Local Safeguarding Children Partnership for Hammersmith & Fulham, Kensington and Chelsea, and Westminster

Serious Case Review: Adam and a wider review of services provided to combat serious youth violence

Independent Lead Reviewer

Keith Ibbetson

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1. INTRODUCTION

Reasons for conducting the review

1.1. Between March 2019 and May 2021, the Local Safeguarding Children Board for Hammersmith & Fulham, Kensington & Chelsea, and Westminster ('the LSCB') carried out a Serious Case Review ('the review') of the services provided for a 17 year old boy and his family. He is referred to in this report as Adam and he was murdered in a knife attack in 2019.

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

1.3. Hammersmith and Fulham Council notified the death of Adam to the relevant government bodies and brought it to the attention of the LSCB in March 2019. The LSCB undertook the rapid review required by statutory guidance.[2] The LSCB independent chair decided that a review was required, noting that concerns about serious youth violence fall within the definition of contextual safeguarding in the statutory guidance. Adam and his family had been well-known to a number of services (detailed in Section 2 of this report). Initial review of the facts pointed to possible concerns about the way in which agencies had worked together to safeguard his welfare, as well as important potential learning for local services.[3]

1.4. Adam's killing has been the subject of a criminal investigation and a young person was found guilty of his murder. In order to safeguard the privacy of Adam, his family and other young people, this report provides no further detail of the circumstances of Adam's death. The review is aware of the highly-charged atmosphere that exists around the killing of a young person, the risk of retribution and further serious violence.

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[1] *Working Together to Safeguard Children* (2015), 4.1 and 4.6. In September 2019 Hammersmith & Fulham, Kensington & Chelsea, and Westminster introduced a new set of safeguarding partnership arrangements, in line with the Children and Social Work Act 2017 and *Working Together to Safeguard Children 2018*. However as part of the transition to these arrangements the LSCB retained the responsibility for completing this work. In April 2020 Hammersmith and Fulham created its own separate Safeguarding Children Partnership (the LSCP) which has overseen the completion of the review and taken responsibility for publishing this report.

[2] *Working Together to Safeguard Children* (2018) Sections 4.20 - 21

[3] *Working Together to Safeguard Children* (2018) Sections 1.30 – 33. Contextual safeguarding refers to children and young people '*vulnerable to abuse or exploitation from outside their families*' and is discussed at a number of points in the report.

Information about Adam, his family and his contact with professionals is only included in this report where it is necessary to support the review findings.

1.5. The review does not address the question of whether the death of Adam could have been predicted or prevented. To do so would require a detailed understanding of the backgrounds, circumstances and the motivations of those involved, which the review cannot obtain. Its focus is on the steps that should be taken to reduce the likelihood of other children dying in a similar way.

1.6. There is no statutory guidance that requires local safeguarding partnerships to review the services provided to young perpetrators of serious violent crimes. This is considered to be a weakness in the guidance that has previously been the subject of a previous recommendation to the Child Safeguarding Practice Review Panel.[4]

The scope of the review and the information considered

1.7. The LSCB appointed Nicky Hill as the independent reviewer in September 2019. She was selected because of her knowledge of serious youth violence and services for young people. Members of the LSCB, senior managers and the independent reviewer appointed to lead and undertake the review agreed initial terms of reference. These are set out in a redacted form Appendix 2.

1.8. The review obtained information from all of the local agencies and contracted professionals that are known to have worked with Adam and his family:

- Hammersmith and Fulham Council, including social care, housing, and education services
- Hammersmith and Fulham Youth Offending Service (YOS)
- Metropolitan Police Service
- Imperial Healthcare NHS Foundation Trust
- Schools and academy trusts
- Voluntary sector organisations

1.9. Agencies provided the review with chronologies that give factual accounts of their involvement with the family and other professionals, as well as a commentary on the involvement. In addition groups of staff and managers who worked with the family spoke directly to the independent reviewer in order to provide more detailed information about their work with Adam, reflect more widely on their experience of

[4] Brent Safeguarding Children (2021), Serious Case Review – Child K and Serious Youth Violence, http://www.brentsafeguardingpartnerships.uk/children/article.php?id=643&menu=0&sub_menu=2 Feedback from the panel to the partnership that published this review supports the practice of reviewing services offered to perpetrators.

work with young people and their families, and suggest ways in which services might be improved. More senior or specialist staff and service commissioners have provided information on policies and procedures.

1.10. There is some information that the review has been unable to obtain. This has largely been because the management and oversight of organisations has changed, organisations no longer exist or records have not been accessible. Adam briefly attended an unregistered, independent school which did not respond to numerous approaches from the review. The judgement of the independent reviewer is that this has not prevented the review from reaching findings on the most important matters. Specific instances when records were not available are mentioned when relevant in Sections 2 and 3 of the report.

1.11. In order to situate this individual case within a wider understanding of serious youth violence, the review took account of reports and strategies commissioned by the council and local partnerships as well as the growing recent body of research evidence and policy discussion about serious youth violence.

Appointment of new independent reviewer

1.12. In December 2020 the LSCP and Nicky Hill agreed that she would be unable to complete the review. The LSCP then appointed Keith Ibbetson to undertake the work necessary to finish the review. This report was written by him, drawing in large part on material obtained by Nicky Hill including interviews with staff. Responsibility for interpretation of the evidence and the review findings sits with Keith Ibbetson and the statutory safeguarding partners.

Family involvement

1.13. Following her son's murder, Adam's mother had remained in contact with a number of professionals including police officers, local authority officers and members of the YOS. The LSCP has involved her in the review, initially providing information about the purpose of the review in writing followed up by direct contact from the independent reviewers. The first independent reviewer held a virtual meeting with Adam's mother in 2020 in order to explain in more detail the reasons for the review and how it was being conducted. The second independent reviewer met Adam's mother twice in Spring 2021 to hear her views about the services that had been provided by agencies. A summary of her views is set out in Appendix 1 and the author has tried to integrate her account of her experience and her views throughout the report. She has been told of the review findings. The review is grateful that Adam's mother was prepared to talk about such very painful events. Adam's father lived

abroad throughout the period under review and was not approached as he had had no contact with services.

1.14. Appendix 1 is a full summary of the parents' contributions, but Adam's mother wished that a number of points should be given particular attention. She wanted readers to understand that parents need to be informed about the challenges and the potential risks of knife crime, gang activity and criminal exploitation much sooner. Then, if their children are exposed to these issues as they become teenagers, they may be better prepared to deal with them. She believes that social workers and others need to be able to provide young people who have been threatened with an immediate place of safety. Adam's mother wished to underline that parents have responsibilities as well. They need to integrate and get involved with the society where they have moved so that they can speak English, find out all about their children's friends, their school, their lessons and whether they are in trouble or not.

1.15. At some points the findings of the review and the views of Adam's mother coincide. For example, the review agrees that the arrangements made to relocate the family in the months leading up to Adam's death did not protect him and added new pressures on his mother. Elsewhere the review has reached different conclusions, reflecting the fact that it draws on different sources of information. For example, the review wishes to underline that professionals were holding meetings in the period leading up to Adam's death, though the review has found that senior managers were not sufficiently involved. These issues are all addressed in more detail in Section 3 of the report.

1.16. Adam's mother above all wished him to be remembered in a positive way as a boy who was loving towards his family and had positive plans and ambitions for his future. She does not believe that he willingly harmed anyone else and that although he was involved in some violent events this happened because he had been coerced.

<u>How can this learning review assist in improving services to reduce violent youth crime?</u>

1.17. The review took place during a period when there was a considerable public and political concern about the large number of young people being killed or seriously injured, often by other young people or young adults. The reasons for this have been set out by the author in a number of other published reviews, but they bear summarising.

1.18. Adam was one of 23 teenagers stabbed to death in London during 2019. This is the largest number of fatal stabbings since comparable records began in 2008.[5] In 2019-20 there were 14,590 crimes involving the use

[5] https://www.bbc.co.uk/news/uk-england-london-50507433 one more was shot and there was one other recorded violent death

of a knife in London, the highest figure since current records began in 2010-11.[6] In England and Wales just under 4,500 knife and offensive weapon offences were committed by 10-17 year olds in 2018-19. In the past five years such offences have increased by at least 60% with year-on-year increases since the year ending March 2014 until 2018-19, when there was a 1% fall. There are significant disparities in homicide rates between ethnic groups, the greatest usually being found among victims age 16-24.[7] This issue is explored further in Section 3.6.

1.19. In the year ending March 2018, 51% of children received a community sentence following a knife or offensive weapon offence. Although the number of children in custody has fallen consistently over recent years, the number of custodial sentences given to children for a knife or offensive weapon offence has been increasing because the number of such crimes has been increasing. In the year ending March 2018, nearly 600 knife and offensive weapon offences resulted in immediate custody, which is nearly double the volume in the year ending March 2013.[8]

1.20. The wider picture has prompted government, charities and 'think tanks' to publish large amounts of research as well as consultation papers and policy recommendations, identifying causes and advocating solutions. As would be expected when attempting to understand a social problem that has such devastating consequences, there are vastly varying and strongly held positions. Some thinking is highly critical of current policies and 'experts' often disagree. One commentary summarises the position as follows: *'the public debate about knife crime has intensified over the last two years but continues to generate single cause explanations, often overlooking the potential complexity and interconnectivity of the problem'.* [9]

1.21. There is a consensus that there should be a collaborative approach to serious youth violence and for some time it has been policy that a 'public health approach' to violent crime is needed. However politicians and others contest what this means, how it should be implemented and how long it could take to succeed. The Association of Directors of Children's Services believes that '*at the most basic level we do not have a shared*

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[6] https://www.statista.com/statistics/864736/knife-crime-in-london/.

[7] Kumar, S., Sherman, L. W., & Strang, H. (2020). Racial Disparities in Homicide Victimisation Rates: How to Improve Transparency by the Office of National Statistics in England and Wales. Cambridge Journal of Evidence-Based Policing, 4 (3-4), 178-186. https://doi.org/10.1007/s41887-020-00055-y Rates of disparity vary greatly from year to year because the numbers in any age group are relatively small.

[8] Youth Justice Board Statistical Bulletin. These are offences resulting in a conviction or caution. The overall figure is 31% lower than 2008-9

[9] Crest Advisory (2019) Serious violence in context: Understanding the scale and nature of serious violence https://static.wixstatic.com/ugd/b9cf6c_654f5b6fab914780bd3f895df353e231.pdf?utm_source=Website&utm_medium=PDF&utm_campaign=Serious-Violence

understanding and / or a clear definition of what constitutes a "public health" approach to reducing serious youth violence and knife crime'.[10] Within the time available this review has taken account of as much of this literature as is reasonably possible. Section 3 of the report considers how work to protect children from criminal exploitation might be linked to wider work to combat organised criminal activity and reduce violence.

The focus on wider issues in the system

1.22. In keeping with the statutory guidance the purpose of this report is not to criticise the actions of individual professionals.[11] Inevitably specific decisions, actions and gaps in activity are highlighted but at each point the focus of the reader should be on the question of whether wider difficulties exist in the multi-agency systems that are currently in place.

1.23. In any retrospective review of a child's life and the services provided by agencies with welfare and safeguarding responsibilities, there is a danger of misusing the benefit of hindsight. This is particularly so when the review involves the life of a young person who was well-known to many professionals has been violently cut short. Because we know how the story finished, it is easy to be drawn to aspects of the narrative that seem to have pointed to its inevitability and asked why no one acted decisively to prevent the tragedy. This is referred to as 'outcome bias' and the review seeks to avoid it.[12]

1.24. In general, the review has sought to avoid this by focusing its attention on the choices that professionals faced and the information that they had at the time. It is only by understanding the real context in which professionals were working that the review can offer positive suggestions. There are however a number of points when the report consciously makes use of a degree of hindsight, because it would be foolish not to take advantage of the overview of events that is now available. Where this approach is being taken, it should be clear. There is no evidence that there was a single point where professional action could have prevented Adam's death.

[10] The Association of Directors of Children's Services Ltd (July 2019) Serious Youth Violence and Knife Crime, https://adcs.org.uk/assets/documentation/ADCS_Discussion_Paper_on_Serious_Youth_Violence_and_Knife_Crime_FINAL.pdf

[11] HM Government, (2018) Working Together to Safeguard Children, Section 4.1 – 4.5

[12] James Reason (1997) Managing the risks of Organisational Accidents (page 38)

2. BRIEF NARRATIVE OF KEY EVENTS

Introduction

2.1. This section of the report provides an account of key events and the services provided to Adam and his family. Section 3 of the report evaluates aspects of services judged to hold the most potential for learning. When necessary, Section 3 provides more detail of some events to support the finding of the review.

Family background

2.2. Adam was black. His mother came to the UK from East Africa in 2000, emigrating with her then husband, via Italy. She was granted indefinite leave to remain a year later. Adam was born in late 2001. At about the same time, his parents separated and Adam's father left the UK. Adam's mother has a number of close relatives living in the UK and there were many families from her country of origin on the estate where the family lived. She told the review that her family is 'like the United Nations' outward-looking, tolerant and with friends and relationships across nationalities.

2.3. In 2007 Adam's mother remarried and had two further children. The police received referrals about domestic abuse incidents in 2008, 2011 and 2012. None of these incidents were or should in hindsight have been categorised as being either medium or high risk, and none was considered serious enough to merit a detailed local authority assessment of possible risk to the children. The couple separated in 2012.

2.4. Adam's mother told the review that she did not believe that he had been badly affected by domestic abuse because, for example, she made sure that the children did not witness any incidents. For a while his stepfather remained involved in the lives of his two children, but played no significant role in Adam's. The review is not aware of reports of further domestic incidents and cannot be certain what their impact on the children may have been. Primary school staff told the review that they believed Adam had been affected by conflict in the family.

Life at primary school, return to East Africa, transfer to secondary school and gaps in education

2.5. Only very limited primary school records are available. Adam had some behavioural difficulties and sometimes lacked the ability to control his emotional response to events. He had a strong sense of right and wrong and would become involved in disputes with teachers and other pupils if he sensed an injustice had occurred. His attendance was around 80%, which is below the level judged to be necessary to make good progress. However his academic achievement did not cause major concern and there are no records of referrals for additional educational support or help with speech and language difficulties. The review was told that he

had one brief exclusion in Year 5 for fighting. His mother told the review that she was happy with his progress. The school told the review that they did think Adam had been affected by exposure to domestic abuse, though it is not clear if this view was ever discussed with his mother.

2.6. Adam's mother withdrew him and his siblings from the school in Year 6. She told the review that she had decided to take the children back to her country of origin because she thought they would be better off and safer there. The family stayed in East Africa for two and a half years, where Adam's mother says the children thrived, only deciding to return to the UK when she witnessed a terrorist incident at close quarters.

School Year 9 – September 2015 – July 2016

2.7. Adam began Year 9 in a school in Hammersmith in September 2015. Again the review has only limited records of his education during the year in which he attended this school, and no evidence of his academic progress. The reasons for this are discussed in Section 3.3. A log of episodes focused on Adam's behaviour details 102 negative incidents, suggesting that Adam found it difficult to adhere to the school's firm disciplinary and behavioural codes. Almost all are persistent, low-level disobedience, such as disrupting the work of others, talking over or insulting the teacher and leaving lessons without permission. Fewer than 10 involve any sort of physical aggression or threatened use of force. There was no incident that caused injury or would be classified as serious violence. The records accessed by the review give no indication of the sanctions, punishments or restorative approaches used by the school.

2.8. Adam's mother described how, on his return to the UK, he wanted to spend time outside the family home, but that the groups of boys he became involved with were a negative influence. He was arrested twice in 2016 and he was also involved in fights outside his school resulting in minor injuries. His mother started to report him missing. In the most serious incident that came to the attention of the police and social care, he was found drunk, to the point of being unconscious with a friend in the company of a group of men in their twenties. They denied any involvement in Adam being drunk. He was taken to hospital by the ambulance service and treated in ICU. This initially gave rise to concerns about possible sexual exploitation. A strategy meeting recognised this concern but could find no evidence to support the suspicion.

2.9. The family immediately arranged for Adam to stay with relatives in South London; then he moved overseas again. A local authority assessment judged that Adam's mother was caring and concerned, and that she had a strong support network. The social worker advised Adam's mother that he might face difficulties readjusting on his return to the UK, suggesting that when he did his mother should contact the early help service for advice and support.

January 2017 – Adam's return to the UK, supervision by the YOS, growing involvement in youth street criminal activity

2.10. Adam returned to the UK in January 2017. On his return the school refused to readmit him. The specific grounds for this are not clear and there is no record that he had ever been excluded from the secondary school. This decision was supported by the local authority's Fair Access Panel. The panel records show only the decision and not the reasons for it. Adam's mother initially refused the offer of a place at the local authority alternative provision and enrolled him at an independent but unregistered school. This arrangement proved to be short-lived and unsatisfactory.

2.11. The police charged Adam over two of the incidents that had occurred the previous year and in February 2017, he was made the subject of a four-month Referral Order (though he was found not guilty of the more serious offence). The focus of the Youth Offending Service (YOS) work was to help Adam resist becoming more involved with young people who were committing criminal offences, to offer alternative positive activities and to support his mother in her efforts to find him a school.

2.12. In February 2017 (age 15) Adam was reported missing and returned home the next day with bruises and a swollen eye. In early March 2017 he was present when a friend was stabbed. Shortly after this he was beaten, and threatened with a large knife. Adam refused to provide a formal statement, though he appeared to know who had been responsible. The pattern of being a victim of violence continued and became more serious over the next two years.

2.13. Between March and July 2017 the police recorded 15 contacts with Adam. All involved groups of young people and concerned suspected drug possession and dealing, anti-social behaviour, and some borderline anti-social / criminal activities.

2.14. These incidents led the local authority to begin a third child and family assessment, finalised in June 2017. In parallel with this, the early help team undertook an assessment. Again the assessments were largely positive about the care provided by Adam's mother but identified the need for Adam to be in a suitable school place, not to go missing, and to adhere to the curfew set by his mother. The early help service worked with Adam and his mother with a behaviour contract to reward him for staying in, avoiding other young people and following her directions about his behaviour. This is reported to have achieved some initial success.

2.15. The YOS Referral Order intervention ended in June 2017. In line with the assessment, the intervention had focused on monitoring Adam's emotional state and behaviour, discussing his relationships with other young people and his offending. He attended specific sessions on knife

crime. At the end of the intervention YOS staff record suspecting that Adam involved in county lines drug dealing, though the police had no firm evidence at the time to support this. On the YOS risk assessment he was rated as being a 'medium' risk of serious harm and of reoffending, ratings equal to or higher than when the Referral Order was made. Professionals believed that Adam was becoming less honest in his accounts.

2.16. Adam's mother accepted a place at the local authority alternative provision in September 2017 although Adam did not start to attend until the end of November 2017 because he was arrested for a serious offence and then stabbed. At this point he was 16 and had been out of effective full-time education since July 2016. When he attended the alternative provision, Adam was viewed as a good and cooperative pupil who presented no difficulties.

<u>August – October 2017 – fourth child and family assessment, early help assessment and further involvement in criminal activity</u>

2.17. Between August and October 2017 Adam was drawn further into criminal activities with other youths. These were more serious incidents, including involved in the harassment of a young person who had distanced himself from involvement in a gang, sending threatening social media messages targeting the young person and his mother. Adam was identified on CCTV as being involved in an attack on a young person by a group of youths, and his stabbing. This led to charges of violent disorder and possession of a knife. Another knife was found at his home when he was arrested. This incident triggered a second early help assessment, carried out by a different member of the early help service. Bail conditions were applied. It is not clear from the records seen by the review if professionals believed that Adam had been coerced into these acts.

2.18. The early help assessment report identified some strengths in the way in which Adam's mother was looking after her children. The concerns focused on Adam were:

- The seriousness of his involvement in anti-social behaviour and offending
- The ease with which others drew him into criminal activity and appeared to take advantage of him
- The lack of what it called '*sustainable routines and boundaries being implemented in the home'*
- Risk of deteriorating behaviour once the current bail and curfew conditions had been lifted
- The significant gaps in education and Adam's poor attendance at the alternative educational provision
- The possible impact of Adam's behaviour and difficulties on his siblings.

2.19. The assessment proposed the allocation to an early help worker who would work on objectives linked to each of these areas with family members, as well as involving Adam in 'positive activities' at a project run by a football club. The plan recognised the need to take account of the environment in which Adam was growing up and the impact of wider factors by keeping '*abreast of ASB and crime developments in the locality and ascertain (ing) what young people are involved and / or associating with Adam'*. It was envisaged that a worker who was part of the YOS team specialising in family support would be involved. This worker (referred to subsequently in this report as the YOS family support worker) and the police officer attached to the YOS, remained key professional contacts for the family until Adam's death 15 months later.

First knife attack, Section 47 enquiries, and YOS family support plan

2.20. Adam was stabbed for the first time in November 2017. The wound in his leg was not serious and he was treated in hospital. For some time Adam pretended that the wound had been caused in a fall, making it very difficult for the police to investigate. It was only over the course of several discussions with the YOS family support worker that he admitted what had happened, though he still refused to provide details of who had been responsible.

2.21. A strategy meeting agreed to undertake a further child and family assessment. After an initial visit it was agreed that there were no immediate grounds to convene a child protection conference. The YOS worker's action plan set an intervention based around four tasks:

- To help Adam understand the negative aspects of his involvement in crime
- To work with and engage his mother
- To support Adam in keeping safe in the community
- To engage him with the YOS and help him comply with his bail requirements

These remained consistent themes throughout subsequent work with Adam. The early help worker remained involved, working mainly with his mother.

2.22. A follow-up strategy meeting noted increased risk to Adam. The meeting discussed the potential risk to the younger children and whether Adam's mother could act protectively towards them. The local authority decided to undertake a Section 47 investigation with that focus. It also agreed that a parenting service should be offered to Adam's mother and that there would be discussions with her about possible relocation of the family outside the borough. Adam continued to come into contact with the police following a similar pattern, but now also regularly breaching bail conditions by associating with groups of young people and being in places he was barred from.

2.23. The Section 47 report was completed. It concluded that safeguarding concerns in relation to Adam were *'substantiated'* and he *'was judged to be at continuing risk of significant harm'*.[13] These risks were judged to be best managed by continuing the work with YOS family support worker on the issues listed above. The assessment concluded that there was no further role for the local authority social care service because there were no confirmed safeguarding concerns in relation to Adam's siblings.

Second knife attack

2.24. On 5 January 2018 Adam was stabbed in the back in an attack by a group of youths. His nose was also broken. Friends he had been with escaped without injury. Intensive emergency medical intervention was required to save his life. Adam told the police that he thought he had been the victim of mistaken identity. The police investigation was closed in March 2018 as it had been impossible to identify the assailants.

2.25. At a further strategy meeting on 12 January 2018 the police repeated Adam's account that this was not an attack directed at him personally, which they appeared to have accepted. At the same time police officers identified features of his behaviour and circumstances that placed Adam at potential risk of a further serious attack. For example Adam was viewed as being affiliated to a specific gang and had incited violence towards other young people.

2.26. The meeting agreed a detailed plan of measures designed to minimise risk to Adam and other family members which included the possibility of Adam staying elsewhere or the family moving. Two weeks later an updated assessment confirmed that Adam was known to be involved in selling drugs; the family were reluctant to move out of the area, and, even if they moved, Adam had said that he would return. There were what were referred to as 'significant community tensions' because of the knife attack, placing Adam and other family members at a high level of risk. Professionals began to suspect that Adam's views now carried more weight than his mother's and that she had little control over him. All of these factors remained concerns up to the time of Adam's death.

2.27. The assessment recommended that a complex child in need meeting be convened to formulate a more detailed plan to reduce risk and keep the circumstances under review. Further recommendations were made on referrals to parenting programmes that might be able to assist Adam's mother in being more assertive and consistent, with continuing support from the YOS family support worker.

2.28. Throughout February 2018 Adam continued to be involved in similar

[13] These criteria are included in the local authority template and are drawn from the statutory guidance.

incidents, including a robbery in which he was identified from CCTV images. He was issued with a written warning for a Community Protection Notice due to continued and persistent anti-social behaviour in local housing estates. He was also a victim of crime and his mother reported harassment at their flat. His name was added to the police Gangs Violence Matrix. The police did not record specific reasons but this suggests that there was evidence that Adam had an affiliation to a specific gang and that he had recently been involved in gang activity. This meant that Adam's name would be regularly checked for involvement in incidents, either as a victim who was vulnerable or as a suspected perpetrator.

March – September 2018: child in need plan and meetings

2.29. In line with the recommendation of the Section 47 enquiry, Adam was discussed at a series of four child in need meetings between March and September 2018. After this the local authority social work service ceased its involvement. The first meeting was chaired by an independent child protection advisor and attended by Adam and his mother, the allocated social worker, the YOS family support worker, a the YOS outreach police team member. Later meetings were led and attended by the workers directly involved. Adam was invited but did not attend.

2.30. Adam did not accept the concerns held by professionals in relation to his safety and the wellbeing of his siblings. He also denied that there was any need for him to avoid being with his siblings when the family was making visits outside the family home. He told the meeting that his mother was over-reacting, being over-protective, and that he was not at risk. It was proposed that the family consider moving home, but Adam's mother stated that she knew and liked the area where they lived and that she felt secure there with a network of support for herself and her family. As a result of the meetings Adam started to attend CAMHS sessions to help him deal with the psychological impact of his recent experiences. Generally the child in need plan and meetings reiterated the proposals and plans made previously.

2.31. Adam continued to be involved in serious incidents. Along with another young person, he was arrested in Surrey for common assault and threatening a young person with a knife. They were released and no further action was taken. Later he was arrested in Oxford and found to be in possession of two mobile phones and a large amount of cash. Shortly after this the police in Hammersmith identified Adam as being part of a group of young males who had taken over the property of a vulnerable woman and was dealing drugs from the address. The activity was disrupted but no arrests resulted. There is no record that Adam was spoken to about this. As part of the response to an increase in local violence and conflict between gangs on his estate he was arrested and again found with a large amount of cash.

2.32. By April 2018 Adam had only attended the alternative educational provision for approximately a third of the expected time. A housing management transfer had been requested, though there was a concern that it might not happen for up to a year. In April 2018 Adam was seen discarding a kitchen knife when he thought he was going to be stopped and searched. Reports continued that young people were blaming Adam's mother for recent arrests on the estate. Further incidents heightened tensions between Adam and his mother who on one occasion were found struggling with one another in the street because she wanted to report an attack on him and seek help, against his wishes.

2.33. Shortly after, Adam was harassed and beaten by five young men and, the same day, hit by a car in an unexplained accident. Professionals understood these events as being linked to Adam's 'drug debts' of almost £1000 which, on this occasion and again later, his mother and members of his community joined together to pay off. This hastened discussions about the family moving and further practical steps to protect family members. Adam's mother initially refused an offer of temporary accommodation in a neighbouring borough because of the disruptive impact on the younger children, but then accepted after further discussion. A strategy meeting agreed plans for a National Referral Mechanism referral, though this was never put into action.[14]

2.34. The family moved to temporary accommodation in Ealing on 18 May 2018. The records do not show what arrangements were made for the payment of rent or housing benefit. Adam's mother already had substantial rent arrears. The move was understood by professionals to be a temporary arrangement and all of the Hammersmith and Fulham agencies remained involved. Despite the move, but in line with his statements about what he would do, Adam continued to be seen in his home locality and involved in criminal activity.

2.35. Further meetings made plans for future court appearances, the family's housing, school arrangements and Adam's mental health. It was now assumed that the family would not be returning to the family home and that the children would need to be enrolled in new schools.

2.36. In June 2018 Adam was convicted for the possession of a knife in a public place, an offence committed 9 months earlier. He was sentenced to a Youth Rehabilitation Order (YRO) with conditions including a night-time curfew and tag, restriction on his movement in certain postcodes unless

[14]The National Referral Mechanism allows those who are identified as victims of criminal exploitation (for example). Information about the NRM is available at: https://www.gov.uk/government/publications/humantrafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slaveryengland-and-wales https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/233310/NRM_child_first_responders_guidance.pdf

accompanied by his mother, and 2 weekly YOS contacts. Adam's mother told professionals that things had been much quieter and felt safer where the family was now living. She told the independent reviewer that she was aware of gang activity around their new home.

2.37. In August 2018 the local authority social worker told the family that the service planned to close the case. This had been planned for some time. There was believed to be no perceived risk to the younger children and the social work team did not believe that it was adding anything to the work with Adam. The YOS expressed concern informally about this, but did not refer the issue to a more senior social care manager. The decision to close the case was not influenced by the recently-made disclosure that Adam's mother wanted to move back to Hammersmith.

2.38. The final child in need meeting (held in mid-August 2018) agreed that the YOS would become the lead agency supervising the YRO, which had many months to run and was likely to be extended, and through the additional voluntary outreach family support work being undertaken. It was recognised that returning to the former home posed additional risks, although Adam had been visiting the locality throughout. The social work service formally closed the case on 18 October 2018.

<u>YOS oversight of Adam and his family from August 2018</u>

2.39. YOS oversight of Adam and his family began at a meeting described as a 'risk strategy discussion' on 31 August 2018. The meeting was chaired by a manager in the YOS and attended by the YOS case coordinator who was responsible for oversight of the YRO, members of the YOS responsible for family support and outreach, housing services, and a clinical mental health practitioner linked to the YOS.

2.40. The meeting noted continuing concern that Adam and his mother were still seen by some families on the estate as police informers. A number of circumstantial factors may have strengthened this impression.

2.41. Adam's mother was noted to be isolated and removed from her friendships and community network. She was continuing to bring her children to the primary school and it seemed more likely that she would return to the family home. Staying with family members did not seem viable, nor did moving abroad. The available housing options needed to be explained to Adam's mother so that she could make an informed decision. The professionals present were of the view that any return to the family home '*puts everyone at risk of serious harm'* and this needed to be put to her in the clearest possible way. It was agreed that this needed to be discussed with social care.

2.42. In September 2018 the court sentenced Adam to an 18-month Youth Rehabilitation Order (YRO), for involvement in violent disorder a year earlier. Conditions attached to the order included a 90-day curfew with

a tag, a weapons awareness course, a 20 day activity requirement and a 2-year Criminal Behaviour Order which restricted his freedom of movement and could be in place for up to two years. His existing YRO, which had less stringent conditions, was revoked.

2.43. Adam initially complied, but from December his involvement with the YOS to meet the formal requirements of his YRO fell away. Some of those involved received custodial sentences further strengthening suspicions about the family, though the outcome was justified by Adam's limited role in the offences and his relatively less serious criminal history.

2.44. The family moved back to Hammersmith in early October 2018. A further professionals meeting noted that Adam was believed to be selling drugs again, though he denied this. The tenancy of the family home was in jeopardy because of his conviction and further complaints by neighbours. Adam's mother had significant rent arrears which she had agreed to start repaying. Adam would be in breach of his order if he failed to attend his meetings and meet other requirements. Adam had enrolled at the local further education college though his attendance was poor and ceased after a month. There was a safety plan and CCTV monitoring of the home and the estate more generally, coordinated by the YOS with support from the police. The social care assessment was that no specific intervention was needed for the siblings and that its role had been '*purely supporting the professional network'*. The meeting noted that the YOS would have lead responsibility in relation to Adam and the primary school would oversee and report any concerns about the siblings. The meeting records show no suggestion that the risks to Adam needed a more formal safeguarding response or continued allocation as a child in need.

2.45. Between September and December 2018 the YOS intervention centred around the safety of Adam and his family. There were also sessions about his relationships with peers, decision-making, thinking, and self-esteem. The YOS clinician had seen Adam for an initial session about his mental health, but she became unavailable. As a result he refused to engage in further mental health work saying that he was unwillingly to retell his story. His YOS case manager also left the service. There was little evidence of a positive impact on Adam's behaviour; although he was not charged with any further offences during this period, evidence suggested he continued to be involved in the supply of drugs. The replacement YOS case manager remained responsible for work with him until his death, though Adam kept few appointments.

<u>Escalation of risk from January 2019 and Adam's death</u>

2.46. From the beginning of January 2019 Adam again came to police attention more often. His mother told professionals that he was being collected at night in minicabs by adults and that a weapon had been found in the home of a close friend.

2.47. On 21 February 2019 Adam's mother reported to the police that he had been missing for two days. He had refused to go to the police station for an appointment to be questioned over new, recent allegations, saying that it was '*too dangerous'*. The police graded Adam as a medium-risk missing person and details were circulated urgently. Three days later Adam's mother reported a concerning phone call from her son. She believed that he was being held against his will and that threats had been made to hurt his siblings if he spoke to the police. Subsequently he did return, but provided no further information.

2.48. These concerning events led the YOS to convene two further strategy meetings. The first was attended by YOS members and focused on Adam's circumstances. The second, which considered risks to Adam in the context of his relationship and contact with two other young men, had a wider attendance including social workers for the two other young people, and workers with specialist exploitation roles.

2.49. Pressure on Adam and his family had continued to mount. His mother and his siblings were staying with a family member because they feared for their safety. It was reported that she had again been paying off debts which criminals said had been accrued by Adam. His mother was now prepared to move out of the borough again and consideration was given to whether Adam could stay with an aunt. The first meeting agreed to place special measures on the family home and identify the risks in the police records, explore Adam's mother's mental health, speak to parents of the two other young people, and share information about events with the siblings' primary school.

2.50. By the time of the second meeting, three days later, Adam's mother and siblings returned to the family home and the police placed the addresses of all three young people on 'special measures'. Adam had returned home so was no longer technically missing, though it was believed that he was out for lengthy periods and possibly overnight. Again he refused to provide any specific information about where or with whom he had been. When seen by the YOS worker he again played down any concerns, stating again that he was not being threatened and that his mother was exaggerating.

2.51. Very concerning new information was available indicating that one of the three young people had been stabbed some days earlier and that another was being pressured to participate in drug selling outside London. There was no specific new information about Adam. However it could be assumed that if these two close associates were being placed at serious risk, it would have implications for Adam.

2.52. The meeting understood that the boys were at risk of harm from adults who were exploiting them. One of the three young men (age 18 and so an adult) appeared to be at particularly high risk of harm and it was advised that he should present seeking emergency accommodation as

he was fleeing threats of violence. It was agreed that the YOS workers should hold further discussions with the respective parents to establish whether they would be prepared to move out of the borough. It was proposed that the parents should be referred to a specific parenting support group called Parents Against Criminal Exploitation. The meeting was to be reconvened two weeks later on 14 March 2019. Information would be shared with the borough's Community Safety Unit and housing service though no specific actions were proposed.

2.53. There are no further agency records that have been seen by the review until a week later the YOS family worker's work was reviewed by her supervisor. This noted the recently agreed action plan and the emphasis on moving the family away from the borough.

2.54. On 6 March 2019 the police stopped a speeding car. Adam was detained by the police. Adam did not try to run away and was the only one of four occupants who remained at the scene. He was searched with no positive result and allowed to go. The police officers involved did not have access to details of the recent events and in any event had no grounds to detain Adam.

2.55. The following day Adam was stabbed. Little clear information has come to light about the reasons for the attack on Adam. There is no firm evidence that the stabbing was linked to the specific risks in relation to Adam identified in the previous weeks.

3. FINDINGS AND LEARNING

3.1. Introduction

3.1.1. This section of the report evaluates the effectiveness of the services provided to Adam and his family. It seeks to draw wider lessons and make recommendations for improvements in practice, recognising that it is now more than two years since Adam's death. During this time all the agencies safeguarding children and young people from serious youth violence have made changes to their services. There have also been changes in the circumstances in which young people are living and professionals are working since 2019, particularly because of the response to the Covid pandemic.

3.1.2. Where agencies have told the review that there have been changes in professional practice this is noted. The review cannot judge the effectiveness of current services. The review asks the local multi-agency safeguarding partnership to test whether the changes that have been introduced have made a difference and to decide what further improvements should be made.

3.1.3. The evaluation is organised as follows. Section 3.2 explains why Adam's history should be understood as part of a pattern of child criminal exploitation and describes the impact that this had on him, his family and other members of the community. It describes some of the background factors that made Adam more likely to be a victim of crime, and then a participant in criminal activity. It includes comment on the role of the police both in relation to the individual concerns and as part of the wider partnership working to combat serious youth violence and criminal exploitation.

3.1.4. Drawing this analysis together the review finds that in order to safeguard children and communities successfully, professionals need a model that addresses the following:

- specific risk factors facing individual children that arise both from within their own family (these risks might be current or may have occurred in the past)
- the experiences of young people in the places they live, socialise and go to school, including risks from other young people
- the role of street groups and gangs
- the impact of organised criminal activity.

3.1.5. Any such approach needs to be accepted as having legitimacy by all of the public bodies with a role in this work, primarily local authority social work and youth services, youth offending services, and the police. It will only make an impact if it successfully addresses the experiences of young people and their families, offers practical solutions, and has the support of affected local communities.

3.1.6. Section 3.3 considers the impact of Adam's very fragmented education and the response of schools and other agencies to this. Adam's involuntary removal from mainstream education and subsequent poor attendance in alternative provision added to his difficulties and made it more difficult to protect him.

3.1.7. The narrative highlights the number of assessments carried out by social care professionals, early help and the YOS. Despite this, both individually and collectively, agencies struggled to know how to respond to the increased risks to Adam in the last two years of his life. During this period concern about him increased but professionals were unable to turn their concerns into meaningful, practical support that matched the nature, scale or complexity of the problems confronting Adam and his mother. In the weeks before his death, responsibility for Adam was held by the Youth Offending Service as the local authority social work service had closed the case. Section 3.4 considers these issues. Linked to this is a discussion about the use of child protection procedures in relation to extra-familial harm.

3.1.8. Section 3.5 considers the steps taken to relocate Adam and his family to a neighbouring borough during 2018. This also draws on the findings of other reviews.

3.1.9. Section 3.6 summarises information provided by the family about Adam's ethnic background and aspects of his experience that may be specific to this. It considers how provision is being made for children and families who share this family's ethnic background.

Examples of effective practice

3.1.10. Inevitably a review of this nature focuses attention on areas in which improvement can be made. However attention should also be drawn to strengths in practice. The review notes the following effective practice:

- The clinical medical and psycho-social care provided by at Imperial Healthcare Trust by the staff in its intensive care unit at St Mary's Hospital. Their practice is not discussed further in the review. It is assumed that the practice of this unit draws from and is disseminated among other ICUs and health safeguarding teams in London and nationally
- The work of the hospital is supported by Red Thread. This is a voluntary organisation that seeks to enable young people who have been victims of a violent attack to make constructive use of the crisis of a hospital admission, alongside statutory agencies. Adam was able to speak to a worker on a number of occasions, though at the time of his hospital admissions Adam usually already had an allocated worker, so there was no need for anyone new to take on a key worker role. However Red Thread sought out relevant information about events and communicated it quickly and effectively to the existing network of professionals.

3.2. Child criminal exploitation and the response of services

Introduction

3.2.1. This section of the report considers the criminal exploitation of Adam, its impact on Adam and his family, and the response of agencies. This section of the report makes a number of references to police involvement with Adam and his family, so there is no separate section dealing with this. Developments in services in Hammersmith and Fulham during and since the period under review are considered and the report makes recommendations.

The pattern of exploitation, violent offending and its impact on Adam and his family

3.2.2. The following made Adam vulnerable to exploitation. This account focuses on his 1) home and family circumstances, 2) the context in which Adam and the family were living, and 3) the effectiveness of services provided. These can be considered as either 'push' factors or 'pull' factors in relation to exploitation.

3.2.3. Adam experienced some difficulties at home. His wellbeing was his mother's priority. Over a number of years concerns for her children led Adam's mother to make significant decisions about where the family should live. In his final year of primary school Adam's mother took him to live overseas because of her fears about the environment in which he was growing up. Later she moved him to stay with members of his family elsewhere in London before taking him overseas for a second time. At the suggestion of professionals she moved the family to temporary accommodation in a neighbouring borough. This move is discussed further in Section 3.5.

3.2.4. Reports made to the police allege that Adam's stepfather was violent to his mother. Adam's mother told the review that there had been arguments but that she shielded her children from the worst effects. However on one occasion Adam reported an incident himself in order to protect his mother. One report states that Adam was assaulted by his stepfather. None of these episodes would have merited recording as medium or high-risk domestic abuse. However it is impossible to tell what the cumulative impact was of living in an atmosphere of persistent conflict. His primary school believed this did affect Adam's behaviour in school and personality.

3.2.5. Adam grew up on an estate which has high levels of deprivation and has sometimes experienced periods when there are high rates of youth crime. At times (including during 2018-19) there has been conflict between gangs associated with the estate and others from outside. It is also an estate with good schools, active community organisations and some good resources for the community. Many young people who grow up there make a great success of their lives, including many from the same ethnic background as Adam's family. Adam's mother liked where she lived and was well-liked in her local community, though relationships with some families were put

under severe strain at times. Perceptions about provision for young people differ. Adam's mother told the review that there was little organised youth provision and that the council needs to do much more. Professionals who know the estate well have a more positive view, believing it to be better served than many in the borough.

3.2.6. The fact that Adam spent significant periods of his childhood in East Africa seems to have made it more difficult for him to become rooted in his local community and to develop positive links with other young people. Aside from his mother he lacked positive adult influences in the local area. For long periods there seems to have been no man in his family or community who played a significant and positive role in Adam's life.

3.2.7. Adam was 15 in January 2017 when the family returned to the UK for the second time. His mother told the review that it was much more difficult for her to directly control how he spent his time and which young people he mixed with. Adam's wanted to spend time with other males outside the family home, seeing this as the right way for a young man to behave. This may be how he spent time when he was in East Africa. There he would have had the positive influence of extended family and friends to keep him out of trouble and reinforce his mother's authority over him. On the estate Adam was attracted to older youths and adults. They were members of street groups (drawn according to his mother from a variety of backgrounds and nationalities) who provided a source of connection, friendship, community and status. They also weakened his mother's influence, some of them exploited him and involved him in crime. This was at a time when Adam had been barred from returning to his previous school and, despite his mother's efforts, no satisfactory education arrangement was made.

3.2.8. Adam was often at risk of physical harm. He went missing from home on many occasions and was suspected of having been coerced into county line drug dealing, twice being arrested outside London.

3.2.9. When Adam was 14, he was found intoxicated and unconscious in a park with a group of young adults giving rise to suspicions of sexual exploitation, though there was no allegation or evidence to show what had happened. Soon after he was present when a friend was stabbed; later he was beaten, punched, kicked, and threatened with a large knife.

3.2.10. In the weeks before his murder he told his mother that he was being held against his will and that threats were being made against his siblings, probably as a means of extorting money from his family. At this point professionals believed that other young people were being forced to 'work' dealing drugs with Adam. They were becoming physically exhausted and put pressure on him to become reinvolved.

3.2.11. There is no specific evidence that the fatal knife attack in March 2019 was related to this pattern of exploitation, but before this Adam had been

stabbed twice (in November 2017 and January 2018) once in the leg and once (nearly fatally) in the back.

3.2.12. Adam came into frequent contact with the police. He was stopped and searched on many occasions, usually because of suspicions of drug possession, dealing, and anti-social behaviour. There were also a number of occasions when he was searched as part of the response to an escalation of criminal activity on his estate. The outcomes of these interventions were recorded and reported but the intelligence obtained did not seem to have contributed to wider understanding of exploitation or interventions to safeguard young people.

3.2.13. Adam was identified from photographs as one of a group of young males dealing drugs from the 'cuckooed' property of a vulnerable woman. He was believed to be involved in harassing a young person who had distanced himself from involvement with a group of youths, including by sending social media messages targeting the young person and his mother. It's not known whether he did this of his own volition.

3.2.14. Adam was convicted of involvement in two serious violent episodes, in both of which a boy was stabbed. It is not possible to tell how central or peripheral he was to these incidents. His mother believes that he was always coerced. It is certainly very difficult to imagine Adam committing offences outside of a set of manipulative and abusive relationships. In one episode, part of which was captured on CCTV, his mother describes how a group of young people came to the house to tell him to join an attack on a rival group. She believes that he was at the back of a group, carrying a piece of wood, while others were at the front, armed with knives. The sentencing of individual young people over this incident suggests this to be true, as well as reflecting the boys' ages and previous convictions.

3.2.15. These offences almost all occurred when Adam was part of groups of boys. Professionals knew that young people had links with each other. However there was no systematic mapping of their connections or relationships until after the death of Adam and no interventions with groups of boys.

3.2.16. It is clear that there was an overall pattern of exploitation but it is impossible to be certain of Adam's reasons for being involved in these incidents and the extent to which – on any specific occasion – he had been coerced. There is no doubt that when part of groups he harmed other children and that he was sometimes a risk to the wider public. This pattern is not unusual and there is a danger of viewing young people who are drawn into crime exclusively as victims of exploitation, just as there is a danger of viewing them exclusively as criminals.

3.2.17. Adam's education in the UK was severely disrupted so that he received only one year of effective secondary education. His educational potential was not fulfilled. Primary school he was above average in some subjects. At 16 he joined a college course at foundation level, and then attended sporadically

before leaving after a month. Adam's education is considered further in Section 3.3.

3.2.18. The number and seriousness of the violent incidents that Adam was involved in had a marked psychological effect. He suffered from poor sleep and recurrent nightmares. He often smelt of cannabis. Perhaps in common with many young people who are involved in or affected by violence this may have been a form of self-medication to reduce stress. When it was suggested that the family should move house, he told professionals that, '*risk is everywhere'* and that '*death is certain'*, betraying a deeply pessimistic view of his own future and a lack of belief that he had any capacity to shape it. By this time he had been stabbed twice and also witnessed a large number of attacks and violent incidents. A clinician believed that he was suffering from a post-traumatic stress disorder, though there was no formal psychiatric diagnosis.

3.2.19. Threats of extortion and the fear of violence disrupted normal family life; they also distorted and poisoned Adam's relationship with his mother. At a point when there had been a series of assaults on Adam, he fought with his mother in the street because she wanted to report the incident to the police. He wanted to stop her, fearing reprisals. Later that day he was run down by a car, underlining the seriousness of the threats.

3.2.20. Adam's mother felt forced to cover for his involvement in criminal activity. On several occasions she paid his debts to criminals, amounting to several hundred pounds each time. More than once she borrowed from family and friends to raise this money. Her own safety and that of her other children was put at risk as rumours were spread on their estate that either Adam or his mother had given information to the police.

Awareness of staff, understanding of the nature of this exploitation and the effectiveness of interventions

3.2.21. The author was not able to interview staff directly involved in working with Adam and his family. (See section 1.12) and is therefore not able to say with certainty how all of the individuals involved viewed Adam's circumstances and behaviour. Overall there is strong evidence of a network of professionals that cared about what happened to Adam and worked hard to safeguard him. Professionals understood that he was the subject of repeated threats. One manager is reported to have over-stated the extent to which he had control over the choices he was making, but the review does not think that this attitude was widely shared. The problem was not that professionals misunderstood Adam's difficulties or used the wrong language to describe them, it was that they could not provide practical solutions that made sense to Adam or his mother or matched up to the size and nature of the problems that they faced.

3.2.22. Professionals in different services carried out a large number of assessments. Individually they identified the impact of specific incidents on

Adam. However taken together they did not provide a coherent account of the nature and extent of the exploitation. Such an account would have brought together:

- Details of the impact of specific incidents and immediate risks
- An account of Adam's underlying needs for connection, community, friendship and status that pushed him into repeated contact with youths involved in offending
- Specific knowledge of those who were harming or threating him
- An account of how he and some of his peers were both victims and perpetrators
- An understanding the extent to which Adam was able to exercise choice and agency, recognising that there were times when this was not possible.

Bringing together this kind of assessment would have allowed for debate about the extent of Adam's knowledge and responsibility, how far he was being exploited and coerced, how much agency he had and the best way to help him and the family. This requires a more complex and ambitious assessment than is normally currently undertaken. It would for example need to bring together the police understanding of violent and drug- related crime on an estate, cross referencing this to knowledge about other young people. It is clearly a challenge to combine this wider perspective with an assessment of individual risk focused on one young person in a timescale that addresses immediate risks. However if this does not happen services will find it hard to be anything other than reactive, with each incident triggering a reconsideration of risk and threshold, sometimes with repeated assessment and case transfer to a different team.

3.2.23. During the two years before Adam's death there was a considerable amount of activity and information sharing (contacts with Adam and visits to the family home, emails, individual discussions, and meetings). There were a number of plans including:

- Early help plan (October 2017)
- YOS family support action plan (November 2017 – March 2019)
- Child in need plans (March – September 2018)

3.2.24. These plans proposed a series of similar basic steps which were designed to:

- Help Adam become more aware of the risks of exploitation
- Engage him in safer and more positive alternative activities
- Help Adam comply with YOS requirements (when he was on an order)
- Find him a school, address the significant gaps in Adam's education and his failure to take up his place in alternative provision (or later college)
- Help the family understand the possible impact of Adam's difficulties on his siblings.

3.2.25. Although Adam's circumstances deteriorated in this time, the plans proposed were largely similar, though they may have led to more frequent

visiting or contacts. At times the focus was on a particular issue, such as the professional belief that the family should move out of the borough. However the intervention as a whole lacked the scope and authority necessary to deal with the nature and extent of Adam's difficulties, and did not escalate as his problems worsened. There was a lack of direct senior management engagement and oversight, given the level of risk identified by front line staff.

3.2.26. For the last six months the formal lead professionals were the two YOS case coordinators. Both acted diligently to gather information about Adam and other boys who were at risk and to coordinate meetings. Day to day interventions were led in the months before Adam's death two experienced but junior members of YOS staff. Too much reliance was placed on these two professionals. Whilst Adam was willing to talk to them, and his mother had confidence in them, generally Adam and his mother were often not convinced by, and did not adhere to, the plans proposed. For example family members were never convinced that they should not go out together as a family, which professionals believed would place Adam's siblings at risk. It was only after much persuasion that his mother agreed to relocate the family to a neighbouring borough, and then only for a very short period.

3.2.27. There was confusion about some aspects of the proposed intervention. A referral to the National Referral Mechanism was proposed, but never made because it was never agreed which professional was to make it.[15] This is likely to have had only limited effect. It would have prevented Adam's prosecution in relation to possession of drugs in relation to county line activity, but is unlikely to have been applied to his involvement in serious violent offences committed locally. Although there was much individual contact with Adam, limited consideration was given to the identification of resources with stronger connections in the community, such as might have been offered by groups linked to a local football club.

3.2.28. Rather than exploring episodes in detail to improve the understanding of risk and respond, the collective sense of powerlessness led to the assumption that workers already allocated to the family were the best intervention that agencies could offer. This is illustrated by the missing episodes in the weeks that preceded Adam's death.

3.2.29. Shortly before Adam's death it was recognised that there were two other young people whose involvement in exploitative networks overlapped with that of Adam. Meetings were convened which brought together professionals working with all three young people, however this did not result in concerted collective action. At the time of Adam's death the focus of activity was on persuading the family to relocate again, an approach that

[15] For an explanation of the NRM see footnote 14

had already failed once. The lack of alternative suggestions as to how to proceed reflects the objective difficulty.

An approach that situates criminal exploitation in a wider context and intervenes at a number of levels simultaneously

3.2.30. The exploitation of children and young people is an integral feature of organised criminal drug supply. It has a sophisticated division of labour and hierarchies; roles are allocated in recruitment, training, management, sales and enforcement, just as they would be in a legitimate business.[16] Violence and coercion are endemic and escalate when there is competition or instability in drug markets. An effective response to this requires a detailed understanding of the way in which exploitation is occurring in specific local circumstances. The work of professionals responsible for the safeguarding of children can only be successful if it is part of the action taken by wider society against those who are responsible for the organised criminality that underpins it.

3.2.31. In the records seen by the review, there was no mention of consideration being given to this during Adam's life. Adam's close associates were known, but connections between networks of youths with whom Adam is understood to have been involved were only mapped after his death. More importantly, those exploiting Adam and other young people were not identified. Police activity in relation to Adam focused on crimes that he committed with other youths. Some were serious offences in which he is believed to have played a relatively minor part. Police officers played a limited role in the strategy and risk management meetings about Adam, with the police almost always being represented only by the YOS police outreach officer. This officer does not appear to have had access to any wider intelligence or insight into the adults and other young people who were responsible for the exploitation of Adam. This is not unusual. Both the national safeguarding practice review and other local practice reviews highlight the lack of activity to disrupt child criminal exploitation. A marked difference is noted between '*the strategies employed by local areas to address child sexual exploitation, where there is often a dual approach to victims and perpetrators'*.[17]

3.2.32. Adam's dual roles as a victim of exploitation and a perpetrator of offences should not be ignored. It is impossible to know how far he was coerced into committing offences, what his motivation was for being involved or how much control he had. This may have been different on different occasions.

[16] Robert Wyatt, Hounslow Youth Offending Service (2020) Conference Presentation, 'The business of organised crime and exploitation'; Simon Harding (2020) County Lines: Exploitation and Drug Dealing among Urban street Gangs, Bristol University Press

[17] The Child Safeguarding Practice Review Panel (2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government (page 20)

It will vary greatly between young people.

3.2.33. The use of the term criminal exploitation underlines similarities between sexual and criminal exploitation, but there are also important differences which need to be considered. In child sexual exploitation, direct and active participation of young people in the abuse of other child victims is known, but considered unusual and seldom discussed in the literature.[18] In contrast, descriptions of criminal exploitation show that harming other children is an intrinsic part of gang and organised criminal behaviour to traffic drugs. Young people who for whatever reasons have been drawn into committing criminal offences, may soon become participants in criminal exploitation, posing a risk to other children and to the public. Patterns of criminal exploitation include experiences that cannot be fully understood if professionals consider young people solely as victims.[19]

3.2.34. Detailed studies of gang activity also highlight differences in the roles and motivations of young people involved. A study of drug dealing based in Merseyside and Glasgow which drew on extensive interviews with young people highlighted the variety of motivations of those involved: '*we find evidence of Child Criminal Exploitation (CCE) in County Lines activity, often as a result of debt bondage; but also, cases of young people working the lines of their own volition to obtain financial and status rewards*'.[20] Otherwise awareness of the dual roles of young people as perpetrators and victims is rarely highlighted in the literature, though professionals are aware that a young person may have been coerced into committing one set of criminal offences (typically selling drugs) but may be a willing participant or instigator in another, or may have committed other offences with no identifiable link to exploitation or gang activity.

3.2.35. Professionals should not underestimate the degree of coercion involved, and the gradual grooming of children, but nor should they fail to give weight to the agency that some young people have. Defining a young person solely as a victim of exploitation may lead professionals to misunderstand the extent and nature of risks, and lead them to overlook possible avenues for change. Interventions to reduce extra-familial harm can only work with the cooperation of young people. They need to identify and build on the agency

[18] An exception is a paper by Firmin who recognises that there are young women who have aided the recruitment of victims and sometimes participated directly in acts of sexual abuse. Firmin, C. (2016) Child Sexual Exploitation and the Victim-Perpetrator Overlap. Luton: University of Bedfordshire (text of the film).

[19] The motivation for this desire to downplay the agency that young people have and the harm that some young people do to others is unclear and merits wider discussion. It may reflect professional overcompensation for errors made in the early understanding of child sexual exploitation in which young victims of rape and sexual assault were characterised as having made poor 'lifestyle choices'.

[20] G Robinson, R McLean and J Densley (2018) Working County Lines: Child Criminal Exploitation and Illicit Drug Dealing in Glasgow and Merseyside, International Journal of Offender Therapy and Comparative Criminology

of young people. Interventions that view young people exclusively through the lenses of victimhood and past trauma are less likely to do this successfully.

3.2.36. Adam's history indicates that addressing the criminal exploitation of children requires collaborative strategies and action involving children's safeguarding, local authority community safety, the policing of neighbourhoods, and the policing of organised criminal activity to disrupt and prosecute perpetrators. None of these is a discrete entity and work on each of them should inform the others. Professionals whose day to day responsibility is safeguarding children need to be well informed about the nature of the criminal activity that is shaping the lives of young people in their localities. Contextual interventions may focus on the local situation, peers, families and networks, but they are likely to be of limited value unless they are also integrated into a bigger understanding of exploitation and the potential to disrupt organised criminal activity

3.2.37. This project requires much better coordination of activity and improved information sharing between agencies (and different sections of agencies) who do not normally collaborate closely. For example, police officers whose day to day focus is on the disruption of organised criminal activity need to work much more closely with safeguarding professionals, neighbourhood police officers and those concerned with anti-social behaviour than they currently do. Currently discussions on how this might happen mainly take place among agencies focused on law-enforcement and are informed by academic criminologists. They appear to have limited impact on safeguarding activity.[21] There is a pressing need for a framework that can be used to situate the risks to individual young people in a wider context, and organise information and activity. Discussions among those involved in policing make use of academic models connecting the different forms of youth group, street gang and organised criminal activity. One such model of 'evolving gang activity' is set out in Figure 1 below.

3.2.38. While such models might be the subject of dispute within academic criminology, and may require refinement in the light of development of new forms of criminality and exploitation, they do at least offer a starting point for discussion between police, community safety specialists and safeguarding professionals. Potentially they offer a framework within which strategies for policing of localities and for responding to safeguarding can be organised. They are descriptive of different forms of group and criminal

[21] For example Cumberland Lodge has held discussions and produced a useful report but attracts attendees largely from the police, criminology and occasionally Violence Reduction Units and local authority public health departments. There is no attendee with a children's safeguarding or operational or youth justice background https://www.cumberlandlodge.ac.uk/read-watch-listen/understanding-and-policing-gangs-cumberland-lodge-report; https://www.cumberlandlodge.ac.uk/what-we-do/cross-sector-conferences

activity, but do not seek to explain how young people move from one to another, which is essential to implementing steps to protect them. If there is a preference for other models which describe the local context better, they can be substituted.

Figure 1 Evolving gang model [22]

RECREATIONAL		CRIMINAL		ENTERPRISE
Occupied by Youth Street Gang		*Occupied by Youth Criminal Gang*		*Occupied by Organised Criminal Group*
Age range 12-16		**Age range 17-25**		**Age range 18+**
Relationships - social		Relationships - social		Relationships - economic
Terminology – self labelling		Terminology – non labelling		Terminology – non labelling
Group activities - recreational, occasionally delinquent and typically revolved around territoriality		Group activities: primarily delinquent and criminal, wide ranging		Group activities: criminal and typically specific
Membership: open, residentially assigned		Membership: closed assigned via friendships		Membership: closed assigned via business arrangements

3.2.39. The need for this type of approach appears to have been recognised, but not implemented. Ofsted's thematic inspection of exploitation ends by stating that the '*only way of responding to and preventing highly organised criminal operations that exploit children is to have a highly coordinated multi-agency and whole-council approach'.*[23] The national child safeguarding practice review calls for *'a whole system approach incorporating policy, prevention, disruption, protection and support across multiple agencies is likely to be most effective'.*[24] The Contextual Safeguarding Network has recently published a paper exploring connections between contextual safeguarding, public health initiatives and problem-

[22] Robert McLean (2020) Understanding and Policing Gangs Cumberland Lodge, Figure 1 – An Evolving Gang Model

[23] Ofsted (2018) Protecting children from criminal exploitation, human trafficking and modern slavery: an addendum (page 10)

[24] Child Safeguarding Practice Review Panel (2020) (page 20)

solving police approaches.[25] This suggests that different types of intervention may have different timescales over which they will make an impact.

3.2.40. In work commissioned in Ipswich by the public health and community safety partnerships, researchers located the safeguarding of children in a wider understanding of organised criminal activity.[26] This was developed to address the problems of a town suffering an upsurge in county line drug trade, rather than an inner-city area. However there are aspects of the approach that are extremely relevant to the development of a strategy. The victimisation of young people (both those involved in the supply of drugs and the potential purchasers) is researched in the context of detailed information about the growth of organised drug selling. Potential methods of intervention are proposed following a detailed review of research on the effectiveness of approaches and presented as part of a local partnership strategy. Interventions range from early help and preventative interventions to tough disruption measures involving the police, YOS and probation. The review underlines the importance of community support for such an approach. The author of this serious case review is not aware that similar work has been undertaken in London.

Development of services in Hammersmith and Fulham since the death of Adam

3.2.41. The review recognises that a number of factors made Adam's case particularly difficult for professionals. As a result of the number of times that he moved between the UK and East Africa, and the length of time that he spent out of education, he had few opportunities to make the normal social contacts that young people need in order to thrive. For a boy with so few ordinary social connections, groups of youths involved in criminal activity became a substitute extended family. Successful interventions with Adam would have required the kind of comprehensive approach that has been described, as well as more successful approaches to some of the specific difficulties he faced. The review is not aware of any part of England in which such a comprehensive approach to combatting criminal exploitation and serious youth violence is being taken, so it is not a surprise that professionals struggled.

3.2.42. It is not the role of this review to establish how effective the current work of agencies with safeguarding responsibilities in Hammersmith and Fulham is more widely. The review is aware of the findings of an inspection by

[25] https://www.csnetwork.org.uk/en/resources/practice-guides-and-resources/practice-guides Evidence based approaches to violence reduction: A discussion paper (March 2021)

[26] P Andell, J Pitts (August 2017), Preventing the violent and sexual victimisation of vulnerable gang-involved and gang-affected children and young people in Ipswich, University of Suffolk, https://www.uos.ac.uk/sites/default/files/Final%20Amended%20Report%20-FINAL%20VERSION%20PDF.pdf

Ofsted of work being conducted in the authority with other children at risk of exploitation and abuse outside the family home. This took place six months after the murder of Adam.[27] Ofsted found that many children were benefitting from *'highly effective responses'* which reduced the risks of '*going missing, criminal and sexual exploitation and gang involvement'*. The report refers to mapping which leads to *'clear identification of the most vulnerable children and informs effective strategies.* It is not clear how many cases of confirmed criminal or sexual exploitation were inspected and whether the young people had problems similar to those faced by Adam and his family. The inspection report referred to the *'recent introduction of a safeguarding adolescents at risk panel (SARP)'* merging the functions of a number of risk management panels, though it noted that it was still *'too early to see the impact of the new arrangements'.*

3.2.43. Senior managers working in the local authority at the time told the review that between 2017 and 2019 the local authority explored the idea of developing a contextual safeguarding approach, and commissioned initial training for key groups of professionals.[28] However the full range of activities and service development was not completed, as a result of which new practice approaches to exploitation that had been envisaged were never implemented. There remains therefore a need to develop an approach that combines individual and contextual safeguarding, locality policing, community safety and the disruption of organised criminal activity. Through discussions during the review the local authority has provided information about its current integrated gangs and exploitation. It can now revisit its thinking about contextual safeguarding, recognising that there is a need to situate this in the wider context of action that is being taken against organised criminal activity.

3.2.44. During the review it has been suggested that a number of practice developments, identified from the gaps identified in the work with Adam, might follow from this:

- broader police representation at strategy meetings sharing information on groups of young people and criminal activity
- interventions targeting groups of young people rather than individuals
- the development of strategies for work to disrupt perpetrators.

3.2.45. This wider collaboration should enable the development of shared strategies, as well as discussions about all aspects of strategy and tactics. If there is evidence that policing interventions and tactics are poorly targeted or counter-productive, professionals who work closely with young

[27] Ofsted (2019) London Borough of Hammersmith and Fulham, Inspection of children's social care services

[28] https://contextualsafeguarding.org.uk/

people and their families should feel able to point this out and contribute to the development of alternative approaches.

3.2.46. There have already been useful local initiatives. In line with the approach taken in many London boroughs and elsewhere, the Hammersmith and Fulham Gangs, Violence and Exploitation Unit has brought together professionals, who had previously worked in a number of services, to focus activity on children at risk of exploitation. Information provided to the review about the systems used to identify levels of vulnerability and risk among young people referred to the team suggests that they are innovative and practical, making good use of management information to enable risks to young people to be understood, ranked and tracked as plans are implemented. The effectiveness of any developments needs to be tested by the multi-agency safeguarding partnership as part of its overall scrutiny of safeguarding arrangements for children.

Recommendations

3.2.47. The Metropolitan Police Service and the local authority should collaborate to develop responses to serious youth violence and criminal exploitation that draw together work on the following: individual and family safeguarding; child criminal exploitation and extra-familial harm; locality policing; and the pro-active disruptive policing of organised criminal activity. This may be best done with the involvement of other boroughs across the police Basic Command Unit. It needs to go beyond the arrangements for cooperation set out in the current London exploitation protocol.

3.2.48. The statutory safeguarding partners should begin work to develop prepare and implement a strategy to prevent and reduce serious violence in the area in anticipation of the legal duties that will be placed on the local authority under the forthcoming Police, Crime, Sentencing and Courts Bill (2021).

3.2.49. Hammersmith and Fulham Council should work with partner agencies to complete the development of its contextual safeguarding approach, taking into account identified gaps in the work undertaken with Adam and his family.

3.2.50. The Hammersmith and Fulham Safeguarding Children Partnership should develop a programme to test the effectiveness of work being undertaken to combat serious youth violence under its independent scrutiny responsibility. If one has not been completed within the past 12 months, this should include a multi-agency audit of complex exploitation and serious youth violence cases. The effectiveness of current multi-agency panel arrangements should be tested.

3.3. Adam's fragmented school and college attendance

Introduction

3.3.1. This section evaluates Adam's involvement with schools, Further Education (FE) college and local authority education services. Adam was without education for significant periods, particularly on his return from East Africa in January 2017, contributing to his vulnerability.

3.3.2. It has been more difficult than usual for the review to consider the systems and arrangements that were in place because, there are fewer school and local authority records than would be expected. Changes in the status and management oversight of schools attended by Adam, making it difficult to secure records from schools that no longer exist. Organisational change also brought rapid staff turnover, making it harder for the review to involve teachers who knew Adam and his family. There were also periods when he was not at school and he was not in the UK for significant periods.

3.3.3. Local authority reorganisations also reduced the amount and quality of information available to the review. During most of the period under review, Hammersmith and Fulham Council made provision of services through a shared three-borough arrangement, from which it withdrew in April 2018, beginning a transfer of services back to local authority control. Over the period covered by the review structures, arrangements and record keeping practices have changed. Where relevant, details of the impact of organisational changes in schools and the local authority are set out below, along with details of new systems introduced by the local authority since the period under review.

Information from the narrative

3.3.4. In January 2013 Adam's mother withdrew him from the school, along with his siblings, and took the family back to her country of origin. She told the review that this was because of wider concerns about their wellbeing. The family returned to the country more than two years later and Adam began to attend a local secondary school. He spent his school year 9 there from September 2015 – 2016 before his mother again moved Adam to stay with family members, first in South London and then in East Africa. There are no records of his academic progress. Records obtained reveal persistent behaviour problems, though there is no record of Adam being excluded.

3.3.5. When he returned to the UK in January 2017 the school (which had by then changed its status and many staff) refused to allow him to return. The reasons for this are not recorded anywhere, however the local authority (Tri-borough) Fair Access Panel supported the school's decision. It has been suggested that the school (and by implication the panel that considered the case at the time) may have been unwilling to admit a pupil who might be disruptive at the beginning of his GCSE courses. If so, that was entirely unacceptable, especially given the relatively minor nature of the earlier problems. At the time, as a matter of policy, the Fair Access Panel kept no

records of the discussion or reasons, only the decision. So it is not clear how far the panel investigated Adam's previous behaviour or academic achievement at the school. The Fair Access Panel still exists as part of the local authority's statutory requirement to support the local education system. It now considers only Hammersmith and Fulham children and keeps records of the reasons for its decisions.

3.3.6. From this point Adam's mother made genuine attempts to find him a school but he received no effective full-time education. He first attended an independent but unregulated school which the review has been unable to properly identify or contact as it no longer appears to exist. From September 2017 until July 2018 Adam was on the roll of the local authority alternative provision, though his admission was delayed when he was stabbed and his attendance was always poor. In September 2018 he enrolled at the FE college. He attended poorly and only for a limited period and it is not clear what liaison there was between the college and other professionals working with Adam.

3.3.7. When the court made Adam the subject of Youth Rehabilitation Orders (in July and September 2018) conditions could have been included to require his attendance at school or an alternative education setting, but this was not considered or proposed in reports to the court. This would have served as a strong reminder for Adam of the need to go to college, but would only have been enforceable by reporting his failure to attend to the court or breaching his order, which the YOS never considered. Managers in the YOS told the review that they are now very aware of the need to propose an educational requirement to the terms of a court order when this is in the interests of a young person.

Wider education concerns

3.3.8. Adam's fragmented education in the UK was largely caused by the fact that he was refused re-entry into school when he returned to Hammersmith and Fulham from East Africa in 2017, a very specific problem. Statutory guidance contains a number of common-sense criteria that legally permit a school to remove a child who has moved temporarily overseas from its roll.[29] But there is also considerable scope for a school to retain a child or to readmit a child who has been taken abroad, especially if the parent was acting to protect the child from harm. Adam's history highlights the risks that are heightened when a child is left without a school place. Whilst it would be impractical for schools to maintain a place for a child indefinitely, it should be a priority for the local authority to seek an agreement with schools in the borough that will enable children to return to school in these circumstances when that is possible.

[29] Criteria include failing to attend, not returning after an authorised absence and living too far from the school

3.3.9. More widely, the findings of national and local safeguarding reviews, building on wider research, show how the removal of a young person from mainstream education, though whatever route, can lead to the weakening of day to day integration into ordinary society that takes place spontaneously in schools and colleges. They also highlight the protective role that schools are likely to play in reducing the likelihood of young people being drawn into criminal activity and gangs.

3.3.10. Poor secondary school attendance is not surprisingly one of the factors found to strongly correlate with self-reported knife carrying or gang involvement.[30] The Timpson review of school exclusion found '*no evidence that formal exclusion is a direct cause for a child becoming involved with crime'.* However it did identify '*evidence to suggest that children who have a history of either fixed period or permanent exclusion from school are more likely to be both victims and perpetrators of crime'*. Individual case reviews suggest that young people who involuntarily leave mainstream education through any route (including managed moves and education at home that would not be the parent's choice) may also be at increased risk. It is often one of many perceived rejections. Poor quality alternative provision or poor attendance at alternative provision may place children at risk. Concern is heightened when organised criminals target those who attend or fail to attend establishments such as pupil referral units.

3.3.11. Too much media coverage and professional debate about serious youth violence offers a simplistic account of the role of schools: they are blamed for excluding pupils who then go on to become victims or perpetrators of criminal offences. It is important that the role of schools is not seen in isolation from the effectiveness of wider welfare and safeguarding systems. As well as having the best possible internal arrangements to support difficult pupils, schools should be able to rely on there being effective multi-agency responses when children experience serious difficulties at school. Too often children who are involved in violent or serious incidents in or around a school are referred for support, but do not receive it because it can only be offered on a voluntary basis. When services fail to engage parents or the young person, schools are left managing high levels of risk with limited options as to the actions they can take. Other reviews have highlighted the unequal burden that some schools shoulder in educating the most difficult

[30] Victoria Smith and Edward Wynne-McHardy (2019) An analysis of indicators of serious violence: Findings from the Millennium Cohort Study and the Environmental Risk (E-Risk) Longitudinal Twin Study, Home Office Research Report 110. This study systematically reviews '*factors linked to more serious types of violence like weapons carrying or use and gang conflict*', following a large cohort of young people over a number of years. Findings are summarised on pages 1-16

pupils.[31] A comprehensive approach to reducing serious youth violence should address all of these issues.

The safeguarding responsibilities of FE colleges

3.3.12. The review did not consider the role of the FE college in detail because Adam only attended very briefly. However other reviews have highlighted the important role that FE colleges can play in the safeguarding of young people, including in relation to serious youth violence. FE colleges educate pupils in years 10-11 who attend vocational programmes, those with special educational needs and those in post-16 education. London colleges that are accessible from across the city can be the site of conflicts between groups of young people from different boroughs. Despite their valuable role, there is evidence that they are sometimes not aware of the educational needs of some young people attending. There is no specific guidance on safeguarding in colleges (DfE guidance for schools applies) but there is evidence that FE colleges are not always fully integrated into local safeguarding arrangements. In Hammersmith and Fulham the FE college has a designated lead who works closely with the local authority.

Current systems and recommendations

3.3.13. Information provided to the review by Hammersmith and Fulham Council indicates that since Adam's death, many of its systems for responding to the needs of children who are at risk of involuntarily leaving mainstream education have improved. The local authority believes that they now address the areas of concern identified above. Reassuring details have been provided about the oversight of managed moves between schools and the tracking and support of children who are out of mainstream school. Alternatives to exclusion are championed and the impact of any exclusion is closely monitored. The local authority now believes that it is in a stronger position to influence the approaches taken by schools and academies within the borough. It says that this is demonstrated by the regular liaison with head teachers and the strong representation of schools at the borough's Fair Access Panel. The panel now operates very differently. Records of children who are out of school are now much more comprehensive so that action can be taken and monitored.

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[31] Islington Safeguarding Children Board (2021) – Serious Case Review – Child P and Serious Youth Violence, https://www.islingtonscb.org.uk/serious-case-reviews/Pages/default.aspx,

Brent Safeguarding Children (2021), Serious Case Review – Child K and Serious Youth Violence, http://www.brentsafeguardingpartnerships.uk/children/article.php?id=643&menu=0&sub_menu=2

3.3.14. The multi-agency partnership should reassure itself that the local authority and its schools have effective approaches to all of the issues set out above. It should also ensure that FE colleges are fully integrated into local safeguarding partnership arrangements. The partnership should satisfy itself that FE colleges are providing an effective response to the safeguarding concerns affecting their students.

3.4. The effectiveness of social work interventions and collaborative working with youth offending, early help and family support services

3.4.1. This section of the report assesses the effectiveness of the social work and other local authority-led interventions with Adam and his family. The role of social workers is considered alongside the assessments and interventions made by the Youth Offending Service and local authority early help services. The focus is on the following:

- The pattern of repeated assessment by social workers and other professionals
- The nature of the assessment undertaken
- Why social workers closed their involvement with Adam at a point when risk to him was increasing
- How child protection procedures should be used when the risk is of extra-familial harm.

Some of these are issues that have been considered in a number of other reviews, including the national child safeguarding practice review, so wider learning is taken into account.

<u>Information from the narrative</u>

3.4.2. Local authority social care services undertook four child and family assessments on Adam and his family:

i. In 2012 because of reports of domestic abuse.

ii. In 2016 because of concerns about an incident in which he had gone missing and been found unconscious, though the assessment was delayed because Adam was taken out of the UK

Neither of these assessments identified the need for a social work intervention.

iii. In June 2017 after Adam had been attacked and threatened with a knife by other young people. Although there were recent indicators of heightened risk, including a period of five days when Adam went missing, it was agreed that interventions by early help services would be sufficient and no social worker was allocated to work with the family

iv. In November 2017 after Adam had been stabbed: during the course of this assessment he was stabbed again.

3.4.3. Adam and the family were allocated to a social worker for assessment between November 2017 – February 2018. The fourth social work assessment was completed as a Section 47 enquiry in January 2018. It focused on the risk of significant harm to Adam and his siblings, concluding that the safeguarding concerns for Adam had been '*substantiated'* and that there was a '*continuing risk of significant harm'*.

3.4.4. The plan recommended was that the YOS family support worker should continue individual sessions with Adam to raise his *'understanding and awareness of his risk-taking behaviour…negative peer associations… the impact of offending on self, family and future life'. It will also benefit for him to raise awareness around weapons and to keeping safe* (sic) *in the community.* It was initially agreed that there was no further role for a social worker because there were no risks to Adam's siblings when in their mother's care.

3.4.5. An update of this assessment in February 2018 repeated these findings and conclusions but recommended that Adam and his siblings should be allocated to a social worker as children in need so that there would be a series of meetings within which the intervention could be coordinated and kept under review. Between March and August 2018 the allocated social worker coordinated four child in need meetings. This involvement ended because social care managers decided that there was no safeguarding risk to Adam's siblings and that the allocation of a social worker was adding no value to the work with Adam. At this point the YOS became the agency responsible for coordinating work with the family.

3.4.6. In parallel the early help service undertook two assessments:

i. In June 2017 (alongside the child and family assessment)
ii. In October 2017 when he was charged with violent disorder and possession of a knife

The first focused on the type of early help services that might benefit the family. The second was superseded by a child and family assessment when Adam was stabbed for the second time. Early help service involvement ceased in February 2018 when it was decided that Adam should have an allocated social worker as a child in need.

3.4.7. There were three YOS assessments, using the AssetPlus format. The assessments were undertaken to support pre-sentence reports for the courts to assist in sentencing and to seek to understand what sort of services might best help Adam and his family. They were prepared:

i. In February 2017, leading to a four-month Referral Order
ii. In May 2018, leading the court to make a 9 month Youth Rehabilitation Order for an offence committed in October 2018
iii. In August 2018, leading the court to extend the Youth Rehabilitation Order for a further 18 months and add more stringent conditions.

3.4.8. The YOS provided supervision and support to Adam during March – June 2017 (the Referral Order) and from June 2018 until his death in March 2019

(the Youth Rehabilitation Orders). Two YOS case coordinators held statutory responsibility for the supervision of Adam, one from June – December 2018 and one from January 2019 until his death.

3.4.9. The family support service based in the YOS worked with Adam and his family between November 2017 and his death in March 2019, including regular visits from the police outreach officer based in the YOS. At the time of Adam's death, the intervention was formally being coordinated by the YOS case manager and the main workers in day-to-day contact with the family were the YOS family support worker and the police officer attached to the YOS. Their focus was to engage Adam in order to help him have a better understanding of the risks to which he was exposed and to help him make changes in his behaviour. They also provided advice and support to Adam's mother, which she told the review she valued.

3.4.10. During the last three months of his life, risks to Adam as a result of criminal exploitation increased significantly. In September 2018 a meeting agreed to bring this to the attention of social care managers to consider whether the case should be reallocated. Some informal discussions are understood to have taken place, however there is no indication that this was fully considered.

The pattern of repeated assessment, intervention and case closure

3.4.11. The pattern of brief social work assessment, followed by referral to early help services, followed then by case closure, has been observed frequently by the author in work where the risk to young people arises because of serious youth violence.[32] When offences have been committed (as with Adam) there are youth offending pre-sentence report risk assessments. Repeated assessment required Adam's mother to go over the same material several times. She seems to have been prepared to do that, though Adam became less willing over time. Although each decision might be individually justifiable, taken as a whole this is an unnecessary duplication. The pattern of episodic assessment and case closure by services operating at different thresholds frequently leads to a large number of professionals, from different services becoming involved with a family. Research on the experience of service users (both young people and their parents) often highlights the negative impact on the family. In particular, it makes it even more difficult for young people to develop trusting relationships with professionals.

[32] For example: Buckinghamshire Safeguarding Children Partnership (2020) Serious Youth Violence: Thematic Serious Case Review, https://www.buckssafeguarding.org.uk/childrenpartnership/wp-content/uploads/sites/2/2020/08/Serious-Youth-Violence-Thematic-Serious-Case-Review.pdf

3.4.12. With the exception of one Section 47 enquiry which drew together a chronology of previous concerns and incidents, the assessments offered no cumulative understanding of Adam's exploitation. The review also found no clear record of key aspects of the family history, including for example why, when and how Adam's parents and extended family had come to the UK. The review will recommend that the local authority provides a more consistent framework for assessment and the maintenance of a chronology of key events that is suitable for extra-familial harm and provides a cumulative understanding. In Adam's case the range of risk factors identified in the assessment in mid-2017 gave a clear indication that he would continue to remain at risk of extra-familial harm, and would therefore require a concerted intervention. Further review and update would have been necessary but it is hard to justify repeated assessments.

3.4.13. As well as providing a cumulative assessment of risk, the local authority has recognised that the focus of assessment needs to reflect in full the risks linked to extra-familial harm. This points to a revision of the assessment templates and formats used, as well as training for staff in the local authority's expectations. According to the local authority this has been achieved in relation to child sexual exploitation, where practitioners are familiar with the range of risk factors that need to be considered, and are able to grade the level and type of risk identified. It may be more challenging to achieve this for criminal exploitation, for example taking into account the dual roles of some young people as perpetrators as well as victims highlighted in Section 3.2. Material developed by the Contextual Safeguarding Network, though too lengthy to be used for an individual child and family assessment, may provide a useful stimulus to the development of local tools.[33] Again managers need to make clear their expectations and monitor the work undertaken to ensure that it is relevant and proportionate. It has been suggested that some assessment in exploitation cases could usefully take place in collaboration with other agencies and services (such as the police and youth workers), solving the problems facing young people and their families rather than focusing on templates and formats.

<u>Why was the YOS left leading work with the young person and his family and is this a plausible position?</u>

3.4.14. The Section 47 enquiry undertaken in January 2018 (after Adam had stabbed for the second time, and had been seriously injured) concluded that the safeguarding concerns for Adam had been '*substantiated*' and that there was a '*continuing risk of significant harm'*. A social care manager decided that rather than convene a child protection conference, a complex child in need meeting would be held in order to develop a child in need plan.

[33] https://www.csnetwork.org.uk/assets/documents/Context-Assessment-Triangles.pdf

A 'complex' child in need case required an independent chair for its first meeting.

3.4.15. This intervention was closed in October 2018 (the decision had been made in August) despite the fact that during the intervening period Adam had been convicted of a violent offence against another child; the family had moved because of professional concerns about the high level of risk to the family, and then returned to the family home; and that Adam was seen as being at a high level of risk. The interventions made in the last few months of Adam's life were made by members of the YOS which was required to remain involved as it had a statutory responsibility to oversee the supervision of Adam's Youth Rehabilitation Order. It is clear that the problems facing the family were too varied and complex to be dealt with by YOS workers. They required the involvement of a social worker who could judge the changing levels of safeguarding risk to Adam and engage a range of services.

3.4.16. From September – December 2018 Adam kept the formal supervisory appointments at YOS. He stopped attending college in October 2018. From January 2019 there was an increased risk and his compliance with appointments fell away. Although they had a good first-hand knowledge of the family's experience, and Adam's mother liked and trusted them, responsibility for leading this complex and difficult work should not have been left with YOS workers. Meetings held in the last months of Adam's life were chaired by managers who, although their concern for Adam and his peers is clear, did not have the same experience of assessment and planning to respond effectively to safeguarding risks. This intervention should have been coordinated and led by local authority social workers and managers. The involvement of both social care and the YOS would not have been an unnecessary duplication. Their work would have had a different focus within a shared plan and joint supervision.

3.4.17. This pattern of case closure has been identified in many cases of serious youth violence. Sometimes case responsibility is left to the YOS, sometimes to youth workers or targeted youth-support workers, employed either in the local authority or voluntary organisations.[34] This is a reversal of the normal approach which allocates responsibility for higher risk cases to staff and managers with social work qualifications. It is important to understand why it happens.

[34] Islington Safeguarding Children Board 2021 – Serious Case Review – Child P and Serious Youth Violence, https://www.islingtonscb.org.uk/serious-case-reviews/Pages/default.aspx, Brent Safeguarding Children Forum (2021) – Serious Case Review – Child K and Serious Youth Violence, http://www.brentsafeguardingpartnerships.uk/children/article.php?id=643&menu=0&sub_menu=2

3.4.18. Unless there is a specific, practical or procedural task to be accomplished (such as holding a strategy meeting, placing a child in accommodation or moving a family) social workers and their managers who are working with young people at risk as a result of serious youth violence often struggle to define their role or to point to stories of successful social care interventions. Some believe that their training and skills are not relevant and that they have nothing to add to the work being undertaken by youth-oriented workers. Some social workers do have substantial and complex caseloads that can require them to spend considerable time in court or writing reports, so they inevitably have less time for direct work with young people.

3.4.19. There may indeed be practical difficulties, but there are also tensions between the roles and responsibilities of social workers and currently-favoured ways of working with young people. Contemporary approaches tend to eschew the ownership and use of authority in favour of engagement. For example, a highly influential report on working with adolescents focuses heavily on engagement, using the terms 'engage' or 'engagement' 43 times, almost always positively.[35] It contains no reference to the terms 'authority' or 'authoritative'. In contrast to youth-oriented workers, social workers and their managers have responsibilities and statutory duties requiring them to hold and are expected to exercise authority on behalf of the state and the wider community.

3.4.20. The primacy given to engagement has implications. Relationships that rely on engagement place great store on not alienating the young person and inevitably require repeated renegotiation of objectives in order to win trust; sometimes the bar for what must be accomplished by young people is set very low. Professionals focused on engagement will tend not to make judgements or set firm boundaries. Engagement is a legitimate and important objective but an exclusive reliance on engagement, if accompanied by a reluctance to make use of personal, professional and statutory authority, may not serve young people well. Social work managers need to offer a framework within which the use of authority is legitimate.

The application of child protection procedures

3.4.21. As well as highlighting the need for clarity about the role of social workers, all professional need a clear understanding of the application of child protection procedures in cases of extra-familial harm. This might encompass a range of questions such as whether there would be any

[35] E.Hanson and D.Holmes (2014) That Difficult Age: Developing a more effective response to risks in adolescence, Research in Practice / Association of Directors of Children's Services. The word 'authority' is found only when referring to 'the local authority'. https://www.researchinpractice.org.uk/children/publications/2014/november/that-difficult-age-developing-a-more-effective-response-to-risks-in-adolescence-evidence-scope-2014/

difference in the conduct of a child protection conference or what a child protection plan would include.

3.4.22. During the period under review the local authority made enquiries under Section 47, Children Act 1989 on two occasions (both when Adam was stabbed). Although on both it was found that the safeguarding concerns were substantiated and he was at risk of significant harm, no child protection conference was held, instead Adam was treated as a child in need. This was consistent with the local authority's normal practice. As a result the independent oversight of the risk to Adam that would have been provided by an independent chair was missing. It is impossible to know what view an independent chair would have taken to the heightened risk to which Adam was subjected from September 2018 onwards, but an independent chair is likely to have challenged the view that the case could be closed by the local authority when there had been no improvement in his circumstances. It is possible that the measures taken to relocate the family would have been more carefully considered, though this is a complex issue which challenges all professionals.

3.4.23. The reasons for not making Adam the subject of a child protection plan were not explicitly stated, perhaps because they were in keeping with accepted practice. Those who advocate for the use of child in need framework believe that the decision to use a child protection plan is perceived as unfairly 'blaming' parents and family members who are not responsible for the harm to the child. In the experience of the author the major concern for parents has not been the label attached to the intervention, but the fact that assessments take too long, workers change, and that little practical action arises from plans. This may be another area in which professionals are unenthusiastic about the open use of authority.

3.4.24. Practice in relation to the application of child protection procedures in cases of extra-familial harm varies between different local authorities in London. Some authorities prefer to use child in need plans for extra-familial risk, others have developed other types of meetings and plans.[36] Recognising the varied approaches taken in London and elsewhere, the national child safeguarding practice review on exploitation recommended in March 2020 that discussions of revision of the statutory guidance to clarify this should be held 'at pace'.[37] This is awaited at the time of writing. Work is also

[36] See for example the review of a child killed in Hackney: City and Hackney (December 2020) Serious Case Review - Child C. https://www.chscp.org.uk/wp-content/uploads/2020/12/CHSCP-SCR-Child-C-Report-PUBLISHED-FINAL.pdf

[37] The Child Safeguarding Practice Review Panel (March 2020) It was hard to escape - safeguarding children at risk from criminal exploitation, HM Government

currently being undertaken to establish how this should be addressed in the pan-London child protection procedures.

3.4.25. The Contextual Safeguarding Network has developed innovative approaches to aspects of extra-familial harm but does not advocate for a particular type of plan for young people, emphasising the *'need to ensure that there is oversight of young people at risk of significant harm regardless of whether the risk exists within or outside of their families'.* The network emphasises the need to be aware of the factors influencing local practice thresholds – such as for example whether it is the severity of the harm that influences the need for a child protection plan, the perception that the harm has been caused or allowed by family members, or other factors.[38]

3.4.26. There is no reason why we must continue to use a traditional approach if it has significant disadvantages. However if professionals are to adopt new approaches, they need to address any genuine disadvantages of existing ones while at the same time being just as robust. This needs to take account of the basic formal structures for information sharing, assessment, planning and review provided by protection plans and less common aspects of practice such as the transfer of cases to other local authority areas. Any national guidance issued or channelled through London procedures is bound to give scope for interpretation at the local level, so the statutory safeguarding partners in Hammersmith and Fulham will need to decide how they wish professionals to practice.

Learning and recommendations

3.4.27. The local authority should review its assessment framework used in cases of extra-familial harm to ensure that it takes better account of contextual influences on children and young people. The revised framework should be multi-disciplinary and multi-agency.

3.4.28. The local practice framework chosen for extra-familial harm should reduce the likelihood of multiple assessments being undertaken and ensure that where there are concerns about exploitation the assessment provides a cumulative account of possible risks. This should identify fundamental aspects of the child's circumstances and not just be a response to current concerns.

3.4.29. The local authority should provide clear guidance to social work managers as to their role in assessment and management of risk arising from serious youth violence and set clear criteria for the involvement of the social care service. This should include mechanisms for resolving disputes when there

[38] C Firmin and J Lloyd (May 2020) A 2020 update on the operational, strategic and conceptual framework, https://contextualsafeguarding.org.uk/wp-content/uploads/2020/05/CS-Briefing-2020-FINAL.pdf

is disagreement about the need for a child to be considered as a child in need / protection) and a social worker involved.

3.4.30. When more than one of the local authority's early help, YOS or social work services are working with a child or family at risk because of serious youth violence, arrangements should be made for there to be a shared plan and joint or shared supervision of staff.

3.5. Relocation of children and their families when there is a risk of serious youth violence

Introduction

3.5.1. This section of the report evaluates the decisions and actions taken in arranging for Adam's mother to relocate the family to a neighbouring borough. The difficulties associated with moving a young person who is at risk of serious youth violence to what is considered a safer location (either alone or with his family) have been considered by the recent national child safeguarding practice review and other reports.[39] This further evaluation is designed to add detail to the analysis in that report in the hope that it will assist families and professionals in discussing and making these very difficult decisions in future. This report considers the following:

- Evaluating the relative risks and practical difficulties of moving a family
- The impact on professional relationships and working arrangements when a family move
- Housing policies and procedures.

Information from the narrative

3.5.2. Professionals first raised the idea of the family moving in February 2018, shortly after Adam had been stabbed for the second time, on this occasion receiving very serious injuries. At that point neither Adam nor his mother wanted to move. Their estimation of the risks appears to have been lower than that of the professionals. Both Adam and his mother made it clear that if they moved anywhere within travelling distance, they would maintain links with their neighbourhood. The plan was not pursued.

3.5.3. In May 2018, following a further series of incidents in which professionals became convinced that Adam's life was once again at risk, they were able to persuade his mother to relocate to a neighbouring borough. Adam's mother was determined to maintain links with other families on their estate and Adam had made it clear that, regardless of the distance, he would keep up contacts with friends and return to the estate. The housing accepted by the family meant that family members could travel home with ease. The

[39] For example: Brent Safeguarding Children Forum (2021), Serious Case Review – Child K and Serious Youth Violence, http://www.brentsafeguardingpartnerships.uk/children/article.php?id=643&menu=0&sub_menu=2

younger children would continue to attend their school and Adam's mother would work in the same job. Records show no detailed discussion about making a permanent and more substantial move to a less accessible location.

3.5.4. Steps were agreed that would make the new location as safe as possible for the family. For example the address was flagged on police records. In July 2018 the court placed restrictions on Adam requested by the police through a Criminal Behaviour Order. Suggestions were made about how family members might limit their activities, such as not going out together, but they were not taken up. Arrangements were also made for meetings with housing officers. Although discussions about methods of securing permanent accommodation elsewhere took place, they were not conclusive. Understanding of housing rights and responsibilities remained confused and became a factor that led to the family moving back to Hammersmith and Fulham in October 2018. The family's return to the borough was brought to the attention of social care, but the decision to close the case was not changed.

3.5.5. Notifications were made to the police and YOS in the neighbouring borough but the recognition that Adam and his family were always going to return to Hammersmith and Fulham meant that there was no attempt to build a meaningful structure of support around him in Ealing. This in turn must have made it more likely that the family would return.

Learning and recommendations

3.5.6. The suggestion that the family should move was an understandable response to Adam being stabbed. However there is a growing recognition, shared by professionals who have contributed to this review, that relocating families because of the risk of serious youth violence is not always the best solution. While it would be wrong to say that relocating a family should never be considered as an option, for this to be an effective approach, a number of conditions should apply.

3.5.7. The young person and other key members of the family need to understand why the plan is necessary and agree to implement it. That agreement needs to be genuine and realistic. Part of the more structured approach to assessing both sets of risks would be to understand the extent to which the young person and his family would accept the proposed arrangements and implement the plan.

3.5.8. As far as possible it should be clear whether the plan is intended to be a short-term measure or a permanent alternative. Either approach requires there to be a long-term plan. Alternative approaches would lead to different decisions in relation to the professional network of support around the child and family. If the move is intended to be a short-term measure, it would make sense to maintain some or all of the existing professional network around the family. If the move is intended to be permanent, then careful

planning is needed to put in place a new support network. Careful account would need to be taken of the difficulty in securing successful professional engagement with some adolescents. Arrangements for the transfer of professional responsibilities should always be considered as part of the plan, particularly as these may vary between agencies.

3.5.9. Risks to the young person moving or not moving need to be considered. This should include topics identified in this report and other case reviews, as well as the national child safeguarding practice review:

- Risks in the locality to which the child is moving
- The possibility that the young person's behaviour will not change because their most important social connections remain in place
- Risks of weakening professional networks so that there is less professional knowledge and oversight
- Practical difficulties (including financial difficulties) created for other family members.

3.5.10. This points to the value of professionals from two localities being involved simultaneously: those from the original location being fully aware of the history and the reasons for risk; those from the proposed relocation locality able to complement this assessment with their own local knowledge of the environment in which the child will be living, local criminal activity, school cultures and strengths etc.

Recommendations

3.5.11. The review has been told that the local authority is working to develop a protocol for the relocation of families. Other local authorities are undertaking similar work and recommendations have also been made to the London Safeguarding Children Partnership. The partnership should produce a protocol as soon as possible, engaging with other agencies and local authorities as necessary.

3.5.12. The Hammersmith and Fulham Safeguarding Children Partnership should test the implementation of this protocol to ensure that it is effective.

3.6. The significance of the family's race and ethnicity

Introduction

3.6.1. This section of the report considers whether the fact that Adam was black and that his family had migrated to the UK from East Africa had any bearing on his experience and the harm that he suffered. The review then evaluates whether this was properly considered by professionals and whether learning from this review can provide any guidance about how agencies with safeguarding responsibilities in Hammersmith and Fulham should work with families who share this ethnic background in the future. More detailed information about the family's ethnicity, race and religion has not been included in order to protect privacy. Those charged with implementing any recommendations have all the necessary details. It is also possible that

similar learning will apply to services for families with other racial and ethnic backgrounds.

3.6.2. The wider picture of the impact of violent crime on black and some minority ethnic families is of tremendous significance. Comparing Office of National Statistics (rate of homicide per 100,000 population between 2008 and 2019) and census data from 2001 and 2011, Kumar et al report very large disparities in homicide rates between racial groups: '*Black homicide victimisation ranged from 200 to 800% higher than that for the White population during that time period, at an average of 5.6 times higher for Blacks. While Black victimisation dropped by 69% from 2001 to 2012, it almost doubled (79% increase) from 2013 to 2019, rising seven times faster than the White victimisation rate. Asian rates remained stable at about twice as high as White rates*.' [40]

3.6.3. The greatest disparities are found among victims age 16-24, the age group in which the largest number of homicides generally occur. On average between 2008-9 and 2018-19 the rate of homicide among black people aged 16-24 was 11 times higher than for white people in the same age group. In 2018 -19 the total number of young black people in this age group who were victims of homicide exceeded the number of young white people for the first time for which there are figures. The disparity is also the highest recorded.[41] This issue merits far more attention than it has received. The review will recommend that, along with other disparities in serious youth violence, it should be a subject of enquiry for the further investigation into criminal exploitation to be undertaken by the Child Safeguarding Practice Review Panel.[42]

Information from the narrative and possible learning

3.6.4. Wider disparities are likely to be explained by a large number of economic, social and cultural factors, as well as by differences in the impact and effectiveness of services that have been provided. The focus of the following brief analysis is on the details of Adam's history that may be important, the practical work of professionals charged with understanding and helping families, and on the role of services in a specific local community.

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[40] Kumar, S., Sherman, L. W., & Strang, H. (2020). Racial Disparities in Homicide Victimisation Rates: How to Improve Transparency by the Office of National Statistics in England and Wales. Cambridge Journal of Evidence-Based Policing, 4 (3-4), 178-186. https://doi.org/10.1007/s41887-020-00055-y Rates of disparity vary greatly from year to year because the numbers in any age group are relatively small.

[41] https://link.springer.com/article/10.1007/s41887-020-00055-y/tables/4

[42] Child Safeguarding Practice Review Panel (2021), Annual Report 2020 Patterns in practice, key messages and 2021 work programme. This will include a 'Phase 2' examination of CCE cases received by the Panel since its first report was published (page 44).

3.6.5. Adam's mother obtained an immigration entry visa to Italy and then moved to the UK. Her account is that when she first left her country of origin, neither she nor immediate family members had been threatened or in danger. She did not seek asylum. Her family hoped to make a better life for themselves and, since coming to the UK, have been able to travel freely between the UK, East Africa and other countries in the Middle East. Adam was born in the UK but on two occasions his mother took her children back to live in East Africa because she was concerned about their wellbeing in the UK. The family's final return to the UK (in 2017) was prompted by her being near to the scene of a terrorist incident.

3.6.6. It is of concern that (despite the numerous assessments described in Section 3.4 above) none of the records seen by the review set out this history or sought to understand its significance. Adam's mother told the independent reviewer that she had given this account to one professional. It is not clear whether professionals did not ask questions about this because they did not think it was relevant. Perhaps there was an assumption that (being members of a particular ethnic community) the family had been through traumatic events and that this somehow explained Adam's difficulties. Either approach would be mistaken and unhelpful. Every family deserves a thoughtful assessment (whether that be Early help, YOS or social care) that explores the possible relevance of family history, influences and experiences that are specific to their ethnic and religious background. The review recognises that there are dangers of thinking of a specific experience as being indicative of a wider pattern of difficulty. Adam's mother told the review of the very wide experience of children from her community living in Hammersmith and Fulham and the great success that many make of their lives.

3.6.7. Some features of the family's history deserved more detailed consideration. It may be significant that, having lived in the UK from birth to the age of 11, Adam was relocated overseas on two occasions. As a result he spent periods amounting to almost three years there before returning to the UK in January 2017. Knowing that he had returned to East Africa a member of the early help service did suggest that Adam's mother should contact the service on his return in case he needed additional support reintegrating.

3.6.8. Adam's reintegration was made more difficult because on this return he was not given a place in the school where he had spent his only year of UK secondary education. This is discussed in Section 3.3 above though the reasons cannot be established. With no school place he had little opportunity to make normal social connections, form positive friendships or to find role models among teachers and other adults. The review is not in a position to say whether Adam was discriminated against by this school. We know that this school has been chosen by many East African parents and was, during some of the period under review, seeking to forge strong alliances with parents from the community.

3.6.9. On his return Adam was also prosecuted over two incidents that had occurred some nine months earlier: one was a minor offence, and he was found not guilty of the more serious. These decisions should have been reviewed so that more consideration could be given to whether the prosecution was in the public interest. This could have been done by the police, the YOS or at the Referral Order panel. Alternative diversionary activities should have been considered, especially as these might have helped Adam's reintegration into UK society.

3.6.10. The review is aware of a number of young men who have been victims of serious youth violence who have been taken overseas by family for their own protection.[43] Sometimes this turns out to be a good experience but sometimes it has been more difficult for the young person to adjust on their return. It is impossible to say if this is a significant factor more widely, however professionals should always consider the impact of this in relevant cases.

3.6.11. Adam's father lived only briefly in the UK and played a very limited role in his life. The record suggests that Adam had a poor relationship with his stepfather. As a young male, Adam believed that it was right for him to spend a lot of time with other males outside the family home. This is not an unusual thing for a young man from many different cultural backgrounds, but without the positive influence and authority of his father, or men in his extended family, and without positive role models, he was vulnerable to becoming involved with local street gangs. This is turn appears to have given him a sense of excitement, comradeship and belonging.

3.6.12. At one point professionals began to be concerned that, as the eldest male in his family, Adam assumed an exaggerated sense of authority in comparison to his mother. The review saw no evidence that this was discussed with him. His mother denies this, though she told the review that she often gave him advice which he failed to heed.

3.6.13. Current approaches in in the youth justice system focus largely on discrimination and disproportionality in outcomes between ethnic minority groups. Such work is unlikely to address the issues set out above and thus should not be considered as an adequate response.

Recommendations

3.6.14. The multi-agency safeguarding partnership should satisfy itself that assessments (whether that be Early help, YOS or social care) always explore the relevance of family history, influences and experiences that are specific to the ethnic and religious background.

[43] For example: Hounslow Safeguarding Children (2020) Learning Review - Systemic Review of Serious Youth Violence. In many others, families have considered this drastic measure.

3.6.15. All professionals should take account of the experience of young people who have been taken abroad in order to protect them from risks associated with serious youth violence. Agencies need to devise the best available steps to identify young people on their return to the UK and to be mindful of the need to support their reintegration. The details of how this is best done will need to be developed at a local level.

3.6.16. The local authority should consider how further to develop its links with young people and families in the community from which Adam's family was drawn in order to improve arrangements to safeguard and promote the welfare of children. Consideration should be given to other minority ethnic communities where specific features of their experience may need to be taken into account.

3.6.17. The Child Safeguarding Practice Review Panel should make racial and ethnic disparities in child criminal exploitation and serious youth violence, and the effectiveness of responses to black and minority ethnic communities, the subject of further investigation in its 'Phase 2' examination. It should consider compiling a research overview of these issues to support this.

4. RECOMMENDATIONS

Collaborative strategies to combat exploitation and serious youth violence

1. The Metropolitan Police Service and the local authority should collaborate to develop responses to serious youth violence and criminal exploitation that draw together work on the following: individual and family safeguarding; child criminal exploitation and extra-familial harm; locality policing; and the pro-active disruptive policing of organised criminal activity. This may be best done with the involvement of other boroughs across the police Basic Command Unit. It needs to go beyond the arrangements for cooperation set out in the current London exploitation protocol.
2. The statutory safeguarding partners should begin work to prepare and implement a strategy to prevent and reduce serious youth violence in the area in anticipation of the legal duties that will be placed on the local authority under the forthcoming Police, Crime, Sentencing and Courts Bill (2021).
3. Hammersmith and Fulham Council should work with partner agencies to complete the development of its contextual safeguarding approach, taking into account identified gaps in the work undertaken with Adam and his family.
4. The Hammersmith and Fulham Safeguarding Children Partnership should develop a programme to test the effectiveness of work being undertaken to combat serious youth violence under its independent scrutiny responsibility. If one has not been completed within the past 12 months, this should include a multi-agency audit of complex exploitation and serious youth violence cases. The effectiveness of current multi-agency panel arrangements should be tested.

Education, school attendance, behaviour and involuntary school transfer

5. The Hammersmith and Fulham Safeguarding Children Partnership should reassure itself that the local authority and its schools have effective approaches to the following issues:
   - improving school attendance
   - reducing other routes through which children involuntarily leave mainstream education
   - oversight of managed moves between schools
   - the tracking and support of children who are out of mainstream school.
6. The multi-agency partnership should ensure that FE colleges are fully integrated into local safeguarding partnership arrangements and that they are providing an effective response to the safeguarding concerns affecting their students

The effectiveness of social work interventions and collaborative working with youth offending, early help and family support services

7. The local authority should review the assessment framework and approach used in cases of extra-familial harm to ensure that it takes better account of contextual influences on children and young people. The revised framework should be multi-disciplinary and multi-agency.

8. The local practice framework chosen for extra-familial harm should reduce the likelihood of multiple assessments being undertaken and ensure that where there are concerns about exploitation the assessment provides a cumulative account of possible risks. This should identify fundamental aspects of the child's circumstances and not just be a response to current concerns.

9. The local authority should provide clear guidance to social work managers as to their role in assessment and management of risk arising from serious youth violence and set criteria for the involvement of the social care service. This should include mechanisms for resolving disputes when there is disagreement about the need for a child to be considered as a child in need / protection) and a social worker involved.

10. When more than one of the local authority's early help, YOS or social work services are working with a child or family at risk because of serious youth violence, arrangements should be made for there to be a shared plan and joint or shared supervision of staff.

Relocation of children and their families

11. The partnership should produce a protocol for the relocation of families as soon as possible, engaging with other agencies and local authorities, and with the London Safeguarding Children Partnership as necessary.

12. Once implemented Hammersmith and Fulham Safeguarding Children Partnership should test the implementation of this protocol to ensure that it is effective.

Working with the community to address needs arising from the family's ethnicity and religion

13. The multi-agency safeguarding partnership should satisfy itself that assessments (whether that be Early help, YOS or social care) always explore the relevance of family history, influences and experiences that are specific to the ethnic, racial and religious background.

14. All professionals should take account of the experience of young people who have been taken abroad in order to protect them from risks associated with serious youth violence. Agencies need to devise the best available steps to identify young people on their return to the UK and to be mindful of the need to support their reintegration.

15. The local authority should consider how further to develop its links with young people and families in the community from which Adam's family was drawn in order to improve arrangements to safeguard and promote the welfare of children.

16. Child Safeguarding Practice Review Panel should make racial and ethnic disparities in child criminal exploitation and serious youth violence, and the effectiveness of responses to black and minority ethnic communities, the subject of further investigation in its 'Phase 2' examination. It should consider compiling a research overview of these issues to support this.

Appendix 1

Summary of discussions with Adam's mother

The following is a summary of the views of Adam's mother, transcribed from notes of two substantial discussions with the independent reviewer. Her views do not necessarily coincide with those of the independent reviewer or the multi-agency safeguarding partnership. Adam's father lived overseas during the entire period when the events under consideration took place and so was not contacted.

1. Adam's mother is happy for his story to be told. The family has suffered so much that she does not feel that the report being published is a problem, and it is important that professionals learn from what has happened.

2. Adam's mother gave the independent reviewer a brief overview of the family history, including the family's migration to the UK. She said that she had previously been asked about this on one occasion. She did not remember having been asked by other professionals. (Author – the mother's account informs the summary in Section 2 of the report).

3. Adam's mother said that it had always been difficult to make sure that the children were safe in London. She had been fearful of gangs and violence and she had twice taken the children back to her country of origin (or nearby in the region) because she believed that they would have better and safer lives there. It was only on the final occasion when she had been directly affected by a serious terrorist incident that she decided that she needed to come back to London. Adam had been born in London and always identified England as being his country.

4. When the family came back to the UK in 2015 (Adam was 13-14) and more independent and headstrong. He would say 'I'm not a woman, I can't stay home.' A's mother explained that this attitude was very typical in her country of origin where women's lives are very much based around the home; men's lives are in work and socialising outside of the home. He expected to be out with friends and socialising. She always believed that a lot of the friends in London he made were a very negative influence.

5. When Adam and the family returned to the UK in January 2017, the school he had previously attended did not accept Adam back. She did not understand why and did not believe that the school had any good reason. Adam's mother did not recall that there had been a Fair Access panel meeting. There was early help involvement but she described the worker as someone who was still studying and 'had no real power' to influence things.

6. Adam's mother found him a place at an independent school in a neighbouring borough. Mother was very critical of this, said that there were a lot of gang members there and the staff had no control over the pupils. There was very little teaching. She withdrew Adam from that school.

7. As Adam got more involved in crime and with young people who were a bad influence, he would completely deny that she had any reason to be worried. He would call her 'paranoid' and obsessed or phobic /mad.

8. Adam's mother believes that he never willingly committed any crimes, or sold drugs but that he was regularly being threatened and beaten. He would often phone her when he was in trouble or missing and tell her some of the things that were going on and that he was being held against his will. She says that she always told the social workers (Author - by which she means the social worker but mainly staff in the YOS). He did not like the life that he was in but he was too scared to do anything when he was threatened. He would go out, even if he knew that there was going to be trouble. In the incident which led to Adam being convicted for violent disorder. She said older boys came to the house and forced him to come out. They were at the front of the attack on the other gang with knives, he was at the back with a wooden stick.

9. The family was relocated but she found that there were gangs in the borough where they were moved (in fact it was worse) and she thought Adam could get drawn into the same problems there, so she did not think there was any point staying away from the community of which she felt part.

10. She paid hundreds of pounds to pay off Adam's 'debts' on several occasions because he was being threatened.

11. Mum did not have specific ideas what could have been done differently. She said that there were too many workers and too many changes of workers, especially in the YOT. Generally she believed that some workers were good and tried everything they could (e.g. the workers mentioned above). She was very negative about one worker as she felt she was disorganised and failed to deal with things in time. Adam's mother thought that he should have been provided with a safe place to go in the days before his death.

12. Main lessons that Adam's mother thinks need to be learnt

- Social workers and others need to be able to provide young people who have been threatened with an immediate place of safety
- Professionals should inform parents about the risks of exploitation, gangs and knife crime at a much earlier point so they can prepare themselves
- Parents really need to integrate and get involved with the society where they have moved so that they can speak English, find out all about their children's friends, their school, their lessons and whether they are in trouble or not

Appendix 2

Principles from statutory guidance informing the review method

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

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

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

Reviews should also:

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

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

Local Safeguarding Children Partnership

Hammersmith & Fulham | Kensington and Chelsea | Westminster

Terms of Reference for the Serious Case Review: 'Adam'

Hammersmith and Fulham

Working Together 2015 required the then Local Safeguarding Children Board to consider initiating a Serious Case Review (SCR) where (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

A Rapid Review was convened shortly after the death of Adam, to review:

- the facts about the case, as far as they could be readily established
- whether there was any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide next steps, including whether or not to undertake a Serious Case Review

The Rapid Review recommended a Serious Case Review be initiated, and the LSCB Independent Chair and the National Child Safeguarding Practice Review Panel agreed with this recommendation. Responsibility for completing and publishing the Serious Case Review now rests with the Local Safeguarding Children Partnership.

Background:

Case details are redacted to safeguard privacy. Relevant details are referred to in the body of the report

Lines of Enquiry:

The purpose of this Serious Case Review is to try to understand whether there are any lessons to be learned from the case in terms of professional practice, early intervention and safeguarding. The independent SCR author, Nicky Hill, is asked to consider a number of lines of enquiry, with a view to reaching conclusions and making recommendations to the Safeguarding Partnership:

NB: for each question, we will consider Adam's family / Community / Environment to integrate the contextual elements into the review.

1. To gain an overview of Adam's early family life experiences and consider the impact of his early exposure to domestic abuse.
2. To consider Adam's pathway through early years and education and consider whether there was an opportunity to intervene earlier or work differently with Adam and his family.
3. To analyse the effectiveness of information and intelligence sharing, in risk assessments and planning for Adam.
4. To evaluate whether the risk assessment and safety plans for Adam were sufficiently robust and considered risk in the context of all forms of exploitation including, financial, sexual, criminal etc. To evaluate the multi-agency professionals understanding of the risks to Adam.
5. To evaluate the professional networks understanding of adolescent development and child exploitation. How did this influence the assessment of risk and safety planning for Adam?
6. To critically analyse the multi-agency response to incidents of harm in the 18 months prior to Adam's death. To comment on the quality and effectiveness of intervention and service delivery at these points and the impact for Adam.
7. To evaluate the engagement with Adam. Were his wishes and feelings sought and what influence did they have in the planning and interventions with Adam? What was the professionals' understanding of his lived experience?
8. To consider whether any factors relating to gender, culture, ethnicity and identity were effectively identified and, did they appropriately inform decision-making.
9. To consider the multi-agency partnership working in addressing accommodation needs of Adam and his family and to analyse the risk

management strategies. To consider whether there were any opportunities to intervene differently, which could have led to a different outcome.

10. To consider the impact of the environmental / ecological issues that might have contributed to creating a context within which the harm took place. What can be learnt to inform future safeguarding adolescents and contextual arrangements?

11. How can the review help the Safeguarding Partnership to understand what interventions worked and what didn't? Were the interventions the right ones?

12. What are the actions required by the Safeguarding Partnership to promote learning to support and improve systems and practice in relation to cases of child exploitation?