Serious Case Review

Child I

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Contents

1. Introduction

1.1 This Serious Case Review (SCR) was commissioned following the death of Child I from natural causes whilst in custody at a Young Offender Institution (YOI). At the time of his death, Child I was 16 years old and on remand for murder. He had a known history of carrying weapons and had been arrested several times in possession of Class A drugs. Over what was a relatively short period of time, Child I's offending escalated significantly. It was entrenched, serious and harmful.

1.2 Exactly how and why Child I became involved in such a spiral of criminal activity remains largely unknown. However, it is reasonable to assume that despite having '*agency*'[1], he was unlikely to have chosen this path for himself. At various points in his life, there would have been a range of factors at play that ultimately determined the actions he took. It is highly likely that one such factor was criminal exploitation.

1.3 That said, the SCR neither seeks to excuse Child I's behaviour nor dilute the impact it had upon many, not least his victims and without doubt, his own family. It does, however, recognise that for many children, the boundary between '*victim*' and '*offender*' will often be blurred. Front-line professionals need to recognise this too and give sufficient priority to both areas as part of their practice. Put simply, when offending is driven by exploitation, one won't be addressed without the other.

1.4 Whilst the SCR noted some positive work that was undertaken with Child I, his story reinforces a number of important lessons for practice. The SCR highlights the need for practitioners to be alert to a broader range of '*critical moments*' that can arise in the lives of children. It also underscores the need for practice to capitalise on the strengths of multi-agency partnerships when risk is predictably going to increase.

1.5 The need for '*early help*' to be explained by professionals in such a way that it is understood by families is a simple, yet important, lesson identified by the review. The SCR also points to whether the offer of early help is early enough. The significance of this latter point cannot be overstated. We know that diverting

[1] the capacity of individuals to act independently and to make their own free choices.

children from criminal activity and protecting them from harm becomes more challenging the older they get. Once groomed and engaged, the pull-factors for children can simply be too overwhelming. Just as Child I was unlikely to have chosen his path, it was equally unlikely he had much choice to leave it.

'Having worked with good and decent young people who have been drawn into a twisted perception of reality by their gang elders – a world of enemies, honour and artificial territorialism that seems utterly alien to those outside the sphere of control – I've seen how lost they can become to reason. However hard their parents try to talk sense into them (and I've seen them try incredibly hard), gang elders exert far stronger control.'[2]

1.6 When looking at Child I's life in the context of criminal activity, serious youth violence and exploitation, a number of themes are present that are neither unique nor unknown. In this respect, the SCR has not sought to repeat many of those findings that have already been established from a range of comprehensive reviews[3] [4] [5], rather it focuses on a limited number of areas upon which the SCR believes the local partnership should apply focus.

Finding 1: Practitioners not only need to recognise and respond to well-established 'critical moments', but 'subtle moments' too; moments that might present clear opportunities to help and protect a child.

Finding 2: We know much about the circumstances in which risk relating to exploitation, criminality and serious youth violence is predictably going to increase. Despite this knowledge, practice does not always accrue the benefits of a coherent multi-agency approach.

Finding 3: Where children are identified as needing early help, it is important that parents and carers fully understand what this involves in respect of a coordinated,

[2] Young perpetrators of knife crime are victims too – Anonymous April 2018, The Guardian

[3] It was hard to escape – Child Safeguarding Practice Review Panel 2020

[4] Vulnerable Adolescents Thematic Review – Croydon Safeguarding Children Board 2019

[5] Serious Youth Violence – Thematic Serious Case Review – Buckinghamshire Safeguarding Children Partnership

multi-agency approach to help and protection. Without this understanding, they may be hindered in their ability to provide informed consent.

1.7 The SCR has not considered the circumstances of Child I's death at the YOI. These have been reviewed by the Prison and Probation Ombudsman (PPO) and will be reported following the completion of Child I's Inquest.

2. Key Circumstances, Background & Context

2.1 Child I was a Black child who lived with his mother, father and older sibling. For much of his childhood, there were no known concerns and his primary school years appeared largely uneventful. This changed following Child I's transfer to secondary school. After a year of being relatively settled, a number of difficulties rapidly emerged.

2.2 In 2015, Child I (aged 13) came to the attention of Children's Social Care (CSC) when he was reported to have stolen around £2k from his father. Throughout this year and later into 2016, there was a noted deterioration in Child I's behaviour at both home and school. There were serious incidents where Child I would bully other pupils for money, many of whom were vulnerable.

2.3 As a consequence, Child I received a number of exclusions. In an attempt to address his worsening behaviour, the school provided weekly sessions of individual and group support via the Pastoral Team. Believing more was needed, attempts were made to engage Child I's family in early help services. Records indicate that this offer was not taken accepted by Child I's parents and that they felt the existing support in place was sufficient. Child I's parents, however, recall a different version of events. They state that they never withheld their consent for help and given the difficulties they were experiencing with their son, they would have willingly accepted any additional support being offered.

2.4 In early 2017, an incident took place at home during which Child I damaged his mother's hearing aid. The Police were called, and Child I was arrested. Whilst in custody, Child I's mother informed the Police that she had found a large knife in a

bag at home. Child I was bailed to return to the Police station with conditions not to contact his parents. He was placed in foster care and subsequently charged with common assault and criminal damage.

2.5 Child I returned home in late March 2017. Case records from the time show that mother felt uncomfortable and sometimes fearful when Child I was at home. She said that her son was very rude to her and had no respect. She described him as wanting to do as he pleased and not responding to any rules or boundaries.

2.6 Both parents were extremely worried for their son's welfare and his peer associations. They believed he would be best placed in secure accommodation for his own safety.

2.7 In February 2017, Child I was permanently excluded (PEX) following six previous exclusions for disruptive behaviour. Child I was subsequently engaged at a local Pupil Referral Unit (PRU), where he remained from early February 2017 until July 2017.

2.8 In May 2017, Child I went missing during the school half-term. Nine days later, he returned in the early hours of the morning with no explanation as to where he had been. When spoken to, Child I said he went missing as he believed his mother would lock him in the house over the holiday period. His mother believed he was running 'county lines'. Around the same time, the PRU reported similar concerns to the Police that Child I was involved in gang activity.

2.9 In June 2017, Child I was arrested on suspicion of Grievous Bodily Harm (GBH) relating to an incident which had occurred in April 2017. Neither his parents nor other family members felt able to continue to look after Child I and he entered Local Authority care under a voluntary section 20 agreement[6].

2.10 After coming into care, Child I remained in his first placement for only three days and was subsequently missing for several weeks. When located, in Brighton, he was with a known drug user, with a knife, a large sum of money and crack cocaine. Child I was detained in a YOI on six charges including one of false

[6] Section 20 Children Act 1989

imprisonment. Bail (with conditions) was granted, and Child I was moved to a residential placement in London.

2.11 At the time, Child I's parents thought it would be best for Child I to be placed outside of London. Records indicate that discussions were held with the family about the availability of local support. They also show that CSC staff were alert to the fact that such action does not always mitigate risk, particularly in the long-term.

2.12 In October 2017, Child I received a 12-month Referral Order for three of the offences committed in Brighton. Later that month, staff at his residential placement called Police to report that they had found a large knife in Child I's bedroom. An appointment was made by the Police to attend and seize the knife. Child I was not seen or spoken to by officers.

2.13 Also in October 2017, Child I was arrested in Reading for Affray and possession of cannabis. This incident was not progressed to charge after he was held overnight and questioned by the Police.

2.14 Over a period of ten days in late November 2017, Child I was 'Absent'[7] from his placement on five occasions. On 28 November 2017, Child I was again arrested in Reading. This time he had 80 - 100 wraps of crack cocaine. He was held in Police custody for two nights and then appeared in court. Child I pleaded guilty.

2.15 In December 2017, Child I started at a new school. He was described as being academically able, although he was not always well focused and was falling behind. Initially, Child I was polite to all members of staff. He followed instructions, cooperated with his peers and had been performing well in lessons.

2.16 In January 2018, he became subject to an Intensive Supervision and Surveillance Order (ISS) and was required to wear an electronic tag.

[7] Police definitions - A person is 'absent' when they are not at a place where they are expected or required to be. A person is 'missing' when their whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk of harm to themselves or another. Note: The Metropolitan Police Service no longer use the definition of 'absent' in their response to missing children.

2.17 Two months after being at this new school, Child I's behaviour and attitude changed. He was reported to respond to male staff members but ignore and be disrespectful to female staff. There was also a concern about the re-emergence of his bullying behaviour, with Child I appearing to target one of the quieter pupils.

2.18 By April 2018, despite work via a Family Learning Intervention Programme, Child I's family didn't feel he could return home. However, they remained supportive and fully engaged with the range of practitioners trying to keep Child I safe.

2.19 In June 2018, Child I was arrested at his placement after staff found a white substance on his bedside table which they believed to be Class A drugs. No further action was taken. Child I stated that it was sugar that he had placed there as a prank. A cannabis grinder was seized from his room.

2.20 In October 2018, Child I was arrested in the company of another male after he had been seen on CCTV to place a large knife in a bush. He returned to retrieve the knife, unaware that the Police had seized it. He was arrested on suspicion of possession of an offensive weapon. He denied any wrongdoing and was released under investigation. No further action was taken.

2.21 In January 2019, Child I was arrested again, this time for intent to supply a Class A drug. He was scheduled to answer bail but did not attend. Child I's parents informed the review that this was on the advice of his solicitor. No further action followed.

2.22 In March 2019, Child I was arrested in relation to an allegation of rape. During a search of his room, a machete was found underneath his mattress. He was bailed to appear at a London Police station. He did not attend. Again, Child I's parents told the review that this was due to the legal advice given to their son.

2.23 In May 2019, Child I was arrested in relation to suspicion of murder. He was bailed to appear at a London Police station in June 2019. The placement where Child I had been for two years served notice due to the significant nature of his recent arrests.

2.24 As a result, Child I moved to another placement. Here, he did not adhere to his curfew, often returning at 1 or 2am in the morning. This was noted as not being unusual. Whilst Child I reportedly kept in regular contact with placement staff, he never disclosed his whereabouts.

2.25 In June 2019, Child I was re-interviewed by the Police and charged in relation to the offence of murder. He was remanded into a YOI.

2.26 In late June 2019, Child I became unwell, and he was found unresponsive by YOI staff on his cell floor. Paramedics were called and took him to hospital, from which he was transferred to another hospital for specialist care. Child I did not respond to treatment and subsequently died.

3. Views of the Family

3.1 The independent reviewer met with Child I's parents to better understand their experiences and to capture any views on how well professionals worked with the family. The CHSCP is grateful for their input. Both were fully supportive of the SCR, recognising that *'whilst we can't go back, we can only change what is ahead for others*'.

- Child I was described by his parents as an intelligent boy, with this being evident from an early age. His parents also acknowledged that Child I appeared to have two sides to his personality, for example they experienced that Child I could be very kind but were also aware that he could bully other children.
- Child I had a trusted mentor in secondary school with whom he had a good relationship. He was noted by his parents to listen to this mentor and was seen to be doing well at this point in his life. However, his mentor left at short notice, and this affected Child I. He was upset and was reported to have helped the mentor pack her things when leaving her office.
- Child I was also noted as getting on well with a subsequent mentor, although this was time limited support. Despite attempts by Child I's mother, she was unsuccessful in her requests to keep this arrangement continuing.

- As concerns escalated in respect of Child I's behaviour, his parents tried to emphasise these to professionals. For example, Child I was taking a different route home from school and was increasingly staying out later. They felt professionals were not thinking about what Child I was doing when he was going missing and that the police did not care. They believe that Child I was just being seen as belonging to a group and not as an individual child at potential risk.
- Child I's mother felt she was repeatedly asking professionals to listen to her, saying *'[Child I] is not showing it but he is scared. Please get [Child I] out of London and get him help. The response was for [Child I] to stay and professionals to work with him here. I wanted my son to be safe and get proper help. They didn't listen to me or Child I's father'.*
- Child I's parents felt frustration in that they were asking for help for issues arising outside of their family, but they did not receive this. Child I came from a loving home, and they felt professionals would have intervened sooner had the concerns come from within the family home.
- When Child I stole money from his father, his parents believed he did this to look '*cool*' amongst his peer group. When challenged by his parents about the consequences of theft, Child I's response was ambivalent and somewhat dismissive. It was as if experiencing prison would be seen as '*a badge of honour'.*
- Child I's parents recall recognising a point in time when the seriousness of the risk their son was facing became starkly apparent. This was when Child I told his mother that she couldn't walk to the shops with him and that she should just meet him there. Child I's parents believe this was his way of protecting his mother from a risk of violence that Child I knew he was exposed to.
- Whilst Child I's parents would talk extensively to their son, it was clear to them that he was telling them what they wanted to hear and that he was being manipulated / threatened by gang elders.
- Child I reportedly said that the Police told him to call his parents whenever he went missing and confirm *"he was okay and just late"*. This was believed to have been said as '*advice*' to Child I so as to lessen the urgency / veracity of any police response. Child I's parents said their son used this strategy several times.

- Whilst research shows that removing Child I from the local area may not have been effective, his mother queried whether other options to keep Child I safe had been fully explored. For example, some interventions appeared to be working whilst Child I wore a tag. Child I would hurry to get home and was actually arriving on time.
- Child I told his father (and another family member) that he left the family home through his own choice and had no regrets about doing so

3.2 Child I's parents also highlighted some key messages for professionals:

- Professionals should see children as individuals rather as a group. What works for one child may not fit another.
- Listening to parents can help professionals help children as individuals; parents know their children best.
- Professionals need to reflect on the language used when engaging parents and explaining the support that might be available. Around the time Child I was being reported to the police, if someone had offered help they would have '*grabbed it with both hand*s'.
- Father particularly noted raising concerns and that these issues could have been *'shut down'* earlier. Both parents were adamant that they never withheld their consent for help and support.
- Professionals need to engage parents at the outset to check whether emerging issues align with the parental perception of their child.
- Rather than focusing on labelling children, professionals need to focus on finding out the underlying reasons about why a child is displaying disruptive behaviours.
- Professionals need to spot early when something is wrong. Child I's father gave the analogy of a tooth decay. '*First, you make sure you're doing the basics such as brushing your teeth properly. If there's a problem, you see a dentist as soon as possible. If you wait too long, the tooth will need to be taken out*'.
- Professionals need to be aware of the risk that children can be exposed to by simply going to school by themselves. Criminal gangs are aware of these children and will engage them on route.
- Child I's mother felt that all children in Year Five and Six should have access to training around criminal exploitation as part of the curriculum.

3.3 Whilst no specific recommendations are made in respect of the key messages suggested by Child I's parents, all of these issues will be formally considered by the Safeguarding Adolescent Working Groups in operation in both the City of London and Hackney. Any actions deemed necessary will form part of the action plans for these groups respectively.

4. Findings & Recommendations

4.1 In the four years preceding Child I's death, his life was characterised by a pattern of escalating risk, deteriorating behaviour and increased criminal activity. This complexity and the challenges faced by those trying to help Child I, including his family, are fully recognised by the SCR.

4.2 Finding 1: Practitioners not only need to recognise and respond to well-established 'critical moments', but 'subtle moments' too; moments that might present clear opportunities to help and protect a child.

4.3 Much has been written on the concept of 'critical' or 'teachable' moments. These are described as '*critical moments in children's lives when a decisive response is necessary to make a difference to their long-term outcomes.*'[8] They include the point at which children are excluded from school, physically injured or when they are arrested.

4.4 The thinking behind such moments is that they present opportunities where children are more likely to be receptive to help. In Child I's case, there was limited evidence that professionals capitalised on these moments or used them to pause and plan in the context of risk.

4.5 This can be seen in Child I's permanent exclusion from school and his entry into care a few months later. Both were critical moments. In a relatively short period of time, there was less oversight of Child I by those that knew him well and given his known history, risk over this period was arguably predictable. Despite these factors,

[8] It was hard to escape Page 3, CSPRP 2020

neither event resulted in any focussed work with Child I about the dangers he might be facing. They were missed opportunities.

4.6 This ultimately meant that there were no real barriers to those who were likely to be manipulating Child I. A strong hypothesis is that gang elders took full advantage of him being 'less visible'. After his exclusion and entry to care, it was now time for Child I to become a more important part of their '*family*' and he was quickly tasked with more criminal activity beyond Hackney's borders.

4.7 The arrests that followed Child I's sharp increase in criminal behaviour were also critical moments. Most can similarly be characterised as missed opportunities. Despite the known indicators, there was little evidence that practice by the police was being driven by a '*safeguarding first*' philosophy and a need to protect Child I. Actions were largely reactive and based on a criminal justice response to his offending. These are seen by the SCR as largely correlating with the concept of 'Adultification'.

4.8 As described by Davis and Marsh 2020[9], 'adultification' is a term '*used to describe how preconceptions of children (specifically Black children) may lead to them being treated and perceived as being more adult-like (Goff et al, 2014[10]). If Black children are seen as less vulnerable and more adult-like, services may overlook their needs and disregard their legal rights to be protected, supported and safeguarded.*' Whilst a relevant learning point, the SCR is aware that Adultification is an acknowledged issue that the CHSCP is responding to locally. As such, no particular recommendation is made in this regard.

4.9 Although Child I's potential vulnerability was noted as being recognised after his arrest in Reading, this didn't appear to result in any escalated response by the police. For example, the SCR found no evidence of any disruption activity aimed at identifying who Child I's exploiters actually were.

4.10 Whilst recognising that a number of local initiatives have been implemented to better respond to critical moments (such as specialist youth workers being located

[9] Davis, J. and Marsh, N. (2020) Boys to men: the cost of 'adultification' in safeguarding responses to Black boys, Critical and Radical Social Work, vol 8, no 2, 255–259, DOI: 10.1332/204986020X15945756023543

[10] Goff, P.A., Jackson, M., Di Leone, B., Culotta, C. and Ditomasso, N. (2014) The essence of innocence: consequences of dehumanizing black children, Journal of Personality and Social Psychology, 106(4): 526–545.

in hospital Emergency Departments), this is an important aspect of practice to reinforce. A critical moment needs a critical response. Practice in this respect needs to be timely, systematic and underpinned by a coherent partnership response. This should prioritise safety planning, mitigate risk and create pathways for children to engage.

4.11 There also needs to be much greater emphasis placed on the disruption of those who are exploiting children. Whilst also a role for the wider partnership, the key powers in this context rest with the police. Without downplaying the complexity of this task, such actions should always be a feature within the multi-agency response to children who are being exploited or at risk of exploitation. This aspect should also form a clear thread of any strategic approach by safeguarding partners, with the fundamental aim of making it more difficult for exploiters to operate and ultimately abuse children.

4.12 Of equal relevance is the recognition that critical moments won't necessarily be defined by a clear set of circumstances or specific events. They might relate to what a child says or how they act. In this respect, the need for trusted relationships with children are essential, as is the need for practitioners to know the children they are working with. Good relationships and effective communication can make a massive difference to children and their safety.

4.13 In Child I's case, one such moment arose whilst in residential care. He told staff that he didn't want his electronic tag to be removed. Not much weight was afforded to this comment at the time. In hindsight, this could have been a cry for help or a serious suggestion from Child I about how he might be kept safe. This could have been his only excuse not to leave his placement and be criminally exploited. This could have been a strategy to escape his exploiters (even if only temporarily), without being seen as the one making that choice.

'Once a child is part of a county lines gang their loyalty and commitment will be tested. The gang will begin to trap the child by making them feel powerless to leave. This might include threats of violence if they leave, making the child feel like they are betraying their new 'family', or telling the child they will get in trouble if they seek help because they have committed a criminal offence.' (Children's Society, 2019).

Recommendation 1: Safeguarding partners should seek reassurance that policy, procedure and practice relating to critical moments (both well established and those less obvious) is sufficient robust to ensure effective safety planning.

Recommendation 2: Safeguarding partners should seek reassurance from the Police about the sufficiency or otherwise of local disruption activity targeting those who are criminally exploiting children.

4.14 **Finding 2: We know much about the circumstances in which risk relating to exploitation, criminality and serious youth violence is predictably going to increase. Despite this knowledge, practice does not always accrue the benefits of a coherent multi-agency approach.**

4.15 The safeguarding sector has a substantial evidence base on which to develop its response to exploitation, criminality and serious youth violence. This has been amassed through front-line experience, research, the Child Safeguarding Practice Review Panel and from local safeguarding arrangements that have undertaken reviews concerning vulnerable adolescents.

4.16 Whilst accepting that intervention in this context is never easy, we do have a good idea of what the early indicators of risk look like and the circumstances where the threat of harm is predictably going to increase. One such indicator is where children are displaying signs of challenging behaviour.

4.17 Whilst acknowledging that there will be numerous reasons why a child's behaviour can deteriorate, the SCR believes a much more nuanced approach is needed to tackle it. A single agency acting in isolation is unlikely to ever get to grips with the root causes of such behaviour, and neither will it be capable of mitigating future consequences, particularly in the context of risk. This latter point is key. Figures published by the Government for 2018-19, show that persistent disruptive behaviour is the most common reason for both permanent exclusions (35%) and fixed period exclusions (31%)[11]. When we know that exclusions (particularly

[11] Academic Year 2018/19 Permanent and fixed-period exclusions in England. Gov.

permanent exclusions) can significantly exacerbate risk for a child, it follows that persistent disruptive behaviour should perhaps be better framed as a core safeguarding issue.

4.18 This does not mean that all such cases require a statutory social work response, but they do require early coordination of support across a range of different agencies, and they need to be seen beyond just a disciplinary matter for the school. A '*Safeguarding Firs*t' approach should apply, with practice being attuned to reflecting on the past and using this knowledge to focus on future risk. As one practitioner said at the Child I's SCR workshop: '*Due to the numerous incidents, professionals were reviewing what had occurred rather than looking forward'.'*

4.19 In Child I's case, he made the transition to secondary school without any immediate problems. One year into his new school, he received his first exclusion. 12 months later, he was permanently excluded. Over this period, the response to Child I's behaviour was characterised by school staff (and some other professionals) working hard in collaboration with Child I's parents. This was positive, but the school was acting without the full engagement of other agencies that might have been able to provide additional support. The school recognised this and attempted to facilitate a referral to early help services, but there was no consent from the family to progress this further (*see Finding 3*).

4.20 The overall result was that whilst practice involved more than one agency, it wasn't multi-agency. There was limited presence of health services, with information on the GP records (a conduit for all health-related information) being scant and no significant involvement from school nursing.

4.21 Early intervention with Child I appears to have been largely focused on his behaviour at school by the school. Improved coordination of this work with a wider set of agencies (and the family) might have helped more effectively addressed the causes of Child I's behaviour.

Recommendation 3: Safeguarding partners should work with primary and secondary schools to ensure that they are able to identify children who show persistent behavioural difficulties. On identification, the partnership's early help

response should be robust and seek to mitigate known or possible safeguarding threats.

Recommendation 4: Safeguarding partners should ensure that a multi-agency response to the persistent disruptive behaviour of children is sufficiently described in the threshold tools of both Hackney and the City of London.

4.22 Commenting further on the issue of exclusions, the SCR does not criticise the individual decisions of Child I's school in this regard. Based on existing framework, the school acted entirely appropriately, particularly in the context of the significant efforts undertaken to help Child I. However, the SCR believes there is a wider systems issue that exposes the inherent flaws in how exclusions are currently governed.

4.23 The SCR recognises that discipline is a key issue for schools, as is their responsibility to ensure all pupils are safe and have the opportunity to learn without disruption. Having said that, permanent exclusion is a known mechanism that can exacerbate risk. It can inadvertently create more danger for children and as such, this should place this issue firmly under the umbrella of safeguarding.

4.24 In the opinion of the SCR, the current exclusion process fails to accrue the benefits of multi-agency working, which as we know, is the most effective way to help and protect the young and vulnerable.

4.25 This does not necessarily mean that the overall accountability for decision making needs to change, but the SCR holds a strong view that no child should ever be excluded without a process that engages the wider partnership. This should be done for two reasons. Firstly, to leverage the maximum support available to keep children within mainstream school and secondly, if this isn't possible, to begin early planning for mitigating the predictable risk that will arise for some.

Recommendation 5: Operating within the current law and guidance concerning exclusions, Safeguarding Partners should explore with both primary and secondary schools how multi-agency involvement could be improved both prior to and at the point decisions are being made about permanent exclusions.

4.26 Of equal relevance to this finding are the questions raised about why formal child protection procedures were never initiated to safeguard Child I.

4.27 Prior to Child I's permanent exclusion and entry into care, a number of risk factors were clearly evident to the professional network. As early as 2016, Child I's father was reporting that things were deteriorating. He told professionals that Child I had been seen with a knife in Brixton and two knives had been found in his bedroom at home. He was said to be climbing out of his window in the evening to leave the house and was not returning from school until very late at night. He had also been talking on his phone until the early hours. At this time, Child I had also told school staff he had been spending a great deal of time '*hanging about his local area*' often late into the evening.

4.28 These incidents, alongside those of Child I stealing from his father in 2015, the bullying for money and his defiant attitude were all potential signs that Child I was being criminally exploited.

4.29 In this respect, there was a strong argument that Child I was at risk of suffering significant harm. Despite this, there was no partnership response that unambiguously placed intervention with Child I on a child protection footing. There was no strategy discussion, no child protection enquiry and no consideration as to whether a child protection plan was required at any stage of involvement with Child I and his family.

4.30 Some practitioners believed that had these concerns being dealt with under a child protection framework, then this might have helped the professional network better recognise Child I's vulnerability and better develop a plan of intervention to make him safer.

4.31 The SCR acknowledges the variability that exists across many local areas in their use of child protection procedures when responding to extra-familial risk. It is also alert to the ongoing debate that is seeking to clarify how this work might better be defined within relevant legislation and statutory guidance.[12]

[12] The legal and policy framework for Contextual Safeguarding approaches (2020) Firmin and Knowles

4.32 That said, learning from this SCR is clear. Whatever the source of risk (intra-familial or extra-familial), multi-agency practice should always be undertaken within the parameters of clear thresholds and clear procedures. These are key to making sure that children receive a service commensurate to their needs and that the multi-agency partnership acts as one. As it was, practice involving Child I lacked this coherence and fell short in developing an agreed multi-agency plan to mitigate risk.

4.33 Whilst accepting that the existing child protection procedures might not cover the nuances of extra-familial harm, practitioners need to guard against this being interpreted that no multi-agency framework is required. In line with the Hackney Child Wellbeing Framework (and depending upon presenting risk), the processes supporting early help, child in need and child protection responses are all available and should be used. Whilst an important issue, the SCR makes no recommendation on this issue given it coverage as part of a previous Local Child Safeguarding Practice Review undertaken by the City & Hackney Safeguarding Children Partnership.

4.34 Finding 3: Where children are identified as needing early help, it is important that parents and carers fully understand what this involves in respect of a coordinated, multi-agency approach to help and protection. Without this understanding, they may be hindered in their ability to provide informed consent.

4.35 Whilst there is no debate that the school attempted to involve early help services, there are differing opinions as to why the family were never engaged. Some case records suggest that a lack of consent stalled the partnership's ability to meaningfully engage Child I at a critical moment in his life. The parents' recollection is different, and they are categoric in their view they would never have refused help if offered.

4.36 The SCR deals with both scenarios as learning points. Firstly, an absence of consent for help is not a new issue for safeguarding professionals. There will always be families who decide that they don't want professionals involved in their

lives. Depending on the needs of the child and potential risks, some of these decisions will be justified, others won't be. How practitioners react when consent is refused (and the level of professional curiosity and challenge they show) is an important finding of the SCR.

4.37 It is established good practice to seek consent from families for help and support, unless doing so might place a child at a risk of significant harm. However, if refused, practitioners shouldn't just end the conversations there. They should be professionally curious about the reasons why this is being refused and challenge those reasons where a child's welfare might be compromised.

4.38 For any case involving similar issues as seen with Child I, these need to be approached with a significant degree of rigour. These should be a firm focus on mitigating future risk and robust conversations with parents / carers that explain the seriousness of what might happen if coordinated support isn't provided and isn't provided early.

4.39 The SCR is already alert to work being undertaken in Hackney to strengthen the approach of practitioners seeking consent prior to referrals being made to Children's Social Care. This work is fully supported by local safeguarding partners and aligns with statutory guidance. This SCR reinforces the need for the issue of consent to be a key focus for the partnership going forward, not only in how this is routinely sought, but the response by practitioners when consent might not be given.

Recommendation 6: Safeguarding partners should ensure that local threshold tools, associated guidance and multi-agency training set out clear practice expectations about seeking consent. These should include guidance for staff on how to respond when consent is not given in circumstances where there are concerns about actual or potential risk.

4.40 In conversation with Child I's parents, it was clear that their understanding of what an early help response might have involved significantly differed to that of the independent reviewer. Neither parent understood this to involve the level of multi-agency coordination that would ideally follow in such circumstances.

4.41 In this respect, the issue of whether consent was given or not may be somewhat of a *red herring*. Focussing on this issue alone detracts from a simple learning point about how well the offer of early help is set out in Hackney and how this is conveyed to parents and carers. If not done in a way that fully explains how this works and motivates the parents or carers to see the difference it can make for their child(ren), they may see little point in engaging. To this end, the SCR makes the following recommendation.

Recommendation 7: Safeguarding partners should ensure that the multi-agency arrangements for early help are underpinned by a defined strategy, clear processes and communication material to help practitioners explain the offer available to families in Hackney.