Serious Case Review – Chris

Executive Summary

Lead Reviewer and Independent Report Author - Nicky Hill

NEWHAM LOCAL SAFEGUARDING CHILDREN BOARD

A Serious Case Review (SCR) commissioned and completed for Newham Safeguarding Children Board (NSCB) in order to establish whether any lessons can be learned and to promote and develop good practice following the death of 'Chris'.

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Introduction

1.1. A Serious Case Review (SCR) was commissioned by Newham Safeguarding Children Board (NSCB) following a notification of the death of Chris, a fourteen year old boy who identified as being of Caribbean heritage. Chris was shot at close range in Newham and was transported to the Royal London Hospital. Chris died later in hospital, with his family around him, after his life support was turned off.

1.2. At the time of writing, there is an ongoing murder enquiry but as yet, no arrests have been made in relation to Chris's death. Exploration and analysis of the murder itself is not within the scope of the Serious Case Review.

1.3. The Serious Case Review provides an opportunity to address the specific questions set out in the terms of reference (see appendix) but to, more broadly, gain an understanding of Chris's life, his identity, the relationships he had with family, friends and professionals and how these may have shaped his world. The SCR allows for exploration, analysis and reflection on the journey of Chris's life, identifying opportunities to learn from the tragic death of Chris and reduce the likelihood of this happening to others. This executive summary provides an overview of learning and recommendations.

1.4. The Lead Reviewer, Newham Safeguarding Children Board and all agencies and professionals involved in this process, express their sincere condolences to Chris's family.

Background Chronological Summary

- Chris grew up with his mum and older sister. The relationship between his parents had broken down in his early years as a result of ongoing domestic violence. He ceased all contact with his dad in 2012, often reporting to professionals that his dad had died.
- Chris had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder and was prescribed Ritalin to manage this, supported by East London Foundation Trust (ELFT). It is the family view that Chris struggled to integrate this diagnosis into his identity, feeling that it made him different and so he was reluctant to take the medication.
- ADHD diagnosis followed the emergence of challenging behaviour at Woodside Primary School in the neighbouring borough of Waltham Forest, including serious and significant incidents such as threats to self-harm with scissors and a ligature.
- Extensive support plans, centred on relational, therapeutic, trauma responsive practice were in place throughout Chris's time at Woodside Primary School, which both school staff and his family report he responded well to, and which, overall, had a positive impact on his behaviour and development.
- The family secured a tenancy in Newham in 2011 where Chris then lived with his mum, in housing provided by East Thames Housing. His maternal grandfather, with whom he had a strong and positive relationship, also lives in Newham with his own tenancy. At the time of his death, Chris was living at his maternal grandfather's address.
- There are strong family links to the London Borough of Lewisham where Chris's maternal uncles live and where he also lived for short periods as part of the risk management plan implemented by the family.

- Between November 2013 to March 2014 Chris was an open case to Newham's Children's Social Care.
- Chris did not follow his classmates and friends from Woodside Primary School into Waltham Forest secondary schools and instead, in September 2014, started at Forest Gate Community School in Newham. This transition, particularly without a trusted peer group, was difficult for Chris. There is little evidence that his SEND (special educational needs and/or disabilities) needs were fully understood or met in this new setting although a pastoral support plan including 1:1 support sessions was in place.
- Chris's behaviour became increasingly unmanageable in this context, as he struggled to regulate himself without the support and trusted relationships available at primary school. He received regular punishment in the form of internal and fixed term exclusions (totalling at least ten days) between September 2014 and January 2016. He was referred to the Tunmarsh School, a Pupil Referral Unit in Newham, in January 2016, aged 13.
- Chris had regular appointments with the Clinical Psychologist from the Child and Family Consultation Service ADHD Clinic who made multiple referrals to other specialist services including substance misuse services and to talking therapy for other family members.
- From April 2016, concerns began to escalate about Chris's behaviour and for his safety. Information was shared, by the Police, with Newham Triage (MASH) in April, indicating concerns regarding gang activity and association with older, pro-criminal peers. The decision was made not to progress to Initial Child Protection Conference (ICPC) and instead to refer to the Youth Offending Team.
- Police reports from April 2016 state that Chris was 'associating with troublemakers'. The officer believed that he may be a target for gangs as he was easily influenced and was associating with gang members.
- Chris was arrested for a serious sexual assault on 6th July 2016 but was not charged, with no further action being taken. School records also highlight concerns about sexualised behaviour at school, which were referred by the Designated Safeguarding Lead to Newham Triage (MASH) in July 2016.
- In July 2016, the case was allocated for assessment by Newham Children's Social Care and opened to Families First[1], however, after one home visit the case was closed due to 'non-engagement'.
- In July 2016, a direct referral was made by the Tunmarsh School to Newham Youth Offending Team for voluntary support delivered by a Disruption offer. This referral includes information about Chris buying a Rambo style knife and being observed looking at knives online. The disruption offer included targeted assessment and intervention for those at risk of youth violence, anti-social behaviour, possession with intent to supply matters and where sexually inappropriate behaviour may be a concern. The family are reported not to have engaged in this offer of support and so the case was closed.
- Further reports at this time make reference to Chris using his maternal grandfather's address to order the Rambo knife online, along with a bullet proof vest.

[1] https://www.newham.gov.uk/Documents/Health%20and%20social%20care/Support-and-protection-for-children-and-young-people-in-Newham-practice-guidance.pdf

- On 6th November 2016, Chris was reported missing from home by his mother and did not return for a week. When he returned home he was debriefed by police but refused to answer any questions as to where he had been.
- On the 14th November 2016, a single assessment by Newham Children's Social Care was initiated following a referral from the police after his mum reported Chris missing.
- On 20th November 2016, Chris was reported to have assaulted his mum after she tried to prevent him leaving the home. In police interview, Chris claimed self-defence and that he had sustained injuries himself. No further action was taken by either police or Children's Social Care and he was returned to the pre-arranged care of his uncles.
- On 12th December 2016, Children's Social Care notified police that Chris had disclosed to his mum that he been pressured into selling drugs. His mum had found him to be in possession of a quantity of drugs and she subsequently disposed of £600 of Class A drugs that belonged to dealers. Information on record by Children's Social Care quotes Chris as saying he was in fear for his life.
- Two days later, on 14th December 2016, a search warrant was executed at Chris's home address in Newham. Officers were looking for numerous items of property, clothing, and weapons used in robberies. A mobile phone stolen in a knifepoint robbery on 18/07/16 was recovered. Chris was not at home as he was staying at his uncle's home in Lewisham following a break down in the relationship between Chris and mum after the alleged assault.
- Children's Social Care records at this time note that evidence pointed strongly to Chris being groomed by older young people for the purposes of selling drugs and being involved in gang related activities.
- Chris's mum is recorded as saying she was concerned for their safety. She made a direct approach to the family's housing provider, East Thames Housing, requesting urgent relocation for the family on the basis of risk.
- In December 2016, Chris was added to Newham Gang Matrix as a green nominal. Also in December 2016, Chris joined Forest Gate Youth Centre where he attended casual sessions.
- At the end of January 2017, Chris's mum arranged for him to live with her brothers in south London as a temporary risk management strategy; at this time she continues to report, in writing to Children's Social Care, being in fear for her son's life and welfare.
- As Chris was no longer residing in Newham, despite remaining on school roll in Newham, voluntary engagement services such as the Youth Offending Team disruption offer were no longer available to the family. Support services local to the temporary address, including Lewisham Youth Offending Service, were not notified that Chris was living locally and so no direct support was in place at this time.
- During his time in Lewisham, Chris was provided with access to virtual learning via the Tunmarsh School.
- The case was not transferred to Lewisham Children's Social Care.
- In April 2017, Chris was arrested and subsequently convicted for carrying a knife in south east London. Records show that Chris explained that he had received threats via social media and was in fear for his safety. He reported, during his AssetPlus assessment, that he took the knife out with him for his own protection, with no intention to use it. However,

during his police interview Chris stated that he was carrying the knife for someone else. It does not appear that details of others involved in either scenario were disclosed by Chris to professionals.

- Chris received a Referral Order from the court, and was initially assessed and supervised by Lewisham Youth Offending Team who worked with him until June 2017.
- In June 2017, the relationship broke down between Chris and his uncles, with whom he was residing and, with no other accommodation available, Chris went to stay with his maternal grandfather back in Newham.
- The case was formally transferred from Lewisham to Newham Youth Offending Team (YOT) in June 2017, where Chris was supervised at an enhanced level and required to attend twice weekly meetings. The YOT co-ordinated regular multi-agency professional meetings attended by the Tunmarsh School and Child and Adolescent Mental Health Services (CAMHS).
- On his return to Newham, Chris was raised to an amber nominal on Newham Gang Matrix.
- In July 2017, Chris reported that he had been chased by a group of youths and felt unsafe travelling to the Youth Offending Team given its location in the south of the borough (an area in conflict with the gang(s) with which Chris was allegedly affiliated) and so taxis were arranged to transport him to and from his appointments to manage potential risk following a safety planning meeting with Youth Offending Team police.
- In August 2017, Chris was arrested in Newham in possession of a corrosive substance (acid) and was due to be prosecuted for this offence. Children's Social Care records again state that Chris had explored the incident with the assessing social worker and stated that he had no intention of proactively using this but obtained it for his own protection.
- On 4th September 2017, Chris was in Newham in a group of four young people. An unknown assailant passed by in a stolen vehicle and fired multiple shots into the crowd of young people; it is not possible to be sure if Chris was the intended victim of the attack. Chris received a bullet wound to his head and was taken to hospital but died as a result of his injuries the following day.

Brief Overview of Learning and Conclusions

The role of each individual agency is addressed in the full SCR report, including examples of good practice with all questions in the terms of reference (see appendix) explored. Key areas of learning and conclusions are included below.

1. The antecedents to this tragic event include a complex constellation of risk factors requiring an analysis of the interaction between community risk factors, family functioning, protective factors and professional intervention. There is limited evidence that this analysis took place or that any intervention was put in place to effectively reduce the risks to Chris.
2. There is evidence that a number of agencies including Woodside Primary School, Tunmarsh School (including Schools Police Officers), the Youth Offending Service, the Youth Service and Health all had strong and positive relationships with Chris and had a degree of insight into his needs, however, the absence of well co-ordinated assessment and multiagency responses limited the impact of intervention by all agencies.
3. Multiagency working arrangements delivered through the local Multiagency Risk and Vulnerability Panel (MRVP) were not adequate to ensure that Chris's needs were well understood or responded to. Co-ordinated support, through a Team around the Family (TAF) approach and an early help record, could have been a key opportunity for early intervention at this point. In the absence of a more holistic and robust assessment, opportunities for intervention were missed, after which issues are evidenced to have escalated.
4. Despite hundreds of professional hours provided by a multitude of people, discussion at dozens of meetings over several years and provision of multiple forms of support (albeit with limited intervention), little changed for Chris and risk was not effectively managed as evidenced by an upwards trajectory of risk and offending. Poor quality assessments and reviews were regularly confused with intervention and activity confused with impact. It does not appear that professionals paused to consider fundamental questions such as 'what does Chris want?' 'What are the underlying risk factors here?' 'What needs to change and why?' 'What does good practice look like and are we seeing it?' 'Who is best placed to lead on this?' 'Is what we are doing working and if not, why not?' 'What do we need to do differently?'
5. It seems that review processes, often not even named as such, were actually discussion and activity planning sessions and did not address the quality or effectiveness of the few interventions in place, this is not in line with the guidance in Working Together to Safeguard Children[2] which states that a good assessment will monitor and record the impact of any services delivered to the child and family and review the help being delivered. They did not effectively consider whether Chris was developing increased resilience, improved engagement in positive activities including education, a sense of safety, positive and healthy relationships, positive sense of self, improved family dynamics and a positive outlook for the future.
6. Review of assessments, plans and meeting minutes show that when one agreed action was unsuccessful, or not agreed to by the family, it tended to be replaced with another solution

[2] http://www.workingtogetheronline.co.uk/chapters/chapter_one.html

without the underlying issues that it was intended to address having been fully identified and quantified. Often these were simply professional actions and not interventions; there was, therefore, no objective way of monitoring the effectiveness of any plan and no sense of coherence, integration, or clear purpose focused on Chris's welfare and wellbeing. In this case, there is no evidence that any of the resources being committed to the case were improving Chris's situation.

7. It is believed that the early identification of Chris as a Gang Nominal, based on offending, risk and partner intelligence, may have unduly influenced decision making when new concerns for his welfare and wellbeing were shared with Triage (Multiagency Safeguarding Hub – MASH) despite police records clearly identifying and communicating concern that Chris was at high risk of exploitation with a range of safeguarding needs.
8. There was a consistent pattern of observing risk associated with alleged gang affiliation solely through the lens of offending behaviour, without adequate analysis or understanding of the complexities of the victim/perpetrator overlap, the nature of child criminal exploitation and the need for robust and timely safeguarding responses to reduce the risk of significant harm. This in turn increases the likelihood of young people being fast tracked into the criminal justice system with automatic referrals to youth offending services, where other services may be more appropriate to holistically assess, plan, intervene and review.
9. There was a lack of consideration given to Chris's relationships with professionals, with missed opportunities to build on positive relationships with youth workers at the Youth Zone, including them in planning and intervention. His engagement with voluntary sector positive activities, such as attending a local boxing club, was also unknown to professionals and so staff were not included in support planning.
10. The churn in staffing within Children's Social Care, characterised by short agency contracts with minimal handover of cases, was prohibitive to ensuring continuity of care, case knowledge and the completion of actions. This included the timely sharing of information with the family's housing provider, as relocation out of borough was the primary risk management strategy in place.
11. In brief conclusion, it must be recognised that young people can be loving, caring, well-liked children but also commit dangerous, harmful offences and take part in harmful risk taking behaviour. These are not always mutually exclusive and work with young people must seek to understand these behaviours as symptomatic of underlying challenges and difficulties, often linked to traumatic experiences and the complex and difficult worlds that young people are living in. This requires the development of trusted relationships with young people, by those with the right skills to engage, understand and analyse needs, create meaningful child centred intervention plans and to work collaboratively across agencies to ensure that all are pulling in the same direction. Focus should always be on keeping children and young people safe by creating spaces for disclosure that is taken seriously, enabling them to make sense of their situation and empowering them to make the changes needed to deliver more positive outcomes.

Recommendations

The following recommendations have been made in response to the full Serious Case Review overview report. Further detail on each recommendation is included within the full report.

1. The board should explore, through discussion, debate and professional development initiatives, ways of improving professional competence in assessment across services.

2. To undertake a full review of the Multiagency Risk and Vulnerability Panel (MRVP)

3. To strategically and operationally realign work with young people at risk of child criminal exploitation (CCE) with Child Sexual Exploitation (CSE), and to consider the creation of a contextual safeguarding hub.

4. To ensure that there are appropriate policies, procedures and pathways in place for children and young people at risk of gang affiliation and criminal exploitation, recognising that there is often an overlap.

5. To ensure that there is access to independent return interviews after young people return from missing episodes linked to child criminal exploitation.

6. To consider the current capacity of specialist case work in Newham that offers flexible and culturally competent engagement opportunities for gang affected and exploited young people using established and evidence based practice models.

7. Where multiple risk indicators exist, consider additional transitional support between primary and secondary education with a focus on reducing the risk of Child Criminal Exploitation (CCE) and gang affiliation.

8. Consider the need for a full review of PRU provision in the borough to ensure it meets the local need

9. Ensure there is a comprehensive professional development offer on Child Criminal Exploitation (CCE)

10. Review local processes for the relocation of young people and families out of Newham, ensuring that best practice underpins all decisions to relocate and the process of relocation

11. Identify Child Criminal Exploitation (CCE) Champions in key services across Newham

12. Increase awareness, across agencies, to the role social media plays in inter group (gang) tensions and violence

13. Consider the commissioning of a specialist Young Men's Service, to include casework around harmful sexual behaviour (HSB) using evidence based approaches such as the Good Lives Model.

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

The implementation of all recommendations should be informed by Equality Impact Assessments and, where appropriate, should include the voice of young people and service users in their design, development and review.

Appendices

Terms of Reference

The focus of the review was originally agreed to be from April 2016, when information from the police was shared with Children's Triage which raised concerns about potential criminal exploitation linked to gangs and the illegal supply of drugs. This was amended, at the request of the Lead Reviewer, and extended to cover the fourteen years of Chris life in order to fully explore the longer term trajectories of offending, risk and responses.

The specific lines of enquiry identified to focus the Serious Case Review are as follows, and are explored in detail in the full SCR report.

1. To gain an overview of Chris's childhood that describes his care arrangements, family dynamics, significant events and relationships and the impact of these on his identity and development.
2. To analyse how well Chris's individual needs and vulnerability factors were recognised and addressed in the assessments, interventions and plans that were made to support him.
3. To analyse critical incidents in the 12 months prior to Chris's death and comment on the quality and effectiveness of intervention and service delivery at these points and the impact for Chris.
4. To analyse the quality, effectiveness and impact of work to protect Chris from criminal exploitation. Did those working with Chris view him primarily as a gang member or 'gang affected' or did they recognise that he was a victim of grooming and criminal exploitation?
5. How well did Chris respond to the services that were offered to him? What was the quality of individual professional interaction with him and how well did he engage with individual professionals? Were Chris's voice, views, wishes and feelings sought and captured in their work with him?
6. To evaluate whether the risk assessment and safety plans for Chris following his return to Newham were sufficiently prompt and robust.
7. To review the response to mother's request to be moved and whether this followed the protocol for urgent rehousing
8. How well was the police intelligence about the involvement of Chris in drug supply used to inform protective plans for Chris; and how thoroughly was the information that mother provided in November 2016 investigated by the police?
9. Are locally agreed pathways for support, protection and case management for young people sufficiently clear and were these followed between 2016-17? Are any changes to these arrangements required as a result of this SCR?

10. What do Chris's mother and other key family members say about the effectiveness of agency involvement? Which services made a positive difference to him and what could have been better?
11. To consider whether the outcome of Chris's death could have been predicted by any individual or organisation involved at the time and were there any missed opportunities that could have led to a different outcome
12. To be cognisant of the rise in serious youth violence in Newham and make recommendation from this review for the Community Safety Partnership and LSCB to ensure that a proactive and effective approach to preventing the criminal exploitation of young people in Newham is underway.

Initiation of the Serious Case Review (SCR)

Working Together 2015[3] sets out the SCR criteria where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The legal advice to the SCR Consideration Panel was not to undertake a learning review. This advice and the information provided to the panel were carefully considered by the Independent Chair of the Newham LSCB who made the decision that a Serious Case Review would be conducted and Ofsted were notified of this decision on 17th September 2017.

Purpose of Review

In this tragic instance, Chris has died and there are multiple indicators that he was subjected to gang violence, or threats of, and criminal exploitation linked to the illegal supply of drugs.

It was known to statutory partners that Chris was at risk of harm and the serious case review will analyse the effectiveness of multi-agency risk assessment, intervention and planning. The purpose of the SCR is for agencies and individuals to learn lessons that improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children.

Participation and Scoping

The following agencies had contact with Chris during the original period of focus of the SCR.

- Barts Health NHS Trust
- East London NHS Foundation Trust (ELFT)
- Child and Adolescent Mental Health Services (CAMHS)
- East Thames Housing

[3] *Working Together to Safeguard Children,* Department of Education, 2015

- GP
- Housing (London Borough of Newham)
- Lewisham Youth Offending Team
- Newham Youth Offending Team
- Metropolitan Police
- Newham Children's Social Care
- Newham School Nursing Service
- Tunmarsh School (Pupil Referral Unit)
- Newham Youth Service

All agencies above were asked to complete an Individual Agency Management Report (IMR), which includes a chronology of key events, agency response, the recorded views of the young person and analysis of the agency response.

The extension of the period of focus, brought contact with the following agencies into scope and so their engagement with Chris was also reviewed within the SCR process.

- Woodside Primary School
- Forest Gate Community School