MK Together | Safeguarding Partnership

Northamptonshire Safeguarding Children Partnership

CHILD SAFEGUARDING PRACTICE REVIEW REPORT

Children N and O

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INTRODUCTION

1.1. This Child Safeguarding Practice Review is in respect of Child N, age 16 years, who was stabbed three times in the street and fatally injured by Child O age 17 years. Child O has been convicted of murder. Child N and Child O knew each other through peers within their social network but had no contact until a few days before the murder. They had had an argument over the phone a few days before the murder because of contact between respective friends. The meeting in the street which resulted in Child N's death occurred by chance.

1.2. This review involves two Safeguarding Partnerships: LA1: MK Together Safeguarding Partnership where the victim lived and LA2: Northamptonshire Safeguarding Children Partnership as the perpetrator was a child in the care of LA2 although placed in LA1. LA1 took the lead for this review although relevant staff from both areas participated. Both partnerships will ensure that learning is widely disseminated locally and publish the full report on both Safeguarding Partnership websites. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning. The Child Safeguarding Practice Review takes into account multi-agency involvement:

for Child N: from April 2019 (decision-making that Child N no longer needed to be the subject of a child protection plan) to the time of his death in November 2020.

For Child O: from March 2019 (when Child O returned to a placement in LA2) to the time of Child N's death in November 2020

1.3. The safeguarding partnerships agreed to undertake this review using a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted as they did at the time. Family members and Child O were also offered the opportunity to speak to the lead reviewer. Child O agreed to do so; his comments have been included in section 8 of this report.

2. LEARNING

2.1. All learning points are listed in section 5, at the end of each theme. What follows is a summary of the most significant learning from this review.

2.2. Partnership working with vulnerable children who have police, social work and youth offending service (YOS) involvement due to offending and links to gangs is inherently complex. This complexity is exacerbated when a child is in care and moves placements between local authorities. It is important that practitioners and agency records are clear about which local authority is responsible for a child and that arrangements to ensure that information is shared promptly with that local authority are effective. Where children have moved areas to keep them safe from gangs it is important to have reciprocal information sharing arrangements between police forces if they are different in the host and home authorities. When the Criminal Justice Liaison and Diversion (CJLD)[1] service practitioners are involved there would be benefits to improved information sharing arrangements that enable CJLD to have access to background knowledge about a child and for them to share information about their involvement with the Youth Offending Service (YOS).

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[1] The CJLD service identifies those who have mental health, learning disability, substance problems or other vulnerabilities when they first meet the criminal justice system. Staff will assess needs, inform criminal justice decision making and help the individual access the right health and social care support as you move through the criminal justice system.

2.3. Children vulnerable to being involved in violent incidents due to their involvement in gangs need to be supported by detailed operational multi-agency, multi-disciplinary risk management plans which are reviewed at key points *eg* when they move placements or when incidents indicate increased risk or vulnerability. Deterioration in behaviour and increase in risk can be very swift if young people involved with gangs in one area connect with gangs in a new area. This needs to be considered in any re-housing of families and requires both social workers and housing authorities to have arrangements to ensure they have or can obtain sufficient local knowledge to make good judgements. Care plans and statutory reviews for looked after children in care who have been placed with their parents should include consideration of the vulnerability of the parent and any risks they pose.

2.4. Being engaged in education is a protective factor for children, and when a child is not in school for any reason this needs to be addressed promptly. There needs to be a range of choices of work experience and other education and training-based opportunities for older children who have disengaged from education or been excluded from school. These children can be highly motivated to obtain employment. They benefit from support to assist getting and keeping a job e.g. work experience, careers guidance, mentoring to develop foundation and interview skills, and practical and financial support.

2.5. Practitioners having strong relationships with young people is a significant factor in reducing offending behaviour and improving outcomes in general, and there is a need to manage the impact when these relationships are disrupted for any reason. When practitioners have raised concerns about a child's safety that are not resolved they should escalate the difference of opinion through their own agency or by using their safeguarding partnership's policy.

3. DETAILS OF THE FAMILIES AND CASE CONTEXT

3.1. Family members will be referred to by their family relationship to each child *eg* Child N's or Child O's Mother, Sibling etc. At the time of his death Child N was living with his mother and three younger siblings. Child N was described as good to work with once a relationship had been established; he could be insightful and had a good sense of humour. He was said to have hidden his sensitivity with bravado. He had a strong initial defensive reaction to being challenged or when he thought he had got things wrong/when receiving negative feedback. He was loyal and very protective of his family. He was good with his hands, at making things for others and DIY, and was keen to have a career in construction work.

3.2. At the time of the murder Child O was subject to a care order and living in supported accommodation commissioned by LA2 but located in LA1. Child O was described by practitioners as seeming quite vulnerable and wanting people to like him and to "fit in". He was also described as having a good sense of humour, and could be caring, kind and thoughtful, and he had several friends. He was reported to be very protective of his younger sibling, with whom he was very close. Child O had enjoyed family picnics in the park and supported a premier league football team. He was keen to obtain employment and was interested in specific types of construction work.

4. EACH CHILD'S STORY: CHILD N (victim)

4.1. Some history prior to the scoping period is relevant. Child N had four younger siblings. During his childhood he was exposed to domestic abuse, alcohol and drugs misuse by his mother who also suffered from mental ill-health. From mid-2015 to mid-2017 Child N lived with his father because Mother could not manage his behaviour. During 2016 and 2017 Child N was offending, went missing several times and was assaulted twice in the community. Father and Child N did not accept offers of

help from the Early Help and Targeted Support services and he moved to live with his mother in 2017.

4.2. Child N was subject to a child protection plan (category neglect) from December 2017 to April 2019 because there were concerns about him offending, being involved in gangs, going missing overnight on several occasions, and being vulnerable to violence in the community, all coupled with the inability of Mother to offer adequate care and protection.

4.3. In May 2018 Child N had transferred from Academy 1 to Academy 2. Prior to April 2019 Child N refused to attend school. For the summer term of 2019 Academy 2 provided him with weekly one-to-one tutoring. His first application to a college was rejected due to his offending history and he was Not in Education, Employment or Training (NEET) at the end of October 2019 despite a second college interview.

4.4. From April 2019 a Child in Need Plan replaced the child protection plan, records show this was because Child N was engaging well with the LA1 YOS; there had been no recent missing episodes, he had been working, was motivated to seek further work, and there had been good engagement with Mother.

4.5. LA1 YOS had become involved in February 2019 to provide Bail Support after Child N was arrested for two offences of assault and four offences of intimidating a witness committed between May 2018 and February 2019. These offences were thought to be gang related. Whilst on bail Child N was subject to a curfew from 7pm until 7am, monitored by a tag from February to August 2019. This intervention by the YOS and the tag was successful; by April 2019 it was felt that Child N should no longer be subject to a child protection plan. In June 2019 Child N was made subject to a Referral Order[2] for six months for a robbery committed in September 2018. In August 2019 this was extended by six months due to the other offences committed in 2018/19.

4.6. Public Law Outline (PLO)[3] proceedings were instigated in August 2019, for Child N and his siblings due to concerns that Child N's Mother continued to misuse drugs, was not consistently engaging with the relevant specialist service and that the school attendance of the siblings was poor. The PLO ceased due to Mother's reduced drug use.

4.7. Child N's behaviour deteriorated quickly in August 2019, with missing episodes restarting. Child N missed a referral panel meeting in December 2019, as well as a YOS appointment in January 2020, which meant he was told about a risk of being returned to court by the Referral Order panel. During 2020 Child N was referred twice by police to the Criminal Justice Liaison and Diversion (CJLD) team for a welfare check when he was in custody.

4.8. In early May 2020 the social worker ceased involvement after a Signs of Safety[4] reflective discussion in supervision. Records show that all members of the Team Around the Child including Mother agreed with the decision to cease social work involvement with Child N, especially as statutory involvement by the LA1 Youth Offending Team was continuing.

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[2] A referral order is the community sentence most often used by the courts when dealing with 10 to 17 year olds, particularly for first time offenders who plead guilty. Referral orders require that an offender must appear before a local panel of trained volunteers to agree a contract of rehabilitative and restorative elements to be completed within the sentence, and attend the panel every 3 months for reviews.

[3] Public Law Outline (PLO) meetings are called if the Local Authority is concerned about the care that a child is receiving where consideration is being given to the potential or actual necessity of starting care proceedings. These are attended by social worker and team manager with the parents who should be encouraged to bring a solicitor; unless the risks are so serious that an immediate application is required their purpose should be to explain to the parents what they need to do to avoid proceedings.

[4]Signs of safety system of working which engages child and parents alongside practitioners to plan and deliver intervention after analysis; What do you think is going well?" "What are you worried about?" "What needs to change?"

4.9. In May 2020, because of a new initiative, the police identified Child N on police records as being at serious risk of youth/gang violence. In June 2020 Child N was arrested for driving a car without a licence and insurance. Because he was still subject to a Referral Order an out of court disposal was not an option. Child N subsequently pleaded guilty at a court hearing in August 2020 and received a conditional discharge and six points on his provisional licence.

4.10. In early July 2020 intermittent compliance with LA1 YOS requirements over a few weeks had resulted in a warning letter. Records show that by July 2020 Child N was getting frustrated with continuing to have YOS involvement although he did recognise that it had helped him. At the end of July 2020, the Referral Order panel discharged his order.

4.11. Between September and early November 2020, Child N came to police attention three times. The first two were for threats to commit criminal damage and robbery. The third occasion was in early November when his girlfriend accused him of assaulting her and her two friends in her home causing minor injuries. Referrals were made to the Multi-Agency Safeguarding Hub (MASH) on both occasions resulting in letters to Mother, the first (after consultation with the previous social worker) suggesting Mother contact them for help if needed and the second advising her of agencies that may be able to assist. Whilst consideration could have been given to contacting Child N directly this would not likely have been successful as he had disengaged from services at this time.

4.12. In mid-November 2020 a chance encounter in the street between Child N and Child O resulted in the stabbing for which Child O was convicted of murder. Both families have been given support by agencies since.

5. EACH CHILD'S STORY: CHILD O (perpetrator)

5.1. Some history prior to the scoping period is relevant. Child O has one considerably younger sibling. From an early age Child O was neglected and witness to domestic abuse and violence between extended family members. His parents misused substances and he was physically abused by his father who had an extensive criminal history. Before Child O reached the age of 10 years records show that his school and Mother were having difficulty managing his behaviour which included physical aggression. In 2016 Child O was permanently excluded from school aged 12 years for aggressive and threatening behaviour; he had assaulted a pupil. As a result of this he was admitted to specialist provision for children with Behavioural Social and Emotional Disorders (BSED).

5.2. In June 2017 Child O became the subject of an Interim Care Order (ICO) due to neglect and was placed with kinship foster carers. In October 2017 the LA2 Youth Offending Service (YOS) became involved due to Child O being subject to a Community Resolution Order[5] after committing two assaults. In January 2018 he was shot with a shot gun; the police believed the perpetrators were from a rival gang. Via a local emergency foster placement, Child O moved to residential care. He was moved to another set of foster carers in May 2018 and then had three residential placements out of county in the north of England between June 2018 and March 2019. He then came back to LA2, where he had three further residential moves.

5.3. During 2018 - 2020 strategy meetings were held in response to Child O going missing on three or more occasions. These meetings were regularly attended by Police, Social Workers and Education professionals. Attempts were made to mitigate the missing episodes.

[5] A Community Resolution Order requires the subject to admit guilt where the victims have agreed they do not want the police to take further action. These do not give someone a criminal record although they can be taken into account by the police if the person commits further offences.

5.4. In April 2019 Child O was the victim of a stabbing by a peer which required stitches. In April 2019 Child O appeared in court for the first time when he was sentenced to a 9-month Referral Order for an offence of possession of an offensive weapon. The Team Around the Child thought it was crucial to get him out of LA2, away from gangs, to keep him safe. In May 2019 Child O was placed with his mother, initially in a hotel in LA2 for about a week pending a family assessment placement being set up in LA1. This was initially a temporary placement for 12 weeks.

5.5. By now attempts to secure a place at a specialist school had been successful, unfortunately it was an hour's journey away in LA2; Child O requested nearer provision in mainstream school. In mid-November 2019 Child O was offered a place in specialist provision in the sixth form (although he was still year 11). Child O was permanently excluded and removed from roll in June 2020 after assaulting another student. In September 2020 Child O secured a place at college but he refused to attend.

5.6. Between mid-August and November 2019 records show consideration was given to an application for a secure order for Child O, because he was going missing and the relationship with his mother had deteriorated. However, the situation had improved, and social work staff thought such a decision was difficult to justify as he was not offending. Although he was going missing, there was no evidence at that time of gang affiliation locally or renewing contacts in LA2.

5.7. At the beginning of January 2020 Child O and his mother were placed in temporary accommodation in LA1, after presenting as homeless. Soon afterwards there were further signs of the relationship between Child O and his mother breaking down including Mother calling the police during an argument after refusing his request for money. At the end of January 2020 came the first report that Child O might be keeping a knife for self-protection. Child O went missing overnight for the first of several times during the remainder of the scoping period and he was also leaving school premises. Over the next few weeks Child O reported threats, including with blades, and an assault. In February 2020 Child O reported an attempted robbery in the street where one of the three people involved threatened him with a knife. At the end of February 2020, Child O was arrested and bailed (but not subsequently charged) regarding an incident for stabbing another young person in their leg and arm. He was seen while in custody by the Criminal Justice Liaison and Diversion (CJLD) team and the only issue of concern was flashbacks for which he declined support.

5.8. In early March 2020 a complex strategy meeting was held due to concerns about whether Child O's placement was meeting his needs and the risks posed by the geographical area he lived in given the level of gang activity. For the first time intelligence had been received that Child O might be pressurised into drug dealing activity in LA2. A move to supported accommodation was being considered, which occurred a week later, and a safety plan was put into place. Child O's social worker made a referral to the National Referral Mechanism (NRM).[6]

5.9. In April 2020 a final Referral Order panel was held, and Child O's Order was signed off as successfully completed. LA 1 YOS offered involvement on a voluntary basis, as they routinely do to avoid an abrupt step down in support. This ceased at the end of July 2020 because Child O had not engaged with this, despite several attempts made by LA1 YOS to contact him.

5.10. In May 2020 Mother returned at short notice to live in LA2 as she did not feel safe where she was living. Whilst in supported accommodation Child O consistently told practitioners that he did not feel supported, and he wanted to live with his mother.

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

5.11. In May 2020, because of a new initiative, the police identified Child O on police records as at serious risk of youth/gang violence. In early June 2020 Child O was arrested twice, once in another part of the country, after being missing from placement for nearly a week, in possession of a large amount of class A drugs and cash, and once for Grievous Bodily Harm[7] after an assault on a fellow student.

5.12. At the beginning of September 2020 Child O attended the A&E department for treatment with a laceration to his finger said to have been caused at work laying bricks. This was confirmed by his support worker, so the hospital staff accepted an accidental explanation and concluded there were no safeguarding concerns.

5.13. At the end of September 2020 Child O was seen with a knife and threatened someone with it. In mid-October 2020 he was presenting as very down and unhappy as he had split up from his girlfriend and lost his job, he hadn't got the college course he wanted, and his request (at a LAC review) to live with his mother was refused. The supported accommodation worker took him to be seen by nurses at the local Urgent Care Centre who provided information and reassurance.

5.14. At the end of October 2020, the national Single Competent Authority declared that Child O was a victim of modern slavery; this meant that the identified exploitation would be considered and may influence whether any criminal proceedings against him continue and be used by him as a statutory defence.

5.15. During October 2020 Child O went missing from his accommodation on a couple of occasions. He was then allowed to stay overnight with his mother without permission from his social worker (this had been requested by email).

5.16. The next contact agencies had with Child O related to the murder of Child N.

6. SUMMARY OF BOTH CHILDREN'S STORIES

6.1. The children had very similar backgrounds; neglect, exposure to domestic abuse and parental substance misuse. Neither child had a positive role model. Child O's father physically abused him and had an extensive criminal record for violence and drug offences. From an early age he influenced Child O to be anti-police. Both children had extensive involvement with social workers, and their parents had difficulty managing their behaviour. For Child N this meant moving to live with his father for two years and then moving back to live with his mother. When living with his mother Child N was made subject to a child protection plan. Child O was made subject to a care order and had had multiple placements, mostly outside of his (home) local authority (LA2), until May 2019 when he was placed with his mother in LA1 to keep him safe. Mother did not settle there and after about 12 months returned to LA2 and Child O then went into supported accommodation.

6.2. Youth Offending Services were involved with both children, and each was made subject to Referral Orders for offences which included violent or intimidating behaviour. Both children were involved in gangs, and at risk of violence. The precipitating factor for Child O to move to LA1 was being stabbed by a peer. Prior to coming into care, he had been shot with a shot gun, probably by rival gang members. Moving to LA1 did not keep Child O safe from gang involvement, especially after he moved to an area of LA1 known for gang activity and, after he was found a long way from home with a large amount of cash and drugs having gone missing for a few days, a successful referral was made to the National Referral Mechanism (NRM).

[7] The offence of GBH means causing extremely serious injuries which severely affect the health of the victim. These can include broken bones or permanent disfigurement.

6.3. Both children had disengaged from education, including being excluded from school/college. They each had a strong desire to obtain employment in a trade using their hands. Although Child O had a long history of vulnerability to criminal exploitation, each child had periods of relative stability and progress during the scoping period, with sudden deterioration in behaviour. During the two months before the murder, with the benefit of hindsight, Child N became more vulnerable due to disengagement with the YOS after the completion of the Referral Order and Child O was heading for a crisis due to not wanting to be in supported accommodation, not having a college place or work and having broken up with his girlfriend.

7. THEMATIC ANALYSIS

7.1. The learning from this review was identified from information and opinions provided in the agency reports and at the practitioner event and from Child O. The themes are:

- **Exploring the relationship between Child N and Child O**
- **Response by agencies to both Child N and Child O's criminal activity including risk of Child Criminal Exploitation and involvement in gangs and knife crime**
- **Decision-making and information sharing about Child O's placement with his mother, their move to LA1 and his subsequent placement in supported accommodation**
- **Meeting educational and health needs**
- **Continuities of service including complexities of cross border working**
- **Impact of Covid and any other relevant organisational contexts**

Theme: Exploring the relationship between Child N and Child O

7.2. Child N and Child O knew each other through contacts within their social networks. They had had an argument over the phone a few days before the murder because of contact between their respective friends. Whilst evidence given to the court suggests that Child O had threatened to kill Child N during that phone call, the murder occurred during a chance meeting in the street. Child O subsequently claimed that the person threatening him with a knife during the attempted robbery in the street in February 2020 was Child N, and that this was why he was carrying a knife because he assumed Child N carried one. Neither Child N, nor either of his two friends who were with him at the time of the murder, were carrying a knife at the time. Child O had not co-operated with the police investigation at the time of the assault against him and declined to do so during the police investigation after the murder.

Theme: Response by agencies to both Child N and Child O's criminal activity including risk of child criminal exploitation and involvement in gangs and knife crime

7.3. Both children were associated with gangs. Gang membership can range from as little as using a hashtag on social media, or living in a particular street, to serious involvement in crime including violence. In 2010 government guidance identified three different categories. Being in a transient "peer group" (which may, or may not, describe itself as a gang), being part of a "street gang" with a specific identity (and where crime and violence are part of that identity) and being part of an

"organised criminal gang".[8] The relationships between these categories are complex and fluid, for example gangs might compete or merge. However, the three elements that tend to be consistently present for street gangs that link back to organised criminal gangs are violence, drugs and defined geographical location. When children move area they often retain their gang membership and are regarded by other gang members to do so. Agencies were aware of the potential risks to Child O arising from a rival from a gang in LA2 who had also relocated to LA1. After the murder consideration was given about keeping Child O safe in custody.

7.4. The 2019 British Crime survey data[9] suggested that 27,000 children and young people in England identify as gang members. In a recent study published in 2019 the Children's Commissioner for England and Wales estimated there were 313,000 children aged 10-17 years linked to gangs, including 33,000 who are a sibling[10] of a gang member and 34,000 who have been the victims of violent crime in the last 12 months *and* are either a gang member or know a gang member. It is this latter group of 34,000 victims of violent crime about whom the Children's Commissioner feels authorities should be most concerned. Both Child N and Child O fell into this definition. When remanded in custody Child O described his gang links in terms of the one he was most closely affiliated to, another he had links with and two others from whose members he would be at risk. Child N was also believed to be associated with a gang, but practitioners told this review his links were weaker.

7.5. From May 2019 when Child O was living in LA2, until December 2019 after he moved to LA1, Child O was supported by staff from the Community Initiative to Reduce Violence (CIRV) which is a LA2 police led multi-agency gang intervention programme designed to reduce gang violence and help those involved in gangs to live a life free of crime. This included mentoring from an ex-gang member and other support to provide an alternative pathway to successful adulthood. After a strategy meeting in early July 2019, which was convened to discuss missing episodes, Child O agreed to voluntarily wear a Buddi tag[11]. However, records show that within days he was requesting it be removed. He only had it for less than three weeks, and half of this time it was not charged. Records show there was a recognition of his desire for work experience and then employment in the construction industry, which would require basic literacy and numeracy skills. This was followed up by a focus on support to get a national insurance card (which is less straightforward for children in care) in time for his sixteenth birthday and foundation skills (*eg* health and safety, first aid) for getting a Construction Skills Certification Scheme (CSCS) card. The involvement of the CIRV co-ordinator was most intensive in the first few weeks, which included liaison with LA1 Neighbourhood Policing Team, and after that she remained in occasional touch with Child O until December 2019 because of the risk of him going back to LA2.

7.6. A child involved with gang related activity is often a victim and an offender over time, and possibly at the same time. When children are found in possession of controlled drugs consideration should be given as to whether they are victims of trafficking; Crown Prosecution Service (CPS) guidance reflects that for all but the most serious sexual or violent offences there is a statutory defence for children accused of possession of controlled drugs; that their action was a consequence of being exploited and that a reasonable person with the same characteristics in the same circumstances would have done the same. Police, local authorities and Youth Offending Services can all make

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[8] Children's Commissioner (2019) Keeping children safe; improving safeguarding responses to gang violence and criminal exploitation Children's Commissioner

[9] Children's Commissioner (2019) Op cit

[10] As well as being at risk of being recruited into the gang, siblings are at also risk of reprisal physical and sexual violence

[11] The tag is designed to be worn securely around the ankle and provides GPS location data on a continuous basis

referrals to the National Referral Mechanism (NRM). The threshold for a referral is low; “suspect but cannot prove” is included in the criteria.

7.7. In March 2020 Child O’s social worker made a referral to the NRM. By the time the Single Competent Authority declared that Child O was a victim of modern slavery he had been arrested in another part of the country, after being missing from placement for nearly a week, in possession of a large amount of class A drugs and cash. Practitioners told this review that although there were concerns that Child N was involved in a gang, the associated behaviour and risks had not put him near the threshold for referral to the NRM.

7.8. In June 2019 Child N was made subject to a Referral Order for 6 months for a robbery committed in September 2018. In August 2019 this was extended by 6 months due to other offences. The LA1 YOS worker provided an intensive package of support: understanding consequences, managing conflict, being organised, sharing problems to find solutions, victim awareness, positive peer relationships grooming, and reparations activity. In May 2019, whilst Child N was on bail, a YOS police officer had begun offering support for Child N to get a Construction Skills Certification Scheme (CSCS) card,[12] the application for which children’s social care subsequently agreed to fund.

7.9. Child N’s behaviour deteriorated quickly in August 2019, with missing episodes restarting. This seems to have been a combination of him no longer being on a tag and believing he could do as he wished now as he was aged 16. Mother asked for help, in particular for YOS to convene a meeting with the social worker. While it was unclear what specifically had been the outcome of that request, practitioners told this review that there had been several joint meetings with the social worker and YOS officer and that the social worker had offered support to Mother.

7.10. After Child N had been refused a college place due to his history of offending, and particularly because he needed help to obtain the Construction Skills Certificate Scheme card, his engagement with YOS improved for a while. However, he missed a referral panel meeting in December 2019, as well as a YOS appointment in January 2020, which meant he was told about a risk of being returned to court by the Referral Order panel. The Information, Advice and Guidance (IAG) worker helped him get a National Insurance Card and arranged work experience from early 2020.

7.11. Once the Covid pandemic started Child N began disengaging again. Practitioners told this review this was because he was demotivated due to not being able to get a job and contact with his YOS officer only being by phone. Practitioners told this review that he had missed a couple of appointments and panel could have returned him to court for sentencing for the original offences. However, in practice the order had only a few weeks to run, he had completed the work required and a return to court would have likely resulted in a fine, which would have had to have been paid by his mother. When discharging his referral order in July 2020 the panel recognised the importance of being in Education, Employment or Training and they hoped that he would continue to engage with the Information Advice and Guidance (IAG) worker; everyone recognised that Child N was much happier when in work.

7.12. Child O’s Referral Order was made in April 2019 in LA2. Where children in care are placed in another local authority it is not unusual for the YOS in that local authority to be asked to caretake the order. However, for a few weeks after the order was made it was unclear where Child O would be living and then, because Child O’s initial placement with his mother in LA1 was for a 12-week assessment period, LA2 YOS continued to hold responsibility for the RO. This, and Child O not attending assessment meetings, even at his home address, meant that there was a delay in holding the first referral panel until mid-July 2019. Child O did not attend this as his social worker was worried about

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[12] CSCS cards provide proof that individuals working on construction sites have the appropriate training and qualifications for the job they do on site.

the risk from others if he went back to LA2. LA2 YOS had had previous experience of making a request for caretaking and then Child O moving before intervention could start so the caretaking request was not made until October 2019. There was a further delay in holding a panel meeting involving both YOS teams until just before Christmas 2019. This was due to a need to confirm the input required from LA1 YOS and that Child O would be staying in LA1 with his mother and remaining subject to a care order. While a service had begun to be offered by LA2 YOS the delay in requesting and finalising the caretaking arrangement meant that Child O did not benefit from LA1 YOS's local knowledge in managing risk.

7.13. The handover in December 2019 involved a review panel where both YOS officers were present. Caretaking arrangements usually include conducting assessments and holding review panels in the area where the child is currently living, however they continued to be held in LA2 at the request of LA2 YOS, because he had engaged with the panel in LA2 and because LA2 YOS had had experience of Child O refusing to engage with previous caretaking arrangements. At the time it was also anticipated that this would best provide continuity of YOS officer (although that was later disrupted by Covid related issues). It also meant that the referral panel did not know LA1 and the characteristics of the local community which made them more dependent on the YOS officers' recommendations for suitable content of the order.

7.14. At the review panel meeting in December 2019, it was discovered that, despite Child O engaging with the contract of work from July 2019, and with subsequent panels, perhaps because he did not attend the first one in July 2019 and had never actually signed the contract of work the order had technically never started until December 2019.[13] Although he would have known the alternative was to return to court for resentencing, it was positive that Child O agreed to continue working with YOS in LA1, despite having to engage for several more months than he had anticipated.

7.15. Work done by LA1 YOS with Child O included intervention about knife crime, gang involvement, peer influence, substance misuse, obtaining education and relationship building between Child O and his mother. Given his involvement with gangs had affected his motivation and capacity to change, practitioners believed he may have benefitted from more specialist intervention, e.g a programme on criminal exploitation which could include access to a gang mentor. After the Referral Order finished in April 2020 LA1 YOS offered voluntary intervention, which Child O declined to take up.

7.16. A report[14] produced by the inspectorate for probation services about Referral Orders (RO) provides a relevant context for this review. These community orders are said to provide an ideal opportunity to help young people cease their offending behaviour before it becomes entrenched. The report stated that ROs are believed to be consistently more effective than other sentences and that YOSs generally performed well. However also that some issues were evident. The report identified two relevant to Child O; the importance of engaging young people in agreeing the intervention and of managing the period after sentence well up until the panel met, to avoid loss of impetus and meaning for the Referral Order. Child O had never signed the contract from the panel meeting in July 2019 and the subsequent panel, when LA2 became formally involved was not until December 2019.

7.17. The Referral order was the main form of intervention to tackle Child N's offending behaviour. His risk level was identified by LA1 police as well below the threshold for involvement by the Problem-Solving Team. Due to involvement in an alleged robbery and an alleged assault in October 2020, he was offered support from another part of the police service; officers from the Violence Reduction

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[13] The referral order finished in April 2020, in line with intended timing when the court originally made it as both YOS felt Child O had completed the necessary work

[14] HM inspectorate of Probation (2016) Referral Orders, do they achieve their potential? HM inspectorate of Probation (2016)

Team visited him and his mother to offer support to get him involved in constructive activities. They were told he had just started a new job and was not interested. Practitioners told this review that perhaps more police proactive support could have been offered during the previous 6 months, when there were some signs his behaviour was escalating, but his circumstances did not distinguish themselves significantly from the other 250 local young people then regarded as at serious risk of youth/gang violence.

7.18. Child O also had contact with and support from the two different police forces covering LA1 and LA2. While the police force from LA2 promptly notified police force in LA1 that Child O had moved to LA1, this was done by sharing of intelligence rather than a formal notification to the police force. This should then have resulted in the neighbourhood policing team and the Problem-Solving Team being proactively aware of his arrival as soon as he had moved, for safeguarding and risk assessment purposes. During May, June and July 2019 there were five brief missing from home episodes. In June LA1 police received intelligence that Child O may be used as a "money mule" which prompted the first contact from the Problem-Solving Team.[15] In early July 2019 LA2 police requested a flag on his address due to a threat to kill from another gang member. This was treated as an administrative matter rather than prompting a conversation between the two police forces, as it should have done. In Mid July 2019 the Problem-Solving Team created a Risk Management Occurrence to manage the risks around Child O. This was two months after Child O had arrived in LA1 and, given his history and vulnerability as a looked after child, this review was told that this should have been considered earlier.

7.19. At the end of July 2019 Child O was discussed at a multi-agency Strategic Exploitation Panel (SEP) meeting. At that time LA1 YOS were not aware whether there was YOS involvement and were tasked to find out, this was still not clear at the time of the next SEP meeting in September 2019, for reasons that are not known. From August 2019 the frequency of missing episodes increased and by September 2019 this has resulted in another Risk Management Occurrence, which was running alongside the one created in July 2019. There is no evidence that the two Single Points Of Contact (SPOCs) liaised, and it would have been preferrable if oversight had been maintained by one person rather than two. Notes from the Strategic Exploitation Panel (SEP) meeting in October 2019 suggest there was no evidence of gang affiliation in LA1, by this stage it was also known that he was subject to a Referral Order to LA2 YOS so his name was removed from the SEP agenda. For the same reasons the RMO raised in July 2019 was also closed. For reasons that are not known there was no liaison with the police force in LA2, or the police officer dealing with him as a repeat missing person.

7.20. A summary of the international research prepared in 2016[16] found a range of features of intervention that had consistent positive (or negative) outcomes. The majority of the studies were from the US rather than the UK. However, whilst some of the programmes of intervention might not be transferable given the different legal systems, the principles on which they are based are. Effective intervention considers: the individual's risk of re-offending, matching the intensity and type of services to that level of risk; the needs of the individual, focusing attention on those attributes that are predictive of reoffending; the individual's ability to respond, taking into account their learning styles, motivation, abilities and strengths. The literature review found that although some young people will always need to be sentenced to custody, the evidence suggests ccommunity-based

[15] The police Problem-Solving Team (PST) in LA1 work intensively with ten young people at any one time. They are identified through scoring criteria for the number of times someone had been a victim, suspect, and missing, considering how seriousness and how recent incidents were. The PST was involved with Child O from June 2020 through the rest of the period covered by this review.

[16] Adler J et al (2016) What works in managing young people who offend? A summary of international evidence. Ministry of Justice

interventions tend to be more effective. In addition, diversionary approaches, including restorative justice, which direct these individuals away from the formal justice system, may be appropriate for some young people because drawing young people who commit low level offences into the formal youth justice system may increase their offending. In the UK diversionary activity involves judgements about the likelihood of desisting criminal activity, the safety and wellbeing of the child and risk of harm to the public. There were some decisions made by LA1 police not to proceed against Child O for relatively minor offending, e.g., possession of small amounts of cannabis, and damage at the supported accommodation.

7.21. The literature review also identifies the benefits of multiple services: addressing a range of offending related risks and needs rather than a single factor. It is important to consider the wider offending context: considering family, peers and community issues. There is evidence that each of the agencies working with both children took a risk-based approach and considered the individual circumstances of the children. For example, each YOS held internal risk management meetings at key points. However, the multi-agency approach for Child O at key points was fragmented and there is no evidence of an overarching closely managed operational, multi-agency, multi-disciplinary risk management plan which the national panel report previously mentioned noted was effective in the local authorities seen to be using them. If the thinking was that due to his "looked after" status the care plan and statutory review function should have served that purpose, this was not effective. At a basic level it became clear during the review that agencies did not have the same addresses for him while he lived in LA1. More importantly, there was no statutory review before Child O moved in with Mother. The next statutory review was held in August 2019, by coincidence at crisis point, which was attended by a LA2 YOS worker who described the referral order as unworkable, for reasons that are not recorded, and who was considering taking it back to court. Records for the statutory review in October 2019 show that Child O was much more settled, but there was no attendee from YOS, or reference to their involvement, which one would have expected given the situation in August 2019. For the August and October 2019 statutory reviews there was no police representative in attendance, and reference to continued involvement from CIRV (LA2), but no reference to liaison with or involvement by the LA1 police force. This was despite evidence in CIRV records of attempts to arrange a multi-agency meeting because of the level in risk in September 2019. There were difficulties in contacting a social worker or practice manager, who were then unable to attend. The next statutory review in March 2020 was held just before the move to the supported accommodation as it should have been, the records are more detailed and holistic than the previous ones. The YOS officer was in attendance, there is evidence of liaison with the LA2 police and recognition that Child O may be more vulnerable when his referral order comes to an end. By the next statutory review in June 2020 Child O had been permanently excluded from school due to the assault. He was working with the Problem-Solving Team (PST) police officer who was in attendance.[17]

7.22. Practitioners told this review that close working relationships between police, YOS and social workers were key to success in their experience of working with the highest risk children. LA1 police felt that one area for improvement to support this would be more consistency by PST team members in producing and sharing chronologies with YOS and social workers which included all incidents and intelligence. There is evidence of close working relationships for both children. However practitioners were not supported by systems and arrangements to promote this, and a co-ordinated approach to risk management, which facilitates multi-agency discussions and planning at key points. For Child O examples of these would be: at the point he moved into LA2; when the placement with Mother appeared to be breaking down; when he was excluded from school; when he moved to the supported accommodation and when he was found in another part of the country with cash and drugs. Children

[17] All the statutory reviews from August 2019 until the end of the period covered by this review were attended by the relevant placement provider and an education representative when he was in school as they should have been.

like Child O are subject to several separate, but potential duplicatory, meetings to manage risk and plan care: meetings because of a legal status (statutory reviews) or a risk of significant harm (strategy meetings) or going missing. None of these operated successfully to bring all the right people together to produce and monitor a holistic risk management plan.

7.23. Young people who had stopped offending who contributed to a report from the probation inspectorate[18] put great store on a trusting, open and collaborative relationship with a YOS worker or other professional, seeing it as the biggest factor in achieving a reduction in offending. This was also a finding from the 2020 National Safeguarding Panel report about children involved with gangs and vulnerable to criminal exploitation.[19] It can be difficult to build trusting relationships with children like Child N and O due to them often having been let down by adults. This can often be even more challenging for children in care, who may have had many changes of placement and changes of practitioners, sometimes at short notice, and without any control.

7.24. Despite their histories of poor care and changes in placements, multiple times for Child O, both children were able to respond to practitioners' attempts to build relationships. There was evidence that several practitioners had persevered with this, but also of a significant impact when those relationships ended for some reason. However skilled the practitioner, building relationships with young people takes time, requiring time spent in understanding the history as well as engaging with the child, and there is evidence that sometimes changes in practitioner adversely affected Child O's engagement in particular.

7.25. More than one SPOC made a determined effort to establish and maintain a relationship with Child O. He engaged particularly well with one and he expressed dissatisfaction when that person was no longer involved. This review has been given different reasons for that police officer ceasing involvement. From Child O's perspective the critical issue is that he no longer had regular contact with him. Whilst Child O did engage with the successor, this was at the point his overall engagement was reducing. The timing of the change was unfortunate as this was the beginning of a very difficult period for Child O. The previous SPOC stayed in touch[20], attempted to follow up with Child O a report he had made about his phone being stolen. The new SPOC contacted him after he had "stormed out" of the LAC review in October 2020. On this occasion Child O expressed frustration at all the "help" he was being offered and "all the people involved in his life" that he had not necessarily asked for.

7.26. During the period under review there were discontinuities of staff, due to workers changing jobs and the Covid pandemic (see section below). Just prior to the period under review the social worker who had been allocated to Child O for the previous two years changed. From March 2019 until the end of the scoping period Child O had four more social workers. Two of these were involved for less than three months. Social worker 5 became involved in June 2020 after Child O had been found with cash and drugs in another part of the country shortly after moving into the supported accommodation. This was because the previous social worker was absent from work, and it was good practice to re-allocate given the escalating risks.

7.27. SW5 built a good relationship with Child O. However she reflected that for young people recently allocated to her who were new to supported accommodation in future, she would visit more frequently to build up a relationship which might better enable young people to confide when they felt unsafe. Having said that the report from the national panel previously mentioned described that

[18] HM inspectorate Probation 2016 Desistence and young people
[19] National safeguarding Panel 2020 It was hard to escape; safeguarding children at risk from Criminal Exploitation
[20] Contacts between the end of September and November 2020 were not recorded until after the murder. They should have been recorded contemporaneously to keep the Problem-Solving Team updated

many young people involved with gangs are not able to be honest about their circumstances, as this may put them at more risk. The careers advisor at the academy changed jobs in October 2019 which was unfortunate timing for Child N as her normal practice would be to stay in touch in the Autumn term. This is because it is not unusual for young people to experience setbacks with planned destinations, and it is very hard for a new person to support young people as effectively without the benefit of a previous relationship.

7.28. From March 2020 neither child was able to see their usual YOS officer face to face due to the Covid pandemic. Practitioners told this review that this had a huge adverse impact on the children's previous good levels of engagement. They suggested that rather than attempt to introduce new people who did not have a relationship with them it might have been better to be more flexible and offer virtual contact with the original officer once the arrangements were up and running.

Learning Points:

- Partnership working with vulnerable children who have police, social work and YOS involvement due to offending and links to gangs is inherently complex. This complexity is exacerbated when a child is in care and moves placements between local authorities.

- Young people who have disengaged from education can be highly motivated to obtain employment. They benefit from support to assist getting and keeping a job e.g. work experience, careers guidance, mentoring to develop foundation and interview skills, and practical and financial support.

- Referral orders can be very effective in supporting young people and reducing their offending behaviour, but this is undermined if referral panels are not convened promptly.

- When a child involved with gangs moves to live in another area the importance of
    - Prompt and effective liaison between police YOS and Children's Social Care in both local authorities
    - The police force in the new area having effective force wide arrangements to provide monitoring of risk and support

- Children vulnerable to being involved in violent incidents due to their involvement in gangs need to be supported by detailed operational multi-agency, multi-disciplinary risk management plans which are reviewed at key points e.g. when they move placements or when incidents indicate increased risk or vulnerability.

- The importance of all key practitioners being involved in statutory reviews.

- The importance of practitioners having strong relationships with young people, and the need to manage the impact when these relationships are disrupted for any reason.

Recommendations A and C

Theme: meeting educational and health needs

7.29. Receiving appropriate education is an important protective factor for young people. Apart from improving their employment opportunities and impacting on a range of other life chances, being in school or college provides access to supportive adults who are positive role models and someone

to turn to in times of difficulties. It also provides constructive occupation which reduces time at a loose end and opportunities to get into trouble. Research consistently shows that risks for children significantly escalate when they are permanently excluded from school, partly due to the difficulties of providing alternative full-time education.[21]

7.30. Both children had chequered educational histories. Between May 2018 until April 2019 Child N refused to attend Academy 2. From April 2019 Academy 2 provided him with weekly one to one tutoring. Out of a possible 43 sessions he attended almost two thirds. When present, the tutor thought Child N was engaging well and making academic progress and he obtained GCSEs in Maths and English. The Academy has since reflected that it would have been helpful to have included more diverse educational opportunities including work experience alongside the tutoring. Practitioners told this review that there were very limited choices for young people in LA1 to provide alternatives to school or college placements when children either won't attend, or are prevented from being offered a place, due to level of risk. These could also enhance and support educational placements by providing work experience, or other practical learning opportunities for older children who struggle to engage with more academic options. Those children might be more accepting of the need to achieve a basic level of literacy and numeracy if delivered by an alternative provider. More leisure activities would also be helpful to occupy children at risk of offending behaviour.

7.31. In June 2019 Child N completed his secondary education at Academy 2 with a destination confirmed with the Careers advisor, who intended to stay involved until October 2019. Child N achieved his wish for a practical job with relatives in July 2019; the careers advisor believed he was still employed in October 2019. However, the job had ended because, although relatives were keen to offer him work, Child N had not wanted to make it a work experience placement. His first application to a college was rejected due to his offending history and he was Not in Education, Employment or Training (NEET) at the end of October 2019 despite a second college interview. YOS records show he was highly motivated to find work, accepted help to produce a CV and applied for jobs on his own initiative in the Autumn 2019. Unfortunately, the work experience placement he started enthusiastically in early 2020 closed due to Covid, and subsequently he was discouraged by the lack of response to job applications.

7.32. Child O's education had been severely disrupted by the number of placement moves he had after coming into care. He was the subject of an Education Health and Care Plan which meant that the lead agency for securing provision was the Special Educational Needs (SEN) service in whichever area he was living at the time. Whenever he moved across local authority boundaries, which he did several times, the responsibility changed, which built in discontinuity and delay. Records suggest that more than one social worker and the IRO were not clear who was responsible for leading on securing educational provision. They both mistakenly thought it was the Virtual School. The role of the Virtual School is to advocate for children in care to support activity to secure appropriate provision. There is also evidence of misunderstanding that it is SEN teams rather than the Virtual School being responsible for reviewing Education Health and Care Plans. Records for statutory reviews show that social workers did not know when the EHCP had been last reviewed.

7.33. The education placement Child O had when first placed in LA1 was in fact one which had been secured after he had returned to LA2 in 2019. It was in LA2, which was an hours' journey, and located in the local authority from which he had moved away to ensure his safety. There is no evidence that this was considered in the placement planning led by children's social care (see placement theme below). It was not until June 2019, some weeks after he had moved to LA1, that the social worker informed LA2 Education Health and Care (EHC) Team that Child O could not return

[21] National safeguarding Panel 2020 It was hard to escape; safeguarding children at risk from Criminal Exploitation

to the LA2 school and requested alternative provision because other pupils were frightened regarding his gang connections and threats of violence.

7.34. In July 2019 the LA2 SEN team asked the SEN team in LA1 to take over responsibility for finding provision. Because he could not attend the site due to his bail conditions and had not previously engaged with tutoring, they also removed Child O's name from the school's roll. This meant the school no longer had responsibility for providing some form of education. This should not have happened until alternative arrangements were in place, especially as this was near the end of term and meant nothing was in place for the next academic year. There were some delays for the SEN staff in LA1 getting involved because they had not had all the necessary information from LA2; staff told this review that in future similar circumstances they would get involved more quickly, perhaps by convening a meeting of relevant people rather than waiting for written information to be supplied. In mid-September 2019 Virtual School staff requested a tutor be provided; this did not start until mid-October and ended within three weeks as Child O would not co-operate. Children in care should have a Personal Education Plan which is reviewed every six months with consideration of it being done at the same time as the EHCP for children who have those. PEP review meetings should still be held irrespective of whether children are on a school/college roll. PEPs were held for Child O in October 2019, December 2019 and Jan 2020, i.e. more than minimum frequency because he was not on a school roll.

7.35. Child O had requested a place be found in a mainstream school, because being in a special school made him feel different. Practitioners told this review he did not understand that he was not ready to thrive in mainstream education. However, they also told this review that, for a child of Child O's age, attempting a placement if the setting thought it was safe could be the difference between a child having some education as opposed to none. In mid-November 2019 Child O was offered a place in specialist provision in the 6th form (although he was still year 11). The school requested a professionals' meeting to discuss risks which was held in the last week of the autumn term. Child O commenced attending three days a week mid-January 2020. This is the standard level of attendance for all students in sixth form, which is less than would have been expected for a pupil in year 11. Despite poor attendance/going missing during the school day, by May 2020 he had managed to achieve a level 1 certificate in construction, engage in work experience and obtain a place at college.

7.36. Practitioners told this review they had significant engagement with the college to get Child O a potential place there because of the perceived risks. Unfortunately, not only was he placed on a construction course of a type that he was not expecting that started with bricklaying, no-one was informed of this in advance of his first day at college. Practitioners told this review that this change of course may have been because he did not have the entry requirements for the specific course he wanted and so was placed on an access course with a wider range of activities, which unfortunately had not started with the one he wanted. The outcome was Child O refused to attend college, and the assault at the school in June 2020 meant he had no backup plan. The social worker and LA1 police Problem Solving Team continued to support him to find a college place; he obtained a constructions skills course place to start after the October half term 2020.

7.37. Both children were seen while in custody by the Criminal Justice Liaison and Diversion Service (CLJD). Child N was seen in February 2020. Discussion and use of a mental health screening tool identified that the only concerning issue was the daily use of drugs. Child N declined a referral to substance misuse services. In September 2020 the worker was unable to contact Child N the police or Mother by phone despite confirming the numbers with the MASH (and checking no social worker was involved). Mother did not respond to two further attempts to contact her, or to a message left the following day.

7.38. Child O was seen by CJLD twice; in February 2020 and after being arrested for the murder. The only issue noted to be a particular concern was periodic anxiety and flashbacks to traumatic events which he said he coped with by using distraction techniques. The worker reported his daily use of cannabis to the social worker, this was believed to be funded by money given by, or taken from, his mother.

7.39. The CJLD practitioners told this review it would have been helpful to have had some background information about both children and that this can be particularly difficult to access outside of office hours including weekends. They said they are reliant on those NHS records which they can access, which may not be detailed, or what the investigating officer can tell them, which is sometimes not very much. Phone calls to MASH usually result in a worker's contact details rather than actual information and then practitioners being busy means they often don't respond for a few days. Some organisations will tell them that they cannot share information without the consent of the chair of a particular meeting.

7.40. Practitioners from LA1 also told this review that it was not standard practice for CJLD staff to contact the YOS after seeing children; there is no evidence they contacted them regarding either child. YOS practitioners felt this would be useful. If the child is known, then having information from the assessment would be helpful. If the child is not known this would act as an early warning regarding young people who had moved into or were offending in LA1. Since the beginning of 2022 CJLD have been emailing a dedicated YOS email with information about children seen in custody who they know are involved with YOS LA1. However, no-one directly involved in this review knew what happened to these messages and whether they were getting through to allocated officers. This system does not include all children, and this is practice used by the daytime service. There is another commissioned service for weekday evenings and nights and no-one involved in the review knew if they had equivalent arrangements.

7.41. Both children were regular users of cannabis by their early teens. In April 2019 Child N attended a first session with a YOS drugs worker but was late to the second and missed the third. Records show sessions with his YOS worker were more difficult when he was asked about his drug use and he declined intervention for this. Records for Child N in February 2020 show reflection by CJLD about how he was funding a daily drug habit without a job, but there is no evidence of any liaison with YOS about this. During an annual health assessment in April 2019 Child O stated he had been smoking cannabis since age 13.

7.42. At the beginning of September 2020 (age 16) Child O attended the A&E department for treatment with a laceration to his finger said to have been caused at work laying bricks. This was confirmed by his support worker. The hospital staff accepted the injury was caused by an accident and concluded there were no safeguarding concerns. A nurse from the health trust reviewed the hospital summary about a week later, noted the lack of safeguarding concerns and concluded there was no role for the school nurse. Neither agency considered whether working as a bricklayer was appropriate, or enquired about the nature of the working environment, for reasons that are not known. Both agencies could have made enquiries to check whether his social worker knew he was working. The social worker did in fact know he was working, had checked it appeared to be a reputable company and had tried to contact the owner, but he did not respond to phone messages. Practitioners were not aware of the employer's responsibility to do a risk assessment for any employee working in construction who is under 18.

7.43. In September 2020 Child O seemed low in mood. He refused to attend his annual health assessment with the LAC nurse despite several contacts from her. He also refused a referral to the LAC mental health team but agreed to see his GP. Unfortunately, the GP had removed his name from their patient register. This was because after making unsuccessful attempts to contact him, they assumed that when his mother moved that he had gone with her. The GP practice has since put in place

systems to prevent children being removed from the patient register without being registered at another practice. The supported accommodation worker took Child O to the local urgent care centre. The nurses there appeared sympathetic and reassuring, clarified he was not self-harming, encouraged him to "think positive" and gave him information about a range of online resources.

Learning Points: meeting educational and health needs

- Being engaged in education is a protective factor for children, and when a child is not in school for any reason this needs to be addressed promptly.
- The importance of a range of choice of work experience and other education and training based opportunities as substitutes for, or enhancement to, school placements.
- The need to raise awareness amongst social work staff of the responsibilities of the SEN team for identifying school placements for children who are subject to Education, Health and Care Plans, including when they are looked after.
- The potential usefulness of better arrangements for the Criminal Justice Liaison and Diversion service (CJLD) to have timely access to background information about the children they see in custody.
- The potential usefulness of CJLD staff sharing information with YOS about the children they see in custody as standard practice. This would provide YOS with helpful early warnings about any children newly moved to the area as well as support their work with children known to them.
- Practitioners need to be aware of the employer's responsibility to do a risk assessment for any employee working in construction who is under 18.

Recommendations B, E and F

Theme: Decision-making and information sharing about Child O's placement with his mother, their move to LA1, including subsequent placement in supported accommodation

7.44. Understanding the timing and decision-making for some of the placement changes for Child O during the period under review has been difficult due to a combination of some characteristics of the social work electronic record (where some key details are only visible in contact records) plus gaps or lack of detail in contact records, coupled with social workers and team managers who were involved before March 2020 not being available to participate in this review. In addition, some agencies who had provided placements or support for Mother were not identified until a late stage in the review and have not provided any information.[22]

7.45. In January 2019, a meeting was held involving social care staff and a legal representative due to concerns regarding Child O's risk-taking behaviours within LA2, alongside the breakdown of placements. The outcome of the meeting was that Child O did not meet the criteria for a secure order application[23] at that time. Advice given by the then Assistant Director, was that all other placement

[22] The provider of the supported accomodation placement and substance misuse services in both local authorities
[23] Secure orders are made under section 25 of the Children Act 1989. The order allows children's services to place a looked after child under the age of 16 in secure accommodation on welfare grounds if one of two conditions applies: the

options needed to be considered/exhausted prior to going down the secure accommodation route. This is in line with national and local guidance. After he was stabbed, a second legal planning meeting was held in May 2019. This led to a Secure Panel meeting being arranged by LA2 two months later in July 2019 (no reason for the delay is recorded) where it was agreed that the threshold was met to make an application to court for a secure order for Child O. Agreement was given by the Director of Children's Services that, pending an application to court, Child O should be placed in secure accommodation without an order for 72 hours. Unfortunately, no placement of any kind was available which could meet his needs. Because of this the Assistant Director agreed it was appropriate to explore the possibility of a placement with Mother. There is no evidence of anyone considering trying to find a bespoke unregulated placement for supported accommodation for Child O, for reasons that are not known. However, given the level of risk and need it might have been difficult to keep him safe in such a placement. Emerging concerns nationally about the use of unregulated accommodation for children under 16 years might also have been a relevant context.

7.46. By this time, Child O's mother had been engaging in support services to address her substance addiction and was willing to care for Child O. Child O was very clear that he would not return to any placements 'Out of County' as he missed his mother and the regular contact he was having with his sibling. Child O's mother was willing to leave her council flat, in order for Child O to be placed with her in LA1. A suitable placement was identified in LA1 which could undertake a specific parenting assessment, and the court responsible for the care proceedings directed that it would be safer for Child O and his mother to move into a hotel (family room) in a town in LA2 for a few days rather than live in Mother's flat until the placement was ready. Records show that Child O was in court on the day of the move to LA1 and that the judge had made clear that if this placement was not successful then it might be necessary to consider secure accommodation.

7.47. Records show that the schedule 3 report assessing the suitability of the placement with Mother was signed by a senior manager before the family moved to LA1, but three days after they had moved into the hotel together in mid-May 2019. Whilst this may have been an emergency placement, which was endorsed by the court, approval should have been given beforehand, although it is clear from the schedule 3 report that information gathering for it had begun sometime previously and that there had been discussions with senior managers. References to YOS noted the need for ongoing involvement due to the recent making of the Referral Order but did not consider which YOS service would provide this. The report stated Child O had an education placement in LA2 due to start in a few weeks. Whilst this was not in the town where he had previously lived there was no evidence of reflection on whether its location was suitable given that it was still in LA2, where it was not deemed safe for him to live, nor on the fact that he had previously expressed reluctance to attend there. It is not known whether anyone considered whether any of the other pupils might have knowledge of him via involvement in gangs. The report indicated that they would have sole use of a family sized home during the parenting assessment and that the police had been involved in a risk assessment of the safety of the location.

7.48. This review was told that the IRO endorsed the decision for Child O to live with his mother, alongside an extensive support package, which included intensive family support, specialist input to help Mother continue to stay drug free, CIRV, NRM and education outreach, but there is no evidence that a statutory review took place either prior to this move or shortly afterwards as it should have done.[24]

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child has a history of running away. The order may be made if the child is likely to run away from any other type of placement, and they would be likely to suffer significant harm if they did run away; the child is likely to injure himself or someone else if they were kept in any other form of placement.

[24] https://northamptonshirechildcare.proceduresonline.com/p_look_aft_rev.html Children Act 1989 Guidance and regulations (2021) Volume 2 care planning placement and case review Chp 3 DfE

There is no requirement in the schedule 3 report to indicate the view of the IRO or the date of a statutory review to endorse the placement. Although the care plan was sanctioned by a court and the plan indicated the IRO's agreement with it, local procedures indicate that a statutory review should be held soon after placement. The absence of a statutory review before August 2019 meant there was no opportunity for all the agencies involved with Child O to get together and discuss the plan. This would have been particularly useful just after the family had moved to LA1 as it would have enabled the staff delivering the parenting assessment to meet other practitioners and for everyone to have an opportunity to discuss their roles and nature of their intended involvement. This might have made more visible the challenges faced by YOS in initial delivery of the referral order and the complexity of the potential involvement of both police forces and their need to be kept informed.

7.49. Between May 2019 and July 2019, most of the occasions of police involvement with Child O involved him going missing for brief periods (five times). Otherwise, records show the placement seemed to be going well from the point of view of family relationships and engaging with the social worker and YOS.

7.50. LA1 was only 30 minutes travelling distance from Child O's previous address, and therefore placed a heavy reliance on him to co-operate with keeping himself safe. Overall, for a few months Child O's situation seemed relatively stable in terms of not offending in the community. However, records show that concerns about him going missing between mid-August and October 2019 had been at a level where consideration was given to an application for a secure order. Some agency records show a belief that secure accommodation was appropriate without necessarily having a detailed understanding of the legal requirements, however records also show that at least one agency tried, without success, to get an understanding of why a decision by LA2 to pursue a secure order had changed. No secure panel was arranged as the situation had improved; social work staff thought seeking secure accommodation was difficult to justify as he was not offending. In addition, practitioners told this review that secure orders could only usually be justified for a few months. Whilst they might be necessary sometimes to protect children, without a good transition plan they were not long enough to do much more than provide a safe pause to try and engage the child who would revert back to the previous behaviour if there was not a good follow-up plan once they were released.

7.51. From August 2019 his relationship with his mother deteriorated, including him asking for money with threats and aggression. In fact the statutory review record shows that the placement was considered to be breaking down in August 2019 to the extent that Mother returned to her accommodation in LA2 while Child O remained in the placement with 2:1 staff support pending an application for secure accommodation. This was unsuccessful for reasons that have been described previously and Mother agreed to return to the placement and resume caring for him. By the next statutory review in October 2019, it was clear that things had improved considerably in terms of family relationships. In addition, three potential school placements had been identified, although the only educational input imminently available was two hours a day tutoring.

7.52. The final care plan produced for court in November 2019 indicated that the outcome of the parenting assessment had been sufficiently positive for Child O to remain in the care of Mother, but that he needed the ongoing protection of a care order to ensure his needs were met. It also stated that Mother had engaged "meaningfully" with the substance misuse service in LA2 and proposed that Child O be supported to understand living with a parent with an addiction. It is unclear what "meaningful engagement" meant, but whilst it is accepted that a person's struggles with substance misuse may mean relapses, by August 2019 there was evidence that Mother was using drugs again. The fact that the family assessment placement had to frequently provide food vouchers, at least

partly because Mother was spending money on drugs, suggests the protection assumed from engagement with services implied more optimism than was warranted. There is also no evidence of any work with Child O on living with a parent with addiction.

7.53. Managers from the family assessment placement told this review that, looking back, they believed that all the practitioners focussed too much on Child O improving his behaviour and overlooked the risk his mother posed. There needed to be a holistic plan that also looked at mother's functioning and risky behaviour and there is no evidence that this was considered after the care plan was presented to court. As is the case nationally, the local authority's recording tools for care planning and statutory reviews are designed for most children in care who are living with foster carers, or in children's homes or supported accommodation. The starting point is therefore that the actual placement is safe and the carer(s) protective, so these documents are not well suited to placement with parents arrangements where, by definition, since the threshold of significant harm has been met in a court, there are likely to be some risks associated with the parent.

7.54. It is unclear which agencies knew that Mother had started using drugs again by August 2019 and appears to have continued to do so throughout the time caring for Child O. There is some evidence in agency records of individual practitioners sharing information and concerns about mother's substance misuse with other individual practitioners. However, there is no evidence of any multi-agency discussion (including at statutory reviews) about what drugs she was using and how often, how she was getting them, what the impact on Child O might be (e.g on household income, contact with people dealing drugs etc) or what support she might need to cease using again. There is a fleeting reference to Mother possibly taking up substance misuse services in LA1. It has not been possible to gain any information about this from the agency concerned as they have been taken over and the records archived.

7.55. The parenting assessment provider allowed Mother and Child O to live in one of their properties after the assessment had finished, pending them finding an alternative. During a social work visit in mid-December 2019, when only Child O was at home, Child O stated that the provider had given them 28 days to find somewhere else to live and that Mother had an appointment with housing in LA1 that week. Records show that the social worker was intending to attend with Mother. It is not clear whether they did, but housing records show that the housing authority was aware that police and social workers from LA2 were involved, and that it was not safe for Child O to return to LA2. Although the property was not available indefinitely there is no evidence that the social worker had planned ahead for follow on accommodation.

7.56. Records suggest it was necessary for Mother to present again at housing early in the new year when she was accompanied by the LA1 YOS officer. The family were offered temporary accommodation that the housing authority deemed suitable and affordable. Unfortunately, this was in a part of LA1 where gangs were operating. There is no evidence of a detailed discussion about the nature of the risks which might have enabled housing staff to recognise that there could be parts of LA1 which would not be suitable for the family. In addition, housing staff told this review that they did not have a detailed understanding of risks in different areas of LA1, and that one of the constraints in rehousing people was the limited amount of temporary accommodation available.

7.57. The LA1 YOS officer had raised his concerns with housing and was informed this was temporary housing. The concerns were also shared by LA1 police and the LA1 Exploitation Lead. Challenges were made to LA2 social workers querying why they had not taken action to house the family and instead the family had to present themselves as homeless to housing which then had potentially increased the risks to Child O in relation to gangs and exploitation, both in terms of the nature of the local area and because insecure housing makes children more vulnerable. Records show this was

escalated to the team manager whose response repeated that the accommodation was temporary and described Mother as having support from the parenting assessment provider to complete some unspecified tasks to secure permanent accommodation. The team manager did not directly address the concerns about the nature of the area itself. This reply seems to have been accepted as there is no evidence of any further escalation. Records show that SW2 was aware that this was a "poor area" where Child O would be at "greater risk" and had in fact asked colleagues to provide evidence and challenge to the housing authority, but this was after the accommodation had been offered.

7.58. The care planning regulations and the Schedule 3 report previously referred to require consideration of the safety of the area in which a child in care is going to live. At the time of the original placement in LA1, there is evidence that SW1 had sought reassurance from the LA1 police that the proposed address was a safe area for Child O to live. There is no evidence of a proactive approach by social work staff in late 2019 to identifying which would and wouldn't be safe areas for Child O and Mother to be offered accommodation. After the family had moved into the temporary accommodation there was no evidence of consideration being given to any options for moving them, for example, by providing financial support to enable the family to rent accommodation elsewhere in LA1, despite the YOS officer passing on Child O's fears to the social worker about being approached in the area where he now lived to deal drugs. It may be relevant that Mother soon became more committed to the solution being to move back to LA2. Records show she was worried about losing her tenancy there and finding it hard due to Covid restrictions to have contact with Child O's younger sibling.

7.59. During this review practitioners expressed differing views about the impact of Child O being housed in an area where he was vulnerable to becoming involved again in gangs. Whilst deterioration in Mother's ability to care for him might have been expected after the cessation of the additional support and monitoring provided by the parenting assessment provider, the nature of the area was a compounding factor which could have been avoided.

7.60. By March 2020 agencies had serious concerns about several things: Child O offending, the risks the behaviour posed to others and himself; Mother's ability to supervise him and to prioritise her finances to ensure there was sufficient food in the house for him; and the two of them were not getting on. In addition, Mother wanted to move back to LA2. Child O moved to supported accommodation in March 2020. This was after risk assessments had been completed which took into account that other residents were in stable circumstances and included seeking confirmation from LA1 police that the address was in a safe area.

7.61. Within two weeks of entering supported accommodation missing episodes increased, including overnights, with at least one being known to be outside of LA1. Child O was upset about how the impact of the Covid pandemic prevented in person contact with his mother and sibling. There was also the issue of getting used to a new group of staff, which was a challenge for both parties given his history. Social work practitioners involved with Child O during his stay in supported accommodation told this review that, especially as he had only been 16 years old when he had moved into supported accommodation, they should have reviewed the nature, level and purpose of the purchased care package (seven hours per week, with 24-hour access to a staff member on site) during his stay. They also felt that perhaps the level of support had needed increasing, and that in future they would monitor packages more frequently, and review them more proactively, for other young people in similar circumstances.

7.62. Since the murder Child O has spoken to his social worker about his time in LA1. He said that he was worried about informing practitioners that he was scared and unhappy, for fear of being moved

further away from his family. Child O had previously been moved to placements in other local authority areas which affected his close relationship with his sibling and family members. Ideally Child O would have felt confident to raise such concerns without the fear of being moved away from his support network. If this worry had been shared, consideration could have been given to ensuring he remained close to important family links.

Learning Points:

- A requirement to add the IRO's opinion or the date of a statutory review which had endorsed the placement of a child subject to a care order back with their parent on the schedule 3 report may assist in ensuring that the care plan is updated to include all multi-agency involvement.

- When children subject to a care order are placed with parents at short notice, including at the direction of a court, a statutory review should be held promptly to discuss this and ensure the meeting and care plan includes attendance or a contribution from all practitioners actively working with the child and parent. This is particularly important when children are placed outside their home authority.

- Some children in care who have not thrived in multiple residential care placements can do better when placed with their families if there is a good package of support.

- Care plans and statutory reviews for looked after children placed with their parents should include consideration of the vulnerability of the parent and any risks they pose.

- Deterioration in behaviour and increase in risk can be very swift if young people involved with gangs in one area connect with gangs in a new area. This needs to be considered in any re-housing of families and requires both social workers and housing authorities to have arrangements to ensure they have or can obtain sufficient local knowledge to make good judgements.

- When practitioners have raised concerns about a child's safety that are not resolved they should escalate the difference of opinion though their own agency or by using the relevant safeguarding partnership policy.

Recommendations D, E and G

Theme: Continuity of services, including complexities of cross border working

7.63. Working with children who offend, who may be victims as well as perpetrators, and who also have social workers brings with it a lot of complex partnership arrangements. This applied to both children. Both Child O and the practitioners working with him also had to deal with the challenge of cross border arrangements. These meant more people were involved, sometimes with overlapping roles, or a change from someone familiar to someone who was not because Child O had moved to LA1 requiring a change in agency delivering a service. Records show more than one example of Child O feeling there were "too many people" involved in his life. This was exacerbated by agencies' uncertainty about whether the move to LA1 was going to be more than temporary. This resulted in some duplication or delay in YOS, SEN and police services.

7.64. Whilst there is evidence of strong partnership working with both children there is also evidence of misunderstandings and gaps. Agencies in LA1 were not always clear that the responsibility for the

care order lay with LA2 rather than LA1 as it would for most young people living in LA1. Nor were they aware that police in LA2, needed to be consistently kept informed due to the risk that Child O might be drawn back to previous activity with gangs there. The police in LA1 needed to be kept informed regarding any incidents that came to the notice of LA2 police. The communication with and by Child O's social workers about incidents and changes in plans was not always consistently good. Police officers told this review that, when there was an incident in LA1 requiring notification, although they always tried to communicate directly with Child O's social worker because of the intensity of the police Problem Solving Team involvement, in practice LA1 police would share information with the local MASH in LA1 (who should contact their counterparts in LA2 so Child O's social worker was aware). Taken as a whole, police records in LA1 show some confusion as to which local authority was responsible for Child O. This makes the MASH-to-MASH communication important as a safety net.

Learning points: continuity of services including complexities of cross border working

- The importance of practitioner and agency records being clear which local authority is responsible for a child in care and that arrangements to ensure that information is shared promptly with that local authority are effective.

- Where children have moved areas to keep them safe from gangs the importance of reciprocal information sharing between police forces if they are different in the host and home authorities.

See recommendation A

7.65. **Impact of Covid and any other relevant organisational contexts**

7.66. The Covid pandemic is known to have had a huge impact on services and young people. Both children engaged best with practitioners in person, but engagement with practitioners was often limited to phone and video conferencing, which took a while to put into place. Overall service continuity and capacity was reduced due to staff sickness and vulnerability to infection and the need for redeployment to meet service priorities. These things also had a big impact on individual staff; they increased the challenges of what are already demanding roles.

7.67. Child N was not able to re-sit the test for the construction skills card. Nor was he able to get a job or engage with a training agency which closed due to Covid restrictions. He was also not living at home for a while when he would not comply with Covid restrictions because Mother worried this would put a vulnerable family member at risk. Child O found restrictions due to the Covid pandemic on his contact with his mother and younger sibling particularly upsetting.

8. CHILD O's COMMENTS

8.1. Child O agreed to have a virtual meeting with the author in the company of his current probation officer. When talking about relationships with practitioners, there were a number who Child O felt he had a good relationship with; the YOS workers from both LA1 and LA2, a police officer from LA1 and two of the supported accommodation staff. Characteristics he identified which helped build his confidence in these people included: having a long term relationship with them; their taking time to seek him out; their being friendly and interested in him and his family and in what he was doing; feeling he could chat about anything without being judged; and practitioners being "straight up" (honest) with him. He also appreciated sometimes being brought snacks and drinks. Child O's top

tips for practitioners working with young people would be to "Listen to them, relate to them and put yourself in their position". Mostly he felt listened to, two occasions where he didn't were decisions about placements: when being placed in a particular part of LA2 in 2019, and in temporary accommodation in LA1 (circumstances discussed in section 7 above).

8.2. He was pleased to be able to live with his mother and thought it was a good idea to go to LA1 in the family assessment placement where he could have a fresh start and they could get used to living with each other again. The YOS worker and the police officer in LA1 both tried to get him into clubs to do activities and make friends to avoid getting in with the wrong crowds, but this was prevented by the Covid pandemic. He felt being placed in temporary accommodation was a big mistake because the area was unsuitable for both him and his mother because they were "surrounded by gangs and drugs". He confirmed there were times when he felt very unhappy and scared but had found it hard to tell people that because he thought he would be removed a long way away from his family, because this was what had happened when he had previously confided being unsafe.

8.3. In talking about his experiences in education Child O was sorry that he had been out of education for so long after returning to LA2. He wanted to be in a mainstream school as he thought this was more likely to be an environment where he would make more progress with his learning. He would have been enthusiastic about more practical learning opportunities to help him get a job in the construction trade. He was disappointed with the college course offered as it was not what he thought he had signed up to. He had done bricklaying before, and he did not want to do art as he feels he is not artistic. He would have liked to have done more carpentry, to build on what he had learnt at school, and gained other skills relevant to the construction trade his uncle and grandfather engaged in.

9. POSITIVE PRACTICE

9.1. When undertaking a review, it is important to also consider the kind of positive practice that might have broader applicability to protecting or supporting other children and families. A number of examples have been previously referred to, others are listed below.

Protective and supportive actions by practitioners
Children's Social Care asked the GP for information which was provided promptly to social workers and the child protection conferences
When Child N was made subject to a Referral Order confirmation of allocation of the YOS worker he knew was prompt.
Information Advice and Guidance worker was able to motivate Child N to improve his CV and apply for a number of jobs
Addiction services changed provider in 2020. Arrangements were made for Mother to continue her treatment with the same worker
Child N attended the child protection conference and acted as scribe
School staff attended the police station with Child N to find out the outcome of his bail
Educational provision was provided for Child N to sit his GCSEs
YOS police officer assisted Child N to prepare and practice to obtain a Construction Skills Certification Scheme card

IAG worker engaged with Child N and helped him complain about unfair treatment at the test centre, which was the context for him failing the test the first time. The complaint resulted in him being given a free resit
Police officer from the Problem-Solving team knew Child N well and visited his mother to offer support and liaised well with his social worker, including calling in at the office and attending core group meetings
LA1 social worker provided support even though Child N was no longer open to her e.g. helping get a birth certificate, which helped with funding support activities
The post 16 centre staff built sufficient rapport with Child O that he was able to be honest about his current circumstances and feelings including anxiety and panic attacks
Regular liaison by college staff with supported accommodation staff, SW and YOS and Mother
Supported accommodation worker was persistent in helping Child O to obtain support when he was feeling low in October 2020
Strong working relationship established between SW5 and police officer from PST who engaged well with Child O
CIRV co-ordinator stayed engaged after Child O moved to LA1
Child O's LA1 YOS officer engaged well with him, and provided him with cooked food and food parcels and liaised well with LA2 YOS
Child O has had the same IRO since 2017
The referral to the NRM was made as a matter of routine practice by the local authority and LA1 YOS at an appropriate moment
There was a close working relationship between LA1 and LA2 YOS which benefited Child O

10. CONCLUSION

10.1. Several practitioners were persistent and thoughtful in the support they provided to each child. Both children responded particularly well to help that they thought would give them a future in terms of obtaining employment. As well as disrupting some key relationships with practitioners, the actual timing of the Covid pandemic was unfortunate at their age in reducing their opportunities for training and employment. Having said that, even without the pandemic, practitioners told this review that training and work experience opportunities for children who have disengaged from education or who have been excluded from school are limited in LA1.

10.2. It is It is striking that for both children a quick deterioration in behaviour could follow periods of relative stability. Placing Child O with his Mother out of LA1 to protect him from violence from gangs in LA2 was both a last resort due to the lack of any alternative viable placement, and a positive move with potential for better outcomes given that he was, initially at least, highly motivated to live with his mother. The deterioration in Mother's ability to care for him eventually resulted in him living in supported accommodation with a low number of hours of proactive support at a young age. This deterioration, and his involvement in further offending behaviour, might have been expected after the cessation of the additional support and monitoring provided by the parenting assessment provider. However, the nature of the area where they moved to was a compounding factor which could have been avoided.

10.3. These children barely knew each other. It was tragic for Child N that they met at a time in Child O's life of significant stress, when, with the benefit of hindsight, it is clear there was a risk of some kind

of serious incident but without any practitioners either knowing how precisely that might present itself, or about the conflict between the children which led to the murder.

11. RECOMMENDATIONS.

11.1. The individual agency reports have made single agency recommendations. Both Safeguarding Partnerships have accepted these and will ensure their implementation is monitored. To address the multi-agency learning, this Child Safeguarding Practice Review identified the following recommendations.

A. That each partnership supports the development of arrangements which will result in detailed operational multi-agency, multi-disciplinary risk management pathway for individual children most vulnerable to being involved in violent incidents due to their involvement in gangs. These arrangements should always include children moving areas for their own protection and risk management plans should be reviewed at key points e.g. when children move placements or when incidents indicate increased risk or vulnerability.

B. That MK Together Safeguarding Partnership supports the development of more alternative educational and training options for children who have disengaged or been excluded from school.

C. That both partnerships reinforce with practitioners the importance of young people having strong and enduring relationships with practitioners and the risk of changes, especially if these are more than one practitioner at the same time. Partnerships should seek assurance from all agencies that they recognise the impact on young people when practitioners changes so that this is avoided where possible and steps taken to mitigate the impact where it is not.

D. For children who have moved areas for their own protection.

   I. That each partnership supports the development of arrangements which will support the nature of the local community being risk assessed for every potential change of address prior to accommodation being confirmed. Such checks are a regulatory requirement for looked after children.

   II. That MK Together Safeguarding Partnership seeks assurance from Milton Keynes City Council that housing staff are aware of the learning from this review and supported to develop arrangements to ensure such checks are completed for looked after children.

E. That Northampton Safeguarding Children Partnership seeks assurance from the Children's Trust that:

   I. Work has been done to review the attendance at LAC reviews to ensure that the right people are in attendance

   II. Work has been done to ensure social workers and IROs understand the respective roles of the SEND service and the Virtual School in securing educational provision and reviewing Education, Health and Care Plans (EHCPs) for looked after children

III. That the learning from this review is used to improve the quality of the care planning, monitoring and review for looked after children who are placed with their parents

F. That MK Together Safeguarding Partnership supports the development/review of information sharing arrangements to

   I. Provide timely information to the Criminal Justice Liaison and Diversion (CJLD) service about the backgrounds of children they see and

   II. For Youth Offending Service to receive timely information from CJLD about the children CJLD see

G. To improve the availability of placements for children at risk in the community

   I. That the two Partnerships consider together whether there are any mutually beneficial joint commissioning arrangements that could be made.

   II. That the two Partnerships jointly draw the attention of the national panel to the learning from this review about the difficulties in finding placements for young people who meet the criteria for secure accommodation and seek their view on whether they can do anything to improve this situation.

H. That each Partnership seeks assurance from each agency involved in this review that learning points have been identified and action has been/or is being taken to address and disseminate them.

I. That each Partnership agrees what arrangements will monitor the impact of action arising from addressing these recommendations.