Learning Event for this review made it clear that both Walworth and Globe would like to be able to access appropriate interventions from partner agencies, particularly CSC, for a vulnerable boy like U. They themselves do not have the resources to carry out wider family assessments, but are aware that these may be needed in many cases, as they would bring together information from several sources that might assist their understanding of a pupil in their school.

5.11.12 School staff told us that they generally experience high thresholds when trying to get CSC involved with a pupil, and this affects their confidence about when and how to involve partner agencies. In U's case, however, there were no referrals to CSC during 2014 and 2015, nor in late 2013 when U stabbed a fellow pupil with a pencil. This assault would have reached the threshold for the Youth Offending Service (YOS) and thus a referral could have been made – which would have opened the door to an assessment. More will be said about this below, in relation to information-sharing (Section D).

5.11.13 In fact, the SSCB's 'Multi agency threshold guide' (2015) includes very clear criteria for referrals, with lists of typical factors and incidents which would meet the threshold for different levels of intervention, as well as flow-charts. U's circumstances are replicated to a striking degree in the guide's description of a child or young person with Level 2 needs, who should be assessed via a CAF, at the very least. This SCR process has highlighted that the guide needs to become more familiar and routinely used by all partner agencies, including schools and academies.

Recommendation 8:

The partner agencies of the SSCB should each take the lead and be responsible for promoting the dissemination and use of the Board's 'Multi-agency threshold guide' (2015), especially schools and academies.

Recommendation 9:

The guide should be reinforced by regular visits from CSC to schools/academies, to assist the formulation and sending of appropriate referrals. The use of 'scenarios' is regarded by schools as a helpful way for them to understand thresholds and what kind of referral to make.

5.11.13 Support for parents: There are parents groups at both academies, providing another way to support parents/carers to help their children achieve in school, and behave well and stay safe in different situations. However, the review was told that Mother did not take up the offer of a parents group at Globe Academy.

5.11.14 Changes in place within the two academies

- From October 2015, there has been a Globe mentoring programme to work with students at risk of carrying/using knives and linking with gangs. These pupils have an official and unofficial mentor (see p53).
- Summer holiday 2016, particularly vulnerable students will be identified and offered a programme of local activities in the borough.

5.11.15 Building Lives

Building Lives provided U with a small group setting, where he acquired a number of new skills, and was reported to be a quick and willing learner. The programme seemed to suit him in many ways. His place was 3 days a week, and he continued to attend Globe Academy for 2 days in order to complete the work for his English and Maths GCSEs.

5.12 Health

5.12.1 U was generally a healthy child who did not need regular health or medical input. He had contact with the Emergency Department (ED) at Guy's and St. Thomas's Hospital in April 2014, when he attended for a facial injury (10pm, alone). The GSTT IMR noted that a risk assessment was done. He was regarded as Gillick-competent, and his injury was apparently consistent with his description of causation. His mother was called to the hospital to accompany him home, which is a routine precaution for any patient with a head injury.

5.12.2 Some participants at the Learning Event regarded this as a 'missed opportunity' to inform and involve CSC, and felt that more questions should have been asked. Had there been an identified concern, there is a clear process within the hospital for advice to be sought from the Safeguarding Team (Named Doctor and Named Nurse). If this contact had been referred to

the MASH, it seems unlikely that it would have reached CSC's threshold for anything other than noting on U's records.

5.12.3 The Emergency Department (GSTT) have an Oasis Youth Worker Project (for under-19s), who can pick up referrals regarding youth violence or gang member. When a young person presents with a 'violent injury', the worker will make contact with him/her, and offer services – on a voluntary basis. A similar scheme (Redthread) is in operation at King's College Hospital, where the ED is a trauma centre and where serious injuries as the result of violent crime are more likely to be presented.

5.13 Children's Social Care, Youth Offending Service and Early Help

5.13.1 There were no referrals to CSC during the period of the case review. The earlier involvement with U's brother ceased in August 2012. YOS were involved with him, largely in relation to housing support, until May 2011.

5.13.2 There were, however, two MERLINS passed to CSC during the period covered by this review. In the view of the current MASH Manager, one of these (July 2015), when U was reported missing for an extended period, should at least have proceeded to an assessment.

5.13.3 There was no referral about U to Early Help during the period of the case review. On a regular basis, members of the Early Help Team (including a new Early Help social worker) provide support and advice to Globe Academy via a weekly meeting between an EWO and Heads of Schools, and attendance at fortnightly Student Referral Group meetings, where pupils of concern are discussed. They can therefore advise about action by themselves, or thresholds for referral to CSC or YOS. There is also input from the Manager for Pupil Inclusion, who has active relationships with all the schools and is readily available for advice.

5.13.4 Given the school's wish to bring multi-agency partners together when needed, it is not clear why there was no proposal for a CAF process for U. This could have established a multi-agency Team Around the Child, and begun the process of bringing information from different services together, to form a holistic picture of U and his family. In U's case, such a group would have benefitted from the inclusion of XLP, who had been involved with U and his family for 4+ years, and who knew a great deal about his life both within and outside of school.

Recommendation 10:

The Safeguarding lead in each agency should lead in the ongoing refreshment of the CAF process, for children and young people with Level 2 needs, with special attention to its effective use by schools and academies.

5.13.5 U's attendance was consistently low enough to trigger a referral to the EWO (71% in September 2014), but this did not happen, possibly because his school was generally aware of the different reasons for his absences, and were 'managing these'. Later, his managed move was discussed with the Manager Pupil Inclusion.

YOS

5.13.6 YOS Police received 5 notifications during the review period regarding arrests of U. None of these contacts progressed to an assessment, though 'he was due to attend Southwark Youth Court on 23/9/15 for possession of an offensive weapon, at which point the YOS court team would have become involved, and in all probability he would have been subject to YOS supervision from that point'. (Para 7.1, YOS IMR).

5.13.7 The YOS manager has commented that U could have been appropriately referred to their service in October 2013, in relation to the assault (stabbing with a pencil) on a fellow pupil. This could have led to an earlier intervention, including an assessment of his needs and risks. YOS do take welfare issues into consideration, alongside the offending concerns, especially now they are also working in a systemic model. The current expectation is that referrals to YOS should come through MASH.

5.14 XLP

5.14.1 XLP is a voluntary organisation doing preventive work with young people at risk of involvement in violent youth crime. U regularly took part in XLP's community youth projects for 5 years. This was entirely appropriate, given his vulnerabilities in relation to his brother's gang affiliations, his mother's struggles to keep him safe and well, and the local environment of youth crime and violence, much of which U seemed to be drawn to. At one point, they got funding for redecorating the family flat, and undertook this with U.

5.14.2 XLP also worked with U in Walworth Academy. However, it is unclear whether there was a mechanism for sharing their longstanding knowledge of U and his family with statutory partners – e.g., the fact that during the last year of his life, he had become more 'disengaged', and may have renewed his relationship with his father.

C. Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

5.15 Electronic databases

5.15.1 The IMRs produced by Police and CSC both point out the pitfalls of data retrieval in their electronic systems which rely on accuracy and consistency in

spelling of names, street addresses, and even dates of birth. In particular for names which need to be transliterated from another language into the English alphabet, there are usually a number of choices about spellings. There is no apparent way to get round these vulnerabilities, apart from requiring staff to use a full set of identifying information: name, address, dob, etc. The CSC IMR notes that *'this is considered a hazard particularly in a borough where the names of children and their family members reflect their world-wide origins'* (Para 7.6)

Recommendation 11:

Individual partner agencies within the SSCB should perform regular audits of the systems used for searching and identifying individuals and connected family members, members of the household, etc., in order to identify any ongoing problems.

- 5.15.2 The CSC IMR identified potential problems in joining up family members on their then electronic recording system, as well as the challenges of different spellings of their names.
- 5.15.3 The search by YOS staff in June 2015 did not find any records for U on their CareWorks system, and therefore his arrest and discussion re the HAMROW meeting were not added to his record at that point.
- 5.15.4 ED records do not link records with other family members (GSTT IMR, Para 4.3.2)
- 5.15.5 Most electronic systems do not talk to each other very well. But in addition, human error can play a role in all these matters, and U himself had (mistakenly) two separate CSC files, created in September 2009 and July 2010 respectively, in the old electronic care management system.
- 5.15.6 Accessing records
A new CSC electronic system resulted in a separation of the new system and the old. The details of historic information can be accessed and linked to files on the new system. The CSC IMR reports reassurances from managers using the new system, that it has 'improved the ease with which previous information can be retrieved when the record is entirely contained in the new system'. (Para 7.8)
- 5.16 Multi-Agency Safeguarding Hub (MASH) and MERLINS
 - 5.16.1 The MERLINS relating to U going missing and other offending incidents were all sent to the MASH Police. They in turn sent some to the YOS, and some (very few) to CSC. This meant that it was not possible for CSC to piece together what was going on for U, his behaviour and associates, and the risks he was exposed to.

5.16.2 Both the Police and CSC IMRs outline the systems problems which were found in this case, relating to that time.

- Police in MASH researched each incident coming to their attention in the context of the known history (of police records). Despite this, a number of low-level incidents were not shared with the LA MASH manager (CSC). The Police IMR author notes that an incident of family conflict in June 2014 was shared with CSC, but the next 4 similar incidents were not, thus missing an opportunity to identify a pattern of 'increasing concern that Mother was struggling to control U'.
- At the time period of this review, 'missing persons' MERLINS were not consistently shared with CSC, as procedures stated they should have been. This has been corrected, and in agreement with CSC, every initial MERLIN (PAC) for a report of a missing child is shared with the CSC Manager in the MASH.
- Some MERLINS have a primary and secondary subject, and this meant that sometimes the 'secondary' missing element got lost and was not reported to CSC. The Southwark MASH has now developed a clear pathway 'to ensure that MERLIN reports which have a primary or secondary issue of missing from home are filtered correctly'. (Para 7.9, CSC IMR).
- The MASH manager has written a refreshed MASH Procedural Document, which refers to the MERLIN triage process and makes reference to the MPS policy around MERLINS.
- CSC has refined their initial screening of MERLIN processes in relation to 'Missing' procedures, and chasing up on outcomes of return interviews prior to a decision on further action being made

NB, both the Police and CSC IMRs have made a number of recommendations to deal with the issues outlined above. These are in the full list of IMR recommendations attached as Appendix 3. For that reason, there are no additional recommendations regarding this area of practice.

5.16.3 Heavy demand and resource constraints

The volume of MERLINS coming into the MASH Police every day is high ('one of the top five in the MPS'), and most of these are about domestic violence/abuse. Approximately 60 are referred into CSC, where a dedicated 'MERLIN' Social Worker makes decisions on these notices. The requirement for swift decision-making is obvious, and challenging, especially when – as we have seen in this case – all the pieces of the jigsaw may not be available to the decision-maker.

5.16.4 The initial staffing of the Police Team within the MASH (in September 2013) has never been attained, and they are 28% down on expected numbers, and without a Sergeant, as had been stipulated. The CSC team in the MASH are better resourced, but nonetheless are faced with fluctuating, often high demand.

D. Was information about risks from or to the young person shared in an effective way amongst the agencies involved?

5.17 Introduction

5.17.1 The lack of information-sharing among partner agencies is the most striking message from this SCR. It chimes with findings from many SCRs over several decades, and as noted in Peter Reder et al's seminal review of 35 child death inquiries, *Beyond Blame* (1993):

'Report after report highlights how crucially relevant information was not passed on to new workers or agencies and that information was not shared amongst concurrently involved professionals.' (p60)

5.17.2 The ongoing recurrence of this silo-working suggests that this is not an easy matter for agencies to resolve. All agencies have their own core business to attend to, and the 'extra' task of sharing information with partners to support safeguarding work may not feel straightforward or even comfortable. This becomes harder when all agencies are under pressure of growing workloads and diminishing resources. Having said all this, all those who took part in this SCR expressed a strong desire to improve their common information-sharing and working in partnership to reduce risks of harm to children and young people like U.

5.17.3 There is another, significant constraint on information-sharing, which is agencies' different approach to confidentiality. All should have procedures in line with Information Governance (IG) which establish the thresholds for information-sharing, and define the requirement for this to be 'necessary, proportionate, relevant, accurate, timely and secure'.

5.17.4 National statutes and guidance are in place to assist practice and decision-making:

- Guidance on information-sharing, responsibilities and thresholds: London CP Procedures, Section 3, 2007
- Section 115 of the Crime and Disorder Act, empowering agencies to share information without permission for the purpose of crime prevention (although obtaining consent is good practice)
- Sharing personal and sensitive personal information on children and young people at risk of offending – a practical guide (Youth Justice Board and ACPO, 2005) www.yjb.gov.uk

5.17.5 To determine whether an agency was allowed/required to share information for a boy like U, it would be essential to agree on the level of risk, to allow agencies to decide on what information they could share.

5.18 What happened in this case?

5.18.1 Generally, agencies worked in 'silos'. The cumulative effect was that, as U's behaviour deteriorated in school and at home, as well as out in the community, there was no single agency or professional who was in a position to assess how this all fitted together and what it meant in terms of his risk of harm. In fact, there was a cluster of risk factors – knives, cannabis use, gangs, going missing from home, and offending – which were affecting U. At the same time, his mother was unable to exert control over his actions in the evenings, due to her night-time job.

5.18.2 The following list illustrates the various ways in which key information about U and the family was held separately (or was not known at all). The reasons for some of the gaps have been referred to above, but a section below will consider the constraints and barriers to sharing information appropriately:

- On admission to Primary and Secondary School there was limited information shared with the schools by parents on personal or family history.
- A number of concerning incidents in school – e.g., U's assault (stabbing with a pencil) – were not shared with the YOS or Police, although it is unclear what was discussed with the Safer Schools Officer. The same holds true of the later assault on a fellow pupil at Building Lives, which was not reported to Police/YOS/CSC.
- Managed move: academy is not required to tell LA about this.
- CSC, Early Help and academies did not know about the increasing frequency of U's going missing and his mother's struggles to control his behaviour and keep him safe. CSC had no information about his offending, and U's school (academic staff) knew about only a small minority of incidents. The Safer Schools Officers did not pass on all of this information which they received in the form of MERLINS.
- The two academies agreed U's managed move, before Globe received a written account of the stabbing with a pencil, and bringing a weapon into school. (The written records arrived after U started at Globe.)
- Building Lives had little knowledge of U's background when he joined them, and did not know about his brother's gang affiliations and criminal history. The same was true of both academies. U's cannabis use was also unknown to academies and Building Lives.
- Because U had been recorded by Police as going missing 5 times, his name was considered at the Child Sexual Exploitation Panel in November 2014 (although it was not believed that U was at risk of CSE). The missing episodes, his mother's difficulties, and his use of cannabis were discussed. This Panel is attended by a member of the Safeguarding Nursing Team. However, the information about U was not passed on to the School Nurse, a route which might have got

some of the relevant information into the academy. (Health colleagues have commented that their expectation would be that Education Early Help, also represented at the CSE Panel, would pass on this information to the relevant academy, rather than the Safeguarding Nurse).

- The Emergency Department at GSTT had no background information about U, which might have assisted in assessing the risk to him. There are no flags on the ED system unless a child is subject of a CP Plan.

5.18.3 This review has identified a number of reasons why agencies may not receive, hold or share information outside their own service. Some of these relate to systems failures in the use of electronic databases and the accuracy and completeness of data held within them. Some may relate to the principles of confidentiality and 'need to know'.

5.18.4 An inconsistency in officers' rating MERLINS in this case meant that only some were shared with partner agencies, and this in turn prevented a 'picture' being developed of a youngster whose risky behaviour was becoming more serious.

5.18.5 Schools are usually the service which knows children best, given the amount of time a child spends in their care. Not surprisingly, schools often make heroic efforts to support a child or young person who is seen as vulnerable or struggling with mainstream education, before turning to partner agencies for help.

5.18.5.1 This is as it should be, and it was very true for U, who was an appealing boy whom people no doubt wanted to help. The academies' and Building Lives' staff described him as cheerful and smiling, a boy with a wish to please, and who was willing to take advice about changing his behaviour. In one-to-one situations, he responded well, but apparently could not maintain his own good intentions when with his peer group, especially not when he was out in the local community.

5.18.5.2 This review heard that at the time it was not easy for academy schools to know when and how they could bring in partners to help a child, and to share information about needs and risks. Alongside this uncertainty, their reported experience was that CSC thresholds were high.

5.18.5.3 This raises the question of whether academies and schools are clear enough about their responsibility to inform Police/YOS/CSC about something which has reached the threshold of a 'crime' – including possession of a knife.

5.18.6 There may be another subtler dynamic, which is that schools may not want to criminalise a young person, and this can lead to keeping problems 'in-house' and not reporting serious incidents to Police/YOS/CSC. This happened on two known occasions, both serious assaults on another young person.

5.18.6.1 How can schools be helped with these dilemmas?

- The SSCB threshold document could potentially be made more useful by adding specific guidance about inviting a MASH Social Worker to a multi-agency information-sharing meeting about a pupil.
- CSC staff should continue to visit schools/academies for discussions about thresholds, referrals, using a range of scenarios as clear illustrations.
- Consultation/advice lines should be well publicised, in CSC, Early Help and YOS
- Regular school meetings where vulnerable pupils are discussed might consider inviting a Social Worker from MASH for some cases, and the Safer Schools Officer should attend on a regular basis (thus enabling appropriate Police information was shared more consistently with the school).
- The use of the CAF process, to bring people together to consider what extra services might be needed for a child, entails information-sharing. A meeting to begin this process might indeed put together enough information to proceed to a referral to CSC. Or it might begin a useful process of regular Team Around the Child meetings, with the expectation that the Safer Schools Officer would be involved, in order to supply information from Police records.
- The process of a CAF referral into the MASH in itself triggers information-gathering from the agencies represented there.

5.18.7 Attitudes and curiosity

Staff in all agencies who are worried about a child should develop a mindset which asks ‘what don’t I know?’, and ‘who else might be able to give important information about the child and family, which fills in a picture of needs and risks?’. They need to be confident that they are approaching partners for this information when a child meets either a Child in Need or a Child at Risk threshold.

5.18.8 Other multi-agency forums

There are multi-agency forums, such as HAMROW, where vulnerable adolescents are discussed, but the route is not defined for how the pooled information will be disseminated to the key agencies working with the young person. The Southwark Association of Secondary Heads and Southwark Police Service met in early February 2016 to discuss ‘new ways of working together and sharing information and concerns’. The Review Panel suggested that this initiative would benefit from wider multi-agency membership. The challenge will be for information about pupils to flow to the operational level in organisations so that it can be useful.

Recommendation 12:

The SSCB key partner agencies should review their individual information sharing procedures, and their consistent use of these, in order to strengthen multi-agency interventions for children in need or at risk of harm.

E. Was effective action taken to mitigate risk?

Addressing the risks to U as an individual child

5.19 Introduction

From an early age, and increasingly as he became an adolescent, there were a considerable number of risk factors for U's safety and wellbeing. Some of these were little known and related to his personal history, including separation from his parents for several years, his exposure to his older brother's aggression and criminality and suspected gang links, and his rejection by his father. His struggles with academic-based learning at school may have been partially related to these aspects of his childhood.

5.20 In addition, U lived in a time and place where, as a young black teenager, he was surrounded by a culture of carrying knives, of knife crime, drug use and drug dealing, and rivalries among groups, even if not officially 'gangs'. In this culture, going to prison or being stabbed may be regarded as a 'badge of honour'. This review has noted U's mother's efforts to keep U safe and out of trouble (including sending her sons away from London for 8 years as younger children). Mother often involved the Police and sometimes sought the help and intercession of an elder from the Sierra Leone community. But there is evidence that U was both attracted to the risk-taking/offending culture, and at the same time frightened by a particular man who was said to be harassing him to sell drugs. There was clear evidence that he accepted the overriding ethos of 'not telling' on his peers.

5.21 So, how do the risks to a young man like U begin to be known about? How do we link emerging elements such as

- Drug use
- Going missing/offending
- Gang associations
- Attraction to carrying knives

with a young person who has

- Low school achievement
- English as a second language
- A history of separation and loss
- A violent older male sibling
- A previous history of living in a war-torn country

It seems obvious that it would help to put the two profiles together, but less clear what would enable this to happen. What do we understand about a young person who regularly comes to the attention of agencies because of struggling to achieve or behave in school, or regularly going missing from home, or coming to the notice of the Police as victim or perpetrator of incidents/attacks, and 'soft' intelligence about drug activities? All these, to varying degrees, should begin to build up a picture of risk of harm to others and to himself.

- 5.22 But if the information is not shared across agencies, and is not linked to the child's personal history, his family circumstances, and the community context, then the levels of risks and needs will not be known or understood. In these circumstances, there is unlikely to be an effective response, either within or across agencies.
- 5.23 This report has noted the need for agencies to be more confident about sharing information regarding individual children about whom they are rightly concerned, and there are recommendations to support them in doing so. The ability to help and protect a boy like U is dependent on joining forces and sharing information in an appropriate, timely and effective way.
- 5.24 Schools are key players because of their role as the predominant setting for children as they are growing up – in terms of time spent in the school, social influences, and learning academic and other skills. However, their principal functions and responsibilities are about academic learning and achievement. The areas of child welfare and safeguarding are given a high priority, but they are in addition to the very demanding 'core business' of the school. The more help school leaders and their staff can get to carry out this area of their work, the better.

Addressing the risks of harm for young people in Southwark getting involved in criminality

- 5.25 Local agencies – Southwark Police, YOS, CSC, schools and hospitals, voluntary organisations like XLP, and others – have demonstrated a major commitment to divert young people from offending, and to reduce the carrying of knives, knife crime and other violent crime. There is a high level of expertise locally, in response to serious youth crime. U was the recipient of many of these efforts.
- 5.25.1 The London CP Procedures quote from Hallsworth and Young, who list 4 different types of 'gang' or group members and the kinds of risks they pose to themselves and others. U's behaviour was shifting rapidly during the last year of his life, and this was probably affected not only by any personal difficulties and circumstances, but also by the actions of others in his local area (we heard of an older man harassing him to take part in drug selling). U probably fitted this description:

‘Wannabee group: includes children who band together in a loosely structured group primarily to engage in spontaneous social activity and exciting, impulsive criminal activity, including collective violence against other groups of children. Wannabees will often claim ‘gang’ territory and adopt ‘gang-style’ identifying markers of some kind.’⁹

It is also possible U may have become more closely involved with gang members than this suggests. This is simply not known.

5.26 Local initiatives

5.26.1 There is a pro-active Police Gangs Team in the borough which operates via intelligence about gangs, knives, and drugs. The work of this team is supported by a central (MPS) Gangs Matrix, which provides a list of ‘nominals’ or names of the persons in the borough who are most frequently coming to the notice of Police. Those on the list, which includes both adults and children, are risk-rated using the following criteria:

- Knife crime
- Firearms
- Victims
- Suspects
- Robbery
- Grievous Bodily Harm (GBH)

The list is updated daily, and information sent out to the specialist borough teams.

5.26.2 Police and wardens conduct weapons sweeps (both routine and intelligence led) in various areas of the borough, including crime ‘hotspots’, parks, estates and streets.

5.26.3 A recent initiative is the establishment of a working group comprising senior borough Police leads and local Secondary Heads, in order to share information about young people coming to attention, and plan diversionary activities for them. The intention is to carry on this work and to include others, to make the group’s meetings much more focussed on joint planning, sharing finite resources to arrive at a suitable action plan and reduce duplication.

5.26.4 DfE guidance stipulates there should be zero tolerance for carrying knives in school, although there is evidence that this is inconsistently adhered to.

⁹ Adapted from Three Point Typology of Urban Collectivities (Hallsworth and Young (2004).

- 5.26.5 XLP is a charity which works across London to create a positive future for young people growing up in deprived inner city estates, dealing with issues such as family breakdown, poverty, unemployment and educational failure, and living in areas that experience high levels of anti-social behaviour, crime and gang activity. They work with young people within schools and via community projects and sports activities; in Southwark, XLP covers one large estate in the Walworth area.
- 5.26.6 It is the intention of local Police and partners to create a monthly panel to bring together people from a variety of organisations and groups, including voluntary services for young people (diversionary). Similarly to the working group between the Police and secondary heads, it is anticipated that this group will share intelligence, and pool resources, in order to avoid duplication of services, and confusion for the young person.
- 5.26.7 The fortnightly police gang crime meeting discusses recent gang-related incidents and offenders/victims of note, and shares information with partners in order to disrupt gang related activity in the borough.
- 5.26.8 Southwark Anti-Knife Crime Forum (AKCF) is a community action forum that has been created to support the borough, in a targeted response to tackle knife crime. It brings together Police, statutory partners, community and 3rd sector organizations who as members focus on local issues with the aim of reducing knife crime incidents, and supporting Police in continuing to make Southwark a safe place to live, work and visit. The AKCF provides independent support through strategic, charitable schemes and specialist advice to the Police for communities of all ages and backgrounds that are affected by knife crime. The AKCF membership reflects the diverse communities it represents and seeks to attract new members to ensure this continues. An important aim is to provide reassurance, increase trust and public confidence in policing in local communities.
- 5.27 Schools and academies commission a large number of preventive programmes, workshops and other initiatives to tackle offending and violent crime, including knife crime – e.g., Safer London – as well as Child Sexual Exploitation (CSE).
- 5.28 Hospital EDs at GSTT (Oasis) and at King’s College (Red Thread) have staff commissioned from these voluntary organisations who respond to patients with perceived involvement (victims or perpetrators) in violent crime or gang involvement.
- 5.29 The HAMROW meeting, which has been described above, is a positive model of a multi-agency process which continues to develop how it assesses and responds to risk, most recently with a particular focus on knife crime. The ‘top’ ten juvenile names on the Southwark Gangs Matrix at each fortnightly

meeting are now the subject of a holistic assessment which will, as appropriate, consider the individual's family, social relationships, education, etc. They receive a joint visit by Police and YOS, as a diversionary step.

Recommendation 13:

The Council, Police and partners, including the SSCB, should review current efforts, and work together to produce an agreed multi-agency strategy for preventing and reducing knife crime and violence among young people in Southwark.

5.30 Efforts to support parents

- 5.30.1 Parents, especially single mothers, of young boys like U may struggle to keep their sons safe, and this may be more challenging if they have come from another country and if they remain isolated in their new environment. U's mother was also constrained by the night-time shifts that she worked, which meant she was not always at home to keep a close eye on her son. Members of this case review have suggested that the local Ward Panels may be able to offer some help and support to parents like U's mother, if only in linking them to local people and actions which are being taken to improve their lives. U's mother is involved in the AKCF, something to which she is strongly committed.
- 5.30.2 It may be useful to explore and strengthen the role of churches, mosques, and temples in supporting families living with the risks of violent youth crime.

6. Conclusion and Recommendations

6.1 Conclusion

- 6.1.1 This SCR has brought together the records and responses from the agencies who were involved with U and his family, and inevitably, by looking at this broader picture, has identified a number of recommendations. The areas for development are familiar ones: recording and sharing information, making timely and appropriate referrals, and the need to communicate and collaborate more confidently across services where there are serious concerns about a child or young person.
- 6.1.2 The SCR has also highlighted the strong commitment of various services to helping Child U, especially staff within Walworth and Globe Academies, at the programme Building Lives, and in XLP projects at Walworth and in U's local

community. The Police were assiduous in responding both to U and his mother, and in trying to keep him safe and well.

6.1.3 As a Review Panel, we do not believe that there was anything that agencies could have done to predict the tragic outcome for U, nor, sadly, to prevent this happening. We hope that this review will reinforce the good work that is being done in Southwark to keep all children and young people safe from knife crime, and that it may also support the efforts of agencies who are striving to protect and promote the welfare of children like U.

6.2 Recommendations

Recommendation 1:

Southwark Education and schools should consider how to make a consistent and appropriate assessment of the needs of children who move into the borough, especially where they have come from abroad under unknown and/or potentially traumatic circumstances.

Recommendation 2:

Southwark Education should establish a consistent set of expected standards about the information passed from primary to secondary school, and from school to school under 'managed moves'.

For the Education Authority, in partnership with schools, to consider: What are the mechanisms for schools to get to know information about a child's family and community situation?

Recommendation 3:

Assessments by Children's Social Care should capture as much as possible about a child's psycho-social history, including the experience of care by other relatives and in another country, and relationships with siblings.

Recommendation 4:

The partner agencies of the SSCB should consistently flag up and share information about siblings who are involved in serious youth violence or are known to have gang affiliations.

Recommendation 5:

Schools, Police and YOS representatives should consider how to enhance the effectiveness of the Safer Schools Officers, especially in how they record and share information and expertise with school staff and managers.

Recommendation 6:

Schools should consider 'at risk of permanent exclusion' as a trigger to convene a multi-agency meeting.

Recommendation 7:

Children arriving in the borough and requiring an education place should, under the following circumstances, have an assessment of their needs so that appropriate services can be offered:

- **Arrival from another country**
- **English as a second language**
- **Evidence of trauma/separation and loss**

Recommendation 8:

The partner agencies of the SSCB should each take the lead and be responsible for promoting the dissemination and use of the Board's 'Multi-agency threshold guide' (2015), especially schools and academies.

Recommendation 9:

The guide should be reinforced by regular visits from CSC to schools/academies, to assist the formulation and sending of appropriate referrals. The use of 'scenarios' is regarded by schools as a helpful way for them to understand thresholds and what kind of referral to make.

Recommendation 10:

The Safeguarding lead in each agency should lead in the ongoing refreshment of the CAF process, for children and young people with Level 2 needs, with special attention to its effective use by schools and academies.

Recommendation 11:

Individual partner agencies within the SSCB should perform regular audits of the systems used for searching and identifying individuals and connected family members, members of the household, etc., in order to identify any ongoing problems.

Recommendation 12:

The SSCB key partner agencies should review their individual information-sharing procedures, and determine how these support multi-agency interventions for children in need or at risk of harm.

Recommendation 13:

The Council, Police and partners, including the SSCB, should review current efforts, and work together to produce an agreed multi-agency strategy for preventing and reducing knife crime and violence among young people in Southwark.

GLOSSARY

AKCF	Anti-Knife Crime Forum
CAMHS	Child and Adolescent Mental Health Services
CareWorks	Previous recording system in Children's Social Care
COVO	A voluntary organisation which provides 'bespoke therapeutic intervention designed for individual students'
CP	Child protection
CSC	Children's Social Care
CSE	Child Sexual Exploitation
ED	Emergency Department (in hospitals)
EWO	Education Welfare Officer
GCSE	General Certificate of Secondary Education: subject-based exams at the end of statutory schooling (Year 11)
HAMROW	Local multi-agency meeting led by Police which considers data about adults and children coming to the notice of Police for a set of offenses. The meeting maintains a local 'gangs matrix' based on the activities of those coming to the notice of Police.
IMR	Individual Management Review (as part of a Serious Case Review)
LEAP	Voluntary organisation which runs workshops for schools, dealing with conflict resolution and aggression
MASH	Multi-agency Safeguarding Hub
MERLIN	Police Notification of a child coming to their notice and who is a subject of concern; routinely sent to Children's Social Care/MASH
Mosaic	New recording system in Children's Social Care
SATs	Standard Assessment Tasks (initial meaning): tests taken by children and young people at different Key Stages of their education
SCR	Serious Case Review
SLaM	South London and Maudsley Mental Health
SSCB	Southwark Safeguarding Children Board
SW	Social Worker
WT	<i>Working Together to Safeguard Children</i> : national child protection guidance for all agencies working with children and families
YOS	Youth Offending Service
XLP	Voluntary organisation working in Southwark (and elsewhere) to support families and divert young people from offending, violent crime and use of knives.

REFERENCES

Hallsworth, S., and Young, T., 'Getting Real About Gangs', *Criminal Justice Matters* (2004) 55, 12-13

London Child Protection Procedures, London Safeguarding Children Board,

Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews, The Welsh Government, January 2013

Reder, P., Duncan, S., and Gray, Moira, *Beyond Blame*, Routledge, 1993

Working Together to Safeguard Children, DfE, 2015

APPENDIX 1

Terms of Reference

1. The Welsh Model and Terms of Reference

1.1 The Welsh Model

The 'Welsh Model' takes the form of guidance for multi-agency 'child practice reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected.¹⁰ It is intended to be used in conjunction with *WT* (2015). The model is suitable for all 'levels' of case reviews, including SCRs, and for cases with good outcomes, as well as more negative ones.

The emphasis is on promoting 'a positive culture of multi-agency child protection learning and reviewing in local areas, for which LSCBs and partner agencies hold responsibility'. The model is inclusive in a new way, involving agencies, staff and families 'in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability'. Other key features include:

- A more focused, streamlined process with a shorter time period to be reviewed
- Consideration of the context in which professionals work in agencies, including 'culture', policies and procedures, and resources
- A **Learning Event** for all those involved in the case
- Exploring not only **what** has happened, but **why**
- Recommendations and actions to improve future practice

1.2 Time frame for review

The Welsh Model recommends a review period of no longer than 2 years. This is so that the learning is about recent, rather than historical practice, procedures and agency circumstances. In this case, a period of just under 2 years was chosen:

1st February 2014 to 14th September 2015

This period has allowed us to review U's last few weeks in one secondary academy, and, following deterioration in his behaviour, his managed move to a fellow Ark academy. The end of the review is the date of U's death.

1.3 Learning areas

The Welsh guidance suggests a set of generic practice areas for exploration and analysis, and these have been adopted by the Board for this review:

¹⁰ *Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews*, The Welsh Government, January 2013

- Ascertain whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. Establish how that knowledge contributed to the outcome for the child
- Establish whether the respective statutory duties of agencies working with the child and family were fulfilled
- Identify whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

In addition, the following questions were added by the SSCB in relation to this case:

- Was information sharing about risks from or to the young person shared in an effective way amongst the agencies involved?
- Was effective action taken to mitigate risk?
- Were appropriate agencies involved with the child/family?

1.4 Lead Reviewers

The review is being led by an independent social worker, Sally Trench, who has a background in local authority mental health social work and children's social care, principally child protection. She currently acts as Chair and author of SCRs.

The second lead reviewer is Kelly Wilson, a member of Southwark Youth Offending Service. She had no involvement with this case.

It is the Lead Reviewers' responsibility to work with the Review Panel, to review all the documentation for the SCR, and to analyse the material which emerges – from written records, interviews, and the Learning Event. They will meet with family members, if agreed by them.

1.5 Review Panel

This is made up of senior representatives of the agencies who were involved in the case. The names/roles listed below comprise the membership of the Review Panel for this SCR.

Independent Reviewer	Sally Trench
Internal Reviewer Health	Kelly Wilson Clarisser Cupid Designated Nurse, Safeguarding Children
Children' Social	Jackie Cook

Care	Head of Quality Assurance, Southwark Children’s Social Care (CSC)
YOS	Jenny Brennan Head of Service Youth Offending Service
SSCB	Hannah Edwards SSCB manager
Police	Caroline Jackson / Russell Pearson Specialist Crime Review Group
Early Help	Sharon Hemley Early Help locality manager
National Probation Service	Becky Canning, Head of Probation for Lewisham and Southwark
School	Joycelyn Thompson Head of Safeguarding, Ark Academy

‘The Review Panel manages the review process and plays a key role in ensuring the learning is drawn from the case’¹¹ Together with the Lead Reviewers, they read and review the relevant documentation and (in this case) analyse the material from the integrated chronology and the Individual Management Reviews. They are also responsible, with the Lead Reviewers, for supporting members of their agency to take part in the Learning Event.

1.6 Individual Management Reviews (IMRs)

The SSCB decided to request IMRs for each agency involved with U and his family. These reports were asked to describe and comment on the work of their individual agency. The reports included an agency chronology, and these were combined to form a comprehensive multi-agency chronology. This report contains a condensed, or ‘key dates’, version of this. Both IMRs and chronologies were features of the ‘Part 8’ methodology under the previous *WT* (all editions up to 2010). They have been combined with the Welsh Model in this review, resulting in a hybrid approach.

1.7 Involving family members

The intention is to invite members of the family (mother, father and siblings) to meet with the Lead Reviewers so that their views can be reflected in the final report. This process has been delayed, on the advice of their Police Family Liaison Officer, because of other recent events which have been distressing for the family.

¹¹ *Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Reviews*, Para 5.20

APPENDIX 2

Individual Management Reviews: Recommendations

Southwark Education

1. Southwark to introduce a process of schools informing the local authority of pupils who have been subject to a managed move so their school records can be updated and any further support can be offered to ensure secure transition. This would be in line with the current proposal by the Department for Education.

Metropolitan Police Service

1. (BOCU – Policy) It is recommended that the Southwark Borough Leadership Team complete a review of the resourcing (staff) of the MPS MASH team.
2. (BOCU – Supervision) It is recommended that the Southwark Borough Leadership Team, in the six month period following the completion of Recommendation 1, complete a Quality Assurance (QA) review of a sample of MERLIN records handled by the MPS MASH team.

Children’s Social Care

1. The MASH should undertake an audit of outcomes for young people who have been identified by its new process of triage of MERLIN reports where a missing young person is either a primary or secondary issue. The audit sample should reflect a cross section of cases that have progressed to assessment in Children’s Social Care or have been signposted by the MASH or Children’s Social Care to another agency to lead on the response.
2. Children’s Social Care senior managers should undertake a quantitative audit to determine the prevalence of assessments including all children living in the same household in current practice. Depending on the outcome of that audit, managers should determine how they might best improve compliance in respect of assessments of siblings where the primary focus is a young person’s behaviours.
3. Social Care administration managers should ensure that:
 - i. data cleansing exercises routinely identify possible duplicate files; and
 - ii. that multiple files, or alias files, relating to individuals are merged, immediately when known, into one file record for each child or young person.
4. Social Care administration managers should:
 - i. Ensure that data cleansing exercises routinely identify gaps in basic data; and
 - ii. work with operational team managers to ensure that such information is recorded as soon as it is known.

5. Children's Social Care should work with the Police with a view to improving the timeliness with which MERLIN reports are received by the agency.

Youth Offending Service

1. The YOS will routinely run data matching exercises within its caseload, ensuring that there are no duplicate records. Where such files are identified, these files must be merged as a matter of priority, into one file record per child/young person.
 - Data checks on current duplicate clients to be completed February 2016
 - The YOS is migrating to a new Database (Capita YJ) in 2016, and procedures to avoid duplication of clients and effective searching will be implemented. New procedures to be introduced in training February 2016.
2. The YOS to formalise its procedures for using the information from MERLIN arrest reports to follow up and identify preventative work where the arrest does not lead to a charge. YOS MASH representatives to actively request YOS involvement in referrals where young people are believed to be carrying weapons. A standard agenda item to consider MERLIN referrals to be added to weekly allocation meetings from March 2016.
3. Where YOS or Out of Hours staff act as Appropriate Adult for young people not currently known to the service, then this to be followed up by a home visit to the family to assess risk of reoffending and offer support.
4. The YOS to review with the HAMROW chair the process for action planning work with young people who appear on the police Gangs Matrix. Joint allocation process agreed January 2016.
5. The YOS to work with the police, YOS Youth Council and community representatives to review our response to knife crime and consider activities to reduce risk of harm to others. Initial community meeting held December 2015, further work planned with the newly formed Knife Crime Initiative in 2016.