Rapid Document Review

PraxisCollab

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Kelly Bracewell, Tessa Horvath, Kim Detjen and Sarah Priest

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Introduction

PraxisCollab has been commissioned by The Children's Society to review the governance and co-ordination of child safeguarding arrangements in London, to clarify the partnership's future role in supporting effective safeguarding practice. The Children's Society will be undertaking a range of activities to build on this work and any identified gaps in knowledge.

This rapid review will examine current safeguarding arrangements under The Mayor's Office for Policing and Crime (MOPAC) and how they function in relation to statutory responsibilities in the Children and Social Work Act 2017. It will review MOPAC's current role in frontline Safeguarding of children and young people (CYP) in London and make recommendations for creating more effective local safeguarding arrangements.

The research team would like to thank Kelly Lewisham and her team for their support throughout the process of this review.

Availability of evidence

The Children's Society gathered the most relevant and up to date policies, guidance, child safeguarding practice reviews, protocols, strategies, action plans, reports and minutes from multi-agency boards, committees and meetings. These documents were shared with the research team to offer an overview of the child safeguarding priorities for individual boroughs across London; information on safeguarding arrangements and implementation approaches; and an overview of content of committee or multi-agency meetings.[1] Further documents were beyond the scope the review, given the time available. Boroughs identified as a priority have been included in the review. This is not to say that there is not wider learning from the remaining boroughs and further information should be collected in the next research phase.

It is clear from staff notes within the handover that policies were not always clearly visible or readily available across the London boroughs. Further difficulties were encountered by the research team due to the varying quality of and inconsistencies between documents, such as documents and policies without dates or names detailed in minutes to note attendance but without the corresponding organisation or role. Such issues created complications in identifying relevance, timing, presence and contribution.

[1] A full list of documents included in this review can be found in Appendix 1

Many of the documents were repetitive and provided similar information. A more in-depth review using more detailed information would be helpful. This could explore areas of duplication and propose potential improvements effectiveness.

In this review, we present an analysis of relevant documents and key themes surrounding child safeguarding arrangements, highlight areas which require further investigation, and set out potential recommendations for improvements.

Background and context

Documentary evidence highlights the challenges experienced by people living in London, including high rates of crime, poverty and deprivation. *Violence in London: what we know and how to respond*[2] shows a 73% increase in rates of police-recorded sexual assaults in London since 2014[3]. However, analysis by MOPAC suggests these increases are largely driven by improved recording practices since 2014[4]. There are also ongoing concerns around youth-related knife crime and gang violence. Within this context, local authorities and services across criminal justice, health and social care within statutory and non-statutory sectors have been under acute financial pressure and austerity measures, including services for CYP.[5]

However, there have been positive reports of funding and new initiatives. For example, Sutton Council[6] has secured pan-London funding for two years from the Ministry of Housing, Communities and Local Government to help local authorities improve their use of data to better plan services for vulnerable children and families. This Data Accelerator Fund aims to enable councils in London to work more closely with police forces, local NHS services and schools to collectively review how they use information to commission services that ensure children and families receive the most effective help and services.

At the time of writing, Coronavirus (Covid-19) remains a serious health risk. Services, communities, families and individuals have been affected by the pandemic since early 2020 and England has experienced various lockdowns and changing government guidance for over 18 months. Discussions concerning Violence against Women and Girls (VAWG) have been prominent during this time,

[2] Wieshmann et al., 2020
[3] London Violence Reduction Unit Strategy Appendix 1
[4] https://www.london.gov.uk/moderngovmb/documents/s64359/Appendix%201%20-%20VRU%20Strategy.pdf
[5] London Violence Reduction Unit Strategy, Appendix 1 for example
[6] https://www.socialworktoday.co.uk/News/London-authorities-win-bid-on-new-data-project-for-vulnerable-children-and-families

particularly the impact of Covid-19 and domestic violence and abuse (DVA). There have been high profile media reports surrounding the murders of Sabina Nessa and Sarah Everard, and the death of 5-year-old Aijah Thomas. This context is important when reflecting on existing structures, procedures and arrangements across London.

1. MOPAC roles and responsibilities

This review uses available evidence to define MOPAC's role and responsibilities within the context of the current safeguarding children statutory arrangements. These arrangements are separate from but connect to the roles and responsibilities of the Metropolitan Police Service (MPS). The MPS are responsible for public protection across the 32 London boroughs, including responsibility for vulnerable and/or exploited children. We attempt to distinguish between MOPAC and the Mayor's Violence Reduction Unit (VRU), however, there often appears to be a blurring of their roles and responsibilities. As such, we will be guided by the relevant document and have not delineated the differences as we understand them.

The VRU was established in 2019 in response to increasing levels of violence in London,[7] and comprises a team of specialists appointed by the Mayor of London to reduce violence and increase safety. This team requires an understanding of local communities, the underlying causes and complexities of violence and the agencies working to address these issues through intervention and prevention[8]. The London VRU Strategy promotes a public health approach to reducing violence and considers the context and influences that impact on individuals at significant points in their life (e.g. unemployment, violence, abuse, marginalisation, inadequate housing). This approach is reflected in some of the available documents from individual boroughs (e.g. Islington, Lambeth).

To illustrate this developing context, responsibility for overseeing and supporting the development of Knife Crime action plans moved from MOPAC to the VRU from April 2019. The VRU, MPS and London Councils continue to support London boroughs to develop and embed their action plans to tackle knife crime and violence, learning from practice identified through the VRU and elsewhere and adapting this to best suit local need.

The strategies and protocols reviewed indicate that MOPAC undertakes a range of activities, including:

Research and data collection

Providing funding for projects and programmes

Promoting multi-agency working

[7] It is modelled on the Glasgow model, see http://www.svru.co.uk/ for further information
[8] https://www.london.gov.uk/content/londons-violence-reduction-unit

Research and data collection

MOPAC appears to undertake research activities both in-house and by commissioning external research[9]. The VRU is also noted as providing partners with resources to enable research, analysis and evaluation. However, there is little mention of MOPAC in local borough documentation beyond data collection, which makes it difficult to provide in-depth detail. For instance, both The Croydon Thematic Review and documentation from Kingston and Richmond highlight MOPAC's role in providing data, but there is little additional evidence. Further clarity about these activities would be beneficial to ensure that MOPAC's role in research and data collection is utilised to its full potential. It is difficult to evidence the effectiveness of this work using the available literature.

Funding projects and programmes

Since 2014/15, MOPAC has contributed funding to support safeguarding arrangements in London. This funding is intended to:

1. support the running of safeguarding partnerships at the local level by contributing funding directly to boroughs.
2. assist London Councils to coordinate the pan-London Safeguarding Children Partnership and maintain London's Child Protection Procedures.

MOPAC also has responsibility for commissioning non-statutory services to support victims of crime, which provides an opportunity to deliver or enhance appropriate service provision. However, the documents indicate that this funding is limited.

- At a local level, MOPAC is mentioned in the Redbridge Local Safeguarding Children Board Annual report 2018/19 and the Redbridge Safeguarding Children Partnership Annual Scrutiny Report 2019/20. Both reports acknowledge MOPAC's financial contribution of £5000 but suggest that this is a disproportionately low contribution - 45% lower per head than the police contribution in other large urban police forces in England. Projects mentioned in the Safer Redbridge Neighbourhood Board minutes include: Victim Support; One Place East Training Stars - raising awareness of disability in schools; and promoting opportunities to apply for funding from MOPAC to Board members.

[9] For example, see Wieshmann et al., (2020).

- MOPAC is also mentioned as a funder for a number of services under the Safer Lambeth Partnership: the gang violence reduction team, integrated offender management service, the Beth Centre for female offenders, and to address the shortfall in violence against women work. MOPAC is mentioned in annual reports as a funder to Children's Services, again contributing £5000. A further 3-year, consortium-led project (Rescue and Response for CYP affected by county lines) does not provide funding details.
- A new serious youth violence and knife crime reduction project in Kingston and Richmond (Project X) was noted as having VRU funding but both the amount and whether this is the same pot of MOPAC funding as those identified above are unclear.

Given that contributions appear small, interviews might wish to investigate the sustainability of interventions which access this funding, given that it is highly likely that organisations are picking up the remaining costs. Further, in-kind contributions or added value of MOPAC and the VRU could also be investigated.

Promoting multi-agency working

Multi-agency working is key to safeguarding and preventing violence. There was emphasis on the importance of collaborative or partnership working across the documents reviewed. Multi-agency working should operate between MOPAC, local authorities, and frontline staff delivering services and interventions. Accountability for multi-agency safeguarding arrangements rests with local safeguarding children's partnerships. The Lead Responsible Officer and Commander from the MPS ensure that other professionals are involved in the Strategic Governance Board, which drives an agreed approach to safeguarding.

It is not possible to determine if or how often MOPAC attends safeguarding boards and partner agency meetings or contributes to decision-making processes. For example, the Safer Redbridge Neighbourhood Board meetings report on MOPAC projects, but MOPAC are unable to regularly attend. In contrast, the Safer Lambeth Partnership Executive appears to include representatives from MOPAC (note: this Partnership is broader than child safeguarding. It includes violence against CYP as a key strand). The Croydon Thematic Review mentions that the VRU will improve coordination between agencies and consider violent crime to be a public health issue. This is illustrative of the blurring between MOPAC and the VRU.

Visibility of MOPAC in borough documents

In addition to the examples above, at borough level, MOPAC was mentioned in the Newham Community Safety Partnership Plan and the Community Safety Partnership Strategic Assessment when providing data and to confirm that the new local community safety plans were aligned with the new MOPAC priorities: *'Ensuring strong links and local delivery of Mayor's Office for Policing and Crime (MOPAC) Police and Crime Plan'* is a key priority in the Safer Redbridge Plan. There is also evidence that the Safer Redbridge Board membership is informed by MOPAC guidance: *This membership takes into account MOPAC's guidance on the involvement of IAG, Stop & Search, ICV, victim's representation, input from Ward panels, and involvement of young people.*[10]

The Safer Lambeth Partnership cites its duty to cooperate with MOPAC: '*There is a reciprocal duty to cooperate with the police and crime commissioner (MOPAC, in London)'.* However, it is unclear what this means in practice. The Kingston and Richmond Youth Safety Strategy 2021-25 mentions that there is a requirement from the VRU and MOPAC for every London borough to have a serious violence reduction plan. It would be helpful to explore the role that the VRU and MOPAC have in relation to supporting and monitoring this requirement in further qualitative data collection.

In contrast, for other boroughs such as Islington and Greenwich, there is no reference to MOPAC in the available documents. The role of MOPAC and/or the VRU is therefore unclear in the implementation of their approach.

Key points

- There often appears to be a blurring of MOPAC and VRU roles and responsibilities.
- The London VRU Strategy promotes a public health approach to reducing violence and considers the context and influences that impact on individuals at significant points in their life. This approach is reflected in some of the available documents.
- The strategies and protocols reviewed indicate that MOPAC undertakes a range of activities, including: research and data collection; funding projects and programmes; and promoting multi-agency working. Further clarity about these activities and their effectiveness and sustainability would be beneficial. In-kind contributions or added value of MOPAC and the VRU could also be investigated.
- The visibility of MOPAC and the VRU across the documents reviewed is varied. Therefore the role of MOPAC and/or the VRU is unclear in the implementation of their approach.

[10] Safer Neighbourhood Board Minutes Oct 2019

- There is a requirement from the VRU and MOPAC for every London borough to have a serious violence reduction plan. It would be helpful to explore their role in relation to supporting and monitoring this requirement in further qualitative data collection.

2. Recent changes in policy and legislation

CYP are a protected group with specific vulnerabilities. Their treatment is governed by domestic legislation and by the UN Convention on the Rights of the Child (UNCRC) which the UK has signed and ratified. Everyone who works with CYP has a responsibility for keeping them safe. This means they have a role to play in identifying concerns about a child's safety and wellbeing, sharing information and taking prompt action when it is needed to protect a child. As part of our review, we sought to investigate any application of recent changes in policy and legislation. Notably, we recognise that updated procedures and guidance (e.g. around information sharing) may be in the process of being prepared but may have been unavailable at the time of this review. It has not been possible to distinguish how partnerships are kept up to date with changes in legislation or how they develop and deliver their safeguarding training offer. Qualitative data collection with practitioners and senior managers could explore this issue further and investigate opportunities for MOPAC and the VRU to support providers to access safeguarding training. Our findings will be summarised below.

Working Together to Safeguard Children

Working Together to Safeguard Children (2018) sets out the arrangements for the work of each Local Safeguarding Children Partnership. Working Together to Safeguard Children (2018) is referenced in documents collected for Islington, Lambeth, Redbridge and Greenwich. For example, throughout the Greenwich, Lambeth and Redbridge annual reports it is evident that they have taken measures to implement the changes highlighted. References are made to the role of the independent scrutineer and approach to serious case reviews.

The Children and Social Work Act 2017[11]

The Children and Social Work Act 2017 is intended to improve support for looked-after children and care leavers[12] [13], promote the welfare and safeguarding of children, and make provisions about the

[11] https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

[12] English local authorities must publish a 'Local Offer' for care leavers, informing care leavers about services they provide under the Children Act 1989, plus anything else they or others offer that 'may assist care leavers in, or in preparing for, adulthood and independent living' including services related to: health and well-being, relationships, education and training, employment, accommodation and participation in society.

[13] The Local Government Association's resource pack on support for care leavers is available here: https://www.local.gov.uk/sites/default/files/documents/15.12%20Support%20for%20care%20leavers%20resource%20pack_02_1WEB.pdf

regulation of social workers. The explanatory note to the Children and Social Work Act 2017 explains that the main purpose of the legislation is to:

- Improve decision-making and support for looked after and previously looked after children.
- Improve joint work at the local level to safeguard children and enable better learning at the local and national levels to improve practice in child protection.
- Promote the safeguarding of children by providing for relationships and sex education in schools.
- Enable the establishment of a new regulatory regime specifically for the social work profession in England.

Some of these developments are little discussed within the documents reviewed. For instance, there was less information across the documents in regard to education.

The Children and Social Work Act 2017 contains several provisions intended to support the educational achievement of previously looked after children. A 'previously looked after' child is a child who was in the care of the local authority but was then immediately adopted, became subject to a Child Arrangements Order or a Special Guardianship Order. The Act addresses disparities between the educational support offered to looked-after children and previously looked after children, and between the duties of state-maintained schools and academies towards currently and previously looked after children.

The Children and Social Work Act 2017 makes significant changes for safeguarding nationally and locally, by amending the Children Act 2004. A local authority must notify the Child Safeguarding Practice Review Panel of any incident where a child dies or is seriously harmed in their area, or where a child usually resident in their area dies or is seriously harmed outside of England. The panel has the power to request any information that will help it in its review. The purpose of the review is 'to identify any improvements that should be made by safeguarding partners or others to safeguard and promote the welfare of children'. The Act effectively abolishes Local Safeguarding Children Boards, replacing them with three safeguarding partners (further detail will be provided later). Two or more authorities can also combine their safeguarding arrangements, and one partner can undertake functions on behalf of the other within the combined area. Their main responsibilities are to:

- involve 'relevant agencies' in their area
- identify and supervise the review of serious safeguarding cases
- publish local safeguarding arrangements
- arrange independent scrutiny of local safeguarding arrangements

- publish a report every 12 months on what has been done as a result of the local safeguarding arrangements

There is also information relating to child death reviews which aim to identify any matters relating to the death(s) that are relevant to the welfare of children in the area or to public health and safety and consider appropriate action to any matters identified. As with the local safeguarding partners, two or more areas can combine their functions and partners can undertake work on behalf of other partners in the combined area.

Helpfully, Greenwich, Lambeth, Redbridge and Islington make references to recent legislation. For example, the Children and Social Work Act 2017 is referenced in the Greenwich annual report 2019/20. The act is referenced in the Redbridge annual reports for both 2018/19 and 2019/20 and it is evident that Redbridge has taken measures to implement the Act, as referenced in relation to the new partnership arrangements.

MOPAC has worked with partners to produce a new protocol for London on reducing criminalisation of looked-after children and care leavers. The protocol 'Reducing criminalisation of looked-after children and care leavers' (2021) sets out the roles and responsibilities of carers, foster parents and professionals (police, health services, local authorities, education etc) involved in the care of looked-after children and care leavers in reducing their involvement in criminal behaviour. The aim is to prevent their involvement in crime and key links are made to the Children and Social Work Act 2017 and the seven corporate parenting principles.

The protocol focuses on avoiding unnecessary criminalisation of looked-after children and care leavers under 18, using responses to offending which divert them away from the criminal justice system. The protocol's call for professionals to ask, 'would this be good enough for my child?' indicates a recognition of their vulnerability. Reference to the United Nations Convention on the Rights of the Child highlights the importance of children's rights within this context and the importance of listening to CYP. Examples of prevention work across London boroughs indicate that each local authority has its own model for successful partnership identification and management of risks for individual CYP. Evaluation of these approaches might be beneficial to identify best practice and inform a more unified approach.

Looked-after children and care leavers from Black and minority ethnic (BAME) backgrounds are at an even greater disadvantage. More than half of the children in prison are or have been in care, with over half of this group having a BAME background. MOPAC are identified as taking steps to monitor and improve data collection around equalities information and protected characteristics such as ethnicity. However, little is detailed in the report as to why this is the case i.e. racism, poverty, ethnic bias and

a lack of cultural competence. The role of MOPAC is more clearly defined in this document. To monitor the effectiveness of the protocol, the MPS will collect monthly data on calls from children's homes. When possible, MOPAC will work with partners to conduct a deep dive into the increase in calls and monitor the impact on protected characteristics, dependant on accessibility of relevant data. MOPAC will also gather qualitative analysis and data from frontline professionals and forums/networks working with children in care to contextualise the impact of the protocol.

The information presented above is relevant to the youth justice section of this report. However, often they appear to be separate systems which make little reference to one another. The feasibility of enhanced collaborative working in relation to these changes could be explored, particularly how they can continuously learn from and inform each other.

New legislation

Future work plans should seek to incorporate recent guidance and legislation such as the Domestic Abuse Bill (2021)[14] and keeping children safe in education (2021)[15]. These key changes were not mentioned across the local boroughs. A great deal of awareness raising has been carried out and so planned changes within work plans was expected prior to their inception. This might, in part, be linked to the timing of the documents retrieved. In some boroughs, such as Redbridge, DVA is referred to as a safeguarding risk in annual reports. The Safer Lambeth Partnership Scrutiny Report (2020) includes references to the Domestic Abuse Bill, particularly with reference to ensuring implementation of the changes outlined in the bill.

There is little across the documents about the participation of frontline practitioners and there are concerns about how the new obligations will be funded. It is important to listen to and understand those who might be hesitant about or resistant to a different way of working. As such, the importance of professionals keeping up to date with legislation and policy that underpins their work in a timely way cannot be over emphasised. For example, the Domestic Abuse Bill is crucial for safeguarding practice and yet it appears absent within the documents reviewed. The role of MOPAC and the VRU could be explored within this, particularly around supporting professionals to understand legislation/policy changes and embed them into practice.

[14] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1014058/KCSIE_2021_Part_One_September.pdf

Key points

- It is not possible to distinguish how partnerships are kept up to date with legislative changes or how they develop and deliver their safeguarding training offer. Qualitative data collection with practitioners and senior managers could explore this issue further and investigate opportunities for MOPAC and the VRU to support providers to access safeguarding training.
- Working Together to Safeguard Children (2018) sets out the arrangements for the work of each Local Safeguarding Children Partnership. It was referenced in documents for some boroughs, including details of measures to implement the changes highlighted.
- The Children and Social Work Act 2017 is intended to improve support for looked-after children and care leavers, promote the welfare and safeguarding of children, and make provisions about the regulation of social workers. It makes significant changes for safeguarding at local and national levels, by amending the Children Act 2004. Again, some boroughs make references to recent legislation.
- Relevant to this, MOPAC has worked with partners to produce a new protocol for London on reducing criminalisation of looked-after children and care leavers. This sets out the roles and responsibilities of carers, foster parents and professionals involved in the care of looked-after children and care leavers in reducing their involvement in criminal behaviour.
- Examples of prevention work across London indicates that each local authority has its own model for successful partnership identification and management of risks for individual CYP. Evaluation of these approaches might be beneficial to identify best practice and inform a more unified approach.
- Looked-after children and care leavers from BAME backgrounds are at a greater disadvantage. MOPAC are identified as taking steps to monitor and improve data collection around equalities information and protected characteristics such as ethnicity.
- The information in this section is relevant to the youth justice section of this report. However, often they appear to be separate systems which make little reference to one another. The feasibility of enhanced collaborative working (and learning) in relation to these changes could be explored.
- Future work plans should seek to incorporate up to date guidance and legislation such as the Domestic Abuse Bill (2021) and keeping children safe in education (2021).
- The importance of professionals keeping up to date with legislation and policy that underpins their work cannot be over emphasised. The role of MOPAC and the VRU could be explored within this, particularly around supporting professionals to understand legislation/policy changes and embed them into practice.

2. Partnership-working arrangements

This review seeks to establish the existing structures and procedures around partnership or multi-agency working and consider whether current local and regional multi-agency safeguarding arrangements across London are robust and consistent. However, we were unable to clarify roles and responsibilities of each safeguarding statutory partner. This would have enabled an identification of any opportunities or gaps in the effective coordination of safeguarding governance. Specialised services are generally run by voluntary sector organisations (for example: Rape Crisis Centres, refuges, DVA projects, services for ethnic minority women and so on). They have a key role in safeguarding CYP and deliver a wide range of innovative activities in their local communities. However, their participation is unclear.

At a strategic level, Local Safeguarding Children Board's (LSCB's)[16] have been replaced with a team of local Safeguarding Partners[17], comprised of key professionals from three sectors: The Local Authority, the clinical commissioning group for any area within the Local Authority and the chief officer of police for any area that falls under the local authority. These partners are responsible for agreeing on and implementing new safeguarding strategies to strengthen multi-agency working and improve safeguarding and child protection arrangements in their local area. The role of MOPAC and VRU is to be confirmed. Whilst these developments were confirmed at borough level, arrangements appear to differ at the local level (information about these arrangements also varied). It would be appropriate to investigate the practices of boroughs where information sharing is more robust.

Frequently, minutes from meetings captured the names of those in attendance but not always their role or organisation (for example, in Croydon, Kingston and Richmond). Voluntary sector organisations were mentioned, but it was unclear who they were and to what extent they were involved. There appeared to be various boards and meetings, but it was impossible to ascertain who attended and if this was consistent. It is therefore difficult to be certain that the right individuals or organisations are attending and what role they play in decision making.

Details gathered for individual boroughs will be presented below. Further work should collect information pertaining to the remaining boroughs.

[16] The Association of Independent LSCB Chairs has gathered together several useful briefings on changes to child safeguarding arrangements
https://www.lscbchairs.org.uk/Public/News_/Government_Review_of_LSCBs.aspx
[17] Working Together to Safeguard Children (2018)

Brent

The Safer Brent Partnership aims to meet quarterly, with a focus on criminal behaviour, offenders, gangs, and serious youth violence. Details of dates and attendance were not included in the minutes. Underpinning the Partnership Board are action groups tasked with delivering each particular priority area. The review found that these action groups should meet monthly to ensure that work is delivering against key milestones.

Croydon

Croydon Safeguarding Children's Board was replaced by the Croydon Safeguarding Children Partnership as a response to Working Together 2018. This partnership meets three times per year. The executive group provides regular progress reports, and an independent chair is responsible for scrutinising these arrangements. Documents for Croydon suggest that they aim to create 'a culture of continuous learning, professional curiosity and challenge'. Multi-agency is a priority, but it is unclear if the communication between various agencies is positive and works well. Indeed, the Quality Improvement Group (2019/20) found that 'thresholds were not adequately understood, insufficient sharing of information and poor communication, quality of referrals and sharing of information is not robust enough'. They did identify ways to improve, including actions around referrals, and information sharing and communication are detailed within their safeguarding priorities. It would be useful to investigate if these proposed improvements have been implemented.

Greenwich

A key priority for Greenwich is to embed the new Partnership arrangements and ways of working under the three safeguarding partners. Their annual report cites the new arrangements under the Working Together 2018 , as a driver for ensuring that safeguarding responsibility was equally shared by the three key partners - the Police, Health, and the Local Authority. There is evidence in their annual report that the CCG and other health partners contribute to the Greenwich Safeguarding Children Partnership. The report suggests that, 'the GCSP to have good oversight of safeguarding in the health sector and to respond well to the challenges of the Covid-19 pandemic'. Responsibility is shared amongst partners through a rolling chair system, which supports their suggestion of existing strong, collaborative working relationships between these agencies in Greenwich.

Following Working Together (2018), an Independent Scrutineer was introduced to comment across all aspects of child safeguarding. This is very evident in the documents, and there are specific reports

produced by the Scrutineer. An Executive sits under the Independent Scrutineer, and a 'Develop, Monitor and Challenge' group sits under the Executive. The Independent Scrutineer notes that commitment to the partnership is also evidenced in the membership and contribution of all relevant agencies, including schools in the Partnership subgroups. The Scrutineer's annual report states that Greenwich is developing strong Quality Assurance mechanisms, to ensure robust processes for monitoring how effectively agencies worked together to protect CYP and promote their welfare. There has also been successful recruitment into the Partnership Business Unit, which assists and progresses the arrangements, and which has strengthened and supported the new partnership.

Islington

The Islington child protection annual report states that: 'We have a clear and consistent format to the sharing of information to support safeguarding children and young people and recognise that this is crucial to developing an understanding of peer networks and exploitation profiles'. It is evident that Islington perceives the information sharing processes to be robust and effective. These include:

- Information is shared at a practitioner level across the partnership through measures such as the co-location of staff, safeguarding meetings, consultations, Integrated Gang Team task meetings and community safety briefings, and fed back into safeguarding meetings to inform the response to CYP and families.
- This information is collated by the Child Sexual Exploitation and Gangs Analyst and feeds into practice panels such as the Multi Agency Child Exploitation Panel and the Exploitation and Missing subgroup. This includes the council's response to contextual safeguarding focus areas such as creating safe spaces for CYP through work with departments such as licensing and estate management.

Responsibility for governance and scrutiny of the child safeguarding arrangements lie with the Children's Services Scrutiny Committee. Additional responsibility sits with Safeguarding Accountability Meetings, chaired by the Chief Executive and attended by the Leader of the Council, Executive Member for Children, Young People and Families, Corporate Director of People, Independent Chair of the Safeguarding Children Board and the Director of Safeguarding. There is also a Corporate Parenting Board, co-chaired by the Executive Member for Children, Young People and Families and the In Care Council (Children Looked After and Care Leavers) and attended by four elected members and senior officers across the partnership. The Islington Safeguarding Children Board has an independent chair and meets four times a year under the new arrangements. The documents explicitly state that the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018 has removed

the requirement for Local Authorities to establish LSCBs and replaced this with new local multi-agency safeguarding arrangements. The Board has sub-committees on Quality Assurance, Training, Missing and Exploitation, Case Review, the Education Subgroup and more recently the Early Help Subgroup.

Kingston and Richmond

Achieving for Children (children's social care) is a community interest company that delivers services for CYP in both boroughs and is owned by both, with a single point of access. However, the health and wellbeing board appears to be confined to Richmond. In Kingston and Richmond, key players appeared to include local councils, children's social care, and the police, but not always education. We noted differences in priorities and issues between the two boroughs. Some documents were produced together, others were on an individual basis. It was unclear which work was individual, which covered both boroughs, and the impact on professionals working in these areas. Some of this uncertainty might be linked to the timing of the documents and the previous existence of the LCSB.

Lambeth

In Lambeth, a report by the Independent Scrutineer found evidence of strong inter-agency communication and co-operation, along with a drive to intervene early and thus redress problems before they become engrained and intractable. As noted above, the Executive is a partnership between the three key statutory partners, plus agencies such as Education and voluntary sector organisations. Under Working Together 2018, new processes enable anyone in the partnership to notify the Safeguarding Executive of a serious incident to be considered for a rapid review.

The Safer Lambeth Strategy sets out plans for increased cross-borough working in relation to CYP and vulnerable adults who are coerced into transporting and selling drugs across borough boundaries. As with other boroughs, Lambeth has amended its safeguarding arrangements in line with *Working Together 2018* and created a new Executive, bringing together Children's Services, the Police and Health, with participation from Education and voluntary sector representatives. Chairing the Executive rotates between the three agencies Rapid Reviews and Child Safeguarding Practice Reviews have replaced the previous Serious Case Review system, to greatly speed up learning within the Partnership, and the practical day to day ways in which the Partnership can work more efficiently and effectively together. An independent auditor was commissioned to audit the partnership's response to child and adolescent neglect. This independent audit has promoted the use of Family Group

Conferences and looked to develop a 'relational style' to safeguarding in the Borough's response to neglect.

Previous work has also included:

- A multiagency audit, to enable the LSCB to have oversight of the quality of frontline practice
- A DVA audit to improve information sharing and use of appropriate assessments
- Development of a Young People at Risk Strategy with four strands: Prevention, Identification, Help and Protection, Disruption. The strategy includes appointment of a Young People at Risk data analyst to increase capacity for intelligence sharing, a multi-agency action panel and a multi-agency contextual harm panel, and a contextual harm champion

Redbridge (with others)

Notably, there is a single set of safeguarding arrangements across Barking and Dagenham, Havering and Redbridge (BHR), in line with new multi-agency safeguarding arrangements required by the 2017 Children and Social Work Act. Their documentation specifies that the legislation details the different agencies that must be represented on the Board, including the local authority, the police, the CCG, NHS hospitals and community health services providers, NHS England, probation services, and the Children and Family Court Advisory and Support Service (CAFCASS). However, the Board had the power to include wider representation in its membership, and in Redbridge this included schools, the voluntary and faith sector, and lay members. The Board also maintained strong links with the Redbridge Youth Forum and Schools Council, representing CYP directly, and worked with a LSCB Youth Forum made up of CYP. The core of the BHR partnership is a Safeguarding Partners Group – the three Directors of Children's Services, the East Borough Command Unit Detective Superintendent with responsibility for safeguarding, and the CCG Chief Nurse.

In Redbridge, a multi-agency Redbridge Safeguarding Children Partnership (RSCP), modelled initially on the LSCB, continues to be independently chaired. It is responsible for identifying and progressing local safeguarding priorities, overseeing performance and the quality of safeguarding in Redbridge, coordinating the response to key local safeguarding risks, and ensuring the dissemination of learning both locally and contributing on a cross-borough basis.

Challenges to multi-agency working

Partnership working is a facilitator to achieving change both within and external to individual organisations and local authorities. These relationships can be important at both strategic and operational levels.

There are practical considerations for VRU participation, notably what can reasonably be expected in terms of attending the multiple local meetings and boards within each of the 32 London boroughs. Whilst this might be unrealistic, there is scope for a greater pan-London oversight role. The VRU could offer support in sharing good practice across all boroughs and provide strategic overview. It might be useful to explore the expertise that the VRU could contribute on a local level in a limited number of key boroughs, with a view to sharing any learning more widely. Many of the minutes, plans and strategies outline what they would like to happen, but it is unclear the extent to which ambitions or plans are achieved, and monitoring appears scant. Without some overview (possibly by MOPAC or the VRU), it is impossible to know what is actually taking place. There are large numbers of meetings, boards and panels that require attendance, and likely take time away from frontline delivery. Greater oversight might achieve effectiveness and efficiency through streamlining.

Two key challenges emerged across the documents with regards to multi-agency working: a lack of resources and an inability to work across boundaries.

Lack of resources

It is important to note that agencies and organisations are working in a context of increasingly limited resources available for service delivery. In Greenwich, the effectiveness of partnership arrangements has been impacted by reductions in the capacity of some key senior partner agencies and forecast budget restrictions during 2020, which affect previously consistent relationships within the partnership. Some subgroups have not worked as envisaged, and the partnership stated its intention to review the arrangements during 2020 to ensure an effective and streamlined structure.

In Redbridge, budget restrictions meant that the post of Partnership Quality Assurance Manager has remained vacant since February 2019. It has not therefore been possible to deliver the multi-agency audit programme which was one of the strengths of the predecessor LSCB. It is unclear whether the first tri-borough multi-agency audit on the theme of DVA, which was scheduled for March and postponed due to the coronavirus pandemic, has since occurred.

Silo working

Previous initiatives indicate that an inability to work across boundaries can undermine the success of violence prevention initiatives. For example, both the London Pathways Initiative and the Shield[18] pilot aimed to address serious gang violence, but were unsuccessful due to a lack of multi-agency coordination, including failure to compel attendance at call-ins, the lack of available civil sanctions, an impractical implementation model, and difficulties engaging local communities in the pilot. These experiences highlight the importance of involving partners and communities in intervention design at a much earlier stage, and that initiatives should be implemented collaboratively rather than top-down. Such work is reflected in some local documents. For example, in Newham, the driving focus appears to be youth safety and criminal exploitation. Their documentation articulates the need for more joined-up working to identify risk early, and work at the community level is described as awareness raising and minimising risk.

We noted other working groups in addition to the arrangements detailed above, and these will be detailed below. Each area appeared to operate different working groups. The possibility and benefits to common structures could be explored further. For example, at borough level, Greenwich Safeguarding Children Partnership Work Groups include an audit group; develop, monitor and challenge group; learning from practice group; schools safeguarding network and a strategic multi-agency child exploitation group. For the purposes of this section, we have endeavoured to focus on the remit of MOPAC and/ or the VRU.

Partnership Reference Group

This group of strategic partners is tasked with providing strategic direction, support and challenge the work of the VRU.

Violence Reduction Reference Group

Meetings and agendas are available online but not the purpose of the group. Our understanding is that this is a multi-agency forum and action group focused on reducing violence. Activities are focussed on early intervention and prevention, including support and provision for CYP to address the impact of trauma and other causes of violence.

[18] In 2014, MOPAC sought to develop an intervention (Operation Shield) that drew on evidence from the US to tackle serious gang violence in the London boroughs of Lambeth, Haringey and Westminster. There was no indication of a reduction in the level of violent offending.

An example of strategic planning linked to this group was found in the Community Safety Partnership Violence Reduction Action Plans report (Jan 2020). This provides a useful model that might be considered against the recommendations made in this review. This model introduces a single format of action plan across all 32 London boroughs to address Knife Crime and Serious Violence. This template was initially devised by the Met and updated by MOPAC to provide a shared and consistent format, but with opportunity to create a bespoke local action plan within each borough around serious violence. The report outlines progress over the previous year, including a summary of the action plans, key areas of good practice and challenge, and next steps. It notes that the VRU, MPS and London Councils intend to 'promote a collaborative approach' across the 32 boroughs to share good practice and understand emerging risks and opportunities. The template is designed for ease of completion, but it is unclear whether it was developed in consultation with key stakeholders, or if training about using the template was made available. However, the document 'Knife crime and youth violence' by the Safer Stronger Select Committee (Feb 2019) describes a more collaborative approach.

Action plans are the responsibility of each CSP. Following completion, plans were submitted to MPS and MOPAC for review. The report[19] notes that an initial review showed the plans to be variable in quality and following the provision of additional support (including learning hubs and a repository to highlight good practice and emerging themes), action plans were resubmitted and their progress assessed. More robust action plans were expected to involve partners across agencies, service sectors, and the community; to include education, prevention and early intervention activities as well as support for both victims and offenders; and contain detailed responsibility and timelines for actions.

It was noted that some plans made little use of optional actions, creating gaps around local authority tasking of resources, risk panels, Looked After Children, exclusions and monitoring, strategic assessment, community tension monitoring, business community and VCS involvement. It was also noted that some CSPs did not use the updated template or had done little to develop their plans, leaving them 'standing still' and 'weak'. It was unclear how or why this was the case; what circumstances might have led to this or what support would be available to remedy this. However, it was noted that an appendix did include best practice examples, although these were not available to the research team.

[19] Community Safety Partnership Violence Reduction Action Plans report (Jan 2020)

Health and Wellbeing Boards

Health and Wellbeing Boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch. They have a statutory duty to produce a joint needs assessment and a joint health and wellbeing strategy, which should be used to plan how best to meet the needs of their local population and tackle local health inequalities. These boards have very limited formal decision-making powers. They are constituted as a partnership forum.

This review included available minutes from the relevant and most recent meetings. Often the role or organisation of participants was not noted, with the exception of councillors. Unsurprisingly, these meetings particularly focused on Covid-19 , and often had a broader health focus than other working groups. For example, there was generally less emphasis on safeguarding priorities such as VAWG and serious youth violence. For example, for Brent, Greenwich and Newham, the health and wellbeing board meeting minutes do not explicitly cover child safeguarding, and child safeguarding representatives are not present. Rather, there was a focus on wider issues such as obesity or diabetes. This is interesting given the most recent case reviews and issues around health need, medical neglect and health assessments noted later. However, meeting minutes show instances of individual participants highlighting key priorities. For example, a member of the Health and Wellbeing Board in Newham stated a desire to see CYP mental health as a priority, and access to mental health support for those with SEND and disabilities.

For Redbridge, there is some evidence of overlaps between the Health and Wellbeing Board and child safeguarding, such as a focus on child and adolescent mental health. However, the minutes do not record the organisations that attendees are representing, and thus it is not possible to know if child safeguarding representatives are present. Health scrutiny minutes are purely focused on health issues such as hospitals and COVID-19, and it is not possible to determine if any child safeguarding representatives are present.

In Islington, by contrast, it is evident that child protection is integrated into the health and wellbeing strategy, with safeguarding leads sitting on the Health and Wellbeing Board and safeguarding integrated into the Health agenda.

In Lambeth, the Children and Young People's Plan will be delivered in line with work to fully integrate health and care locally, led by the Lambeth Together Strategic Alliance. This will join up the health and care system to make efficient use of resources and improve experiences for those accessing services and support. (Lambeth CYP Plan 2018-22). The strategic Director for Children's Services was present at Health and Wellbeing Board meetings. The minutes suggest that child safeguarding is incorporated into the broader Health and Wellbeing approach.

Community Meetings

The VRU identifies community and youth involvement as a core principle. However, it was not always clear if or how community organisations are involved in or engaged with MOPAC, VRU activities or safeguarding arrangements. However, it was not always possible to locate evidence of these activities, such as public meetings. To illustrate, the Brent Safer Neighbourhood Board met online on 19 August 2020[20], with more than 100 people in attendance. Key policing challenges were identified: the top priority is listed as violence and its prevention, and involves stop and search, including section 60. Prior to the meeting, some residents felt that reporting to the police had no effect and community intelligence should be better used. Continued reporting was encouraged and residents had asked for anonymous ways to report ongoing issues to the police and council. Residents also highlighted the need for increased community engagement, including greater police transparency about what they were doing and why, particularly given concerns about disproportionate use of section 60 powers in certain communities.

Examples of Local Authorities working together include:

- Islington working with other Local Authorities to improve their practice and outcomes for children by sharing their Motivational Social Work Practice model.
- Newham has a Joint Borough Command Unit with Waltham Forest (detailed below).
- Cross-borough policing approach –the Greenwich Independent Scrutineer noted that the South East Basic Command Unit comprises the London boroughs of Bexley, Lewisham and the Royal Borough of Greenwich, and part of Detective Jim Foley's role has been to work across all three local authorities to support their work to safeguard CYP. This was important as the CYP are not constrained by geographical boundaries and there is significant cross over between the local authorities.

Whilst information details the many ways in which individual boroughs are working, or at times working with other boroughs, there is little reference in the available documents about how local efforts fit with a wider pan-London approach. The benefits, issues and tensions between a pan-London and an individual borough approach could be explored further.

[20] See the Summary of: Brent Safer Neighbourhood Board online public meeting 5pm Wednesday 19 August 2020

Key points

- It was difficult to clarify roles and responsibilities of each safeguarding statutory partner.
- At a strategic level, LSCB's have been replaced with a team of local Safeguarding Partners. The role of MOPAC and VRU is to be confirmed. Whilst these developments were confirmed at borough level, arrangements appear to differ. It would be appropriate to investigate the practices of boroughs where information sharing is more robust.
- Frequently, minutes from meetings captured the names of those in attendance but not always their role or organisation. There appeared to be various boards and meetings, but we were unable to ascertain attendance and if this was consistent. It is not possible to identify issues of duplication in the documents, and further research is needed to understand more about the successes and challenges. We suggest that this is explored in the interviews.
- Partnership working is a facilitator to achieving change both within and external to individual organisations and local authorities. These relationships can be important at both strategic and operational levels. Key challenges to multi-agency working were highlighted: a lack of resources and an inability to work across boundaries.
- There are practical considerations for VRU participation. Nevertheless, there is scope for a greater pan-London oversight role. The VRU could offer support in sharing good practice across all boroughs and provide strategic overview.
- We noted other working groups in addition to the arrangements detailed, with each borough appearing to operate different working groups. The possibility and benefits to common structures could be explored further. There is little information about the successes and challenges of the practical implementation safeguarding arrangements.
- Whilst information details the ways in which individual boroughs are sometimes working with other boroughs, there is little reference about how local efforts fit with a wider pan-London approach. The benefits, issues and tensions between a pan-London and an individual borough approach could be explored further.

3. Safeguarding priorities

In addition to the operational work outlined above, we considered safeguarding priorities for individual boroughs. We have analysed documents from ten boroughs identified as a priority by The Children's Society: Barking and Dagenham, Brent, Croydon, Islington, Greenwich, Kingston (and) Richmond, Lambeth, Newham, and Redbridge. Hillingdon, Enfield and Croydon were also highlighted as key but documents were unavailable.

Evidence shows a link between area-level deprivation/poverty and violence in London. Three-quarters of boroughs with the highest levels of violent offending are also in the top ten most deprived[21]. They also have higher proportions of children living in poverty than the London average. The Greater London Authority (GLA) shows that rates of youth violence are highest in boroughs of multiple deprivation, including high long-term unemployment, low educational attainment, high numbers of residents on Universal Credit, high numbers of mortgage non-payment claims, more people earning below the minimum wage, and higher estimates of rough sleepers. Furthermore, MOPAC have identified that six in ten of the highest volume wards for DVA offences are also 'most vulnerable' wards as measured by the Vulnerable Localities Profile (VLP).

Consistently, two overarching priorities were found across key MOPAC and VRU documents:

Violence against women and girls (VAWG)	**Keeping CYP safe** (e.g. from CSE, knife crime)

In addition, safeguarding partners determine their own local priorities, which should be specific to local population need (detailed below). The two overarching priorities were sometimes mirrored at a local level. For example, serious youth violence is a priority in the Safer Lambeth Strategy, along with VAWG, counter terrorism, Drugs and gangs, and Modern Slavery.

There was limited discussion at the local level about addressing VAWG, and this is reflected in the priorities below. One example is the Phoenix Project in Redbridge, a partnership with Barnardo's aimed at creating systemic changes within families experiencing DVA, addressing the impact on the mental health and wellbeing of children in the family.

Across the documents, there was more emphasis on young people rather than children *and* young people or families. Whilst it is significant to recognise the specific experiences, risks and opportunities

[21] Available from: Appendix 1, London Violence Reduction Unit Strategy.

associated with adolescence, it is important to consider their experiences more widely given the importance of early intervention. Evidence indicates that even young children are involved or recruited to some of the activities identified as problematic i.e. gangs, serious youth violence.

Local priorities for Safeguarding partners

Whilst each locality has listed their priorities separately and used different language or terminology, they have been grouped thematically where possible. For example, Islington identified a priority around DVA specifically rather than VAWG more broadly. Whilst it is important to understand issues at the local level, a common language would be helpful to enable wider understanding and sharing of practice. For example, Croydon identifies children with disabilities as a priority. Kingston and Richmond secured grant funding during 2018/19 from the Careers and Enterprise Company to develop innovative new approaches to careers advice for CYP with Special Educational Needs. However, outcomes are not detailed and there is no evidence of shared knowledge and experience.

Individual boroughs had varying numbers of priorities with some described in broad terms, creating a lack of clarity about what was involved and how they might be implemented i.e. 'learning from practice'. Commonality of priorities might help to create more specific, tangible and measurable outcomes. A shared system might also reduce potential inconsistencies within boroughs, although this might be linked to changing priorities upon annual review. For example, DVA is not identified within the Safeguarding priorities for Croydon, but it is identified in the Croydon Thematic Review. The latter highlights the impact of, and lack of support given to, vulnerable adolescents who have experienced DVA-related trauma and bereavement. The Thematic Review notes that agencies take a reactive approach to deal with the immediate crisis and do not take the individual's history into account. This is consistent with findings across domestic homicide reviews, and the lack of understanding leads to increased risks, serious behaviour and poor service engagement from CYP.

Priorities were available for two consecutive years for Redbridge and three for Lambeth. There were significant changes between each year. The extent to which priorities were more or less important, the evidence on which they are based, and the impact for professionals, is unclear. To illustrate, we have detailed the priorities below. Interestingly, we were able to note that a major priority within the Redbridge LSCB's Business Plan for 2018/19 was to develop and deliver a multi-agency strategy and action plan to reduce and ultimately eliminate the practice of female genital mutilation (FGM) in the borough; to effectively identify and safeguard children at risk of FGM; and to support young women who themselves have experienced FGM. This has then transferred to more recent priorities.

Table 1: An example of changing priorities

2018/2019	2019/2020
- Improve services for CYP experiencing mental ill-health. - Strengthen the protection and support of CYP exposed to any form of exploitation or at risk of going missing. - Raise awareness of and develop services' response to peer on peer abuse, harmful sexual behaviours and violence. - Develop engagement with CYP and families to raise awareness of and inform development of safeguarding. - Develop new multi-agency safeguarding arrangements and Child Death Review process as required by Children and Social Work Act 2017. - Strengthen the protection and support of CYP exposed to dangerous cultural practices.	- Safeguarding vulnerable adolescents. - Support to schools and other educational settings. - Learning from practice - Learning from CYP and families - Tackling exploitation of CYP in all its forms - Help for young people experiencing mental health difficulties - Improving quality of referrals to children's social care - Early help/ early intervention - CYP going missing from care - FGM - Transitional safeguarding - concern about vulnerable young people who become vulnerable adults and potentially fall through the gaps between two safeguarding systems

Consistent with earlier findings, many boroughs (such as Croydon, Islington, Newham, and Kingston and Richmond) identified priorities around partnership or multi-agency working, including information sharing. This has direct relevance for the Children and Social Work Act 2017, which aims to improve joint work at the local level to safeguard children and enable better learning at the local to improve child protection practice. In Croydon, this included improving the quality of referrals, a multi-agency referral form for Children's Social Care, including the views of frontline workers and building a culture of professional curiosity and challenge. Greenwich emphasised embedding the new partnership arrangements and ways of working under the three safeguarding partners, and Redbridge aimed to improve quality of referrals to children's social care. Kingston and Richmond identified a multi-agency approach as key to reducing serious violence, including the need for training and awareness strategies about contextual safeguarding and exploitation. They also highlight the importance of including parents/carers, the wider community around CYP, and a broad range of professionals in information gathering and to look at locations where harm may occur (contextual safeguarding, to be discussed further).

There was emphasis across the themes on risks from and risks to young people. A priority for Redbridge was to safeguard vulnerable adolescents. Greenwich aimed to tackle the risks to

adolescents, particularly those associated with exploitation, violence and neglect, whereas other boroughs focus on youth crime. As we explore later in this report, these risk factors are interconnected. Redbridge was concerned with transitional safeguarding – that is, vulnerable young people who become vulnerable adults and potentially fall through the gaps between two safeguarding systems.

Many of the priorities below fit with the London VRU Strategy, which considers the context and influences that impact on individuals at significant points in their life (e.g. violence, abuse, marginalisation).

Table 2: Priorities of local boroughs

Priority area	Borough
Anti-social behaviour	Newham Brent
Child mental health (focus on self-harm and suicide)	Greenwich Redbridge Kingston and Richmond
Children with disabilities	Croydon
Exploitation and vulnerability	Newham Islington Greenwich Redbridge Kingston and Richmond
Inequalities and disproportionality of young BAME men in CJS and poor health (of young BAME men)	Islington
Knife Crime/ weapon-based crime and violence	Croydon Islington Kingston and Richmond Newham
Looked After Children (Children who go missing from home or care)	Croydon Islington Kingston and Richmond Redbridge
Modern Slavery	Islington Lambeth
Neglect	Croydon Islington Greenwich
Preventing and reducing youth offending/re-offending	Brent Newham
Recognising vulnerability and providing the right support to protect and nurture during pregnancy and early infancy	Greenwich
Reducing crime/ targeting crime hotspots	Brent Newham
Reducing substance misuse	Brent Kingston and Richmond
Reducing VAWG (DVA, female genital mutilation and sexual exploitation)	Brent Islington Redbridge Lambeth
Serious youth crime	Croydon Islington Kingston and Richmond Lambeth

Unaccompanied Asylum-Seeking Children	Croydon
Youth safety (18-24)	Newham
Support to schools and other educational settings	Redbridge
Learning from CYP and families	Redbridge
Early help/ early intervention	Redbridge
Counter terrorism	Lambeth

At a local level, Islington highlight key elements of their approach to action these priorities, including preventative assemblies and sessions in schools on knife crime, joint enterprise, keeping safe, hate crime, Stop & Search, gangs, personal safety and social media. However, VAWG does not seem to be included within these activities. In Kingston and Richmond, a new Multi-Agency Risk and Vulnerability to Exploitation (MARVE) panel has been implemented, and their Vulnerable Children and Adolescents' strategy clearly lays out partner agency roles, processes for referring any concerns about exploitation, and guidance for Multi-Agency Professional Meetings. How these priorities and processes link (or do not link) across boroughs/regions/Basic Command Units is not always made explicit. We do know that Newham has a Joint Borough Command Unit with Waltham Forest, but little detail is provided.

Child Protection Procedures should have been updated following changes to guidance and regulations, including the publication of 'Working Together to Safeguard Children' 2018 (updated December 2020)[22], 'Keeping Children Safe in Education' (September) 2021[23] and the Domestic Abuse Act 2021.[24] However, as indicated from the outset, policies and procedures were not always easily accessible. Croydon's Thematic Review notes that the council is experiencing significant financial issues which impact CAMHS wait times, which the Scrutiny Children and Young People Sub-Committee felt was unacceptable. This is relevant to other boroughs such as Kingston and Richmond, who identify a concern about an increase in CAMHS referrals, particularly for young people who self-harm.

It is challenging to consistently identify evidence of positive practice from the documents alone, given that practices and plans are often described but with less detail about their success (or otherwise). Further exploration in research interviews would be helpful. However, there are examples where boroughs perceive their approach to be successful and where this is validated by an external regulatory body. For example, Islington uses the Motivational Practice Social Work model, which is reported to have been successful.

[22] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[23] https://www.gov.uk/government/publications/keeping-children-safe-in-education--2
[24] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet https://www.legislation.gov.uk/ukpga/2021/17/contents

> *The practice model is relationship based and feedback from children, families, staff, services and Ofsted has been very positive; "A stable workforce and manageable caseloads enable social workers to develop positive and enduring relationships with children… is well embedded, and workers demonstrate a good understanding of the impact of trauma on children's lives. Practitioners build effective relationships with parents and provide appropriate challenge." This Practice Model has demonstrated impact on our data for example the reduction in re-referral rates to Children's Social Care.* (Islington Child Protection Annual Report 2020).

Their model incorporates Trauma Informed Practice. Interestingly, there are two practice weeks per year where senior managers shadow frontline staff to retain their connection to the realities of frontline work.

Notably, both Croydon and Greenwich prioritise the importance of communicating the voice of CYP, which is consistent with the findings of child safeguarding reviews. An Ofsted report for Redbridge noted that direct work and the promotion of the child's voice are particularly strong (see annual report 2018/19). Croydon specifically highlighted the role of Youth Congress, Children in Care Council and Youth Engagement Team to assist with this. Kingston and Richmond have developed Child Friendly Easy Information with six CYP. In Newham, the voices of CYP come through in some documents, as well as the voices of others within the community.

The Ofsted inspection of Redbridge Children's Services (2019) marked them Outstanding[25], and commended senior managers and leaders for having a relentless drive and ambition for children, leading to the provision of consistently strong and highly effective services. Staff enjoy working in Redbridge and feel safe and well supported. This results in purposeful work and positive outcomes for CYP. Workers are afforded the time and capacity to get to know CYP well and exercise their professional expertise, securing positive experiences and good progress for children. There is clear evidence of a reflective and questioning working culture which provides proactive steps to improve outcomes for children. Independent reviewing officers offer strong challenge and oversight, and permanence planning is carefully tracked and begins at the earliest opportunity.

Existing and potential opportunities for local authorities to share good practice should be explored, particularly where there are overlapping priorities and existing initiatives.

[25] annual report 2018/19

Contextual Safeguarding

Contextual Safeguarding is an approach to understanding, and responding to, CYP's experiences of significant harm beyond their families. It recognises that different relationships (e.g. in their neighbourhoods, schools or online) can feature abuse and/or violence. Parents/carers have little influence in these contexts, and CYP's experiences of extra-familial abuse can undermine the parent-child relationship. Therefore, children's social care, child protection systems and wider safeguarding partnerships must engage with individuals, groups and sectors who do have influence over/within extra-familial contexts and recognise that assessment and intervention is a critical part of safeguarding practice. Contextual Safeguarding, therefore, expands the aims of child protection systems to recognise that CYP are vulnerable to abuse beyond the home.

The documents indicate that many local authorities are utilising contextual safeguarding in their response to extra-familial harm. For example, Lambeth is building a new community partnership to promote community engagement mechanisms and enable the voice of local people to be heard within the safeguarding approach. However, in general, the ways in which different boroughs are approaching contextual safeguarding is not necessarily clear from the documents reviewed.

It is clear that the local authorities would like to do more, but progress is limited by ongoing pressures which include a lack of resources, ensuring that all new staff are trained appropriately and efficiently, the need for community buy-in, and access to other professionals (such as bus drivers, retail staff, etc). Adults in the community and CYP need to know where they can go for support, and building trust and relationships is key. Professionals must be alert to the language used to describe CYP's behaviour; in some cases, it conveys a sense of victim blaming. Initiatives to address issues of language include the Women's Aid Trusted Professional model and the Safe and Together model. Information at the local level has been included below to provide examples of the different approaches to contextual safeguarding.

Islington

The Islington documents make specific reference to their approach to contextual safeguarding. Based on their examination of trends over the previous two years they state that their analysis:

> *….consistently highlights that Islington's profiles of children and young people at risk, or a victim of Child Sexual Exploitation, harmful sexual behaviours, trafficking and modern slavery, gangs, and serious youth violence are intrinsically linked through vulnerability, peer groups and offending*

networks…children and young people vulnerable to exploitation overlaps significantly with children and young people that go missing from home and care."

They suggest that Islington has developed a less siloed and more flexible model of assessment, intervention and governance. This seeks to provide CYP across the spectrum of risk with timely and targeted interventions, and that those children at acute risk receive a consistent safeguarding response. Islington's shift toward a more fluid approach to Exploitation and Missing risk supports a trauma informed practice model; focusing more on the experience, vulnerabilities, strengths and needs of the individual child, rather than on the specific type of risk label and subsequent intervention pathway.

Newham documents make only brief reference to contextual safeguarding, but the influence of this model in their safeguarding approach is evident. For example, they note plans to roll out training about child exploitation to the wider community.

Lambeth

Future goals are to: 'Revolutionise our approach to complex contextual safeguarding by working with experts in the field to develop new tools and systems to better safeguard our young people from a range of complex contextual harms'; and implement findings from the National Panel's review of safeguarding young people against criminal exploitation, *It was Hard to Escape*, as well as a local review focused on serious youth violence, to develop new tools that ensure progress, rather than process in order to safeguard young people against contextual harm.[26]

Redbridge

The tri-borough approach is reported as effective in addressing adolescent risk, dangerous drug networks, gang membership and knife crime (annual report 2018/19). They report that borough boundaries are irrelevant for these issues, and contribution from all agencies is required. The community Family Intervention Team (FIT) includes social workers, youth workers, family support workers, and staff from voluntary sector agencies. The team engage with young people aged 11-17 years affected by sexual exploitation, drug misuse, criminal exploitation or gang membership. While other social work teams also work with exploited children, the FIT has developed as a centre of expertise, and the team coordinate a range of other specialist services, including a recently

[26] 2019-20 annual report

recommissioned voluntary sector service for young people involved with gangs; and two Barnardo's services: (1) working with young people exhibiting harmful sexual behaviour; and (2) with young people who have been sexually abused.

The examples above indicate the differences in working practices in a small sample of local authorities. Various local authorities are also utilising restorative practice, as well as systemic practice, alongside the Signs of Safety model. Contextual safeguarding is a further concept that managers, frontline practitioners and those in the community need to engage with and understand how to implement in practice. It is important for practitioners to feel heard and able to participate in decision-making and operational plans. The extent to which a participative culture is fostered could be explored with a survey or interviews. For example, do professionals feel that they know how plans will work out in practice? Do they have some say over the way they work?

To summarise, it is evident that local authorities have a desire understand the issues facing CYP and are taking steps to improve knowledge about the multiple factors that impact on their safety. However, it was not always possible to situate local actions and priorities within the research evidence base. For example, Dr Carlene Firmin states (TED talk)[27] that CYP are at most risk between the times of 3.30pm-7pm. It would be useful for local authorities to reflect on their actions to minimise the risk between these times, and in areas that they know CYP are frequenting. This level of detail was not contained within the documents reviewed. The context of safeguarding needs to be re-examined, as it is a key shift in how child protection is viewed in the UK[28].

Key points

- Evidence shows a link between area-level deprivation/poverty and violence in London. Three-quarters of boroughs with the highest levels of violent offending are in the top ten most deprived.
- Two overarching priorities were found across key MOPAC and VRU documents: (1) Violence against women and girls and (2) Keeping CYP safe. In addition, safeguarding partners determine their own local priorities, specific to local population need. Often there was limited discussion at the local level about addressing VAWG. There was particular emphasis across the themes on risks from and risks to young people.

[27] Contextual Safeguarding Keynote by Dr Carlene Firmin MBE at NYCC Children & Families Service Day (2020) https://www.youtube.com/watch?v=ET4ZhxTSNs8
[28] See: www.contextualsafeguarding.org.uk

- Each locality has listed their priorities separately and used different language or terminology. Commonality across priorities might help to create more specific, tangible and measurable outcomes. A shared system might help to reduce potential inconsistencies within boroughs, although this might be linked to changing priorities upon annual review.
- Barriers to addressing their priorities included significant financial issues. Further exploration of barriers and facilitators to positive practice would be beneficial. Existing and potential opportunities for local authorities to share good practice should be explored, particularly where there are overlapping priorities and existing initiatives.
- Many local authorities are utilising contextual safeguarding in their response to extra-familial harm. However, the ways in which different boroughs are approaching contextual safeguarding is not necessarily clear. Progress is limited by ongoing pressures, such as lack of resources, training, community buy-in, and access to other professionals.
- Various local authorities also utilise other safeguarding approaches. Contextual safeguarding is a further concept that managers, frontline practitioners and those in the community need to engage with and understand how to implement in practice. The extent to which a participative culture is fostered could be explored further.
- Local authorities aim understand the issues facing CYP and are taking steps to improve knowledge about the multiple factors that impact on their safety. However, it was not always possible to situate local actions and priorities within the research evidence base. The context of safeguarding needs to be re-examined.

4. Child Safeguarding Practice Reviews

Contextual risks and learning can be identified in child safeguarding practice reviews[29]. In England, when a child dies or is seriously harmed as a result of abuse or neglect, a child safeguarding practice review is conducted to identify ways that local professionals and organisations can improve the way they work together to safeguard children. 'Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children' (Department for Education, 2018) provides key guidance for these reviews. The NSPCC helpfully provides a national repository[30].

The responsibility for learning lessons from serious child safeguarding incidents lies with the Child Safeguarding Practice Review Panel at a national level, and safeguarding partners at a local level (local authorities, police, and clinical commissioning groups, detailed earlier). The Department for Education has published a series of reports analysing the learning from child safeguarding practice review published between 2003-2017[31].

Statutory agencies often have significant contact with families prior to the incidents that can trigger case reviews. They can be directly involved when CYP commit offences, go missing or when offences are committed against CYP. They may also become involved indirectly, through the criminal behaviour of parents or carers. Case reviews highlight that agencies need to work together to respond quickly and holistically to child protection concerns. Police need to be aware of the impact of abuse and neglect on children and recognise the signs of abuse. They also need to consider how the criminal behaviour of family members affects children.

Commonly, CYP have died or been seriously injured in a number of different ways, including: being killed by a parent, carer, partner or acquaintance; suicide; serious injury following physical abuse; chronically neglected; sexually exploited; or sexually abused. A number of issues for learning and barriers to help-seeking have been highlighted, such as engagement with services, fears of retaliation and feelings of shame/ embarrassment. There has also been poor understanding by practitioners, lack of professional knowledge about the impact of trauma, a failure to recognise vulnerability and a criminalisation of CYP. In terms of both youth offending and DVA there has been a focus on one-off incidents rather than looking at patterns of or reasons for behaviour.

[29] An analysis of statutory reviews of homicides and violent incidents is also available and has relevance to the issues and priorities identified within the SCRs and this review: https://www.scie.org.uk/safeguarding/reviews-of-homicides/london-2020

[30] Available at: https://learning.nspcc.org.uk/case-reviews/recently-published-case-reviews

[31] 'Complexity and challenge: a triennial analysis of SCRs 2014 to 2017' (2020) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

Given time constraints, five of the most recently published child safeguarding practice review were analysed. These local reviews considered cases in relation to their borough. However, learning from other cases includes (but is not limited to): concerns about professional knowledge; skills and safeguarding systems for children at risk of criminal exploitation; multi-agency coordination; and training available for practitioners.

Table 3: Recent Reviews in London

Locality	Case reference	Year
Thurrock Local Safeguarding Children Partnership	Serious case review: Sam and Kyle: overview report	2020
Waltham Forest Safeguarding Children Board	Serious case review: Child C: a 14-year-old boy	2020
Wandsworth Safeguarding Children Board	Frankie: serious case review: overview report	2020
City & Hackney Safeguarding Children Partnership	Serious case review: Child A	2021
Ealing Safeguarding Children Partnership	Child safeguarding practice review: Child "James"	2021

Common themes

Whilst the five reviews appeared very different, some common themes were found. Several children had learning difficulties or physical health needs. One case involved criminal exploitation, and specifically mentioned MOPAC in its recommendations: 'Waltham Forest Council should refer this report to MOPAC and request that the current uncertainties about the catchment area of the 'Rescue and Response County Lines' are rectified by a clear and unambiguous statement made to each Police Force in England and Wales (and their relevant partners), as well as a revised statement sent to each London Borough'[32].

Common across the cases was contact with services; in some cases this was significant. There were often features of silo-working; the child not being at the centre and lack of child voice, with little coordinated insight; a lack of multi-agency discussion; and poor information sharing. Review recommendations were made across and between agencies to address these issues. Given the nature of these SCRs, a large number of recommendations were made for health professionals. This included

[32] Serious case review: Child C: a 14 year old boy, p58.

multi-agency and single agency safeguarding training about the safeguarding impact for children who are not taken to health appointments.

The reviews varied in quality and length. Details of the review panel or their roles were also not listed in every review, which made it difficult to ascertain who had participated in the safeguarding review process. Sometimes the child's voice was absent in the review reports, and issues around equality and diversity not always included consistently. Only one review specifically detailed taking a rights-based approach. The introduction of a standard form or template could be considered. This would improve consistency and help with data analysis (although we note that reviews are not published for research purposes). The template should include details about specific actions as a result of the review – who should do what, and by when. Caution should be taken to avoid duplication of work undertaken by the NSPCC, however the potential for MOPAC to provide strategic oversight should be explored. They could be responsible for mapping and monitoring child safeguarding practice review across London to measure the implementation of actions, their impact and improvement. This might also assist with targeting their available funding based on the available data.

Sharing learning

Generally, it was unclear how any safeguarding review learning was disseminated more widely. It would be beneficial to share knowledge about risk factors and lessons amongst professionals working with CYP. For example, in a number of cases, service engagement by children and their parents was considered patchy. At other times, safeguarding was not as effective as it could have been As the Thurrock Review (2020, p.17) notes:

> *'The family was supported at different times by a range of individual practitioners and under different legal and service frameworks. Both mother and father were understood to have a degree of learning difficulties… it is not clear how well these different arrangements, and their different requirements and expectations, were explained to the family.'*

To disseminate learning to frontline practitioners, creative methods could be utilised to minimise further reading and paperwork, such as short video briefings. This would be more immediate than waiting for mandatory refresher training and allows wider learning beyond the immediate local authority.

In Greenwich, the focus of the Audit Work Group has been on holding regular multi-agency audits into key identified practice areas, to provide assurance and evidence to the Partnership that safeguarding

review and local learning review recommendations are implemented, understood, and are making difference, as well as the priority areas that the partnership has agreed.

At the pan-London level, it is difficult to recommend an effective mechanism to implement the recommendations of Child Safeguarding Practice reviews (previously Serious Case Reviews), and the role that MOPAC and the VRU could adopt to support, given the lack of resources available. A key area for MOPAC and VRU support could be empowering professionals and community members as champions with specific responsibility for driving any changes. The extent to which those attending multiple meetings use their structural position to promote the work needed is unclear. Champions should be 'senior enough' and 'committed enough' to drive the agenda forward at the outset. However, to ensure sustainability and avoid reliance on individuals, institutional commitment must be foregrounded. This should also extend to the community and general public. It is important to promote wider understanding of the risks and challenges that professionals face. Again, various initiatives take place at a local level, such as the Women's Aid Ask Me scheme, focused on training community Ask Me Ambassadors. However, this is neither consistent nor on a stable footing. There is potential for MOPAC and the VRU to assign champions with responsibility for relationship building within the various local authorities and promote a focus on learning rather than blame.

Key points

- Recent reviews were analysed and shared themes were found. Several CYP had learning difficulties or physical health needs. Service contact was common; sometimes significant. Features included silo-working; the child not being at the centre and lack of child voice; little coordinated insight; lack of multi-agency discussion; and poor information sharing.
- Review recommendations were made across and between agencies. Given the nature of these reviews, a large number of recommendations were made for health professionals. This included multi-agency and single agency safeguarding training about the safeguarding impact for children who are not taken to health appointments.
- Reviews varied in quality and length. Details of the panel or their roles were not listed in every review, which made it difficult to ascertain participation in the safeguarding review process. Sometimes the child's voice was absent in the reports, and issues of equality and diversity not included consistently. Only one review detailed taking a rights-based approach.
- The introduction of a standard form or template could be considered. This would improve consistency and aid data analysis. The template should include details about specific actions

as a result of the review. The potential for MOPAC to provide strategic oversight should be investigated.

- It was unclear how any safeguarding review learning was disseminated more widely. It would be beneficial to share knowledge about risk factors and lessons amongst professionals working with CYP. Creative methods could be utilised to minimise further reading and paperwork, such as short video briefings to promote wider learning beyond the immediate local authority.
- At the pan-London level, it is difficult to recommend an effective mechanism to implement review recommendations. A key area for MOPAC and VRU support could be empowering professionals and community members as champions with specific responsibility for driving change.

5. The youth justice context

Given the lack of coverage across the range of documents this section required a substantive introduction. Wider literature highlights the greater likelihood that offenders have suffered social exclusion compared to the rest of society (Williamson, 2019; Gray, 2007), with significantly greater degrees of mental health problems, substance abuse and poor physical health in prisoners than in the general population. Within this, young offenders and those from minority ethnic groups have distinct health needs. Protected characteristics such as gender, ethnicity, sexual orientation and history of abuse contribute to risks for victimisation, which highlights a need to consider such characteristics when developing safeguarding policy and practice. This has implications for youth custody, and the need to ensure that needs are met effectively and appropriately during their time in an institution and upon resettlement.

There are various forms of youth custody in the UK: Young Offender Institutions (YOI, which account for the majority of those in custody), Secure Training Centres and Local Authority Secure Children's Homes. Historically, YOI's have received criticism from both the government and general public. Problems have included self-harm, suicides, bullying, violence and unsafe conditions. Critics of YOIs assert that imprisonment is inappropriate for CYP. The majority of CYP within the institutions have complex educational, social and mental health needs and have experienced violence, abuse and exploitation. For example, the YCS review highlights that the CYP in custody are the most vulnerable and disadvantaged, and often present significant risk factors to themselves or others. Incarceration might exacerbate trauma and risk of harm. During the inspection at Cookham Wood, 31 CYP were remanded or sentenced for murder or attempted murder; 28% were on remand; and in the previous 6 months, 23% had been referred to the national referral mechanism (NRM). The large majority of CYP had children's social care involvement[33].

Broader Context

The Youth Custody Service (YCS) was established in September 2017 as a distinct arm of HM Prison and Probation Service (HMPPS). YCS now has operational responsibility for the CYP's secure estate, which accommodates all CYP aged up to 18 years held in England and Wales[34]. YCS is responsible for:

- providing a safe, decent and secure living and working environment

[33] HMIP (2019)
[34] Brooks et al. (2019)

- ensuring provision maximises safety outcomes for CYP and staff
- reducing reoffending

The YCS Safeguarding Review outlines their role in reviewing, defining and communicating policies, procedures and responsibilities in relation to safeguarding CYP at a national level[35]. This review details the current landscape and considers the interplay with other agencies in safeguarding CYP in custody. Whilst the findings and recommendations are at a national level, many mirror the themes found in the local documents made available to the research team. This provides useful context before we highlight specific institutions below.

Despite a reduction in the custodial population, the number of sites have subsequently decreased[36]. Consequently, CYP are placed at significant distances from home, with some sites not easily accessible by public transport to enable visitors. The absence of secure children's homes has been noted in London. This limits protective factors such as family support and affects access from the home Local Authority for looked after children. This has specific repercussions in terms of the Children and Social Work Act 2017 and its mandate for improved support. The YCS review advocates for a multidisciplinary approach to assessing and managing risk and promoting welfare and placements of CYP.

The YCS review found common use of isolation across the different institutions. There appeared to be little effort directed towards shortening periods of isolation, and a failure to recognise the importance of adolescent development. The Feltham inspection found high numbers of CYP locked in their cells for the majority of the time (26%). According to local PRISM reports, keeping CYP apart can actually increase risks of violence and self-harm. Maintaining keep apart lists can promote an ongoing culture of violence, without addressing the underlying function[37]. The review found that some sites had multiple keep apart lists, often without a clear rationale. CYP reported not knowing with whom they were not allowed to mix.

The safety of YOIs is a significant concern across the national and local documents reviewed. Safeguarding practice should be an ongoing, iterative process to effectively meet evolving policy and guidance. However, the YCS review found that commissioned contracts had insufficient emphasis on safeguarding.[38] The nature of contract management appeared to impact the culture at private secure training centres. The focus on reporting and delivering quantitative key performance targets negatively impacted a child-centred approach. Minimising risk factors took precedence over maximising protective factors.

[35] Brooks et al. (2019)
[36] Ibid
[37] Ibid
[38] Ibid

Pertinent to the London context is that the YCS review found that YOIs had a good understanding of local children's services, but relationships differed across Local Authorities[39]. They suggest that further work is required to understand the roles and responsibilities that each local children's service and YOIs have in relation to the other. For example, it was highlighted that the absence of regular meetings leads to a shortfall in provision, including a lack of suitable accommodation for CYP on release - a key issue identified in the local documents (detailed below).

Protected Characteristics

Race and Ethnicity

Notably, across the reports, a disproportionate number of CYP were from a BAME background in both YOIs and training centres. This mirrors ONS (2019) figures for CYP in custody, coupled with a predominantly white workforce. The YCS review highlights the importance of the Equalities Act (2010), additional vulnerabilities linked to race and ethnicity, and gaps in cultural competence[40]. This has direct relevance to the protocol for London on reducing criminalisation of looked-after CYP and care leavers.

The Lammy Review (2017), an independent review into the treatment of, and outcomes for, BAME individuals in the Criminal Justice System, found BAME disproportionality and racial bias across the system. However, the biggest concern surrounded the youth justice system. Whilst there are fewer CYP entering custody, the BAME youth prison population is rising - linked to arrest rates, court decision-making and custodial sentencing. Interestingly, the Lambeth Made Safer Strategy for 2020-2030 aims to tackle racism and embed an anti-racist approach.

The Lammy Review (2017) also found that BAME prisoners are less likely to be recorded as having mental health problems, learning difficulties and troubled family relationships. This highlights an area of unmet needs and fails to address root causes of re/offending among BAME prisoners. The Lammy Review (2017) also found that young black people spend longer in custody than young white people, with sentence lengths for violence against the person, theft and possession of weapons driving this trend. The recommendations for addressing the disproportionality of BAME people in the criminal justice system (which have significance for the work of MOPAC and the VRU) include improved partnership working with communities. It also suggested that the Mayor's review of the Trident Matrix should address disproportionality and made key recommendations for the police. Improved data is a

[39] Brooks et al. (2019)
[40] Ibid

key theme. As noted earlier, MOPAC are detailed[41] as improving data collection around equalities information and protected characteristics. It might be helpful to explore how this data can be gathered collaboratively and utilised to inform practice and interventions within the community.

The Lammy review (2017) identifies 'trust' as one of the three core principles to tackle disproportionality - among defendants, offenders and the wider BAME population. It highlights the importance of community trust and early intervention across services alongside the role of community safety partnerships, local authorities and community leaders. Any local involvement to address inequality and disproportionality is unclear from the wider documents. However, the review highlights examples of positive practice. This includes:

- Work in Hackney to improve outcomes for young black men, using a theory of change to address disproportionality in a range of areas including school exclusions and offending.
- Lewisham conducted its own review of disproportionality in the criminal justice system, which included analysis of the recommendations of the Young Review, interim report of the Lammy Review and Casey review, and finding opportunities for local implementation.
- Newham and Hammersmith and Fulham Youth Offending Services used the Ether Programme to support CYP from BAME backgrounds to increase personal development and leadership skills.

Our review of local priorities found that Islington had identified the importance of work to address inequalities and disproportionality of young BAME men within the criminal justice system, including poor health outcomes. The extent to which such examples of positive practice have been retained and embedded since the review warrants further investigation.

Disability

The YCS review found that most sites did not routinely cater for physical disabilities, including in rooms and showers. Facilities overall were not appropriate for meeting specific needs, such as those with visual impairments or requiring wheelchair access. Whilst most sites had good arrangements in place to identify and support learning difficulties, (although this primarily applied to educational settings), many notices and information for CYP did not consider learning or developmental needs such as dyslexia or autism. The YCS review recommended that a multidisciplinary, psychologically informed approach would ensure that CYP with learning difficulties and disabilities are cared for appropriately across all areas of service provision.

[41] In the protocol 'Reducing criminalisation of looked-after children and care leavers' (2021)

Religion and beliefs

Provision for a variety of religions was present in most sites. Most CYP were observing either Christianity or Islam. Respective Ministers for other religions were provided according to need. In some sites, areas for worship were multi-use, and efforts appeared to have been made to respect the needs of different religions, albeit in need of capital investment and requiring modernisation. The physical environment of these areas could be further enhanced to facilitate CYP wellbeing.

Age

Chronological age is considered when placing CYP. However, sites invariably accommodated CYP ranging in age and psychosocial maturity. In some areas, such as educational settings, decisions to mix CYP of differing chronological age appeared responsive to ability and thus individual need. Nevertheless, exposure to older peers can increase risk, and therefore age remains an important consideration both in the placement and ongoing care of CYP in custody.

The London picture

Evidence for review was provided for three institutions:

- Cookham Wood YOI
- Feltham YOI
- Medway Secure Training Centre

Documentary evidence demonstrated that each institution had developed differently. However, some common themes emerged that link to the wider context detailed above, including safeguarding issues and transportation to sites.

Cookham Wood YOI

The (unannounced) inspection of Cookham Wood YOI, Kent, a facility holding up to 188 boys aged 15-18 years old, found deterioration - to the extent that outcomes were insufficient against healthy prison tests. This was linked to issues of recruitment and retention, and a knock-on effect of Feltham YOI being issued an Urgent Notification[42]. The majority (75%) of CYP had children's social care

[42] HMIP (2019)

involvement[43]. Despite statutory responsibilities to support CYP in custody, boys still did not receive their full support entitlements. This is significant given the Children and Social Work Act 2017 and its principles relating to children in care and care leavers. The inspection recommended that a memorandum of understanding be developed with the local authority and social care provider, to ensure that arrangements are in place if a child requires social care.

Safeguarding procedures had improved since the previous inspection, and levels of self-harm were lower than at comparable institutions[44]. There was a good safeguarding policy in place, which was well-advertised to staff. The designated officer attended the prison weekly and offered advice to the safeguarding team. A monthly safeguarding meeting was well attended, including by the governor, and analysis was undertaken. The governor sits on the Medway Children Safeguarding Board. Referrals to the designated officer had increased, with most referrals involving excessive use of force. Most were returned with no further action, but there were cases where staff had been challenged and action taken[45].

Levels of violence, some serious, remained high. Work to address conflict was impeded by staff shortage or redeployment. The inspection reported that high rates of low-level poor behaviour went unchallenged and little was done to encourage fuller engagement. Safety was undermined by an overreliance on reactive 'keep apart' lists and by significant amounts of lock-up. Accommodation standards and the regime for separated CYP was also found to be poor[46].

There was little time out of cells, including for education or at mealtimes. Access to the gym and library was restricted. There was little mention of faith services. Despite some improvements to provision, punctuality and attendance at education and vocational training were poor, which limited education hours and contributed to a course completion rate of only half. Overall, Ofsted judged the learning and skills provision as 'requires improvement'. Given the concerns highlighted across the literature, providing education, training and employment opportunities to CYP could be key for their release.

Generally, the inspection found poor relationships between staff and CYP. Consultation arrangements needed more support, and CYP experienced limited access to application and complaints procedures. The promotion of equality was poor, but the quality of health provision remained good[47].

Oversight of resettlement work was unacceptable, lacking focus and coordination. The casework department operated in isolation, case managers needed better training and only half of CYP thought

[43] HMIP (2019)
[44] HMIP (2019)
[45] Ibid.
[46] Ibid.
[47] Ibid.

they had a custody plan[48]. Completed plans often failed to consider risk of harm or usefully support resettlement. They found that assessments and public protection work were not sufficiently robust, and their survey indicated that just a quarter of CYP thought someone was helping them with their release. There was also a concern surrounding the shortage of suitable accommodation for release.

Recommendations for improvement included higher standards of living conditions and CYP's behaviour, a more active regime that incentivises and engages CYP, and a robust and coordinated delivery of effective resettlement services. There is a need to improve links with community support agencies and training providers, to provide CYP with effective support after release. The casework department had recently started to contact community agencies to monitor outcomes for CYP on release. However, meaningful data were not yet available. This could be an area for MOPAC support. Further support might also be needed around the enacting legislation, particularly for those CYP leaving custody and those in the care system. This might be an area which would benefit from strategic oversight.

An action plan was developed to address the concerns outlined in the report. It sets out agency/professional roles and responsibilities, but there is no mention of MOPAC or the VRU. It focuses on identifying any safeguarding concerns and engages external support and advice, with an emphasis on regular incident review, including by the Medway Children Safeguarding Board. Both internal and external scrutiny provides an opportunity to identify and address deficiency[49].

The HMP Cookham Wood Reinspection report[50] relates to the period in which the prison was used for female offenders, however it does offer some useful insights into the potential learning opportunities that could be replicated for CYP currently residing at Cookham Wood. For example, there was a range of work and accredited training opportunities available, including tailoring and light assembly workshops, gardens, catering, physical education (PE), painting and cleaning. This report highlights a clear and effective strategy for the development of education and training, positive working relationships with partners, creative activity to promote and celebrate diversity, and system to observe teaching and learning. However, we note that the wider context has changed significantly since the time of this report, as noted at the outset of this report.

[48] Ibid.
[49] HMPP (2020.
[50] Adult Learning Inspectorate (2006)

Feltham YOI

Feltham YOI is located in Hounslow, West London and accommodates up to 180 CYP (aged up to 18) and 360 young adults (aged up to 21). The most recent available report was from 2010. Given the context identified in other reports[51] and its media profile, we considered this to be outdated. The PraxisCollab research team located a July 2019 report, presenting the inspection of healthcare services provided by Care UK Practices Limited (Care UK) . This noted improvements since the January 2019 inspection, in which a Requirement Notice under section 29 of the Health and Social Care Act 2008 was issued[52]. However, they also identified new risks related to medicines administration, which had not been sufficiently assessed or acted upon. We also located the 2019 report for an unannounced inspection of Feltham A Children's Unit. This judged that Feltham was not safe enough for CYP. Arrangements to receive CYP into custody were adequate. Risk assessments on arrival were appropriate, although first night accommodation needed to be cleaner and better prepared, and induction needed to be delivered promptly.

There was evidence of a significant increase in the numbers of CYP self-harming. General child protection and safeguarding arrangements remained robust, but a survey found that 13% of CYP said they currently felt unsafe and levels of violence had increased significantly since the last inspection[53]. Violence reduction initiatives existed but needed more rigorous and co-ordinated application. Similarly, a comprehensive behaviour management strategy had been formulated, but applied inconsistently.

The enhanced support unit to help CYP with complex needs, was underused; incentive arrangements did not sufficiently motivate CYP; and operational staff were not sufficiently challenging antisocial behaviour. 'Keep-apart protocols', a mechanism to separate individuals or gangs who were perceived as a threat to each other, had become all-consuming. Existing arrangements were having an impact on all aspects of the regime, limiting opportunities for CYP to make any progress. The survey also found that nearly two-thirds of CYP found that they had been physically restrained and the use of force had reportedly increased. Oversight and scrutiny were, however, lacking and we found evidence of poor practice, including the use of pain-inducing techniques, that had not been accounted for.

CYP did not feel respected by staff, and many reported feeling victimised. It was highlighted that many staff were too preoccupied with keeping CYP apart to be able to develop trusting relationships. The

[51] E.g. HMIP (2019b)
[52] Care Quality Commission (2019)
[53] HMIP (2019b)

residential environment had deteriorated. There were also gaps around promoting equality. Health services met most needs.

However, there was evidence of improvements to the education and training curriculum, and to the management of teachers. Most CYP valued education and behaved well, but attendance and punctuality were poor. Ofsted judged the overall effectiveness of learning and skills as 'requires improvement'. Outcomes in resettlement work were reasonable, but there were a number of shortcomings. The reducing reoffending strategy and oversight arrangements needed to be updated, although partnership working with third-sector organisations provided invaluable support. Most CYP had a training or remand plan which were reviewed regularly. Case workers needed further training support. Public protection arrangements were managed well, but offending behaviour interventions had been limited by staff shortages and also by the imposition of the 'keep-apart requirements'.

More than half of CYP at Feltham had looked-after status and processes to identify them on arrival were well established. Local authorities with responsibility for CYP were notified promptly of their reception and reminded of their obligations to the child by the seconded social workers based at Feltham. The social workers were robust advocates for the CYP, particularly in relation to securing their financial allowances. Some local authorities were more diligent than others in providing this support, but social workers monitored payments and followed up when necessary. Looked-after reviews were held in conjunction with training or remand planning reviews where possible. There was evidence of good co-working between social workers and caseworkers, in some cases meeting a child together to discuss behaviour, progress and concerns. The timely provision of release accommodation for CYP who were looked after remained a significant issue.

Feltham YOI managed a range of policies to safeguard and protect CYP. Useful reports on self-harm, violence and restraint were discussed at monthly and quarterly safeguarding meetings. However, few actions were generated from these discussions to address the continuing high level of incidents. The prison had a positive relationship with the local authority and the head of safeguarding attended Hounslow Safeguarding Children Board meetings. During the previous six months, 47 child protection referrals had been made to Hounslow Children's Services, more than at the previous inspection. Oversight by the safeguarding team remained good. Upon referral, the team consulted the local authority designated officer within 24 hours and managers took appropriate action to protect CYP from potential harm while the investigation was continuing. Some allegations submitted on complaint forms were unnecessarily delayed before the safeguarding team was informed, because complaints staff had not prioritised them. Most child protection investigations concerned allegations about use of force, which had increased since the previous inspection and is consistent with the experience at

Cookham Wood. Independent social workers continued to provide support for CYP who made allegations of abuse or harm.

Medway Secure Training Centre

Secure Training Centres are smaller, purpose-built establishments compared to YOIs. 'Learning for organisations arising from incidents at Medway Secure Training Centre' serious case review highlighted the public and media scrutiny following a BBC Panorama report, which showed excessive use of force in restraints by staff, inappropriate language, shouting, bullying and aggressive behaviour, and highlighted the impact that this had on some CYP. Inspections of Medway secure training centres (Ofsted, 2018) found that despite progress, all areas (with the exception of one) required improvement. Safeguarding arrangements were developing but were not yet good overall. External scrutiny and transparency are promoted through regular liaison with local safeguarding services, including the designated officer, about individual concerns and attendance at regular centre meetings. This is positive, but the centre needs to improve standards of safeguarding knowledge within its own workforce, particularly those with responsibility for this area, and reduce reliance on partner agencies for guidance and advice. The quality of referrals to external agencies and other safeguarding record-keeping was variable and required improvement. Some matters of concern were regarded as security issues and overlooked the safeguarding element, and vice versa[54].

Further inspections indicate development in some areas to improve practice, but by 2019 it was reported to be inadequate. Little progress had been made in those areas that significantly impact on CYP's experiences, wellbeing and safety, and senior managers were considered too slow to accept this and respond. Serious weaknesses meant that CYP are at risk of harm and are not safeguarded. To illustrate, a serious child protection concern was not referred to the relevant authorities according to safeguarding procedures. The safeguarding manager confirmed that they did not identify this concern, and this placed CYP at risk of harm. When the matter was brought to the safeguarding manager's attention, liaison took place with the local authority's designated officer to take the matter forward[55].

Summary

Effective sharing of information is essential for early identification of need, assessment and service provision to keep CYP safe. The YCS review identified gaps in information sharing between those with

[54] Ofsted (2018)
[55] Ofsted (2019)

legal responsibilities in their work with CYP. There were also barriers to accessing wider information; for example, health records, school records and chronological histories from social workers.

The YCS review advocates for a child-centred, rehabilitative culture, with safeguarding seen as an overarching aspect of all roles and functions[56]. However, the reports highlight a focus on incarceration, rather than rehabilitation and care. To be effective, youth justice interventions must be responsive to a vast range of needs. It might be helpful to draw together evidence of the needs of CYP across the institutions, in relation to age, ethnicity and vulnerabilities.

Concerns surrounding safety and levels of violence are highlighted by various stakeholders across the literature. Use of force has increased significantly, and pain-inflicting techniques continue to be used on CYP. There were issues with the standards of the physical environment and CYP were locked up for significant portions of the day, with little to occupy their time. Despite being a source of resilience, disrupted education was a key issue, and was also impacted by Covid-19[57] due to measures such as social distancing, restricting educational activities further.

There were issues associated with adolescence as a period of turbulence, but also issues with vulnerabilities versus risk. There was less emphasis on the voice of CYP in the documents, which underscores that institutions were less child-centred and that generally there was poor communication between staff and CYP. However, improved relationships would better benefit outcomes for CYP, particularly around continuity of care[58]. Barriers to resettlement were common across the sites. The outcomes of these circumstances - including reoffending rates - are unclear. However, their experiences are likely to further undermine present and future opportunities, and there appeared to be little in the way of resilience-building activities.

Using the documents available, it is not possible to explore how well community activities to address the causes of violence is impacting on offending rates. Unsurprisingly, CYP described in the reports mirror those identified across the local authority priorities, such as CYP with complex personal problems, social exclusion, involvement in criminal activities and gang affiliations. It is unclear the extent to which a public health approach has transferred to the prison setting. This is important given the relevance of issues in the community i.e. gang activity and living on the social margins. Given the lack of activity and high rates of isolation, it would be helpful to explore possibilities for replicating community initiatives within the prison setting, to help address the high rates of violence identified within the institutions.

[56] Brooks et al. (2019)
[57] https://thenayj.org.uk/cmsAdmin/uploads/state-of-youth-justice-2020-final-sept-(1).pdf
[58] Brooks et al. (2019)

Practice was underpinned by a restricted focus on risk mitigation and protectionism over maximising opportunities. We recommend the implementation of a more collaborative and empowering approach, whereby agencies work together to identify opportunities to increase the safety and support available. The feasibility of a joined-up approach to mental health, education, employment and training should be explored. It would also be useful to investigate how priorities in the community, for instance around gang and serious youth violence, can be addressed within the prison setting. Currently, it appears that CYP in the community and those within the prison setting are separate, rather than overlapping. Greater priority could be given to the complexities of working with this group and improved co-ordinated support within the prison setting and after resettlement. Finally, the documents provided recommend ongoing review and action in order to be meaningfully integrated into existing practice.

Key points

- The majority of CYP in the youth justice system have a wide range of complex needs and experiences of violence, abuse and exploitation. It might be helpful to collate evidence of the needs of CYP across the London institutions, in relation to age, ethnicity and vulnerabilities.
- A disproportionate number of CYP in the youth justice system are from a BAME background. Exploration of how equalities data can be gathered collaboratively with MOPAC and utilised to inform practice and interventions would be beneficial. The extent to which positive practice examples have been retained and embedded warrants further investigation.
- Evidence was provided for three institutions: Cookham Wood YOI; Feltham YOI; Medway Secure Training Centre. Documentary evidence demonstrated that each institution had developed differently. However, common themes emerged, including safety, safeguarding issues (such as self-harm and excessive use of force).
- Levels of violence remain high and there are increasing reports of excessive use of force. There was little time out of cells, including for education. Opportunities for education, training and employment are a concern. Participation of CYP and improved relationships with staff are needed. The voice of CYP is currently missing.
- Resettlement work requires significant improvement and coordination. There is a shortage of suitable accommodation for release. Improved links with community support agencies and training providers, to provide CYP with effective support post-release are required. Enacting legislation, particularly for those CYP leaving custody and in the care system, might be an area for improved strategic oversight.

- Practice was underpinned by risk mitigation and protectionism. We recommend the implementation of a more collaborative and empowering approach, whereby agencies work together to identify opportunities to increase the safety and support available. The feasibility of a joined-up approach to mental health, education, employment and training should be explored.
- It would also be useful to investigate how community priorities, such as gang and serious youth violence, can be addressed in the prison setting. It appears that CYP in the community and those within the prison setting are separate, rather than overlapping.

6. Future work plans

MOPAC and the VRU could provide more support in mapping and understanding successful multiagency safeguarding arrangements in London.

There are several initiatives which share a view of CYP as vulnerable and requiring protection through safeguarding responses. However, concerns are also expressed about children being 'risky' and capable of harm. There is a need to develop shared strategic and operational approaches that balance 'risks to' children with 'risks from' (sometimes the same) children. Some safeguarding policies are out of date (e.g. Brent, Barking and Dagenham). Currently, the Islington sample safeguarding policy for organisations refers to the London Child Protection Procedures as a key framework.

The London Child Exploitation Operating Protocol (2021) is a multi-agency protocol led by the police. It details how professionals should identify and address a child to provide a consistent response across London. It is seen as complementary to existing child protection procedures and replaces the 2017 Pan London CSE Protocol. It includes wider forms of exploitation, including County Lines and online exploitation, as well as an Adolescent Safeguarding Practice Framework. The Protocol emphasises that children are vulnerable to or at risk from exploitation, and whilst they may be perpetrators as well as victims, they must first be considered 'as a child'. The document outlines different types of exploitation. It aims to:

- Identify children at risk of exploitation and keep them safe
- Up-skill all Safeguarding Partnerships to achieve a standardised collaborative approach to Child Exploitation
- Provide early intervention opportunities to stop or prevent children becoming victims of exploitation
- Provide frontline responders with the correct disruption tools

Some boroughs were also developing plans to address child exploitation. For example, Newham planned to implement a new 'Preventing Child Exploitation and Harm Hub' in April 2021 (it is unknown if this has happened at the time of writing).

Islington Council and Police have identified Single Points of Contact (SPOCS) to lead the development of a joint response to Modern Slavery/Trafficking. Training in Modern Slavery and Trafficking (including county lines) has been delivered through the Exploitation and Missing Team across Safeguarding and Family Support and Youth & Communities since January 2019. This training covers the safeguarding response to children at risk from, or victims of, Modern Slavery and Trafficking,

including those at risk of county lines. Referrals to the National Referral Mechanism (NRM) and the Rescue and Response team (for county lines cases) are incorporated within this response.

Future work plans should seek to incorporate up to date guidance and legislation such as the Domestic Abuse Bill (2021)[59] and keeping children safe in education (2021)[60]. Across the local boroughs, these key changes were not mentioned despite a great deal of awareness-raising prior to their inception. This might, in part, be linked to the timing of the documents retrieved. In some boroughs, such as Redbridge, DVA is referred to in annual reports as a safeguarding risk. The Safer Lambeth Partnership Scrutiny Report (2020) includes references to the DA bill, particularly pertaining to ensuring implementation of the changes outlined within the bill.

It is also important to listen to and understand those who might be hesitant or resistant about a different way of working. Following our review, we emphasise the importance of professionals being updated on legislation and policy that underpins their work in a timely way. For example, the Domestic Abuse Bill 2021 is crucial for safeguarding practice, and yet it appears absent in the documents reviewed. The role of MOPAC and the VRU could be explored in raising awareness about legislation and ensuring that boroughs are providing adequate upskilling support to staff in response to legislative changes. Quality assurance of these processes might also be an area for consideration.

[59] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

[60] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1014058/KCSIE_2021_Part_One_September.pdf

Review Summary and Recommendations

This rapid review has examined current safeguarding arrangements under MOPAC and how they function in relation to statutory responsibilities in the Children and Social Work Act 2017. The strategies and protocols reviewed indicate that MOPAC undertakes a range of activities, including: research and data collection; providing funding for projects and programmes; and promoting multi-agency working. However, further clarity about MOPAC and their effectiveness and sustainability would be beneficial. In-kind contributions or added value of MOPAC and the VRU could be investigated.

Two overarching priorities were found across key MOPAC and VRU documents: (1) Violence against women and girls (VAWG) and (2) Keeping CYP safe (e.g. from CSE, knife crime). These issues are relevant to child safeguarding practice reviews and domestic homicide reviews. In addition, safeguarding partners determine their own local priorities, specific to local population need. However, often there was limited discussion concerning VAWG. There was more emphasis on risks from and risks to young people.

Many of the documents were repetitive and provided the same information. In some cases, policies and procedures were not always easily accessible. An in-depth mapping exercise with partners could explore areas of duplication and propose potential improvements effectiveness. Further documents were beyond the scope the review, given the time available. Boroughs identified as a priority have been detailed in the review. Wider learning from the remaining boroughs and further information should be collected in the next research phase.

In analysing the differing local arrangements across London boroughs there was evidence of both similar and diverging structures and procedures. The role and responsibilities of MOPAC and the VRU requires more detailed clarification. Understanding at a practice level is unclear and documentary evidence is limited. Further work is needed to explore their potential role in supporting safeguarding, particularly in regard to strategic oversight.

There is a need for a robust recording system to proactively monitor the governance and co-ordination of child safeguarding arrangements. This should include the roles and responsibilities of MOPAC, the VRU and the MPS as well as individual partners. Once developed, this will help to identify any gaps in policies, procedures, training, partnerships or priorities. It might also encourage greater opportunities for shared practice.

Local and regional multiagency safeguarding arrangements across London would benefit from improved consistency. Currently there are multiple approaches (of varying degrees) to intra and extra-

familial harm. Each borough seems to operate differently which might be confusing for both partners and service users. Barriers include the large geographical area, inequalities between boroughs, limited resources, staff training, community buy-in, and partnership working. In addition to examples highlighted, further exploration of facilitators to positive practice would be beneficial, particularly regarding implementation.

Connected to this, the same professionals (particularly strategic managers) might be attending multiple meetings but given the lack of details included in the minutes (i.e. of their role or organisation) we were unable to map attendance and make suggests for streaming of groups or processes. It would be useful to improve administration and subsequently investigate the possibility to share information and learning across groups and committees which encompass multiple boroughs with them aim of improving efficiency and reducing silo-working across the 32 boroughs.

Recommendations

We propose a number of recommendations based on the core themes of this rapid review.

1. A diagram would be helpful for practitioners to outline MOPAC's roles and responsibilities, and to understand the structure and processes around statutory procedures.
2. The oversight function of MOPAC must be more clearly defined across documentation at both the pan-London and local authority level.
3. It would be helpful to explore the role that the VRU and MOPAC have in relation to supporting and monitoring the requirement to have a serious violence reduction plan.
4. Further clarity about MOPAC activities (data collection, funding, promoting multi-agency working), their effectiveness and sustainability would be beneficial. In-kind contributions or added value of MOPAC and the VRU could be investigated.
5. MOPAC should drive a culture of iterative research and evaluation. In practice, this means collecting and using data, building evidence to develop responses, and evaluating violence prevention approaches to establish what works and for whom.
6. There should be a shared recognition that interventions take time to implement, and a move away from short-term initiatives.
7. Standardised meeting templates and a central repository might be helpful to improve consistency and provide increased opportunity for shared learning.
8. Evaluation of prevention approaches might be beneficial to identify best practice and inform a more unified approach.

9. The feasibility of enhanced collaborative working with the youth justice sector could be explored.
10. Further exploration of barriers and facilitators to implementation of safeguarding arrangements would be beneficial.
11. The potential for MOPAC to have a strategic role in sharing learning, policy/ legislative changes and good practice across the boroughs should be investigated.
12. Given the length of some documents, accompanying video briefings developed by MOPAC might also be helpful for practitioners.

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22. Wandsworth Safeguarding Children Board (2020) Frankie: serious case review: overview report
23. City and Hackney Safeguarding Children Partnership (2021) Serious case review: Child A
24. Ealing Safeguarding Children Partnership (2021) Child safeguarding practice review: Child "James": 3 January 2010 - 16 August 2020

Available evidence reviewed by borough

Barking and Dagenham

Barking and Dagenham Family Information Service (no date) Safeguarding our Children A child protection guide for all early years and childcare providers

The Community Safety Partnership minutes (June 2021)

The Community Safety Partnership minutes (March 2021)

Health and wellbeing board minutes (March 2021)

Health and wellbeing board minutes (June 2021)

Minutes of health scrutiny committee (February 2021)

Minutes of health scrutiny committee (March 2021)

CSP VRU Action Plan 2020/21

Brent

Safeguarding Children in Early Years Settings in Brent (no date)

Brent health and wellbeing board meeting minutes (Oct 2020)

Brent health and wellbeing board meeting minutes (April 2021)

Safer Brent Partnership Overview & Scrutiny Committee Report from the Interim Policy & Partnerships Adviser (no date)

Brent Safer Neighbourhood Board, Online public meeting. Summary: 19 August 2020

Croydon

Croydon Safeguarding Children Board—Child Protection Partnership Practice Framework, PPT. (n date)

Croydon Safeguarding Children Partnership—Local safeguarding partnership arrangements in response to Working Together 2018 (2019)

Croydon Safeguarding Children Board—Vulnerable Adolescents Thematic Review (February 2019)

Croydon Safeguarding Children Partnership Annual Report 2019-2020 (November 2020)

Croydon Safeguarding Children Partnership Learning and Improvement Framework (November 2019)

Safer Neighbourhood Board Minutes (5 December 2018)

Scrutiny Children and Young People Sub-Committee (20 April 2021)

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Health and Well-being Board Minutes (21 October 2020)

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Croydon Learning from Rapid Reviews (December 2020)

Greenwich

Greenwich Safeguarding Children Partnership Annual Report 2019/20 (2020)

Children and Young People Plan 2020 – 2024 (no date)

Multi agency involvement in Child Protection Conferences – Royal Borough of Greenwich

Greenwich Safeguarding Children Partnership, Children held in custody report (February 2020)

Community Safety and Environment Scrutiny Committee meeting minutes (February 2021)

Community Safety and Environment Scrutiny Committee meeting minutes (April 2021)

Greenwich CYP Scrutiny Panel meeting minutes (June 2021)

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Children's Services Scrutiny Committee meeting minutes (July 2021)

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Health and Care Scrutiny Committee meeting minutes (June 2021)

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Health and Wellbeing Board meeting minutes (November 2020)

Health and Wellbeing Board meeting minutes (March 2021)

Islington Youth Safety Strategy 2020-2025 (November 2020)

The Disproportionality Project evaluation report (May 2020)

Kingston and Richmond

Children and Young People's Plan Refresh 2017-2021

Kingston and Richmond Safeguarding Children Partnership—Neglect Strategy 2018-2021

Richmond Health and Well-being Board Summary Presentation—Joint Health and Wellbeing Strategy 2016-21 (PPT)

Richmond Health and Well-being Strategy 2016-2021

Kingston and Richmond Section 11 Audit of Strategic Partners (Audit Tool)

Kingston and Richmond SCP Multi-Agency Vulnerable Children and Adolescent Subgroup

Kingston and Richmond SCP—Local learning review subgroup: terms of reference (October 2020)

Kingston and Richmond SCP Annual Report 2019-2020

Kingston and Richmond SCP Child Friendly Easy Information 2020

Kingston and Richmond SCP—Vulnerable Children and Adolescent's Strategy (including MARVE—Multi-Agency Risk and Vulnerability to Exploitation)

Kingston and Richmond SCP—Mental Wellbeing Summary

Neglect Action Plan January 2019

Minutes of Health and Well-being Board Meeting (April 2021)

Minutes of Health and Well-being Board Meeting (August 2021)

Richmond Community Safety Plan: Tackling Crime, Protecting Communities 2017-2021

Self-Reflection Tool for LSCB by research in practice

Kingston and Richmond Youth Safety Strategy 2021-2025

Lambeth

2020 Safer Lambeth Partnership Scrutiny Report (March 2021)

Lambeth Children's Services Scrutiny Sub-Committee Minutes (March 2021)

Lambeth Children's Services Scrutiny Sub-Committee Minutes (June 2021)

A Children and Young People's Plan for Lambeth 2018-22

Lambeth Health and Wellbeing Board Minutes (April 2021)

Lambeth Health and Wellbeing Board Minutes (July 2021)

Lambeth Made Safer Strategy. For Young People Strategy 2020/2030

Lambeth Safeguarding Annual report 2018-2019

Lambeth Safeguarding Annual report 2019-2020

Lambeth YOS Building Brighter Futures Strategy (A strategy for improving the way we work with young people who are offending or at risk of offending in Lambeth).

Safer Lambeth Partnership Strategic Assessment 2020-2021

Newham

Health and Well-being Board Minutes (December 2020)

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