



CSCP
CROYDON SAFEGUARDING
CHILDREN PARTNERSHIP

CHILD SAFEGUARDING THEMATIC REVIEW **SERIOUS YOUTH VIOLENCE**

December 2023

“The importance of place as a reflection of self”

A Guide for The Reader

This report is a tribute to the children and families who shared their stories and insights with us. Bridget Griffin is the Independent Author and lead. (She was also a co-author for the [CSCP Vulnerable Adolescent Review](#) published in 2019). Bridget acknowledges that this report is enhanced by the collaboration from professionals and the community who were so open and passionate about Croydon and their desire to see credit and improvement for the work that happens daily in Croydon, to reduce risk for young people affected by serious youth violence.

Additionally, the following are recognised for their valuable contribution, tenacity and co production. Vicky Hersey (CSCP Administrator) Paulin Sullivan & Natasha Reynolds (CSCP Project Officers) and Donna Swirski (CSCP Business Manager).

Together, we urge you to read the entire report to appreciate the complexity and diversity of the children and families' experiences, as well as the perspectives of the practitioners and the community.

We understand that reading this report may take some time and effort, so we ask that organisations and community groups provide adequate time and support for their staff to do so. The contents page has been designed to be interactive to help you navigate the report and find the topics or references that are relevant to you or your work.

You can also use this report as a reference tool. Should you only want to select a question or a finding, the numbered tabs on the right-hand side of each page should be used to locate the corresponding sections. The square will take you back to the contents page. This method, along with the shorter briefings, can be useful for initiating actions and enhancing learning within teams or forums.



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Executive Summary

This Child Safeguarding Practice Review (CSPR) has been written on behalf of children and young people, multi-agency services, practitioners, family members and the community in Croydon. There was a desire to bring these voices to the fore - their voices have been reflected throughout this report. This CSPR has been a long review involving multiple strands which has included extensive information gathering and consultation. Throughout the process, multi-agency services have learnt from what has emerged and services have adapted and evolved in order to make a difference to children and families in real time.

The CSPR is focussed on seven children/young people who were charged in association with the deaths of three children in 2021, these tragic deaths were not linked. The CSPR panel recognised the dynamic interplay between victim and perpetrator and therefore concluded that referring to these children/young people simply as a perpetrator would be misleading. During almost the entire period of multi-agency interventions all but one of the children/young people were under eighteen. The panel recognised that although it is common/preferred practice to refer to adolescents as 'young people' the term children/young people will be used throughout in recognition of the legal definition, and unique vulnerabilities, of a child.

There has been active and committed involvement of multi-agency services and community representatives including over sixty front line practitioners. On behalf of Croydon Safeguarding Children Partnership (CSCP), the Independent Reviewer was privileged to meet with four parents and a child. These meetings were a humble reminder of the trauma and immense grief that follows from serious youth violence both from the perspectives of parents who lost their son and from the perspective of parents whose son was charged in association with the death of another child. All were open and frank about what needs to change and were grateful for the opportunity to tell their story and be heard. Their perspectives have been included in this report.

The six Key Lines of Enquiry (KLE) were agreed at the start of this CSPR.

KLE 1

Review the support provided.

KLE 2

Identify where/why support ceased and any learning outcomes.

KLE 3

Include the voice of the child, understand his daily life, and consider reasons why support may not have been accessed or effective.

KLE 4

Review current community support provision, especially where it may be possible to empower parents of young people.

KLE 5

Learn from the families (including the families of the children who died)

KLE 6

Learn from the experiences of front-line practitioners in terms of what works well and what more may be needed locally and nationally to improve outcomes for young people affected by SYV.

Key Line of Enquiry 1: Review the support provided

A wide range of services and interventions were provided to six of the children/young people over several years and persistent attempts were made to engage them. The overriding message is that by the time statutory services were involved it was too late – more robust early intervention was needed at an earlier point in the child/young person's life. However, as suggested by the national picture, it is not entirely clear what interventions would have made a discernible difference – there is little hard evidence about the effectiveness of interventions.

Perhaps unsurprisingly, exclusion from school and managed moves was a key feature of their lives - all six were either excluded from school or the subject of a managed move. There was a strong call to do more to avoid managed moves/exclusion and be persistent in avoiding negative language when referring to children who are displaying help seeking behaviour- negative labels can shape perceptions of self and frame the response by practitioners/ services. A consistent message was the need to identify any learning needs, in particular any speech and language difficulties, as early as possible and there were concerns about the lack of availability of, and lack of engagement with, Child and Adolescent Mental Health Services (CAMHS). The work across all services illustrates the importance of relationship-based practice and the need to strengthen an approach that sees young people exposed to serious youth violence/extra- familial harm as children in need of safeguarding at the earliest possible point.

Unsurprisingly, the vital importance of school and doing more to avoid managed moves/ exclusion was emphasised. Consistent, reliable, and trustworthy relationships with children and families is key and there is a need to cease negative labelling and avoid expectations that multiple services/multiple practitioners are helpful.

Key Line of Enquiry 2: Identify where/why support ceased and any learning outcomes.

In addressing this KLE, the CSPR has been severely hampered by the way in which multi-agency services focus primarily on factual recording of services provided/interventions. There is no facility built into the recording systems to record the unique outcomes for a child as the result of an intervention/service. As a result, records are largely limited to detailing what and when a service was provided and the ending of this provision – records detailing impact/outcomes are few and far between. This impacts on the ability to test what works. It is a systemic issue that is not unique to Croydon.

Families, practitioners and members of the community, stressed the need to intervene early instead of at a point of crisis. Gaining consent was identified as an important issue resulting in engagement and non- engagement and the revolving door of service provision. The report stresses the need for services to be resilient in seeking engagement and observes the need to pay attention to intersectionality, intergenerational experiences of poverty, discrimination and previous experiences of state intervention in family life and how this might influence engagement with statutory services.

The importance of positive role models and envisioning a different future is emphasised alongside avoidance of negative labelling or adultification – seeing the child as in need of protection, kindness and care rather than an adult making 'lifestyle choices'.

This is particularly relevant to Black British children.

The findings from this KLE emphasises that consent must be pro actively sought and used to ensure engagement, not as a means/excuse to disengage – services need to be resilient in the face of non- engagement. How professionals describe a child and a family, and outcomes of interventions, matters – this impacts not only the engagement of children and families but on the engagement of professionals.

Key Line of Enquiry 3: Include the voice of the child, understand his daily life, and consider reasons why support may not have been accessed or effective.

Practitioners understood the children's lived worlds and the systemic context in which they lived. The importance of nurturing hopes and dreams, and a sense of belonging, was stressed.

The importance of hearing a child's voice was widely understood and professionals could easily recall the children's voices, but routine recording of the child's voice on casework notes was inconsistent. If this voice is held largely in the memory of the professionals who have been involved, the child's voice can be lost to future professionals/services.

Building positive identities including promoting healthy masculinity and seeing the importance of father/father figures in their lives was seen as an area that should be strengthened. Practitioners, panel members, children and families and members of the community felt strongly that the recent changes in Croydon town centre may be eroding a positive sense of community and belonging.

The findings from this KLE emphasises the importance of 'place' as a reflection of self and a source of identity and belonging. How positive identities are formed and maintained, and the societal influences on identity, are important to understand and ways should be found to mitigate the risks of negative stereo typing.

Key Line of Enquiry 4: Review current community support provision, especially where it may be possible to empower parents of young people.

The importance of relationships that are human (rather than bureaucratic) and trustworthy was identified as key - providing practical support that improves the day-to-day life of a family can be a critical way to provide meaningful support and nurtures engagement/trust. The importance of empowerment through the provision of community-based services that provide positive role models, nurtures belonging and builds a positive identity was stressed. The council and partners working alongside the community in a respectful relationship is key.

The findings from this KLE highlights the importance of creating and maintaining flexible opportunities for the council and partners to work closely with the community and to seek ways to support families and communities that are founded on an understanding and appreciation of the day-to-day challenges of ordinary life. One practical step would be to publish a comprehensive directory of services in Croydon that supports a whole family, positive enhancement approach rather than a list of agencies to support families when there are challenges.

Key Line of Enquiry 5: Learn from the families (including the families of the children who died)

Families set out key areas they felt needed attention in schools and across multi-agency services. They spoke about the need to provide interventions as early as possible in a child's life and were keen for these interventions to be provided within the community, alongside the community and as far as possible by the community. Many of the issues raised by families were shared by practitioners and members of the community.

Parents spoke about the need to have a swift and robust response when children carry knives or are at risk of involvement in Serious Youth Violence (SYV). Delays in children facing the consequences of their actions, through the courts, was identified as a key area that required attention.

The findings from this KLE emphasises the importance of continuing to nurture and sustain trusted relationships with families and involving them in the co-production of future service developments.

Key Line of Enquiry 6: Learn from the experiences of front-line practitioners in terms of what works well and what more may be needed locally and nationally to improve outcomes for young people affected by SYV.

Again, the key message was the need to provide consistent and trustworthy relationships. Many examples of what works well were identified alongside what may be needed nationally and locally - and at a strategic and operational level.

The findings from this KLE emphasises the quality and often innovative work with children at risk of SYV. The value of an experienced workforce with the time to engage effectively was stressed. In summary, preventing harm caused by serious youth violence are complicated systemic challenges. The learning reaches across systems and hierarchies illustrating that a whole systems partnership approach is needed hand in hand with children and families and the community. However, as articulated by the Association of Directors of Children's Services (ADSC)¹:

“Yes, we need to understand and act on individual risk factors, such as being out of formal education or early exposure to violence in the home, but unless we turn our attention to wider societal determinants, young lives will continue to be lost on our streets; research clearly shows there are links between higher levels of inequality and increased violence.”

¹ ADSC Discussion Paper *SERIOUS YOUTH VIOLENCE AND KNIFE CRIME* July 2019 The Association of Directors of Children's Services Ltd

10 KEY PRINCIPALS

K.I.D.S. V.O.I.C.E.S.

To reduce the risk of children becoming involved in Serious Youth Violence, all multi-agency and community services should apply these key principles to current service delivery models and any new initiatives.

KNOWLEDGE

Empower children to understand that carrying a knife won't keep them safe. Teach them how to think differently and provide support to help change this ideology.

IDENTIFY

Identify the children who require help early and ensure timely progression of support particularly SALT / emotional well being support / identification of learning needs in school and in transition.

DUPLICATION

Identify and eliminate any unnecessary overlaps or repetitions for children and their families. Work in the spaces that already exist.

STICK WITH IT

Tenacity should be applied to all forms of engagement with children, young people and families. Ask why when faced with non-engagement.

VOICE

Strategic and senior leaders should respond to the feedback of families and practitioners about what more is needed in Croydon to reduce Serious Youth Violence.

OUTCOMES

Understanding and evaluating the outcomes of interventions by statutory and community services is required. This should not be solely reliant on short term key performance indicators but on long term outcomes for a child.

INNOVATE

Good practice locally and nationally should be used to inform service developments (such as the Youth Justice Service approach to tackling discrimination, including Adultification).

COMMUNITY

There should be a continued and evolving focus on finding creative and flexible ways to work with the community and with families in full and equal partnership.

EDUCATION

Principles to achieve stability of education should be agreed with senior education leads including specialist providers and mainstream schools. The work of the Alternative Provision Specialist Taskforce Programme should continue to be built on.

SPACES

The importance of place, and the risks posed by the changing landscape in Croydon, must be at the centre of strategic decisions and related policies.

Introduction

Youth Violence is a global, public health problem. It includes a range of acts from bullying and physical fighting to more severe sexual and physical assault to homicide¹.

In 2021, the worst year on record was reported in London for children dying because of serious youth violence. Tragically, 30 teenagers died, five of these deaths occurred in Croydon. The reasons why the numbers rose to such levels at this time are not completely understood although it is important to acknowledge that at the time of the children's deaths, the UK was emerging from fluctuating periods of lockdown caused by the Covid 19 pandemic. By May 2021, retail outlets were opening as were leisure facilities and by July most legal limits on social contact were lifted. It is important to recognise that the children who are the subject of this review would have spent over 16 months of their adolescent years in the pandemic. The implications of this are not widely researched although some research suggests that there has been a significant impact on children's mental health and well-being, and on the services they have received.²

The Croydon Safeguarding Children Partnership (CSCP) reviewed the circumstances of the children who had died and concluded that a thematic Child Safeguarding Practice Review (CSPR) was required to understand what could be learnt about how children could be better safeguarded from serious youth violence. It was recognised that various Serious Case Reviews/Child Safeguarding Practice Reviews have been completed in Croydon in the recent past,³ focussing on the victims of serious youth violence and an extensive review⁴ regarding children who were considered most vulnerable (many due to extra familial harm). The learning that has emerged has been shared widely in Croydon and has informed significant service developments.

Family members who had been part of two Serious Case Reviews⁵ in Croydon commented that reviews would be better focused on those responsible for the death of their child. Learning from these various reviews, and from family members, led CSCP to conclude that this review should focus on the services provided to those children/young people who had been charged in association with three of the tragic deaths in a strong desire to better understand what more might be done to prevent children suffering from acts of serious youth violence.

Review Focus

This CSPR will focus on seven children/young people who were involved in three, unrelated incidents, which led to the deaths of three children/young people. Initially these seven children/young people were considered 'the alleged perpetrators'. However, this review recognises that children/young people involved in serious youth violence often experience the dynamic interplay of being both a victim and a perpetrator and that for all children/young people involved in serious youth violence the outcomes for these children are too often tragic. Therefore, this CSPR will refrain from describing the children/young people as simply 'perpetrator/s'.

¹ World Health Organisation, 2022

² Growing problems, in depth: The impact of Covid-19 on health care for children and young people in England. Nuffield Trust February 2022

³ Such as: Croydon Serious Case Reviews Child Q & Child Y 2019

⁴ Croydon Safeguarding Children's Board. Vulnerable Adolescent Review 2019

⁵ Croydon Serious Case Reviews Child Q & Child Y 2019

It is widely recognised that many children involved in serious youth violence have experienced adverse childhood experiences, the children/young people in this review are no exception. However, much is already known about the impact of these experiences on children's outcomes. The intention of this CSPR is not to repeat what has already been learnt in Croydon, or from the significant body of national learning that exists.

Methodology

This CSPR aims to provide a proportionate and meaningful account of the multi-agency support and interventions offered to the seven children/young people and the outcomes of that support to add reflection and learning into the local safeguarding system. Independent Reviewer, Bridget Griffin⁶ was appointed to chair the CSPR Panel, facilitate reflective conversation workshops with practitioners and contribute to the report. The Panel was convened from multi-agency professionals who were previously members of the Vulnerable Adolescent Priority Group⁷. They had been responsible for completing the actions relating to the Vulnerable Adolescent Review in Croydon⁸ and had significant expertise of working with children at risk of serious youth violence/extra familial harm but had no direct involvement with the children/young people who are the subjects of this review.

At the outset, there was a strong desire to include the perspectives of the children/young people and their families. Speaking to the children/young people has proved difficult as the majority were in custody either having been convicted or facing criminal proceedings relating to the incidents. One child/young person agreed to speak with the Independent Reviewer and three families have generously shared their views about the services provided.

Key Lines of Enquiry

The following key lines of enquiry were agreed by Croydon Safeguarding Children Partnership (CSCP):

1. Review the support provided.
2. Identify where/why support ceased and any learning outcomes.
3. Include the voice of the child, understand their daily life, and consider reasons why support may not have been accessed or effective.
4. Review current community support provision, especially where it may be possible to empower parents of young people.
5. Learn from the families (including the families of the children who died).
6. Learn from the experiences of front-line practitioners in terms of what works well and what more may be needed locally and nationally to improve outcomes for young people affected by Serious Youth Violence (SYV).

⁶ Bridget Griffin CQSW, BA, MA, Social Care Institute for Excellence (SCIE) Accredited Lead Reviewer

⁷ The Vulnerable Adolescent Priority Group is a subgroup of CSCP

⁸ Croydon Safeguarding Children's Board. Vulnerable Adolescent Review 2019

Information Gathering and Analysis

Information gathering and analysis involved several key strands of multi-agency work. A targeted council wide review of multi-agency services provided to a group of five children/young people who tragically died during a specific period of time, including the three children identified in this CSPR, has been completed by Croydon Council. The learning from this review has informed this CSPR.

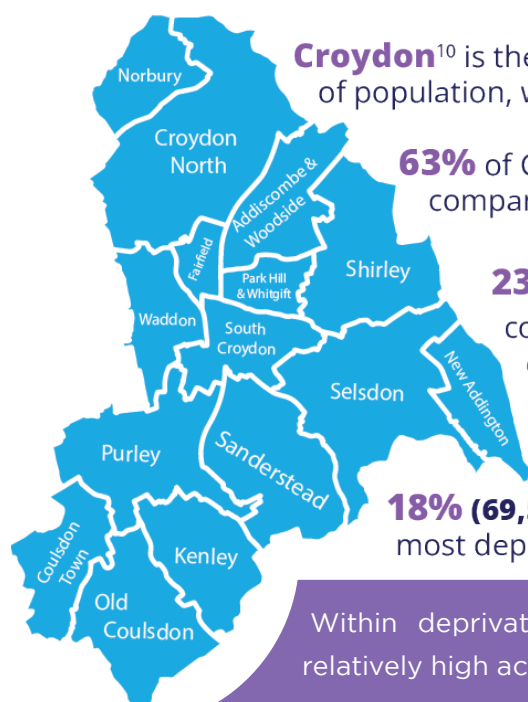
A survey was sent to all professionals identified as working with the seven children/young people with an expectation that the chronology of multi-agency involvement would be reviewed focussing on service involvement from the age of ten until the time prior to the significant incidents which tragically led to the deaths of the three children. The survey posed questions about the interventions/services that were provided/offered and the outcomes. This enabled information to be gathered about the lives of these children/young people and their experience of the support that was offered or provided. This informed the panel discussions about the key themes that required further exploration with practitioners.

Three reflective conversation workshops, three case discussions and a webinar took place equating to the involvement of over 100 multi-agency practitioners. These were led by the Independent Reviewer and involved professionals who knew or worked in the services identified as supporting the seven children/young people. A meeting involving over fifty community members took place to gain their perspectives. These learning events focused on the key lines of enquiry and included additional lines of enquiry identified by the panel. An online tool⁹ was used to enable anonymous, real-time participation by professionals and community members, as well as the ability to add further reflections up to a week after the events.

Concurrent to this review, the Community Safety Partnership has been developing its [Youth Safety Delivery Plan](#) (YSDP). Launched in September 2023 much of its work is aligned with this CSPR. There is ongoing collaboration to ensure the findings and recommendations of this review inform the YSDP.

⁹ Mentimeter enables engagement with workshop participants online using live polls, word clouds, quizzes, multiple-choice questions and more. It enables views to be given and results to be available to the group in real time.

The Local Context



Croydon¹⁰ is the largest of all the London boroughs in terms of population, with approximately 390,800 residents.

63% of Croydon's residents are in the 18-64 years age band compared to 66.6% in the same band in London.

23% of Croydon's population are aged **17 years and under** compared to the London average of **22%**. This has inevitable demand implications for education provision and all multiagency services provided to adults and young adults.

18% (69,576) of Croydon's population are among the **20%** most deprived nationally.

Within deprivation subcategories crime and housing deprivation are relatively high across Croydon.

Levels of **permanent exclusions** from primary and secondary schools in Croydon are **similar to the regional average and lower than the national average**.

The rate of children subject to child protection plans (CPP) per 10,000 children has been going down in Croydon and **is now lower than the regional and national rates**.

There continues to be a drop in the annual numbers of first-time entrants aged 10-17 years to the Croydon Youth Justice System.

Croydon reports a high level of gang involvement in the borough with children/young people being exploited by drug dealing through 'county lines'¹⁰ - it is deemed to have the highest numbers in London (Rescue and Response 2023).¹¹ *Young people are being exploited by gang members into conducting violent acts in the name of the gang, this can lead to retaliation which continues the cycle of violence.*

A children's services Ofsted inspection in 2017 led to significant investment in services for children with a strong ambition to improve the services provided. During monitoring visits that followed the 2017 inspection, Ofsted noted the scale of the challenge facing Croydon due to the size and complexity of its children's service.¹²

In February 2020, inspectors found the service 'dramatically improved' and 'transformed' concluding that 'services for children in need of help and protection are now good, and services for children in care and care leavers are improving well.' Since this time, Croydon has faced considerable financial challenges and as a result there has been significant organisational flux and change in service provision. Many of the practitioners involved in this CSPR identified that these changes had a direct impact on the services provided to these children/young people at a critical time in their lives.

¹⁰ County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs.

¹¹ [Croydon Youth Safety Plan 2023 - 2026](#)

¹² [Croydon Youth Safety Plan 2023 - 2026](#)

The Children Who Tragically Died

The Terms of Reference (TOR) for this CSPR have been intentionally focused on the children/young people who were charged or have been sentenced in association with the deaths of three children/young people. Information known about the children/young people who died was expected to be considered in this CSPR. The internal targeted review completed by Children's Social Care (CSC) was a thorough analysis of the services provided and the learning that emerged will be implemented alongside the learning from this CSPR. It was the view of the panel that including full details of the victims in this CSPR risked skewing the focus of the review. It is important to acknowledge that **whilst disproportionality was a feature for all, and this may have contributed to increased risk and vulnerability**, the children who died were unique – whilst two shared some common life experiences – one did not. The incidents that led to their deaths were not linked. Each of their deaths involved distinct circumstances with one in particular illustrating that children engaging in an everyday activity can be at risk of serious youth violence because of random acts of violence.

The Children/Young People¹³ Linked to these Deaths

All of the children/young people are Black British, of varied cultural heritage. Their ages, at the time of the deaths of the three children, ranged between 15 - 20 years old. All the children/young people have lived within some of the most deprived areas of Croydon. Some areas of the North, where the children/young people resided, are amongst 5% of the poorest areas within the country, other parts being 10 - 20% of the most deprived areas in the country. Several of the children/young people knew each other and lived in relatively close proximity; all had links to being exposed to sources of extra familial harm.

At the time of the incidents leading to the deaths, 4 children were under 18, 3 were over 18. In terms of court outcomes for the seven children/young people: Ade, Gabe and Fynn were found guilty of murder, Blake and Cole of manslaughter¹⁴, Ethan and Dane of robbery. **All the children/young people are referred to using pseudonyms to protect their identities.**

Ethan was not known to multi-agency services in the local area¹⁵ (apart from minor involvement with the police). Information relating to the six other children/young people is known and this information suggested they experienced the following factors – although not all these experiences were shared:

- Involvement with statutory services at an early age
- Domestic abuse within the family
- Difficulties in relationships with their parent and/carer which led to violence.
- Exclusion from education
- Offending behaviour
- Missing episodes

¹³ As some were children (under 18) and others young people (over 18), where they are referenced as a cohort the term 'children/young people' is used. When referencing a time in their lives (when referring to an individual under 18) 'child' is used.

¹⁴ Of the group of 5 convicted of murder or manslaughter other offences included robbery and possession of a weapon in a public place

¹⁵ There may have been a history of multi-agency involvement in his younger years in another area but as Ethan had no multi-agency involvement in the local area, this history was not known.

- County lines
- Mental ill health/emotional troubles
- Substance Misuse

There is also evidence of positivity in some of their lives including:

- Faith
- Engagement in education
- Strong maternal/paternal relationships
- Strong relationships with grandparents
- Career minded
- Thoughtful and positive engagement when attending appointments
- Trusted relationships with professionals

Statutory services were involved with the six children/young people at various points in their lives, four were known to have been victims of serious youth violence. Four of the children/young people received specialist interventions to meet their learning needs during adolescence. Ade had an Education and Health Care Plan (EHCP) and an EHCP was requested for Gabe but not approved. Cole and Dane were assessed by an educational psychologist and Cole engaged in Cognitive Behavioural Therapy provided in his school. Dane was assessed by the Speech and Language Therapy service (SALT) and Fynn received a SALT service

Life Experiences - Six of the Children/Young People

The Croydon Violence Reduction Network Strategic Assessment (2019) used a sample of ten high risk and prolific offenders to conduct a Life Analysis (Public Health model). The aim of the analysis was to identify any common events or factors which contributed to their involvement in serious youth violence (SYV). This CSPP has used this model to analyse the life experiences of the six children/young people, (not including Ethan) identifying the shared issues within their lives.

0-9 years:

Their early years featured adverse childhood experiences. Domestic Abuse was a common theme. Other issues included parental illness/mental health, difficulties with housing and multiple primary schools. One of the children was referred multiple times to the Child and Adolescent Mental Health Service (CAMHS) as it was suspected he may have autistic spectrum disorder (ASD), or attention deficit hyperactive disorder (ADHD). One child was referred to CAMHS for an ASD assessment and remained on the waiting list for a neurodevelopmental assessment. One child was the subject of a CAMHS assessment as there were concerns about his mental health, this did not result in a diagnosis at the time. For all six of the children/young people there was regular contact with Children's Social Care (CSC) at different points in their lives, the earliest involvement of CSC was with one of the children when they were four years old. One child was the subject of a child protection plan from the age of seven for three years.

With the benefit of hindsight, the current outcomes for these children suggest that this early intervention by statutory services was not effective. However, it is important to recognise that these interventions happened up to ten years ago, there have been significant service changes since this time and therefore no relevant conclusions can be drawn about current service provision. Nevertheless, as the following section illustrates, it is reasonable to suggest that their lived experiences influenced the children's ability to learn, regulate their emotions, engage and thrive.

10-12 years:

Agency records suggest that three of the children were beginning to misuse substances at this age. There was no evidence seen of a referral to a specialist substance misuse service which may have allowed for early intervention to prevent the development of problematic use.

13-14 years:

Risks began to emerge outside the home with missing episodes, suspected county lines, and gang membership. One child was taken into the care of the local authority, but the risks of extra familial harm did not reduce. Extra familial harm began to seriously impact on the children's lives with an increase in offending behaviour and being both associated with, and victims of, serious youth violence. There was evidence of criminal exploitation through county lines and gang membership interspersed with periods in hospital because of injuries sustained after being a victim of youth violence. There were concerns regarding missing episodes and the longevity of those episodes. Both statutory and voluntary sector services were in place to support the children and engagement was reported but interventions did not appear to lead to a fundamental change in behaviour or a reduction in risk.

15-16 years:

Consequences for their behaviours (crossing over from 13 -14 years) were faced with the children receiving community and/or custodial sentences for their offending behaviour. However, it was recognised that the children were also being exploited/were the victims of modern slavery and four of the seven were referred to the National Referral Mechanism (NRM)¹⁶.

¹⁶ The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

Key Line of Enquiry 1: Review the support provided



Introduction

As previously detailed, many of the children/young people experienced adverse childhood experiences. Research firmly establishes that these experiences would have had a significant influence on their lives in childhood and adolescence. With the benefit of hindsight, it was clear that there were missed opportunities to make a difference to these children earlier in their lives. As previously stated, this CSPR seeks to avoid duplication of what is already known, however, it is important to hold in mind how their early childhood experiences may have impacted on their trust/engagement with services and their ability to access support.

Multi-agency Interventions

The following section summarises the involvement of key multi-agency services in the lives of children and young people. The survey results illustrate that six of the children and young people received extensive interventions from a range of statutory, non-statutory, and community services. The survey asked services to identify any 'reachable moments' or missed opportunities in their lives. The overall response indicated that opportunities to intervene early in the child's life were missed, with a particular emphasis on providing emotional support to children who have lived in households where there has been domestic violence. A handful of 'reachable moments' were identified during adolescence. It is important to note that none of these children and young people were known to the Early Help Service.

Learning from the National picture

The concept of reachable moments/missed opportunities to respond differently to prevent difficulties escalating for children/young people is a reoccurring theme in various CSPRs¹. However, identifying these 'reachable moments' appears to happen only with hindsight. Preventative action is required at an early point in children's lives, however there is insufficient evidence available to test which interventions can really make a difference².

For the purposes of this CSPR, it is not proportionate nor is it possible to measure or quantify the impact of each service intervention with the children/young people. Reliance on outcome measures such as educational attainment or criminal behaviour are relevant but a blunt way in which to understand the unique outcomes for a child/young person and their family of the myriad of services provided. It is important to acknowledge that current systems are focused on offering services and recording attendance/compliance but not outcomes. Data collection systems in public sector services are not set up to measure, record and collate outcomes in children's lives. Therefore, there is little hard evidence about the effectiveness of any particular service

¹ Such as: Birmingham SCP CSPR Child A & Child B (September 2021), Waltham Forest SCP CSPR Child C (May 2020)

² It was hard to escape. The Child Safeguarding Practice Review Panel, 2020 (page 8)

or intervention to reduce the risks: The issue of arriving at genuine outcome measures is difficult in all child protection work and none more so than in this area³.

It is important to bear in mind that all these children/young people are unique individuals – whilst they may share some common life experiences they should not be regarded as a homogeneous group. Each have their own unique personalities, families and life journeys. It is a credit to the multi-agency practitioners involved that they have recorded or remembered, as part of their involvement in this CSPR, specific details about the children/young people which reflects on their care for the child/young person and a unique knowledge of their lived experiences.

Children's Services

At some point in their lives, all received services from Children's Services (as a child in need of protection or a child looked after). The records suggest that statutory meetings took place as required. Multi-agency working was achieved overall, although multi-agency attendance at statutory meetings was not always consistent. There appeared to be some strong relationships formed between the allocated social worker and the child although the detail of the direct work/interventions was not well documented. There was a significant flux in the social workers allocated to the children. Frequent changes in a child's social worker meant that new relationships had to be formed with the child and the family; and trust re-established. This undoubtedly impacted on the continuity of the relationship, on the direct work that was completed, and on the engagement of children and families. Social workers and managers are clear that trusted relationships are at the very heart of achieving good outcomes for children.

Learning from the National picture

When considering outcomes and why interventions don't effect change, the Child Safeguarding Practice Review Panel comments on the superficiality of relationships that children form with practitioners and the fact that while it is relatively straightforward for practitioners to identify contextual harm, children are not meaningfully sharing what is going on in their lives. Despite most of the children being described as bright, respectful, likeable and warm, they only engaged with practitioners on a superficial level⁴.

It appears that there was an exception to this when the Croydon Adolescent Team were in place. This team of fifteen social workers worked closely with children who were at risk of serious youth violence/extra-familial harm, and their families. Practitioners, who contributed to this CSPR, described the clear vision, passion and expertise of this team in working with children and their families. There was evidence that some of the children/young people, who are the subject of this CSPR, benefited from the interventions of this team. The team was reduced to five social workers after urgent financial savings had to be made as a result of a S114 notice⁵ (colloquially known as 'bankruptcy') for Croydon Council in 2020.

³ It was hard to escape. The Child Safeguarding Practice Review Panel, 2020 (page 41)
Wokingham Safeguarding Children Partnership CSPR 'Harry' December 2022

⁴ It was hard to escape The Child Safeguarding Practice Review Panel, 2020

⁵ Councils are required by law to have balanced budgets. If a council cannot find a way to finance their budget then a Section 114 (S114) must be issued. The issuing of a S114 notice bans all new spending with the exception of protecting vulnerable people and statutory services and pre-existing commitments.

Learning from Families

“She (the adolescent team social worker) was ‘a little feather’ in our lives – she went above and beyond – instead of just talking to (child’s name) in her office and ticking a box – she would take him out for a walk – go for something to eat – he came back a different person – she went above and beyond in the support she provided to us as a family – I will never forget her.”

The social worker moved to another team when the adolescent team was disbanded.

Whilst it is understood that the contextual safeguarding approach used by the team was embedded within the statutory safeguarding teams in the Children’s Service, practitioners said that disbanding the team represented a loss of very experienced contextual safeguarding practitioners who were passionate about working with children at risk of serious youth violence/extra-familial harm and the continuity of relationships with children was lost.

Current Service Approach (Children’s Social Care)

During discussions within Children’s Social Care (CSC) about current interventions/approaches with children at risk of serious youth violence, it was clear that various evidence-based approaches and tools are in use. These approaches are delivered within a contextual safeguarding approach and often aimed at strengthening emotional wellbeing by, for example, improving self-esteem, regulating emotions, strengthening emotional well-being, and improving relationships with family and peers. It was understood that social workers who are more experienced in contextual safeguarding are better able to form relationships with children at risk of serious youth violence/extra-familial harm. The biggest barrier to achieving engagement was identified as the frequent changes of social workers. The retention of social workers was felt to be critical in building trusted relationships and thereby promoting positive engagement.

It was recognised that the statutory nature of the social work role can mean that some children choose not to engage with social workers. It was stressed that in these circumstances it is important for the multi-agency network to identify who is the right person to deliver an intervention/form a trusted relationship with a child.

Learning from the National picture

Several reports comment on this issue – Waltham Forest Safeguarding Children Partnership highlights the sheer number of professionals involved with the family and the risk of confusion and duplication⁶. It was hard to escape⁷ highlights the need to focus on one person having the key relationship and a team around the relationship approach while resisting the temptation to engage more and more different practitioners into the network, especially if they are to have limited involvement and the idea that which agency is in the lead should be a secondary consideration to the relationship itself.

⁶ Waltham Forest Safeguarding Children Partnership CSPP Child C May 2020 (page.59)

⁷ It was hard to escape The Child Safeguarding Practice Review Panel, 2020

Learning from good practice – Fynn

Fynn came into the care of the Local Authority when he was 14 – there were significant concerns about criminal exploitation at this time and his mother felt unable to safeguard him at home. Fynn lived in a foster placement and later in a residential unit. Extensive work was completed across the multi-agency network to safeguard Fynn and, in line with his wishes, to enable him to safely return home. The team around Fynn and his family included the Youth Justice Service, the Social Work Team, the Edge of Care Team and the Youth Engagement Team. This network worked closely together with Fynn and his mother and promoted ‘a team around the relationship’ approach when the family resided in Croydon.

Education Services

Exclusion from education is continuing to play a part in the escalation of vulnerability among young people who become victims of exploitation and the role of education is key in ensuring a more holistic and earlier intervention⁸.

Learning from Families

“Exclusion from school was the biggest issue for him – it was at this point those things got worse – there was no clear plan for him to return to mainstream school – this was very important to him – I lost my child.”

“Managed moves have to stop – children get a label, and the label stays with them – they get bounced around – chucked into another school – what must this be like? They have lost their friends – they try hard to make new friends – be sociable but this can mean they end up with friends who pose a risk to them.”

“There should be a defined pathway for children at risk of exclusion and all possible resources should be put in then – not at the point when they have been excluded or when awful things happen – when they have been stabbed/or have ended the life of a child and their family.”

“Why is it that some schools can manage children – why do some teachers manage to respond and not escalate a situation when a child is being challenging? – there have been so many incidents when there has been an overreaction to minor challenges but then there are some teachers who are passionate about their work and don’t overreact – it is a lot to do with the leadership of the school.”

Overall, engaging with education seemed to present challenges for the children – none benefited from a stable school place. In the most part, their experiences of secondary education were subject to change although for two children there was evidence of disruption in their primary years with one child attending three primary schools. Within mainstream schools, interventions were put in place to support the children. This included a range of pastoral support, behavioural programmes, and support from individual staff such as learning mentors.

⁸ It was hard to escape The Child Safeguarding Practice Review Panel, 2020

Of the six children/young people who were known to multi-agency services all were either excluded from school or the subject of a managed move due to their behaviour and eventually placed within an Alternative Provision (local or outside the borough) or were working with the 'Virtual School'⁹ (local or outside the borough). During the reflective conversation workshops, practitioners stated that some of the children were academically able but disruption in their education appeared to have a significant impact on attainment and an escalation of risk followed. Community members highlighted exclusion as a key factor in children's lives impacting on their outcomes and various national reports have identified this as a significant point in the children/young people's lives.

Learning from the National picture

"Exclusion from mainstream school is seen as a trigger point for risk of serious harm. Seventeen of the children [included in the review] who died or experienced serious harm had been permanently excluded from mainstream education. Permanent exclusion was identified by practitioners and family members as a trigger for a significant escalation of risk."¹⁰

- Wokingham, Hackney, Birmingham and Waltham Forest Safeguarding Children Partnerships identify this as a significant issue¹¹.

For some, the environment provided within alternative provisions allowed them to thrive. There was evidence to suggest that these children built strong relationships with staff, were able to engage with education, talk about their life experiences and express their views.

Learning from the experiences of Cole

For Cole, education (school and alternative provision) was identified as a 'safe space' where he did relatively well. Feedback during the reflective conversation workshop from practitioners who had been involved with him suggested that he may have excelled in school if there had been a successful intervention regarding his home life at an early point in his life - emotional difficulties within the home environment had a significant impact on his educational attainment and behaviour throughout his life and that critical moments to intervene to improve his experiences at primary school were missed.

Learning from the experiences of Fynn

Fynn spoke with warmth about a schoolteacher that he met in school towards the end of his secondary education - he said the teacher believed in him and Fynn said to a practitioner, with joy and pride: "he said I could pass my GCSEs" - it seemed that for the first time Fynn believed he might be able to achieve something meaningful in his education.

Learning from practitioners

Fynn's experiences of feeling believed in, and that he might achieve, is a poignant illustration of what practitioners felt to be a critical message relevant to all children particularly those who are caught up in serious youth violence/at risk of extrafamilial harm.

⁹ The Virtual School is not a teaching institution. It is a model used by Local Authorities/county councils to provide services and support the education of children in care and a constructive challenge to those providing the services.

¹⁰ It was hard to escape The Child Safeguarding Practice Review Panel, 2020 (page 3)

¹¹ Wokingham SCP CSPP Harry (December 2022). Hackney SCP CSPP Child C (December 2020). Birmingham SCP CSPP Child A & Child B (September 2021). Waltham Forest SCP CSPP Child C (May 2020)

They spoke about the importance of conveying messages of hope and belief in a child/ young person's future, of building on aspirations and dreams and that the language that is used to describe a child in schools and by services, such as;

Defiant, non-compliant, out of control, unable to engage, troublesome, difficult, a liar can shape a child's perception of self – their internal narrative of who they are as well as shape the service response. This is discussed later.

Overall, the most consistent message from the wide range of practitioners who contributed to this CSPR was that the children they work with who are gang associated/ criminally exploited/ involved in SYV/ criminal behaviour have learning needs that have not been recognised/ diagnosed at an early point in their lives, this then leads to increasing withdrawal from school including non-attendance, behavioural difficulties and eventual exclusion. This is supported by the Youth Justice Service (YJS) experience of having a high number of their cohort requiring SALT services.

Learning from good practice – Schools

Croydon schools, who were represented at the reflective conversation workshops, spoke positively about the training they are currently receiving in trauma informed practice and how using a trauma informed approach can improve the response to, and perceptions of, children who are displaying behaviour that is difficult to manage in school.

What works for Children's Social Care (WWCSC) pilot: Social Workers in Schools (SWIS)

The Social Work in Schools Programme is currently in eight Croydon schools – the intention of this national pilot is to increase access to social work support by children and families and provide support as early as possible - this has been a very welcomed development in Croydon although CSC have been recently informed that the funding for this project will not be renewed.

Child & Adolescent Mental Health Services (CAMHS)

One child was referred to CAMHS for an assessment for autistic spectrum disorder (ASD) at the age of eight although a diagnosis was not made. He was referred again at ten but there is no record of the outcome in the records seen. When he was eleven a diagnosis of oppositional defiant disorder (ODD) was made and when he was twelve, he was diagnosed with attention deficit hyperactivity disorder (ADHD). One child was referred due to serious mental health issues, he was diagnosed with psychosis and sectioned under the Mental Health Act (1983) after the tragic incident.

A number of these children gave consent for a referral to CAMHS then withdrew consent, and later, gave consent again. Some were not brought to appointments with CAMHS. CAMHS practitioners use a wide variety of means to engage young people – home visits, therapeutic letters to young people, linking in with community services. However, this pattern of consent and withdrawal of consent, lack of engagement and delay in provision seemed to become a revolving door of referral and service provision.

The CAMHS context

There are high waiting lists within CAMHS, and this reflects a national picture. At the time of concluding this report, the local waiting time was reported to be two years - active attempts are being made to reduce this. Concerted efforts are made to achieve engagement with a child &/or their parent/carer. If this is not achieved, the case will be closed, and the inevitable process of re-referral and waiting will recommence. This is reflective of the high demands on this service and the need to keep waiting lists as low as possible to allow other children to receive a service from CAMHS.

Learning from the National picture

Child A had ADHD and he was taken to the GP who made a CAMHS referral for him. Mother was concerned about his 'hyperactive' behaviour, with violent outbursts at school and no sense of danger. He attended CAMHS once after which he 'was not brought'¹².

Learning from good practice - joint working

Gabe had severe mental ill health but found engaging with CAMHS difficult. He had formed a trusted relationship with a CAMHS practitioner, but this practitioner left the service and Gabe disengaged. Gabe had a trusted relationship with his YJS worker who supported the CAMHS worker to re-engage with Gabe via home visits which led to him re-engaging with CAMHS for a limited period enabling some therapeutic work to be completed - this was a positive piece of work delivered in partnership between the YJS and CAMHS.

Learning from the experiences of practitioners and panel.

It was identified that the pattern of giving and withdrawing consent, to the involvement of CAMHS, was familiar when working with children/young people at risk of extra familial harm. Experienced practitioners and managers in Croydon spoke about several barriers faced by children/ young people accessing CAMHS including:

- the stigma that is associated with mental health services.
- the long delay experienced by the child/young person in waiting to be seen.
- the practical difficulties experienced by children/young people in simply getting to an appointment.
- the difficulties for many young people in engaging with a traditional 'talking therapy' approach.

Learning from the National picture

A common theme found in local reviews and various thematic analyses by the Panel is the need for accessible mental health support to address early childhood trauma and reduce risk-taking behaviours. A frequent finding was that the eligibility criteria for Child and Adolescent Mental Health Services (CAMHS) support limited flexibility and responsiveness to meet children and young people's mental health needs¹³.

¹² Birmingham SCP CSDPR Child A & Child B September 2021 (Page 4.)

¹³ Child Safeguarding Practice Review Panel 3rd Annual Report 2022

Learning from good practice – Saffron Valley Collegiate (SVC) Croydon

The Alternative Provision Specialist Taskforce Programme¹⁴. A multi-disciplinary team was established and co-located at Saffron Valley in 2022 providing:

- Creative and flexible ways for the children/young people to engage in therapeutic relationships.
- Access to a range of therapies including EMDR (Eye Movement Desensitisation and Reprocessing)¹⁵, EFT (Emotionally Focused Therapy)¹⁶ & systemic family approaches.
- A team approach to understanding and responding to the needs of the children/young people.
- Accessible speech and language therapy.
- Specialist advice on learning needs.

During the academic year 2022 – 2023, as a result of this programme, out of a total of 183 students: 133 children accessed mental health therapies, 120 children accessed Speech & Language Therapy and 94 accessed the support provided by assistant educational psychologists. Where needed, additional multi-agency services were quickly identified and progressed although overall, the support provided at Saffron Valley led to a significant reduction in referrals to other services.

The perspective of children/young people and families at SVC

About mental health therapies - a child's perspective. "Hearing about myself and my life from someone else and in someone else's voice has really helped me to feel less angry and accept myself – hearing 'the sadness and the fury' helped a lot."

About Speech & Language Therapy - a child's perspective: "It helps me be more confident in class and I answer a lot more questions."

About Speech & Language Therapy - a parent's perspective: "Thank you so much for this report. I witnessed domestic violence when he was younger and didn't talk until we left when he was 2 and half years old. Eye contact and speech always an issue. Thank you, this is a really helpful report."

Youth Justice Service (YJS)

Six of the seven children/young people were known to the YJS. They were the subject of a range of orders, from community orders to custodial sentences. Two of the children/young people who had received custodial sentences had long offending histories inclusive of Serious Youth Violence (SYV). One young person, who was over 18 years at the time of the incident, was not known to YJS.

One child/young person had experienced escalation of serious youth violence over five years including being a victim of crime, being present when a young person was seriously injured when a crime was committed and committing SYV. All six had been both harmed because of SYV and charged with acts of SYV. All the children/young people had experienced a

¹⁴ This national pilot, funded by the DfE in 2022, has been established in areas where there are high rates of SYV

¹⁵ EMDR helps the processing of negative images, emotions, beliefs and body sensations associated with traumatic memories that seem to be stuck. These can contribute to a range of mental health problems.

¹⁶ Emotion-focused therapy is a therapeutic approach based on the premise that emotions are key to identity. According to EFT, emotions are also a guide for individual choice and decision making. This type of therapy assumes that lacking emotional awareness or avoiding unpleasant emotions can cause harm. It may render us unable to use the important information emotions provide.

breakdown in their secondary education prior to being known to YJS. Overall, the children/young people engaged well with the YJS, there was evidence of good multi-agency working, joint work, timely compliance with relevant court orders, procedure and guidance and a range of services, including mentoring/ involvement in community-based projects. There were poignant examples of some solid trusted relationships being formed with the children/young people and their families.

Learning from Families

“They (two YJS practitioners) were amazing – they cared about my son – they cared about us as a family – they always answered my calls – they responded to me and my son when we needed their support – they communicated with us – did what they said they were going to do – they did not just tick boxes – they are real - caring humans.”

Learning from good practice – YJS

Risk & Vulnerability Panel and Integrated Offender Management Panel: Croydon Youth Justice System recognise that many of the children open to their service have complex and traumatic histories, often arriving to the Service with an array of Adverse Childhood Experiences - 77% of the Youth Justice cohort has some form of identified Speech and Language need and many enter the system having already been excluded from school. The dual role of the Youth Justice System is to apply a child first approach whilst keeping others safe and requires the use of various models including a trauma informed workforce, relational and systemic approaches.

Reflective spaces: attended by the multi-disciplinary partnership, are used when considering Serious Youth Violence. The Risk and Vulnerability Panel, chaired by the Service Manager, acts as a way of monitoring risk identified ensuring the work of the YJS supplements and supports existing plans held by other partners in addition to reflecting on criminogenic risk factors. The panel enables practitioners to be assisted with the navigation of complex risk management.

Integrated Offender Management Panel (IOM): chaired by the Gangs and Youth Engagement Manager jointly with the MET Police supports agencies jointly monitoring those who are assessed as presenting most risk. The framework enables information sharing between the agencies to happen swiftly and incidents responded to quickly.

Police

The involvement of police with the seven children/young people was wide ranging including coming to the notice of police due to being missing, drug/weapon possession, being associated with other children/young people who were involved in criminality, being the alleged victim of crimes, possession of a knife and anti-social behaviour. Information was regularly shared with multi-agency partners and required processes followed. From the perspective of the various officers and teams involved, managing the risks for each of the children/young people was difficult as the various crimes involved multiple teams and multiple meetings across various forums and at different levels.

Practitioners spoke about a lack of trust, especially within the Black community, of the police. The statutory role of the police in enforcing law undoubtedly affected the engagement and the quality of relationship that children/young people and their families had with police officers. However, there was an important exception to this.

Learning from good practice – Police

Over a significant period of time, the police officer working with Gabe checked on him daily and formed a trusted relationship with Gabe and his family. The officer reported,

“.....we didn’t receive training on how to deal with an exploited child we simply used our knowledge acquired from our police careers. With Gabe I had a lot of contact with Mum and made sure we attended when it was deemed the right time for Gabe, not just turning up.

I spoke with Mum separately about ways that she felt would work well to keep Gabe safe. I kept mum updated throughout in relation to safeguarding and our proactive investigation in which suspects were arrested charged for the drug line used to exploit Gabe. This I believe made the relationship better as she was in the loop and understood we were working hard to help keep her family and Gabe safe. I spoke with Gabe as well as listened to him. Then spoke with him and the family together.”

Disruption

The London Child Exploitation Operating Protocol 2021¹⁷ sets out the responsibilities of the Metropolitan Police, in partnership with all agencies, when acting to prevent the exploitation of children. The guidance sets out the role of specialist crime units in targeting/disrupting known perpetrators linked to ‘non-crime child exploitation investigations’ where a child is being exploited sexually or criminally by a known organised crime group. Croydon police were the first to introduce a dedicated child criminal exploitation team running alongside the more historic child sexual exploitation team. Disruption is attempted in a multitude of ways and by differing police teams. In order to disrupt, the local team has worked closely with a London wide hub (Op Orachi) and there has been substantial work to regularly engage with the young people in tandem with Children’s Social Care. The flow of information is managed under the Complex Adolescent Panel.

Youth Justice – Youth Courts & Enforcement

Learning from Families

“Children learn through facing consequences for their behaviour - when a child is stopped for carrying a machete or commits an offence against someone but does not face any immediate consequences – how can they learn? – There should be stronger and quicker consequences in real time.”

Family members and practitioners spoke passionately about the delays in court hearings/disposals. The family who had suffered the devastating loss of their son spoke about their strong desire to leave a legacy for their son by campaigning for swift court disposals/

17 The London Child Exploitation Operating Protocol 2021 - Metropolitan Police in association with the London Safeguarding Children Board, NHSE & London Councils

enforcement action when a child/ young person is found to be carrying a weapon/ has committed a criminal offence against another person – this was their overriding wish for change. Practitioners spoke about court cases falling into an ‘administrative hole’ where there are extensive delays in a case coming to court. This can mean that the Youth Justice Service are unable to become involved with a child to complete preventative work as there is no compulsion for them to engage.

An argument exists that carrying out prompt enforcement actions prior to a court hearing as part of routine procedures, or in response to children who are regularly coming to the attention of the police, or completing routine stop and search tactics may represent a deprivation of human rights/ a deprivation of liberty. This is of particular concern for Black children/young people.

Families of children who have been involved in this CSPR and in previous reviews in Croydon¹⁸, whose child has died as the result of the actions of another child/young person, have been clear that it is better to take proactive steps to manage the carrying of weapons or restrict the liberty of a child (in some cases their own child) than for their son/grandson/brother/cousin/nephew to die and for the family to live forever in grief.

The second annual report from the Youth Endowment Fund also explores teenage children’s experiences. The report is based on the answers of more than 7,500 children aged 13-17 in England and Wales¹⁹ and reflects some of views presented in this report.

This illustrates the delicate balance that police and statutory services have to achieve between enforcement and protection of liberty.

Learning from the National picture

What works well: The use of a tag (electronically monitored curfew) which meant the child had to be at home for specified times, usually from 7pm to 7am, was reported by practitioners and parents to be particularly effective. Similarly, children’s behaviour could be managed, at least to a degree, by use of strict curfew restrictions including areas or buildings which the child was not permitted to enter, only being allowed to see one friend at a time, specific named persons they could not see, and not being allowed on public transport without a parent²⁰.

Local Panels & National Services

Croydon Complex Adolescent Panel: The Complex Adolescent Panel (CAP) is a multi-agency forum for practitioners to share information and develop/review multi-agency safety plans for young people vulnerable to extra-familial harm. Six of the children/young people were referred to this panel and there was evidence that this panel supported the work on the frontline. The work of this panel is discussed later.

Croydon Youth Justice Panels: Risk and Vulnerability Management Panel, Integrated Offender Management and Gangs panels all co-work in partnership with Police and partners such as Social Care, Health and the anti-social behavioural management team to share information/intelligence and mitigate risk to children/young people and the community.

¹⁸ Croydon Safeguarding Children Board Serious Case Review (SCR) Child Q 2019 and SCR Child Y 2019

¹⁹ [Children, violence and vulnerability 2023 The second annual Youth Endowment Fund report into young people’s experiences of violence](#)

²⁰ [It was hard to escape The Child Safeguarding Practice Review Panel, 2020](#)



Croydon Community Safety Strategy: A Community Safety Strategy is in place in Croydon. It was unclear how this strategy was used to support the work of multi-agency practitioners/services when working with these children/young people. Practitioners spoke about a lack clarity & detail about the operational work that is expected or where the work should progress, and views were expressed about an unclear strategic vision to drive the multi-agency framework & processes when providing services to children/young people at high risk.

Safer Croydon Partnership: The Safer Croydon Partnership (SCP) is the statutory crime reduction partnership that brings together the Police, Council, Health, Probation, and Fire Brigade to tackle crime and disorder in Croydon. The Partnership uses data and intelligence to identify the key issues facing the borough and then commits resources through a partnership plan and strategy to tackle those issues.

National Referral Mechanism: The purpose of the NRM is to assess the information and consider whether there are grounds to suggest that the child/young person is the victim of modern slavery which includes criminal exploitation. Information obtained during this CSPR suggests that consideration was given, at different times, to referring each child/young person. The inconsistent quality of the early referrals/recording of these referrals mean that the outcomes are not possible to determine for Ade and Blake. The outcome of the referrals for the remaining four children/young people were:

Dane: reasonable grounds (December 2019)

Fynn: reasonable grounds (September 2020)

Cole: reasonable grounds (February 2020)

Gabe: positive conclusive grounds (December 21)

Some partnership agencies were aware of the referral being made and the outcome, but many were not. There was little evidence that these referrals made a difference to these children/young people's lives.

Learning from Ade & practitioners

Ade was heavily linked to gang activity in the area – he was often involved in acts of violence, a known weapon carrier and known to sell drugs indicating likely exploitation. The risk to Ade was held primarily by children's services and police, even though it would have been advisable, there are no details within records to suggest a referral to NRM was made²¹.

Learning from the National picture

The National Referral Mechanism (NRM) is not well understood and is inconsistently used. Young people who are being criminally exploited are often referred to the NRM in the hope that it will give them protection. The review found that the NRM's original purpose does not always fit well with the circumstances of this group of children and that understanding and use of the NRM was patchy²².

²¹ Findings from CSPR case analysis

²² It was hard to escape The Child Safeguarding Practice Review Panel, 2020 (Page 9.)

Learning From Multi-Agency Services

Local Panels. Panel members and practitioners spoke about various panels in place in Croydon but there were concerns about duplication, a lack of joining together and the need for a clear governance structure.

Joining the data. The Vulnerable Adolescent Thematic Review identified the need for multi-agency services to come together to join up the data/intelligence held across services about children/young people at highest risk. It was highlighted that this remains a challenge although it is acknowledged that the Community Safety Strategy (2022- 2024) has identified this as a key theme and work is being actively undertaken to address this.

Articulating Risk. Practitioners spoke about how children do not view risk in the same way as professionals. It was felt that crystallising and articulating the risk at the start of any work is crucial. In serious cases, the use of models to show the likely trajectory for a young person may have some impact on their understanding of risk and ensuring that the child has a positive relationship with the messenger is likely to improve their chances of receiving it.

Ensuring parents also understand the risk, as well as supporting their ability to reinforce the messages about risk, was said to influence the chance of their child understanding and engaging in work likely to support better outcomes.

Learning from the National picture

Child B's mother seemed to be unable to take protective action, such as reporting him missing, and discuss risk with him directly, because she did not see, or possibly understand, the risk the way professionals did²³.

The voice of children/young people and their families

It is important to acknowledge that it has only been possible to hear directly from one of the children/young people about the services provided. When talking to this young person, on two separate occasions, he was unable to recall many of the services involved in his life or what he found helpful. He was clear that his family needed support with their housing - in part because of overcrowding and in part due to the locality the family lived in - which meant he and his family were exposed to risks from adults and young people in the area. This limited recollection of the service input was a common theme for parents despite the myriad of services/interventions recorded in agency records. Interventions that were remembered involved practitioners who made a lasting impact through the relationship they formed with families, and the timely practical support they provided. This is echoed in relevant CSPRs²⁴.

²³ Birmingham SCP CSPR Child A & Child B September 2021 (Page 9.)

²⁴ Such as : Waltham Forest Safeguarding Children Partnership CSPR Child C 2020

Learning from Gabe

Practitioners who currently have/or had direct involvement with Gabe were asked to represent his voice. These practitioners were clear that of greatest importance to Gabe was the continuity of relationships across the professional group. Gabe currently has an established relationship with his YJS worker and social worker which he responds well to. Previously, he experienced several changes in his social worker and changes in his CAMHS clinician which he found very difficult to cope with and resulted in disengagement. It was emphasised that continuity of relationships is important for all children but for Gabe and other children like him, who have a diagnosis of autistic spectrum disorder, this is critical.

Conclusion

The six children/young people known to services were offered a range of interventions and opportunities designed to reduce their risk of becoming involved in activity likely to result in serious harm to them or others. There was a great deal of evidence to show that they had good, trusted relationships with many of the multi-agency practitioners involved.

The commitment of many practitioners working with these children/young people was exemplary - creative and adaptive ways of working were evidenced alongside compliance with relevant policy and procedure and good multi-agency working and dialogue. Many examples were seen of practitioners going above and beyond what is required of them in their respective roles. To a certain extent, interventions were successful in achieving engagement in specific pieces of work. However, despite the wide-ranging multi-agency services provided all were charged in association with the tragic deaths of three children/young people.

Key Line of Enquiry 2: Identify why/where support ceased and any learning outcomes



Throughout this review the consistent message that has been heard from practitioners, and evidenced in the case records, is that by the time the children reached adolescence, there had been opportunities missed at an early point in their lives to prevent difficulties escalating. These opportunities included responding to early trauma swiftly and effectively – a number of these children/young people lived in households that featured domestic abuse and/or suffered a significant bereavement at a young age. Members of the community recognised that responding to a child's needs as early as possible was critical in preventing the escalation of difficulties, particular emphasis was placed on providing support to children who live in households where there is domestic abuse.

There were opportunities to provide an integrated early approach to support parents struggling with physical and/or mental health difficulties and further opportunities came later in their lives to identify and respond to their emerging behavioural and learning needs/ provide an early diagnosis of possible neuro-developmental needs, such as ADHD/ASD and/or to emerging speech and language difficulties. This is reflected in relevant CSPRs¹.

The reason opportunities were missed was in part due to the availability of specialist services to provide a response – such as:

- specialist services to work with children who have experienced domestic abuse.
- speech and language therapy in schools.
- services provided by educational psychologists.
- the impact of long waiting lists and high thresholds in CAMHS.

A number of these services subsequently became (or were made) available during adolescence when the children/young people were at high risk. However, as identified in this review, accessing many of these services is dependent on consent and voluntary engagement. From the perspective of services, the reasons why support was not provided or ceased was largely attributable to the lack of consent provided by parents/carers or the child/young person or a lack of engagement in the service offer (particularly during the children's early years).

Other reasons identified by parents, particularly in early years, were described as their child's needs not meeting a threshold for a particular service/their case being 'stepped down' when the risks appeared to reduce – only to emerge again. Gaining consent for the involvement of services, particularly in the early years of a child's life, is critical. The following section is focussed on how consent can be gained and how engagement might be achieved.

¹ Such as: Wokingham Safeguarding Children Partnership CSPR Harry 2022

Working With Consent

Systems can allow for consent to be a barrier (or a reason for ending intervention). In a multi-agency system, where demands are high and resources are finite, closing non-statutory involvement because of a lack of consent or engagement is perhaps understandable. However, practitioners, panel and parents were of the view that children/young people can be given too much responsibility to 'decide' whether they want to engage, and their initial wishes are often seen as paramount rather than seeking support of parents, other trusted adults or different approaches to support engagement.

The 'stop-start' that occurs when children/young people engage, disengage, engage at a later date and dis-engage, creates delay and dilutes plans, often meaning a particular intervention is no longer an option. This can exacerbate the revolving door of service provision. Establishing a trusted relationship with parents, who may be able to have a significant positive influence over their child's engagement, can be a benefit. Conversely, a parent who does not support, or see the benefit of an intervention can present a challenge to services. Parental views may dominate the nature of a child's engagement/influence their consent.

Learning from the National picture - What works well?

When parents and wider family members were actively involved in the risk management plan, we saw evidence of progress. For example, when a father who didn't live with his family took and collected his son from school, the boy's attendance significantly increased. Equally, we saw examples of wider family involvement in enabling children to live with extended family away from their local area where the risk was high. In one area, a family group conference was successful in establishing a shared family plan to manage risk².

Understanding the impact of intersectionality: Practitioners spoke about the importance of services understanding the experiences of black families with mental health services, which takes account of possible multi-generational experiences of discrimination and misdiagnosis of family members.

People in Britain from [marginalised] communities face fundamental inequalities in access to treatment, experiences of care and outcomes from mental health services. They are less likely than white people to receive treatment for mental health problems, and more likely to be subject to detention under the Mental Health Act³.

Engagement

Traditionally, there has been a tendency for services to place the burden of responsibility to engage on children/young people and their families rather than focussing on building the resilience of services when engaging with children and their families. The second and third annual reports by the National Panel identified working with engagement/non-engagement as a key practice theme.

² It was hard to escape The Child Safeguarding Practice Review Panel, 2020

³ <https://www.solentmind.org.uk/news-events/news/mental-health-matters-video/>

Learning from the National picture

Reviews often refer to ‘lack of engagement’ by vulnerable families, citing patterns of missed appointments, cancelled home visits, and offers of support not taken up. This is sometimes characterised as ‘disguised compliance’ or ‘resistance’. It is important to understand the underlying issues giving rise to reluctant or sporadic engagement, particularly where professionals are ‘working with consent’.

Practitioners need to be aware of the intersectional nature of social hazards and to consider how these may impact on practice. For example, poor parental engagement by minoritised parents has been linked with fear, including fear of perceived power practitioners hold. Professionals need to recognise, explore and seek to address these fears in their work with parents and carers⁴.”

“Child B’s mother is a woman with no recourse to public funds or an asylum seeker, who also may have a different view of people in authority due to experiences in her country of origin.....Her hostility is possibly due to fear⁵.”

The tendency to place the burden of responsibility to engage with services has been the experience of the community. It is promising that there have been some hopeful developments in Croydon to redress this imbalance of power – this is discussed later.

The issues discussed below are relevant when considering engagement in its broadest sense.

Intersectionality

The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination intersect to create unique dynamics and effects: All forms of inequality are mutually reinforcing and must therefore be analysed and addressed simultaneously to prevent one form of inequality from reinforcing another⁶.

Intersectionality: Poverty

Practitioners and panel identified that most of these children/young people lived in a low-income household in areas of high deprivation, and this was a significant factor in their lived experiences and influenced the engagement of children/young people and their families with services. Practitioners said that for some of the children/young people the drive to bring money into the household, by whatever means, seemed to dominate the decisions they made. Many lived in areas where the pull of gang activity, and the presence of adults who posed a risk of criminal exploitation, was a significant feature of daily life. The combination of these factors had a significant influence on the choices they were able to make and their engagement with services. This was of particular note at a time when the children/young people had experienced disruption in their education.

⁴ Child Safeguarding Practice Review Panel Annual Report 2020 Patterns in practice, key messages and 2021 work programme

⁵ Birmingham Safeguarding Children Partnership CSPR Child A & B

⁶ Centre for Intersectional Justice. <https://www.intersectionaljustice.org/what-is-intersectionality>

Intersectionality: Discrimination/disproportionality

Multi-agency practitioners and managers showed a clear understanding about the impact of discrimination on the experiences of the children/young people - including the disproportionate representation of Black children in the youth justice system. The Youth Justice Board (YJB) statistics for England & Wales show a decrease in the number of children who come into contact with the youth justice system, a key caveat is the continued over representation of Black children in the system: The statistics show a youth justice system succeeding in fewer children coming into the system, fewer children in custody and lower re-offending rates, but categorically failing on every count to halt the over representation of Black children throughout the system⁷. Nationally, Youth Justice Services (YJSs) are required to report to the Youth Justice Board their local statistics and set out action plans to tackle disproportionality.

Practitioners and the community spoke about the need for children/young people to have access to positive role models to enable aspirations to be promoted and a positive successful future envisioned. It was said that only when this future is envisioned that a decision may be made by the child/young person to 'break the cycle' and it is at this time that engagement with services can be fully achieved, this is particularly important for Black British children/young people. This is discussed later.

Learning from good practice – Youth Justice Service (YJS)

Disproportionality Dashboard. The work of Croydon YJS is underpinned by a matrix which specifically references how a child/young persons ethnicity, culture and (where relevant) disability might feature in plans and associated actions to utilise this knowledge to strengthen work. This good practice has been shared across services to encourage services to adopt a similar approach.

Diversity Champion. The role of the diversity champion is to ensure that disproportionality is regularly discussed within YJS team meetings. All discussions are fed back to the management team for action. All team members are responsible for identifying disproportionality, the champion leads on this area. Everyone is expected to reflect on their own bias (unconscious or not). This work has been shared at multi-agency meetings to promote replication in other agencies.

Positive Role Models. The Youth Justice Service have acknowledged the pressing need for children and young people to be a part of their community and the need for positive role models outside of the system are necessary. Mentivity Mentoring is an example of one community organisation working with the YJS where young people are matched with local mentors to support and promote opportunities for the young person. The Youth Justice Service is a stakeholder to the 'My Ends' Project, promoting accessibility to community resources and promoting partnership work with the voluntary community sector. Such work had proven beneficial in identifying support networks within the community.

⁷ Keith Fraser, YJB Chair and Board Champion for Over-Represented Children. <https://www.gov.uk/government/news/annual-statistics-a-system-failing-black-children>

Practitioners and services showed a good understanding of the impact of intersectionality on the children/young people's lives, and a desire to counteract these lived experiences wherever possible. However, it was less clear how intersectionality was understood and worked with in relation to the engagement of parents/carers/families.

Learning from the National Picture

A second critical message of this report is that there is much more to do to develop practice frameworks that take account of intersectional thinking to explore how ethnicity, age, gender, sexuality and other social factors including age, sexuality, poverty shape the identities and experiences of children and families. Evidence about the impact of bias and prejudice has perhaps been most articulated in terms of disproportionality of Black boys among children who are criminally exploited. We need to be more inquiring about how cultural assumptions and biases shape how we 'see' and safeguard different groups of children. Too often attention is scant and somewhat superficial⁸.

The cultural origins of families - their generational histories of migration from their country of origin - their faith and family beliefs, their experiences of discrimination and of state intervention in family life, are all critical to respectfully explore and understand when providing services. If services do not understand how they will work to secure trust and engagement, particularly in the context of current and inter-generational inequality and discrimination, consent will remain a barrier to families accessing the services they may need.

Adultification

The concept of Adultification is when notions of innocence and vulnerability are not afforded to certain children. This is determined by people and institutions who hold power over them. When Adultification occurs outside of the home it is always founded within discrimination and bias⁹.

Practitioners and panel shared concerns about occasions when they saw in case recordings what appeared to be adultification of the children/young people concerned and the need for the multi-agency team to challenge this. Additional concerns were raised about the negative language that can be used when describing a child/young person where it seemed that the fact that this was a child who may be displaying help seeking behaviour, rather than 'difficult' or 'defiant' behaviour, was lost. It was felt that this is particularly relevant to young Black men/boys.

Learning from the National picture

CSPRs have highlighted implications for practice, for example how some children became marginalised and made responsible (at least in part) for their situation, with their childhood vulnerability and innocence being diminished. While these are important issues for all children, they can have greater resonance and impact with children from minoritised communities.

⁸ [Child Safeguarding Practice Review Panel 2021 - annual report](#)

⁹ Davis, J. and Marsh, N (2022). 'The myth of the universal child', in Holmes, D. (ed.) *Safeguarding Young People: Risk, Rights, Relationships and Resilience*. London: Jessica Kingsley Publishers.

Learning from the experiences of Dane, Fynn, Cole & Gabe

Dane was described in some agency records as ‘an angry and difficult young man’ (other practitioners described him as a ‘scared young boy’)

Fynn was described in agency records submitted to this CSPR as ‘calculating’.

At school Cole would repeatedly bang his head– he was described as ‘angry and difficult’.

At various times Dane, Fynn, Cole and Gabe were variably described as ‘aggressive’, ‘manipulative’ and ‘angry’.

In understanding and counteracting Adulthoodification, Davis 2022 states:

Black children are more likely to experience Adulthoodification bias. Racism is a core issue influencing the identification of Black children. Black children are more likely to be met with suspicion, assumed deviance and culpability. Adulthoodification reduces professional and organisational responsibility to safeguard and protect children yet increases the responsibility on children to safeguard themselves. Adulthoodification bias is a breach of child safeguarding legislation and guidance. 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 safeguarded¹⁰.

Systems and professionals must be vigilant to the risks of adulthoodification and question whether an unconscious bias may be influencing the way services respond to children by regarding, and treating, children as adults. Whilst the term adulthoodification is relatively new in safeguarding work, numerous serious case reviews and CSPRs reviewing the services provided to children who have been sexually exploited have identified this concept as influencing how services may respond to what has been regarded as ‘lifestyle choices’ rather than regarding children as children who cannot safeguard themselves from abuse.

Learning from the National picture

One feature believed to have a significance to the experience of Child Q is that of adulthoodification bias. This concept is where adults perceive Black children as being older than they are. It is ‘a form of bias where children from Black, Asian and minoritised ethnic communities are perceived as being more ‘streetwise’, more ‘grown up’, less innocent and less vulnerable than other children. This particularly affects Black children, who might be viewed primarily as a threat rather than as a child who needs support’. In reflecting on how adulthoodification bias might have been evident in practice with Child Q, this can be seen in the fact that she received a largely criminal justice and disciplinary response from the adults around her, ‘rather than a child protection response’¹¹.

¹⁰ Davis, J. and Marsh, N (2022). ‘The myth of the universal child’, in Holmes, D. (ed.) *Safeguarding Young People: Risk, Rights, Relationships and Resilience*. London: Jessica Kingsley Publishers

¹¹ Local Child Safeguarding Practice Review Child Q March City of London and Hackney SCP 2022

Key Line of Enquiry 3:

Include the voice of the child, understand his daily life and, consider reasons why support may not have been accessed or effective.



Understanding a child's lived experiences has been identified as a key practice theme by the National Panel in various reports. Understanding what a child sees, hears, thinks and experiences on a daily basis, and the way this impacts on their development and welfare, is central to protective safeguarding work.¹²

There were many examples seen of how practitioners sought and recorded the voice of the child/young person throughout service interventions. There were many examples demonstrated in the records and during the reflective conversations of practitioners getting beneath these words to understand the children/young people's daily life and as described in the previous section, the systemic context in which these children/young people lived was emphatically understood.

Learning from Cole and practitioners

Cole had a history of early trauma. His mother suffered with mental ill health and spent periods of his childhood in an inpatient mental health unit – she was unable to care for Cole. Cole lived with his grandmother who wanted the best for him but struggled to show him affection. There were times when Cole would show extreme distress through anger – he would not remember what had happened afterwards. Cole was described as a sad, angry little boy who wanted his mum – he was desperate to belong and be loved. His mum had written him a letter and spoke about her love for him – he carried this letter in his backpack at all times. He was bright, responded well to nurture and had dreams and aspirations for the future – he wanted to be a lawyer. It was felt that he would do well at a boarding school that offered emotional support – giving him a place to belong and a place where he would be able to adapt and thrive – this option was not available.

There was a strong sense that there was a limit to how far services could make a discernible difference to the daily lives of these children/young people who; had a childhood history of unresolved trauma; who were expelled from school, living in poverty, spending their daily lives in close proximity to gang activity and to adults whose intention was to exploit them; contending with the risks posed by social media and facing discrimination in a society where they could see no positive future.

¹² Child Safeguarding Practice Review Panel Annual Report 2020 Patterns in practice, key messages and 2021 work programme

Hopes and Dreams

Despite this context, it was clear that practitioners actively sought to understand the child's daily lived experiences and make a difference in their lives. The services that were provided resulted in many positive outcomes in their daily experiences. The systemic reasons why support may not have been consistently accessed or effective have been previously discussed. In the view of practitioners, panel and the community, a key area that is felt to need attention in supporting a child's experience of daily life, and in accessing services, is how aspirations and dreams are recognised, honoured and promoted – how a sense of belonging and future can be envisioned so the cycle might be broken.

During the early part of their secondary education, most of the children/young people were described as bright - able to manage their schoolwork and teachers were positive about their educational aspirations. However, it was less clear how their dreams and aspirations were understood across services or how (when school attendance became more difficult and the curriculum less accessible) their dreams and aspirations could be nurtured, creative future thinking/ envisioning promoted, and pathways facilitated.

Learning from Cole, Fynn, Dane and Gabe

"I want to be an actor.....I want to be lawyer..... I want to work in my faith.....I am good at cooking, music and sport.....I like basketball.....I like American football and boxing."

Identity and belonging

Adolescence is one of the most dramatic stages of life development. During adolescence there is a search for a sense of self and personal identity and a strong desire to belong, and fit in. At this time of life, role models and peers are of central importance and a sense of self is developed primarily through social relationships: *The adolescent brain goes through a rapid process of developing new neural connections and this process is fundamentally shaped by social interactions and relationships – thus contributing to this life stage as one that offers a significant window of opportunity.*¹³

Panel members, practitioners and parents raised the critical importance of identity and belonging. Based on the extensive experience of the YJS it was suggested that 99% of those children/young people known to this service struggled with a positive sense of their identity and feelings of belonging. It was reported that many of the young people known to YJS experienced a life where their basic needs had not been met including - a lack of stable housing and school environment; learning needs not identified and met; the existence of unresolved trauma. When these unmet needs are combined with the dynamic interplay of intersectionality, the constellation of these issues serve to destabilise and undermine a sense of future and belonging. The search to belong in a group of peers can become a powerful driver, and for these children/young people, the unintentional consequences can result in being vulnerable to serious youth violence and extra familial harm.

¹³ That Difficult Age: Developing a more effective response to risks in adolescence Dr Elly Hanson and Dez Holmes. Dartington 2014

Masculinity

A further area discussed by panel members, practitioners and parents was how masculinity is viewed in current society. Social movements¹⁴ over recent years have highlighted the power of men over women and the harm that can be perpetrated by men and the term 'toxic masculinity' has gained traction. Whilst the purpose and intentions of these movements are not in any way disputed, the question of how young men interpret this in terms of their own identity was raised: How do young men learn to embrace their masculinity in a healthy way and not be constrained by traditional societal constructs about how men should behave – such as:

- A man should suffer physical and emotional pain in silence.
- A man shouldn't seek warmth, comfort, or tenderness.
- A man should only have the emotions of bravery and anger. Any other emotions are weaknesses. Weakness is unacceptable.
- A man shouldn't depend on anyone. Asking for help is also weak.¹⁵

The importance of fathers

Learning from the experiences of Fynn and a YJS practitioner

"There was so much to be said around his feeling towards his father and how this arose in his relationship with his mother. There was a strong link to male attachment and identity that really required thought and reflection." Fynn's father sadly died during Fynn's childhood.

Practitioners often recognised the importance of fathers in the lives of the children/young people but there was little evidence seen to show how fathers, who were known to be an active parent in their child's life, were engaged by services. Maternal narratives were the dominant narrative in agency records. As identified by the National Panel¹⁶, services often allow fathers to be absent from meetings, decision making, assessments and plans and multi-agency services are urged to address this. It is important to recognise the existence of any unconscious biases that may exist when working with men and how this might be addressed, this is particularly relevant when working with Black British children/young people and was passionately discussed by a father who was engaged in this review (see next section).

Social media

The influence and reach of social media, and the multi-faceted impact on children and young people's daily lives, was an area of concern for practitioners and parents. Social media platforms were described as having an immense impact on the children/young people – on their sense of identity – on their interactions with peers – on their daily presence. A practitioner spoke about a social media platform that is home to 'Croydon Bait 500' – which posts videos of fights in Croydon and appears to bait children/young people to replicate this/beat this by engaging in similar activity. However, despite the view that social media

¹⁴ Such as the #MeToo Movement

¹⁵ Psychology Today <https://www.psychologytoday.com/gb/blog/talking-sex-and-relationships/202103/what-is-toxic-masculinity>

¹⁶ The Myth of Invisible Men, Child Safeguarding Practice Review 2021

was a dominant factor in determining a child/young persons beliefs about themselves and others, on their emotional worlds and decision making – it is said to be a world that is out of reach of practitioners/services. In the words of a practitioner social media is – a whole world we know nothing about.

A practitioner with good knowledge of social media and how search engines work spoke about the need to continue to raise awareness amongst young people, parents and practitioners about the digital footprint that can remain forever. The unregulated machine learning that drives our technology is inadvertently supporting grooming and drip feeding the user with unsolicited content. The fast-moving growth of social media and the impact of the pandemic on children during adolescent years when opportunities to learn about negotiating ‘human connections’ (which is such a vital part of their social learning and development) were lost.

It is early days in the research about impact on an individual and a social group, concerns about overuse compounding depression, anxiety, envy and loneliness, and the potential of social engineering, correlates with the literature currently available. It is accepted that there are likely to be digital challenges, and possibly some ethical considerations to overcome, but there was a suggestion that there should be a robust, national and local approach to using intelligence gained from social media in the disruption of criminal exploitation.

Croydon – A place of identity and belonging?

Parents, the community, practitioners and panel members spoke about the recent changes in Croydon. Whilst there have been significant new builds in the centre offering social and private housing, there has also been a decline in the fabric of the centre – retail business are increasingly shutting down and the area was described as unsafe. A parent described the retail high street as a place she and her family no longer visit as young people with balaclavas gather in groups and dominate. She was keen to show the Independent Reviewer the High Street. It was evident that some retailers had withdrawn from the High Street – some outlets were permanently closed. There were few people visiting the High Street, young people were gathering in groups and police were attending an incident – her fear was evident. She spoke with sadness about how Croydon used to be a place she would enjoy going to with her mother for a day out but that she and her family no longer visit the area. Panel members, the community and family members spoke about how ‘neglected’ or ‘unkempt’ the area now feels and how these environmental factors can have a detrimental impact on a sense of positive identity and belonging.

Learning from the National picture

The importance and powerful influence of what Carlene Firmin describes as ‘Place’ for where children live, visit, and grow up is important for professionals to understand in order to try and safeguard them from criminal exploitation and to divert them from getting involved in criminality. The strategic targeting of the ‘Place’, in this case is the relevant inner-city neighbourhood in Birmingham and is important in order to improve the environment for children in that area to safeguard them from CCE¹⁷.

17 Birmingham Safeguarding Children Partnership CSPA Child A & Child B (September 2021).

Key Line of Enquiry 4: Learn from families (including the families of the children who died)

Learning from families

The CSCP were keen to learn from the families of both those who had tragically lost their child and those whose child had been charged in association with these deaths. A total of ten parents were contacted. Six of the seven young people were contacted by letter which was either sent to their current address or, where there was continued service involvement, hand delivered by a practitioner. Three families including three mothers, one father and one young person, agreed to share their perspectives. The Independent Reviewer had the privilege of meeting these families and the experience of hearing their perspectives was deeply humbling. CSCP is grateful for their engagement and for the full and frank discussions that took place. At relevant points, their perspectives have been included in this report. The following is a summary of additional points that were made. It is relevant to note that many of the issues identified by parents were identified by the practitioners and members of the community who contributed to this CSPPR.

About schools

“Appreciate that an exclusion from school means that our children’s dreams fade and aspirations for the future get lost.”

“Do more in schools to manage a child’s behaviour – don’t overreact – understand what is at source.”

“Don’t label a child as bad/not good enough/not achieving/ not capable – these labels stay with the child and influence how a child thinks about themselves and influences how future teachers/schools respond to them.”

“Provide services to children in the school.”

“Provide more male role models in primary and secondary schools – the teaching profession is still female dominated.”

About multi-agency services

“Decide what kind of approach is needed with each child - which are the children whose future can be reasonably predicted who - because of their life experience and because of their violence/criminal past are likely to groom or strongly influence another child to be involved in their criminal behaviour and violence - there are some who mean to do harm and others who are caught up through fear.”

“Read the records before you see our child - understand our child and our family.”

“Put resources in early - don’t wait to provide everything when something terrible has happened.”

About engagement

“Don’t just tick boxes - be human in how you respond to us - do what you say you are going to do - understand that we do not fit a box - do not make assumptions about us.”

“Don’t overwhelm us and our child by the number of professionals involved/the amount of appointments we have to keep.”

“Do not stereo type us - respect the traditional family and our traditions. Respect the role of the father - you may not agree with traditional masculine and feminine roles in families, but it is our belief that this works well for our children - don’t shame us.”

“Respect us for being hard working families - understand that we often work long hours and cannot always be there for an appointment.”

“Respect that families understand the system - and can often feel judged by professionals - don’t patronise or judge us.”

“Respect the father/male in the household - do not stereotype men - do not shame their masculinity and their role in the family - this is particularly relevant to Black men/fathers.”

About community services

“There are not enough safe spaces or activities for children/ young people.”

“Be flexible and creative in what you offer - do not put up a barrier for our child to access community activities such as football/boxing/rugby because we do not meet a high enough threshold/criterion or because we are not claiming benefits.”

“We cannot be there to always collect our teenager from school and may not be at home as we are at work - find flexible ways to engage children in after school activities such as providing transport to and from an activity.”

The key learning from the involvement of families in this CSPR is that the experiences and views of families are critical in any future service development/design.

Key Line of Enquiry 5:

Review current community support provision

“It takes a village to raise a child...but it takes a community to raise a generation. The Child who is not embraced by the village will burn it down to feel its warmth¹⁸.”

It is clear that there are a variety of community provisions in Croydon that provide a range of support to children and families in the local community. Many are focussed on providing positive role models and activities for children/young people. At the heart of many of these provisions is an intention to build resilience through an emotional connection to trusted adults and to nurture dreams and aspirations to promote a vision of a positive future. These are critical foundations in life for any child. For children/young people at risk of serious youth violence/extra familial harm their lived experiences of exclusion in its broadest sense means that community services providing this kind of support are essential. During this CSPR, practitioners, panel, families and community members shared a strongly held view that positive role models/trusted adults were needed by children at risk of serious youth violence/ extra familial harm as early as possible in their lives.

Learning from families

“In the early days, a mentor was involved with my son. He was amazing – he really made a difference. He would be flexible and creative about how he would connect with (name of son) - he would meet him from school take him out to eat – talk to him – get him engaged with activities -- take him to appointments - make sure he got home OK – he was a good role model for my son. This was really important for us as a family – I work long hours and cannot always be there after school/take him to activities.”

The mentoring organisation ceased involvement after the risks were felt to reduce – mother’s perspective is that the service stopped as a result of cost saving.

In Croydon there are a variety of local and national projects and organisations offering support to children/young people through schools and in the community. The Croydon Local Intervention Programme (CLIP) offers support & guidance for those aged between 8-17, living and/or educated in Croydon. The programme is designed to support young people who are showing early signs of criminality, anti-social behaviour or risky behaviour. Many community organisations provide positive role models and work with children/young people and their families to safeguard them from harm, build positive identities and nurture belonging (see below).

However, there appeared to be a fragmented knowledge held in statutory services, by community groups and by families about the range of support groups available to children/young people and the barriers to the reach of these services. One community group suggested that these barriers were largely due to demand outstripping capacity alongside a

¹⁸ Proverbs originating from various countries in Africa.

lack of referrals/take up from statutory organisations such as schools. In addition, members from community groups, and members from Croydon Council staff who work closely with the community sector, raised the importance of building trust and engagement within the local community - in the absence of trust, services will not be accessed by children/young people and families.

The Croydon Black Minority Ethnic Forum (BME) offer a range of accessible services to the local community and are critical in building trust in multi-agency services. The My Ends Project and Renew Addington (ReNA) are good examples of community-based initiatives proving a safe space for the community to engage with council and multi-agency services. Empowerment of families is at the heart of the work. These are excellent examples of building trust and engagement. However, the consensus seemed to be that more needs to be done by the council and partners to foster engagement and trust and thereby empower the local community.

During this CSPR it was difficult to get a clear picture from agency records, from meeting with practitioners, families and community groups about the nature and extent of community support provision. Croydon Early Help Partnership Board is currently designing a community facing directory of services to improve the pathway to access appropriate services: [Children, young people and families support directory](#) and [Young Croydon](#).

Learning from families

The perspectives of the families was that although 'on paper' there appeared to be a range of community services in Croydon for children/young people there is not enough to meet demand - there are often waiting lists, or they are told that their child's needs/ the circumstances of the family do not meet a criteria for acceptance onto an activity. They spoke about the need for creative and flexible approaches to meet the needs of 'working families' such as the provision of transport to and from activities after school. In addition, the messages they gave about the need for services to build trusted relationships are important messages about how empowerment can be nurtured.

Learning from the Community

During a community event, held as part of this review, members of the community were asked to give their views about what more was needed in Croydon to safeguard children/young people from serious youth violence, these views have been reflected throughout this report. Much of what was shared echoed the views of practitioners and families, key messages included the need to :

- Provide support to parents and take a whole family approach early - before a child is born - **break the cycle**
- **Provide support to children in the schools they attend**, including primary schools, identify learning needs as early as possible to prevent future managed moves/ exclusions
- **Don't give up** - be resilient in providing support to children & families
- Focus on youth provision/activities/safe spaces for children and families - **detailed mapping of provision/the offer is needed**
- Improve inclusion and co-ordination between the different public and community provisions, local businesses and faith groups - minimise duplication - **don't suffocate families with (multiple) assessments** - maximise existing capacity and identify gaps

- Listen to the voice of the child and family and the community – **keep talking** - share this review with the community, provide more sessions such as this, **share power and a shared agenda**
- Open existing buildings to the community – **use what we have and share**
- The need for forums and spaces where organisations can come together to share experiences of working with children in Croydon and where appropriate co-ordinate which organisation is best to provide support – **maximise the expertise**
- **A multi-agency collaborative model is needed** where the funding follows the child (not the community organisation). **Right child – right person – right service**

Learning from what works well in Croydon.

Croydon BME Forum: This forum is the umbrella organisation for Croydon's Black and Minority Ethnic voluntary and community sector supporting partners and the wider Croydon community to create sustainability and strengthen the impact of services. A Family Practitioner has recently been appointed to work with parents and carers offering one-to-one sessions, providing advice, guidance and support. The work of the forum includes co-producing person-centred care plans with individuals and families. Workshops are facilitated online and in person and regular coffee mornings take place providing opportunities for parents and families to socialise and have access to other support groups and services.

My Ends: This project originated from the Violence Reduction Unit (VRU) in response to the violent crime rates within inner city areas and is funded by MOPAC¹⁹. The funding aims to holistically desist young people from crime, through initiatives such as mentoring, parental support, trauma and mental health training, establishing community partnerships and giving voice to residents. Regular weekly meetings have been held in the community hosted at Croydon Voluntary Action (CVA), involving the community and attended by local police offers, council staff and community representatives. At one meeting a mother used it as a forum to raise awareness about her son who was missing and spoke about her worries for his safety. The community searched for him until he was found.

Renew Addington (ReNA): Supported by the Mayor of London's Regeneration Fund ReNA is a project involving several initiatives to improve the environment of the local area and nurture the engagement of the local community. Dialogue between the community and local services is promoted by way of regular community meetings to discuss community concerns which includes finding grass root solutions to serious youth violence²⁰.

Barbershop project: This project started in 2017, the aim of the project was 'striving to thriving' with the intention of supporting positive mental health for young boys/men. Twelve barbers in Croydon were trained in active listening skills and facilitating conversations. Referral cards were made giving young people information on how to refer themselves to local counselling services to gain support for their mental health. It is a 'gentle touch' project facilitating conversations with barbers and young people around self-care, therapy and mental health. Young people are encouraged to identify

¹⁹ Mayor's Office for Policing and Crime (MOPAC)

²⁰ <https://www.inyourarea.co.uk/news/community-groups-tackle-youth-violence-in-new-addington-with-help-from-local-police/>
<https://www.youtube.com/watch?v=baegilTijho>

positive outcomes, to realise they could thrive and develop. Free haircuts were offered to encourage engagement (young people aged 11-18). The project works with the community in hotspots that have experienced Serious Youth Violence. They have extended their work to an Alternative Provision outside of Croydon.

Community (Youth) Organisations: There are various community youth organisations in Croydon offering support to children/young people. Organisations include but are not exclusive to: Mentivity, Ment4, Project 4 Youth Empowerment (P4YE), Safer London, Redthread, 'Palace for Life', Reaching Higher, Lives not Knives. Many of these are specialist mentoring organisations providing one-to-one intervention for children/young people with emotional or behavioural challenges. Positive role models are allocated to establish connection in order to inspire change and help navigate the young person through the life challenges. Ment4 offers a 24-hour wrap-around service, alongside bespoke enrichment sessions - covering areas of sport, music, and enterprise. Referrals to Ment4 are received from statutory services and now parents via a recently established 'hardship scheme'. P4YE offers a similar mentoring service alongside accompanying the police on patrols of the local area and having an outreach space in a local shopping centre.

Croydon Voluntary Action Group: This group is made up of charities, faith leaders, education, community activists, politicians and police who work together to provide a voice for the Croydon community and is a safe place to challenge all sides in order to promote a close working relationship.

Safe spaces: Concerns about diminishing 'safe spaces' during the summer months when schools are closed has led to the recent trialling of a local initiative with the Mayor's office to provide safe spaces for children.

Key Line of Enquiry 6: Learn from the experiences of front-line practitioners

What worked well and what more may be needed locally and nationally to improve outcomes for young people affected by serious youth violence?

It was clear that practitioners in Croydon are committed to the children/young people and their families describing their work in positive terms. Their dedication, resilience, and skill to make a positive difference for the vast majority of young people they encounter was humbling. However, it was clear that the pace and quantity of the workload could be overwhelming. A recurring theme in the workshops was the need for trusted relationships at all key points with young people and it is evident that many of the practitioners working with the young people currently work hard to build these trusted relationships.

Learning from the National picture

A key learning point for leaders is to ensure that there is sufficient emphasis on relationship-based work and the building of capacity to allow practitioners to have both the skill and time to do this work.²¹ The report identified that a significant number of practitioners were working with the children, few achieved enough depth or trust to influence their behaviour.²²

Of greatest threat to these relationships, and to their work loads, is the turnover of staff. Practitioners were clear that this continues to require focussed attention although acknowledged that problems in recruitment and retention are unlikely to be remedied in the short term. They were keen to stress that there should be a focus on how the continuity of relationships with children/young people and families can be disrupted by the way services are structured where 'false' transition points are built into the system such as when a social worker or a child/family are moved to a different team within the service. A recent CSPR in Croydon identified this as an important issue but it is unclear how the relevant recommendation has been implemented.

Learning from a local CSPR – Chloe²³

There are examples of service structures that follow the journey of a child thereby avoiding 'false' transition points (that lead to a change of social worker). There are examples of this kind of structure across the country, Camden Children's Service was provided as an example.

Recommendation 6. Multi-agency partners to consider how false transition points within agencies (including the private and voluntary sector) might be reduced to maximise the opportunities for practitioners to build consistent relationships with children. CSCP to maintain overview and provide support and challenge.

²¹ It was hard to escape The Child Safeguarding Practice Review Panel, 2020 (Page 28)

²² It was hard to escape The Child Safeguarding Practice Review Panel, 2020 (Page 20)

²³ Croydon Safeguarding Children Partnership SCR Chloe 2020

What works well in Croydon?

Working together - the commitment and passion of multi-agency practitioners.

Throughout this review, multi-agency practitioners engaged with passion and compassion and demonstrated a heart felt desire to make a difference. There were good examples of collaborative working including; intelligence sharing across agencies and with families, joint safety mapping, clear guidance and expectations, and empowering children/young people and their families by forming trusted relationships. Specialist teams and specialist roles were identified as a clear asset. The communication, dialogue and joint work across the YJS & CSC teams is described as working well – use of the AMBIT²⁴ model allows the team to deliver trauma informed relationship-based practice.

Group Supervision (extra-familial harm). Group supervision forums are in place in CSC facilitating reflection and learning across the social work teams – bringing the team together to discuss plans and identify avenues of support for children and families effected by extra – familial harm. The intention is to expand this to include the multi-agency group.

Contextual Safeguarding Chair. An extra familial harm conference chair has recently been appointed. Their role is to chair most of the Extra Familiar Harm Child Protection Conferences providing expertise, developing stronger links with relevant services and learning from other Local Authorities about best practice.

Complex Adolescent Panel (CAP). In 2019, CAP was formed in Croydon. This Multi-Agency Child Exploitation Meeting is aligned with the Child Exploitation Pan London Operating Protocol and has run weekly so that all young people, where there are concerns of modern slavery, are quickly reviewed and followed up. Reviews on high-risk cases are held monthly with this practice standard upheld and monitored by the Data and Performance team. The Panel consists of a diverse range of strategic and operational leads from both the London Borough of Croydon and safeguarding partners.

Trauma Informed Leadership. Practitioners gave examples of some senior leaders taking an active interest in their work - demonstratively appreciating the challenging nature of their work, complimenting them on work that went well, holding risk at a senior level and taking responsibility for risk sensible decision making. It was evident that practitioners appreciated this.

Systemic Practice²⁵. Training in systemic practice has been available in Croydon for some time, this systemic approach supports a focus on the child/young person and their families whilst understanding and working with the systemic context.

Turnaround is an initiative led by the Ministry of Justice. Turnaround focuses on prevention and diversion of those at risk or on the cusp of the Youth Justice System aged 10-17. Young people are assessed, and individual plans of intervention created inclusive of family work and community integration.

²⁴ Adaptive Mentalization Based Integrative Treatment (AMBIT) is an approach to support teams develop systems of help around particularly vulnerable, excluded clients who may have little confidence or trust in the possibility of 'help' being helpful in their lives, and where there are multiple services/practitioners involved which impacts on co-ordination and can lead to overwhelm <https://www.annafreud.org/clinical-support-and-services/adaptive-mentalization-based-integrative-treatment-ambit/what-is-ambit/>

²⁵ Systemic practice seeks to make sense of the world through relationships, focusing on the whole family and wider system rather than solely on individuals. Through a systemic approach, change can be achieved through exploring relationship patterns and understanding how they impact on children.

Mental Health in Schools Team. This service is provided in partnership with schools in Croydon with the purpose of providing effective early intervention to children/young people who are identified as needing support with their emotional health and wellbeing to build resilience and prevent difficulties escalating. The range of services include one – one sessions with a specialist practitioner, family support, classroom and workshop-based support, staff consultation, advice and guidance.

‘Engage’ is primarily based at Croydon Police Station, to offer support to those under 18 who are arrested with No Further Action or Released Under Investigation. The offer of support includes a short yet robust intervention of signposting children and young people into education and activities.

Young Croydon consists of 3 teams: ‘Families Together’ work with children who are at risk of entering care, the ‘Adolescent Support Team’ work with children experiencing risks from extra-familial harm and abuse and a ‘Missing Lead’ (and a team of adolescent workers) is focused on supporting children who are/vulnerable to being ‘missing’. The three teams work closely together and support the whole practice system and partnership with keeping children safe.

Recent Service Developments

Children’s Social Care: Recruitment and Retention of Staff: It is understood from practitioners that the relatively recent stability in senior leadership has provided a level of containment. A recent restructuring of CSC has increased the management support and additional sources of support and guidance available to social work teams. It is hoped that these changes will support recruitment and retention however, social work retention remains problematic.

Youth Safety Plan 2023 – 2026 : The Youth Safety Plan is now published. It is in response to the Mayor of Croydon’s vision for Croydon: ‘Keeping children and young people safe on the streets of Croydon’. This plan has been informed by the council wide review of the multi-agency services provided to the children who sadly died. Working in partnership with the community, the voluntary sector and children, young people, and parents / carers the plan is focussed on four key themes including prevention, intervention, disruption, and diversion. This work is jointly led by the Violence Reduction Network and Children’s Services with clearly articulated plans for the ongoing work to be co – produced in equal partnership with the voluntary sector, young people and families.

Croydon Community Safety Strategy 2022 to 2024: The principles set out in this strategy reflects the Framework for The Public Health Approach to Violence Reduction in Croydon and are issues that have been consistently voiced at community meetings, with young people and by those directly affected by violence, offenders, victims, and families. The following themes are the focus: Theme One - Using Data to drive our approach. Theme Two - Preventing Violence before It Occurs. Theme Three - Community Based Support. Theme Four - Targeted Interventions. Theme Five – Intensive Interventions and Enforcement.

National Referral Mechanism (NRM): Croydon has been selected as a pilot project for new NRM funding from government. Croydon's participation in the National Referral Mechanism Pilot Scheme went live on 27 February 2023 and decision making now takes place in Croydon with panel members from the Safeguarding Partnership. It is anticipated that there will be a direct benefit to victims of modern slavery involved in criminal proceedings with more timely decisions made as well as victims receiving specialised support much more quickly. It is expected that there will be a significant reduction in children experiencing uncertainty over their futures and being recognised as victims of exploitation as well as awareness of modern-day slavery increasing across the practice system.

Challenging Disproportionality - Assessing the Extra Familial Risk for Black Male Children & their families: Training has been commissioned by the Croydon Safeguarding Children Partnership based on a recommendation from a relevant CSPP in London. Workshops will allow practitioners to build on their existing skills and knowledge regarding risk assessing and working with specifically black male children and completing safety plans. Initial courses have had excellent feedback and good attendance.

What more may be needed?

Families, practitioners and panel and community members were keen to engage in reflective conversations about what more may be needed, multiple issues were identified.

Nationally

- Concerted action to tackle poverty and discrimination.
- Change the way services collect data to enable impact, not input, to be measured.
- Consider/review how some services are predisposed to focus service provision on either victim or perpetrator as this is often a false delineation and creates barriers.
- Increase the resources available to schools to enable prompt identification of learning needs/assessment by an educational psychologist/ involvement of SALT.
- Improve the waiting times for CAMHS and neuro-developmental assessments.
- Re-instate Knife Crime Prevention Orders.
- Invest in early intervention and protect these services from future cuts.
- Address the delays in criminal processes from an incident to outcome/consequences for the child/young person.

Locally – strategic

- Continue to find creative and flexible ways to build community engagement and trust.
- Explore how Croydon can strengthen the importance of partnerships across the council, across agencies and communities and across organisational hierarchies.
- Highlight the risks posed to children/young people and families, and the wider community, resulting from the changes in Croydon Town centre.
- In collaboration with the Child Safeguarding Practice Review Panel explore how the relevant local and national recommendations relating to data sharing will be implemented.
- Consider/review how the different remit and criteria of risk/response may impact on multi-agency work including how disruption of known perpetrators is enacted.
- Consider what more can be done to prevent exclusion – such as embed and equip

(where needed) Saffron Valley Collegiate to provide outreach/intervene early when a child is at risk of exclusion.

- Consider/review how health services can better compliment the multi-agency work – determine what could be done to address how recruitment is affected by the pay banding for Croydon.
- Clarify the strategic vision for responding to SYV – clarify the multi-agency framework processes, pathways and the practice model including aspects identified by the National Panel: Relationship-based practice and making use of the ‘reachable moment’, such as arrest, school exclusion and physical injury, are critical for this group of children. Include within this practice model the importance of paying attention to language, dreams and aspirations.
- Reinstate the post of Housing Safeguarding Officer to bridge the gap between housing and children’s services to provide liaison advise and resolution of urgent housing needs.
- Recommission the involvement of CAMHS with the YJS including CAMHS attendance at the Complex Adolescent Panel.
- Review the Community Safety Strategy to clarify & detail the operational work that is expected/ where work should progress.
- Keep a close focus on improving staff retention and support.
- Develop a systems wide approach to involving fathers in multi-agency work – learn from the good practice currently being progressed by other safeguarding partnerships.
- Consider opportunities for strengthening multi-agency work such as through sharing intelligence/information, co-location of practitioners from different services/ disciplines to strengthen multi-agency working.
- Consider setting up a multi-agency serious youth violence panel with strategic oversight/governance.
- Continue to strengthen the reach & number of preventative services/positive activities in the community such as youth venues and community-based projects.
- Raise awareness of the lifelong trauma that can be caused to children by living in household where there is/has been domestic violence. Provide accessible services for children and families to heal from the associated trauma.
- Support Croydon schools to provide consistent training about SYV/extra familial harm.
- Consider creative options for children/young people who cannot live at home – those who are striving for belonging and want to achieve but struggle with their emotional worlds. What alternatives to state care could be considered by pooling budgets?
- Strengthen the services provided to young people who are transitioning to adulthood.
- Consider what more may be done to improve continuity of relationships provided to children/young people and their families including those who move across service/ teams and borough/geographic boundaries. Take a more fluid approach to the allocation of social workers - decisions about allocation should be child centred.
- Create reflective forums/spaces which include the whole multi-agency network.
- Pay closer attention to children who are struggling to achieve in school as early as possible – explore the barriers of referring for an Education Health Care Plan (EHCP) and of involving specialisms – such as Speech & Language Therapy (SALT), emotional wellbeing services and educational psychology.
- Raise greater awareness about the influence of social media with children/young people, carers and practitioners and consider how social media could be used to disrupt criminal exploitation.

Locally – front line

- Consistently use the team around the child approach such as the AMBIT²⁶ model - share intelligence and regularly complete safety mapping.
- Focus on creative and practical ways to support and engage all family members.
- Map and include all community and voluntary sector services involved with a child in safety planning. Consider, and attempt to mitigate, any risks posed by use of social media.
- Strengthen a focus on dreams, aspirations and identity in direct work with children/ young people and in plans.
- Pay attention to the language that is used to describe a child/young person - encourage a re-focus on behaviour as help seeking and provide respectful challenge when the language being used is demeaning/derogatory. Challenge adultification.
- Focus on how services will work to engage families and kinship by working through a trauma informed intersectionality lens.
- Focus on the whole professional network/ consider who is working/ involved with the family. Pursue the involvement of all services/practitioners in multi-agency planning/ decision making/ service provision with a particular emphasis on the involvement of housing²⁷ and adult services where relevant - escalate in circumstances where the full multi-agency group is not actively involved.

²⁶ Adaptive Mentalization Based Integrative Treatment (AMBIT) is an approach to support teams develop systems of help around particularly vulnerable, excluded, and underserved clients who may have little confidence or trust in the possibility of 'help' being helpful in their lives, and whose many difficulties often attract large numbers of different teams and professionals around them, that can make it complicated to coordinate who does what, and when, and may sometimes be rather overwhelming to the very people we are trying to help. <https://www.annafreud.org/clinical-support-and-services/adaptive-mentalization-based-integrative-treatment-ambit/what-is-ambit/>

²⁷ Issues around housing were identified as an important concern and good liaison with housing departments was seen to be a crucial part of a child safeguarding. Child Safeguarding Practice Review Panel 3rd Annual Report 2022 (Page 29)

Final Conclusion and Recommendations

This CSPR has gathered a wealth of information from a wide variety of multi-agency services, community services, community members, practitioners and families. Based on this very significant breadth of knowledge and lived experience, a number of suggestions have been made to strengthen the local and national response to extra-familial harm and serious youth violence. It is important to acknowledge that the challenges of preventing extra-familial harm/serious youth violence are systemic, involving significant national, strategic and resourcing issues many of which are out of reach of local services and the CSCP. However, this does not mean that services have stood still since the tragic deaths of these three children/young people and the convictions of those associated with their deaths.

There has been a very significant local response by the partnership and the community to these tragedies. Community and statutory services have adapted and evolved with new initiatives and new ways of working being established. It is of critical importance to note that since 2022, whilst there has been an increase in knife enabled offences, there have been a significant reduction of children/young people dying from serious youth violence in Croydon. This is a testament to the dedicated work, of statutory and community services and the people of Croydon, to find creative solutions together.

This CSPR is concluding at the time of the Government response to the independent review of social care²⁸ has been published²⁹. This response sets out five key pillars that underpin the forthcoming changes in how children/young people and their families will be supported – several of these key pillars are relevant to the experiences of the children/young people who are the subject of this CSPR. In recognition of these expected national changes, and of the local initiatives that have commenced, it was concluded that it would be unhelpful to set out a set of recommendations that may be at risk of duplication, may be redundant now/overtime or may contradict the direction of travel of the Croydon partnerships which has been informed by contemporary local intelligence and service evolution.

When consulting with families, panel members, community representatives, community members, senior leaders and practitioners about the recommendations that need to be made, it is clear that it is they who know the local area best, and it is they who are best placed to conclude what more needs to be done in Croydon to progress the learning detailed in this CSPR. Therefore, three recommendations are made accompanied by a broad set of principles (set out at the beginning of this report) to support the future direction of travel.

Recommendations

1. **Croydon Safeguarding Children Partnership to actively seek evidence to demonstrate how the 10 Key Principles (K.I.D.S. V.O.I.C.E.S.) are being applied across multi-agency services, schools, and across various panels and strategy forums and seek evidence of impact.**
2. **The voices of children/young people, family members and the community should be actively sought to achieve co - production in the future design of services.**
3. **Croydon Safeguarding Children Partnership to highlight the national issues raised in this CSPR with relevant national bodies such as the Child Safeguarding Practice Review Panel.**

²⁸ The independent review of Children's social care. Final Report. J. Mac Alister May 2022

²⁹ Children's social care: Stable homes built on love. DfE Feb 2023



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