TORBAY COUNCIL

Tuesday, 5 January 2021

OVERVIEW AND SCRUTINY BOARD

A meeting of **Overview and Scrutiny Board** will be held on

Wednesday, 13 January 2021

commencing at **5.30 pm**

The meeting will be held remotely via Zoom (the links to the meeting are set out below)

Join Zoom Meeting
https://us02web.zoom.us/j/83277095799?pwd=UlNtNGw2TVY3ajAzdVd6a2Z3TXUwUT09

Meeting ID: 832 7709 5799
Passcode: 785411

One tap mobile
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+442034815237,,83277095799#,,,,,,0#,,785411# United Kingdom

Members of the Committee

Councillor Howgate (Chairman)

Councillor Atiya-Alla
Councillor Barrand
Councillor Brown
Councillor Bye (Vice-Chair)
Councillor Mandy Darling
Councillor Foster
Councillor Kennedy
Councillor Loxton

Together Torbay will thrive

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Teresa Buckley, Town Hall, Castle Circus, Torquay, TQ1 3DR

Email: governance.support@torbay.gov.uk - www.torbay.gov.uk

OVERVIEW AND SCRUTINY BOARD AGENDA

1. Apologies

To receive apologies for absence, including notifications of any changes to the membership of the Board.

2. Declarations of Interest

a) To receive declarations of non pecuniary interests in respect of items on this agenda

For reference: Having declared their non pecuniary interest members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda

For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

3. Urgent Items

To consider any other items that the Chairman decides are urgent.

4. Update on County Lines and Child Exploitation in Torbay (Pages 6 - 137)

To receive a multi-agency update on county lines and child exploitation in Torbay. The key lines of enquiry are:

(a) to provide an update on the changes to working practices in respect of county lines and child exploitation in Torbay; and

(b) Lessons Learned from Serious Case Review Jaden Moodie, Waltham Forest.

(Note: representatives from Devon and Cornwall Police, Children's Services, Adult Safeguarding and Safer Communities Torbay have been invited to the meeting for this item.)

5. Establishment of a Children and Young People's Overview and Scrutiny Board (Pages 138 - 145)

To consider a report on a proposal to establish the above Sub-Committee of the Overview and Scrutiny Board to be responsible for all overview and scrutiny functions in respect of children and young people.

Instructions for the press and public for joining the meeting

If you are using an iPad you will need to install Zoom which can be found in the App Store. You do not need to register for an account just install the software. You only need to install the software once. For other devices you should just be taken direct to the meeting.

Joining a meeting

Click on the link provided on the agenda above and follow the instructions on screen. If you are using a telephone, dial the Zoom number provided above and follow the instructions. (**Note:** if you are using a landline the call will cost up to 13p per minute and from a mobile between 3p and 55p if the number is not covered by your inclusive minutes.)

You will be placed in a waiting room, when the meeting starts the meeting Host will admit you. Please note if there are technical issues this might not be at the start time given on the agenda.

Upon entry you will be muted and your video switched off so that only the meeting participants can been seen. When you join the meeting the Host will unmute your microphone, ask you to confirm your name and update your name as either public or press. Select gallery view if you want see all the participants.

If you have joined the meeting via telephone, your telephone number will appear on screen and will be displayed for all to see until the Host has confirmed your name and then they will rename your telephone number to either public or press.

Speaking at a Meeting

If you are registered to speak at the meeting and when it is your turn to address the Meeting, the Chairman will invite you to speak giving the Host the instruction to unmute your microphone and switch your video on (where appropriate) therefore please pause for a couple of seconds to ensure your microphone is on.

Upon the conclusion of your speech/time limit, the Host will mute your microphone and turn off your video.

Meeting Etiquette for Registered Speakers – things to consider when speaking at public meetings on video:

- Background – the meeting is public and people will be able to see what is behind you therefore consider what you will have on display behind you.
- Camera angle – sit front on, upright with the device in front of you.
- Who else is in the room – make sure you are in a position where nobody will enter the camera shot who doesn't want to appear in the public meeting.
- Background noise – try where possible to minimise background noise.
- Aim to join the meeting 15 minutes before it is due to start.

- **Official - Sensitive – Information contained may be discussed with relevant parties, but should not be copied further without the author's approval.**

Devon & Cornwall Police

Name of Meeting: Torbay Overview and Scrutiny Board		**Agenda item Number:**
Date of Meeting: 13 January 2021		
Freedom of Information Classification: – S.22 Information intended for future publication		
Other Boards that have considered this paper:		
For Decision:	**For Information:** (X)	**Appendices Attached:**

Lessons learned from the serious case reviews (SCR) and an update on the changes to working practices in respect of county lines and child exploitation in Torbay

1. Introduction

This paper serves as a pre brief for Board. During board there will be a multi agency presentation to elaborate on the paper and for all relevant services to provide updates around this critical area of partnership working.

We have specifically been asked to consider what safeguards and actions the police have in place to monitor and ensure the SCR tragedies do not happen to our vulnerable children and adults.

This paper references The Child Safeguarding Practice Review Panel (CSPRP) paper "It was hard to escape" – Safeguarding children at risk of criminal exploitation recommendations.

The learning and key considerations of the July 2020 vulnerability, knowledge and practice programme paper on these SCRs is also used to shape this brief.

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2. Overview

We welcome the opportunity to present to board. The conversations, reflections, work and actions in preparing for board have catalysed further focus and review in this critical area. Whilst broadly confident in our service offering we readily acknowledge we cannot stand still as this activity constantly and rapidly evolves – reflected in our new force mission pillar of being agile. We see further opportunities to improve both internally and in partnership.

3. Oganisational and local level safeguards and actions

It is important to reflect how the police service and locally Devon and Cornwall Police have developed our focus on vulnerability. Our executive lead for crime was renamed as lead for *vulnerability and crime* in 2019. This is not semantics but indicative of the high level support and cultural change required to engender effective focus and drive change. This is also reflected in National Police Chiefs Council (NPCC) roles and resultant activity from various agencies including the College of Policing.

As we move towards a new operating model Chief Superintendent Jim Gale is the force strategic lead for the Vulnerability portfolio bringing together the various departments and partners. It is significant that our criminal justice department is part of this with a real focus on victims and witnesses whether they themselves are involved in criminality or not.

This strategic focus is complemented by tactical substance. We have invested in a *strategic safeguarding improvement hub (SSIH)* to support our delivery. Our safeguarding managers in this hub have responsibility for both adults and children and their role is

- To manage the child safeguarding and adult safeguarding statutory and non-statutory working arrangements and protocols.

- To help identify opportunities to improve the strategic direction of child safeguarding requirements and Adults at Risk safeguarding requirements, managing and implementing Working Together 2018 and S42 Care Act, ensuring a public service that is efficient, effective and meets the aims and objectives of safeguarding children partnerships, whilst also meeting all related legislative requirements.

This is direct evidence of the force actioning the CSPRP "It was hard to escape" report key learning points for local agencies with specific regard to

Tailored support for frontline staff
Service design and practice development
Quality assurance

There is a force governance group represented by all departments which sets strategy, reviews policies and procedures and promotes identified best practice.

Each area including Torbay has a specialist department dealing with County Lines and broader exploitation linked to criminality. In Torbay this is our specialist proactive policing

team. This team has weekly meetings and daily contact with the intelligence management unit to trigger not just enforcement activity but safeguarding activity. This includes cuckooing visits and sharing of information at local multi agency meetings. This unit has received very positive feedback for the effective way it prevents and protects as well as pursues.

The intelligence directorate has a dedicated County Lines analyst and researcher who produce regular threat assessments and ensure any intelligence is shared with the intelligence manager and is raised locally at daily management meetings as well as tactical tasking and co-ordination meetings.

There is an organisational county lines 4P plan in place and there are regular intensification weeks linked to national activity. The force control strategy features county lines as a priority and therefore there is a regular assessment of threat risk and harm ensuring our resourcing decisions are harm focused, intelligence led, evidence based and prevention oriented.

Our force strategic assessment allows us to plan to fill our gaps against the control strategy. This is aligned with a vulnerability reduction strategy and child centred policing strategy.

The Torbay Community Safety Partnership has exploitation as the first of 3 key priorities and that clearly focuses our attention. Within the CSP governance structure there has been an exploitation governance group, an anti-slavery partnership (ASP) and operational delivery group. The ASP recently commissioned anti-slavery partnership Unseen to deliver accredited training to 376 frontline professionals in the community and voluntary sector.

MACE meeting (Missing and Child Exploitation)– This is key to sharing info regarding individuals and locations where CCE (Child criminal expoloitation) not just CSE (Child Sexual Exploitation) is a concern. This meeting has had excellent support from specialist officers (YIOs and MPSOs) and now has the management support and links into our tasking and management processes.

MET group (Missing Exploited Trafficked) – This is being refreshed in light of the recent review and wider learning and is the group that oversees the MACE.

NAIRA pilot (missing young people) and the Philomena protocol - In February the NAIRA pilot (No Apparent Immediate Risk, Absent) is being rolled out across Torbay. For 6 hours, missing young persons reports which have been assessed at NAIRA will be held by the control room specialist incident resolution team. Locally this is being led by DS James Dowler who ran such a project in South Wales. It showed positive outcomes for the Police in regards to demand reduction but also enabled a more consistent and effective partnership approach to managing missing occurrences. This was particularly effective with young people placed in care. The Philomena Protocol / Process is for the Care Providers to progress so they and their staff fully understand the risks of their young people.

Recent good work as a case study – "L.A" was recently dealt with by the proactive team for County Lines drug supply. He had been placed in Torquay by Devon social services after issues in Exeter where drug supply and exploitation was a concern. Missing incidents had increased in Exeter. Tis was picked up by MPSO Dave Quick who recognised the risks and vulnerability and initiated activity through our tasking processes. Phone enquiries showed

that L.A was very active in drug supply locally and was still going missing for long periods of time. The proactive team took on enquires and they were able to arrest him in North Devon, with another young male, for drug supply. There was a very high level of risk and the arrest has been a gateway to further support to break the cycle and reduce the risk.

4. Lessons learnt from the 2 specific SCRs

The force lead (and I) agree with the findings and recommendations.

There were clear opportunities to share more information and we must remain vigilant. If the scenario were presented locally I would expect a ViST to be submitted graded as a red triggering a strategy discussion and referrals to other agencies. If the officer submitting fails to identify the risk as red, the Central Safeguarding Team (CST) act as another gatekeeping function and can re-assess the risk. If the individual was in custody this would be discussed and picked up at daily management meeting without doubt. There is more below reflecting on wider considerations of the findings.

5. Reflecting on the vulnerability, knowledge and practice programme paper key considerations

Are officers equipped with the relevant training to identify criminal exploitation and trafficking?

Yes, but we recognise there is always more to do and to refresh. The force measures described above and indeed the SSIH QA function seeks to further promote learning.

Do officers know when and how to make a referral to the National Referral Mechanism (NRM)?

Yes, particularly the proactive team, however, we recognise the need for oversight. Guidance does state that all CCE and exploitation suspected cases should be referred to the duty detective inspector so this should be picked up either then or through the daily management meeting.

Is there a clear process for information sharing with partners/other forces?

The ViST processes described above are clear. There may be further opportunities for improvement by performance managing some of our custody processes which I have highlighted with the SSIH.

What is our approach to out of force children we arrest?

We adopt the national guidance change from Feb 2020 in which a national PNC marker (CL) County Lines can be added to a subject so when checked the higher risk can be quickly identified

- **Official - Sensitive – Information contained may be discussed with relevant parties, but should not be copied further without the author's approval.**

How does our pre release risk assessment manage loss of items from a child that could cause debt and risk?
This would be picked up by the NRM process in custody.

Is there a clear process for other statutory / non statutory services to refer intelligence into your force?

Through the MASH which would generate appropriate risk management meeting, strategy meeting or multi agency discussion.

Officer mapping and do they know local safeguarding arrangements?

There are significant resources invested on our sharepoint computer system as well as safeguarding hub and specialists to support.

How is your force establishing processes to review actions/decisions and practice to ensure the eradication of bias and disparities relating to detention and outcomes for children?

Within the force independent advice structure feeding into the equality diversity and human rights strategic group there is a legitimacy board. This board pulls together work around stop and search as well as sub groups looking at ethnicity within victims and witnesses as well as criminal justice outcomes.

Every single youth detention is reviewed by a custody inspector to ensure detention was proportionate and appropriate action was taken.

How do frontline managers ensure frontline staff responses do not become normalised to the type of harm that children involved in CCE are at risk from?

This is cultural and whilst it does come down to supervision, some of the horrific things our staff see don`t ever become completely normalised and our language, structures, working practices and mission focus us on our role in protecting the vulnerable, albeit on occasions this may be frustrating. Ultimately these are vulnerable people and they could under different circumstances be our loved ones.

How might our local safeguarding childrens partnership implement learning findings?

Learning is shared by briefings but the SSIH will have a key role in sharing learning going forward. As can be seen above we are also keen to drive "next practice" eg NAIRA pilot.

Author - Superintendent Brent Davison - Local Policing and Partnerships, South Devon

Sponsor - Chief Superintendent Nikki Leaper – Commander South Devon BCU

Overview and Scrutiny Board Exploitation and Serious Case Review

Overview and Scrutiny

January 2021

Exploitation in Torbay

- Introduction and Context
- **Nancy Meehan**
- Director of Children's Services

Exploitation in Torbay

Devon and Cornwall Police

Nikki Leaper

Chief Superintendent and South Devon Commander

Brent Davison

Superintendent Local Policing and Partnerships

CHILDREN MISSING TRAFFICKED AND EXPLOITED
Torbay Children's Services

Overview and Scrutiny

January 2021

Child Exploitation in Torbay - Overview

- Following the redesign activity for Children's Services, the Exploitation Team is now firmly established within front door services and is resourced with a Team Manager, an Exploitation Coordinator and a Business Support Officer.
- The primary focus of our work in 2020 has been to address the concerns raised in previous inspections and to develop a child centred focus to our practice.
- We are becoming increasingly confident that we have a clearer understanding of the picture of exploitation in the Bay and continue to develop processes and tools to enhance our understanding of exploitation and importantly our responses to children who are victims of exploitation.

Child Exploitation in Torbay - Overview

- The introduction of a revised and fit for purpose Child Exploitation Toolkit has enabled colleagues and partners to address contextual safeguarding concerns in a much broader context. The previous CSE Toolkit very much focussed on Child Sexual Exploitation and gave little opportunity to consider Criminal Exploitation (including gang involvement) or Trafficking.

Child Exploitation in Torbay - Overview

- Since the introduction of the new toolkit we have recorded a significant increase of children at risk of Child Criminal Exploitation (CCE).
- The numbers of children being assessed as at risk of CSE has remained fairly consistent since the beginning of the year.
- During lockdown we did see an increase in on-line exploitation and had an increase in the number of new referrals in relationship to this.
- We currently have seven children who have been referred to the Home Office via the NRM (National Referral Mechanism).

Child Exploitation in Torbay - Current Picture

Child Criminal Exploitation (CCE)	57
Child Sexual Exploitation (CSE)	60
National Referral Mechanism (NRM)	7

Exploitation Screening Tool Data – Q1, Q2, Q3

Qtr 1	
Total number of screening tools	68
Male	31
Female	37
HIGH	8
MEDIUM	38
LOW (No Alert)	22

Qtr 2	
Total number of screening tools	93
Male	48
Female	45
HIGH	13
MEDIUM	58
LOW (No Alert)	22

Qtr 3	
Total number of screening tools	117
Male	52
Female	65
HIGH	17
MEDIUM	65
LOW (No Alert)	35

Totals	
Total number of screening tools	279
Male	131
Female	147
HIGH	38
MEDIUM	161
LOW (No Alert)	79
CCE	57
CSE	60

Missing and Exploitation Forums

Overview of the 3 key forums designed to respond to identified risks.

Triage

Meets on the 1st Tuesday of every month.

- This meeting considers all of the children who have had a missing episode in the last month. It is multi-agency and ensures strong partnership oversight on all children who go missing in Torbay.
- The meeting also considers all of the new Child Exploitation Toolkits that have been completed in the previous month.
- Triage will refer any children that have been looked at in the meeting to CEMOG (Child Exploitation and Missing Operational Group), where it is agreed that additional consideration to addressing the risks to the child is needed.

CEMOG

Meets on the 3rd Thursday of every month.

- The Child Exploitation and Missing Operational Group meets with social workers of children referred from Triage. Social Workers will present the case to the CEMOG panel to address any potential barriers to progress regarding exploitation or missing episodes.
- Actions to address these will be agreed and subsequently followed up with agreed professionals and or resources to progress.

MACE

Meets on the last Thursday of every month.

- This multi-agency meeting focuses primarily on addressing Adults and Locations that have been referred in, that present a potential risk for young people. Any concerns can be referred in to this forum via the link below and should also be copied in to the Police Intel Online Sharing Form (also linked below).
- http://www.torbaysafeguarding.org.uk/workers/missing-cse/
- https://www.devon-cornwall.police.uk/contact/contact-forms/partner-agency-information-sharing-form/
- All of these forums continue to (virtually meet) during the lockdown and during these challenging times they remain an important aspect of our ongoing drive to safeguard children from exploitation in the Bay.

Exploitation Strategy and Governance

- Following the emergence of the new safeguarding arrangements and governance structures there will be an opportunity for a sub group to sit below the Business Management Group to develop an Exploitation Strategy and associated plan of activity.
- This forum will be responsible for the development of a cohesive strategy clearly outlining our intent and approach and will be accountable to the Business Management Group in reporting progress against the associated plan of activity using the four ‘Ps’ approach: Prepare; Pursue; Protect; Prevent.

Missing Children in Torbay - Overview

- As we moved through the government's range of responses to emerging risks to the Covid-19 pandemic, there has been a fluctuating picture of missing children in Torbay. Numbers vastly reduced in the early stages of lockdown earlier in the year. As restrictions eased we saw a steady increase in missing episode to pre lockdown levels.
- Some intelligence suggested that hidden missing was in all likelihood more prevalent as we moved out of lockdown with some parents indicating a reluctance to report children missing in fear of detrimental outcomes if the police became involved (i.e. fines).

Missing Children in Torbay - Overview

- Checkpoint have continued to deliver a virtual service in responding to undertaking Return Home Interviews (RHIs). Some children have indicated a preference for this and engagement has remained consistent and compliance to the statutory to duty to undertake RHIS has remained consistent.
- We had an increase in new contacts during lockdown with many attributed to tensions in the family home as a result of lockdown leading to family arguments (a push factor) which in terms resulted in children leaving and being reported missing.

Missing Children Data – Q1, Q2, Q3

Qtr 1	
Total number of missing episodes	108
Total number of children	49
Males	58
Female	50
CP	15
CIN	23
CLA	47
TH	6
S47	5
Pending ICPC	0
No status recorded	12

Qtr 2	
Total number of missing episodes	159
Total number of children	65
Male	59
Female	100
CP	20
CIN	15
CLA	94
TH	4
S47	6
Pending ICPC	4
No status recorded	16

Qtr 3	
Total number of missing episodes	147
Total number of children	63
Male	83
Female	64
CP	36
CIN	23
CLA	50
TH	10
S47	6
Pending ICPC	2
No status recorded	19

Totals	0
Total number of missing episodes	414
Total number of children	134
Male	200
Female	214
CP	71
CIN	61
CLA	191
TH	20
S47	17
Pending ICPC	6
No status recorded	48

Top 10 Missing Children - Q1, Q2, Q3

Number Of Missing Episodes	Gender	Age	Status
33	M	14	CPP
32	F	17	CLA
31	F	17	CLA
20	M	16	CLA
18	M	16	CPP
14	M	16	CLA
11	F	16	CLA
11	F	14	CLA
10	M	14	CLA
9	M	15	CPP
8	M	14	CLA

Return Home Interviews

- The current pandemic has lead to a change in the way RHIs have been delivered. Throughout lockdown they were conducted by phone via Checkpoint workers who were working from home.
- As we emerged from lockdown there has been a gradual increase and return to face to face delivery. This has created some challenges as some of the venues previously used (e.g. schools) have resisted accepting external visitors to ensure they remain Covid secure environments. This has lead to some delays with conducting RHIs but figures for completing Rhis has remained consistent.
- As further restrictions are being announced we will maintain regular communication with delivery partners to ensure continuity of service delivery.

Trafficking in Torbay - Overview

- We currently have seven children who have been referred to the Home Office through the National Referral Mechanism (NRM)
- There is further work to be conducted regarding a more cohesive response to children with NRM status. Initial conversations are underway with Community Safety Partnership to look at a more joined up approach that will be clearer about expectations once NRMs have been made.
- Police have shared some concerns that perpetrators are encouraging children to request an NRM to protect them against prosecution should they be arrested. This does not indicate that the child is not still at significant risk of exploitation and harm.

NRM (National Referral Mechanism) - Data

Age	CCE/CSE	Current Level of Risk (Assessed by most recent Exploitation Screening Toolkit)
17	CCE	GREEN
16	CCE	GREEN
17	CSE	RED
17	CCE	AMBER
17	CCE	GREEN
16	CCE	AMBER
16	CSE	AMBER

Operations and Investigations ongoing

- A review of our screening tool is being undertaken to address the issue of tracking live investigations and CPS decisions in relation to child exploitation.
- We need to strengthen our joined up response to Pursue as this remains an area of work that is still under developed in terms of a partnership approach.
- We currently have one adult awaiting trial for Child Sexual Exploitation with two identified victims. (Exeter Crown Court May 2021)

Locations of Concern/Disruption

- A joint response with partner agencies in South Devon is currently underway following a weaponised assault between rival groups of young people in Teignmouth recently.
- Whilst effective mapping of children has been part of this activity, there has been disappointing progress in identifying the adults who are potentially involved with supplying drugs for the local market.
- In Torbay we have seen a recent increase in violent assaults involving large groups of young people across a variety of our parks and open spaces in Torbay. Multi agency discussions developed to ensure a joined up and strategic response to engaging young people in the community.
- Additional short term resource was given to Love Sport to enhance their detached youth work response to these areas.

Exploitation Team – Engagement and Delivery

- Checkpoint – Enhanced approach to CSE interventions
- IYSS – ensuring clarity regarding, exploitation pathways, managing and understanding risk
- Development of draft Exploitation Strategy
- Vertical Expansion – Bid to Home Office for funding and Research in Practice to develop a strategy to support children identified as at risk of exploitation who are approaching their 18th birthday. This can be seen as a 'cliff edge' where often services are not resourced to work with children beyond this age and transition arrangements for exploited children are under developed.
- Exploitation Coordinator is permanent attendee at Targeted Help Panel on a weekly basis to offer advice and support regarding any children referred to the Panel who have been identified as victims of exploitation.

Serious Case Review – Child C Waltham Forest

- Recommendations:

1. D of E – Elective home education. Waltham Forest Concerns raised re safeguarding children educated at home.
2. Reachable Moments – How do we work with other local authorities to share information regarding Children from other LAs picked up in Torbay. Ensure concept of reachable moments is built in to workforce development activity. (Case example)
3. Review of arrangements for recovering Children located out of area and suspected of being exploited. Exploitation sub Group review of recent child missing episode.

Serious Case Review – Child C Waltham Forest

5 & 6 – London Boroughs communique and National System for arrested and detained children.

7. All agencies involved in case discussion – Torbay Strategy Meetings / Risk management Meetings / CEMOG / MACE - Audits regularly conducted

8. Review of multi-agency meetings regaring exploited children in Torbay has included membership of MACE and CEMOG.

9. Review of multi-agency guidance for D of E.

10. Involvement of Housing Services – See 8 above – Housing to be included as permanent member re MACE an invites to appropriate strategy meetings.

11. Audits of Exploitation SCRs to be scheduled in to Exploitation Sub Group and under new arrangements to include Learning Reviews and Thematic Reviews.

Transition and Adult Social Care

Transition: Safeguarding And Exploitation.
14+ information gathering sessions

Multi-Disciplinary	Information Sharing	Planning and Preparation
• Attended by Specialist Children and Adult Teams • Health and Social Care • Education • Finance • Mental Health • Intensive Assessment and Treat Team (IATT)	• Known to children's health and social care at age of 14? • Low level information sharing with adult services with consent from representative	• Develop understanding of care and support needs. • Start to plan and prepare for smooth transition

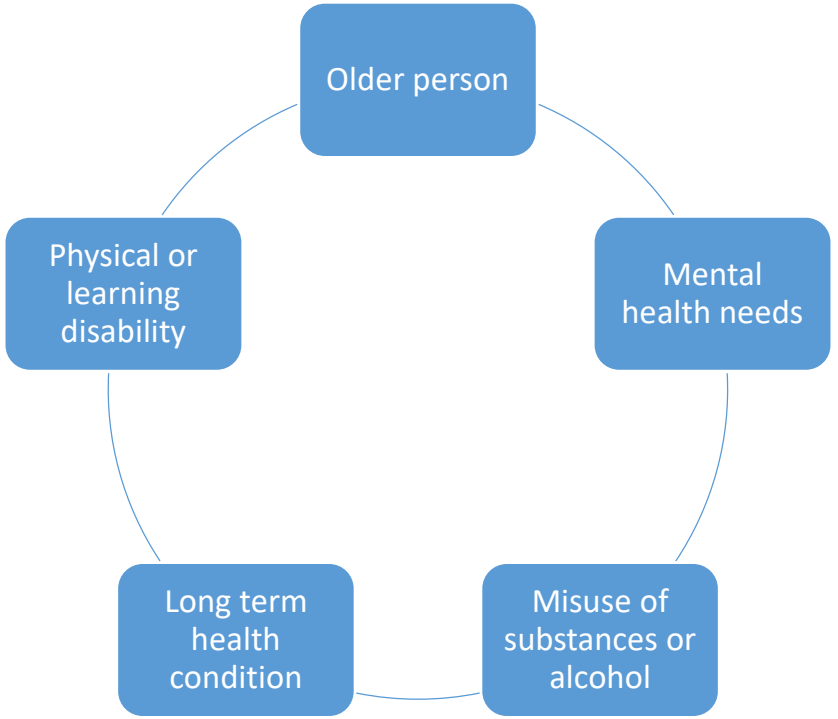
Transition – Safeguarding and exploitation

Specialist transition team in adult social care	• Created stronger links • Good Information sharing
- 171/2 yrs - Risk of exploitation - Child protection proceedings?	• Children's service contact adult transitions team • Attendance at subsequent meetings
Promotes smooth transition and signposting	• Pathway to adult social care services including safeguarding • Facilitates signposting to health, social care, voluntary sector prior to 18yrs.

Adults With Care and Support Needs

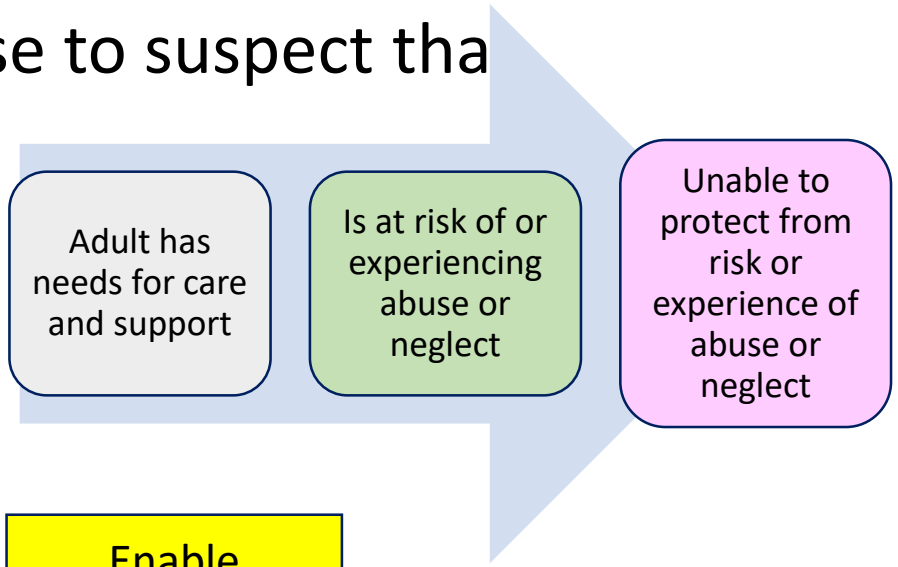
- Particularly vulnerable to exploitation so essential we remain vigilant in our safeguarding approach

An adult with *care and support needs* may be (not exhaustive)

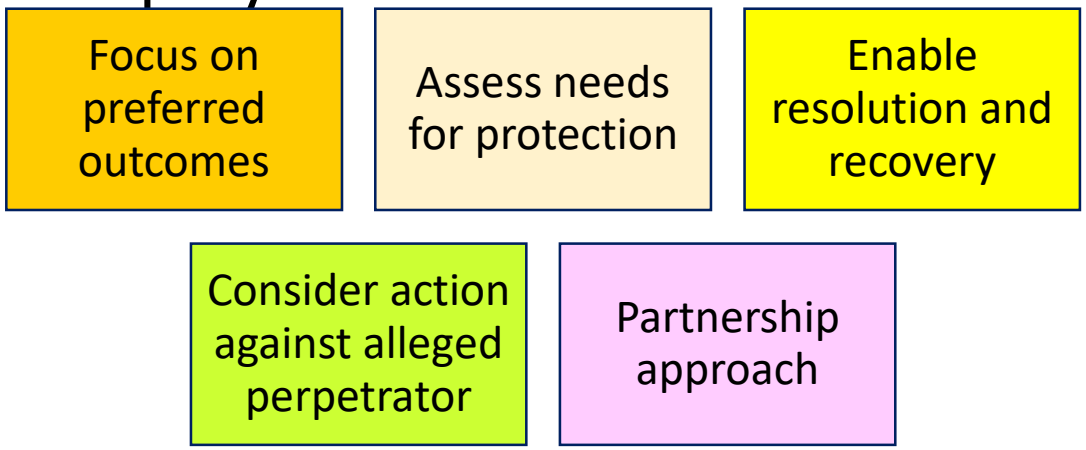


Contributing to the jigsaw

- Statutory Safeguarding duties under s.42 Care Act 2014. Reasonable cause to suspect tha



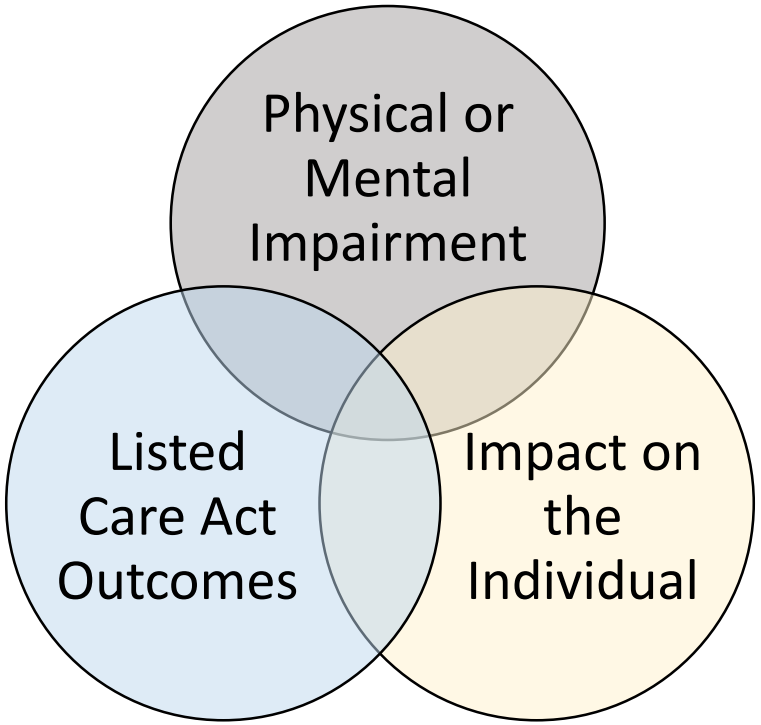
- Enquiry to include



General Duties

- **Duty to promote well being** for adults with care and support needs as defined within the Care Act Statutory Guidance.

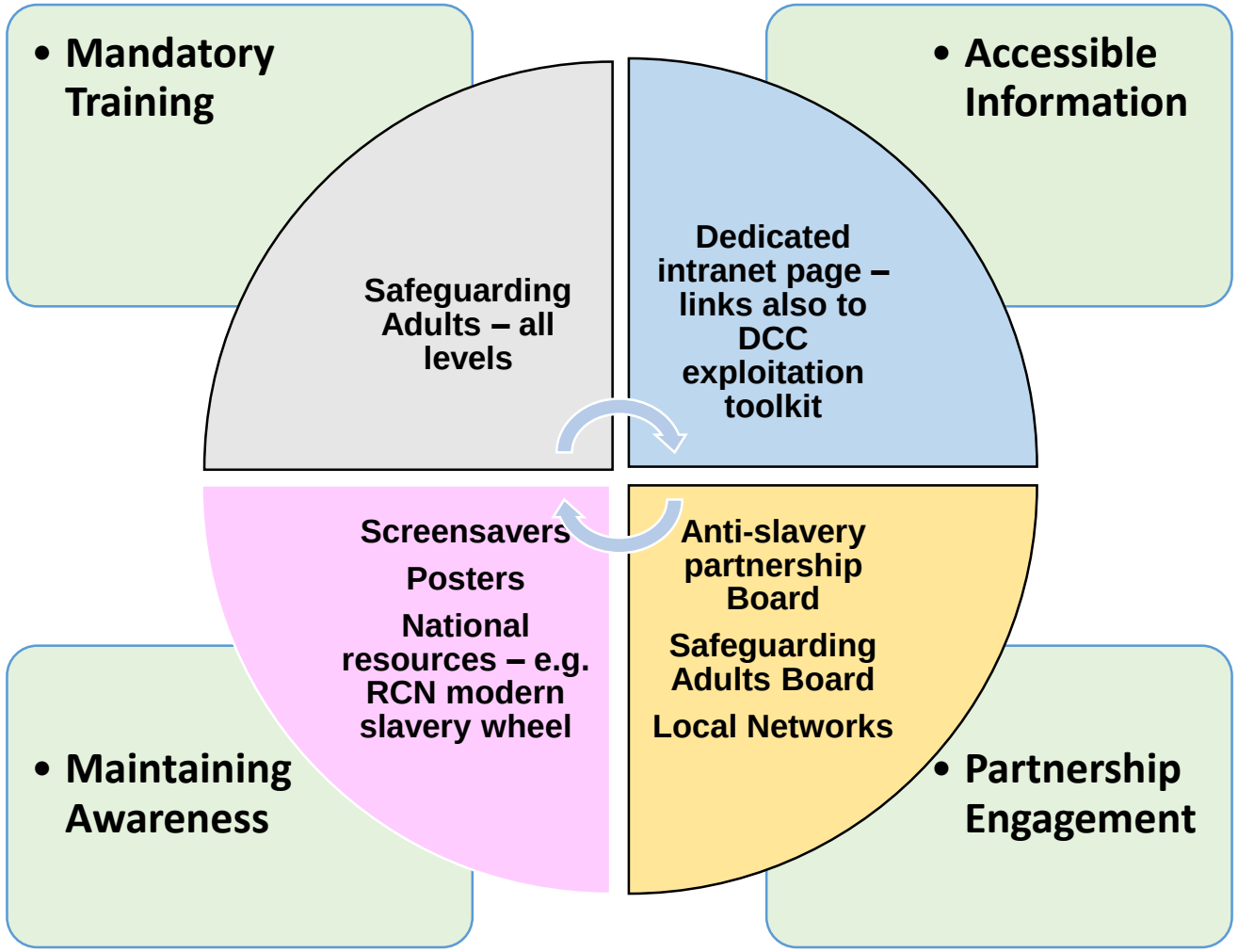
- Focus



- Eligibility not met / no consent

Partnership Intelligence information sharing / signposting

Keeping Staff Informed



Adult and Child Test Cases

- Adults Test Case – Laura

- Childs Test Case – Brian Mason

Exploitation Delivery Group

- The Exploitation Delivery Group is a subgroup of the Community Safety Partnership Board.

- A key part of the development of Torbay's partnership approach to exploitation is to ensure clear consistent response across the life course.

- This will reduce the risk, vulnerability and impact for all individuals effected by exploitation.

Development of the Exploitation Delivery Group

- In January 2021 partner agencies from the Community Safety Partnership, which includes members of the newly formed Children and Young Persons Exploitation Subgroup, will review the function of the Exploitation Delivery Group to:

1. Ensure there is a robust strategic link between the Exploitation Delivery Group and Children and Young Persons Exploitation Subgroup, that clearly supports effective operational delivery across the children and adult's systems.
2. Ensure that the work being undertaken to support children and young people who are being exploited, though their transition into adulthood, is linked and supported by the work being undertaken by the Exploitation Delivery Group to ensure they remain safeguarded and supported.
3. Ensure that the Torbay approach to exploitation is a whole system approach to support effective, interconnectivity, communication and delivery to generate meaningful and effective change for individuals.

Waltham Forest Safeguarding Children Board

Serious Case Review

Child C

a 14 year old boy

Final May 2020

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Chapter One: Executive summary

This Serious Case Review concerns the murder by stabbing of Child C, a 14 year-old child, in Waltham Forest in January 2019. Five men, one of whom has subsequently been identified, first knocked Child C off a moped he was riding by ramming it with their car, and then four of them stabbed him repeatedly. One 19-year-old was found guilty of his murder on the 11th December 2019 and has subsequently been sentenced to life imprisonment.

Child C's story

Child C was born at the Leicester Royal Infirmary in 2004. He was Black British of African Caribbean heritage. His mother and father separated in the year of his birth, and his mother, DE, brought up Child C on her own, but with considerable support from her extended family. At the time of his death he was sleeping on a sofa at his maternal grandmother's house while his mother, who was staying nearby, pursued an application for housing with Waltham Forest Council.

Child C's early life was in the East Midlands, although his family also spent time in East London. Several agencies had had contact with Child C from the beginning of his school days in 2008. From 2011 he and his family were living in Nottinghamshire. Having started well at primary school he began to have a troubled time at secondary school, especially from 2016. This had led to suspensions and other disciplinary measures being taken against him.

DE decided to educate him at home from 2017, and he was then at home for more than a year. However, by the end of the summer of 2017 these arrangements were beginning to break down, eventually leaving Child C with a lot of unsupervised time, a pattern that repeated at regular intervals for the rest of his life. Child C also started getting into trouble in the community at this time, leading to increasingly formal responses from the authorities. His mother believed he was falling under bad influences. On more than one occasion she and her family were threatened by people she did not know about repayment of debts that Child C was said to have built up. She decided, in April 2018, to move him to Waltham Forest to live initially with his grandmother while she applied to be rehoused in Waltham Forest from Nottinghamshire. DE moved to London later but there was no room for her and Child C to be together.

A potentially pivotal event occurred in October 2018 when Child C was found in a 'cuckoo house'[1] in Bournemouth with a 17 year old. On his return to Waltham Forest the Council began to assess his needs for help and protection. However, at this time the Council and its partners did not have enough information to understand the full extent of Child C's vulnerability to criminal exploitation[2]. Three weeks after being found in Bournemouth Child C was permanently excluded from school for a gun-related incident – this was not the first time that guns had featured in his risk-taking behaviour; the Council and its partners increased the priority attached to assessing and addressing Child C's vulnerability. Two initial assessments[3], from Waltham Forest Children's Social Care Services[4] and the Waltham Forest Youth Offending Service[5] were very near to completion by the time of Child C's murder eight weeks later.

Some services were already in place. The Youth Offending Services worker, Child C's key worker, had held a first session engaging Child C about the risks involved with his current situation. The Children's Social Care social worker had prepared a four-point action plan for her own involvement that was to be shared with Child C and his family. Full time alternative education was being arranged. It had been agreed with the family that another Council worker, a 'Missing Children Outreach' worker, would provide a series of mentoring sessions for Child C. The Waltham Forest Housing Service[6] had just accepted a duty to rehouse Child C's mother and family, and a housing offer had been made.

However, there had been delays both in assessing the family's application for rehousing and in securing a full time education. The housing delay meant that the family as a unit had no settled residence and Child C slept on his grandmother's sofa. The education delay meant that Child C was left once more with considerable free time to spend as he chose. He was 14 at the time.

Child C's family and friends and also many of the professionals who met and talked to him describe him as a polite and articulate boy with considerable social skills. It would

[1] A cuckoo flat or house is typically occupied by a vulnerable individual, who is targeted by organised crime groups so that their accommodation can be used to deal drugs.
[2] No definition of 'child criminal exploitation' has as yet achieved consensus but the Children's Society uses a definition from children and young people who describe it as *"when someone you trusted makes you commit crimes for their benefit".*
[3] Two assessments had to be completed as a result of the separate provisions of the Children Act 1989/*Working Together 2018* and *Referral Order Guidance 2018* issued by the Ministry of Justice and the Youth Justice Board.
[4] Waltham Forest Children's Social Care services are the directorate of the Council primarily responsible for supporting children who have specific needs and for the protection of children who are at risk of being harmed. The directorate is part of a larger strategic unit for Families.
[5] The Waltham Forest Youth Offending Service is a multi agency partnership, managed within the Council's directorate of Wellbeing and Independence. Like Youth Offending Services (more properly known as 'Youth Offending Teams') throughout England and Wales, the Youth Offending Service works with children who have got into trouble with the law. Its task is the look into the background of a child, and to try to help that child stay away from crime. The directorate is part of a larger strategic unit for Families.
[6] The Waltham Forest Housing Service is a directorate of the Council responsible for the management of the Council's housing stock, for homelessness, and for the Council's housing strategy. The directorate is part of a larger strategic unit for Residents Services.

also appear that he engaged in risk-taking behaviour[7] that he had been counselled against by his mother and grandmother as well as by the professionals who met him.

It is not known how Child C spent much of his time after his return to Waltham Forest. It is clear from the Bournemouth episode that he had access to drugs to sell (there is no suggestion that he used hard drugs himself) and at the time of his murder he was carrying a bag the contents of which were suggestive that he had been involved in some way in the selling ofcannabis that day. He had also been reported on four separate occasions, in Nottinghamshire and Waltham Forest, to be in possession of firearms, although on each occasion Child C insisted that the guns did not belong to him. During the trial of the young man who was later convicted of Child C's murder, the prosecution stated that Child C had an affiliation to an organised crime group known locally as the Beaumont Crew (or "Let's get rich") that operates in Waltham Forest[8] but I am aware of conflicting evidence about this 'fact' and I could reach no certain conclusion as to whether it was accurate[9]. I believe DE also disputes this 'fact'.

Whatever the extent of Child C's connection to this or any other group it is clear that he was the victim of criminal exploitation

My findings

My findings are as follows.

So far as larger scale or systemic issues are concerned:

1. Child C spent all but 3 of his last 22 months out of school and for much of this there was limited adult guidance or supervision in regard to how he spent his time. Time spent out of school, for whatever reason, is recognised to constitute a significant risk to children who are vulnerable to criminal exploitation. Half of Child C's period out of school came while he was the subject of Elective Home Education. In Child C's case the current arrangements governing home education contributed to his vulnerability to criminal exploitation. The approach that underpins the current government guidance in respect of Elective Home Education, an approach of minimum intervention or supervision, does not seem to be compatible with safeguarding children who are vulnerable to criminal exploitation.

[7] The most obvious examples of this were his trip to Bournemouth to sell drugs and the Snapchat video involving his brandishing the gun.
[8] For further information about this and other groups operating in Waltham Forest see Whittaker A., Cheston L., Tyrell T., Higgins M., Felix-Baptiste C., and Havard T. [2018] *From Postcodes to Profit – How gangs have changed in Waltham Forest* London: London South Bank University on commission from the London Borough of Waltham Forest
[9] The assertion is made in the 'Agreed Facts' for the trial, a statement of facts agreed between the Prosecution and Defence, but significantly *not with anyone representing Child C's interests,* was made under the terms of section 10 of the Criminal Justice Act of 1967. I comment on the evidence for and against this assertion in Chapter 5, section 'Why was Child C attacked and murdered'.

2. The response to Child C while detained in Bournemouth and then on his return from there in October 2018 did not capitalise on a 'reachable' moment[10] for a child who was clearly being criminally exploited, and nor was all the information available from the authorities in Bournemouth transferred to their counterparts in Waltham Forest.

While the importance of maximising the potential of reachable moments in working with children is beginning to be recognised, there is as yet no satisfactory approach to covering the whole country when a child who is exposed to 'county lines'[11] style operations is found a distance away from their home and so reachable moments are being missed.

There were also difficulties in communication between the authorities in Bournemouth and Waltham Forest, and there was an incomplete transfer of information between them. The absence of a national approach to guide all concerned at such moments serves children like Child C badly.

3. By early January 2019 there were considerable numbers of professionals[12] involved with Child C and his family, creating obvious risks of duplication and confusion. When children are exposed to child criminal exploitation there is a strong argument for case discussion[13] involving all agencies engaged with the child and family to be held in every case and for this principle to be stated clearly in national and local guidance.

So far as smaller scale or more local issues are concerned:

4. Information about the first two gun-related incidents involving Child C. (in 2016 and 2017) was not shared by the Nottinghamshire Police with other agencies, and nor did Nottinghamshire Police share information about the threats made against Child C in the summer of 2018[14]. Nottinghamshire Police

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[10] A 'reachable moment' is a concept taken from education, where it is called a 'teachable moment', and describes an unplanned opportunity that arises in a classroom where a teacher has a chance to offer insight to her or his students. In other areas of life the same opportunity can be called a 'reachable moment', and constitutes the same opportunity to break through a carefully constructed façade that is resistant the development of personal insight. In their report *'It was hard to escape',* cited elsewhere – see Appendix 5, the national Child Safeguarding Practice Review Panel describe a similar concept as 'critical moments'.

[11] The Home Office defines 'county lines' as *"a term that is used to describe gangs and organised crime networks involved in exporting illegal drugs into one or more importing areas* [within the United Kingdom] *using dedicated phone lines or other forms of 'deal line'. They are likely to exploit children and vulnerable adults to move* [and store] *the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons."* HM Government, 2018 *Serious Violence Strategy.* London: Home Office

[12] I count five front line 'case workers' together with the relevant staff of the prospective alternative education provider

[13] I have deliberately used the general phrase 'case discussion' here. WFSCB have stated clearly that if the meeting in question was designated as a 'safeguarding strategy meeting/discussion' it would not involve the Housing Service as a point of standard process. In Child C's case this would have meant that access to housing resources and important information, known only to the Housing Service, would not have been covered in such a meeting, and therefore the meeting would have been less effective than it needed to be.

[14] DE believes that there were threats made against her and one daughter as well.

have now amended this information sharing protocol to the effect that such information would be shared in future.

5. There was a delay in processing DE's application for a place for Child C at a Waltham Forest High School in May 2018. Both the School and the Admissions Service have revised their arrangements to attempt to ensure this does not reoccur.

6a. The initial response to DE's application for housing in Waltham Forest was slow and no new action was taken following DE's request that her application for rehousing be reopened by Waltham Forest in August up until the end of October 2018. It is my opinion that this could have had an impact on DE's ability to exercise parental control and supervision over Child C. The Waltham Forest Housing Service accepts my finding of fact but do not accept my opinion that this could have impacted on DE's parental control.

6b. The Housing Service was not engaged in multi-agency discussions about how to respond to the criminal exploitation of Child C. Despite the Housing Service holding information not known to any other agency, and also controlling resources that were an important component of the plan to protect Child C from future criminal exploitation, they were not involved in discussions about protecting Child C.

7. The initial gathering of background information about Child C carried out by the Waltham Forest Multi Agency Safeguarding Hub (MASH)[15] in October 2018 was incomplete and the Waltham Forest High School should have been alerted to the involvement of one of their pupils in these events. The MASH has reinforced with its staff the need for them to comply with the MASH's standard procedures to require a wide trawl of sources, while acknowledging, reasonably in my view, that a full intelligence check on every referral that it receives would be disproportionate in all cases.

8. While the overarching approach of the partnership's response to children who are criminally exploited is sound, and in particular, contextualised safeguarding is well described in the Waltham Forest safeguarding partnerships' Adolescents Practice Guide ('Safeguarding Adolescents: A Practice Guide'**) there may be learning for the partnership from a number of specific features of Child C's case in respect to speed of initial response, assessment and response to contextual safeguarding issues, and awareness of the threat of drug debt bondage.** The safeguarding partners may wish to audit further cases to satisfy themselves that their aspirations in respect of protecting children from criminal exploitation and developing contextual safeguarding are being achieved.

[15] The Waltham Forest Multi Agency Safeguarding Hub (MASH), in common with MASH's elsewhere in the country, is the first point of contact for all referrals to Children's Services in Waltham Forest. It consists of professionals from a wide variety of services. This means it can make joint decisions about how best to meet a child's needs.

During my review I have found no evidence that Child C's murder could have been predicted.

It is not possible to say with confidence whether different responses to Child C, particularly from September 2018[16] onwards would have reduced the ultimate threat that he faced on the 8th January 2019 because of the continuing uncertainty about why he was attacked that day. It is, however, the case that considerable resources were being mobilised for continuing work with Child C and his family in the two months prior to his death, the aim being to reduce his vulnerability to criminal exploitation. In my report I describe my views of the strengths and weaknesses of these responses. In my findings and concluding comments I bring this analysis together in one place. My recommendations address the strategic lessons from this review.

This review of Child C is of events where judgement can be affected far more than most by hindsight and outcome bias[17]. I have tried at all times to temper my analysis of the key events in Child C's life by asking myself 'what interpretation might a reasonable person have made at the time on the basis of what was actually known then?'

[16] I chose the date September 2018 here because by September the family was relocated, albeit in separate houses, in Waltham Forest, DE had expressed her concern about the risks to Child C on several occasions to different people, and some of his more problematic misbehavior had been known for some time. It would, of course, be possible to reset this date to an earlier moment, as the full chronology I use in the next Chapter will show.

[17] 'Hindsight bias' is the tendency to consistently exaggerate what could have been anticipated in foresight, while 'outcome bias' is the process whereby decisions and actions that are followed by a negative outcome are judged more harshly than if the same decisions had ended either neutrally or well. For a further exploration of these issues see Social Care Institute for Excellence [2019] *Serious Case Review Quality Markers*

Chapter 2: Introduction

The death of Child C

On the 8th January 2019 Child C, who was 14 at the time, was riding a stolen moped[18] on Bickley Road in Leyton when a car deliberately rammed into him. It appears from CCTV footage of the incident, and of the events immediately leading up to this, that this was not a random accident, that the car purposefully changed direction once it has spotted the moped, and was then driven with force at the moped. However, it is not clear whether his assailants knew who was riding the moped[19].

Child C was knocked off the moped and was then attacked by three of the passengers from the car. In a seven second attack he sustained nine stab wounds and died on the ground where he fell. The causes of his death have been given by an Assistant Coroner as *"Hypovelimic Shock[20] and Stab Wounds to the Torso"*.

Ayoub Majdouline, a young adult aged 19 years old, was arrested and charged with Child C's murder on the 19th January 2019. He was convicted of the murder on the 11th December 2019. During the trial his defence team acknowledged that he was associated with an organised crime group known locally as the Mali Boys. The prosecution stated that Child C's assailants were carrying out a *"ride out"*[21], looking for members of a rival organised crime group known as the Beaumont Crew or Let's Get Rich (LGR). The prosecution stated, on the basis of intelligence gathered by the Metropolitan Police Service, that Child C was associated with this group[22] Child C's mother, DE, cannot be sure who was exploiting Child C but does believe that her son was being groomed by people who represented a serious risk to him[23].

The murder remains the subject of a continuing investigation by the Metropolitan Police Service.

[18] The moped had been reported stolen four days earlier.
[19] At the time of the attack Child C was wearing anonymous clothing and a full-face, indistinctive helmet. There appears to have been nothing about his clothing that would identify him. The Metropolitan Police have told me that s different person was seen riding the moped earlier in the day.
[20] 'Hypovolemic shock' results when a body loses more than 20 percent (one-fifth) of its blood or fluid supply. Such a shock can lead organ failure.
[21] A "ride out" occurs when associates of one group go into another's "territory" looking for rivals to attack or confront.
[22] This assertion is contained in the 'Agreed Facts' presented during the trial of Ayoub Majdouline. See also reports in 'Your Local Guardian' and 'The Guardian', both on 19.12.19.
[23] DE's statement to me via her solicitor and her interview published in 'The Daily Telegraph', 14.12.19

About this review

Immediately following Child C's murder the Waltham Forest One Panel[24] agreed that the criteria outlined in the statutory guidance for undertaking a serious case review had been met. Child C had died and there was a shared concern to identify whether there were any lessons to be learnt from his life and death about the ways in which the Safeguarding Children Board partners, and other relevant people, had worked together to try to keep him safe[25]. The Safeguarding Children's Board (SCB) for Waltham Forest commissioned this review. I[26] was asked to lead the review, prepare the report of the review, and present my findings to the both Waltham Forest and Nottinghamshire SCBs. The review drew on a systems approach focusing on multi-agency professional practice, and its methodology followed the guidance or *"Quality Markers"* for Serious Case Reviews that have been developed jointly by the Social Care Institute for Excellence and the National Society for the Prevention of Cruelty to Children[27]. The goal was to start with the specifics of this particular case – what happened and why – but then to move on to identify the deeper underlying issues that were or are influencing practice more generally.

This SCR concentrates on the events leading up to Child C's murder. The review analyses these in detail and concludes with findings that highlight potential learning for local and national systems, as well as individual practice issues, arising from this tragedy.

In carrying out the review I have drawn on records and interviews provided by a large number of organisations and individuals. Those involved in the review are listed in Appendix 4.

I had hoped that Child C's mother, DE, and family would be key participants in the review and made several overtures to them. DE has been devastated by Child C's murder and did not feel able to meet me at any time over the past year but she did kindly provide answers to 60 specific short questions I asked her, through statements prepared by her solicitor. She also made nearly 50 comments on a late draft of this

[24] The Waltham Forest One Panel is a multi-agency sub-group of the Children's Safeguarding Board, Adults Safeguarding Board and SafetyNet is responsible for the commissioning of children and adult reviews as well as domestic homicide reviews.

[25] See Department for Education (2015) *Working Together To Safeguard Children*. London: HM Government paragraph 4:18 – NB This guidance has now been superseded by *Working Together 2018* [op cit] but at the beginning of this Review it was still in place, hence this reference.

[26] I am John Drew, a former children's social worker, with nearly 50 years of experience of working with children in trouble. I was Chief Executive of the Youth Justice Board for England and Wales between 2009 and 2013. Since retiring from full time work in 2013 I have chaired the Medway Local Safeguarding Children's Board (2015-2019) and carried out a variety of safeguarding and other related review work.

[27] Social Care Institute for Excellence and NSPCC (2016) *Serious Case Review Quality Markers – Supporting dialogue about the principles of good practice and how to achieve them* London: SCIE & NSPCC.

report. I have made extensive use of these answers in this report[28]. I did also ask to meet other family and friends but this opportunity was not taken up.

Where there is some disagreement or alternative interpretation of issues I have described both sides of the matter, a practice that I have also followed with the evidence provided by the organisations that have participated in the review.

Throughout all of this I am indebted to DE's solicitor Alice Hardy and her associates at Hodge Jones & Allen for their help. This has meant that some parts of Child C's mother's account could be included in this review, although this is not the full participation that would have been ideal. I have also included material published by the Daily Telegraph from an interview with DE[29].

I have been greatly assisted throughout my review by Suzanne Elwick for the Safeguarding Partnership and by Daniel Phelps, the Senior Responsible Officer for this review. They have put up with my countless enquiries with patience and good humour and have allowed me a virtually free hand in pursuing my enquiries. A large number of people, too many to mention here individually, in Waltham Forest, in London more generally, in Nottinghamshire, and in Dorset have also played a significant part in the review.

The data gathered during the course of this review, the analysis, and the findings were the subject of scrutiny by a Review Team set up for this purpose. There were cycles of feedback and amendment by the Review Team, which is a central feature of case reviews that use this methodology.

[28] To avoid tedious repetition I have used the device 'DE says' or similar to describe those views that I have included in this report.
[29] The Daily Telegraph, 14.12.19

Chapter 3: Chronology and appraisal of professional practice in respect of Child C and his family

This chapter provides an overview of Child C's life, examining the 'what happened' and 'why' questions, which are at the heart of any Serious Case Review.

Family structure

Child C was born on the 16th June 2004 in Leicester. He was the youngest of three children born to his mother and father. His parents separated in the year of his birth. He also had an older half sister and half brother

Family Members	**Ages on 8/1/19**[30]
DE, Child C's mother	44
Half sister	26
Half brother	25
Sister	18
Sister	16
Child C	**14**
Maternal grandmother	60
KL, Child C's father, living in Jamaica	52

At the time of his death Child C was living at his grandmother's address with one of his sisters and a cousin. His mother, DE, was staying nearby with another sister, and was applying to Waltham Forest Council for housing.

Child C's father, KL, was deported to Jamaica in 2010, having spent 17 months in prison for drug supplying offences. His mother says that she and Child C visited him regularly while he was in prison as it was important to her that Child C had a relationship with his father and adds that Child C had regular Skype contact with his father. Child C spent some time with his father in Jamaica during the summer of 2017. DE says that Child C loved his father dearly.

[30] The date of Child C's death.

Child C's early life

Child C's early life was in Leicester and then Nottingham. DE says he was a loving baby boy. He had a big beaming smile. He was a joy. He was a mummy's boy and would often cling to his mother.

In 2009 his family moved to London for just less than a year and he briefly attended primary schools in Waltham Forest. In 2010 Child C and his family returned to the East Midlands to live in Arnold, Nottinghamshire.

Child C's life in Nottinghamshire

Child C had already started school in Nottinghamshire in 2009 when he was five years old. He continued at his original school when he returned to Nottinghamshire. His time at Infant and Junior schools was largely unremarkable. DE remembers him as being clever and sporty. He played in the school football team in his second primary school he attended in Nottinghamshire.

DE says he loved bikes and always had one. He was very close to his three sisters and his big brother. He had a big heart and was very giving. On one occasion he persuaded DE to buy gloves and she and he walked around Nottingham giving them to homeless people. When he had money he often gave this to street homeless people.

Child C started his secondary education at an Academy[31] in Nottinghamshire in September 2015, when he was 11. The Academy describes his first year there as largely straightforward. He was noted to be a popular child, good at sports, and coping with the academic requirements of the school. Twelve relatively minor incidents of misbehaviour were recorded, mainly concerning Child C not following teachers' instructions. He was formally disciplined twice, once for kicking another child and once for an incident that was classified as bullying.

There seems little dispute that relationship between Child C and the Academy deteriorated from the beginning of his Year 8 (2016/17), when he was 12. His teachers noticed deterioration in his behaviour at the Academy and in the community. For example, very soon after the beginning of the new term Child C was reprimanded by the Academy for threatening to 'beat up'[32] another child.

At this time the Academy also knew of an incident three days earlier that had been reported to them by Nottinghamshire Police in which Child C was alleged to have threatened to stab and shoot another boy with a BB gun[33]. The Police believed that

[31] The Academy, hereafter called 'the Academy' is a secondary school and sixth form with academy status situated in Nottinghamshire. At the request of the commissioners of this report I have anonymised this school.
[32] This is the phrase used by the Academy.
[33] A BB or ball bearing gun is a type of air gun designed to shoot metallic ball projectiles called 'BBs'. They are widely available in the United Kingdom. Their sale and use is governed by various pieces of legislation and is too complex to summarise accurately here.

this earlier incident involved Child C lifting his shirt to show the handle of a gun and making a threat against another child. Neither the other child nor his parent wished to make a statement; this incident was not taken any further. In accordance with local custom and practice at that time this information was not shared with the Youth Offending Service (YOS).

The police and school records indicate that DE was advised about both of these incidents but DE has no recollection of either incident.

During the remainder of the autumn term the Academy disciplined Child C on three occasions for bullying other children, the third incident leading to his temporary exclusion from the Academy for five days.

Two further exclusions for five days each followed in the first half of the spring term of 2017, on each occasion for persistent bullying. Child C denied all these allegations. At the completion of his second exclusion of the term the Academy developed a support plan to help his reintegration into the Academy.

DE recalls two of these incidents. She characterises Child C's behaviour at this time as being *"laddish".* She does not recall any mention of a gun at any time. The Academy have provided a minute of a meeting at which both Child C and DE are recorded as being present, and actively engaged in the discussions. There is no mention of any episode involving a gun in these minutes.

DE believes that there was an element of racism in the way the Academy, educating predominantly white pupils, treated Child C and describes him as feeling humiliated when he was excluded from PE lessons. DE says that Child C was *"almost the only black boy in the school".* She feels that one particular teacher seemed to dislike him and report him regularly for fairly minor misdemeanours, misdemeanours that she believes that would not have led to disciplinary action for other, white, children. In articulating these concerns DE is echoing wider concerns expressed by many parents of black children in contact with institutions catering mainly for white children.

DE describes Child C's experience at the Academy as *"terrible"*. She added that he *"did not have a chance and the teachers did not understand him."* For their part the Academy refer to their final meeting with DE where she thanked the staff for all the support they had provided to Child C.

DE chose to remove Child C from school at this stage and opted to educate him at home because she was worried that if he remained at the Academy he might be excluded permanently.

Since I have not been able to meet DE I have not been able to discuss this allegation of racism further. I would have liked to understand her perspective and judgement better. It is clear that she distrusted the Academy and its staff. She did not feel able to discuss this distrust with the Academy. This issue of distrust, certainly from DE, features throughout her contact with the various agencies described in this report.

DE's decision to remove Child C from the Academy is easily understandable but it unwittingly also meant that Child C passed outside the education system, from whence it was very hard to return. He was 12 years old at the time his home education started.

Child C did not return to a school for the remaining 13 months that he lived in Nottinghamshire but he was visited twice, in April and October 2017, by an Elective Home Education Advisor for Nottinghamshire County Council who was very satisfied by the arrangements made by his mother. DE drew up a detailed timetable in an attempt to mimic a school day. She provided most of the education herself.

In July 2017, by which time Child C was just 13, he was detected stealing another child's bicycle. The incident took place at 10 p.m., after sunset. One account taken at the time said that one of the children involved in the theft had a gun but this was never substantiated. Child C admitted this involvement in the theft and was dealt with by means of a 'Community Resolution'[34]. Again in accordance with local custom and practice at that time the details of this episode were not shared with the Youth Offending Service.

This was the second time that Nottinghamshire Police held uncorroborated information about Child C's possible access to and threats to use firearms that they did not share with other agencies, most notably the YOS. Even when, in early 2018, the YOS was required to consider whether Child C should receive a Youth Conditional Caution (YCC) for an offence involving a gun, the YOS was not told of this history. The YOS told me that they did not believe that this knowledge would have altered their ultimate response at that stage. They developed a programme within the terms of the YCC that focussed on Child C's holding and possible firing of a gun. Had they known of the two previous episodes of misbehaviour where a gun probably featured there would have been an additional emphasis on this, but this would have still been within the terms of a YCC. This knowledge would also have assisted the Waltham Forest Multi Agency Safeguarding Hub (MASH) later in 2018 when they were considering what was known about Child C. On this basis I consider this lack of communication a systemic weakness and refer to it in my findings[35].

Later in the summer of 2017 Child C spent time in Jamaica with KL, his father, evidence of the continuing role that KL played in his life notwithstanding that the fact that he had not been a principal carer since 2005 and had been deported in 2010. DE described KL to me as a good father and explained that it was important to her that Child C had a relationship with his father[36].

While in Jamaica during the summer of 2017 Child C developed a close friendship with another boy of his age and was very upset when he heard, shortly after returning

[34] A 'Community Resolution' is an informal non-statutory measure used for dealing with less serious crime or antic-social behaviour where the 'offender' accepts responsibility. It is not a conviction.
[35] Nottinghamshire Police have now amended their information sharing protocol to the effect that such information, even as in this case when it is uncorroborated, is now shared via a Public Protection Notice with the relevant Multi Agency Safeguarding Hub.
[36] I have tried to contact KL but the contact details I have been given, a mobile telephone number, does not reach him.

to England, that this boy had died. A number of adults who were important to Child C also died in this period. It seems likely from this account that Child C would have been helped by some professional help with his grief, but no such help was sought and this loss only surfaced during this review. DE says that her priority at this time was to ensure that Child C had a school to attend.

In September 2017 Child C's mother asked Nottinghamshire County Council to place her son at a specific 'Alternative Provision' (AP) school in the City of Nottingham[37]. In a letter DE said that she could no longer educate Child C at home as she needed to return to work in order to support better all her children. Nottinghamshire were unable to place Child C at this school for two reasons. First, the school was outside their area, Nottingham City Council being quite separate to Nottinghamshire County Council for these purposes. Secondly, the rules that apply to children who are educated at home do not allow them to move directly from home education to an AP seeing. Any child would need to be back on a school roll first.

DE's Elective Home Education Advisor visited on the 3rd October and endeavoured to explain this intricate position to her. DE told the advisor that she had now returned to work each afternoon and into the late evening. Her 26 year-old daughter looked after the younger children during this time, and there was also mention of an aunt who would help.

During this visit DE identified a school, the Nottingham University Academy of Science and Technology (NUAST), which both she and Child C would like him to attend. Places at NUAST were only available for Year 10 and Year 11 pupils, so Child C could not start, *if accepted,* at NUAST until September 2018. The Elective Home Education Advisor's notes, written three days later, show a lengthy discussion about the advantages and alternatives to this route back to school-based education. The advisor left this meeting under the clear impression that DE was content to continue with Child C's home education for the rest of this school year on the basis that he would start a specific course at NUAST in September 2018[38]. DE does not remember the precise conversation but her subsequent actions suggest she was initially content with this situation, and a week later she applied for a place for Child C to start at NUAST in September 2018.

However, on the 5th January 2018, and unknown to Nottinghamshire County Council, DE applied directly for a place for Child C in another local academy. This academy turned down this application because the year group was full. Had they been aware that DE wanted Child C to return to school at this stage Nottinghamshire Council would have made an alternative offer but when DE had been told of this in October her advisor believes she replied that she was happy to wait until September 2018 when her son could start at NUAST. For her part DE recalls these events differently and

[37] 'Alternative Provision' (AP) is education outside school, arranged by local authorities or schools, for pupils who do not attend mainstream school for a variety of reasons

[38] Child C was offered a place on to this course in March 2018 and DE accepted this offer on the 4th April 2018.

says she was not happy with the slow progress made to find her son a school. She does not recall agreeing to wait until September 2018 for Child C to return to school.

I found no evidence that the County Council withheld resources from DE and her son. I cannot comment on the quality of advice provided by the advisor as I was not there, but it is clear that a process complicated by the particular circumstances of Child C caused confusion between the County Council and DE. The delay in returning Child C to a full time school place is important as it increased the amount of time when he, still only 13 at this time, was often unsupervised. There is evidence he was out of home late in the evening as well as during the day.

It appears from her comments at the time that DE was working at times during the autumn of 2017. Two friends and Child C's sisters attempted to supervise him in his mother's absence but she told me that he *"kept running away from home"*, most worryingly in the evening beyond the curfew he had been set, which was 9.00 p.m. On one occasion he climbed out a window to avoid a locked door. DE was very worried about this and it would become one of her reasons for sending Child C to London in April 2018.

On the 8th January 2018 DE says she was threatened by *"an older youth"* who said that Child C *"had money for them".* DE says that she contacted the Nottinghamshire Police after this event. She says that they did not contact her until about four weeks after the incident. DE believes that the Police did not take the incident seriously[39]. Nottinghamshire Police has no record of this incident[40].

On the 17th January 2018 at 11.00 p.m. on a Wednesday night while Child C was still 13 he was seen holding a handgun during a street altercation. A witness claimed that the gun had been fired at a house although no bullets or pellets were found and no motive could be established for this. Child C ran from the scene but was stopped by Police Officers and found to be in possession of an air gun, a large 'Rambo' style knife in a sheath on his waistband, and a small amount of cannabis. He was arrested. He told Police Officers that he had only just bought the gun but he would later tell a Youth Offending Service worker that it belonged to one of the other boys who was with him at the time. He said that a friend had just given the knife and cannabis to him. DE blames the other boy who was with her son at the time for this episode.

The Elective Home Education Service was not notified of this episode. They would have expected to have been informed as, amongst other things, they believe it would cast doubt on the effectiveness of the Home Education arrangements and could have prompted a review of these.

[39] DE has added that she waited for four weeks to hear from Nottinghamshire Police, and that a Police Officer visited her there was a heated row, which culminated in the Officer saying she would not return again.

[40] Nottinghamshire Police also commented that *'there is no record of* [DE] *raising this concern whilst* [Child C] *was in custody'* a week later. They would have expected some mention of such a threat at that stage as it could have counted as mitigation for Child C carrying a knife and being involved with a gun, i.e. for self-defense.

Following his arrest and charge Child C was assessed by the Nottinghamshire YOS to see whether he should be given a Youth Conditional Caution (YCC)[41] for possessing a firearm, a knife and some cannabis. They concluded he was a suitable candidate and he was cautioned in March 2018, the conditions attached to the caution being that he undertook a programme designed to highlight the dangers of carrying knives or firearms, and that he discuss the dangers of cannabis with a youth offending service team member. I was impressed by the quality of the programme prepared by the YOS but, as I have already discussed, the YOS was unaware of the Police intelligence that Child C had twice previously been linked with allegations that he possessed a gun in a public place.

The January episode had also been referred to Nottinghamshire's MASH. No further action was taken due to the involvement of the YOS. I believe this was a reasonable decision to make; it is hard to see what another agency would have added to the work being done by the YOS.

Child C's mother welcomed the intervention of the YOS. She says she felt her son was being *"groomed"*[42] in Nottinghamshire. DE has told me that she was aware that Child C had become involved with a family who she felt were a bad influence on him. She was aware that at least one member of this family had convictions, and this gave her cause for concern.

There was another indication that Child C's behaviour was deteriorating at this time. On the 25th January 2018 Nottinghamshire Community Housing Association (NCHA), the family's landlord, received a complaint from a neighbour about alleged incidents in which Child C (then aged 13) had been causing a nuisance riding a motorbike[43] around his estate. The complainant also alleged that Child C was outdoors, unsupervised, on a regular basis. The NCHA asked Child C and his mother to sign an 'Acceptable Behaviour Contract' (ABC)[44] about his behaviour[45]. Child C and his mother agreed to sign this contract but DE says she felt that they were being victimised and singled out by their Housing Association as a result of the word of one neighbour.

Child C had undertaken two sessions of the programme of work with Nottinghamshire YOS, which DE says had gone well, when, on the 9th April 2018, she notified the Youth Offending Service that she had moved Child C from Nottinghamshire to live with her mother in Waltham Forest. She told the YOS she was doing this because Child C was 'getting into trouble' with another boy. She asked the YOS to transfer their work with

[41] A 'youth conditional caution' is a caution with one or more conditions attached to it. It can be given to a child who has committed a criminal offence if they admit that offence, and on this basis the Police believe they have enough evidence to prove an offence has been committed. The children cannot consent to receiving such a caution themselves, the matter has to be considered by an Appropriate Adult, in this case Child C's mother, DE.

[42] 'Grooming' is when someone builds a relationship and trust with a child, using a wide variety of rewards both material and emotional, so they can manipulate, exploit and abuse them.

[43] DE had bought Child C an old motorbike as part of his home education programme in order to further his interest in mechanics

[44] An 'Acceptable Behaviour Contract' is an early intervention mechanism used against individuals who are perceived to be engaging in anti-social behaviour.

[45] The ABC refers to Child C riding the motorbike, standing outside on his estate swearing and shouting with others, and also refers to the incident involving the Police of the 17th January 2018.

Child C to Waltham Forest YOS. In fact they would have done this automatically under the terms of YCC.

From this time until his death Child C did not live with his mother, although she did sometimes spend nights at her mother's house; once she returned to London she never stayed more than a couple of miles from there. Child C slept on a sofa at his grandmother's three bedroomed house. As well as his grandmother, the house was shared with his cousin, who was 18, and his 16-year-old sister.

April 2018: Child C's move to Waltham Forest

Child C arrived at his grandmother's house on the 8th of April 2018.

DE made an application for a school place to Waltham Forest Council on the 25th April. This was passed by e-mail to the admissions officer at a Waltham Forest High School[46] on the 27th April but not acted on by that person or the Deputy Head responsible for admissions. In June the Headteacher was alerted to their mistake. She acted promptly to rectify this mistake with a new member of pastoral staff now responsible for the admissions role and a pre-admission interview was held on the 28th June. Both original members of staff have left the school and I have been unable to establish why this mistake occurred.

Waltham Forest School Admissions Service did not send a reminder to the school that this issue was outstanding. They do now have an automated system that automatically chases such issues after 15 days.

Adding a further two months to the period of time when Child C was out of school was undoubtedly unhelpful. The importance of regular school attendance, with all the opportunities to influence a child's behaviour that follow from this, as well as the risks to children who are not in school, is stressed in research on child criminal exploitation[47]. These two lost months contributed to the earlier periods in which Child C had been left to his own devices.

The Waltham Forest Youth Offending Service (YOS) completed the three outstanding sessions of his YCC in May. His YOS worker understood from Child C that he would be starting school on the 4th June. Child C was excited about this. However, Child C was mistaken about this and no pre-admission interview had yet taken place. He was eventually admitted to the High School on the 3rd July 2018. The school did not receive any information about the previous concerns about Child C's behaviour, either from the Police or from any other source.

[46] The Waltham Forest High School, hereinafter referred to as 'the High School' is a coeducational community secondary school and sixth form, located in Waltham Forest. Following representations from the commissioners of this report I have anonymised the name of the school

[47] See for example Turner A., Belcher L. and Pona I. (2019) *Counting Lives – Responding to children who are criminally exploited* London: The Children's Society

In the meanwhile his mother says that Child C spent his time watching movies and playing computer games. He spent a lot of time in the company of his cousin and his mother believes he did not spend much time outside his grandmother's home.

Child C had no contact with his G.P. or other health services during the last nine months of his life.

May – August 2018: DE's application to be rehoused in Waltham Forest

Child C's mother made three housing applications to the London Borough of Waltham Forest during 2018. The first of these was made on the 31st May 2018 when DE was still a tenant of NCHA in Arnold. She told Waltham Forest Housing Service that her family needed to leave Arnold because Child C was beginning to be involved with a local gang there.

At this stage DE was entitled to a 56 day *'Prevention Duty'*[48] from the Council to establish if there were grounds to prevent her homelessness. No action was taken on this application for a month until the 4th July[49] when the Housing Officer, Housing Officer A, visited Child C's mother and also e-mailed the NCHA to seek their perspective on the application. Housing Officer A also advised DE to get supporting information for this account from Nottinghamshire Police.

The Estate Officer for NCHA replied to Housing Officer A promptly on the 10th July, explaining that there were previous reports of anti social behaviour apparently involving Child C that had led to the agreement to sign an 'ABC' but the NCHA had had no recent contact with the family. On the basis of this information Housing Officer A took no further action on DE's housing application.

However, unknown to Housing Officer A, Child C's mother then contacted the Estate Officer for NCHA[50] and in an interview on the 18th July 2018 with this officer she is recorded as telling her that it had come to her attention that Child C had been involved with a gang since January 2017[51] (when he was 12) and as a consequence she had been having problems with Child C's behaviour. She said that at one time she had been required to pay off a debt accrued by Child C of £300 to get these *'teenagers'*[52] from her doorstep.

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[48] Section 195 of the 1996 Act

[49] The chronology provided initially by Housing Services stated that NCHA had been contacted on the 4th June, but this is not born out by an examination of records in Waltham Forest or the NCHA. The Waltham Forest notes were written several months after these events.

[50] The article in the 'Your Local Guardian series' that I have already cited – see footnote 16 - refers to this incident but states that DE made the report to 'social services' in Nottinghamshire. However, DE has confirmed to me that this is wrong and she had reported it to the NCHA.

[51] This is the earliest date that DE has given for problems with Child C's behaviour.

[52] Commenting on this, DE told me that they were *"only children but they were very intimidating and aggressive*". She added, *"the person didn't say who* [Child C] *supposedly owed the money to or what it was for."*

The Estate Officer recalls that she also said she had once found a large knife and she had thrown this away, only to be confronted by acquaintances of Child C asking for its return. DE said that she had not reported this incident to the Police, but she described two more recent occasions when both she and one of her daughters had been threatened in separate incidents, and a direct threat had been made to her that Child C would be stabbed *("like one of his friends"*) if the alleged debt were not settled. DE told the Estate Officer that she had reported these incidents to the Nottinghamshire Police and at the time of the interview DE was waiting for them to visit her, which they did two days later.

During the interview with the Housing Association DE also said Child C had come home with a lot of new clothes that she knew she had not bought for him[53].

When DE was interviewed by the Nottinghamshire Police on the 20th July they tell me they took the view that no crime had been reported to them, that the threat against Child C was *"more implied than specified"*, and that Child C was not at risk as his new location in Waltham Forest was not known to anyone in Nottinghamshire other than his family. DE believes this account does not reflect what she told the Police Officer at this time. She says she told the Officer that there had been two incidents of threats to kill people, one against her and one against her daughter. Nottinghamshire have no record of this but they do acknowledge that the intelligence of the threat they were aware of, *that concerning Child C*, should have been shared either with the Metropolitan Police or the MASH in Waltham Forest, and it was not[54].

DE emailed the Estate Officer for NCHA twice in the next fortnight, describing the subsequent visit of Nottinghamshire Police. She interpreted their response to her as meaning that they did not believe she was at risk. I believe this was a reasonable interpretation for her to make.

None of this additional information was relayed to Waltham Forest and so Housing Officer A was unaware of the more recent concern about threats to DE and her daughter. The most recent communication Housing Officer had had from NCHA had been sent eight days before the estate officer had been told of the most recent threats.

Although the housing prevention duty would have expired by the 26th July, the application was actually still open when DE emailed the Housing Service on the 6th August asking that her case be closed. Housing Officer A recorded this as being due to the lack of support for her view of events from Nottinghamshire Police. DE added in this email "*My son is no way out of danger if anything happens at least I notified*

[53] DE's comments of this sort about clothing are a recurring theme in the records made by various agencies. She later gave a similar account to a Waltham Forest social worker later in 2018, but when I asked her about this in June 2019 she said that she has since *'discovered the* [to her mind legitimate] *source of some of those possessions'.* She does, however, have a remaining concern about the origins of a Stone Island jacket that Child C possessed.

[54] It is impossible to establish to what incident the threat might have been a reference. Seven months earlier Child C had claimed to be a friend of a boy who had been stabbed to death near his home in Nottinghamshire in January 2018, although there was no other record of this association and it was not considered significant. In July the reference was taken to a stabbing was taken to be to a more minor stabbing that had happened recently.

Waltham Forest also of the difficult situations". Although at the time DE was asking for her case to be closed, she now believes strongly that Housing Officer A should have made further enquiries into the risk and harassment that she has reported to Nottinghamshire Police and the NCHA.

As I have written, I am wary of reaching judgements influenced by the bias that can come from hindsight but I believe Housing Officer A should have spoken to DE after receiving this reference to the danger to Child C. An option available to both of them would have been for Housing Officer A to seek DE's consent to refer Child C's circumstances to the Waltham Forest MASH for an early help assessment. I do not know whether Housing Officer A was aware of this option (although I believe he should have been) but in any event Housing Officer A appears to have interpreted DE's account of the Police view as proof that the family was not in any danger, and taken her request to close her application at face value.

On the 28th August DE contacted the Housing Service again by email and asked for her housing application to be re-opened because she had been forced to give up her tenancy in Nottinghamshire. She also contacted NCHA and told them of her intention to surrender her tenancy as neither she nor her children felt safe.

Housing Officer A did not respond to DE's email. I have not been able to interview Housing Officer A as he has left the Council's service but the housing officer's inaction here appears to reflect a very limited interpretation of what the officer's responsibilities towards DE and her family might be. This was clearly a moment where a referral could have been made to the Waltham Forest MASH in order possibly to trigger an early help assessment.

Meanwhile Child C's first term (just over two weeks) at the High School had finished on the 21st July. The school felt he had settled particularly well for a child moving into the borough and noted how well assimilated he appeared with the other children. There were no significant concerns other than punctuality; Child C had arrived late on four occasions. His records from the Academy in Nottinghamshire only reached the High School after the end of his first term. The High School was also unaware of the previous incidents involving contact with Nottinghamshire Police.

One further incident from August 2018 is worthy of record. While DE was still separated from her son and living in Nottinghamshire, Child C was involved in an incident outside his grandmother's house. DE told me that:

"a person drove past the house and said to [Child C] *that they 'don't want to see you hanging around Beaumont … there's a bullet for you with your name on it'".*

DE was not told of this incident at the time and she does not know if it was reported to the Police. It is then repeated in the 'agreed facts' presented at the time of Ayoub Majdouline's trial. The incident was never described to any of the people assessing Child C's needs in the autumn of 2018. It is, in my view, highly likely that knowledge of this incident would have added to the assessment of the risk of harm to which Child C was exposed had it been known at that time.

September – October 2018

Housing Officer A did not need to reinstate DE's application as it had not closed at the beginning of the month, but Housing Officer A took no further action in respect of this application until the 26th October when finalising all his notes on DE's application prior to leaving the Council three days later. Technically the application for housing application remained open. It would appear that Housing Officer A relied on previous knowledge of the case and did not investigate DE's statement that she had given up her tenancy, together with her reason for doing this.

DE's application was then closed, without reference to her, at the end of October on the basis that she was not deemed as homeless or threatened with homelessness within 56 days of her application.

Senior managers in the Housing Service have confirmed to me their view that Housing Officer A's approach at this time was *"reasonable and proportionate".* As they know I do not agree with them on this. In my opinion Housing Officer A's approach was not satisfactory because the officer had not taken any new action since July 2018. Had the NCHA been contacted after the 26th August to find out if they had gained additional information about the family situation (as a second Housing Officer, Housing Officer B did at the end of October) Housing Officer A would have learnt that the NCHA had indeed heard more from DE since his last contact with NCHA on the 4th July.

Coincidentally on the day that DE's housing application was closed, the 29th October 2018, she herself reapplied for housing in person. A new officer, Housing Officer B, was assigned to her case because the Housing Service now acknowledged that she had given up her tenancy. Housing Officer B advised DE to seek a private tenancy, described the support the Housing Service could provide to such an arrangement, and reopened enquiries into DE's story of risk and harassment in Arnold. Housing Officer B also maintained contact with DE and her family via a home visit.

I contend that this course of action had also been available to Housing Officer A two months earlier, but Housing Officer A chose not to take it.

Child C's mother feels her application for housing was handled *"terribly".* She was not offered any temporary housing until January 2019[55].

The service has made a number of changes to the management oversight of such cases in the light of the learning from these events. I described these in Chapter 5 under my sixth 'Finding of Facts'.

25th. October 2018: Child C's arrest in Bournemouth, Dorset and the immediate response to this

[55] She thought this property, in Tilbury, Thurrock, in Essex, unsuitable both because of the distance from her family and the disrepair of the property in question. However, she accepted it, as she believed she would not be offered anything else.

On the 24th October 2018 Dorset Police received information about concern about a property in Bournemouth that was allegedly being used as a cuckoo flat[56] by an organised crime group or groups[57] for the illegal drugs trade. They visited the flat the next day at 9:22 a.m. and found two children there, the younger of whom was Child C. The other child was also from Waltham Forest and was two weeks short of his eighteenth birthday.

There was significant evidence of drug use and sales being made in the flat. Child C was found to be in personal possession of 39 wraps of crack cocaine[58], a greater amount of crack cocaine as yet in two packages rather than in wraps[59], a mobile phone, and £ 325 in cash.

Child C was arrested for being in possession of class A drugs[60] with intent to supply, and, after a period in which he gave two false identities, his identity and age was established (he was 14 years and 4 months old at the time). Child C gave the names of two people who he would like to be contacted, one being his mother's maiden name. Dorset Police conducted a risk assessment, and Child C was interviewed under caution in the presence of a duty solicitor and an Appropriate Adult provided by Bournemouth Borough Council[61], providing a 'no comment' interview. This may have been on his solicitor's advice.

An independent Review Officer has reviewed the Dorset Police's response to Child C's arrest and detention for this report. His work has included interviewing the officer in the case as well reviewing the footage from the Body Worn Video[62] camera worn by the Police Officer. He is clear in his mind that the Police Officer concerned was empathetic to the circumstances in which Child C found himself. On more than one occasion the various issues surrounding his arrest and his rights were explained to Child C, and offers to arrange for help for Child C from the police and others were made. Very specific questions were asked about safeguarding issues in the presence of Child C's solicitor and the Appropriate Adult but at that stage Child C did not respond to any of these questions.

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[56] See footnote 1.

[57] An organised crime group is usually defined as a group of three or more people existing over a period of time acting in concert with the aim of committing crimes for financial or material benefit.

[58] A recent government report (HM Government (2019) *Increase in crack cocaine use inquiry: summary of findings* London: Home Office, Public Health England*)* published in March 2019 estimated that a typical wrap of crack cocaine might have a street value of between £ 6.50 and £ 8, so 39 wraps could be worth between £ 250 and £ 320. This possibly understates the street value of these drugs.

[59] Using the Home Office formula, these additional drugs could have had a street value of between £ 350 and £ 450.

[60] 'Class A' drugs, typically heroin, cocaine, crack, ecstasy, amphetamines or Lysergic acid diethylamide (acid or LSD) are judged to be the most harmful group of harmful and illegal drugs whose use of controlled under the Misuse of Drugs Act 1971. Conviction for their possession carries the highest potential level of punishment

[61] An 'Appropriate Adult' is an independent person whose role is to safeguard the interests of a child or vulnerable adult who is detained or questioned by police officers in circumstances where a parent is not available. In this instance the Appropriate Adult was a volunteer appointed by the Dorset Combined Youth Offending Service.

[62] Body worn video, also known as body cameras and body-worn cameras or wearable cameras is a wearable audio, video or photographic system, in this instance worn by Dorset Police Officers.

The Appropriate Adult has told me that his recollection of the time he spent with Child C *"was of him appearing as a vulnerable young person frightened by what he was being groomed and coerced into by others, including the co-defendant*[63]*. He gave me the impression that he definitely wanted to find a way out of the mess he was getting into … In discussion with* [Child C] *he came across as polite, intelligent, wanting to continue in full-time education which he enjoyed, and build a career path towards something useful and interesting. He expressed his love for his Mum and was keen to get back home (but not in the company of the co-defendant."* The Appropriate Adult also referred in his report to the *"excellent Police Officer"* who conducted the formal interview with Child C but added *"there did not seem to be any way in which* [Child C] *could pass on information safely to them without exposing himself to greater risk from others".*

At 9:00 p.m., while still, in custody Child C asked to be allowed to contact the Samaritans. For reasons of confidentiality I have not been allowed to know the content of this call but I have been assured that if the discussion had touched upon safeguarding issues Samaritans would have triggered a safeguarding referral, which they did not do[64].

At 11:00 p.m. Dorset Police had completed their interview and Child C was free to be 'released under investigation'[65]. His mother had been invited to collect him from Bournemouth but neither she nor her mother could drive. The Waltham Forest Council Emergency Duty Team were then contacted but, in common with most local authorities, could offer no service that could respond to this type of situation at this hour[66] and expected Bournemouth Children's Services to make arrangements either to accommodate Child C or have him brought back to London. A local decision was taken by Dorset Police and the local Children's Services Out of Hours team that it was more desirable to return Child C to his home than to place him with foster carers overnight, so Child C was released from custody at 3 a.m. to be returned to the care of his family. He was driven back to London by two Police Officers, arriving at his grandmother's house at 5:00 a.m. on the 26th October.

DE met these officers there and told them that she thought that Child C had been staying with his brother. She explained that that was why she had not reported him missing. Child C had been away from home for at least 36 hours by this time.

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[63] Dorset Police have advised against taking too simple a view of the relative importance here of the ages of the two boys, 14 and 17. Without commenting on the specific relationship between Child C and the older boy they have said *"Being younger does not always equate to them playing a lesser role … it has been common for the younger ones to be running older people."* Other interpretations are, however, available on this point, see footnote 60 later.

[64] This information only emerged during my investigation for this review and was therefore not known to any of the agencies in Waltham Forest until December 2019.

[65] Being 'released under investigation' means that a person has been interviewed under caution and will now be allowed to leave the police station while police offices continue to investigate the crime. Dorset Police say that this was explained to DE when Child C was returned to her.

[66] One social worker was providing cover for four London Boroughs at this time.

The coordination of services between Bournemouth and London in respect of Child C was not as strong as it could have been:

- Dorset Police reported to me problems in trying to get information from the Metropolitan Police Service about Child C; they particularly drew attention to the fact that there was no obvious single point of contact for them to access.
- Dorset Police also described challenges in getting London based social workers to support Child C's return to Waltham Forest, or to make arrangements for him to go to an alternate place of safety. For their part Waltham Forest Council are clear that the immediate responsibility for safeguarding a child lies with the local area in which the child is found, while stating that they will cooperate as fully as they can[67]. The responsibility for returning a child to their home area was not clear then. In October 2019 the Ministry of Justice published well-intentioned guidance[68] intend to clarify the matter but I will contend in my Findings of Fact and Appendix 3 that there is still considerable confusion in this area of practice.
- Very little information was forwarded to Waltham Forest Children's Social Care about the any aspect of this episode. In particular at this stage there was no agreed system for assessing the circumstances around a detained child and then transmitting this information on to the child's home area. A national County Lines Vulnerability Tracker, developed by the National Police Chiefs Council and partners[69], is now in the process of national roll-out, and was introduced been by Dorset Police[70] after April 2019. Local safeguarding partners in Bournemouth[71] have also produced a Child Exploitation Assessment but this is only used for children from their home areas[72]
- As I will explain shortly Waltham Forest Council did not have access to specialist child exploitation workers who could reach as far as Bournemouth.

The arrangements for responding to Child C and eventually returning him to London in particular represent a missed opportunity. Had it been possible for Child C to have met specialist child exploitation workers while still in custody, and then brought back to London by these workers, and ideally if they could have continued to work with him

[67] In this instance the referral to Waltham Forest was made after 11 p.m. on a Thursday night when only the Emergency Duty Team was working.
[68] Ministry of Justice [2019] *County Lines Exploitation – Practice Guidance for YOTs and frontline practitioners* London: Ministry of Justice. See also footnote
[69] The purpose of the County Lines Vulnerability Tracker is to highlight *'the vulnerabilities and exploitation of young people, to mitigate and reduce the risk of young people in county-lines drug dealing through effective collaboration and safeguarding practices, and to support victims undergoing criminal prosecutions under the Modern Slavery Act legislation'*. The National Crime Agency, the National Police Chiefs Council and the national Regional Organised Crime Unit network have designed it.
[70] Implemented in Dorset on the 17th January 2019 the County Lines Vulnerability Tracker has subsequently been used 71 times there, 19 of these children being from the Metropolitan Police area. Of these 19 children, 11 were found in Bournemouth and 8 elsewhere in Dorset (e.g. Dorchester, Poole, Weymouth etc.)
[71] The Dorset Police, the Dorset Safeguarding Children Board and the Bournemouth and Poole Local Safeguarding Children Board.
[72] Bournemouth, Christchurch and Poole Council have, however, told me that they will send details of their 'concerns' to a child's local MASH to assist that area carry out an assessment of the child's needs.

for a time after his return, I believe such workers would have been able to exploit the 'reachable moment'[73] of this crisis in the Police station, during the car journey, and then subsequently, and start exploring with Child C the risks to him of his vulnerability to exploitation[74]. But this was not the brief of the Dorset Police Officers who were providing a well-intended but basic service in driving Child C back to London[75].

Waltham Forest is part of a pan-London consortium using a 'Rescue and Response Service' commissioned by the Mayor of London. However, the rescue element service was not fully operational until January 2019 and so was not available to help Child C in October 2018.

This service is still developing as this report is published (May 2020). It was initially described as operating only with a radius of 50 miles or two hours travelling from London[76]. Bournemouth is further away than this, so the service could not have reached Child C even if it had been operational in January 2019. During the period of the review, these rules were amended, perhaps more than once, and I have been assured that by the St. Giles' Trust, the charity that operates the service, that no such restriction applies any longer. The commissioners told me that they were able to travel as far as Plymouth on one occasion, and they also made one recovery from Bournemouth in 2019.

However, I found continued confusion on this point. For example, neither the Youth Offending Service in Bournemouth nor the Emergency Duty Team in Waltham Forest were aware of the possibility to use this service when I was conducting my review. This is important because the trigger for the service would have been with them. Asked about this the Service acknowledged that the wording of their briefing about the service, which during the review still referred to the limited catchment area, may stop agencies responsible for children outside the area from contacting them to request help.

It seems clear to me that there should be an appreciable demand for such a rescue and response service. The Mayor of London's Office for Policing and Crime (MOPAC) has itself identified Bournemouth as the fourth most cited destination by a large sample of individuals having a link or suspected link to county lines[77]. In the twelve months to

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[73] See footnote 10.

[74] The Appropriate Adult recorded that Child C said to him *"After the Police interview I sat with* [Child C] *in private and he revealed that he was frightened and did not want to be caught up with bad people."* The Appropriate Adult added that *"It seemed to me that there were issues concerning* [Child C]'s *safety and vulnerability and what he knew about other people who were arrested with him … but there did not seem to be any way in which* [Child C] *could pass on information safely … without exposing himself to greater risk from others."*

[75] The Ministry of Justice practice guidance referenced in footnote 68 covered, amongst other issues, this question of the return of children to their home areas. This new guidance states that *'If a child is found outside of their home area, they should be returned to their home area by the local police force'.* I disagree with this particular element of the guidance, and explain why in Appendix 3.

[76] These restrictions were put in place initially so that the service was not overwhelmed by demand (the Rescue team consists of only 4 people).

[77] See MOPAC [2019] *Rescue and Response County Lines Project – Strategic Assessment (August) 2019* London: MOPAC.

the end of August 2019 36 children from London Boroughs were found in similar circumstances to those of Child C in Bournemouth alone. Dorset Police, counting differently, produced a smaller figure for me[78] but this, too, pointed to there being an appreciable demand for such a service.

Child C's mother says that she expected further contact from the Police following this episode, as she knew nothing about the details from their perspective. However, she has told me through her solicitor that she has had no further contact from the Police[79].

The day Child C returned, the Waltham Forest MASH[80] reviewed what was known about Child C in the light of his arrest in Bournemouth. As part of this process his mother's views were sought by telephone. She explained that she had thought Child C had been visiting his older brother in West London at the time. She agreed to accept help from Waltham Forest Children's Services with parenting, and arrangements were made for her to be visited as part of an 'early help' assessment of the family's needs.[81] At this time she repeated her previous account that she was getting worried about the source of some of Child C's possessions ('tracksuits, trainers, and rings') as she had not bought these[82].

The decision to carry out an early help assessment, rather than to intervene at a higher tier was, I believe, the appropriate first step to take in the context of the Safeguarding Children Board's thresholds document and what was known about Child C and his family at the time.Had the MASH been able to gather a fuller picture of what was known about Child C's background it is possible that a 'child and family' assessment would have been commenced. The decision was finely balanced.

The MASH was as yet not in possession of significant information about Child C and his family. No checks had been made at this stage with any Nottinghamshire agencies although it was known to the MASH that Child C's family had lived in Nottinghamshire. No checks were made with Waltham Forest YOS either, who held highly relevant background information about Child C. Child C's High School were not notified of this

[78] Dorset Police's statistics relate to the calendar year of 2019 (bar 17 days) and only count those children whose details were kept on the County Lines Vulnerability Tracker that was introduced from the 17th January 2019. They recorded tracking nineteen children from London in this time, eleven being found in the immediate Bournemouth area and a further 8 in 'the county' (i.e. Dorchester, Poole, Weymouth etc.)

[79] DE says that she assumed that no further action was being taken and interpreted this to mean that this was not seen as a particularly serious incident.

[80] The Waltham Forest MASH is the first point of contact for all referrals to Children's Services in Waltham Forest. It consists of professionals from a wide variety of services. This means it can make joint decisions about how best to meet a child's needs.

[81] The threshold for an 'Early Help assessment' for an adolescent in Waltham Forest is described in the Safeguarding Children Board's 2018 publications *A guide to thresholds and practice for working with children and families in Waltham Forest* and *Safeguarding Adolescents: A Practice Guide*. The threshold for a Level 2 assessment or early help assessment is described in the practice guide as being that the child *'may be showing early signs of abuse, neglect or risk of harm outside the family … Their needs may not be clear, known, diagnosed, and/or being met.'*

[82] See my earlier footnote 53.

Bournemouth episode either by Waltham Forest Council or through their Safer Schools Police Liaison Officer by the Metropolitan Police Service[83].

DE now believes that the MASH should have immediately sanctioned the higher tier, 'children and families' assessment from the outset. I believe the issue here is less about the level of assessment commissioned by the MASH since this was changed within three weeks, and more about the limited checks that were made by the MASH. Waltham Forest Children's Services tell me they have now reinforced the requirement in their procedures that checks with other authorities' children's services and the local youth offending service must take place in these circumstances.

DE was also concerned to discover that the early help assessment was allocated to a student social worker. However, a qualified social worker was supervising her work and attended the two meetings that the student had with the family and so was actively involved in the process. I can find nothing to fault here.

On the 1st November DE was telephoned again by the early help social worker who had been allocated to work with her, and an appointment to start the early help assessment was made with her for the 20th November (later brought forward to the 14th and 15th November). A target for this to be completed by the 3rd January 2019 in line with the locally agreed time limit was set.

DE says she was not happy with this delay and wanted help earlier. The Council contends this was the first date on which she said DE was available. DE denies this. The Council has added that it's managers, too, were unhappy with the delay and asked the early help social workers to bring this appointment forward. The cause of this delay are an important point of disagreement, and I have been unable to reconcile the two entirely different accounts.

No other action at this stage was taken in response to the events in Bournemouth by any agencies in Waltham Forest.

This was a pivotal moment in providing support to Child C. For the first time the authorities in Waltham Forest had been presented with completely unequivocal evidence that Child C was being criminally exploited. This would have been even more clear to them if they had known about the gun incident in Nottinghamshire ten months earlier, if they had known of the two earlier references to Child C and guns, and if they had known about the threats made against Child C in Nottinghamshire in the summer of 2018.

There were several aspects of this episode in Bournemouth that were strongly suggestive that Child C had been supplied with drugs by an Organised Crime Group and was working to their instructions. These included:

[83]The school were also unaware of the decision to carry out an early help assessment.

- he had found his way to a flat that was being used as a venue for the drug trade[84];
- he was in the company of an older Waltham Forest boy (GH), just short of his 18th birthday so three and a half years older than Child C - this child's conduct at and after arrest led the Appropriate Adult to speculate that the older boy was the 'senior' partner in the enterprise[85];
- he was holding an unregistered phone that was not his own; and
- he appeared to have been rehearsed by someone on how to behave if arrested[86].

In addition, as this Review has demonstrated, there was a great deal of other information potentially available to cause considerable alarm about Child C's vulnerability to exploitation.

* * *

There is one final aspect of the Bournemouth episode that I need to explore here and that is to seek an answer to the questions of how Child C got the drugs that he took to Bournemouth to sell and how he knew where to go when there. The relevance of this to my Review is the possibility that these might shed more light on the degree to which Child C was being criminally exploited at this time.

My principal source is the interview that DE gave to the Daily Telegraph that was published on the 14th December 2019. DE, the article states, *"says her son was taken there* [Bournemouth] *by a gangster who picked him up at 'the school gates'".* I asked DE, through her solicitor, about this and she said that after his return Child C had told her that a child had said to him that if they went together to sell drugs he could make money. Child C told DE that this child, who I will now call Child M, picked him up from school and they travelled to Bournemouth together by train. Child M was not arrested with him. DE did not know Child M's name.

The Bournemouth episode occurred during the half term school holidays so I doubt they met at the High School's gates. However, I have been able to identify the child who most closely fits the account provided to DE by Child C. Records suggest it is possible that Child M accompanied Child C to Bournemouth on the day of (or more probably the day before given the timings involved) his arrest. Three weeks after the incident involving Child C., Child M. was also found at the same address in Bournemouth.

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[84] Dorset Police raided this flat three times in the space of a month, on the 19th. and 26th. of October and again on the 16th November. On each occasion they arrested children from the London area with no obvious personal connection with the tenant of the flat, a 38 year old woman.

[85] GH was not in possession of the drugs or the cash at arrest, which is typically a sign of seniority - furthermore, the Appropriate Adult, who met both boys, was firmly of the view that he was the dominant one of the pair. Dorset Police are less certain that this hierarchy between the two boys existed.

[86] Child C gave misleading information about his mother's name and contact details and asked to make a call to an apparently fictitious name that may have been an emergency call to whomever had supplied the drugs he held – he also gave a 'no comment' interview to the Police although this may have been on the advice of the duty solicitor.

Child M was know to have been highly vulnerable to exploitation and was taken into care shortly after the Bournemouth episode. However, Child M's care authority, who have discussed with Child M these issues in detail, think it unlikely that Child M was a prime influence on Child C. So I am left to conclude that Child M was possibly a link in a chain of associations and affiliations but may not have played as prominent a part as that described to DE by Child C[87].

The care authority do not have reliable intelligence on Child M's affiliation to organised crime groups and cannot, therefore, shed further insight into this episode.

In writing this section of my review I have taken care with my language in order to protect Child M's identity.

Early November 2018: Child C's exclusion from school

On Friday 9th November the Metropolitan Police Safer Schools officer at the High School was alerted to the existence of a Snapchat video featuring a pupil, identified as Child C. This video appeared to show him pulling some form of handgun out of a rucksack. Child C was wearing his school uniform on the video. The video was circulating around a number of pupils. The officer was also aware of a story that children from the High School were planning a fight with children from another school over an apparently minor dispute between the two groups. According to the Police the wording on the video was *"looool don't fuck wid us please were here again"*.

Child C was arrested at High School. He admitted it was him on the video. He later provided a written statement, saying that the gun was a ball bearing gun that he was looking after for a friend he would not name[88]. As Child C subsequently pleaded guilty to this offence and the gun was never recovered, the type of gun cannot be authoritatively identified. Child C was charged with possession of an imitation firearm in a public place.

When interviewed on the 15th November by the early help social workers DE said that the decision to film and post this video was another child's.

On the following Monday, 12th November, Child C was permanently excluded by the High School following consultation with the Police. This decision was further confirmed by the school's Governing Board's Disciplinary Committee on the 3rd December.

His mother thinks this exclusion was *"very unfair. The incident did not happen on school premises. He was permanently excluded immediately, without any period of temporary exclusion or other intermediate steps short of permanent exclusion."*

[87] I should also record here that when DE was interviewed on the 15th November 2018 about this episode she did not mention Child M but said that Child C had been approached by an adult who asked him if he would like to make money by going to Bournemouth to sell drugs.
[88] He would insist to the youth justice worker in December 2018 that he had not been coerced into looking after the gun.

The school felt they had no alternative given the potential seriousness of the incident and the apparent threat to the safety of other pupils and anyone else in the school. The school also took into account the fact that the episode was widely known as, in their words, the video had gone viral. The fact that Child C was wearing school uniform was also taken into consideration.

The incident itself was a clear breach of the school's behaviour policy[89], and I conclude that the High School's decision was reasonable. At the same time the correlation between children being criminally exploited and children being excluded from school is widely reported[90].

One disappointing element of this exclusion is that Child C's family were not present at the Disciplinary Committee meeting. The Council are clear that DE was provided with five days notice of the meeting, along with information about two advocacy organisations[91] that would be able to represent her interests at the meeting. DE has told me that she was *"so angry with the school that she decided not to"* appeal and had already begun to look for alternative education for Child C. DE's decision was understandable but it did mean that she gave up her chance to make representations to the High School about the exclusion.

A Senior Education Officer of the Council was present at this Disciplinary Committee meeting. The Council feel that her presence at the Committee provided a degree of independent oversight of the decision. I do not believe there was an alternative to the meeting going ahead.

Mid and late November 2018: Children's Services interventions

The original children's services plan was for the family to be the subject of an assessment for early help support, a response reflecting the lack of previous contact with Child C and his family. This assessment was not simply a gathering of information but also commenced the process of intervention.

In any event Child C's arrest for the firearm offence (9th November 2018) made an early response more important. The MASH decided to bring forward the date of the first visit by Children's Services. Two visits were made on consecutive days within 72 working hours of the report of the arrest. Child C, his mother and one of his uncles were seen. DE told the early help social workers that Child C was *"vulnerable and easily led"* and that she said she could not *"supervise Child C constantly and prevent him from leaving home to gangs* [sic]*".* She told the social workers that she thought Child C was being groomed and she was powerless to stop this. She is also recorded as saying, *"he is vulnerable, easily led and young minded".* She is recorded as adding that Child C had a friend in care and had threatened his mother that he wanted to be

[89] I have included a section from the school's 'School Behaviour Policy' in Appendix 2.
[90] Turner A. et al (2019)
[91] These were the Children's Legal Centre operated by the Thomas Coram Foundation for Children, and ACE Education, both well-respected organisations.

in care himself.[92] Sensible and potentially searching lines of enquiry had been established for these interviews with supervisors in advance of the interviews.

Child C's circumstances were then reviewed afresh by the MASH. The planned assessment of his circumstances, which was just beginning, was 'stepped up' from an 'early help' assessment to a 'child and family' assessment[93]. This involved a change of social workers. Meanwhile on the 20th November additional responsibility for working with Child C was allocated to a caseworker (hereafter referred to as the youth justice worker) working jointly for the Family Partnership Team[94] and the Youth Offending Service, via the Bronze Panel[95] process. This decision was prompted by the combination of the Bournemouth and more recent firearm incidents.

There were now two strands of casework involvement with the family, carrying out similar work, and these were soon to be joined by a third in December.

On the 24th November Child C was reported missing from home since 4:00 pm on the previous day by his mother. He returned two days later, saying he had been with a cousin in Ilford. He would not identify the address where he had been staying and his mother did not know it. The Police Officer carrying out a *"safe and well interview"* the next day recorded DE as saying this incident was just an incident of disobedience.

On the 28th November Child C pleaded guilty to possessing an imitation firearm in a public place[96] (the offence from the 9th November) and was sentenced to a Referral Order[97] for 10 months. This meant that the youth justice worker had to prepare an assessment of Child C for a meeting of the Referral Order Panel on the 15th January 2019[98]. Like the children's social care assessment, this assessment was nearing completion at the time of Child C's death.

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[92] These are not directly quotations from DE but from the Council workers' notes of what DE said to them.

[93] Whereas early help services are based on whole family interventions to help children with multiple needs, child and family assessments, carried out under the provisions of section 17 of the 1989 Children Act are designed to assess whether the child has complex needs. The *Safeguarding Adolescents: Practice Guide* already cited states that such assessments are designed to consider whether the child needs *'specialist services to achieve or maintain a satisfactory level of health or development or to prevent significant impairment of their health and development …'.*

[94] The Family Partnership Team's recent 2019 Service Level Agreement describes its task as being to *"to provide a trauma-informed voluntary service for children and young people under 18 utilising the Think Family model to build resilience and achieve better outcomes for young people"*. The most specific reference to working with children facing the same challenges as Child C commits the Team to *"co-produce solutions with those who have lived experience of gang-related issues'.*

[95] The Bronze Panel is an operational group in Waltham Forest that meets monthly and coordinates the response to children where there are concerns about gang involvement. This initial action was taken outside of the regular set of meetings, but the Panel did then meet to discuss Child C, amongst others, on the 12th December, see page 35.

[96] An offence under the 1968 Firearms Act.

[97] A Referral Order is an order available for children who plead guilty to an offence. On receiving the order the child is referred to a panel of two trained community volunteers and a member of the Youth Offending Team. Together with the child's parent (and victim where appropriate) the panel will agree to a contract aimed at repairing the harm caused and addressing the causes of the offending behaviour.

[98] The requirement to carry out this additional assessment is made in the Statutory Guidance on the operation of Referral Orders by the Ministry of Justice and Youth Justice Board.

November – December 2018: Finding a new school place for Child C

The crisis generated by Child C's exclusion from the High School was in considerable degree mitigated by the very prompt response of the Council's systems for responding to such permanent exclusions, which is led by the Behaviour, Attendance and Children Missing Education Service (BACME). The BACME service responded in the same week of the exclusion and had explained the alternative provision to Child C's grandmother within a week of the exclusion (they were unable to contact DE). Child C was then allocated a place at Burnside Pupil Referral Unit[99]

This offer was relayed to his grandmother because the Council could not contact DE mother. DE says she is not aware of any attempt to contact her, and that only one attempt was made to contact her mother but the Council's records indicate that, in a 20 day period, nine contacts and attempted contacts were made to the family and seven messages were left for DE to contact them.

I was impressed by the tenacity with which the BACME service pursued the establishment of an alternative education provision for Child C. It was clear that they appreciated from the outset the vulnerable position in which Child C found himself and were active in attempting to make alternative arrangements. This represents good practice.

After a fortnight of delay in contact from the family the BACME worker received a message from the youth justice worker that DE was rejecting the offer of a placement in a Pupil Referral Unit and wanted to explore an Alternative Educational Provision (AP). DE told me that she believed the PRU would be full of *"troubled children, vulnerable to exploitation by groomers".* She also felt the PRU would not fill his day.

The BACME worker responded promptly to this, and despite some further communication problems confirmed DE's choice of an alternative education provider, the Boxing Academy in Hackney[100] within eight days. The Council's records show that on the 17th December the BACME service confirmed, both by telephone call with Child C's grandmother and a follow up email to her, an interview date with the Boxing Academy had been set for the 20th December. DE disputes this and says that she was personally unaware of any attempts to contact her before the 20th December. She says she was aware that an email had been sent to her mother but again not until after the date of the interview. DE says that her mother only opened her in-box *"every once in a while but not frequently"*.

[99] A 'Pupil Referral Unit' is a school that is specifically organised to provide education for children who are not able to receive education in an ordinary school. Burnside School is responsible for children aged 11 to 16.

[100] The Boxing Academy, a free school, offers an alternative education pathway for children aged between and fourteen and sixteen who are at risk of exclusion. The Academy offers a full-time school schedule.

Child C failed to attend the interview on the 20th December. A further interview date was set for the 10th January 2019. DE planned to attend this with him.

December 2018

On the 3rd December the youth justice worker carried out his first key worker session with Child C and his mother. At this time DE is said to have described Child C as *"selfish"* and that she could no longer cope with his behaviour.

On the 12th December the Bronze Panel met to discuss progress in the handling of Child C's case. This provided a level of oversight into the work of the different individuals working with Child C and his family.

The next actual contact with the family came on the 14th December when the 'Missing Children Outreach' officer from the MASH visited Child C at home to conduct a return home interview in response to DE's report of his absence from home on the 24th November. An agreement was reached with the family that he would provide Child C with eight mentoring sessions, starting on the 11th January 2019. This offer was made following discussion with the Children's Social Care social worker, and was consistent with the fourth and final point in her plan for interventions with Child C. I believe this was good practice, although it did add to the complexity of three different caseworkers being engaged with Child C at the same time (together with a BACME worker, a housing officer, and in due course professionals from his new school once a place had been secured).

Housing Officer B's enquiries had continued since the end of October with commendable tenacity. At the beginning of December NCHA responded to a further contact from Housing Officer B by sending the contact details of a Nottinghamshire Police Officer who had first hand information about DE's complaints of harassment while living in Nottinghamshire. Housing Officer B contacted this Police Officer. As a result of the information received on the 24th December Housing Officer B was satisfied that there was evidence to support DE's application for rehousing by Waltham Forest.

Two things followed from this. First, the Council's Private Sector Rental Team were deployed to help DE. Within a week they identified a property in Tilbury that could be offered to DE and her family. Secondly, the facts of DE's case were presented to Housing Management.

All the information uncovered by Housing Officer B would have been available to Housing Officer A from mid September 2018 at the latest (and the most pertinent information was available in August) onwards. In these circumstances I have to conclude that Housing Officer A could and should have done better. Had Housing

Officer A done so, I consider that the Council are likely to have accepted that it held a Housing Duty to DE and her family by the end of October 2018[101].

In addition to the circumstances in which Child C and then DE left Nottinghamshire, there was also the question of Child C's housing arrangements in Waltham Forest, sleeping on a couch in his grandmother's house with his mother staying elsewhere.

In my opinion this increased his vulnerability to exploitation as it limited DE's ability to exercise parental control and supervision. Having said this it is evident there apparently were problems with such control and supervision long before Child C lived apart from his mother[102].

Senior managers in the Housing Service do not agree with my view on the issue of delay. They have commented *"We would … disagree with the assertion that Child C sleeping on a couch in his grandmother's home added to his vulnerability to exploitation. Overcrowding within family homes is not only commonplace within many households within Waltham Forest but overall in London and reflects the severe shortage of housing that persists within the capital."*

This shortage is, of course, well documented and these are reasonable comments to make. However, my view remains that the proper parental oversight and care of Child C, still only 14 years old at this stage, would likely to have been impeded by the lack of adequate housing. Child C appears at times to have come and gone as he chose. The strongest evidence to support this assertion includes:

- his disappearance to Bournemouth,
- at least one other occasion in November 2018 when he was reported missing from home by his mother, and
- comments allegedly made by DE to the early help social worker on the 15th November that Child C was becoming involved again in 'gangs' and that he would not return to his grandmother's house when asked to, for example returning at midnight when he had been asked to return by 8pm.

DE's personal ability to influence this behaviour was obviously affected by the fact that she was living in temporary arrangements elsewhere and so not physically present for some of the time. DE says that she spent a part of every day with Child C, waiting until her mother returned from work to ensure there was always an adult with him. However,

[101] The logic behind this calculation is that it took Housing Officer B from the 29th October 2018 to the 24th December 2018 to complete her enquiries and reach her recommendation to her managers, a period of precisely eight weeks. Had Housing Officer A followed the same lines of enquiry from the 28th August 2018 – the date on which DE asked him to reinstate her housing application – the eight weeks would have been completed on the 23rd October 2018.

[102] DE has told me that she believes this is an unfair comment for me to make. She believes it deflects attention away from my criticism of the handling of her housing application in Waltham Forest. This is not my purpose. I believe it is important to acknowledge that descriptions provided by DE at the time (and by others) indicate there were significant problems with the control of Child C from the summer of 2017 (when he was just 13 years old) onwards. At that time DE told agencies that Child C sometimes came and went from her home at will, and was reported at times by others to be on own, sometimes well after dark. This is backed by the incontrovertible evidence of the incident on the 17th January 2018, when he was clearly away from any supervising adults at 11:00pm.

work meant that she could not be with him in the evenings and obviously she was not at her mother's house overnight.

In my opinion it is simple common sense to state that this was not a remotely ideal arrangement and so I maintain my view on this issue. I believe that the delay in providing satisfactory housing represents a significant weakness in countering his vulnerability. It is worth adding that both the social work and youth justice assessments, written at the time, agreed that the housing situation added to Child C's vulnerability[103].

Over the seasonal break the youth justice worker had arranged for a colleague to contact DE by telephone to check how Child C was. This initiative, which demonstrated a growing view about Child C's vulnerability, is to be commended as good practice.

January 2019

On the 4th January 2019 the family were offered private sector temporary accommodation in Tilbury in Essex. Although this offer was initially rejected because of distance from home area and the state of the property, Child C's mother eventually accepted it.

In the first week of January both the Children and Family Assessment and the parallel assessment being prepared for the Referral Order Panel were in the final stages of completion. The Children's Social Care social worker had made one visit to the family and this had included seeing Child C on his own. She also had the notes from the Early Help social workers who had had three contacts with the family, and had seen Child C once. She had sought information from a 'Gangs' Police Liaison Officer who had told her that he did not believe that Child C was actively linked to any Waltham Forest gangs. I believe this comment downplayed the significance of the Bournemouth episode and quite possibly the subsequent gun incident.

I have reviewed the Children and Family Assessment and discussed its content with the children's social care social worker. My view is that it represented a strong starting position from which to work with Child C and his family. The social worker was aware that there were other professionals offering help to the family (the youth justice worker from the Family Partnership Team/Youth Offending Service, the missing children outreach worker from within the MASH, the worker from the BACME service and Housing Officer B) and saw her role as bringing together all of these strands but not replicating this other work. This was a sensible approach. Her assessment captures the Child C's more obvious vulnerabilities in December 2018 and her plan, which Child

[103] The Children's Social Care social worker wrote *"the current accommodation arrangements are not ideal given that DE … is sofa surfing, this raises the instability that the family are facing … The risk is that DE is splitting herself from living with her friends and family … there is no consistency of care and this would affect her ability to effectively look after all her children"* while the youth justice worker wrote that *"I am of the view that housing issues have played a significant role towards Child C's offending and his sense of self-reliance for his age".*

C's murder overtook, focussed on four important areas: [1] parenting and boundary setting, [2] rehousing, [3] education, and [4] mentoring.

Ideally, the assessment would have also analysed:

- the degree to which Child C was being criminally exploited in late 2018,
- the implication of the debt bondage[104] that would have arisen from the Bournemouth episode,
- Child C's pattern of associations outside the family (and the implications of any significant relationships),
- and other vulnerabilities and experiences of Child C that were likely to increase his victimisation.

The social worker had raised these broader issues, as had the Early Help social workers in November 2018. Their notes reveal them asking questions about Child C's possible gang affiliation; involvement in 'county lines'; access to firearms and drugs; and friendship and support groups. These issues are summarised in the children's social workers' final assessment, but there is no plan as to how they were to be addressed either by the Children's Social Care social worker or the two other workers who were by now involved with Child C. However, I believe the assurances provided by the caseworkers involved with Child C that these issues would have been explored further in future work with Child C, and the youth justice worker had been provided with helpful notes about working with children associated with 'gangs' by the Police Officer working with the Youth Offending Service on these issues.

Child C had told the children's social care social worker that he had made a conscious decision to change his life and not be involved with others who he felt exercised a negative influence on him. I can see no reason to doubt his sincerity at that moment, but it is clear that he had made very similar comments in the past, for example to the youth justice workers who he met in the early months of 2018, to the Appropriate Adult in Bournemouth, and to the YOS/Family Support team member. Child C's need for additional support to achieve this change is obvious. Two of the three interventions in place by January 2019 planned to analyse whom his *'negative peers'* were or what help he might need to change his life.

The other assessment nearing completion in January was that being carried out by the youth justice worker for the meeting of the Referral Order Panel. The youth justice worker had met Child C twice in this process.

I have also reviewed this assessment and discussed its content with a youth justice manager responsible for overseeing this work. The assessment, like that carried out by the Children's Social Care social worker, is reasonably comprehensive, but would be more complete if it had included information held by the Waltham Forest Housing Service and agencies in Nottinghamshire.

[104] Debt bondage is the pledge of a person's services as security for the repayment for a debt. In 2005 the International Labour Organisation described it as the most common method of enslavement.

The youth justice worker adopted a more critical tone in his approach than the children's social care social worker. The youth justice worker's assessment is less convinced by Child C's profession of his determination to change the course of his life. After a first Keyworker session with Child C the worker wrote of gaining the impression that Child C *"has no real intention of changing his lifestyle … Throughout it all I gained the impression that* [Child C] *does not want to embrace responsibility*[105] *for his decisions or actions".* The ultimate assessment reflected this view. The assessment was also more analytic in its assessment of the needs or goals that lay beneath Child C's behaviour (*"sense of belonging, a sense of notoriety amongst his peers, financial gain"*).

What was missing from this assessment was a reasoned analysis of the degree to which Child C was the subject of exploitation in the autumn of 2018. The assessment would also have been strengthened by consideration of the wider context and relationships that were making Child C vulnerable.

The youth justice worker planned to challenge Child C on these issues further over the 10 months of the Referral Order, hopefully building a personal relationship with Child C that would give such a challenge greater impact. I think this is reasonable. Winning the trust of a child in Child C's circumstances and building a relationship for change from that is a sensible strategy to achieve long term change.

By the end of the first week in January 2019 a broad framework for working with Child C and his family had been established:

- The Children's Social Care social worker had established her own four-point plan.
- The youth justice worker was planning to work with Child C over the 10 months of the Referral Order with a particular focus on getting Child C to address his offending behaviour.
- The Missing Children Outreach worker based in the MASH was offering a series of mentoring sessions to Child C, which his family had accepted.
- Child C was poised to start at a highly appropriate alternative education provision provided he could be got to the interview scheduled for the 10th January 2019.
- The Housing Service had arranged to rehouse the family, and as it happened this was 'out of area'[106].

[105] This important insight about Child C not wanting to *'to embrace responsibility'* for his actions will be strongly suggestive to many readers of the need for a therapeutic or psychologically informed approach to be adopted in the future engagement with Child C. The observation is also consistent with the finding of the national panel's review (see Appendix 5) that most children in their sample of cases *"only engaged with practitioners on a superficial level."* The Youth Offending Service worker had alluded to this apparently superficial engagement earlier when he reported to the Bronze panel on the 12th December that when attempting to engage with Child C about his response to the concerns expressed by his mother and grandmother Child C *"did not provide much other than to say that he 'understands' why they are concerned."*

[106] Note that research suggests we should be careful about assuming relocation will disrupt the criminal exploitation of children, except for a very limited time. See Appendix 6.

Taken together this was a reasonable plan although I do believe it would have been strengthened had these workers, and others engaged with Child C and his family, met in a formal case discussion to share their knowledge of the family and develop together a concerted plan of action. I return to this issue in next chapter[107]

* * *

On the 7th January DE telephoned the Children's Social Care social worker. She was unavailable. DE told me she left a message *"asking for help to be moved immediately as* [Child C] *believed that something was going to happen to him."* DE says that Child C had been *"behaving strangely and had gone very quiet."* The Council could find no record of having received this message.

The next day, the 8th January 2019, a friend of Child C has told the Police that Child C telephoned him mid-afternoon before the attack and said, *"I'm in the beef again".* The friend says that Child C was laughing at the time so he did not take him seriously[108]

Three hours later Child C was seen riding a stolen moped in Leyton. Shortly after this a black Mercedes that had been reported stolen four days before collided head on with the moped he was riding. Child C was thrown to the ground. Four men got out of the car and three of these stabbed him while he lay on the ground. They then left in the car with a fifth man who had remained in the car throughout.

Forensic and other evidence identified a 19-year-old suspect and he was arrested on the 19th January, subsequently being charged with Child C's murder as well as with the possession of an offensive weapon. He was convicted and sentenced to life imprisonment for the murder on the 11th December 2019.

[107] See pages 44 and 45.
[108] This detail was provided in the 'Agreed Facts' presented at the Central Criminal Court during the trial of Ayoub Majdouline.

Chapter 4 – Analysis of systemic issues arising from this review

Introduction

In this Chapter I turn to the questions set for me by the Safeguarding Children Board, together with an additional issue of my own.

The Safeguarding Children Board asked me to consider and address any learning from the review in the following systemic areas:

- Does the safeguarding children partnership provide a consistent response to children criminally exploited and is [it] able to assess the risk associated with drug debt bondage?
- Is the partnership delivering a contextualised, trauma-informed approach to adolescents as outlined in the Board's 'Safeguarding Adolescents Practice guide?
- Is there a gendered bias to this response?
- Does the focus on "gang-affiliation" support or frustrate attempts to safeguard children who are at risk of both sexual and criminal exploitation?
- Is there a system in place that is equipped to respond effectively and timely to requests for families to relocate both in and out of borough, which includes a risk assessment?
- How do we respond as a partnership to children who present a challenge to schools? How are children supported to keep them in mainstream education?
- Is there a flexible and responsive trauma-informed debriefing and clinical support available to staff and volunteers across the children's workforce and is self-care and staff wellbeing embedded in policies, procedures and organisational culture?
- How are professionals working with parents as part of the contextualised approach and is this in a Think Family framework? Is the use of Child Protection/Child in Need frameworks a detriment to working with parents?

I have then added a further systemic issue of my own:

- Were issues of race relevant to the responses provided to Child C and his family?

I shall address these questions in turn.

Does the partnership provide a consistent response to children criminally exploited, is [it] able to assess the risk associated with drug debt bondage and is the partnership delivering a contextualised, trauma-informed approach to adolescents as outlined in the Board's 'Safeguarding Adolescents Practice guide'?[109]

I have a number of points to make in relation to this question.

I can see that at a **general policy level** the partnership has recognised the threats of child criminal exploitation. I did not encounter staff with inappropriate attitudes to Child C[110], it was clearly the view of all working with him and his family that he was a victim in need first of assessment and then support. It is also obvious that the Council and the Metropolitan Police are very alert to the dangers of child criminal exploitation and have taken action, jointly and separately, to counter these. Their very action in immediately identifying the need for this review speaks clearly of this commitment.

The MASH did comment that responding to vulnerable children with links to 'county lines' operations was both a newly emerging and also relatively rare experience. By their calculation they have no more than 1 referral of the same type as that of Child C's in any month[111]. The Mayor of London has published the first strategic assessment from his 'Rescue and Response County Lines project'[112], which shows a similarly low level of referral to that project in respect of children and young people from Waltham Forest, with only eight referrals made in a twelve month period to June 2019, the second lowest in London. This relatively low level of referral is possibly a lesser frequency than the prevailing media narrative.

Other material in the Mayor's report about the general incidence of concerns around numbers of people exposed to county lines exploitation identifies over 200 people living in Waltham Forest who have a link to (or are suspected of having a link with) county lines, this representing the sixth highest total in London[113].

This gap between estimated exposure to county lines exploitation and more specific numbers of referrals to the Rescue and Response service seems likely to be linked to the fact that the exploitation of children by 'county lines' style operations is an emerging issue, and still requires greater focus. The St. Giles Trust acknowledged candidly that *"children who are involved* [in 'county-lines' style exploitation] *may be known to a*

[109] I have run the first two questions I was asked into one as the issues clearly overlap.
[110] For example, believing that Child C was complicit in his own criminal exploitation.
[111] This statistic is consistent with the Strategic Assessment published recently by the London Mayor's Office for Policing and Crime on the Rescue and Response service which reported that 8 referrals had been received concerning children from Waltham Forest across a twelve month period [MPAC [2019] *Rescue and Responses County Lines Project Strategic Assessment (August) 2019* London: MPOAC] and needs to be considered in the context of the MASH receiving more than 1,200 referrals per month of all types, 200 to 300 of which pass on to various assessment stages.
[112] See MOPAC [2019] op cit
[113] Waltham Forest's own figures are slightly different, partly a consequence of counting a different period and also looking beyond just links to 'county lines'. In the year 2018/19 the Council's children's services identified 338 children *"who had 'gangs' identified as a risk factor in a referral, child missing or assessment step."*

variety of agencies, but … it is rare that all similar cases are known to one body – this is the likely explanation of the low numbers seen by [the Waltham Forest] *MASH."*

I believe there may be learning for the partnership from a number of features in this case. The first of these relates to the **speed of initial intervention**. In Child C's case many of the responses from October were purposeful and carried out at pace but not all were. I believe that in the early stages of responding to cases of child criminal exploitation, when the safeguarding partnership has not been able to identify the level of exposure to harm to which a child such as Child C is exposed, there is a strong case for fast tracking initial engagement. This could have begun with the engagement of specialist workers to bring Child C back from Bournemouth. The early help social workers workers deployed by the MASH were following guidelines about the time to be taken for initial assessments and emphasised this point in my conversations with them. These guidelines are sensible in ordinary circumstances but may not be in the case of the criminal exploitation of children, especially where the level of vulnerability is unknown. Children's Services management have highlighted in response how little they actually knew at the time that their staff were planning the response to the Bournemouth episode. This is a fair comment. Once the incident on the 9th November 2018 that led to Child C's exclusion from school was known Children's Services responded with speed.

I also believe that insufficient focus was given to **the contextual elements of safeguarding in developing a plan for working with Child C**. The partnership has paid considerable attention to contextual safeguarding[114] in its adolescents policy and also in commissioning an independent audit in March 2017[115] by acknowledged authorities in this field. However, in Child C's case the two post-assessment plans have limited content in this area. MOPAC's 2019 review, which I have already cited, makes the clear statement that *"evidence indicates the factor that puts young people most at risk of county lines exploitation is association with someone who is already involved; whether that be directly through association with a gang, or indirectly through a friend of a friend."* Investigation of this factor was missing from these assessments.

The Council, the Police and their safeguarding partners have invested heavily in intelligence, mapping the associations of children in trouble. They do this via the production of 'i2 charts'[116] for multi-agency panels. I have seen a very informative series of such charts in respect of Child C. However, these were not put together until after Child C's murder. They were not requested as part of the assessments or

[114] The phrase 'contextual safeguarding' describes an approach to safeguarding children that looks beyond issues within a child's family to vulnerabilities to abuse or exploitation from outside the family. *Working Together 2018,* the Government's guide to inter-agency working to safeguard and promote the welfare of children, refers to *"extra-familial threats that may arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online"* Department for Education [2018] *Working Together to Safeguard Children* HM Government: London, paragraphs 33 to 37. Further information on this model can be found at https://www.contextualsafeguarding.org.uk/en/about/what-is-contextual-safeguardin

[115] Lloyd, J. and Firmin, C. [2017] *Local Area Audit: Waltham Forest* Luton: MSUnderstood

[116] An 'i2 chart' is a visual analysis tool that helps the user turn data into intelligence using features such as network visualisations and social network analysis, with the aim of helping a better understanding of hidden connections and patterns in data.

intervention planning for Child C. There is a field within 'MOSAIC'[117] that allows children's patterns of friendship to be plotted but this is not as powerful a tool as the i2 chart.

This may simply be a matter of timing; in other words it may be that this work would have followed later. But my feeling is that it ought to be a standard part of an assessment of a child who is considered to be vulnerable to criminal exploitation.

The specific issue of **drug debt bondage** did not feature in the initial contacts with Child C, despite it possibly already featuring in DE's narrative about Child C's life in Nottinghamshire, and it being an obvious consequence of his being found selling drugs in Bournemouth. Had those workers carrying out assessments seen the notes of the Appropriate Adult they would have wanted to focus on this, but I am not aware of these being requested until the convening of this Review.

This leads me to **the issue of multi-agency case discussion**. The *Safeguarding Adolescents Guidance* is clear that a *'Strategy Meeting/Discussion'* should have been held in respect of Child C as soon as there was "*reasonable cause to suspect that a child is suffering or is likely to suffer, significant harm".* The function of such a discussion is spelt out. This did not happen in Child C's case, and nor did any of the other multi-agency forums that could have discussed his case do so before his murder[118], with the exception of the brief discussion at the December Bronze Panel (where only one of the five people who knew Child C and were working with Child C was present). The practice guidance also states that an *"immediate care plan"*should have been produced but this did not happen.

I appreciate there is considerable debate across the country about how best to develop systems and processes for safeguarding children who are being criminally exploited. The current majority view would appear to be that while children in Child C's circumstances are 'at risk' and are thought of as being in need of safeguarding as a consequence of the level of exploitation to which they are exposed, many of the remaining processes that have evolved to keep usually younger children safe from what is predominantly inter-familial abuse are not appropriate in combatting this newest of safeguarding challenges.

I believe the lessons of Child C's case point us in a different direction. I believe that a concerted effort, by all agencies including the Housing Service, to pool in a meeting all that they separately knew about Child C is likely to have led to a sharper focus on his vulnerability from the end of October onwards. An *immediate care plan* arising from such a meeting might have been expected to analyse in more detail the non-familial contexts of his life (including identifying what was not known and how to close some

[117] 'MOSAIC' is the social case management software system used by the London Borough of Waltham Forest.

[118] It is worth noting that there is a trade off between discussion in a regularly convened meeting and action. In Child C's case, for example, he was referred on to the Family Partnership Team in November rather than waiting for a regular meeting of the Bronze Panel. This was admirable in itself, but I do not believe it takes away from my point about the need for an actual discussion of his predicament in a meeting with all professionals who were involved with him and his family present.

of these gaps), including within this some reference to the issue of drug debt bondage, his need for mentoring and other immediate interventions, and the contribution of the housing stress that the family were exposed was making to his vulnerability. Staff were able to identify a range of meetings where such discussions and planning could have taken place but no such discussions did take place, until to a degree the Bronze Panel meeting of the 12th December.

The flaw with the Bronze Panel discussion was that it was not dedicated to Child C. Most of those involved with Child C and his family were not present or represented during the discussion, the meeting itself considered the circumstances of 25 children, providing only approximately 11 minutes discussion per case. While this was better than nothing I do not consider it sufficient.

WFSCB's thresholds document refers to the role of a *"Lead Professional for Whole Family Intervention"* and describes this person as being *"the single point of contact"* for the family. This was not happening in this case, instead there were probably five case workers engaged in different ways at the time of Child C's death. I would have found the number of people working with Child C confusing had I been DE. It is tempting to speculate that had there been a multi-agency case discussion this complexity might have been simplified.

In the light of this confusion, as well as the national debate about how to best respond to criminally exploited children, I strongly support the recommendation from the national Child Safeguarding Practice Review Panel[119] that *"the government moves at pace to review Working Together … to explore how best to ensure the narrative and requirements of Working Together reflect the risk of harm from outside the home, with a view to agreeing amendments to the current guidance".* My own Recommendation No. 9 touches upon this issue.

I received, mid-review, a series of flow charts, *Process map for gang referrals (under 18YO) in Waltham Forest[120],* that show that the Safeguarding Partnership amended their processes in September 2019 to include a requirement that the lead social worker convenes a *'strategy meeting'* in the early stages of responding to situation like that faced by Child C.[121] However, I believe case discussion needs to continue beyond just the early stages of working with a child and family.

There is one final point to make here and that is the question of **the involvement of the Housing Service in case discussion**. I accept that for pragmatic reasons Waltham Forest's current practice is to limit initial strategy meetings/discussions to children's social care and the police. However, *Working Together 2018,* the

[119] For more details and discussion about this review, see Chapter 6.
[120] Private communication from the Waltham Forest Safeguarding Children Board, November 2019
[121] This process map does not require a more senior and experienced officer to be present and/or chair such meetings, necessary requirements in my view, but this may just be a question of how much detail is included in a process ma. In any event my 7th and 8th recommendations take this issue forward.

authoritative guide to inter-agency working to safeguard and promote the welfare of children is clear that:

'Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care … the police, health and other bodies [my emphasis]*'* [122]*.*

This approach is also echoed in the relevant sections of the London Child Protection Procedures, which are used in Waltham Forest[123].

However, in Child C's case this strategy meeting/discussion occurred at the MASH and the Housing Service was not involved. I acknowledge there will be some practical issues here but in my opinion any meeting considering Child C's vulnerability to exploitation without Housing would have been an inadequate forum. *Working Together* 2018 is clear that its requirement that *'a local authority social worker, health practitioners and a police representative'* be involved is a minimum.

So far as Child C is concerned I have two reasons for holding the opinion that the Housing Service needed to be present in a case discussion:

- in October and November there were facts highly relevant to an assessment of Child C's vulnerability that were only known to Housing, and, as both subsequent assessments indicate
- addressing the housing needs of the family was an important element of the plan to reduced Child C's vulnerability to exploitation.

While I have only looked at Child C's case I doubt that his were the only circumstances where the participation of the Housing Service would be essential to a discussion about keeping a child safe. So I recommend that the WFSCB reviews this aspect of their procedures and either broadens the invitation list to strategy meetings/discussions or creates provision for case discussions that do involve Housing where this is needed.

At that same time I recommend that the WFSCB reviews the level of understanding of public-facing officers in the Housing Service about thresholds for intervention with families (and the range of services available to help families) in the light of the possibility that Housing Officer A was unsighted on such issues[124].

Is there a gendered bias to this response?

I understand the Safeguarding Children Board to be concerned that the past focus on the exploitation of girls may have been to the detriment of boys who were either being sexually or criminally exploited. I saw no evidence to substantiate this concern.

[122] Department for Education [2018], Chapter 1, page 39
[123] London Safeguarding Children Board [2017] *London Child Protection Procedures Fifth edition* London.cp.uk, see paragraphs 3.4.5 and 3.4.11.
[124] See page 22.

Does the focus on 'gang-affiliation' support or frustrate attempts to safeguard children who are at risk of both sexual and criminal exploitation?

All the staff I met during this review[125] were very careful with their use of language surrounding 'gang-affiliation' and observed, scrupulously, the need for caution about applying such a label to exploited children. At all times I felt we were discussing the case of a child who had been exploited and who was, rightly in my view, seen as being a victim.

Is there a system in place that is equipped to respond effectively and timely to requests for families to relocate both in and out of borough, which includes a risk assessment?

Once Housing Officer B became involved with DE's application I believe she the Housing Service responded effectively and in a timely manner. However, I believe the assessment of DE and Child C's housing needs could have been handled in a timelier manner by Housing Officer A. Senior Managers in the Housing Service have said that *"we do not fully accept … [this] assertion".* Senior Managers have acknowledged the importance of Housing Officer B's individual judgement and feel that the variation in action of the two officers falls within acceptable patterns of variation.

They have also described significant progress that they have subsequently made with reviewing local processes for the relocation of young people and families in and out of Waltham Forest and identifying how to avoid the delays in trying to support families who agree to relocation. I understand that a series of meetings has taken place, involving representatives from Housing, the Metropolitan Police and Community Safety/Well-Being & Independence, and Children's Social Care. The resulting actions included closer working between the Bronze Panel and the Social Needs Panel, a workshop for housing officers to improve the quality of referrals to the Social Needs Panel and engagement with registered providers regarding their process when a family requires relocation. These actions will continue to be monitored through the Adolescents Safeguarding and Resilience Strategic Group.

However, I could find little evidence of the Housing Service being closely tied into the operational work of the Safeguarding Partnership. As a consequence information that was only known to the Housing Service took time to percolate to the other partners, while the implications of the housing stress under which Child C's family was placed was not discussed in a multi-agency forum. It appears to have been left to the Children's Social Care social worker to see it as being her role to advocate for the family to be rehoused, rather than this issue being seen as a more collective issue.

[125] Including those in Nottinghamshire although this question was clearly being asked of Waltham Forest based staff.

It is an observable fact that the Housing Service in Waltham Forest, as throughout London, is struggling to meet the housing needs of the London population.

How do we [Waltham Forest Local Safeguarding Children's Board] respond as a partnership to children who present a challenge to schools? How are children supported to keep them in mainstream education?

I accept that it was reasonable for the Waltham Forest High School to conclude that they had no choice but to exclude Child C.

The subsequent meeting of the Disciplinary Committee provided an obvious opportunity for this decision to be reviewed. I am satisfied that the Council took all reasonable steps to persuade DE to attend the Disciplinary Committee at the High School, and good advice was given to her, in writing, about her ability to seek independent and expert advice about her rights. In the end she chose not to attend for her own reasons.

The prompt response of the Council's Behaviour, Attendance and Children Missing Education service to this exclusion is to be commended and could have gone a long way to offset the additional vulnerability experienced by Child C as a result of his permanent exclusion.

Is there flexible and responsive trauma-informed debriefing and clinical support available to staff and volunteers across the children's workforce and is self-care and staff wellbeing embedded in policies, procedures and organisational culture?

I took time in all my individual meetings with staff in Waltham Forest to ask them about the support they have received in response to Child C's murder, and was impressed by the obvious care for their staff exhibited by the management of Council Services.

How are professionals working with parents as part of the contextualised approach and is this in a Think Family framework? Is the use of Child Protection/Child in Need frameworks a detriment to working with parents?

The Safeguarding Partnership's 'Think Family' approach is set out very clearly both in its Guide to Thresholds and Practice and in the Safeguarding Adolescents Practice Guide to which I have already referred. I believe that the tiered approach to assessment and work is described well and it was apparent that staff were at ease with this.

As I have already commented, while the overarching approach of contextualised safeguarding is well described in the Adolescents Practice Guide, the plans produced in relation to Child C contained very few elements of contextualised analysis. This may

simply reflect that the response to Child C, at the stage it had reached when he was murdered, had not had time fully to consider the risks outside the family context to which he was exposed. However, I believe the partnership should take the findings of this review as an opportunity to consider whether their pre-existing programme of planned audits either has looked or is intended to look in more detail at this issue. In other words, was the relative lack of contextual analysis in Child C's assessment atypical?

On the specific question of whether the Child Protection/Child in Need framework constitutes a detriment to working with parents I cannot see why it should be. DE clearly welcomed the assessments that were offered to her by Children's Services.

When asked to elaborate this DE described poor experiences working with Nottinghamshire Police, schools in Nottinghamshire and Waltham Forest and the housing service in Waltham Forest. Her solicitor added that DE *"does know that there were clear signs that* [Child C] *was being groomed and the authorities were aware of this, or should have been. She did her best to protect him and sought help from numerous sources but the response was always too slow or inadequate."*

I have not met any other parents, partially because of the Safeguarding Children Partnership's concern to ensure that my review stuck closely to its terms of reference, and so cannot comment more generally on this issue.

Issues of race

Child C was a Black British child and so it is important to consider whether issues related to his race played any part in the response of the various agencies to him. I am aware of the many challenges that black children and families can face in our society. I am also conscious that issues of race and ethnicity can often go missing from Serious Case Reviews[126]

In respect of Child C there is one specific episode to examine, as well as the more general response to him to review.

First, *the specific episode*: DE has described her concerns about possible racism in the response of the Nottinghamshire Academy to Child C, particularly the events leading up to his second fixed term exclusion in February 2017. I have looked in detail at this episode. It involved allegations from a girl (together with supporting evidence from two other girls) that Child C had been making cruel remarks about her, and in particular her appearance, for some time and that this behaviour had got worse in early 2017. DE describes this as *"laddish*" conduct and believes that the Academy exaggerated its seriousness but this does not fit with the accounts provided by the Academy, including the victim's statement. All of this was contained in an 'Exclusion

[126] See Bernard C, and Harris P. ed. (2016) *Safeguarding Black Children.* London: Jessica Kingsley and Bernard C. and Harris P. (2018) 'Serious case reviews: The lived experience of Black children *Child & Family Social Work* 2018; 1-8

Report' that DE had been given. When she was asked in the Governors' Discipline Committee meeting whether she wished to make any comments on this she said that she did not.

While I am struck by the fact that both Child C and the girl he was accused of bullying were only twelve years old at the time, I believe the Academy's actions in making a fixed-term exclusion fell within acceptable boundaries of reasonableness, especially given they had already had to deal with 14 previous episodes of poor behaviour in Child C's first four terms at secondary school. The Academy staff outlined, to DE and Child C, in the Discipline Committee meeting the support that they were keen to offer Child C on his return to the school at the end of the fixed term exclusion.

Secondly, the more general question: DE says that she did not experience racism from the agencies she came into contact with in either Nottinghamshire or Waltham Forest, with the sole exception of the Callan Academy.

At the most obvious level I found no evidence during my review that racial stereotyping came into play in the judgements made by the various professionals who met Child C and DE.

More generally the strengths-based model of practice that underpins the Think Family approach adopted in Waltham Forest is widely recognised as being more suitable to negate the risks of racial stereotyping that can arise in working with black children and black families.

None of this is to underplay the real risk that such stereotypes can easily come into the picture when responding to a black boy whose behaviour at school is seen as being unruly, or who is at risk of criminal exploitation. Black families have entirely legitimate concerns that they and their children may be judged more harshly and may be denied support that would be provided to other families and children in similar circumstances.

The staff who worked with Child C and his family and with who I have discussed Child C, showed a keen awareness of the interplay between issues of race and trust. They all had professional experience of this issue and most had personal experience of the interplay between race and trust because they themselves came from minority ethnic backgrounds. They spoke with authority about how their training and professional supervision helped them scrutinise their own practice and ensure that it was anti-oppressive. I doubt they were insensitive to the fact that Child C, DE and other members of his family would be likely to have reservations, perhaps severe reservations, about trusting them or the agencies they represented.

It is also important to reflect on what may have been the day-to-day realities of Child C's life, and how they may have shaped his view of the world around him. Bernard and Harris[127] wrote about this.

[127] Bernard C. and Harris P. [2018]

"In each of the SCRs [that their study reviewed]*, there was a noticeable absence of professional curiosity about the everyday lives of the children. Notably, the lived experiences and emotional lives of children were not known to professionals, particularly their daily realities …"*

and, of these SCRs

"there is a tendency to state the child's ethnicity in broad terms without unpacking that that means for the day-to-day realities for the children within their ethnic and cultural context."

I have been acutely aware of the importance of this issue throughout my review. I have not been able to discuss Child C's 'lived experience' with his family (and am conscious there would be gaps in their knowledge anyway) so what follows in highly speculative. My own 'unpacking', in no sense complete, would include: his father being deported; some other members of his family being in trouble with the authorities; he himself feeling he had been unfairly punished at school; having to sleep in his grandmother's sitting room, while his mother slept on sofa's in other houses because no housing was available; as well as the attraction that aspects of counter culture held to him[128]. Some at least of this fourteen year old's childhood dreams must have seemed very far from reality.

Conversely organised crime groups appeared to offer a way of earning money; possibly an exciting lifestyle; a certain notoriety and with it status on the streets and in his peer group.

Child C appears to have distrusted many of the workers he met, but seen from my perspective this was misplaced. A number of workers with roles to play in his life were clearly prepared to go went well beyond a limited interpretation of their role to try to help Child C and his family. I also know that the school at which Child C ought to have started in January 2019 feel they had a lot to offer him. Tragically none of these people were provided with that opportunity.

[128] In drawing up this list, I make no judgement here as to whether these elements were exactly as Child C saw them; I am only speculating that each of these issues probably bore down upon his consciousness.

Chapter 5 – Findings and Recommendations

Introduction

Before I summarise my findings I would like to start by making three more general observations that seem central to this review of the last months of Child C's life.

Why was Child C attacked and murdered?

During the trial of Ayoub Majdouline for Child C's murder, the Prosecution alleged that the attack on Child C was part of a conflict between two organised crime group, the Mali Boys (also known as Mali Strip) and the Beaumont Crew (also know as "Let's Get Rich" or LGR). Ayoub Majdouline's legal team acknowledged that he was associated to the Mali Boys. The prosecution and defence teams agreed between themselves that Child C was associated with the Beaumont Crew, thereby suggesting a motive for the attack.

However, no-one representing Child C was involved in this discussion, so the fact that the Court was told that Child C was associated with the Beaumont Boys does not mean it is accurate; the assertion has not been tested. Ayoub Majdouline pleaded not guilty and therefore made no contribution to explaining the motivation for the attack.

The 'agreed facts' about Child C's association with the Beaumont Crew were based on slight evidence, accounts provided to the Metropolitan Police by unnamed 'friends' of Child C. There were (and still are) a great deal of stories circulating from children and young adults about Child C and his life. In the course of this Review I have heard some but undoubtedly not all of these. Those that I have heard often contradict each other and none have been tested robustly. I would advise any one hearing such stories to treat them all with caution.

There are also possible contradictions in the 'agreed facts' about Child C's associations. For example reference was made to an incident of Child C being threatened, four months before his murder, by an unidentified man who was thought to be a member of the Beaumont Crew. This might be taken to be evidence that he was not linked to the Beaumont Crew. In addition at the time of his murder the Liaison Police Officer linked to the Youth Offending Service was unaware of any suggested link between the Beaumont Crew and Child C.

All in all I believe we cannot be certain whether Child C was associated with either of these organised crime groups, although someone was clearly supplying him with

drugs to sell[129]. This uncertainty about his associations leads in turn to uncertainty as to why Child C was attacked.

If we cannot be clear why Child C was attacked, it follows that we cannot be completely certain about measures that could have been taken to help safeguard Child C. If we do not know from where the threat to him came, or for how long it had been there, or even for absolute certainty that he was the intended victim of the attack, then we cannot know for certain what measures were needed to protect him.

What is known about the criminal exploitation of Child C?

There are great gaps in the knowledge of the people I have interviewed about Child C's life in the months before he died. DE's account is that Child C *"was either at his grandmother's house, or at the Christian youth club where he has been the evening that he was murdered, or at the garage where he would sometimes be allowed to ride the bikes"*, but this does not seem to be a complete account; is not what DE is reported as telling the children's social care social worker and the youth justice worker at the time; and most specifically does not explain how he came to be riding a stolen moped on the 8th January, or in possession of articles that suggested strongly he had been involved in some capacity or other in the selling of cannabis[130].

These gaps make it impossible to understand to what level of risk he was exposed. At the same time it is, I believe, quite clear that Child C had been a victim of criminal exploitation for a considerable period by the time of his death. DE's contemporaneous accounts would date this back to late 2017 or early 2018, at which stage Child C was thirteen years old.

In her various statements made recently, including some made to me, DE has played down parts of his troublesome past. At other times DE has clearly been very aware of the risks to which Child C was exposed. Her decision to relocate him to Waltham Forest without having secured a home, job or schools for her children is clearly indicative of her desire to go to any lengths to protect her son.

Such facts as exist suggests the criminal exploitation experienced by Child C became significantly greater in the autumn of 2018. His appearance in Bournemouth on the 25th October 2018 is the principal evidence of this exploitation, supported by the items found in a bag he was carrying when he was murdered. As already mentioned the Police were also told that an unknown person had threatened him in August 2018 outside his grandmother's house in August for 'unauthorised' selling of drugs.[131]

[129] He had drugs to sell when he was arrested in Bournemouth and at the time of his death he was carrying articles in a bag that were strongly suggestive that he had been involved in the selling of drugs.
[130] These are itemised in the 'Agreed Facts' presented during the trial of Ayoub Majdouline.
[131] I have not included Child C's possession and brandishing of a BB gun in November 2018 in this list, as I do not believe it provides clear evidence of criminal exploitation, anymore that do the earlier references to guns and knives that are to be found in the narrative chapter of this report. However,

While the authorities did not know most of this at the time of Child C's murder, they did know about the Bournemouth episode and it was this evidence of exploitation, together with the behaviour that brought on his exclusion from school, that their various plans were designed to counteract.

Did Child C get the help he needed, when he needed it?

The tragedy described in this Serious Case Review concludes in the murder of a 14-year child. These circumstances might make it easy to answer this question with a resounding 'No'. Such help as was provided to Child C and his family could be dismissed as a failure since he was killed.

But I believe to answer this question in such a way is to miss a more fundamental point and that is that no-one, and in this I believe I am right to include Child C's mother, imagined that Child C was at risk of being murdered (though I accept that something in his mood on the 7th January 2019 alarmed her). The question that was being asked of Waltham Forest Council and its partners in the autumn of 2018 was never 'how can we prevent Child C from being attacked and possibly killed?'[132]. Instead it was the less dramatic question 'how can we reduce or eliminate the criminal exploitation to which this child is being exposed?' This is a very different matter.

I have set out in some detail in the narrative of this report how Child C's needs gradually came into focus. There is no doubt in my mind that some of this work could have been given greater priority. I am thinking here in particular of the response to the family's housing needs, where as I have calculated, settlement could have been reached two months earlier. In addition at least one reachable moment could have been seized. The complex tapestry of the work being undertaken with Child C and his family could have been better coordinated. Information exchange was not always good, a fact exacerbated by his living in Nottinghamshire and then Waltham Forest. I have identified the weaknesses in these areas as I see them in the main body of this report. But none of these issues on there own appear to be decisive and by November 2019 there was clear engagement by a number of branches of the Council and its partners to support Child C's family and to protect Child C. By mid December all the key elements of this plan were in place and being implemented.

What no one knew was how little time was available to try to reach Child C and turn his thinking, as well as the circumstances around his life. I believe that the particular tragedy that overtook Child C could not have been anticipated on the basis of what was know about Child C's life at that time.

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this behaviour would obviously concern those involved in assessing the level to which he was being exposed to criminal exploitation.

[132] I have not heard of any threats made being made against Child C's life, although it is important to acknowledge that there are significant gaps in the authorities and his family's knowledge about his life.

So while it is clear that Child C was not protected either by the Council, or its partners, or by any other person, from the ultimate danger that engulfed him, I do not find any major fault in the response to his circumstances. It is possible to criticise the speed of the response of some bodies, but even if, for example, Child C and his family had been housed in November 2018, it is a giant leap from this possibility to be able to say this would have eliminated the danger that he faced. For example, had he been rehoused in Waltham Forest, as his family wanted, I doubt it would have had any real impact on his day to day activities.

Equally we can speculate as to whether there was a reachable moment on the 25th October that could have been exploited, or whether if an adult had ensured he attended the Boxing Academy interview on the 20th December this would have been a turning point. But in the end this is just that, speculation.

It is certainly possible to criticise the absence of full coordination and a 'guiding hand' to oversee the whole operation, and it is easy to see the weaknesses in the exchange of information. But the plan or plans themselves were coming together in what in any normal circumstances would be considered a reasonable fashion. Tragically what none of those involved knew was that there were other forces at work.

Summary of findings and recommendations

I identified eight findings from this review for the Local Safeguarding Children Board to consider. At the request of the SCR Panel I have split these into broader, systemic, findings that may have relevance beyond Waltham Forest or Nottinghamshire and more local practice-based findings that appear to be of more restricted relevance.

Systemic findings

	Findings
1.	**FINDING OF FACT:** **Child C spent all but 3 of his last 22 months out of school and for much of this there was limited adult guidance or supervision in regard to how he spent his time.** Child C was only 12 years old when his mother withdrew him from school in order to educate him at home. Her account is that this went well particularly at first, a view shared by the Elective Home Education Advisor who visited twice. However, DE's need to return to work to support her family in the autumn of 2017 may have reduced the supervision and guidance he received. On his arrival in Waltham Forest a school place was not found in late April, as it should have been, adding a further two months to the number

	of months that Child C was out of school. He was still only 13 for much of this time. The systemic issue here is that the national education policy contains a presumption that only very limited supervision of home education arrangements is required. No one in authority was aware that the home education arrangements that had been agreed no longer involved significant reliable supervision of Child C's activities. In particular, there was no consequent requirement that the Elective Home Education service in Nottinghamshire should have been alerted when signs of Child C's lack of supervision first appeared in January 2018 or that a more comprehensive review of his circumstances should have taken place at that time. **IMPLICATIONS FROM THIS FOR THE RELIABILITY OF THE CHILD PROTECTION SYSTEM:** **Time spent out of school, for whatever reason, is recognised to constitute a significant risk to children who are vulnerable to criminal exploitation. The current arrangements governing home education contribute to this risk. The approach that underpins the current government guidance in respect of Elective Home Education, an approach of minimum intervention or supervision, does not seem to be compatible with safeguarding children who are vulnerable to criminal exploitation.** **RECOMMENDATION:** **Recommendation No. 1** **The WFSCB will be referring this report to the Department for Education, and in so doing should formally ask the Department to clarify whether (and how) it intends to review the current guidance of home education in the light of this finding of fact.**
2.	**FINDING OF FACT:** **The response to Child C while detained in Bournemouth and then on his return from there in October 2018 did not capitalise on a 'reachable' moment for a child who was clearly being criminally exploited, and nor was all the information available from the authorities in Bournemouth transferred to their counterparts in Waltham Forest.** *Reachable moments* There is a clear indication from Child C's conversation with the Appropriate Adult he met in Bournemouth (see page 25) that the crisis of his arrest there constituted a 'reachable' moment. However, this opportunity was not taken.

	Work could have begun at this moment of crisis on the broad issues of Child C's vulnerability as well as the obvious specific issue of debt bondage. The current system for collecting and returning London children to their homes in such circumstances has only relatively recently been extended as far as Bournemouth despite this being an obvious area for 'county lines' operations to target. My understanding is that some other authorities whose children are found in Bournemouth may not have any such arrangements in place. *Transfer of information* Communication at this time between the authorities in Bournemouth and Waltham Forest was incomplete and frustrating to all involved. Very little information was transmitted back to Waltham Forest from Bournemouth and at least one key element of the contact with Child C, his request to speak to the Samaritans from his police station cell, did not re-emerge until uncovered by this review. The Pan-Dorset Safeguarding Children Partnership is keen to act on the learning from this review. The incident occurred prior to the new Local Authority of Bournemouth, Christchurch and Poole Council being established and the formation of the Pan-Dorset Safeguarding Children Partnership. The Partnership have, in year one, named child exploitation as a priority and have commissioned, with the Community Safety Partnership, a Home Office and the Office of the Dorset Police and Crime Commissioner sponsored local review using the Home office methodology which will be conducted in March 2020. The areas of multi-agency learning from this SCR of Child C will be captured in these activities. The National Police Chiefs Council's sponsored *'County Lines Vulnerability Tracker'* has also been designed to improve the flow of information (see page 26 and footnote 70). *In summary* *Working Together 2018* provides no guidance on the issues of reachable moments and the transfer of information between areas in these circumstances, although, as already mentioned, the Ministry of Justice has recently issued practice guidance on *County Lines Exploitation* that does cover the issue of who should return children to their home area – guidance with parts of which I disagree (see Appendix 3). **IMPLICATIONS FROM THIS FOR THE RELIABILITY OF THE CHILD PROTECTION SYSTEM:** **The importance of maximising the potential of reachable moments in working with children is beginning to be recognised. However, there is no satisfactory approach to covering the whole country when a child who is exposed to 'county lines' style operations is found a distance away from their home. There were also difficulties in communication between the authorities in Bournemouth and Waltham Forest, and there was an incomplete transfer of information between them. The**

	absence of a national approach to guide all concerned at such moments serves children like Child C poorly. **RECOMMENDATIONS:** **Recommendation No. 2** **The WFSCB should revise its procedures, guidance and training to embed the concept of 'reachable moments' in the safeguarding of adolescents in Waltham Forest.** **Recommendation No. 3** **Waltham Forest Council should review the current arrangements for recovering children from outside of the borough in order to satisfy itself there are comprehensive arrangements that can reach any part of the United Kingdom.** **Recommendation No. 4** **The WFSCB should ensure that children who are returned to the borough are brought back by adults with skills relevant to working with children who are being criminally exploited. The WFSCB should also ensure that these adults are then able to continue in personal contact with the children they return, when such contact is identified as being of importance as part of an intervention plan with the child.** **Recommendation No. 5** **Waltham Forest Council should refer this report to the London Mayor's Office for Police and Crime and request that the current uncertainties about the catchment area of the 'Rescue and Response County Lines' are rectified by a clear and unambiguous statement made to each Police Force in England and Wales (and their relevant partners), as well as a revised statement sent to each London Borough.** **Recommendation No. 6** **Waltham Forest Council should raise the issue of the absence of a national system for responding to children who are arrested and detained away from their home areas with the Department for Education (children's issues), the Home Office (policing issues) and the Ministry of Justice (youth offending team and other frontline practitioner issues).** **The Council should include at this time a request that the Ministry of Justice review its guidance on the arrangements for returning children to home areas in the light of the findings of this review. The Ministry should be asked to seek other evidence of effectiveness and what**

	works best for children from agencies and authorities who are active in this field including the MOPAC's 'Rescue and Response service'. The Ministry of Justice guidance does cover the issue of transferring information from the authorities where the child is found to the 'home' MASH. In the light of this I have no further recommendations to make on this particular point.
3.	**FINDING OF FACT:** **By early January 2019 there were considerable numbers of professional involved with Child C and his family, creating obvious risks of duplication and confusion.** Adolescents live complex lives outside of their families, lives that bring them into contact with a great variety of people, situations and agencies. *'Contextual safeguarding'* requires guidance that reflects this. Even though the children's social worker held discussions with the other caseworkers involved with Child C and his family there appears to have been a compelling case for bringing together, under strong leadership, all those who had information and insight to contribute to developing a unified response to Child C's vulnerability. The case of Child C also highlights the importance of Housing Services being fully integrated into such an approach. There may be good practical reasons why discussions within the MASH do not involve all possible parties, but I believe Child C's case provides a clear example of an occasion where Housing Services not only controlled access to a service that was highly relevant to keeping him safe, but also where they held information that was not known to any other agency, these being the twin drivers for holding multi-agency case planning meetings. **IMPLICATIONS FROM THIS FOR THE RELIABILITY OF THE CHILD PROTECTION SYSTEM: When children are exposed to child criminal exploitation there is a strong argument for case discussion[133] involving all agencies engaged with the child and family to be held in every case and for this principal to be stated clearly in national and local guidance.** **RECOMMENDATIONS:** **Recommendation No. 7**

[133] See my earlier footnote 13 about why I use the general term 'case discussion' rather than any other in this context.

	WFSCB should audit the use made of case discussions (however named) so as to satisfy itself that multi-agency discussion always takes place in cases where a safeguarding plan is being developed. **Recommendation No. 8** **In the light of the outcome of this audit WFSCB should review its current arrangements for multi-agency case discussion in safeguarding cases, in particular those arrangements applying to adolescents, in order to satisfy itself that all agencies with a contribution to make either to the knowledge base of such a discussion or the plan of action to improve safeguarding for the child are invited and involved.** See also Recommendation No. 10 **Recommendation No. 9** **The WFSCB will also be referring this report to the Department for Education, and in so doing should formally ask the Department to clarify whether (and how) it intends to review the current guidance on multi-agency case discussion in the light of this finding of fact.** N.B. This reference appears consistent with the recommendation of the Child Safeguarding Practice Review Panel[134] that the government should move at pace to review Working Together in the light of its own review of the issue of criminal exploitation.

Local practice based findings

	Findings
4.	**FINDING OF FACT:** **Information about the first two gun-related incidents involving Child C. (in 2016 and 2017) was not shared by the Nottinghamshire Police with other agencies, and nor did Nottinghamshire Police share information about the threats made against Child C in the summer of 2018.** *Gun-related incidents:* The failure to share this information with the Nottinghamshire Youth Offending Service meant that not only were they unaware of this background when assessing Child C for a caution after the

[134] See Appendix 5.

	episode in January 2018 but also the information about the first two incidents never became part of the background knowledge passed on to Waltham Forest agencies after Child C's move from Nottinghamshire. *Threats made against Child C:* The failure to share this information with either the Waltham Forest MASH or the Metropolitan Police Service meant that Waltham Forest Council was not aware of this when they began to assess Child C's vulnerability to criminal exploitation in November 2019. Nottinghamshire Police has now amended this information sharing protocol to the effect that such information is now shared. In the light of this I have no further recommendations to make on this point.
5.	**FINDING OF FACT:** **There was a delay in processing DE's application for a place for Child C at the Waltham Forest High School in May 2018.** This contributed a further two months to the 20 months in which Child C did not receive adequate supervision or guidance. The School Admissions Service did not spot this delay. Both the School and the Admissions Service have revised their arrangements to attempt to ensure this does not reoccur. In the light of this I have no further recommendations to make on this point.
6.	**FINDINGS OF FACT:** **a. The initial response to DE's application for housing in Waltham Forest was slow and no new action was taken following DE's request that her application for rehousing be reopened by Waltham Forest in August up until the end of October 2018.** **b. The Housing Service was not engaged in multi-agency discussions about how to respond to the criminal exploitation of Child C.** *Slow response* This delayed the establishment of adequate housing for Child C's family and restricted DE's ability to supervise her son. It is my opinion that this could have had an impact on DE's ability to exercise parental control and supervision over Child C. The Waltham Forest Housing Service accept my finding of fact but do not accept my opinion that this could impacted on DE's parental control. The Waltham Forest Housing Service have made a series of changes to their monitoring arrangements in relation to applications for rehousing in response to this case. These have been described to me as:

	• 'we monitor cases that are overdue in 'Approach or Application Triggered' when they remain in this status beyond 28 days'; • 'we monitor cases that are overdue in 'Prevention' beyond 56 days in this status'; • 'we monitor cases that are overdue in 'Relief' beyond 56 days in this status'; and • 'we began monitoring overdue cases in 'Approach' from September 2019'. In the light of this I have no further recommendations to make on this point. *Involvement of the Housing Service in planning to reduce Child C's vulnerability to exploitation* Despite the Housing Service holding information not known to any other agency, and also controlling resources that were an important component of the plan to protect Child C from future criminal exploitation, they were not involved in discussions about protecting Child C. Any meeting considering Child C's vulnerability to exploitation without the Housing Service would have been an inadequate forum. **IMPLICATIONS FROM THIS FOR THE RELIABILITY OF THE CHILD PROTECTION SYSTEM: In this case any meeting considering Child C's vulnerability to exploitation without Housing would have been an inadequate forum.** **RECOMMENDATION** **Recommendation No. 10** **WFSCB should review the references to the involvement of Housing Services in case discussions and meetings in their procedures and either broaden the invitation list to strategy meetings/discussions or create provision for case discussions that do involve Housing where this is needed.**
7.	**FINDING OF FACT:** **The initial gathering of background information about Child C carried out by the MASH in October 2018 was incomplete and the Waltham Forest High School should have been alerted to the involvement of one of their pupils in these events.**

	Only limited checks were made when Child C was first drawn to the attention of the Waltham Forest MASH after his arrest in Bournemouth. The MASH has reinforced with its staff the need for them to comply with the MASH's standard procedures to require a wide trawl of sources, while acknowledging, reasonably in my view, that a full intelligence check on every referral that it receives would be disproportionate in all cases. In the light of this I have no further recommendations to make on this point.
8.	**FINDING OF FACT:** **While the overarching approach of the partnership's response to children who are criminally exploited is sound, and, in particular, contextualised safeguarding is well described in the Waltham Forest safeguarding partnerships' Adolescents Practice Guide (**'Safeguarding Adolescents: A Practice Guide'**) there may be learning for the partnership from a number of specific features of Child C's case in respect to speed of initial response, assessment and response to contextual safeguarding issues, and awareness of the threat of drug debt bondage.**

	This learning from Child C's case may arise in these areas: Speed of initial intervention – is there a case for fast tracking initial engagement when the safeguarding partnership becomes aware of cases of criminal exploitation? Assessment and response to contextual safeguarding issues – on a practical level how well do assessments currently describe the context in which adolescents are 'at risk', and how adequately do plans address this context? Drug debt bondage – how well is this issue understood by caseworkers working with criminally exploited children? The partnership should take the findings of this review as an opportunity to consider whether their pre-existing programme of planned audits either has or is intended to look in more detail at these issues. For example, was the relative lack of contextual analysis in Child C's assessment atypical? **RECOMMENDATION:** **Recommendation No. 11** **The Waltham Forest Safeguarding Children Board should consider including within their programme of planned audits an examination of the specific learning from Child C's case, and in particular whether their aspirations in respect of protecting children from criminal exploitation and developing contextual safeguarding are being achieved.**

Action taken by other agencies in response to this review

Although not formally a party to this review members of the Pan-Dorset Safeguarding Children Partnership have been actively involved throughout are keen to act on the learning from this review. The incident occurred prior both to the new Local Authority of Bournemouth, Christchurch and Poole Council being established and to the formation of the Pan-Dorset Safeguarding Children Partnership. The Partnership have, in year one, named child exploitation as a priority and have commissioned, with the Community Safety Partnership, a Home Office and Office of Police and Crime Commission sponsored local review using the Home office methodology. This was due to be conducted in March 2020 but may have been disrupted by the Covid-19 emergency. The areas of multi-agency learning from this Serious Case Review of Child C will be captured in these activities.

Chapter 6: Concluding comments - How can the services that have been designed to keep adolescents safe from criminal exploitation be improved to prevent further harm?

The Waltham Forest safeguarding children partnership has invested heavily over the past four years in developing services to keep adolescents safe. They were one of the earlier adopters of the 'contextual safeguarding' model. In my findings and recommendations I have put forward some ideas for improvements. I have been given great cause for optimism by the willingness to discuss these as this report has passed through various drafts.

I have three personal messages for all policy makers reading this report, whether they work in Waltham Forest or elsewhere, and these are echoed in the review for the national panel (see Appendix 5).

First, the scourge of 'county-lines' style exploitation seems likely to remain with us for a long time yet. **We do not have a national system for responding to county-lines style exploitation**. The ideas of how to protect children exist. The task is to implement them everywhere.

Secondly, and more specifically, **every area needs to have some form of 'rescue and response' system** and those in control of resources have a moral responsibility to ensure these are properly funded and widely publicised. Seizing 'reachable moments' when they occur, and ensuring continuity of relationships once children are found away from home will be critical in our response to this type of exploitation.

Lastly, **we all of us need to understand why it is that children and families may distrust people in authority and, reacting to this, we need to develop ways of working that are based on reaching out to these families**. It is dangerous to start this work by expecting criminal exploited children and their families will trust them. Trust has to be earned, particularly when it needs to cross boundaries of ethnicity, race, class, or other barrier. We need to listen purposefully to criminally exploited children and their families, and act on their testimony as to what is needed to earn and build that trust.

John Drew

1st May 2020

Appendix 1 – Glossary of acronyms and terms used in this report

Acronym	Meaning
ABC	Acceptable Behaviour Contract – see footnote 44
AP	Alternative education provision – see footnote 37
Appropriate adult	See footnote 61
Ball bearing gun	See footnote 33
BACME	Behaviour, Attendance and Children Missing Education service
Bodily Worn Video	See footnote 46
Bronze Panel	See footnote 91
CCE	Child Criminal Exploitation – see footnote 2
Class A drugs	See footnote 60
Community Resolution	See footnote 34
Contextual safeguarding	See footnote 114
County lines	See footnote 11
Cuckoo flat or house	See footnote 1
DE	Child C's mother
DfE	Department for Education
Drug debt bondage	See footnote 104
Family Partnership Team	See footnote 94
GH	The child found with Child C in Bournemouth
Grooming	See footnote 42
Hindsight bias	See footnote 17
Hypovolemic shock	See footnote20
i2 chart	See footnote 116

LBWF	London Borough of Waltham Forest
NCHA	Nottinghamshire Community Housing Association
Mosaic	Case management system - See footnote 117
MASH	Multi Agency Safeguarding Hub - see footnote 14
One Panel	Waltham Forest One Panel - see footnote 24
Organised Crime Group	See footnote 57
Pupil Referral Unit	See footnote 99
Reachable moment	See footnote 10
Referral Order	See footnote 97
Released under investigation	See footnote 65
SCR	Serious Case Review
WFSCB	Waltham Forest Safeguarding Children's Board
YCC	Youth Conditional Caution - see footnote 41
YOS	Youth Offending Service – see footnote 5

Appendix 2 – Extract from the Waltham Forest High School's 'School Behaviour Policy'

"Discipline beyond the school gate cover the school's response to all non-criminal bad behaviour and bullying which occurs anywhere off the school premises and which is witnessed by a member of staff or reported to the school. The school will sanction any bad behaviour when the child is:

- *taking part in any school-organised or school-related activity or*
- *travelling to or from school or*
- *wearing school uniform or*
- *in some other way identifiable as a pupil at the school*

or misbehavior at any time, whether or not the conditions above apply, that:

- *could have repercussions for the orderly running of the school or poses a threat to another pupil or member of the public or could adversely affect the reputation of the school.*

"Sanctions will be enforced for poor behaviour beyond the gate. In all of these circumstances the Headteacher will consider whether it is appropriate to notify the police or anti-social behaviour coordinator in their local authority of the actions taken against a pupil. If the behaviour is criminal or poses a serious threat to a member of the public, the police will be involved. In addition, school staff will consider whether the misbehavior may be linked to the child suffering, or being likely to suffer significant harm. In this case the School staff should follow it safeguarding policy. Pupils who fail to meet our high expectations in or out of school could face exclusion."

Appendix 3 – Ministry of Justice guidance on the return of children subject to exploitation to their home area

While this review was in progress the Ministry of Justice produced practice guidance for Youth Offending Team and frontline practitioners on *County Lines Exploitation*[135]*.* This guidance covers a range of subjects, including that of how children should be returned to their home area. It is a well-intended attempt to fill a number of gaps in guidance as to how practitioners should respond to children who are being criminally exploited, including those identified in this report.

On the question of returning a criminally exploited child to his or her home area, the guidance states:

"The home area of the child always retains responsibility for the child, wherever they are found.

"If a child is found outside of their home area, they should be returned to their home area by the local police force. The local police should inform both:

- *The home area police force*
- *The home area local authority children's services social care team of local equivalent."*

The guidance is described as 'Best Practice'.

The practical effect of this guidance, if followed literally, would appear to be to invalidate the 'Rescue and Response service' operated under the MOPAC aegis, as well as similar schemes operated by other authorities. I have been told informally that this is not the intention of the guidance. If that is the case then it should, as a minimum, say this.

But my criticisms go beyond this point,

A former police officer who advised me during the review described the practical consequences of the adoption of this guidance as being in his opinion that:

"it doesn't allow for early engagement and risks further criminalising the child by often uniform officers taking him home … and [it brings with it] *the likelihood that we will have him informally under our protection while arrangements are made to find a unit which is likely to be the next shift on duty."*

To these criticisms I would add two of my own:

[135] Ministry of Justice [2019] op. cit.

1. There can be no guarantee that the officers returning the child will have any specialism in working with children, in particular those who are being criminally exploited
2. There can be no continuing relationship between the child and the returning officers after this journey and so no potential to capitalise on any reachable moment during what will often be a long journey with plenty of time for reflection.

It is hard at this stage to be sure of the standing of this practice guidance. The Ministry of Justice is not the most obvious department to advise police forces of their responsibilities (that would be the Home Office) or to advise children's services on how to discharge their responsibilities towards unaccompanied children found many miles from home (that would be the Department for Education). Certainly when I consulted with the London Rescue and Response service they were unclear as to whether local police forces were now obliged to follow the guidance when they were aware of a resource, like their own, that was *'more suited'* to returning children home and working thereafter with them.

This uncertainty is not hinted at in the Ministry of Justice guidance and needs urgent clarification. The second part of my recommendation No 6 calls on the Ministry of Justice to review its guidance on the return of children to home areas in the light of the findings of this review. I also suggest that the Ministry be asked to seek evidence of what works best for children from agencies and authorities who are active in this field including the MOPAC 'Rescue and Response service', if it has not done so already. Children being exploited, whether in 'county lines' type situations or at other times, will not be served well by the current confusion over responsibility, nor will they be served well by a less expert service than that which can already be provided.

Appendix 4 – those involved in the preparation of this report

For Child C

DE, Child C's mother, with the assistance of her solicitors, Hodge Jones & Allen Solicitors of North Gower Street, London NW1

The Children's Safeguarding Partnerships

Nottinghamshire

Waltham Forest

The Councils

Bournemouth, Christchurch and Poole Council

Dorset County Council

London Borough of Waltham Forest

Nottinghamshire County Council

The Police Forces

Dorset Police

Metropolitan Police Services

Nottinghamshire Police

Youth Offending Services

Dorset Combined Youth Offending Service

Nottinghamshire Youth Offending Service

Waltham Forest Youth Offending Service

The NHS bodies

North East London Foundation Trust

Nottingham University Hospitals Trust

Nottinghamshire Clinical Commissioning Group

Waltham Forest Clinical Commissioning Group/Waltham Forest and East London Clinical Commissioning Groups

Other Agencies

(London) Rescue and Response Service

St. Giles' Trust

The schools

Two Primary Schools in Nottinghamshire

An Academy in Nottinghamshire

A High School in Waltham Forest

Appendix 5 – Report of the national Child Safeguarding Practice Review Panel "*It was hard to escape"*

At the time of this Review, the national Child Safeguarding Practice Review Panel (hereafter 'the national panel') were also sponsoring a review into how best children might be safeguarded from the risk of criminal exploitation. Their report[136] should be required reading for all working in this area. The national panel drew up 10 key findings from their review and I shall compare these with the learning from Child C's story.

Ethnicity and gender appear to be factors

The Review Panel's finding: *"Boys from black and ethnic minority backgrounds appear to be more vulnerable to hard from criminal exploitation."*

Child C was a Black British boy of African Caribbean heritage.

Known risk factors around vulnerability don't always act as predictors

The Review Panel's finding: *"The common indicators of vulnerability were not present in the lives of many of the children who were the subject of … criminal exploitation."*

Several of the known risk factors around vulnerability were present in Child C's and his family's background but the review's linked finding that *"Most of the children were not known to children's social care before the problems associated with their potential exploitation surfaced"* was very largely true.[137]

Exclusion from mainstream school is seen as a trigger point for risk of serious harm

The Review Panel's finding: "*Exclusion from mainstream school is seen as a trigger point for risk of serious harm."*

In my view exclusion from school was less of an issue in Child C's case than in many other instances of criminal exclusion. While living in Nottinghamshire he had been

[136] The Child Safeguarding Practice Review Panel [2020] "*It was hard to escape"* London: Asset Publishing Service

[137] Youth Offending Services in Nottinghamshire and Waltham Forest had had limited contact with Child C before October 2018.

briefly excluded on three occasions for short periods but the period during which he was subject to elective home education arrangements may have established patterns of behaviour and association that then contributed to Child C's longer term vulnerability to criminal exploiters.

His permanent exclusion from the Waltham Forest High School came after his most obvious criminal exploitation had already begun and the speed with which the BACME service responded could have minimised the break between his exclusion and his starting at an alternative education provider[138]. The BACME service was not at fault in the delays that followed Child C's exclusion from the High School

Effective practice is not widely known about or used

The Review Panel's finding: Many local areas or practitioners were *"not confident about what they could do to help".*

Practitioners in Waltham Forest were able to develop plans for work with Child C and his family. I found good evidence of insightful direction from their supervisors. I have, however, referred at length to the weaknesses I perceive existed in January 2019, and may still exist today, about how to retrieve children from 'county lines style' exploitation.

The national review panel's view that there is *"little reliable evidence of what works and no central* [i.e. national] *point where effective evidence is evaluated and disseminated"* is clearly supported by Child C's story.

Trusted relationships with children are important

The Review Panel's finding: *"We believe that building a trusted relationship between children and practitioners is essential to effective communication and risk management. Establishing such relationships takes time and skill."*

Both the youth justice worker and the children missing outreach officer from the MASH who offered to mentor Child C were clearly alert to this. My one concern on this point is the amalgamation of the Family Partnership Team and Youth Offending Service, which I describe on page 33. It seems to me the functions of the roles of these teams are different[139] and this could have presented problems in terms of Child C's perception as the statutory framework within which the youth justice worker may have dominated the style of their work. In their report the national panel write approvingly about *"some voluntary sector partners, youth services workers and gang mentors"*

[138] The national panel's report describes seeing *"examples in the comparator groups when children were placed in a new school very quickly and this was seen as a key factor in keeping them safe."* Elsewhere the report emphasises the need for *"an immediate response in providing suitable full-time education"* after an exclusion, a response that I believe was provided in this instance.
[139] I have summarised their roles at footnotes 94 and 5 respectively.

being able to *"spend more time with children and get to know them better. There was evidence of a more relaxed and less formal relationship between these practitioners and children."* However, the offer of mentoring from the MASH worker could easily have filled this need.

As it happens there was no time to test any of this in practice. For this reason, and because it would be wrong to launch into a service redesign on the basis of the observations from one child's story, I have not made any recommendation on this. I know from conversations with the leadership of the Youth Offending Service that they will keep this under review.

Responding to the 'critical moment'

The Review Panel's finding: *"There are critical moment in children's lives when a decisive response is necessary to make a difference to their long-term outcomes."*

I agree entirely with the national panel on this, although my reference to 'reachable moments' is possibly slightly different to what they had in mind.

Parental engagement is nearly always a protective factor

The Review Panel's finding: *"Parents and extended family members need effective support in helping them manage risk from outside the home."*

I am certain this support was on offer to DE as a fuller picture of the level of risk to Child C emerged in the autumn of 2018. However, I suspect from DE's perspective she found it hard to trust the Council, her attitude affected in particular by her perception that the Council should have done much more to help her with her homelessness. The children's social care social worker clearly shared DE's view that this needed to be resolved (as indeed it was shortly before Child C's murder) but DE may not have realised this.

At other times I believe that DE found it hard to trust the 'authorities' and so was at time selective in her description of Child C's conduct, tending to present a very optimistic view of his behaviour, as well as his motivation to change. As I have not been able to meet her, this remains a theory. What is not a theory is that full engagement between the Council and DE did not exist.

The national panel refer to one example where a local partnership set up *"a small team … specifically to support parents".* I cannot say whether such provision would have made any difference to Child C's story. However, I have highlighted this option to the Strategic Partnership in Waltham Forest.

Moving children and families works for a short period but is not effective as a long-term strategy

The Review Panel's finding: Moving families physically away from a child criminal exploitation arena works for a short period but is not an effective long-term strategy.

This was not a feature of the authorities' response to the dangers to Child C. It was, perhaps, a part of DE's thinking in moving Child C from Nottinghamshire to Waltham Forest.

More priority should be given to disrupting perpetrator activity

The Review Panel's finding: More priority should be given to disrupting exploitative activity.

At the time of his death there was very little knowledge of Child C's patterns of association, so the issue of disruption did not arise.

The National Referral Mechanism (NRM) is not well understood and is inconsistently used

The Review Panel's finding: The NRM is not well understood and used inconsistently.

The NRM was not triggered in this instance.

Comprehensive risk management arrangements can make a difference.

The Review Panel's finding: Comprehensive risk management arrangements can make a difference.

"Intensive risk management" in respect of Child C was left to the caseworkers in his case, and in particular to the children's social care social worker. I have criticised the absence of any actual case discussion and my **Recommendation No. 7, 8 and 9** address this point.

Waltham Forest Safeguarding Children Board

The Local Safeguarding Partnership's response to the Serious Case Review for Child C

26 May 2020

Introduction

The Serious Case Review for Child C is about the murder of a 14-year boy who was Black British of African Caribbean heritage and had been living in Waltham Forest for approximately 9 months before his death in January 2019. One 19-year-old was found guilty of his murder on the 11th December 2019 and has subsequently been sentenced to life imprisonment.

Safeguarding Adolescents in Waltham Forest

In Waltham Forest the Strategic Partnership has been working together on this challenging agenda for over six years and while progress has been made, we recognise there is more to do. The WFSCB recognises both the complexity of safeguarding adolescents and the need to have a dynamic strategic and operational response that is live to the changing landscape and can reflect, review and change as required. (Safeguarding adolescents includes Child Sexual Exploitation (CSE), Harmful Sexual Behaviour (HSB), Child Missing Education, Home or Care (CM/E), Child Criminal Exploitation (CCE) and peer on peer abuse etc.)

The Violence Reduction Partnership, which uses a public health approach to tackling all forms of violence has provided the framework for further development and enables some of the challenging conversations to take place about how we can improve our practice and outcomes for children being exploited and recognising the connected issues of violence against women and girls, serious youth violence, and organised crime groups etc. There are several different working groups that are focused on different but connected areas of work including training and development. This review and the lessons learnt will be used to refresh and bench mark all the work that is being undertaken**.**

As discussed in the Serious Case Review (SCR) the work around safeguarding children from exploitation by organised crime groups is complex and ever changing. It is imperative that agencies keep up with the changing dynamic. It is 15 months since Child C was tragically murdered and the partnership has already begun new areas of work and made changes to existing work which is being influenced and informed the lessons learnt during the process of this review.

We have an ambitious agenda, which has now been further strengthened by the learning from this review. The action plan which is overseen and monitored by the Adolescents Safeguarding and Resilience Strategic Group had existing actions in relation to:

- Prevention work in primary schools
- Development of a "single view of risk" that uses key data including school attendance and exclusions, youth offending, changes of address to enable practitioners to have a more comprehensive view of the young person and risk factors and context
- Direct work including community mentors and Barnardo's "Night watch" programme
- Provision of specialist practitioners across the partnership, who work directly with practitioners to provide case by case discussion and advice
- Improving relocation by housing, of families in and out of the borough
- Developing a Youth and Family Resilience service, bringing together two key aspects of adolescent risk (offending and missing education)

As a direct response to this report we are undertaking new work and the headlines of this is outlined below. The work falls into two main areas, local partnership working and national policy. The detail of this work has been incorporated into the existing action plan for the strategic group.

Recommendations relating to areas of local partnership working

Recommendation	Changes already in place	Changes planned
Recommendation No. 2 The WFSCB should revise its procedures, guidance and training to embed the concept of 'reachable moments' in the safeguarding of adolescents in Waltham Forest.	• The existing pathway from the major trauma centre at the Royal London Hospital (RLH) into MASH has been reviewed and strengthen to provide reachable moment to children affected by gun and knife crime • New all-age multi-agency Exploitation and Risk Panel has been formed by merging existing panels who had oversight of children suspected of being exploited by organised criminal groups, children missing from education, care or home and children being sexual exploitation • New service to provide an urgent response within 24 hours of child being identified through the Multi-Agency Safeguarding Hub (MASH)	• New section on reachable moments added to practitioner's guidance document • New training material developed for rollout across the partnership in an inter-active resource pack • Rollout of training material through practitioners' network • Video being developed by young people affected by exploitation for practitioners on reachable moments and drug debt bondage • New pathway and service being finalised with Whipps Cross Hospital and the MASH to provide direct support to people presenting at Emergency Dept. affected by violence • Strengthen pathway being developed in Police Custody to ensure all reachable moments are maximised • Adopting the new Contextualised Safeguarding Implementation Toolkit • A dedicated new Youth and Family Resilience practitioner will be placed in the MASH to facilitate information sharing with YOS and provide additional advice and support.
Recommendation No. 3 Waltham Forest Council should review the current arrangements for recovering children from outside of the borough	• Jointly commissioned Rescue and Response service has consolidated the "rescue element" - see recommendation 5 below. MOPAC to re-issue guidance to all highlighting that the 50 miles radius is no longer in place	• To be further explored by the WFSCB BMG to identify further areas that need to be developed

Recommendation	Changes already in place	Changes planned
Recommendation No. 4 The WFSCB should ensure that children who are returned to the borough are brought back by adults with skills relevant to working with children who are being criminally exploited.	• Jointly commissioned Rescue and Response service has consolidated the "rescue element" - see recommendation 5 below	
Recommendation No. 7 WFSCB should audit the use made of case discussions.	• We have revised the audit process to ensure appropriate focus on the use of case discussions and have added an additional question regarding multi-agency case discussion meetings	• We will add a new section highlighting use of multi-agency case discussions to practitioner's guidance
Recommendation No. 8 In the light of the outcome of this audit WFSCB should review its current arrangements for multi-agency case discussion in safeguarding cases.		• We will review the audit findings regarding use of multi-agency case discussions from all agencies in the cross-cutting learning and improving practice forum and ensure that we take appropriate action
Recommendation No. 10 WFSCB should review involvement of Housing Services in case discussions where this is needed.		• WFSCB is bringing together senior managers and front-line safeguarding leads in Housing and MASH to review joint working practice and implement changes to address gaps.

Recommendation	Changes already in place	Changes planned
Recommendation No. 11 The WFSCB should consider including within their programme of planned audits an examination of the specific learning from Child C's case, to identified if the learning has been embedded	The partnership conversations within our Violence Reduction Partnership have already clearly identified and actioned important innovations that are expressly informed by this learning, for example in relation to drug debt	WFSCB will continually test for embedding through surveys and focus groups with practitioners and feedback from the practitioner's network and multi-agency training, and respond accordingly

Recommendations relating to areas of national policy

Recommendation	Response

Recommendation No. 1 – complete
The WFSCB will be referring this report to the Department for Education, regarding national policy on Elected Home Education
	WFSCB has shared this finding and discussed the issue with the DfE and received the following response:
	• Home Education, in many cases is appropriate, well-delivered and involves the parents in considerable sacrifice.
	• In recent years, however, there has been a significant increase in the number of children being educated at home and there is considerable evidence that many of these children are not receiving a suitable education. There is also a safeguarding issue around the oversight of home-educated children, though there is no evidence of an increased risk compared to children who attend school.
	• Nevertheless, a child being educated at home is not necessarily being seen on a regular basis by professionals, such as teachers, and this logically increases the chances that any parents who set out to use home education to avoid independent oversight may be more successful by doing so.
	• Local authorities have a duty to identify, in so far as possible, children of compulsory school age who may not be receiving a suitable education. They also have safeguarding duties in respect of all children, whether or not they are attending school. The government wishes to support local authorities in these roles and better understand how they can exercise the oversight of children not in school effectively and proportionately.
	• To that end, the department published strengthened guidance for EHE in April 2019. This updated guidance confirmed the existing statutory duties of local authorities and brought into sharper focus the action that they can, and should, be taking in light of any instance where children are not receiving suitable education. The guidance also set out ways in which local authorities should explore the scope for using agreements with health bodies, general practitioners and other agencies, to increase their knowledge of children who are not attending school.
	• Further to this, the 2019 government consultation on Children Not in School sought views on four proposals:
	  ○ a duty on local authorities to keep a register of all children of compulsory school age who are not registered pupils at a state or registered independent school/Non-Maintained Special Schools, showing where they are receiving education, whether at home and/or in some other settings;
	  ○ a duty on parents of children to supply information for such a register;
	  ○ a duty on proprietors of various defined settings to supply information on relevant children; and
	  ○ a duty on local authorities to provide support to home educating families.
	• We are considering the responses received to the consultation as well as our analysis of these and the government will publish a consultation response in due course.
	• Our aim is to ensure that home education is suitable and delivered well, but in any instance where this is not the case and children are not receiving suitable education, local authorities are able to identify them more easily and take appropriate action.

Recommendation	Response
Recommendation No. 5 – complete WFSCB refer this report to London Mayor's Office for Police and Crime (MOPAC) regarding 'Rescue and Response County Lines' service.	WFSCB has discussed this finding with MOPAC and St Giles who are commissioned by MOPAC to deliver the "Rescue and Response" service and received the following response from MOPAC • MOPAC recognises London's leading role in tackling county lines and has put in place a comprehensive programme of work to better understand it, target it and respond to it, aiming to reduce levels of exploitation. In 2018 the first pan-London County Lines response service launched - an investment of £3million over 3 years - supporting young people who are vulnerable and caught up in 'county lines' drug distribution networks. • Following the findings of the Rescue and Response strategic assessment in September 2019, which lifted the lid on the true scale of county lines activity, the Mayor has increased the funding in 2020/21 by a further £750,000 to allow more young Londoners to receive specialist support from St Giles Trust, Abianda and Safer London and to ensure the continuation of the 'rescue' element of the service. • While JM was never referred to Rescue and Response – and the 'rescue' part of the service was not yet operational at the time of his arrest in Bournemouth – our hope is that any young person in similar circumstances might be proactively identified by partners, supported by the project, and given the best chance of exiting county lines exploitation. • MOPAC has also commenced a wider piece of research to refresh the evidence base on violence linked to groups and gangs in London. This will inform the development of policy and practice, particularly future commissioning, and ensure the Mayor is well placed to effectively support the MPS, local authorities and the voluntary and community sector in reducing this violence.
Recommendation No. 6 and 9 – complete WFSCB to share report and findings with the Department for Education, the Home Office and the Ministry of Justice regarding the absence of a national system for responding to children who are arrested and detained away from their home areas. Additional for the DfE asking if they plan to review the current guidance on multi-agency case discussion	• Letters sent awaiting response

7 minute briefing: Summary of findings from SCR Child 'C'

For all those working with adults, children and families

Strategic Partnership Boards
SAFETY SAFEGUARDING WELLBEING

Visit www.walthamforest.gov.uk/strategicpartnerships for the full report and other useful resources

01 What is a Serious Case Review? (SCR)

The purpose of a SCR is to look at what happened and why, focusing on the systems that practitioners work within and what action we need to take to change those systems so that practice can be improved.

02 What happened?

Child C was 14 years old and had been living in Waltham Forest for 9 months before his murder in January 2019. He was deliberately knocked off a moped and then stabbed repeatedly.

He had previously lived in Nottinghamshire and had started being home educated but this arrangement broke down. He then had a lot of time unsupervised and was getting into trouble in the community. His mother moved him to Waltham Forest because she was concerned he was falling under bad influences. Before Child C's murder there several assessments and interventions in place as a result of criminal exploitation, weapon related incidents and exclusion from school

07 WHAT YOU NEED TO DO NOW!

READ

- Full report and board response
- Safeguarding Adolescents Practice Guide

REVIEW

- Safeguarding Adolescents Resource Pack
- Contextual Safeguarding tools 1 / tools 2

DISCUSS with your team / in team meetings

- How you can create more opportunities for children to take up support throughout their journey with your service
- How to improve developing trusting relationships with children you are working with to maximise take up of support
- Who in your team will join the practitioner network which provides peer support and advice around all aspects of this complex area of practice
- Whether you and your colleagues all feel confident in your understanding of the complexities of exploitation, debt bondage etc. so that a child will feel more able to accept support

WATCH the bitesize video guides on safeguarding adolescents and language matters

LEARN about the new services / pathways in development to maximise how you support children and where to go for specialists advice and support for yourself

EMBED identification and analysis of peer group mapping/networks in your work with children

03 NATIONAL ISSUES

- **ELECTED HOME EDUCATION AND MULTI-AGENCY CASE DISCUSSIONS** (DfE) Current guidance is not compatible with safeguarding children, particularly those vulnerable to criminal exploitation. WT 2018 guidance could include more on the use of multi-agency case discussions
- **RESCUE AND RESPONSE COUNTY LINES SERVICE** (MOPAC) Clarity is needed on the catchment area
- **ABSENCE OF A NATIONAL SYSTEM FOR RESPONDING TO CHILDREN WHO ARE ARRESTED AND DETAINED AWAY FROM THEIR HOME AREAS** (DfE / Home Office / Ministry of Justice) No country wide consistency processes

The WFSCB has now written to all the above departments, asking for review and a response and offering to work in partnership with them to address these matters.

04 REACHABLE MOMENTS

There are circumstances when a child may be more likely to take up offers of support. For example, after being arrested in a county lines situation, or when they have been stabbed or shot and are in hospital etc. We need to capitalise on opportunities to reach out to children.

We have already:

- Created new services/pathways to increase the opportunities for reachable moments in Whipps Cross and the Royal London Hospitals when children attend with violence related injuries
- Strengthened pathways in Leyton Custody Suite
- Implemented a new urgent response protocol for children within 48 hours of identifying exploitation.
- Strengthened the MASH with a new specialist practitioner to facilitate information sharing with YOS
- Joined Operation Harbinger (Golden Hour), where within 1 hour of a child being booked in at the custody suite Police contact MASH so information can be shared which could create a reachable moment.

06 MULTI-AGENCY CASE DISCUSSION IN SAFEGUARDING CASES

This review highlights the importance of using multi-agency case discussions to ensure that all agencies who can contribute to a child's assessment and/or safeguarding plan are able to do so, for example housing

We have already:

- Ensured all county lines police reports now go to the Daily Risk Management Meeting (DRM) in the MASH, starting the multi-agency discussion, planning and response at day one
- Commenced the refresh of the joint assessment agreement with housing to embed joint working with housing

05 CONSISTENT CONTEXTUALISED SAFEGUARDING APPROACH

Not all assessments and intervention plans consider risks from a contextualised safeguarding perspective/approach.

We have already:

- Created an all-age multi-agency Exploitation and Risk Panel by merging 3 existing panels that had oversight of children going missing and children suspected of or being sexually/criminally exploited
- Developed more focus on identifying and analysing peer group mapping/networks in strategy meetings
- Adopted the contextualised safeguarding tools of peer group mapping/networks and peer group assessment triangle to support practitioners
- Refreshed the training material and approach with a new interactive resource pack

LONDON BOROUGH OF WALTHAM FOREST

Committee/Date:	9 September 2020 Children's and Families Scrutiny Committee
Report Title:	Embedding lessons learnt from the Serious Case Review for Child C
Directorate:	Families
Contact Details	Suzanne.Elwick@walthamforest.gov.uk, Head of Strategic Partnerships, LBWF
Wards affected:	All
Public Access	Open
Appendices	Appendix One – Local Safeguarding Partners response to review Appendix Two – 7-minute briefing for Child C

1. SUMMARY

1.1 On the 26 May 2020 the Waltham Forest Safeguarding Children Board (the Board) published the Serious Case Review for Child C, who was 14 years old when he was murdered. He had been criminally exploited.

1.2 The review identified 8 findings which are set out below at section 4.

1.3 The purpose of this report is to provide assurance to this Committee that the Board and its partners are undertaking work, at pace, to embed the recommended changes and make improvements to practice.

2. RECOMMENDATION

2.1 The Committee is asked to note the work that has been completed to date and that further details on improved practice and outcomes for children will be available at the end of the financial year.

2,2 Members may find it helpful to utilise the resources produced to disseminate lessons learnt, particularly the 7-minute briefing to raise awareness of the review findings and the work being undertaken to address them, with other elected members.

3. BACKGROUND

3.1 Child C was murdered on January 8th, 2019. The Serious Case Review was commissioned independently and commenced in Feb 2019. It was approved by the Local Safeguarding Partnership (LA, Police and CCG) for the Board on the 7 May 2020. The time delay in completing the review occurred because the reviewer needed to take account of the trial of one of those charged with Child C's murder.

3.2 The full report and action plan have been signed off and shared with partners and has been uploaded on the Waltham Forest Strategic Partnership's website, see statutory reviews tab at https://www.walthamforest.gov.uk/content/strategic-partnership-boards

4. Summary of findings

Please see below a summary of the subject areas of the findings of review together with the agencies responsible for responding to them.

Findings		
Number	**Subject**	**Lead**
Finding 1	Elected Home Education	Dept of Education
Finding 2	Reachable moments - initial response. Role and function of the Rescue and response MOPAC service to be clarified. Guidance from Dept of Education and Ministry of Justice for practitioners to be cleared	LBWF, MOPAC, Dept of Ed and Ministry of Justice
Finding 3	Multi-agency case discussions, guidance from Dept of Education to be clearer	LBWF and Dept of Ed
Finding 4	Information sharing between Nottinghamshire Police and other agencies	No rec as system amended
Finding 5	Processing application for school place at Heathcote	No rec as system amended
Finding 6	Initial application for housing and Housings involvement in multi-agency meetings and strategy discussions	LBWF
Finding 7	Information gathering in MASH	No rec as system amended
Finding 8	Contextualised Safeguarding approach	LBWF

5. Action taken to embed learning and improve practice

5.1 There are two aspects to this work: improving the practice of individual practitioners; and the development of new services and using resources differently.

5.2 Practice Improvement

5.2.1 The redesign of training (resources and approach):

A multi-agency task and finish group (CSC and Wellbeing and Independence are members) has totally re-designed the approach to training and the material used to include guidance on reachable moments and multi-agency case discussion as per recommendations in SCR. The material is very interactive and agile so it can be used in many different settings and time slots. The Safeguarding Adolescent Leads Network is supporting the dissemination of these resources as

well as meeting to provide peer support and sharing of good practice. The Network, made up of practitioners from across the partnership including CSC and WBI, is continuing to grow and now has 60 members and has met 3 times since March 2020. Training sessions have also been delivered virtually and two sessions have already taken place for a total of 84 practitioners from across the partnership. See the new resource at: https://www.walthamforest.gov.uk/sites/default/files/PDF_SAFEGUARDING%20ADOLESCENTS%20resource.pdf

5.2.2 A 7-minute briefing has been created which not only provides a summary of the learning it also includes signposting to the many resources available on the strategic partnerships' webpage including bitesize videos, practitioner's guidance, new training resource, victim blaming language video etc. This 7-minute briefing has been disseminated through the strategic partnerships to all partners who have confirmed that they have cascaded throughout their agency. Recent feedback has included" "*Really, well done with these 7-minute briefing notes. They are concise, readily available and so easy to pick-up and discuss in team meetings. I've just used during our weekly staff meeting. Excellent. Thank you so much. Registered Manager of a care home*

5.3 New services/processes developed since Child C's murder

5.3.1 County Lines police reports: all of these now go to the Daily Risk Management Meeting (DRM) in the MASH to start the multi-agency discussion, planning and response at day one.

5.3.2 Operation Harbinger (Golden Hour): Waltham Forest is one of a few London Boroughs that is part of the pilot. Within one hour of a child being booked in at the custody suite, Police contact our Multi-Agency Safeguarding Hub (MASH) so information can be shared regarding any safeguarding or welfare concerns which could impact on the child's safe stay in the custody suite which could create a reachable moment.

5.3.3 Urgent response service: normally within 48 hours of a child being identified through the MASH as potentially being at risk of exploitation to capitalise on reachable moment and provide specialists support to the child. 64 children have received a response, almost all within 48 hours of coming to notice, since this service commenced in May 2020.

5.3.4 A Multi-agency, all-age, Exploitation and Risk Panel (ERP) has been developed by merging three existing panels that had oversight of children suspected of being exploited by organised criminal groups, children missing from education, care or home and children being sexual exploitation which supports comprehensive risk assessments in one place with all relevant professionals taking part. There has been an increase of the use and focus on networks in strategy meetings which

is evidenced in cases that are being discussed at the Exploitation and Risk Panel. There has been a significant increased use and focus on the networks that the children are part of, in strategy meetings and the Need2know reports when children go missing. Networks are identified and analysed within a contextualised safeguarding approach. An audit is being planned for later in the year to identify the impact of ERP on outcomes for children, exploring if there has been a reduction in missing episodes and repeat referral to ERP and if more children have been successfully engaged.

5.3.5 The Missing Outreach Team (MOT) and Missing Outreach worker (MOW) have been working in different ways with children during lockdown and capitalise on reachable moments. These reachable moments when the family are at home during lockdown has enable the team to offer advice support and help to reduce missing episodes in the future. An example of the work they have completed:
"A young person who regularly was going missing before lockdown due to gang involvement and CCE, since lockdown a number of telephone calls and video calls to him and the family, enabled the worker to advocate on their behalf and they were moved out of the area to keep the whole family safe."

5.3.6 The MASH has been bolstered through a dedicated new Youth and Family Resilience practitioner to facilitate information sharing with YOS and provide additional advice and support at the first point of contact.

5.3.8 We have strengthened the work within the Leyton custody suite through additional investment from the Mayor's Violence Reduction Unit and are exploring opportunities to work with legal colleagues in relation to the support and advice they give to young people in custody so that more reachable moments can be created.

5.3.9 For family's needs housing related support due to violence and exploitation we have developed closer working between the all-age Exploitation and Risk Panel and the Social Needs Panel, and a workshop for housing officers to increase understanding of the issues so to improve the quality of referrals to the Social Needs Panel. For family's needs housing related support due to violence and exploitation we have developed closer working between the all-age Exploitation and Risk Panel and the Social Needs Panel, and a workshop for housing officers to increase understanding of the issues so to improve the quality of referrals to the Social Needs Panel.

5.4 <u>Changes in the pipeline</u>

5.4.1 A video is being developed and designed by young people affected by exploitation for practitioners on reachable moments and drug debt bondage.

5.4.2 We are in the process of developing a new pathway from Whipps Cross Hospital into the MASH to provide direct support to people presenting at Emergency Dept. affected by violence.

5.4.3 We are in the process of refreshing the joint assessment agreement with housing through MASH strategic group to embed joint working with housing. Monthly meetings are now taking place between housing and MASH to discuss any issues and aid collaborative work.

6. Equalities and Diversity - Issues related to race disparity, intersectionality and Adultification

6.1 All actions to address the findings of the Child C review are part of the action plan for Adolescents Safeguarding and Resilience Strategic group, reporting to the WFSCB. This action plan is now being reviewed through a lens of the intersectionality of race, class and gender, to ensure that the needs of Black children, particularly, but not exclusively, Black boys from poorer families are being met. This may require different or additional actions for different children to ensure that all children have the best possible outcomes.

6.2 We always focus on working on seeing children as children first but we have spoken less about the issue of Adultification where we not only perceive children as adults, but also find it difficult, as practitioners to really put ourselves in their shoes and experience the world as they do, as children. The strategic group will address this issue in September and again review the guidance we are providing for staff.

7. Action to address national policy issues

7.1 WFSCB received the following response from Dept of Education, Ministry of Justice and Home Office to the findings regarding Elected Home Education, Working Together guidance and national system for responding to children who are arrested and detained away from home.

"We will be reviewing the content of the guidance and identifying other areas for improvement to safeguard vulnerable children and prevent such tragedies in the future. ….

The Home Office is investing significantly to strengthen the response of Government. In 2020/21 this includes a £20 million package of activity to increase the law enforcement response, expand the National County Lines Coordination Centre, fund a dedicated British Transport Police

county lines taskforce, and increased specialist support for children, young people and their families who are affected by county lines exploitation. This will include a rescue element to ensure that children and young people can be safely returned home and that opportunities are seized to support them to safely escape from county lines dealing."

7.2 Presentation of the review to the London Safeguarding Children Board Executive**:** the independent Scrutineer for the WFSCB presented the SCR to the Executive, which included officers from MOPAC, and this led to a discussion about the need to take forward the findings on a Pan- London basis. We are awaiting further details from MOPAC.

8. Conclusion and next steps - How will we be assured changes have been made, how are we testing if practice has changed

8.1 Improved practice will look like:

- More National Referral Mechanism (NRM) referrals being made for children being criminally exploited (CCE)
- Succinct care plans for children at risk of Child Sexual Exploitation and/or CCE influenced by the relevant professionals at the new all age Exploitation and Risk Panel.
- More children will take up support offered through the increased number of reachable moments through police custody, emergency dept at the hospital, missing outreach, and urgent response through MASH. This is to be captured in end of intervention surveys completed through CSC.
- Continued increase of identifying networks and use of contextualised safeguarding toolkit by CSC, resulting in plans for child targeting the right areas of risk and intervention.
- Practitioners reporting through the practitioners network an increase in confidence and understanding about contextualised safeguarding approach.

8.2 Assurance: WFSCB will use a range of tools to test out if the learning has been embedded and practice has changed. For example:

- Feedback from children and families at the end of intervention about the quality of the support offered
- Single agency (CSC, Health, Police etc) and multi-agency audits
- Surveys and focus groups with practitioners
- Feedback through our multi-agency practitioners' network.

8.3 We would welcome the opportunity to return to the Committee in six months' time to provide further details of the progress of work and share the findings of audits and provide further feedback on improved outcomes.

TORBAY COUNCIL

Meeting: Overview and Scrutiny Board **Date:** 13 January 2021

Wards Affected: all wards

Report Title: Establishment of a Children and Young People's Overview and Scrutiny Board

Cabinet Member Contact Details: Councillor Law, Cabinet Member for Children's Services, cordelia.law@torbay.gov.uk

Officer Contact Details: Anne-Marie Bond, Interim Chief Executive, anne-marie.bond@torbay.gov.uk

1. Purpose of Report

1.1 The Interim Chief Executive has been reviewing the Council's governance and approach for the management and oversight of the delivery of Children's Services, to ensure that we are collectively doing all that we can to ensure the provision of good services for the children of Torbay. A Children's Services Strategic Quartet has recently been established, comprising the Interim Chief Executive, Director of Children's Services, Leader of the Council and Cabinet Member for Children's Services, to provide high level key leadership to ensure the Council and agencies/partners improve outcomes for children.

1.2 As part of this review, the Interim Chief Executive is proposing the establishment of a Sub-Committee of the Overview and Scrutiny Board, namely a Children and Young People's Overview and Scrutiny Board, chaired by the Scrutiny Lead for Children's Services with Terms of Reference and Membership as set out at Appendix 1 to this report. With the genesis of the proposal being to ensure a dedicated and focussed political oversight and challenge in respect of all issues relating to children and young people to help improve the delivery of these key services. This will enable the Overview and Scrutiny Board more capacity to focus on other areas within its work programme and approve and monitor the work of its review panels.

1.3 To ensure that there is a good link between overview and scrutiny and the delivery of the Children's Services Improvement Plan the Scrutiny Lead for Children's Services will also become a member of the Children's Services Improvement Board.

2. Reason for Proposal and its benefits

2.1 The proposals in this report help us to deliver the ambition of our residents thriving, by improving the governance and political challenge in respect of services for our children and young people to ensure the best outcomes.

2.2 The reasons for the decision are to improve the governance and accountability for the delivery of overview and scrutiny of services and support for children and young people. Also to enable dedicated focus on these key services provided by the Council and our partners.

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3. Recommendation(s) / Proposed Decision

(i) that a Children and Young People's Overview and Scrutiny Board be established, as a Sub-Committee of the Overview and Scrutiny Board, to be chaired by the Scrutiny Lead for Children's Services, with Terms of Reference and Membership as set out in Appendix 1 to the submitted report;

(ii) that Children and Young People's Overview and Scrutiny Board considers appointing additional non-voting co-opted members who will help provide expert advice and support to the Board; and

(iii) that the Overview and Scrutiny Board reviews the effectiveness of the Children and Young People's Overview and Scrutiny Board in six months time.

Appendices

Appendix 1: Terms of Reference and Membership for the Children and Young People's Overview and Scrutiny Board

Background Documents

None

Supporting Information

1. Introduction

1.1 The Council currently has a single Overview and Scrutiny Board which carries out all of the overview and scrutiny functions of the Council, including health scrutiny and children's services. The Board meets monthly and also sets up task and finish groups to undertake deep dives into certain areas and report back to the Board with their final recommendations, which are in turn then presented to the relevant decision maker e.g. Cabinet or Council. This approach has led to some very large agendas, covering a multiplicity of issues, with meetings often lasting up to four hours.

1.2 Previous Ofsted reports have highlighted a lack of appropriate challenge in respect of Children's Services and, whilst in recent months the Overview and Scrutiny Board has effectively challenged issues such as the impact on Covid-19 on children and young people and the Children's Services Improvement Plan Quarterly report, this has often been part of a larger agenda, which has limited the amount of time and focus available to the Board. One of the areas of judgement from Ofsted is 'the impact of leaders on social work practice with children and families' and as part of this overview and scrutiny has a critical role in ensuring additional and enduring challenge to the service.

1.3 It is therefore proposed to establish a Children and Young People's Overview and Scrutiny Board as a Sub-Committee of the Overview and Scrutiny Board to discharge all functions in respect of children and young people. This Board would be chaired by the Scrutiny Lead for Children's Services, who would also have a place on the Children's Improvement Board to ensure a joined up approach to improving outcomes for children and young people.

1.4 The membership of the Board will include the statutory education co-opted members, namely parent governor representatives and church representatives, who will have voting rights in respect of education matters only, plus it is recommended that the sub-committee co-opt members who will help provide additional expertise and support to the Board.

2. Options under consideration

2.1 To do nothing, this option was rejected as there would be limited capacity to make improvements under the current arrangements.

3. Financial Opportunities and Implications

3.1 There are no financial implications as the new Children and Young People's Overview and Scrutiny Board would be supported within existing resources from within the Governance Support Team and Children's Services staff would be required to attend this meeting instead of the main Overview and Scrutiny Board.

4. Legal Implications

4.1 There are no legal implications. It has been identified as good practice by other local authorities to have a separate committee for overview and scrutiny of children and young people.

5. Engagement and Consultation

5.1 The Group Leaders, Overview and Scrutiny Co-ordinator, Scrutiny Lead for Children's Services and Director of Children's Services have been consulted on the proposals and are supportive of the way forward. The Commissioner for Children's Services, Nigel Richardson, has been consulted upon the proposal and is in complete support, indeed in his recent report to the Minister he referenced the proposal as a positive approach from the Council.

6. Purchasing or Hiring of Goods and/or Services

6.1 Not applicable.

7. Tackling Climate Change

7.1 Initially the meetings will be held remotely and will therefore reduce the need for members and officers to travel to the Town Hall for the meetings, this will help to reduce carbon emissions, in addition agendas and documents for meetings will be made available electronically to reduce the need for printing and postage. Documents still be available in an accessible format for those who require this.

8. Associated Risks

8.1 There is a risk that due to the number of evening meetings being held there will be limited availability to schedule these meetings in the Governance diary and therefore meetings may need to take place during the day, this will impact on which members of the Overview and Scrutiny Board will be able to sit on the Children and Young People's Overview and Scrutiny Board due to work and other commitments. This will be reviewed together with the overall work programme for the Overview and Scrutiny Board.

Equality Impacts

9.	Identify the potential positive and negative impacts on specific groups			
		Positive Impact	**Negative Impact & Mitigating Actions**	**Neutral Impact**
	Older or younger people	The proposals will ensure greater focus is placed on overview and scrutiny of children and young people's services to improve outcomes for children.		
	People with caring Responsibilities	The work of the new Board will look at ways to improve outcomes for children and also their carers.		
	People with a disability	The work of the new Board will also look at ways to improve outcomes for children with a disability.		
	Women or men			There is no differential impact.
	People who are black or from a minority ethnic background (BME) *(Please note Gypsies / Roma are within this community)*			There is no differential impact.
	Religion or belief (including lack of belief)			There is no differential impact.
	People who are lesbian, gay or bisexual			There is no differential impact.
	People who are transgendered			There is no differential impact.

	People who are in a marriage or civil partnership			There is no differential impact.
	Women who are pregnant / on maternity leave	The work of the new Board will help to support mothers and fathers as well as their children.		
	Socio-economic impacts (Including impact on child poverty issues and deprivation)	The work of the new Board will explore ways of supporting children and families impacted by socio-economic issues.		
	Public Health impacts (How will your proposal impact on the general health of the population of Torbay)	The work of the new Board will support public health outcomes for children and their families.		
10..	**Cumulative Council Impact** (proposed changes elsewhere which might worsen the impacts identified above)	The work of the new Board will have a positive impact across all services, as well as those with our partners as there is a multi-agency approach to supporting children and their families.		
11.	**Cumulative Community Impacts** (proposed changes within the wider community (inc the public sector) which might worsen the impacts identified above)	None		

Terms of Reference and Membership of Children and Young People's Overview and Scrutiny Board

Name and Terms of Reference	Membership
Children and Young People's Overview and Scrutiny Board: 1. to review how the needs and interests of children and young people are met by all departments, policies, services and decisions; and how performance is evaluated and improved; 2. to review universal, targeted and specialist services for children and young people including: • prevention and management of risk; • social care; • children's and young people's wellbeing; • education – supporting and enabling learning for all children and young people; • internal and external partnership working for children and young people; • supporting parents and families; and • relevant financial management; 3. to assess the effectiveness of decisions of the Cabinet in these areas of the Council's statutory activity; and 4. to make reports and recommendations as appropriate arising from this area of overview and scrutiny.	This is a Sub-Committee of the Overview and Scrutiny Board and comprises 5 members of the Council in accordance with the political balance requirements. Conservative (2): Liberal Democrat (2): Independent Group (1): **Statutory Education Co-opted Members:** Statutory parent governor representatives (2): Statutory Church of England representative (1): Statutory Roman Catholic Diocesan representative (1): **Non-Voting Co-opted Members:** (to be confirmed by the Sub-Committee)