Buckinghamshire LSCP

Serious Youth Violence:
Thematic Serious Case Review

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1. INTRODUCTION

The events that triggered the review

1.1. Between December 2018 and October 2019, Buckinghamshire Safeguarding Children Board (the LSCB) carried out a review of the services provided for three teenage boys. The review was triggered by a violent crime in which one of the boys was very seriously injured.

1.2. The review was carried out under the guidance *Working Together to Safeguard Children 2015*. Its purpose is to undertake a *'rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'*. The LSCB is required to *'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.*[1] This document sets out the review findings.

1.3. Further details of the incident are not provided because of the likelihood that this would lead to the identification of the young people, placing them and their families at risk of serious harm. The safeguarding partnership has done everything possible to prevent that from happening, while at the same time seeking a wide professional audience for the learning in this review. The partnership specifically asks that professionals who may know the identity of those involved do not make it public, either deliberately or inadvertently and that the media do not seek to connect this report to any specific event.

1.4. In order to make the report easier to understand the three boys are referred to where necessary as Child A, Child B and Child C.

Reasons for conducting the review

1.5. The incident was brought to the attention of the LSCB by the acute hospital trust that initially treated the victim. The LSCB was also approached by the mother of one of the boys because she believed that he had been treated unfairly by his school and other services which had failed to identity his mental health problems and provide him with education suited to his special needs.

1.6. The LSCB decided that a SCR should be undertaken because children involved had suffered serious harm and that there had been concerns about the way in which agencies had worked together to safeguard them.[2]

1.7. In reaching its decision the LSCB also took account of the wider context. The incident was one of a growing number of serious knife crimes in the Thames Valley Police area in 2018. In the six months

[1] *Working Together to Safeguard Children* (2015), 4.1 and 4.6
[2] Section 4.17 *Working Together to Safeguard Children 2015*

during which this offence took place the number of incidents was 19% higher than the equivalent period in 2017. The increase in the local police area where it happened was close to 40%, bringing it in line with the busiest urban areas covered by this police service.[3]

1.8. This highlighted the need to ask how services in Buckinghamshire should respond to a problem that had previously been considered to be one that affected London and other large cities. The LSCB therefore decided that greater benefit would be derived from a wider thematic review of the response of agencies to the emerging problem of serious youth violence in Buckinghamshire, building on the review of the services provided for the young people whose circumstances were judged to meet the criteria for a SCR.

The scope of the review and the information considered

1.9. The Terms of Reference for the SCR are set out in full in Appendix 1 of this report along with details of the review method.

1.10. Given its thematic approach, the SCR has sought to obtain information from a wide variety of sources and informants. Information about the three boys involved in the incident has been provided by all of the local agencies and contracted professionals that are known to have worked with them, all of which are based in Buckinghamshire:

- Buckinghamshire County Council (children's social care, SEN service, early help services, youth services)
- Buckinghamshire Youth Offending Service
- Buckinghamshire Healthcare Trust (health services including acute hospital services, community paediatrics and health visiting)
- Thames Valley Police
- Oxford Health NHS Foundation Trust (Child and Adolescent Mental Health Services – CAMHS)
- Schools, academies and colleges
- District Council housing services
- General Practice.

1.11. Agencies provided the review with chronologies and management reports that give factual accounts of agency contacts with the family and other professionals and evaluate the services provided. In addition a small number of staff and managers who worked with the family have spoken to the reviewers directly in order to provide more detailed information about their work, reflect on their experience of work with the young people and their families and suggest ways in which services

[3] Thames Valley Police management report provided to the SCR. Figures refer to reported violent or sexual crimes involving the use or threatened use of a knife or bladed weapon. Not all violent knife crime is committed by young people

might be improved. More senior and specialist staff have been able to advise the reviewers on policies and procedures.

1.12. The report has also drawn on the large number of published reports on serious youth violence, publicising research and advocating solutions. Two reports by other safeguarding children boards which build on a detailed knowledge of individual cases to reach wider thematic findings are particularly relevant.[4] In addition the independent reviewers have drawn on their own work in reviewing services aimed at preventing serious youth violence and gang activity in other local authority areas.

1.13. The review does not address directly the question of whether the incident could have been predicted or prevented. To do so would require a detailed understanding of the circumstances and the motivations of those involved and of other young people, which the review cannot obtain. The review has however examined the histories of the young people involved to consider whether different approaches could reduce the risk of this type of incident in future.

Family involvement

1.14. The review has sought to involve the families and the young people themselves.

1.15. The independent lead reviewer and a representative of the LSCB met the family member who had made the initial representation to explain how the review would be conducted and that it would not be able to investigate all of her concerns in detail. She accepted this, agreeing that the main focus of the review should be on improving services for the future.

1.16. Representatives of two families participated through direct meetings with the independent reviewer. The father of the third young person drew attention to previous lengthy complaint correspondence with social care, which the review has taken into account, but did not respond to further requests to be directly involved. The views of all three families informed the report at a number of points.

1.17. Information about the review was provided to the young people involved via family members or professionals who had direct contact with them. Two were in youth custody at the time limiting the possibility of direct access to explain the reasons for the review. None was willing to contribute to the review, leaving a disappointing gap.

[4] Alex Chard (2015) *Troubled Lives Tragic Consequences – a thematic review*, Tower Hamlets Safeguarding Children Board; Charlie Spencer, Bridget Griffin & Maureen Floyd (February 2019) *Vulnerable Adolescents Thematic Review*, Croydon Safeguarding Children Board. The citation of these reports should not be taken as an indication that the author or the board endorses their thinking or findings.

How can this learning review assist in improving services to reduce violent youth crime?

1.18. Although the review is concerned to focus on all serious youth violence, knife crime is an important part of this. As this review began its work in late 2018, there was a spate of murders and woundings involving young people in England. In early 2019 the surge in the number of serious knife crimes involving young people appeared to stop, although there remain weeks when a series of incidents coincide, underlining the persistence of the problem.

1.19. Overall the recent trend is clear. Violent or sexual offences involving knives or sharp instruments increased from approximately 31,000 per year in 2010-11 to over 44,000 in 2018-19. [5] The spread from cities to smaller urban areas and counties is reflected in national as well as local figures as *'there were increases in 32 of the 43 forces in England and Wales, including big percentage rises in rural counties'.*[6]

1.20. Much professional and political discussion of these trends highlights common risk factors among the perpetrators and some victims.[7] Professionals working with young people (who are often perpetrators of crime but also most likely to be the victim of a violent crime) recognise common factors in their backgrounds. They are also aware that most young people who grow up in deprived circumstances or who have suffered difficult early experiences don't commit violent crimes and that successful work with young people requires an emphasis on their own responsibility and agency.

1.21. Regardless of the common factors in the individuals' backgrounds, or how constrained their choices are, it is dangerous to blur the moral distinction between robbing or stabbing someone and being robbed or stabbed, even if the individuals concerned come from similar backgrounds or might a few days or weeks before have been victim rather than perpetrator, or *vice versa*. The perpetrators of violent crimes have made choices which have brought harm and distress to victims and their families.

1.22. The view of the author is that to blur that distinction in any way will give a confusing message to young people and make it harder for their parents, responsible adults in their communities and professionals to help them behave differently. This does not prevent professionals from recognising that some young people who are committing offences are being exploited, sometimes by adults and sometimes by older or more ruthless adolescents whose criminal behaviour is more entrenched. Nor

[5] https://www.thetimes.co.uk/edition/news/jump-in-knife-crime-puts-overall-offending-at-15-year-high-prm5dvqzb accessed on 18 October 2019
[6] ibid
[7] Croydon LSCB op cit

does it reduce the responsibility of professionals to understand and to seek to address factors in young people's background and social context that have made them more vulnerable.

1.23. It is common sense that there should be a collaborative approach to serious youth violence and for some time it has been policy that a 'public health approach' to violent crime is needed. Politicians and others contest what this means, how it should be implemented and how long it could take to succeed.[8] Appendix III has links to background material about this. Section 2.4 of this report contains some information about the practical measures taken by Thames Valley Police since 2018 to combat knife crime in Buckinghamshire.

1.24. If it is to have any value, a collaborative approach must be developed and put into operation at a local level, informed by young people, families, communities and the professionals who are working with children. Young people can only be helped if professionals are able to understand the effectiveness of the services that have been provided for children and their families: what worked well; gaps and weaknesses in existing services and ideas about what might have been done differently. This review has sought to make some sense of the lives of the young people involved in one incident in a way that can contribute to that discussion.

[8] The public health approach has in fact been government policy since 2011, though it is be a matter of dispute as to whether it has been implemented. See for example https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97861/gang-violence-summary.pdf

2. FINDINGS AND LEARNING

2.1. Introduction

2.1.1. This section of the report seeks to shed light on the pathway that for these young people led to involvement in serious youth offending and the points at which professional intervention may have safeguarded the young people more effectively. It evaluates the impact of service provision made over more than a decade. Given the scope of the review, the most important and recurring themes are highlighted and not every episode is considered in detail.

2.1.2. The review identifies points in the development and education of children and young people and themes in the provision of services that are particularly important because signs and symptoms which may be associated with later youth violence are seen and there may be opportunities to intervene.

2.1.3. In Sections 2.2 – 2.6 the review considers the services provided to children under the following headings:

- Problems and help in early childhood and the primary school years
- Transfer to secondary school and the emergence of difficulties in school years 7 - 8
- The ability of the criminal justice system and other agencies to address emerging criminality and possible gang associations
- The kind of multi-agency plan needed to protect children when the risk comes from the wider community rather than (or as well as from) the family and when the child's behaviour is also a risk to others?

2.1.4. The analysis points to the need for a model of service delivery which will draw on the skills and knowledge of different professionals groups to respond quickly to children at these points, sometime because there is an immediate risk, sometimes to offer support that may help a family avoid later difficulties.

2.1.5. Some patterns in service provision are clear. Lack of engagement (for whatever reason) with services such as CAMHS, Speech and Language Therapy (SALT) or educational support services when problems are first recognised has been identified in many children's histories as prefiguring latter difficulties.

2.1.6. In the past the families of young people involved in serious offending have often experienced intermittent service delivery, including professionals closing cases because there has been a little progress, or the child has not been brought to appointments. Such cases are often re-referred and the pattern repeats.

2.1.7. The extent of some young people's offending is often not appreciated because so many reported offences are not successfully prosecuted.

Taken together this suggests the need for coordination of the services so that action is based on the full and rapid sharing of information and that assessment can take account of a full history, including whether or not services have engaged with the family successfully.

2.1.8. The review has found that during the period under review prior to 2018, some aspects of service coordination are currently poor. Examples are given in each of the following sections. Better operational coordination in turn requires strategic oversight and a framework for planning. Without this better coordination and oversight improvements in individual services will have less impact. This is addressed further in Section 2.6

2.1.9. The risk factors associated with serious youth violence may apply to different degrees to any child. The review points to a concentration of risk factors in some minority ethnic families in Buckinghamshire and to barriers (some arising from the professional side and some arising from families) to addressing them. This is addressed in Section 2.7.

2.2. Early help and difficulties in primary school

Introduction

2.2.1. This section considers the early infancy and primary school years of the three young people, identifies the difficulties that they experienced, evaluates the services provided and identifies areas of possible improvement. The provision discussed was made over several years before 2018, under different Buckinghamshire early help policies and strategies so the learning focuses on general principles.

2.2.2. Recommendations on early help services are made in Section 3. Recommendations 2 and 3

Information from the narrative

Domestic abuse and safeguarding concerns in early childhood

2.2.3. Police were called to reports of domestic abuse in two of the families. Child C was referred to social care on several occasions but not assessed because the individual reports of domestic abuse were not deemed to have been serious enough to merit this. There was a high level of concern about this child at school.

2.2.4. His younger siblings suffered from chronic illnesses and disability. The family was very happy with the health services that were provided and did not want to receive any voluntary support from the local authority.

2.2.5. There was persistent domestic abuse in Child A's family, including allegations of serious assaults on the mother by members of the extended family. The circumstances were never fully understood by professionals but this is likely to have caused significant distress and harm. In this family the long-standing, safeguarding concerns bi-passed the early help services.

2.2.6. The boy and his younger brother (who also went on to commit serious criminal offences) were the subject of a child protection plan which focused largely on their living arrangements and practical care but did not seek to understand the origins of the family's difficulties. Had it done so agencies are likely to have realised that they were profound and persistent, probably meeting the threshold for statutory legal intervention.

2.2.7. The children's father (who did not live with the children and had been released from prison) believes that there were no proper safeguards in place when the children were living with the extended family. He also believes that professionals failed to give him enough opportunity to be involved in his children's lives.

2.2.8. When the child protection plan ended (when the children were 11 and 9), a lot of professional effort was made to support the care of the children but there was little parental or wider family cooperation so a meaningful child in need plan could not be drawn up.

Behavioural problems at primary school

2.2.9. Two of the boys experienced behavioural difficulties in primary school. Schools made efforts to address these problems and were supported by the primary age Pupil Referral Unit (PRU) which supported the boys and their schools by visiting, observing them and offering advice.

2.2.10. Child C changed school which helped keep him in mainstream schooling because his parents had more faith in the staff at the new school. Child A was offered a special school place on secondary transfer, but said he did not want to attend. His family went along with this, so it was refused.

2.2.11. Chronologies suggest that the level of external additional support available to primary schools varied. The interventions appear to have been largely focused on the child's school problems and were not linked to work with the families which might have more effectively addressed the causes and severity of the children's behaviour problems.

Failure at the time by services to engage the family in an early help offer

2.2.12. Child B had no marked problems in primary school (this would have been before 2017), though investigations were made into some specific cognitive problems. There is no evidence that these seriously impaired his learning and he was not identified as a child with any additional emotional or behavioural difficulties at the point of secondary transfer, an indication that the most potentially risky children will not necessarily always have severe difficulties at primary school.

2.2.13. Over several years there were a number of incidents that might have led to the involvement of early help services. On each occasion there were delays in offering help, sometimes there was a gap of several weeks or months between the referral and the assessment. His mother refused help saying that by the time an early help assessment was offered, things had improved. She told the SCR that she genuinely believed that this was the case. The refusal was accepted and involvement ceased without considering the full range of information that could have been made available (such as the extent of Child B's educational difficulties) and the repeated pattern of family difficulties.

Learning and questions for the partnership

2.2.14. It is useful to draw on the findings of reviews conducted by other safeguarding boards, avoiding simple comparisons with other local authority areas that are very different in their social and cultural makeup. The Buckinghamshire histories have a number of similarities to the findings of the Croydon and Tower Hamlets thematic reviews. In Tower Hamlets *'several of the children who subsequently perpetrated extreme violence were displaying behavioural difficulties in primary school'.*[9] In Croydon 19 of 60 adolescents categorised as 'vulnerable' had received fixed term exclusions in primary school, all of whom subsequently received criminal convictions.[10]

2.2.15. The Croydon review found that *'the primary schools had limited interventions available to them to address such behaviour and referred on to other agencies. It is not clear if they were aware of any potential causal factors that could explain the children's behaviour to inform the interventions that were put in place. There was a range of parental*

[9] Tower Hamlets LSCB (op cit) page 3
[10] Croydon LSCB (op cit) page 9

factors, such as absent parents, substance misuse, mental health problems, parental criminality and domestic abuse, but parental interventions and interventions for children were not joined up in a coherent whole family plan. Adult services and children's services did not work together, and the needs of the children remained unmet.'

2.2.16. In Buckinghamshire professionals in the family support, early help and youth services described the evolution of their work over recent years from one that had been focused exclusively on the child in school to one where the intervention (if it was accepted by the parents) would consider the needs of the family as a whole, including parents and older children who might be influencing younger siblings.

2.2.17. Very often in the case histories decisions about the level and type of need and therefore the relevance of different services were not made on the basis of all-round information about the child and family, the child's educational difficulties and the extent to which the family had previously engaged with services. This led to a pattern of repeat referrals and assessments that covered the same ground.

2.2.18. Early help and child in need services should ensure that their assessments take a full account of the child's history, information from the full range of agencies involved and relevant information about all family members. As with younger children there is a case that more should be done to work with families and young people who do not engage with early help or child in need services.

2.2.19. The Buckinghamshire youth service described how it is now looking in detail at the histories of the young people who cause the most concern and looking back to understand how they presented in primary school in order to target interventions at that age more effectively. There is now greater clarity about the way in which those children who are at risk of behaving violently later on may present at primary school.

2.2.20. The local authority and the safeguarding partnership have recently reviewed the early help strategy and it is important that in its implementation it takes account of the learning from this SCR. The report makes a recommendation in relation to this.

2.3. School transfer and the emergence of difficulties in the early years of secondary school

2.3.1. This section considers the response of schools and other agencies to the emergence of attendance and behaviour problems in the early years of the boys' secondary education. A recommendation is made in Section 3 of the report (Recommendations 4,5 and 6).

Information from the narrative

Transfer to secondary school

2.3.2. Based on school records and interviews with some staff who knew them, all three boys made the transition to secondary school without immediate problems. During the first two years of secondary schooling all three found it increasingly difficult to participate constructively and their behaviour deteriorated, resulting in a large number of temporary exclusions, despite efforts by the schools to avoid this.

The route to unplanned school moves -including permanent exclusion

2.3.3. All three boys left mainstream secondary school when alternative approaches had failed though their routes out of mainstream school were different.[11] Many of the exclusions took place because of persistent, severe disruptive behaviour, including violence or threatened violence to staff, pupils or both.

2.3.4. Child A was assessed as being in need of a special school secondary place and offered one. He refused to attend and his family went along with this. In year 7 his attendance was poor and his behaviour problems were managed within the achievement and behaviour policies of the school that he attended. During years 8 and 9 his behaviour became more openly defiant and aggressive, leading to a number of temporary and then permanent exclusion.

2.3.5. At this point he transferred to the PRU where staff found that he fitted in well, though his attendance was never good and he did not engage much with education. His parents were not able (because of mental health problems and absence from the family) to support his education and his extended family carers do not feature in school records. It is strongly suspected that he was involved in criminal activity from about the age of about 13.

2.3.6. Child B had a large number of fixed term exclusions. His school believes that the deterioration in his behaviour and attendance at secondary school was explained by academic difficulties and his desire to be accepted by friends who did not value academic achievement. In contrast his mother's view is that the school failed to recognise that Child B had special educational needs because of ADHD, which adversely affected his behaviour, and specific educational needs which made it difficult for him to organise himself, produce written work and cope with mainstream secondary school. Differing definitions of the cause of the child's difficulties led to a deterioration in the relationship between the school and parents. The school did not believe that there was consistent support for its strategy.

[11] There is no evidence that any of the boys was removed from mainstream school using 'illicit' methods. Nor is there evidence that the removals took place to protect the schools' league table positions, as has been recently suggested nationally. For example https://www.bbc.co.uk/news/education-48172917 and other media reports (accessed and checked 4 November 2019)

2.3.7. The school referred Child B to CAMHS in 2016 because of his anger in school including an assault on another child. There was only a very brief screening and gathering of information from other agencies which established that Child B had been referred to the early help service and there was a proposal for him to see an educational psychologist. There was no CAMHS assessment and the outcome was to rely on early help family support services (which were due to be involved but his mother came to believe she did not need). It was also agreed that Child B should be seen by an educational psychologist, which happened but after a considerable delay. Symptoms of ADHD, recognised in 2018 after Child B had attended three different secondary schools and been permanently excluded, were not identified at this point.

2.3.8. An assessment by staff from the PRU suggested that Child B would manage much better in smaller classes, which the PRU could provide and proposed a planned transfer to pre-empt exclusion. This happened only shortly before his managed move and his mother says that she was not aware of the recommendation.

2.3.9. In a final effort to avoid permanent exclusion the school arranged a managed move to a new school, but Child B was quickly excluded. Teachers from the schools involved told the SCR that such moves represent a genuine attempt to offer a fresh start to a child, but that they often break down because for schools to be able to trust one another to accept a pupil who is known to have problems, they tend to take place between schools that have similar philosophies and approaches to managing behaviour.[12] His mother believed that having failed in one school he would inevitably fail in another that was making essentially similar provision and that both schools therefore failed to assess his special needs. Further disagreement between his mother and the education authorities meant that he then had to be educated at home.

2.3.10. Child C was temporarily excluded for a total of 32 days over 12 episodes in the first two years of secondary school, culminating in his permanent exclusion at the age of 13. Child C's father complained that his son had been bullied and threatened and that his school responded unfairly when this happened, failing to investigate fully or protect him. It is not possible to know whether this account is correct. It is clear that Child C bullied and threatened other pupils. Again the breakdown in trust meant that it was impossible to for the school and family to collaborate in efforts to help his son.

[12] The review has been given different information by schools and by the education service about the overall effectiveness of managed moves. Schools report that they offer a limited chance of success whereas the education authority maintains that there is a high success rate, which would of course be influenced by the criteria used to measure success.

2.3.11. Managed moves to other schools were attempted and the PRU tried to assist. Between the ages of 13 and 16 Child C was on the roll of two different PRUs, firstly a local authority managed unit and then a setting managed by a national organisation that specialises in PRU provision. At both the problems of poor attendance and disruptive behaviour, including assaults on other pupils, continued. Child C sought to be at the centre of attention by boasting about his criminal and anti-social exploits and being physically dominant in every interaction with staff and other pupils.

Learning and recommendations

2.3.12. Although the specific factors leading to exclusion were different there are common patterns. Two features of the service provision stand out.

An effective partnership between schools and parents

2.3.13. Permanent exclusions happened in part because – for a variety of reasons – the schools had been unable to achieve parental or wider family support for their strategies to help the child. Child A had no family to support the school. Child B's mother and the school defined his problems in different ways. Child C's father had no trust in the school. Almost by definition, without parental engagement, schools were unable to understand the child's problems in relation to their family background or to involve family members in management and solutions.

Multi-agency engagement

2.3.14. Schools often appear to have been acting without substantial support from other agencies when seeking to help these pupils. Sometimes other agencies were not involved, or if they were information was not being shared between agencies, leaving schools unaware of important factors, such as the extent to which children were involved in anti-social or criminal behaviour in the community, or had severe family problems. Conversely in this case it appears important external agencies such as social care and the Youth Offending Service (YOS) may not know in detail about school problems.

2.3.15. Sometimes this meant schools placed reliance on parents to exercise a degree of control or influence that other agencies (who knew the family better) would have known was unrealistic. For one boy social workers appear to have taken the existence of an educational plan or a very limited level of compliance with school regime (for example attendance at the PRU) as a positive when in fact the child was not attending well, engaged or cooperative. Overall, it is likely that more could have been achieved if external agencies (such as family support and social care, behaviour support and CAMHS) had been more involved and had worked together in a collaborative way from the point of secondary transfer.

2.3.16. School governing bodies have the final responsibility for school exclusion, but there is a strong case that a permanent school exclusion or any hasty,

unplanned move to a different educational setting should only happen after the full range of resources of the multi-agency professional network has been engaged to support the child, family and school.

2.3.17. There is no doubt that schools can play a vital protective role:

'Both research and wisdom show us that regardless of the adversity they face, if a child can develop and maintain a positive attachment to school, and gain an enthusiasm for learning, they will do so much better in their lives. The role of teachers in the lives of traumatised children cannot be underestimated.'[13]

2.3.18. The best way to achieve this must be to harness a greater, more collaborative, multi-agency effort to address the early deterioration in the secondary school attendance and behaviour of children (mostly but not exclusively boys) who have a history of violence and other behavioural difficulties (often linked to past adverse experiences) where it has proved difficult to achieve family engagement in the approach proposed by the school.

2.3.19. The questions posed for the multi-agency network about service design and coordination mirror those for primary schools (see the previous section) with the recognition that by the age of 13-14 the need for action has become more urgent and it is more likely that the child has begun to experience unhelpful external influences from other pupils or from the community at large.

2.3.20. Secondary schools and the safeguarding children partnership should consider how best to promote this approach, considering the following:

- Is sufficient help targeted at this critical phase in children's development and how can resources best be protected, focused and coordinated?
- Is there a need for specific additional help to liaise between parents and school in situations where the relationship has broken down?
- Are professionals sufficiently aware of the range of risk factors that should be used to prioritise children and families that need help? Is this being used to identify pupils who need additional support? Can the current work of the youth service focused on primary school children be extended?
- Is the multi-agency early help assessment tool being used and is it effective? Does it trigger a comprehensive sharing of information so that other agencies involved with the child (for example the YOS) are made aware of the extent of school difficulties? Similarly does it enable

[13] Child Safety Commissioner in the Australian State of Victoria (2007).*Calmer Classrooms* cited in Tower Hamlets LSCB op cit (page 4)

schools to be more aware of difficulties in the child's home life and the community?

- If referrals are made to external agencies (such as early help, social care, educational support services and CAMHS) do approaches to assessment and the thresholds used to allocate resources reflect knowledge about risk?
- As it appears that engagement with more specialist services is vital in achieving positive outcomes for children, can the multi-agency network as a whole do more to enable parents to take their children to appointments?
- If practice that is informed by an understanding of children's histories is believed to be the most effective, can school staff be trained to work in this way or does this approach require the involvement of the multi-agency group? Does the school structure support this?

2.4. The ability of the criminal justice system and other agencies to address emerging criminality and possible gang associations

2.4.1. This section considers the evidence about the response of agencies to the emerging criminal activity of the three boys. Much of this criminality was serious, involving violence that affects the community at large including, other young people and vulnerable individuals.

Information from the narrative and staff interviews

2.4.2. In order to understand how their criminal activity developed, it is necessary to distinguish the small number of convictions which the three boys had before the incident that triggered this review from the much larger number of episodes in which there was strong suspicion of their involvement in offences but insufficient evidence to achieve a criminal prosecution. The latter form an important part of their pattern of behaviour and assessments of risk should take account of both.

2.4.3. Child A was involved in criminal activity, which became increasingly violent, from the age of 13. The offences which the police were aware of were consistent with involvement in local drug dealing. It is not clear who organised this, how organised it was or how Child A became involved. Professionals believed that there was no family or community pressure to desist from offending. After the incident that triggered the SCR he continued to offend and received a custodial sentence for possession of drugs with the intent to supply.

2.4.4. Child A was referred to YOS in his early teens on a voluntary basis and later under an order, but he did not cooperate in any meaningful way and the interventions had no effect.

2.4.5. Child B's initial contacts with the police included incidents in which he was missing from home, assaulted his mother and assaulted a younger vulnerable child. Police believe that Child B was involved in local drug dealing but have no evidence of wider exploitation. His family believe that Child B was being pressurised into criminal behaviour.

2.4.6. In 2017 there were three significant episodes involving threatened violence and the use of knives in the 9 months before the incident that triggered this SCR. The YOS has recognised that the incidents in which knives were found did not receive the intervention that they merited. One incident in which Child B was a target of gang-orchestrated violence pointed to risk to Child B and family and possible gang / revenge motivation. It is acknowledged that it should have been taken more seriously by the agencies that were aware of it.

2.4.7. Child C had a long history of behaving aggressively towards other pupils at school (which was not reported to the police) but relatively little history of violence in the community. If the information about the extent of Child C's home and school problems had been compiled systematically and the

very negative influence of some of his peers had been taken into account, together with the lack of apparent adult concern for his welfare, agencies may have recognised a higher level of risk.

2.4.8. Although probably the least serious offender, Child C was caught more often and as a result had more contact with the YOS. These interventions give the appearance of having been designed to comply with a required process, rather than thinking about Child C's individual needs, and were not effective. In the months before the incident that led to this reviewthere were social care interventions which proceeded separately from the work of the YOS and did not inform or support one another. The YOS has recognised that its interventions did not pay sufficient attention to the children's family background and circumstances.

2.4.9. At this point a teacher who knew two of the young people well initiated a mapping exercise seeking to understand the contacts and relationships between different boys in his school in order to better understand the influences on them and risks to them. He experienced frustration at the time because other agencies showed little interest in this well-intentioned and potentially useful exercise. When he brought individual pieces of information about networks of young people to the attention of the local authority it did not lead to any action, probably because when considered in isolation the information did not point to the need for intervention. This initiative was not taken on at the time by senior members of staff.

Learning and recommendations

2.4.10. It is important to underline the distinction between the small number of convictions which the boys had before the incident that led to this review from the much larger number of episodes in which there was insufficient evidence of their involvement to achieve a criminal prosecution. These included assaults and robberies in which:

- the victim was unwilling to make a formal complaint
- the perpetrator could be recognised on CCTV but there was insufficient other evidence, or by a witness who refused to provide a formal identification
- there was plausible intelligence of a suspect's involvement but no useable evidence
- forensic or circumstantial evidence linked the individual to the crime without sufficient corroboration

A large number of other crimes go unreported, especially if the victim is vulnerable or known to the perpetrator. Two of the young people had been involved in complex and serious incidents which remained 'under investigation' some months later.

2.4.11. These instances are significant because information about them (including information about arrests and release under investigation) was not always

shared between agencies, or was shared only after a delay. One of the reasons for this is that police officers viewed the young people involved in the alleged incidents as potential perpetrators and did not recognise that they might also be in need or at risk. Thames Valley Police has recognised that there needs to be clarity about the need to share information about such incidents with the Multi-Agency Safeguarding Hub (MASH), which screens possible referrals to the local authority and for the MASH to consider relevant cases, linking this information to that held by other agencies.

2.4.12. If information about strongly-suspected criminality is not shared with other agencies it will not inform their assessment. When there are violent incidents this can be an important gap which may significantly alter the professional understanding of risk and need.

2.4.13. Other factors influence the extent to which information about criminal activity can be acted on by the police or comes to the attention of other agencies. During much of the period under review, political influences discouraged the use of stop and search powers, police training emphasised the need for officers to be extremely cautious in its use, there was less confidence among officers using the power and a fear of negative community reaction. Consequently records show only a small number of instances in which these three young people were found carrying a knife, although police intelligence indicated that two of them did so habitually.

2.4.14. At this time when a young person was found with a knife the outcome may have been a caution or a caution associated with a referral to the YOS, even if it was a repeat occurrence. When Child B refused to engage in activities, the YOS was not keen to return him to court to offer the court the option of a different sentence.

2.4.15. As a result young people are likely to realise that there is little chance of being caught in possession of a knife and that if they are caught the punishment for carrying or threatening to use a knife is not one that acts as a strong disincentive. [14] Taken together this is extremely frustrating for the police and others working in the criminal justice system.

2.4.16. It is often stated that the police acting alone cannot solve the problem of serious youth violence and that other agencies need to address the underlying causes. However if there is no effective response to patterns of serious offending (including carrying knives) the message that this risks giving to young people is that the adults have lost control, rendering

[14] A flexible approach is sometimes adopted by other professionals. Research by Ofsted in London has shown that many school heads choose not to report children who bring knives to school to the police though there is no evidence that any of the Buckinghamshire schools adopted this stance. Ofsted, March 2019, Safeguarding children and young people in education from knife crime

measures to address wider welfare, social and educational concerns less likely to be successful. Positive welfare, health and social measures need to run alongside strong enforcement and firm sentencing.[15] This was always clear in the development of the 'public health' approach developed in Glasgow, but is not highlighted in some current discussions.[16]

2.4.17. To be effective the response to organised criminal activity involving young people must be better organised. Based on the incidents involving these three young people this requires six things:

- consistent reporting and sharing of information about offending (including suspected events that remain under investigation) between all of the agencies involved in the criminal justice system and a proportionate sharing of information with other agencies.
- mapping of incidents and networks to provide a more fully informed assessment of risk
- rapid responses to incidents which cannot depend on the outcome of a criminal investigation, including disruption activity directed against illegal activity
- more attention from the YOS to children's family circumstances and history
- tighter supervision from the YOS when young people are referred for voluntary preventative work to ensure that the intervention is meaningful.

All of these require that professionals have a greater awareness of the signs and symptoms of gang affiliation and criminal exploitation.

2.4.18. This all in turn requires a closer and more responsive working relationship between agencies (particularly but not exclusively) police, YOS, social care and schools. Additional information and support must come from health agencies (such as Emergency Department, other unscheduled care settings and CAMHS)

2.4.19. Since the period under review there has been a recognition on the part of Thames Valley Police and the Youth Offending Services that some existing approaches were not effective. As a result there was a significant (27%) rise in the use of stop and search in the town where the incident took place. Positive outcomes in this area have been the highest in the Thames

[15] See for example Centre for Social Justice (2018) It can be stopped: A proven blueprint to stop violence and tackle gang, Chapter 2. This summarises the approach taken in many cities including Cincinnati, Boston and Glasgow which included more effective detection, gang call-ins making it clear to gang members that there was no community tolerance of their behaviour while at the same time offering positive avenues for gang members.

[16] For example the Violence Reduction Unit set up by the Mayor of London which has little focus on heightened police enforcement, https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence

Valley Police area (28%) during this period, suggesting effective use of the power.

2.4.20. There has been a greater focus on the involvement of young people who are involved in criminal drug supply through closer weekly scrutiny of all 'possession with intent to supply' crime reports. When youth suspects are identified, their details are shared with the relevant social care team. In January 2018 there was a period of intense activity targeting 'county lines' activity.

2.4.21. There is a recognition that some of the crimes in these reviews pose particular challenges for investigators including multiple offenders, multiple victims (some of whom might be involved in criminality or are reluctant to engage through fear of retribution), complex forensic enquiries and digital / media interrogation.

2.4.22. The police service has a programme of improvement for investigative work in place which takes account of the complexities of criminal activity raising safeguarding concerns. This will need to ensure that risks associated with knife crime and substance misuse are fully documented so that they can be considered by the MASH.

2.4.23. The YOS has also provided the SCR with a comprehensive account of the improvements in management and oversight of staff and young people implemented since 2018, based on its audit work.

2.4.24. At the time the assessments of the young people failed to identify the specific needs of the individual child, which resulted in intervention plans that were weak, containing very general objectives and failing to address specific problems for the child and his or her family. Management oversight did not test the effectiveness of interventions for individual children due to only specific levels of risk being signed off by a manager.

2.4.25. The safeguarding partnership will now want to confirm that these improvements are having a significant impact on outcomes for children. A recommendation is made in Section 3 of the report (Recommendation 7)

2.5. What kind of safeguarding plan is needed to protect children when the risk arises from the community as well as the family, and when the young person also poses a risk to others?

2.5.1. This section of the report highlights the need for a wider discussion about the most effective approach to the safeguarding of children when risks arise from their contacts in the community (including from gang affiliation) as well as from the family, and when the behaviour of the young person itself poses a risk to others in the community (referred to as 'contextual safeguarding'). A recommendation is made in Section 3.

Information from the narrative

2.5.2. Child A was first made the subject of a protection plan when he and his younger brother were at primary school. The children's parents were living separately. There were allegations of domestic abuse including assaults by extended family members on the mother. The children had severe behaviour problems in school which therapy services could not improve. The mother had very poor mental health which prevented her from caring for the children who were living intermittently with extended family members. The father later spent a period in prison.

2.5.3. At this time there are a substantial number of professional meetings and social work visits to see the children but it is hard to establish from the records what the objectives for the work were, other than to check that the children had somewhere secure to live and that they were able to keep in contact with their mother.

2.5.4. The local authority has recognised in hindsight that too much attention was focused on these basic issues, rather than on the quality of the children's day to day lives, the care they were receiving, its impact on their health and development and whether it was a satisfactory way of safeguarding their welfare in the long term. The records seen do not explain why this plan was closed when the child transferred to secondary school, a point at which it would have seemed likely that the family might need more, rather than less, help. The local authority was not involved over the following two years (Oct 2012 – 2014) when the child's behaviour at school and education deteriorated, nor for a further year.

2.5.5. The boy and his younger brother were made the subject of a further child protection plan again in 2015 (under the category of neglect). This remained in place throughout a period when both boys were involved in increasingly serious and violent offending.

2.5.6. This plan was not effective. This was acknowledged by late 2017 when discussions began about the use of the Public Law Outline (PLO) as a possible pre-cursor to care proceedings. It is now recognised that there may have been grounds to make a court application much earlier. It is also not clear whether the use of the PLO – which challenges the parents to provide better care in order to avoid the need for care proceedings – was relevant to the main concerns about the boys at that time particularly the risks arising from their offending and involvement with other young people.

2.5.7. Across several years, social care interventions took insufficient account of Child A's problems at school and escalating pattern of offending. Social workers seemed to know about developments in these areas but to treat them as issues to be dealt with by separate interventions, rather than an indication of overall risk that needed to be addressed in a single plan or linked plans.

2.5.8. The child protection plan directed measures to address these concerns at his parents when it is doubtful if they were in a position to exert effective control over their children. At some points it appears that reliance was placed on involvement with the YOS but during 2017-18 the YOS interventions were not effective, there was limited coordination between the YOS and social care and the impact of the work of the YOS was never critically evaluated as part of an overall protection plan. There is no evidence that the protection plans ever directed attention to external influences and risks.

Learning and recommendations

2.5.9. It is clear from talking to a number of social care professionals who worked with this family that there was a considerable effort to help the children and their parents but that the work done prior to 2018 when the children were younger was not effective. Throughout the period under review professionals involved in the child protection and child in need plans seemed at a loss to know how to intervene. As a result the activity was characterised by repeated re-assessment and discussion.

2.5.10. Work was hampered by frequent changes in social workers and managers sometimes leading to inconsistent supervision and plans that were not informed by interventions that had already been attempted. Consequently assessments did not properly understand the day to day lives of the children or delve sufficiently deeply into the origins of their problems. Plans often lacked focus and responded to the changing circumstances of the child without having clear objectives. Steps to address the safeguarding concerns arising from peers and the community (including possible gang involvement) did not seem to be part of the professional vocabulary.

2.5.11. This must be understood in the context that local authority social care services as a whole in Buckinghamshire were judged by Ofsted to be 'good' in 2011 but 'inadequate' in 2014 so the shortcomings in these plans were not unusual.[17] However there are very similar findings in the Croydon LSCB thematic review suggesting that other local authorities struggle with similar problems. Discussing the effectiveness of child protection plans it notes that *'throughout their childhood, children continued to come to the notice of Children's Services; some were placed on new child protection plans, and at age 14 there was a peak of children in the cohort coming into care, suggesting that the children's situations had deteriorated and interventions to that point had been unsuccessful.'*

2.5.12. The Croydon LSCB review interviewed a smaller sample of the 60 children who it found appeared to be *'resigned to their situation'* because *'the*

[17] Individual inspection reports and monitoring visits can be found at https://reports.ofsted.gov.uk/provider/44/825

issues of domestic abuse, bereavement and related trauma were never addressed and as indicated in research, the impact of these traumas became entrenched. Family difficulties often remained'. The report identified a link between this and gang involvement because *'the children subsequently sought a sense of belonging, purpose and safety from their peers'.*[18]

2.5.13. Two issues are highlighted by this. The first is a well-established one. How can plans for children (both child in need plans and child protection plans) be made more effective for younger children who are identified as being at risk so that the repeated pattern of referral, assessment, plan, disengagement and re-referral in deteriorating circumstances is broken?

2.5.14. The local authority in Buckinghamshire is subject to close external monitoring. In January 2019 the quality of child protection plans still required improvement, in part at least because rapid staff turnover.[19] It is not necessary for the SCR to make a specific recommendation in relation to the way in which the local authority should seek to improve its practice as there are a number of models of practice that have been proposed nationally to ensure greater effectiveness in this type of work with families. It is important however that the multi-agency safeguarding partnership should continue to monitor and challenge the local authority in its improvement work.

2.5.15. The second issue is one that many local authorities are seeking to address: what is the most effective way of intervening to prevent further harm when young people (who may have entrenched family problems) are at risk from other young people or adults in the community, including through criminal exploitation or gang affiliation, and who may in addition also be placing others at risk?

2.5.16. The risk to these children stemmed from factors both within their family and from their contacts in the wider community – for example poor school engagement and contact with other criminals. This illustrates the difficulty of applying existing thresholds and approaches to a problem that is rooted in the young person's interaction with the local community. The contextual safeguarding approach advocates a series of community-focused interventions targeting wider patterns of behaviour and attitudes that are seen as condoning or promoting violence by and against young people. This may prove to be more effective than seeking to apply child protection procedures designed for families in which the parents are believed to be the source of the risk.

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[18] Croydon Safeguarding Children Board (2018) op cit

[19] Ofsted Monitoring Visit Letter 8 January 2019, https://files.api.ofsted.gov.uk/v1/file/50048619

2.5.17. Buckinghamshire has previously participated in efforts to address the problem of 'contextual safeguarding' through projects on 'peer-on-peer abuse'.[20] It now needs to address the needs of young people who are involved in serious youth violence, some of whom may have been exploited by criminals.

2.5.18. The local safeguarding partnership will need to consider how effectively its current provision addresses contextual risks, what sort of interventions are most effective and how they should best be coordinated. These are likely to include youth services, the voluntary sector, substance misuse services and a range of others.

2.5.19. . Recommendations 8, 9 and 10 address these findings.

2.6. The planning, operational coordination and strategic oversight of services to combat serious youth violence

2.6.1. The majority of the professionals who contributed to the review noted that serious youth violence is a growing problem in Buckinghamshire; one that requires different solutions. More than one told this review that '*this is organised crime and it needs a better organised response*'.

2.6.2. Two themes emerge strongly from this overview. Firstly, giving priority to certain services such as the early years prevention, early help in primary schools and behaviour support in years 7 and 8 in secondary schools. Secondly intensive responses to emerging serious youth offending, coordinating the activity of different agencies and partnerships in early help, for those on the cusp of becoming involved in violent crime and those already involved.

2.6.3. Cooperation and coordination will require (among other things) agreement on priorities, the allocation and reallocation of resources as well as agreement of thresholds, information sharing arrangements and joint training, as well as challenges to agency culture and methods of working. This in turn will require strategic oversight.

2.6.4. At present a number of partnerships, boards and reviews have an interest in this work, including:

- Youth Offending Service Board
- Safer Stronger Partnership Board
- Bucks County Council Improvement Board
- Early Help Review
- Special Educational Need Review

[20] C.Firmin et al (2016), Towards a contextual response to peer-on-peer abuser: Research and resources from MsUnderstood local site work 2013 -2016, International Centre Researching Child Sexual Exploitation, Violence and Trafficking ,

2.6.5. During the course of the SCR it was agreed that responsibility for oversight and coordination of the work on criminal exploitation and serious youth violence would sit with a subgroup of the Safer Stronger Partnership Board. The safeguarding partnership should continue to work closely with this partnership board and this is reflected in Recommendation 1.

2.7. Services for black and minority ethnic families

2.7.1. All three of the boys came from black and minority ethnic backgrounds, including Asian and mixed heritage. This section of the report deals with the adequacy and appropriateness of service provision to minority ethnic and religious communities in Buckinghamshire.

2.7.2. Information provided to the review by the Youth Offending Service indicates that there is a slight over-representation of young people of mixed heritage in the youth justice population. In contrast young Asians are understood to be under-represented generally in the population that is known to the youth offending service, but over-represented among those arrested and convicted for possession and supply of drugs.

2.7.3. Professionals report that Child A's family was very fragmented during most of the period under review, his father living separately and his mother suffering periods of mental illness. The perception of statutory agencies is that members of the mother's family who were caring for Child A and his brother were very difficult to engage and would do enough to be seen to comply with agency requests without ever accepting the agency's agenda.

2.7.4. Child B's mother discussed her concern about the disproportionately high levels of temporary and permanent school exclusion for black and mixed-parentage children with the independent reviewer.[21] However she does not claim that his school racially discriminated against him.

2.7.5. Child C's father presented a mixture of experiences. He described the town where he lived (and Buckinghamshire generally) as open, friendly places where he felt accepted. He described living in a mixed part of the town and being on good terms with neighbours, people drawn from a variety of backgrounds. He was extremely angry with one his son's schools, which he said had failed to stop him being bullied and with the actions of the local authority education services. However he was very positive about other schools attended by his children and about the health provision made for his children. His descriptions of the extent of his son's conduct at school played down the level of difficulties.

Learning and recommendations

2.7.6. These young peoples' stories highlight some important themes, including gaps in understanding between some statutory services and some minority communities.

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[21] https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/absence-and-exclusions/pupil-exclusions/latest#temporary-exclusions-by-ethnicity-and-local-authority Exclusion rates for Asian children are lower. The greatest disparity is the higher rate of permanent exclusion of black pupils. These rates of simple comparisons which do not take account of any additional background social information on the population of pupils.

2.7.7. The Asian community in Buckinghamshire is unusual. About 50% of Britain's black and minority ethnic population lives in areas with relatively high migration and pockets of high social deprivation, with about half living in London, Birmingham and Manchester.[22] In contrast the Asian communities in Buckinghamshire live in a county which is predominantly white and largely, relatively affluent, concentrated in a small number of wards in the two towns of High Wycombe and Aylesbury. Numbers of children from black and minority ethnic communities in Buckinghamshire are expected to grow significantly during the next two decades.[23]

2.7.8. The Asian community in Aylesbury is currently poorly represented on the local authority [24] and (according to staff interviewed) there are relatively few professionals working in statutory agencies who come from this minority community or who have first-hand personal experience of it. Some professionals experience this as an inward-looking community with a low level of integration with the majority population, sometimes seemingly motivated by different values and priorities. Numerous examples given to the review suggest that standards of practice with families from the Asian communities can be poor, with some professionals showing limited knowledge or curiosity about the lives that people lead or the factors that shape the need for services. This lack of knowledge can lead both to negative assumptions being made and to risks not being recognised.

2.7.9. Services, other than community health providers, had not succeeded in making good provision for the families of Child A and Child C. Their parents had been reticent to engage and there are records that show how from a very young age, Child A, his brother and Child C expressed negative attitudes to school, police and sometimes wider mainstream British society. On a number of occasions the women and children in the families have been harmed by violence from partners but also from the wider community. The records all indicate a desire to 'resolve' problems within the community rather than approaching or trusting statutory agencies.

2.7.10. These difficulties have been identified before, but not successfully addressed. The panel that led the LSCB case review on child sexual exploitation (CSE) went to very great lengths to consult and involve the communities in its work, because of the marked racial and religious disparity between the known perpetrators and the identified victims of

[22] Figures are from Louise Casey Review, Department for Communities and Local Government (2016)

[23] Buckinghamshire Early Help Partnership Plan

[24] For example only two of the 29 Aylesbury Vale DC councillors appear to be from the Asian community, https://democracy.aylesburyvaledc.gov.uk/mgMemberIndex.aspx

sexual abuse.[25] This evidently needed to be understood and although the CSE review made considerable efforts to do so, it failed. Apart from meeting with individuals and some small groups, attempts to engage the community were abandoned.

2.7.11. At its conclusion the review made a general recommendation on this directed at a subgroup of the LSCB, which is unlikely to have had the power to influence the high level strategy or the culture of agencies. The review has been told that this subgroup spent some time working out a strategy about how to engage with and consult minority ethnic communities but did not then take forward the work.

2.7.12. There is a strong case that a similar wide-ranging effort is needed to understand the specific factors that affect this community in relation to crime and serious youth crime. In what ways are members of the Asian communities victims of crimes and what crimes? What is the experience of Asian youths of crime as victims or perpetrators? What are the specific factors that have driven involvement with gangs and drug dealing? This needs to enable better informed practice across all of the areas of prevention, early help and specialist services discussed in this review. This approach is reflected in Recommendation 11.

[25] Buckinghamshire Safeguarding Children Board (2016) http://www.bucks-lscb.org.uk/wp-content/uploads/Serious_Case_Reviews/CSE-Serious-Case-Review.pdf

The action plan is also published http://www.bucks-lscb.org.uk/wp-content/uploads/Serious_Case_Reviews/CSE-SCR-Action-Plan.pdf

3. RECOMMENDATIONS

Strategic oversight of activity to combat serious youth violence

Recommendation 1

The multi-agency Serious Violence Strategy should include a strategy to combat serious youth violence (including but not limited to knife crime). The Safer Stronger Buckinghamshire Partnership Board ('Community Safety Board') should have oversight of the coordination of activity, the prioritisation of resources and the training of staff required to address the areas of service provision identified in this review.

The Serious Youth Violence Strategy should focus on services which can make the most impact during the phases in children's development highlighted in the review. The recommendations are broad, allowing for action plans to be shaped by local knowledge. As the review had little information about the early years of the children involved, it offers no recommendations in relation to early years.

Recommendation 2

The safeguarding partners should work with primary schools to ensure that they are able to identify children who show severe behavioural difficulties, especially physical violence and anti-social behaviour, respond to their needs and if necessary make an appropriate referral for additional early help services.

Recommendation 3

The safeguarding partners should ensure that early help interventions for children in primary schools, even when triggered by concerns about school behaviour and attendance, are family-focused and take a full account of the child's history, family circumstances and any safeguarding concerns.

Secondary school transfer

The review has highlighted secondary school transfer and the response to emerging behaviour problems in school years 7 – 9 as crucial

Recommendation 4

Maintained and academy schools in Buckinghamshire should provide assurance to the safeguarding partners to demonstrate that secondary school transfer arrangements identify any child who has shown severe behaviour problems in primary school and that there is a concerted effort to successfully integrate the child into secondary school involving the full range of school and external services.

Recommendation 5

When children in school years 7-9 are experiencing severe behavioural or emotional difficulties, schools and other family support services should make and document persistent attempts to engage the parent in efforts to support the child's plan.

Recommendation 6

Schools and the safeguarding partners should take steps to further reduce unplanned school moves drawing on a multi-agency approach to support the pupil, school and family. This should be informed by improved management information about the reasons for exclusions and other unplanned school moves.

The review has shown that there needs to be a better multi-agency response to incidents of serious youth crime in real time and that this should not rely on charges being brought or conviction as in many serious instances this is delayed or does not happen

Recommendation 7

The safeguarding partners should ensure that there is a much more rapid, coordinated, multi-agency response to the emerging serious criminality of young people.

The review has shown that failure to engage parents in plans for their children is strongly predictive of poor long-term outcomes, including refusal to take the child to a service, repeatedly miss appointments or drop out before anything is achieved.

Recommendation 8

The safeguarding partners should ensure that there is a renewed focus on those parents who (for a variety of reasons) do not take up services for their children (including for example CAMHS, Speech and Language Therapy and educational psychology, early help and family support). This should be a feature of the actions taken to implement all of the above recommendations.

The poor outcomes for the children were adversely affected by the poor overall quality of local authority safeguarding work. There is an existing improvement plan which the partnership should monitor

Recommendation 9

The safeguarding partnership should seek assurance from the local authority that there is continued improvement in the effectiveness of safeguarding work with younger children who are subject to CP or CIN plans so that those plans reflect the daily experience of children and the pattern of referral, assessment, plan, disengagement and re-referral in deteriorating circumstances is broken.

The review has highlighted a low level of awareness among some staff in relation to the risk of serious youth violence, gangs, criminal exploitation and contextual safeguarding. The partnership must develop a coherent approach to safeguarding problems originating outside the family.

Recommendation 10

The safeguarding partners should ensure that its policies, procedures and practice reflect the best current thinking about contextual safeguarding risks.

Black and minority ethnic groups are over-represented in some aspects of serious youth violence in Buckinghamshire, but agencies have not

engaged with communities to the extent necessary. This is an important issue as the percentage of ethnic minority children in the local population will increase significantly over coming years.

Recommendation 11

The safeguarding partners should ensure that agencies and partnerships actively engage with black and minority ethnic communities over the prevention and reduction of serious youth violence.

Appendices

Appendix 1	How the review was undertaken and Terms of Reference
Appendix 2	Roles of staff interviewed or in attendance at group sessions
Appendix 3	References and links to information on the 'Public Health Approach' to serious youth crime

Appendix I

Principles from statutory guidance informing the review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

Reviews should also:

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

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

Terms of reference for Serious Case Review – Serious Youth Violence

REDACTED VERSION

Overall objectives

1. To provide a multi-agency narrative of the services provided to (three children involved in serious violent youth crime) and to their families.
2. To evaluate the services provided in order to identify areas in which improvements can be made and to make recommendations
3. In addition to coming to a detailed understanding of the specific case histories, the review will seek
   - to establish how far the practice in this case is representative of wider approaches and
   - to understand whether there are underlying weaknesses in safeguarding arrangements and in the services to prevent serious youth violence that the participating agencies and partnerships should understand more fully and address.
4. The review will take account of information about cases that have similarities and draw on relevant inspection findings and research to identify wider or recurring problems.
5. The SCR findings will be reported to the Buckinghamshire Safeguarding Children Board (or its successor body) and will also inform the strategies of the following local partnerships:
   - *Youth Offending Service Board*
   - *Safer Stronger Partnership Board*
   - *Bucks County Council Improvement Board*
   - *Early Help Review*
   - *Special Educational Need Review*

Specific lines of enquiry and wider questions to be addressed

6. To establish the quality of assessments and plans for the young people
   - prior to their involvement in the youth justice system
   - during the period when they were part of the youth justice system (drawing on audits and inspections already undertaken)

7. To consider whether individual assessments are taking sufficient account of the relationships that young people form in their neighbourhoods, schools and online (referred to as contextual safeguarding) to inform an understanding of risk to the young person, to his or her family and to the community, and to manage that risk.
8. To assess the effectiveness of multi-agency working arrangements for early help and prevention (in circumstances when the needs of the children did not meet statutory thresholds for social care or criminal justice intervention)
9. To establish whether the services received by the young people were timely and appropriate to the level and type of need identified (noting any wider findings on work with adolescents).
10. To evaluate how adequately professionals understood the impact of the children's social, ethnic, religious and linguistic background and any disability or special educational needs
11. To understand how professionals obtained and took account of children's wishes and feelings and involved their parents or carers
12. To understand more about the indicators of risk and vulnerability for children at risk of entering the youth justice system in Buckinghamshire.
13. To consider what more should be done by local partnerships and agencies to increase understanding of 'contextual safeguarding' (defined above) to inform and develop interventions to reduce serious youth violence in Buckinghamshire.

<u>Areas excluded or limited in scope</u>

The focus of the SCR activity and the published report will be on the areas that are considered to be the most important, as the work of the review progresses. The review panel may add additional items may be added to the terms of reference if new information emerges.

The SCR will not address directly the question of whether the trigger event could have been predicted and prevented. It will examine the histories of the young people involved to consider whether there were indications that an event such as this should have been anticipated.

The objective of the review is to point to potential improvements in services in order to make an event such as this less likely to happen in future. It will therefore not seek to make detailed judgements about all of the services provided to the three young people. The decision to conduct the SCR will not in any way restrict the rights of the children or their parents to seek further detailed enquiry which might be warranted within the complaint procedures of individual agencies.

Review method

1. The LSCB asked member agencies to compile chronologies of key events based on the written and electronic agency records.
2. The LSCB established a review panel to oversee the conduct of the review consisting of an independent chair, an independent lead reviewer and author and senior staff from participating agencies.
3. Agency representatives prepared brief management reviews of their involvement with the young people and their families
4. The lead reviewer obtained and considered a range of original documents and records
5. The lead reviewer and independent chair spoke to staff and managers from participating agencies in agency or separate professional groups .
6. The lead reviewer prepared draft reports and findings which were discussed with the review team
7. Further drafts of the report were prepared and circulated to panel members taking into account feedback from the agencies and professionals involved
8. An action planning session was held with senior managers to refine the recommendations arising from the review and begin the development of an action plan
9. The report was discussed by Buckinghamshire Safeguarding Children Partnership

Appendix II

References

Guidance

Working Together to Safeguard Children (2015), 4.1 and 4.6

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97861/gang-violence-summary.pdf

Other research and case reviews

Buckinghamshire Safeguarding Children Board (2016) http://www.bucks-lscb.org.uk/wp-content/uploads/Serious_Case_Reviews/CSE-Serious-Case-Review.pdf

The action plan is also published http://www.bucks-lscb.org.uk/wp-content/uploads/Serious_Case_Reviews/CSE-SCR-Action-Plan.pdf

Louise Casey Review, Department for Communities and Local Government (2016)

Centre for Social Justice (2018) It can be stopped: A proven blueprint to stop violence and tackle gang, Chapter 2.

Alex Chard (2015) Troubled Lives Tragic Consequences – a thematic review, Tower Hamlets Safeguarding Children Board;

David Finkelhor, (2008) Childhood Victimization-Violence, Crime and Abuse in the Lives of Young People, Oxford

C.Firmin et al (2016), Towards a contextual response to peer-on-peer abuser: Research and resources from MsUnderstood local site work 2013 -2016, International Centre Researching Child Sexual Exploitation, Violence and Trafficking ,

Charlie Spencer, Bridget Griffin & Maureen Floyd (February 2019) Vulnerable Adolescents Thematic Review, Croydon Safeguarding Children Board.

Violence Reduction Unit set up by the Mayor of London which has little focus on heightened police enforcement, https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence

Links to articles on the 'public health response' to serious youth violence

Government summary (2011)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97861/gang-violence-summary.pdf

Led by the Home Secretary (alongside the Secretary of State for Work and Pensions), the review looked into the scale of the problem of gang and youth violence, analysed its causes, and identified what can be done by government and other agencies to stop the violence and to turn around the lives of those involved.

The cross-government report, published on 1 November 2011, set out detailed plans to make this happen through:

- providing support to local areas to tackle the problem
- preventing young people becoming involved in violence in the first place, with a new emphasis on early intervention and prevention
- pathways out of violence and the gang culture for young people wanting to make a break with the past
- punishment and enforcement to suppress the violence of those refusing to exit violent lifestyles
- partnership-working to join up the way local areas respond to gang and other youth violence

Government report (2012) government report

- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216977/Violence-prevention.pdf

Information about the 'Glasgow approach'

https://www.theguardian.com/uk-news/2018/apr/06/treat-london-violence-as-public-health-crisis-say-scottish-experts

"*It is about stabilising the patient first of all. We're 12 years into this now, but we started off with policing – police on the ground, stop and search, mass enforcement*," he said. In its early years, the VRU lobbied successfully for increases in maximum sentences for carrying knives.

The style of policing was critical to success in London, said McCluskey. "*You need to put your best cops into the community and keep them there. People who are genuinely motivated, understand that they've got a latitude and discretion to engage and get to know people, because they're also gathering intelligence at the same time. If you just have loads of cops in cars rushing from call to call, that's not the same. You have to police by consent*."

The VRU adapted initiatives first used in the US city of Cincinnati, targeting known gang members and asking other members of their community, including bereaved mothers, to explain the ripple effects of violence. It offered young men a way out through education, training and mentoring – importantly, delivered by someone with similar experience of street violence. It has gone on to develop ground-breaking prevention programmes for schools and A&E departments, as well as bystander training for bar and nightclub staff.

Niven Rennie, the director of the Scottish violence reduction unit, said: "The SVRU started by treating violence as a disease which was infecting our communities. From teachers and social workers to doctors and dentists, police and government, we have all worked together to make Scotland safer.

https://www.theguardian.com/uk-news/2018/sep/19/sadiq-khan-london-mayor-launches-anti-violence-plan-based-on-glasgow-unit

To do this the VRU has had to think and work creatively looking around the world for inspiration.

In tackling gang crime the unit imported a successful anti-gang violence initiative spearheaded in Boston in the 1990s. The Community Initiative to Reduce Violence (CIRV) programme broke up Glasgow's long established gangs by offering members an alternative to the violent lives they were living . The VRU also successfully lobbied for increases in maximum sentences for carrying knives.

With studies suggesting police under-recorded violence by as much as 50 to 70% the VRU's researchers have carried out injury surveillance in A&E departments, helping to fully define the scale of the problem facing Scotland.

The unit has also supported the training of vets, dentists, hairdressers and firefighters to identify the signs of domestic abuse, giving professionals the skills to safely and effectively intervene.

The VRU team is a mixture of researchers, police officers , civilian staff and former offenders who have turned their lives around and are now seeking to help others do the same.

http://actiononviolence.org/about-us

British Medical Journal (May 2018)

https://www.bmj.com/content/361/bmj.k1578

London Violence Reduction Unit

https://www.bbc.co.uk/news/uk-england-london-45570905

https://www.london.gov.uk/city-hall-blog/mayor-sets-violence-reduction-unit-tackle-violent-crime

https://www.london.gov.uk/press-releases/mayoral/new-public-health-approach-to-tackling-violence

There is a view that the London VRU has failed to adopt key elements of the approach taken in Glasgow

Centre for Social Justice (2018) It can be stopped: A proven blueprint to stop violence and tackle gang, Chapter 2.

The evaluation of an initial pilot undertaken in three boroughs in 2015-16 explored the reasons for this in more detail

https://www.london.gov.uk/sites/default/files/gvi_london_evaluation270117.pdf