1 Introduction

1.1 This Child Safeguarding Practice Review (CSPR) is being conducted in response to a 15-year-old boy (referred to in the report as Child A) resident in Greenwich with his mother and siblings. Child A was known to a number of services in Greenwich and neighbouring boroughs. He had an Education Health and Care Plan (EHCP) due to having moderate learning difficulties. At the time of this death he was allocated within Children's Social Care (CSC) in Greenwich. This was due to concerns about his behaviour and risks associated with being gang affiliated. Child A was fatally stabbed in September 2019 in the London Borough of Newham after responding to a message on social media to meet some friends.

1.2 The case was notified to the Greenwich Safeguarding Children Partnership (GSCP) and a Rapid Review meeting took place a few days after his death. Members recommended a Local Child Safeguarding Practice Review should take place and notified the National Panel who agreed with the recommendation.

1.3 At the time of writing the review a police investigation had been conducted resulting in the conviction of two defendants for Child A's death. They were sentenced to lengthy prison sentences in July 2020.

2 Key principles underpinning the review

2.1 Child Practice Safeguarding Reviews (CPSR) are an important learning tool for any organisation and the review aims to be as inclusive as possible to ensure that all voices are heard. With that in mind the panel had some key principles in mind. These were:

- Recognition that safeguarding children is a complex area of work, particularly in the area of contextual safeguarding
- The importance of understanding not only who did what, but why they did what they did, the *underlying reasons* that led individuals and organisations to act as they did are equally important in obtaining a full understanding of what happened
- Understanding practice from the viewpoint of the individuals and organisations is vital to being able to form a view based on what was known and what was knowable at the time rather than using hindsight.
- Relevant research and case evidence informed the panel's thinking about best practice
- Practice is critiqued from the child's perspective
- The family should be involved in the review as much as possible

3 Terms of Reference

3.1 The Terms of Reference are attached at Appendix 1. Agencies involved with the family were asked to analyse their involvement via a brief written submission. The timeframe for the review is from the start of agencies' involvement as this gives context to the later events. Agencies first became aware of Child A in 2014 and the panel used this early history to build a picture of him and his family. The summary of professional involvement therefore starts there.

3.2 The Terms of Reference were agreed with the Panel overseeing the review. The broad areas that the Panel agreed were the most important to look at were:

- Agencies understanding and response to Child A's gang association?
- The capacity of each agency to respond swiftly and effectively to the increasing risks in safety planning for Child A and his family.
- How agencies assessed other aspects of Child A's lived experience e.g. home life, school, significant relationships, extended family, community etc.
- Agencies response to risks of gang involvement when looking at emergency moves for families?
- How were Child A's learning needs and associated vulnerabilities assessed in light of his gang affiliation?
- Agencies understanding of the threshold about high risk missing young people and their response?
- How the voice of the child was represented by agencies?
- The impact of Child A being a victim of modern slavery
- What good practice did agencies demonstrate?
- How effective was management supervision and oversight in this case?

4 Review Process

4.1 The report is based on the agencies' submissions (referenced above) and a practitioner event with key staff that had worked with the family and knew them well. The report author had access to other documents relating specifically to the family such as assessments and minutes of relevant meetings held with the family.

4.2 In order to provide context to the working practices at the time of the review, the author also read a number of contemporary policies and procedures. These are referenced in relevant sections.

5 Agencies Involved in the Review

- Children's Social Care, Greenwich
- Children's Social Care, Bromley
- Children's Social Care, Croydon
- Youth Offending Service, Greenwich
- Metropolitan Police Service (MPS)
- Housing Services Bromley

- Bromley Children's Project
- St. Giles Trust
- Greenwich Community Safety Partnership
- Harris Federation (Greenwich Academy)
- Lewisham and Greenwich NHS Trust
- StreetVibes Academy

6 Summary of professional Contact

Family Members	Age at the time of the death of Child A
Child A	15 years
Younger sibling	10 years
Older sibling	17 years
Mother	41 years
Father (not resident in the family home)	37 years

6.1 Agency's submissions as part of the review process have been co-ordinated into a combined chronology, summarised here. Further factual information is provided in subsequent sections to add context where relevant.

6.2 A specific feature of this family was the number of times they moved which inevitably hampered the timeliness and delivery of services to them. For ease of reference the table below details the family's moves between 2005 and 2019.

Date	Details of move
2005	Living in the London Borough Croydon
2014	Evicted from property in Croydon. The family's whereabouts not clear but believed to be in Bromley.
March 2016	Bromley accepted a duty to house the family and they were accommodated immediately in temporary accommodation
July 2018	The family moved to different temporary accommodation in Croydon
May 2019	The family moved again to temporary accommodation in Greenwich

Early background

6.3 Historically the family were known to services in Croydon from as early as 2005, mainly in relation to issues around housing, Mother's immigration status and Father's mental health difficulties.

6.4 Croydon CSC conducted two assessments – one in 2012 and one in 2014. In 2012, a referral was received from Father's Mental Health Services about issues of contact between Child A (aged 8 at the time) and his father. There were concerns about his father having a diagnosis of schizophrenia, being violent and having perpetrated domestic abuse against Child A's mother. In 2014, a further assessment was completed when the children aged 5, 10 and 12 were left 'home alone' whilst mother went to work. Both assessments were completed without any further action.

6.5 The family are believed to have moved to Bromley in 2014 and were assisted by Bromley's No Recourse to Public Funds (NRPF) Team. Between 2015 and 2016 Bromley Multi Agency Safeguarding Hub (MASH) received two referrals. In 2015 a member of the public reported that Child A was alone outside a fast food outlet at midnight. The police gave Mother strong words of advice and Bromley MASH wrote to Mother informing her of the referral but took no action.

6.6 At the end of 2016 a further police notification was received by Bromley MASH reporting that child A had been detained after being found in a flat in with "a small blade about 2-3 cm hidden inside a small plastic coating". Child A was upset and crying uncontrollably. There were concerns that Child A was being groomed into dealing drugs for older juveniles (two 17 year olds were also at the scene). As well as the blade, Child A was also observed to have condoms and lubricant in his possession. When Mother was contacted, she would not attend the police station to be an appropriate adult for child A and she was unable to collect him, reportedly stating that it "would teach him a lesson". Bromley CSC conducted an assessment with the outcome of support from Early Help Services that the family received throughout 2017.

6.7 In September 2017, Child A moved schools to be closer to his home and towards the end of that year the Early Help work came to an end. The work undertaken was said to have been successful as Mother seemed more on top of running a busy household, she was moving on from the children's father and had started to run a successful business. Child A had begun to make better choices about his friendship group and although he had some teething problems in his new school, he was beginning to settle.

6.8 The role of the Lead Professional for the family passed to the younger sibling's school and the Team around the Child (TAC) meetings continued through to the end of 2018. The younger sibling's school being the lead for these inevitably meant that they focused more on that child's needs, rather than those of Child A or his older sibling.

6.9 In the summer of 2018 the school referred Child A to Greenwich Adolescent Risk, Safeguarding and Prevention Panel (GRASP) as they had growing concerns about his affiliations. Child A and his family were not living in Greenwich at this

time but the referral was made in relation to issues at Child A's school that was in Greenwich. The referral mainly targeted other students but Child A was included because of his association with them. The panel gave the school details of organisations who could help by talking to groups of students about the dangers of gangs. Child A was not discussed as an individual at this stage as he was deemed to be low risk.

6.10 At around the same time the family moved to Croydon. This proved to be a strain for Child A in getting to school on time. School accommodated him by allowing a later start, but in the September term of 2018 he was late on several occasions. Mother requested a move back to a Bromley school to ease this. This was delayed but then agreed by the Special Educational Needs service (SEN) in Croydon. The process was initiated but never came into fruition.

6.11 In late 2018 Child A was attacked by a group of boys near to his school. A member of staff from school noted the incident and reported it to the school police officer who went to support. The police officer accompanied Child A by ambulance to hospital and remained there until Mother arrived. At the hospital Child A said 5 young people had assaulted him and that he had been punched in the head. He denied that any weapons were involved.

6.12 Staff in the ED contacted Croydon CSC Emergency Duty Team (EDT) for background checks but Child A left hospital before these came through. The following day the information sharing form (sent by staff in the Emergency Department) was triaged by Croydon CSC but did not result in any assessment or on going work. The police took action by putting in place 'reassurance patrols' around the area but neither Child A or his mother responded to their attempts to investigate. No suspects were identified and it resulted in a police outcome of 'No further action'.

6.13 Mother decided that Child A could not return to that school or any school in the Greenwich area due to her feeling that it was not safe for him. Child A's behaviour deteriorated following his assault and Mother continued to express her concern to the school. It was discussed that she would look for other schools in Bromley. An alternative on line provision was arranged to support his schooling in the interim.

Events in 2019

6.14 At the beginning of 2019, Croydon Gangs Prevention Team attempted to contact the family to discuss working with Child A. The family did not engage and the referral was closed down in March 2019 after three failed attempts. Child A had no school place at this time, despite his school making efforts to secure a place for him. His annual review for his EHCP took place and Mother expressed preferences for three schools closer to their home – all three schools declined to accept him.

6.15 The family moved to Greenwich at the beginning of May – this was not Mother's preference but more due to the state of repair of their current property. Child A's school facilitated an introduction between Croydon Education and Greenwich Education to try and expedite a school place for him. They gave a detailed overview of Child A's position with school and stressed the importance of a school place as a matter of urgency. Child A had been out of school for five months at this point. To this end in June he was enrolled in an Alternative Provision (AP) in Greenwich where he remained on role until the end of the summer term in 2019.

6.16 At the beginning of July police officers were called to the family home due to an argument between Child A and Mother, which escalated to 'pushing and shoving' between the pair. Child A was described as "rude and disrespectful" and this culminated in the police removing him from the house to calm him down. This incident was reported to Greenwich CSC. Before they could respond to the referral it was superseded by another incident that resulted in the AP making a further referral. Child A disclosed to them that his mother would not let him in the house when he returned in the early hours of the morning. He had therefore spent the night travelling around the local area on buses and walking around.

6.17 Mother had been finding Child A's behaviour difficult to deal with. He had started to come home late and she had refused to let him in at 1am. Mother had tried a number of strategies - she had replaced his smart phone with an ordinary phone and had tried to keep him at home. She suspected gangs and drugs but had no clear evidence. Mother was also aware of an incident with his 'friends' whereby Child A said he went to stay at a house in East London for a week. Some boys had accused him of 'trying it on' with one of their sisters and he had been threatened with knives because of it. This had prevented him going out for a while but he had started again. He had also been chased by the same group of boys near his school and had gone into the school building to escape them. Greenwich MASH allocated the family for assessment. **NB** It was conflict with this group that ultimately led to his stabbing two months later.

6.18 Throughout the assessment period in July and August, concerns for Child A's welfare escalated. He was frequently missing and increasingly aggressive. At the beginning of July he received a four day fixed exclusion from the AP following a violent incident in which he assaulted his mother and caused damage to property in their reception area. The exclusion took him to the end of his scheduled placement at the AP as it was so close to the end of term. School expressed concerns about his safety in the vicinity of his home. In 'Return Home Interviews' (RHI) Child A was unforthcoming with information about where he was when he was missing and was annoyed that his mother reported him to the police. Mother began to notice new clothes and possessions that she had not purchased.

6.19 In line with current practice Child A was presented at GRASP as a vulnerable young person and was discussed there a number of times. He was linked with

older associates known to be involved in gangs and criminal activity, notably drugs. Greenwich CSC continued their assessment. St. Giles[1] became involved with the family and the two agencies worked together undertaking joint risk and safety planning. Strategy meetings were held to try and make a safety plan for Child A and a referral to the National Referral Mechanism (NRM) was made.

6.20 At the end of July workers from St. Giles made a visit to the family home. Child A was guarded and would not discuss his activities or affiliations. He received a call on a 'burner' phone and became increasingly anxious and in a hurry to leave the house. He presented as aggressive, anxious and determined to leave – eventually fleeing via the back wall. The following morning, the worker saw Mother and asked if he returned last night and she said that he had not. She had not yet reported him missing.

6.21 Agencies grew increasingly concerned for his safety – A Child Abduction Warning Notice (CAWN) was being considered in relation to two older associates. The possibility of an urgent housing move was discussed with Bromley Housing and they confirmed that if the family were deemed to be high risk then a move could be facilitated. Visits continued to the family and Child A was at times less guarded, speaking of his knowledge of selling drugs and admitted he had sold cannabis. He spoke of the debt drug dealers may accrue if drugs were seized from them. At the same time he expressed an interest in engaging with services and getting involved in activities, such as Go karting. Due to his learning needs he struggled to gauge the risks associated with his behaviour and presented as naive.

6.22 In mid August police officers saw Child A in the company of a known drug supplier. Police believed he was being forced to hold drugs, and when they reassured him that they were concerned for his welfare, he spat out 6 bags of class A drugs. He was returned to his mother and she was advised he would need to return for a caution+3[2] interview. In his RHI he stated he might be in debt due to the loss of drugs.

6.23 At the beginning of September 2019, the events that led to this review unfolded and two of his associates murdered Child A in an East London borough.

7 Findings

Agencies understanding and response to Child A's gang association

[1] St. Giles is a national organisation whose work involves direct, intensive help for young people and those around them. They work with those at risk, through prevention and awareness raising and offer support to parents and professionals working with young people.

[2] Voluntary attendance at a police station with 3 stipulations of; not under arrest, free to leave at any time and entitled to legal advice

7.1 There were very early indications that Child A was involved in criminal exploitation as whilst the family were living in Bromley an assessment was completed in relation to Child A being detained by the police after being found in a flat with a blade, condoms and lubricant. Child A was 12 at this time and was said to be crying uncontrollably when the police detained him. He was linked to youths much older than him and there were suspicions that he was being groomed to criminal exploitation by selling drugs. There was a swift response and the correct threshold was applied, with the decision that an assessment needed to be conducted with the family. The assessment appropriately included direct work with Child A and some engagement with the rest of his family. There was little challenge to his mother about her initial response when she would not collect him from the police station.

7.2 Consultations were had with other agencies and a meeting held to try and understand the risks but this did not include any kind of mapping exercise to identify peer relationships for Child A. More importantly, it did not examine the impact of his young age, his learning needs and his increased vulnerability due to these factors. Association with other (often older) young people is believed to be a significant factor that increases the chance of involvement in criminal exploitation. Gangs also exploit specific vulnerabilities such as learning needs and these were not sufficiently taken into account.

7.3 Bromley CSC assessed Mother had engaged positively with the assessment and had shown commitment to ensure child A's safety in the community. At the conclusion of the assessment the school had agreed to identify a mentor to undertake some 'Keep Safe' work with child A and the family were allocated Early Help (EH) services. The family received EH services in Bromley throughout 2017, which continued through to the end of 2018 when the family moved. An EH plan was still in place when Child A was assaulted at the end of that year.

7.4 This early episode in Child A's life is vital to understanding Child A's vulnerabilities to exploitation and although work continued with the family, this was not focused on Child A and the risks of exploitation. Having completed the assessment, the worker felt that as she got to know the family this was less of an issue. It appeared that Child A had started to make better choices in his friendship group and his older sibling's behaviour seemed to become the focus of the worker's attention. Some individual work was completed with Child A but there was no Team around the Child (TAC) until the work had been in progress for six months. Given that Child A was displaying fear and possibly trauma at this stage, a stronger multi agency approach would have been beneficial. This may have elicited a more targeted response to the risk of exploitation in the plan.

7.5 When Child A was assaulted near to school at the end of 2018, this was not responded to robustly by agencies. The hospital 'information sharing form' was not a formal referral and it lacked detail regarding the incident. Croydon CSC did

not take any action. The rationale for the decision was not recorded but workers did not show sufficient curiosity regarding the incident or assess risks in relation to his current circumstances. This was a serious attack and as such information gathering and multi agency enquiries should have taken place, especially in view of the fact that the Police were involved. There appeared to be little or no communication between CSC and the police about this incident. It is likely that Croydon CSC did not receive this as a formal referral as the hospital staff had sent it for information sharing purposes rather than flagging the safeguarding issue.

7.6 A formal referral should have been made and multi-agency enquiries, including contact with the family would have clarified the circumstances of the assault. This would have led to more knowledge about the concerns about links to gangs and Child A's vulnerabilities associated with this. Ultimately it would have allowed them to assess the risk to Child A from others in his vicinity. In effect, there was no multi agency response to this incident.

7.7 Croydon CSC were unaware of previous involvement and the concerns about exploitation from Bromley CSC or about his learning needs. They would also have been unaware that at the time of the incident the family were receiving early intervention services via Bromley. This is likely to have also led to earlier link up with the Gangs Prevention Team. Although the Gangs Prevention Team attempted to make contact with the family, after 3 unsuccessful attempts in early 2019 they closed the case without making contact. There is no evidence that this team liaised with other agencies such as school to try and work with the family in a different way and there was a missed opportunity to tap into the work already taking place with the family.

7.8 In the summer of 2019, more concerns were raised in relation to Child A's association with gangs and more is said about the pace in which they escalated in the next section. The concerns that built over July and August of 2019 were appropriately referred to CSC and allocated for assessment under s17 of the Children Act 1989. On the information known at the time, this was a good response. The allocated social worker responded to tasks swiftly, liaised with the family and professionals and additional resources such as St. Giles were put in place. There was good joint work and liaison between workers from St. Giles and the social worker and they carried out at least one joint visit. Child A was also referred to GRASP and was discussed there a number of times.

Agencies response to the increasing risks and safety planning for Child A and his family

7.9 Professionals became aware of increased and escalating risks in July and August of 2019. As stated in the previous section many actions were put in place to try and address the risks to try and reduce them. Child A was missing on several occasions and for lengthy periods. He was often found in the company of other

(older) young people affiliated with gangs and drug dealing. Good practice would dictate that resources should not wait to start until the conclusion of an assessment and in this case practitioners and managers demonstrated that help was available to Child A immediately. It is however necessary to look at, (given Child A's various needs and vulnerabilities) whether the resources allocated and responses made at that time were sufficient to safeguard him.

7.10 There was good communication between agencies at this time. Practitioners were working towards reducing the risks to him and they had a good sense of the fact that a move out of the area would be beneficial. Child A's mother was also keen to move out of Greenwich back to Bromley. To that end the SW had some liaison with housing in Bromley to try and facilitate a move. This was not however successful in this timeframe and the family's housing move was not treated as an emergency. This may have been due to Bromley Housing not attending the multi agency strategy meetings, so the gravity of the situation was not fully evident to them. As part of their written submission for this review, Bromley Housing have recognised that they need to attend meetings to be informed of the situation and advise on the course of action from a housing perspective. Similarly, it may have been prudent for CSC to escalate their lack of effective collaboration in the safeguarding plan.

7.11 Some agencies suggested that Child A should be accommodated by Greenwich and removed from the area. What we know from research however is that despite the benefit of physical separation from a contextual situation, this can also introduce other risk factors by isolating young people from their family, thereby making them more exposed to the influence of others. This would likely have been the case for Child A and given his additional vulnerabilities, this action would have been a last resort. It seems improbable that the family, including Child A, would have agreed to this at the time although Mother shared as part of this review that she regrets not moving out of London. A more likely scenario would have been a move to (or at least some respite with) other family members, especially as risks were escalating in August of 2019. The objectives and the plans coming out of the multi agency meetings was to try to build resilience within his immediate family and support Mother to better manage the situation. It is not clear how other agencies understood this rationale but it was not formally challenged, indicating that it was at least accepted.

7.12 Two strategy meetings were held - CSC, the police, Child A's school (he was not attending but remained on role) and staff from St Giles attended these. These were not strategy meetings conducted to determine whether s47 enquiries should be conducted. Whilst it was good practice to hold multi agency meetings, there is a question about the increasing risks to Child A in the latter part of July into August and whether these should have led to s47 enquiries. The school expressed a view that an Initial Child Protection Conference (ICPC) should be held. The reason this was not pursued was because Mother was seen to be co-operating and receptive

to the help being given.

7.13 In mid August during a home visit, Child A admitted selling cannabis. Two days later he was arrested by the police with class A drugs in his mouth which he was persuaded to spit out. This was the strongest indication that Child A was under obligation to sell drugs. The police officers that found him and returned him to his home were worried that he was being coerced and were concerned for his welfare. He mentioned later that he thought he might now have a 'lien' (drug bondage debt), as the drugs were lost to the police.

7.14 There was no multi agency safeguarding response to this incident despite it being very compelling evidence that he was at risk from, and being coerced by, others. A multi agency strategy meeting to consider s47 enquiries would have been one approach in this instance to consider Child A's immediate safety (especially since a referral the NRM had been made). This would have been an opportunity to escalate the concerns, consider the threat he was under from others (especially now he believed he was in debt) and reflect on the capacity of the community-based (including his family) resources to tackle these. This would have been in line with the expectations laid down in Greenwich Partnership's Threshold document[3].

7.15 In cases relating to contextual risk there is always a debate to be had about whether the more traditional child protection processes are effective for risk outside of the home. The multi agency nature of the intervention is, however key. This work did start to take shape in August 2019. For example Mother provided some details of Child A's more mature associates who could influence him to return home and the police were considering a CAWN (though these did not come into fruition) in relation to some of the young people Child A had been found with. The social worker had also begun to explore family members who could be protective towards him. Sadly, there was little time for these to be developed.

7.16 The panel noted that with children in these circumstances, there is no 'one size fits all' approach and that decisions are made on an individual basis. In keeping with this, the National Child Practice Safeguarding Review Panel[4] made a recommendation in 2020 for the response to children at risk of contextual safeguarding (i.e. the merits or demerits of formal child protection responses vs. less formal approaches) in Working Together 2018 to be reviewed. [5] In the same review, the National Panel also refer to 'critical moments' in a young person's life,

[3] https://www.greenwichsafeguardingchildren.org.uk/wp-content/uploads/2019/10/GSCP-Thresholds-for-website.pdf

[4] The National Child Practice Safeguarding Review Panel is a panel of highly experienced and professional experts who form an independent panel which commission's reviews of serious child safeguarding cases.

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf p36

generally thought to include (amongst others) exclusion from school, physical injury and being arrested. All three of these things happened to Child A in the time period covered by this review and it is important that agencies recognise these and respond accordingly.

7.17 The referral to GRASP meant that actions were put in place. For example St Giles were allocated to work alongside the social worker. Although GRASP had good knowledge of the other young people (also of concern) Child A was associating with, there was no official mapping. Disruption techniques were discussed such as issuing CAWNs to older associates but these did not materialise in the timeframe.

7.18 As part of the plan Greenwich CSC made a referral to the National Referral Mechanism (NRM). They received a swift response a few days later confirming that Child A met the criteria for being a victim of modern slavery. This had no impact on the services provided by agencies. The review has underlined agencies' lack of understanding and knowledge about this process and the limitations in its application to be of benefit when dealing with families in this kind of crisis. A recommendation is made to try and address this gap in knowledge.

Agencies understanding of the threshold about high risk missing young people and their response?

7.19 Mother appeared to have some resistance to reporting Child A missing when he failed to return home. On occasions he was missing for several days and when he returned he disputed that he was missing and was not willing to share information about where he had been. On occasions when she did report him missing, she felt that she was not always able to convey the seriousness of the situation to the police and that he was not treated as high risk.

7.20 The review has highlighted that there are some discrepancies in the way that risk is perceived when a young person is missing, particularly when this is a frequent occurrence. The police assess high risk as immediate risk to life whereas other agencies would be concerned at a much lower threshold than this. High risk missing young people for the local authority may depend on a variety of factors as vulnerabilities and risk of harm contribute to why a young person may be considered high risk.

7.21 That said in this case there were close working relationships between agencies including both the local missing Police and Central Missing Co-ordinator. The Central missing co-ordinator attended strategy meetings and there was a partnership approach to the Police trigger plan for Child A.

How were Child A's learning needs and associated vulnerabilities assessed in light of his gang affiliation?

7.22 The impact of his learning needs was well documented by agencies. He had an EHCP (finalised in 2018) that detailed both his communication issues and his specific difficulties with reading and writing. Practitioners were also aware of his need to please others, for him to fit in with his peers and belong to a group. This is a familiar scenario experienced by the majority of teenagers as they go through adolescence. For Child A this made him particularly vulnerable and more susceptible to exploitation as he did not recognise risky situations. Early on in the timeline of the review, Bromley CSC acknowledged that '*There was missed opportunity to consider further how Child's A learning needs might impact on likelihood of further exploitation'* and this work was not carried out with him in the subsequent Early Help service provided by Bromley through 2017 and 2018.

7.23 Although criminal exploitation was the main reason for the referral to Early Help services in Bromley, the focus of this for Child A slipped off the agenda very soon. At the end of 2018 (when the family had moved to Croydon) there was a lost opportunity to work with Child A and his family in regards to his possible gang affiliation. Coupled with the fact that he was out of school at this time for at least six months, this left him vulnerable in the community and inevitably would have meant that he was even further behind his peers academically. In turn this led to difficulties in him being integrated back into a mainstream setting. Although on line alternatives were suggested and tried, Child A did not engage with them. Given his level of learning need he was unlikely to have had the motivation or capability to access this kind of education.

7.24 The assessment and trigger plans completed by agencies in Greenwich in 2019 contain information about his learning needs and state clearly that this factor increases his vulnerability. This demonstrates good identification of the increased risk but it is difficult to see specific interventions aimed at his needs arising from his learning disability manifest themselves in agency's plans. There was perhaps a lack of creativity in proposed recommendations to engage Child A, given the limited impact discussions and conversations in terms of direct work had already had. A referral to Charlton Athletic Community Trust (CACT) had been made but had not yet started.

7.25 The assessment also rightly had started to identify family members who could help and act as protective factors for Child A, particularly his paternal aunt with whom he was said to be very close. There may have been an opportunity to instigate a family solution earlier in the piece e.g. there was a suggestion that his aunt could offer some respite and a Family Group Conference (FGC) was a recommendation from the assessment. Sadly these things were not in place at the time of his death as there was too little time.

How agencies assessed other aspects of Child A's lived experience and captured his voice e.g. home life, school, significant relationships, extended family and community

7.26 From information gathered during this process from those who knew and worked with Child A, it is clear that he was an extremely likeable and engaging young person. He was interested in clothes and had aspirations to work in the fashion industry and to have his own label. Although he could be challenging, he was brought up in a loving family and his mother did her utmost to try and address the difficulties he encountered. Child A was however extremely vulnerable and his learning needs made him susceptible to the negative influence of others. The many moves and the stress associated with these undoubtedly took their toll on the family and Child A would have been affected by these.

7.27 Various attempts were made by practitioners to engage Child A in direct work and at times he was happy to be involved in what was being offered. At other times however, he was withdrawn and could be less cordial. The social worker and workers from St. Giles took time to spend with him to try and elicit his wishes and feelings but struggled to engage him fully. He became harder to engage in the summer of 2019, no doubt by this time he was deeply involved in the drug world and the short term rewards in terms of money and possessions were difficult for him to resist. He was guarded about his friends and was reluctant to say where he was when he was missing. As stated, workers were well aware of his learning needs and he was encouraged to be open and honest in an attempt to reduce the risks he faced when he was outside the influence of his family. To this end they did as much as they could to ensure that his voice was heard.

7.28 Much has been covered in other sections but the assessment of him and his family undertaken in Greenwich elicited as much information as possible. It took account of his thoughts, aspirations and struggles and those that he was not able to articulate are included in the assessment by describing his body language to indicate his discomfort at times. It would perhaps have benefited from more analysis about the longevity of this problem, drawing on the previous incidents in 2016 and 2018. This would have demonstrated in the assessment to Mother and Child A how much a way of life this was for him and how entrenched it had become.

7.29 The assessments undertaken do speak about Child A and his family and to a certain extent, his community. They do not however analyse the impact of structural inequality and racism he and his family would have encountered up to this point in their lives. Research tells us that black boys in particular, make up the overwhelming majority of young people who are exploited through being recruited to sell drugs. Two very recent studies confirm this notion the studies linked the fact that black children and their families are far more likely than their white counterparts to be affected by poverty, their young people are more likely to be

excluded from school and are more likely to be vulnerable to having a negative view of themselves through the effects of racism[6],[7]. When developing services to help young people affected by criminal exploitation it is important to note that the vast majority of these are boys and young men. The challenge of offering services to this group is one being faced by a number of agencies.

7.30 Work to try and establish a safe network in Child A's own community was due to take place but unfortunately never materialised due to the short time between the completion of the assessment and his death. Similarly, more work was due to take place about his extended family through a Family Group Conference.

The effectiveness of communication between boroughs

7.31 Within the review period there were three boroughs (Bromley, Croydon and Greenwich) involved with the family due to their many moves. There were limited opportunities for cross borough communication as much of the time services that were offered were not in place at the time of the moves. There was good cross borough communication at the time of the Greenwich CSC assessment and practitioners were aware of previous involvements.

7.32 Where communication fell short of expectations was in relation to his schooling in the first half of 2019. After the incident at the end of 2018, Child A did not return to school in Greenwich. As he was living in Croydon, his school liaised extensively with Education Services in Croydon to try and expedite an appropriate school place for him. Although an on line provision was found and tried in the meantime, the liaison between the two boroughs was protracted. From a child centred perspective this effectively meant that Child A was out of school until he was enrolled in an AP in June 2019. Given his vulnerabilities and how he benefitted from school as a protective factor, the delay was unacceptable. The review has not been successful in trying to uncover why the allocation of a school place in Croydon was so delayed. It would appear that records were not sufficiently kept and as a result a recommendation is made for Croydon to review their practice and record keeping in relation to requests for school placements from other boroughs.

7.33 When the family moved again in May 2019 (this time to Greenwich) his school went to great lengths to introduce the two education departments so that the progress that had been made was maintained and the momentum gained was not lost. In this time it was noted that three schools had been approached but declined to accept him. Again the reasons for this are not clear but it is another indication that his needs as a vulnerable child were not prioritised.

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf

[7] https://www.london.gov.uk/sites/default/files/rescue_and_response_county_lines_project_strategic_assessment_2019.pdf

7.34 During the course of this review it has become apparent that Bromley Housing were not aware that Child A was no longer attending school in Greenwich. The temporary accommodation that was sought was to enable Child A's easier access to his school. The school however had concerns about him being in the Greenwich area (either schooling or living) due to the incident where he was attacked in late 2018. School had expressed their concern to SEND services in Greenwich but by this time the move had taken place. This demonstrates the importance of Housing's communication with agencies, when dealing with vulnerable families.

8 Family Contribution

Mother's views on Child A's education

8.1 Mother stated that she did not believe Child A's school understood him and his vulnerabilities. She spoke about his additional needs and how he was a visual learner and not always able to meet his potential. She stated that following his exclusion from school there was no plan of support for him, which led to long periods out of education. Mother did not feel that it was safe for Child A to travel the distance to school after he had been attacked. She had wanted to be able to try and keep him safe by taking him to and from school but this was not possible. It was after this that he stopped attending.

8.2 Although the school directed Child A to some home learning online, he was not confident in learning independently, so she felt this was not suitable for someone with his additional needs. Mother tried to help him with this learning, but she also found it challenging. She would have preferred a more collaborative approach in trying to meet Child A's individual needs. Child A went from a mainstream school with a high level of support to learning from home independently and this was not suitable. He was not motivated to learn online especially when he struggled to understand the work, and this is why he needed a programme tailored to his individual needs.

8.3 Mother said that Child A was out of school for a long period of time and moving to different boroughs exacerbated this. She stated when Child A resided in Croydon they attended a meeting as he was out of education. Croydon informed them that they would arrange for private tutoring at the home which did not happen. Communication between Education and Housing was not good.

8.4 Mother wanted to inform the review that school did explore other schools with her and Child A. At the time she was interested in him attending other schools especially in the Bromley area, however, they did not feel they could meet his needs. Mother thought Child A felt rejected by this, further impacting upon his confidence and self-worth. Child A's lack of school place for so long should have been escalated to someone senior in Croydon and this may have moved things

along. Mother feels that they were ‘sidelined’, and this was unacceptable as Child A was coming up to his GCSE year and she wanted him to do well.

8.5 Mother contested that the right place for her son was a ‘unit’. She felt Child A was easily swayed and vulnerable and therefore the AP did not meet his needs. Mother would have much preferred that Child A was placed back into a mainstream school as she was not keen on what she saw as negative influences. She believes that Child A met some associates at the AP who were not a good role models and led him into being exploited. For that reason, she would have fought hard for him not to attend a ‘unit’ after the summer holidays. She would have much preferred for him to be placed in a mainstream school and to repeat year 9 if it was felt that was necessary for him academically.

8.6 She did however appreciate that the staff at the AP that Child A attended in the summer of 2019 were kind and tried to do their best for him. She had not wanted him to attend this unit for the reasons already stated but she decided to send him as there was no other option at that point. Being out of school altogether was worse for him.

8.7 Mother questioned what schools do to keep children safe when they leave the school premises and whether more could be done. She is aware of schools that offer interventions such as going to find vulnerable pupils in particular ‘hot spots’ and diverting them back home again. She also noted that fast food outlets were attractive to young people but felt that sometimes these could be risky places for them to congregate all together and there should be a system in place to discourage this.

Mother’s views on Housing Services

8.8 Mother discussed the risk to the family and questioned if alternative accommodation could have been found to ensure their safety. She further added she remembered a discussion with the social worker around leaving Greenwich. She said that if she could go back in time, she would have left London and that she regrets that she did not do this.

8.9 Mother further felt that Housing was a major issue for them and they did not listen or take note of their individual needs. She felt as though she was left to deal with her housing issues alone and she was often not able to contact the right people. She found this tiring, difficult and challenging. The lack of coordinated services for the family which included Housing was frustrating for her.

Police/Children’s Services

8.10 Mother said that at the trial she was informed of the assailants' previous criminal backgrounds which included other aggressive crimes. One of the boys was on tag at the time and was not allowed into Greenwich. Mother questioned was this enough and did CS do enough for those boys when they were growing up. She questioned if the Police and Youth Offending should have monitored Child A's attacker more closely given the risks he posed. She felt that he had too much freedom to manipulate the system which ultimately led him to be in a position to commit other crimes.

8.11 Mother spoke positively about the help she had received in Bromley in 2017 and was glad that this work had passed to the younger child's primary school. She said that the whole family had been helped by this process and this had been a coordinated approach which had benefitted them all. The social worker in Greenwich along with the workers from St Giles were also making good progress in getting services to help them and she appreciated this.

9 Lessons Identified

9.1 The overarching multi agency response to contextual safeguarding in Greenwich is generally well developed as noted in the Joint Targeted Area Inspection (JTAI) in 2018.[8] There are a number of services to draw on both at a strategic and local level. The following paragraphs detail the main learning from this case which the panel and practitioners involved also thought applied to other children, young people and their families they worked with.

9.2 This review mirrors many other national and local reviews, studies and SCRs that show the disproportionality of black boys of African Caribbean heritage who are more likely to be susceptible to risks of criminal exploitation. National research data confirms these local findings of over representation, which is also replicated in exclusions from school, increased likelihood of being victims of serious crime and being over represented in the criminal justice system. This structural inequality in terms of gender and ethnicity needs to be addressed.

9.3 Housing services were not engaged in multi agency discussions about how agencies were seeking to reduce the risks to this child. As an agency therefore, they were unable to contribute to the plan. This is in part due to Bromley being responsible for placing a family in another borough (or multiple boroughs) as in this case. Discussions at GRASP did not include the family's location (which had been raised as problematic) and whether a move could be expedited quickly. Colleagues from Greenwich Housing were not invited to try and explore this and support GRASP in helping to convey the seriousness of the situation to their

[8] https://www.justiceinspectorates.gov.uk/hmiprobation/inspections/joint-targeted-area-inspection-of-the-multi-agency-response-to-exploitation-gangs-and-missing-children-in-greenwich/

counterparts in Bromley. It should be acknowledged that although these are considerations for learning and future cases, the actual risk in this case was due to a historical incident that no one could have practically foreseen.

9.4 It is a familiar theme from other reviews involving children and their families that frequent moves between boroughs hampers and delays services to them. The review has also noted difficulties for Child A and his family in the quality of the housing provided, their lack of choice in where they were housed and the disruption caused by frequent moves. Mother was very wary of the locations in which she was housed but ultimately had little control over it. As a parent she could exert little influence over this despite the fact that it increased the risks to her and her family.

9.5 Connected to the above, Child A's schooling was problematic throughout much of this period some of which was exacerbated by the many house moves the family experienced. Being out of school for any reason is a well rehearsed area of vulnerability for those at risk of criminal exploitation. Education services in Croydon failed to recognise the vulnerable position Child A found himself in and did not deal with the damage the delay was causing. In addition, some of his vulnerabilities were increased by the distance he travelled to school (due to the many moves) as well as the substantial periods of time he spent without a school place. His vulnerabilities to criminal exploitation were not taken into account by Croydon education services and he remained exposed to those who would seek to exploit him.

9.6 Children and young people are much more likely to have a positive outcome if their difficulties are recognised at an early stage and they receive help. The trauma and fear caused by criminal exploitation needs to tackled at the outset of the involvement of agencies. The importance of early interventions that are understood and owned by all agencies are crucial. Early signs of criminal exploitation were not fully explored with Child A in 2018 and the focus of the intervention aimed at addressing this became diluted with other family issues.

9.7 The initial response to the concerns about Child A were responded to swiftly and appropriately by Greenwich CSC and members of the Partnership. What is more challenging is the subsequent escalation of events and how these were responded to from a multi agency perspective. GSCP's threshold document would suggest that the incident in August 2019 whereby Child A was holding drugs in his mouth was an incident of 'significant harm' and therefore should have been responded to by way of a multi agency strategy meeting to consider his immediate safety. The use of the statutory framework in these circumstances needs to be clear for practitioners and managers.

9.8 The review has highlighted a national issue regarding the NRM which although frequently used in Greenwich appeared to have no impact on this case. There

was confusion and inconsistency about the purpose of such a referral and the impact of what should then be done in terms of good practice. This is a worrying scenario considering the information that came back from them was that they considered that Child A was a victim of modern day slavery. At the time of the incident, Greenwich had no practice guidance in relation to this. This has now been rectified but it is in its infancy and the impact will need to be measured.

10 Recommendations

A note about these recommendations

The following recommendations should be read in conjunction with individual agency action plans. Although some of them are specific to certain agencies as learning from this review, it should be noted that the learning (and therefore these recommendations) are relevant across the Partnership.

10.1 Bromley Safeguarding Children Partnership to ensure that practitioners in their Early Help services are knowledgeable and are equipped to work with children and families affected by criminal exploitation.

10.2 London Borough of Croydon SEND to conduct its own review as to why Child A's school placement was delayed. Croydon Safeguarding Children Partnership to oversee the review and assure itself that proper systems and processes are in place when parents request education of their child in the borough.

10.3 Where issues of contextual safeguarding is an issue Greenwich, Bromley and Croydon Safeguarding Children Partnerships should ensure that their staff are equipped to identify, assess and make robust plans for those children whose learning disability increases their susceptibility to criminal exploitation.

10.4 Greenwich Safeguarding Children Partnership should contribute to the national debate about arrangements for the use of statutory frameworks (i.e. Child Protection Enquiries) in cases where contextual safeguarding is an issue. The result of these discussions should inform the Partnership's approach to enhance the consistency and quality of practice in this area.

10.5 Greenwich, Bromley and Croydon Safeguarding Children Partnerships should ensure that their guidance, best practice and training around multi agency safeguarding discussion and meetings involves Housing services.

10.6 In line with the above, Housing Services in all three boroughs should ensure that they respond to invitations to multi agency meetings and that their policies and procedures reflect their responsibilities to attend these.

10.7 There is an opportunity for GRASP to enhance their role in looking at the context

of a family's location e.g. GRASP meetings should always consider the location of any family and consider what action to take with Housing colleagues if a move is deemed necessary? .

10.8 As a result of learning from this review and similar multi agency reviews where a family's housing situation has been noted to be challenging, Greenwich Safeguarding Children Partnership should raise this with the National Panel. This is with particular regard to Housing's role in statutory child protection processes and the effectiveness of notifications to boroughs when families move.

10.9 Greenwich, Bromley and Croydon Safeguarding Children Partnerships should consider their response to children and young people who are deemed victims of modern slavery via the National Referral Mechanism. They should provide guidance to ensure that all staff are aware of this mechanism and ensure that there is a process to assess risk adequately.

10.10 Greenwich Safeguarding Children Partnership to seek assurance that staff employed in Emergency Departments of Lewisham and Greenwich NHS Trust can identify and are equipped to deal with, issues of contextual safeguarding.

10.11 Greenwich, Bromley and Croydon Children Partnerships design a programme of learning to ensure practitioners are skilled in undertaking assessments and carrying out work with children and families from black and ethnic minority communities. This is specifically in relation to practitioners competently assessing the impact of the additional risks black children (particularly black boys) face in the context of contextual safeguarding.

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