Child Safeguarding Practice Review

Children Exposed to Serious Youth Violence[1]

Contents

1 Introduction

1.1 The South Gloucestershire Children's Partnership (SGCP) agreed to undertake a Child Safeguarding Practice Review (CSPR) to consider practice and systems when there are reasons to be concerned for a child due to their involvement in or exposure to serious youth violence (SYV).

1.2 This follows a thematic CSPR 'Cross-Border Peer-on-Peer Abuse and Child Criminal Exploitation' which was undertaken in 2021 and commissioned by the SGCP together with the Keeping Bristol Safe Partnership and the North Somerset Safeguarding Children Partnership. A relevant local learning review in respect of another South Gloucestershire child 'Harry' was also undertaken in 2021, after he received stab wounds in the community. The decision to undertake this further CSPR was because of the 2023 death from a stab wound of a child named Child T[2].

1.3 It is acknowledged that a considerable amount of work is being undertaken both nationally, regionally and locally in respect of SYV. This review is being undertaken in this context and the wider picture will be referred to in this report when relevant, with the understanding that there are likely to be related progress and changes while the review is being undertaken and after it is completed.

1.4 As well as considering the South Gloucestershire child and wider context, this review has also noted the available learning about the out of area children[3] who have been convicted of killing Child T[4]. Agencies in the other areas attended the rapid review meeting following Child T's death, and panels as part of this CSPR, and have since undertaken pieces of work to consider learning regarding the professional involvement with the other boys prior to the critical incident. Two boys were originally

[1] "Violence that occurs among young people aged 25 and under, outside of the home, between young people who are not related, and who may or may not know each other" Bristol Safer Options Strategy 2020.
[2] Anonymised for publication.
[3] Initially two children, but at time of writing, three children have been charged.
[4] There is currently no evidence that the assault was planned. Several knives were recovered by police from those attending the party. The rapid review group were concerned that carrying knives is commonplace among children in the areas being considered.

charged, then in October 2023, a third child was also arrested and charged. The outcome of the court case was that one boy was convicted for murder and two for manslaughter.

1.5 The learning from considering Child T, heeding the larger regional and national context, is in the following areas:

- The importance of identifying, sharing, and considering 'intelligence' about children who have a history of SYV, and recognising while there may not be evidence, there may be a risk.
- Knowing which children are more at risk of SYV.
- The need to understand and engage with all members of the child's family.
- Effectiveness of responses to National Referral Mechanism.
- Monitoring and considering a child's drill music.
- Difficulty in knowing and understanding the child's lived experience.
- Serious incident response.

1.6 The additional learning in respect of the other children who were involved in the fatal incident is summarised from 3.41 below.

2 The Process

2.1 An independent lead reviewer[5] was commissioned to work alongside local professionals from South Gloucestershire to undertake the review. Several panels were held. Firstly, with South Gloucestershire managers and safeguarding leads, then including those from both partnership areas where the other boys lived. The panels worked with the lead reviewer to identify the overall learning, and the recommendations included in this report.

2.2 A detailed and extensive rapid review process was held after Child T's death with representatives from across the three areas and in respect of the three boys. The information shared prior to and at the rapid review meeting was used as the starting point for the CSPR. Each agency involved was also asked to provide further reflection on their agency involvement and consider whether any single agency recommendations were required.

2.3 A face-to-face multi-agency meeting with South Gloucestershire professionals who had been involved with Child T and / or his family at the time was held. It involved discussions about the professional involvement with Child T and about the wider systems in which they work[6]. Learning has been identified, but there was also evidence of much positive practice and a commitment to Child T from those involved, and a willingness to reflect on their practice from those who attended.

2.4 The lead reviewer and a representative of the SGCP met with Child T's mother and stepfather, to hear more about him and about their engagement, as a family, with professionals prior to his death. Learning was identified from their perspective. Their views and this learning are included below. Child T's father is aware of the CSPR and has been kept updated on the progress and learning.

[5] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and entirely independent of the SGSCP.
[6] Those who could not attend the meeting were spoken to individually by the lead reviewer and a representative of the Partnership.

2.5 The two other Safeguarding Partnerships involved in this review, due to their responsibility for the boys arrested for killing Child T, are considering how they will engage with the boys themselves, and their family members. The local Partnerships will reflect on what emerges from this engagement and decide whether any further improvement actions need to be undertaken.

3 The Learning

3.1 The learning identified for the safeguarding system and partnership is highlighted below, followed by detailed and case specific analysis.

Research shows that some children may be more at risk of harm from serious youth violence due to their adverse childhood experiences, and there is a need for practice to be trauma informed. However, there can still be a risk to children in the community from involvement in SYV who are not otherwise well known to services.

3.2 Child T came from a loving family and his parents, while separated, maintained a healthy and civil relationship that appears to have been focused on Child T and his needs. This was reassuring for professionals, despite concerns about him carrying weapons and his suspected involvement in criminal activity. Much of the known research in respect of child exploitation and knife crime appears to provide a picture of children marginalised from their families as well as society, and Child T did not really fit this 'profile'. A report published by HM Inspectorate of Probation in 2021[7] states that early experiences of 'justice-involved children' are characterised by disproportionate adverse childhood experiences, with their experience of abuse and neglect impacting on 'the likelihood of both future violence perpetration and victimisation'. The impact of this type of early experience on increasing vulnerability was well known to those working with Child T. The National CSPR 'It Was Hard to Escape', published in 2020, also considered the literature which largely highlights risk factors for criminal exploitation including 'poverty, abuse and neglect, behavioural difficulties, school exclusions, special educational needs, drug use, children looked after and those with physical or mental health issues'. Interestingly, the findings from the National CSPR show that, apart from school exclusion, 'these factors were mostly not present, or not at a level to bring the children to the attention of children's social care or other services.' At the time, Child T's situation appeared to be reflected more in the national CSPR rather than in other studies, but the involved professionals were aware that he did have some of vulnerabilities that increased his risk to this type of harm, including school exclusion, which was significant both generally and in respect of Child T. His vulnerabilities are considered further below.

3.3 Child T had a history of anxiety and low mood, along with an ADHD diagnosis when he was 12 years old. There was also understandable evidence of trauma for Child T due to the unrelated murder of one of his friends. ADHD and exploitation are linked themes which have been repeatedly highlighted in multi-agency exploitation audits in South Gloucestershire and were highlighted in the Thematic Cross Border CSPR completed in 2021. The social worker who knew Child T well said that his combination of ADHD and anxiety had an impact on his responses to others and that this increased his risk. After

[7] Serious youth violence and its relationship with adverse childhood experiences. Dr Paul Gray, Professor Hannah Smithson and Dr Deborah Jump. (November 2021)

initially taking ADHD medication, Child T decided against taking them due to the side effects. It is relevant that Child T had been permanently excluded from a mainstream school due to him assaulting another pupil. There were also concerns about his poor attendance at the time (33%) and the review understands this was largely due to his anxiety about school.

3.4 There was evidence that Child T could resort to violence if provoked, including an incident with a baseball bat when he was nine years old, and concerns about him possibly carrying a knife from the age of 13. There was a view at the time that he was mixing with a group of peers where violence and aggression was common. There is no evidence of abuse or neglect or criminality within his close family, but potential information about the wider family was not explored. When considering what is known about Child T, and some of his peers who professionals have also been concerned about, it seems that there is a need to ensure professional awareness that children who do not have a significant history of agency concern due to their own parenting may also get involved in serious youth violence. Those who knew Child T well, such as school staff, social workers, and youth justice workers, told the review that they would never have predicted that he would be killed in this way, as he appeared to be doing well and there had been no significant recent concerns. However, some ongoing risks were suspected in the months prior to the incident. This is considered further below.

3.5 There had been professional and family concern about Child T in 2021. He had been made the subject of a Multi-Agency Risk Management Plan (MARM) in May 2021 after he was arrested with a large knife in the company of individuals the police had serious concerns about. He was charged and convicted and received support from the Youth Justice Service as well as the Children's Social Care Exploitation Team, that he engaged with. His MARM plan ended in February 2022, as it was felt that the main aims of the plan had been met and the risk of further harm appeared to have reduced. Significantly, Child T was settled in his new alternative education setting and at home, he was reporting reduced cannabis use, and his CAMHS assessment was underway. Both those present and the chair of the MARM felt that a step down to Child in Need was appropriate. The new plan included the original safety plan, the social worker to remain involved and to continue to work with Child T to understand the risks of criminal exploitation, his curfew to continue, and the school to support Child T in bolstering his skills around conflict resolution and self-regulation.

3.6 It is stated that Child T and his mother engaged well with the child in need planning, which lasted until May 2022. It was reported that there was less evidence of any risk for Child T, few concerns, and little evidence of exploitation or crime. Child T did not come to the attention of the police or other agencies between 1.5.22 and 11.9.22. A serious incident in Bristol in September 2022 indicated that Child T may be carrying a weapon and may be involved in gang activity[8]. The response to these indicators is considered further below, including the difficulties of acting when there is no firm evidence of involvement, denial (or no comment) from the child and the fact that he was reported simultaneously to be more settled at home and at school.

[8] Child T's mother told the review that children living in the area can be labelled and assumptions made. She was clear at the time and remains clear, as was her son, that he was not involved in the serious incident in Bristol.

3.7 It is interesting to reflect on the impact on Child T of him being excluded from mainstream schooling and attending alternative provision. For the majority of children where there are concerns about SYV and/or exploitation, this is a negative situation that increases their risk of harm. For Child T, it appears that him being excluded from a mainstream school where his needs were not being met, to alternative provision where he settled and exceeded expectations this was positive. There is no evidence that he met other children who increased his risk of contextual harm at the new education setting, and he was able to remain and to sit some GCSEs. This was not the plan initially, as this should be a short time step before a move back to another school setting, but flexibility in the system ensured that Child T could remain in the setting that was so positive for him. This shows the importance of having alternative provisions that can be longer term for children whose needs are not met in mainstream school, but who have the ability to engage in a form of schooling and take exams or vocational courses.

The importance of identifying, sharing, and considering 'intelligence' about children involved in SYV and the difficulty in undertaking a robust assessment when new concerns emerge about a child where there have been previous indicators, without any **evidence** of their involvement in SYV.

3.8 The review was told that Child T was the first child in South Gloucestershire to be made the subject to a Multi-Agency Risk Management (MARM) plan, in May 2021. Prior to this, children at risk of exploitation were considered using child protection procedures and child protection conferences and plans, despite the harm not being attributable to the care they received from parents/ carers.[9] MARM meetings are held instead of child protection conferences, but they are similar in that they are chaired by a trained Child Protection Conference Chair / Independent Reviewing Officer, and a Business Support officer will attend and take notes. In between the three-month first review and subsequent six-month reviews, the multiagency meetings are recorded as child in need meetings, rather than core groups. They are held to share information and update the MARM plan.[10] The procedures clarify that 'the MARM meetings will share information; analyse risk; consider connectivity; explore push and pull factors; and to enable further actions for the child or young person to be decided. Within the meeting a MARM plan will be produced to include support of the young person and their family and disruption of perpetrators/ activities/ locations linked to exploitation. Consideration is also given as to whether a missing person's trigger plan is required and whether an NRM (National Referral Mechanism) referral should be made'. There is a view that while the initial MARM meetings include a confidential information sharing section and most of the professionals involved with a child attend, there is a need to improve engagement in review meetings and ensure there is a space for intelligence to be shared. It would be helpful to explore this issue further by undertaking a dip sample audit of the MARM review

[9] Procedures state – 'The Risk Management Pathway is a different approach which: • recognises the young person's vulnerabilities • recognises the seriousness of the situation and the need for a safeguarding response • does not place blame on the young person but recognises them as a victim • involves the young person and their family/ carers and builds on their strengths • provides a multi-agency response which is focused on support, disruption and which includes addressing the cause of the harm e.g. actions relating to a location or perpetrator.'

[10] There is currently frustration with limitations in Mosaic (the CSC database) because a MARM workflow has not yet been set up. This means the MARM gets written up as a word document and is then attached to Mosaic, with the need to flag records and open a child in need workflow. This means visits to children subject to a MARM plan would need to be recorded as a child in need visit. This is a process issue, not that the concerns are less than a child protection plan.

meetings to see whether this is a systemic vulnerability. A request has therefore been made for this to happen while the review is being undertaken.

3.9 When Child T's MARM plan then subsequent Child in Need support came to an end in May 2022, there was a view that Child T was more settled at home and educationally. He had been regularly attending alternative education provision from October 2021 and actively engaging with learning, and his mother was reporting improved behaviour at home. The Exploitation Identification Tool had been updated for Child T, which is good practice. He was assessed as low risk (tier three/green – for those where there may be limited or negligible risk of harm and who require monitoring for future incidents/intelligence.) Those who attended the CSPR practitioners meeting stated that there is a need for the tool to be updated to ensure it includes proper consideration of a child with special needs and the carrying of knives.

3.10 There is a process of information sharing and multi-agency[11] consideration of exploitation risk in South Gloucestershire, using the risk management pathway. Part of this is the Partnership Intelligence Management Meetings (PIMM) which are fortnightly meetings held virtually.[12] They are well attended and have multi-agency engagement. The meetings consider any new referrals where a child may be at risk of exploitation and updates are provided on children previously discussed. The level/tier of risk for each child is decided by the PIMM and there is an expectation that each agency in attendance feeds back to the relevant front-line services/professionals. The PIMM also considers contextual information and intelligence, such as locations and adults of concern, but most of their work focuses on individual and groups of children and their contexts, which is largely due to time and capacity and those professionals who sit on the PIMM. There is a limit to the consideration of a broader community safety context, which means the work is not truly contextual. The review has made a recommendation in respect of this.

3.11 The PIMM is felt to work well regarding information sharing and risk assessments about individual children. There is no issue with sharing information without consent in the PIMM setting, and this is expected. The South Gloucestershire PIMM now has a consistent and committed membership, and a group of professionals who work well together and share information effectively. They understand the local context and know most of the children they are considering well. This system was felt by professionals to be helpful and effective. This is particularly the case if they are allocated in the CSC exploitation service, less so for children allocated elsewhere within CSC. These can also be the most vulnerable children, if they have disabilities, if they are children in care or on a child protection plan.

3.12 It was reflected that processes for children at risk of harm from outside of the home in South Gloucestershire can be focused on children's services rather than the wider community safety context. The services and processes need to be considered and developed alongside the PIMM model, to ensure that the right people are 'around the table' with the required knowledge and skills / expertise, including those from voluntary and community organisations, and thinking in a more focused way about

[11] Community health, CSC, the sexual exploitation service, youth justice, education safeguarding lead, drug and alcohol services, early help, voluntary sector service providers and BASE (Barnardo's Against Sexual Exploitation.)
[12] They are held virtually to ensure maximum attendance.

those working in communities, such as GPs. Thinking wider and 'outwards' is required in this work. As is building professional relationships over time, to ensure shared purpose, ownership, and mutual responsibility. Other agencies such as CAMHS should also be involved.

3.13 It has been identified during the review that there is a systems wide issue with the understanding of what a MARM is. It also appears that it is not understood, or at best it is seen as reflecting a 'child in need' rather than a 'child protection' plan by some agencies. This is perhaps due to the terminology not immediately identifying them as statutory child protection plans for children where the risk is from outside of the home. Health agencies identified an issue with engagement with MARM processes, possibly because it is not recognised as a statutory process, and because it is not always easy to identify who from the wider health agencies needs to attend meetings, as the children tend to be older and not necessarily engaged with services. Identifying the right health[13] professional to take responsibility for the plan is therefore a challenge. It has also been identified that GP records, for example, do not identify these children by flags that there is a child protection plan when they have a MARM, and that there is an issue with CPIS alerts being flagged if a child on a MARM has an unscheduled attendance at a hospital. In Wiltshire the terminology used for this type of plan is clearer. The child who is currently being investigated for killing Child T was on a CP-ROTH plan at the time. This stands for 'child protection - risk outside the home'[14]. In Wiltshire and some of their neighbouring authorities, this is being promoted as equivalent to standard child protection planning but with a focus on contextual harm. DfE funding has been provided to them to support this way of working[15]. They told the review that the changes have been helpful for all agencies and for children and families regarding recognising the risks.

3.14 Despite the previous MARM and how well Child T was known to the PIMM, there was an issue with the lack of information sharing in respect of an incident in September 2022, where a number of young people were reported to be involved in an incident in Bristol with weapons. During the investigation into the incident, Child T was identified as a possible suspect in November 2022. There were delays in Police sharing information both internally and externally, with no BRAG being completed and submitted to the Lighthouse Safeguarding Unit and therefore no safeguarding referral was made at this point to South Gloucestershire CSC. This means that the PIMM did not consider the concerns until December 2022. This appears to be because of a delay in identifying the children involved. Other agencies became aware of this information in January 23 and when contact was made with Child T and his family, they did not want support from the exploitation service and said that they felt the situation was settled. As there was no evidence that Child T was involved in the incidents of concern, and both Child T and his mother were adamant that he was not involved[16], the families view on the offer of support was accepted. The threshold for intervention without consent was not justified.

[13] There is a wider issue with 'health' being seen as one agency rather than a complex system of different agencies/professions.
[14] In Wiltshire there is a separate category on their ICPC list that is CP- ROTH - with a clear Child Protection Plan status.
[15] https://www.wiltshire.gov.uk/article/5656/Wiltshire-Council-leads-new-regional-drive-to-help-increase-young-people-s-safety-outside-the-home
[16] Mother said Child T was not on the CCTV, and no professional who knew him (for example someone from his education provision) was asked to view the CCTV to confirm this.

While it is essential to consider the wider context of a child's life outside of their family when there are concerns about extra-familial harm, it is also important that those working with a child understand the child's family and history and engage with all significant adults.

3.15 In recent years there has been a shift, locally and nationally, from a family focused system of risk assessment and management when it comes to children at risk of exploitation or serious youth violence, to an extra-familial system. This is due to the understanding that the harm to a young person can come from a wider context and the influence of peer group and/or external relationships. Professionals had a good relationship with his mother, and to a lesser degree his stepfather, who lived with Child T and was involved in his day-to-day care and support. It was acknowledged that less was known about his father, who was not often seen by professionals. This was despite Child T spending a lot of time in his father's care throughout his childhood. Mother told the review that her ex-partner found speaking to professionals difficult and that he preferred her to do this. There was no evidence that this was questioned, but there were some attempts to ensure his meaningful engagement in plans. The social worker met him several times, but this took persistence and taking the opportunity to 'pop in', rather than as part of any plan for Child T. Although he is not mentioned much in written reports, Child T's mother's partner was also known by professionals and believed to be an important person in Child T's life who needed to be engaged to safeguard Child T. He was known to most of the professionals working with Child T, including the school. The review has found however that it was effectively Mother who was seen by professionals as the key person to engage in respect of communications about Child T. The 2022 CSPR called Family A made a recommendation that the SGSCP must make 'including fathers[17] as equal parents' a priority for 2023 onwards, as it was shown in that review, and to an extent when considering Child T, that truly understanding the child's history, their lived experience and making plans to safeguard them includes a need to fully understand and work with the key adults in their life.

3.16 Those involved acknowledged that the focus with Child T, as with other young people known to the exploitation service, was on extrafamilial harm. While this practice does not appear to have missed any significant risk factors within Child T's immediate family, there was limited consideration of his wider family. A system that focuses entirely on extra-familial harm is vulnerable as many children who are victims or perpetrators of knife crime may also have risks within their homes. For most of the children in the cross-border CSPR, home was not a protective environment, with known backgrounds of domestic and physical abuse, neglect, and parental criminality. Those involved with Child T reflected that there was a need for more focus in many contextual cases on issues within the home and family as well as outside the home.

There is a need to consider the effectiveness of responses to National Referral Mechanism (NRM) referrals, to ensure that they are a joined-up part of the wider plan for a child where SYV is a concern. (It is acknowledged this is a national issue and changes are being considered.)

3.17 An NRM referral was made in respect of Child T in 2021, as is expected practice when a child is known to have been carrying a weapon, as there is a need to consider if exploitation is an issue for the child.

[17] Or a non-birthing parent in a same sex relationship

The NRM is a framework for 'identifying and referring potential victims of modern slavery' and 'ensuring victims receive the appropriate support'. It is used in cases where there may be criminal exploitation, but it was never designed for this purpose. Where a professional suspects that a child has 'been trafficked or moved from one location to another for the purpose of exploitation,' they should be referred. The reason for using the NRM for children involved in County Lines evolved because of the recognition that they were not necessarily criminals, but were likely to be victims of exploitation, and possibly trafficking - a form of modern-day slavery. It is acknowledged nationally that the NRM system is under pressure from the increase in referrals due to this shift, and that a specific criminal exploitation referral process for UK born children would be more helpful. New Guidance was introduced this year in relation to Modern Slavery, which includes a big section on criminal exploitation and children and young people. It states that local authorities must complete a maturity matrix to identify areas for improvement to ensure they are meeting their statutory responsibilities. Community Safety Teams are responsible for that assessment and where there are gaps an action plan will be agreed. This is currently being completed in South Gloucestershire. Early anecdotal findings are that the take up for Modern Slavery training is poor, despite it being mandatory for all staff.

3.18 In Child T's case there was a one-off visit from a uniformed police officer[18] after the referral was made, which Child T did not understand or engage with. Child T told his social worker that he thought he was being recorded by the officer and that the questions being asked were a repeat of what his social worker had already asked him. His mother confirmed this. Those who knew Child T well felt this was a missed opportunity to provide focused support, and that if it had been coordinated with the assistance of the wider team around Child T at the time, it might have had an impact. It is possible that the officer undertaking the visit was not clear exactly how the concerns about Child T met the criteria, and what was required from the visit. The opportunity to use this process to avoid Child T being criminalised in 2021, rather than being seen as a potential victim of exploitation, was therefore missed.

Drill music available on-line, can provide information to professionals where there are concerns about children involved in SYV. It needs to be monitored, taken seriously and transparently discussed with the children known to be involved in this music scene and those at risk of involvement in SYV.

3.19 The professionals involved and the South Gloucestershire PIMM were aware that Child T and his friends were interested in and involved with Drill music, with Child T emerging as a popular drill artist on You Tube. The PIMM considered the added risk due to this, including taking advice from a specialist team within the Metropolitan Police. Drill music originated in the USA and emerged in the UK in about 2012, largely in disadvantaged inner-city areas. Many Drill artists, including Child T, cover their faces in their videos, and the lyrics often refer to knives, guns, gang violence and drugs. In 2018 the Metropolitan Police 'singled out Drill music videos for fuelling the surge of violence in London'.[19] It is often used when prosecuting young people, and there is research from The University of Manchester's

[18] The review was told that local practice has improved in respect of NRM interviews with children at risk of exploitation since Child T was visited in 2021. They are now undertaken by the violence reduction partnership, not uniformed police officers.
[19] Children's Society 2021

Prosecuting Rap project which found rap evidence, lyrics and music videos were used between 2020-23 in more than 70 criminal trials.

3.20 However, there is also some evidence that Drill music can heighten aggression between young people and be used to single out individuals who are then victimised. The Metropolitan Police's statement in 2018 was followed by an outcry of concern that Drill music is being wrongly used as evidence in court against young black men.[20] Drill artists argue that the music is a 'form of creative escapism from the violence that surrounds young people, a reflection of their reality'. Those working closely with these children state that criminalising Drill is unlikely to reduce violence, and that there is a need to address the root causes of violence such as poverty and deprivation, childhood trauma, school exclusions and closure of resources such as youth clubs. This is important to consider, as there is a history of drill artists being victims of violent crime.

3.21 Child T's mother told the review that she thought it was better that he was spending his time in a recording studio rather than on the street, and that he was using the money he earned in a part time job to buy studio time. She thought that her watching the videos was a protective factor, but she now acknowledges that she was not aware of a lot of the language used and what the implications might be in respect of Child T becoming a target for violence due to the serious threats he made in his music. She would like to see the parents of children who are Drill artists being educated about this issue. This would be good practice. In the case of Child T's Mother, her being aware of his music and a belief that she was protective, led to professionals being over optimistic about this as a safety factor for Child T.

3.22 During the rapid review it emerged that Avon and Somerset Police are no longer resourcing a service that interprets Drill music to enable identification of children who require support and may be a risk of extra-familial harm. This is a significant loss and those involved in the review felt it would negatively impact on information sharing about risk to a particularly vulnerable cohort of young people. However there has been a recent (November 2023) Avon and Somerset wide meeting on Drill music that considered both intelligence and some of the wider risks, but on a case-by-case basis local officers need to take advice from the Metropolitan Police to analysis Drill music content.

3.23 The government have addressed the issue about Drill music that is available on You Tube and other such channels, stating in 2021 that they 'expect social media companies to proactively remove harmful content and take steps to prevent it from being uploaded.' They highlighted that the 2023 Online Safety Bill includes 'priority offences for content that incites violence and threats to kill.' It is not yet known what impact this will have, and how partner agencies need to respond.

3.24 It is possible that Child T's profile as a Drill artist may have been a factor in what happened on the evening he died. This identifies learning for professionals about needing to take seriously the significance of Drill when thinking about the risk to a child in respect of SYV.

[20] It is also noted that there is an ongoing discussion about institutional racism within the Metropolitan Police service.

Difficulty in knowing and understanding the child's lived experience when they are involved in SYV.

3.25 Those involved with Child T over the two years prior to his death were shocked and perplexed that he was in a situation where he was stabbed, and that he may have been carrying a knife himself. This was despite knowledge that he had carried a knife in the past. His mother told the review that he had explained to her that he felt vulnerable without one, and that knife carrying was very common amongst his peers. This was not shared with professionals at the time. The 2020 National CSPR 'It was hard to escape' heard that the children they considered felt that carrying a knife was for their personal safety, which 'outweighed any other risk or consequence'. Some of the children, like Child T, had received support and education in this area. Child T's known anxiety and, in some contexts his low anger threshold, put him at particular risk of harm from SYV. On other occasions he showed restraint and the ability to manage difficult situations. Individual social work support and input from the YJS worked with him on the risks and challenge about knife carrying. There was a genuine belief in his family and among the professionals involved about Child T's behaviour having changed in respect of carrying a weapon and being involved with those where the risk of violence was higher.

3.26 The national CSPR also found that it was very hard for professionals or even family members to establish the daily lived experience of a child who was at risk of exploitation or serious violence from their peers, which means that 'ascertaining the level of risk and the management of that risk was difficult'. The children were described as guarded and protecting others by not telling practitioners what was happening in their lives. Despite most of the children being described as bright, respectful, likeable, and warm, they only engaged with professionals on a superficial level. Child T's social worker confirmed this was the case with Child T and his peers. The social workers experience is that they often find out what children are involved in from other children rather than the child themselves. It is not clear how active Child T was in a gang, he told his mother that he had no real choice about being affiliated to the gang for his postcode, as he would likely be labelled anyway and was therefore a gang member by association. This risk needed to be known and considered by professionals.

3.27 In the months leading to Child T's death there were indicators that there might be more things to worry about than were overtly known to the family or to professionals. Child T reassured his parents and teachers about what was going on in his life, even with 'rumours' and 'potential sightings' of Child with weapons, stealing bikes and having difficulties with gangs in Bristol. It was agreed by the professionals involved with him at the time that the stakes were not particularly high, and it does seem to be the case that another child was wrongly identified as Child T on at least one occasion. In March 2023 a brick was thrown through the window of the family home, there was intelligence shared at PIMM that Child T's phone number may be linked to County Lines,[21] and that he may have been involved in the theft of a motorbike. Neither of these issues have ever been confirmed and were likely not the case. Mother was reassured by Child T that the concerns were exaggerated, and because he was well behaved

[21] Where illegal drugs are transported from one area to another, often across police and local authority boundaries, usually by children or vulnerable people who are coerced into it by gangs.

when spending time at home, and had engaged well at school, there was no consent given for a further assessment by the CSC Exploitation Team.

3.28 Professionals told the review that the risk was generally thought to be relatively low at the time, or at least was hard to quantify. Neither professionals nor his parents were overly concerned, and this means there was no pressure put on Child T or his family for further involvement from children's social care. The social worker who knew Child T and his family well was off sick at the time, and so it was not possible to use this relationship to persuade the family that an intervention was required. There does not appear to have been consideration of whether there was anyone in the wider network, who had a good relationship with Child T, such as the youth justice worker, undertaking the visit to assess the risk and encourage the family to allow some additional and focused work to be undertaken with Child T. Given Child T's history and the previous risks, the opportunity to robustly consider if there was in fact enough of a concern at the time to try again to persuade Child T and his family to engage would have been warranted. Considering a chronology at this stage would also have been helpful, to see the more recent concerns in the context of the past risks.

3.29 When consent isn't provided, this can limit professional contact with a child. This is often the case when a child does not identify themselves as a victim or at risk due of exploitation. However, their lack of consent does not stop information sharing during the PIMM. It was clear to all who knew Child T and who work in the PIMM, that there was no evidence available that would have warranted a strategy meeting and a MARM at the time (both of which can be held regardless of consent). It is still not known if Child T was involved in the incidents, although there is a view he may well have been.

3.30 The 2021 CSPR which was jointly commissioned by the Keeping Bristol Safe Partnership, South Gloucestershire Children's Partnership and the North Somerset Safeguarding Children Partnership, was in respect of eight young people impacted by peer-on-peer abuse and knife crime. Like Child T, the subjects of the reviews were known by professionals to carry knives. They were also receiving education through alternative provision. What was different however, was that attending such a school was felt to be a positive for Child T. He was 'seen' daily and was doing far better both in respect of his attendance/engagement and academically, than he had been in mainstream schooling. At the time of his death Child T had started to take some GCSE exams. The professionals who work within and alongside the alternative provision speak positively of the service and it appears to be the case that it does not have the negative reputation of some pupil referral units elsewhere. (These types of provisions were highlighted as a potential risk for exploitation in the national review.) Child T's parents spoke very highly of the support and attention Child T received at the school and they felt it had 'saved his education', as there was no way that he would have thrived in mainstream schooling.

3.31 Locally and nationally, there are very few positive education provisions for children who, like Child T, cannot be maintained in a mainstream secondary school. It is unusual that a child can remain in a provision like Child T did beyond an assessment period, and those involved worked hard to ensure he was able to stay until he had completed his GCSEs. This was child centred and met Child T's needs beyond the needs of the service. There was good support for Child T at school regarding planning for

his future, that would not have been available in mainstream schooling. He met the careers advisor around 20 times and had plans for the future. This was just one example of professionals going above and beyond to support Child T. All involved felt he was on a positive trajectory with his education and were relatively optimistic about his future because of this indicator.

3.32 It is essential that professionals consider the impact of social media on the lives of young people. As identified in the rapid review meetings and confirmed by the professionals working in this area, what is known about a child or groups of children in a community and the risk to them can change swiftly due to social media. Social media also means that there are far more links across boundaries than there ever were previously – young people are friends with young people who they met via social media in different areas to where they live. This is extremely challenging for professionals.

3.33 Beyond consideration of Child T's case, it is important to consider the wider picture to have an impact on SYV. Statistics form the Youth Crime Survey show that knife carrying among young people is at a higher level than ever known before. This shows there is an urgent need for agencies to consider wider and longer-term preventative responses. The Violence Reduction Partnership (VRP) in South Gloucestershire and the wider Avon and Somerset strategic VRP must be enabled to undertake this work, which must then be used to make a difference in individual cases in a timely way. Consideration should also be given to how the Avon and Somerset VRP can work with areas outside of the area, including Wiltshire.

3.34 This remains a much-needed priority as the review was told that since Child T's murder there have been two further incidents of a child stabbing another child in the local authority area. They are not linked to each other or related to Child T's death but is an indicator of the high incidence of knife carrying.

There is a need for a clear and effective serious incident response which can be used out of hours.

3.35 Child T was killed late on a Saturday night, and mobile phone footage was being circulated almost immediately, including among children. There was a need to ensure that a plan was in place immediately that considered all factors. Those professionals who knew Child T were not convinced that the response from the early hours of Sunday morning was robust and told the review about how they largely heard of this death informally and were concerned about what was happening over the rest of the weekend. This was partly due to confusion about where Child T was from, and which local authority had responsibility for him. It was undoubtedly a complex matter for agencies to deal with, as there were over 45 children that were considered as significant witnesses from at least five local authority areas. In the days that followed the death a number of multi-agency meetings were held, including a complex strategy meeting chaired by Bath and Northeast Somerset (BANES), where the incident took place, a Police Force briefing of partners held specifically to manage repercussions, and a Risk Management Meeting, also in BANES.

3.36 South Gloucestershire coordinated a Rapid Review meeting[22], where several shortcomings in the response were identified. Included was the continued need for the establishment of cross-border forums to increase the effectiveness of joint working – as was raised within the 2021 Cross-Border CSPR Thematic on Serious Violence but has not yet been progressed and remains outstanding. Concerns were identified prior to and at the rapid review meeting about the attendance of key agencies at the meetings held in respect of the incident. A need was identified for each local authority area to have a named allocated individual to be responsible for coordinating information sharing and ensuring the required attendance at meetings. Along with using a Complex Abuse procedure in respect of the individual children involved, a serious incident response protocol is required - the latter should consider issues such as information sharing with schools and communities. Schools were essential partners with a role in supporting children at a very distressing time, as are child mental health professionals. This required coordinating immediately, and the need to include education in any information sharing and meetings held is reinforced by this review.

3.37 The CSPR was told that work is being undertaken to shore up plans that can be put into action immediately following a serious incident. A piece of work is being led by the Office of the Police and Crime Commissioner (OPCC) with the aim of a bespoke local process to guide the required responses to any future significant incidents. The review was assured that there has been a robust cross boundary, multi-agency response regarding potential retribution/ community tensions arising from Child T's murder, to avoid further incidents of serious violence for young people across a wide area, using a toolkit borrowed from the London Safeguarding Children Procedures.

3.38 There is a need to support children, families, communities, and staff after a serious incident. All agencies need to ensure they recognise the impact on professionals who have worked closely with a child when they die in unexpected and traumatic circumstances and should ensure that timely and specialist counselling is in place. Those involved with Child T spoke about the positives they gained from supporting each other but felt that better organisational ownership was required. A trauma informed supervision offer is also required for professionals especially those who may have worked directly with a child that dies unexpectedly.

3.39 This review has not considered in any detail if there is learning in respect of professional involvement with the family where the party was held. They were well known to services and the day before the party the allocated social worker for the children had shared concerns with neighbourhood police about the planned party. Avon and Somerset Police told the review that this intelligence was handled in accordance with policy and the police would have had no legal powers to take action to prevent the party from taking place or otherwise intervening based on the intelligence. In addition, the demands on neighbourhood policing teams mean any expectations of them intervening are unrealistic. However, the relevant local safeguarding partnership is considering whether there was robust practice in respect of indicators that the address was potentially being used to harbour missing young people, including one of the boys convicted of killing Child T.

[22] Chapter 4 Working Together 2018.

The relevant wider context:

3.40 The Serious Violence Strategy was published in 2018 following national increases in youth knife crime, with the aim of tackling youth public space violence. This led to the development of Home Office funded Violence Reduction Units (VRUs) including one in Avon and Somerset, and in respect of the five Local Authority areas they cover. The VRUs aimed to ensure that partners collaborated to deliver a public health response to tackling SYV. The review has found that the arrangements for delivery were complex and complicated. The Government then launched a Serious Violence Duty (SVD)[23] in January 2023, which requires each area to undertake a needs assessment, with a public health approach, that targets resources to where it is most needed. There is a requirement to have a local Serious Violence Strategy by January 2024, which is in the process of being written.

3.41 The Avon and Somerset VRU was reviewed independently in 2023 and the draft findings (as yet unpublished) are that governance arrangements require improved oversight and scrutiny, and leadership, that a strong and sustainable long-term strategic commissioning model is needed to deliver statutory duties, more consistency and efficiency is required across the police force areas so that the work is joined-up, with improved monitoring and evaluation to ensure impact is known. (The Home Office 'What Works?' expectations.) A new local VRP Board has very recently been established to fulfil this role with representation at an executive level across the five local authorities. It is essential that this Board is effective and uses the opportunity to ensure positive outcomes on a case-by-case basis.

3.42 While there is a plan in place to ensure more consistency in Avon and Somerset, it is acknowledged that the cross-border issues for this review were wider, with Wiltshire being particularly key. Wiltshire told the review that at the time of the incident their focus was on identified child exploitation issues occurring between Wiltshire, Devon, and Cornwall. This shows the limitations of consistent practice in police force areas when children's lives can include connections and links with those from outside of the area. Resource limitations mean that the focus tends to be on the most pressing known cross border issues at any time. For children a local authority or police area boundary is meaningless. This issue requires further review, as the review was told that the Topaz team (the police exploitation disruption team covering BANES, Bristol and South Gloucestershire) no longer holds monthly multi-agency meetings to discuss their investigations, intelligence relating to potential victims, locations and perpetrators across the three areas. The review also considered challenges currently in how information about lesser-known children who are at risk of getting more involved, and those who are seen as being medium to low risk, is shared. Child T's case shows that things can change very quickly, with violence escalating, resulting in a tragic outcome.

Learning specific to agencies in Bournemouth, Christchurch and Poole and Wiltshire

3.43 Two children who live in Wiltshire have been convicted in respect of Child T's death. One of them was charged later, and towards the end of this review being completed. The Wiltshire Safeguarding People Partnership have undertaken local learning reviews for both boys. They have identified learning in

[23] 'Introduced as part of the Police Crime Sentencing and Courts Act 2022, the SVD requires specified authorities to work together to prevent and reduce serious violence in their local area. This Duty is supported by national guidance, finalised in December 2022, which balances prescriptive expectations with room for flexibility'.

respect of what was known about the children and the services involved with them prior to Child T's death, in the following areas:

- Early and targeted support to prevent exclusion from school, and where there are concerns about poor attendance and poor engagement by parents with agencies.
- Additional management oversight before closure of a case to the young peoples' services where parents are refusing to engage.
- Impact of neurodiversity and impairment of executive functioning behaviour.

3.44 The other child convicted for the death of Child T is the responsibility of Bournemouth, Christchurch and Poole, and is a child in the care of that Local Authority. A local event was held with practitioners involved with the child and learning has been identified by local partner agencies in the following areas:

- The difficulty in balancing the best interests of the child with their wishes and feelings, and the need to consider risk in these circumstances.
- The wider challenge of finding suitable, good quality, placements for children who are the most vulnerable to SYV, including secure placements. This includes the provision of education.
- The need for face-to-face[24] multiagency meetings to ensure information sharing, ownership and oversight of children at risk for SYV.
- Impact of the child's race and heritage.
- Need for improvements in the timeliness of EHCPs (education health and care plans).
- The importance of managerial support and the need to listen to those who know the child.
- Social care staff needed support and advice from mental health professionals when planning for a child.
- Cross border working, information sharing and clarity of 'ownership' when a child in care is placed outside of the responsible area.

3.43 Recommendations have been made, and actions are being monitored by the local Partnerships.

4. Conclusion and recommendations

4.1 In June 2023 a report was published by the Open Innovation Team on the role of systems of support in serious youth violence. The key themes they identified were: 'The drivers of violence are complex, so it's hard to evidence solutions. Stigmatisation is part of many children's journeys to violence. Positive relationships with practitioners can protect against violence. Limited resources mean that some children and young people don't access the right support in time to prevent violence. It would be helpful for the report to be considered further by the partnership to guide their on-going journey in this difficult area of practice. Child T's outcome shows that despite multiagency working, the risk associated with carrying knives was not impacted.

4.2 The review also shows the need to improve cross-border communication and information sharing.

[24] Practitioners fed back that they would like less meetings to be held virtually generally, especially those that require the child and family to be present.

4.3 The SGCP has acknowledged that the learning from the thematic CSPR have not led to the hoped for improvements. There is, therefore, a need to ensure that the learning from this CSPR, alongside the PIMM review and the development of the Violence Reduction Partnership locally and across the region have a positive impact on those at risk of SYV.

4.4 Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans.

4.5 Having considered the learning, the following recommendations are made with the aim of ensuring that the required improvement actions are achieved:

Recommendation 1

The Partnership to ensure that a local critical incident plan is developed, with other partnerships in Avon and Somerset, using this case to inform its development. Those involved at the time should be consulted to ensure that their experience in the days following Child T's death is heard.

Recommendation 2

That the National CSPR Panel requests that the correct government department/s consider the need for a national standard operational procedure for responding to a critical incident.

Recommendation 3

The partnership to request that the current status and terminology of MARM is changed to Child Protection Plan – Risk Outside of the Home (CP-ROTH) and their expectation that all relevant processes reflect this change and provide clarity that these children are subjects of statutory child protection planning. There should be a discussion with the other partnerships in the Avon and Somerset area to request that this is also implemented across the three local authority areas.

Recommendation 4

That assurance is provided to the Partnership about the outcome of the PIMM review, as part of the wider independent review of the Risk Management Pathway, to include an update on capacity, membership, remit, and focus. This should include assurance on how wider contextual safeguarding is being considered in South Gloucestershire in respect of exploitation and SYV.

Recommendation 5

The Partnership to request that partner agencies consider how they will support staff to ensure that child victims of exploitation are prevented from being 'criminalised'. This should include improved promotion of and uptake of the current training offer for awareness of modern slavery, including the National Referral Mechanism which is essential to front line staff who may encounter children at risk of exploitation.

Recommendation 6

That the partnership seek assurance in respect of the development of the work of the Violence Reduction Partnership (VRP) in South Gloucestershire and the wider Avon and Somerset VRP in respect of their response of serious youth violence. This should include:

- Consideration given to how information on specific children, including investigations, intelligence, locations, and perpetrators is shared regularly across the five Avon and Somerset areas.
- Consideration given by the Pan Avon and Somerset Needs Assessment for SYV to the importance of working with and sharing information with areas outside of Avon and Somerset, including Wiltshire.
- Consideration of the impact of the Online Safety Bill 2023 across the system.

Consideration should be given to how the partnership can receive updates regularly on the effectiveness of new arrangements.