

## Executive Summary: Local Child Safeguarding Practice Review regarding Andre

### Introduction

1. The Safeguarding Children Partnership conducted a rapid review which, despite the circumstances of his death, identified good practice in engagement with Andre in managing risk. There was also learning around information sharing, duplication in systems that supported working with young people, and difficulties in re-housing families.
2. A Local Child Safeguarding Practice Review was initiated regarding Andre after the National Child Safeguarding Review Panel advised this Safeguarding Partnership of possible further areas of further inquiry to inform learning:

*“We thought your LCSPR should be proportionate and build on the learning you have already identified through your rapid review and should focus on the two identified areas of learning. In particular, to explore the interaction between **diversity and culture** and to look at how your **newly established adolescent safeguarding service is working** and how it impacted on this case”.*

The Rapid Review had also identified that there was merit in exploring further the theme of practice and planning when working with **parents with parental mental health**. Therefore these are the three key themes that the LCSPR addressed.

3. It should be noted that there is an ongoing criminal prosecution underway relating to Andre’s death and so the detailed report is currently restricted in terms of publicity and dissemination.

### The young person

4. Andre passed away shortly after completing school. It is essential to preserve the young person’s anonymity and that of his family, however the practitioners emphasised their approach as *“child first, offender second”* and so it is important to reflect this and share some comments they made, so as to describe him. Andre was well-liked by those who met him professionally. He was described as having *“a presence: there was something about him”*. He was also described as *“a pleasure to work with”, “polite and never rude”* and a *“real family man”*. Andre was mixed-heritage, from two diverse ethnic backgrounds.
5. For 2 years up to the time that he died, Andre had had significant professional involvement with professionals and received statutory interventions within two key systems. Prior to this period under review, Andre had not been known to statutory services.

### Part One of the report focuses on working with culture and diversity.

6. A recent HMIP report noted that *“the knowledge and integrity of the worker and the relationships they form with black and mixed heritage boys are the most important factors in supporting and promoting meaningful and effective engagement.”*<sup>1</sup> In examining and reflecting on practice with Andre, practitioners showed this in how they worked with Andre, how they understood his culture and specifically his experience of racism in the following ways, against a broader backdrop of structural challenges of disproportionality, racism and poverty to young black and mixed -heritage people:
- The practitioners in this review spoke of *“honesty, integrity and transparency”* in their work with Andre and his peers as the basis for successful engagement.
  - The practitioners were curious about Andre’s complex lived experience.
  - Recognised the different forms of racism that this young person experienced and that he had experienced racism within his primary attachment relationship and sought to consider what that might have meant for Andre.
  - Trauma- informed practice meant actively acknowledging and engaging with difficult issues especially around structural and individual racism (for example as part of school exclusion) , fear, anxiety, poor mental health; hopelessness and hope, in order to offer a different response from violence.
  - Understood that Andre’s everyday experience of racism and a sense of purposelessness was at the forefront of his and other similar young people’s poor mental health.
  - Celebrating things important to the young person – clothes, music, role models.
  - Acknowledging friendships as a positive, not always a negative, as an antidote to the perception that friendship groups of young black people are increasingly seen as negative or are even criminalised.
  - Allowing Andre to reflect and explore his behaviour as a response to the very real adversities experienced which formed his responses. This was his culture.
  - Exploring and acknowledging the ‘pull factors’ of the gang and possible risks through scenario-based work.

### **Key practice pointers in working with culture and diversity:**

7. Below are some practice pointers which appear to underpin the approach to working with culture and diversity with young people such as Andre:
- Ensuring that the young person’s voice is central to the intervention - *“doing with, not to”*.
  - Be transparent and honest about your role and statutory duties and who you work alongside e.g. courts, police, but also create safe spaces for young people to talk
  - Being informed about the young person and the contexts they move through – what is happening now that is relevant.
  - Working in a strength-based risk informed way with young people – risk is everywhere, everyday; as are resources and protective influences, and sometimes risk and resource can be found in the same place.
  - Communicating in real time with practitioners in partner agencies around new or relevant information which informs risk management

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<sup>1</sup> <sup>1</sup> The experiences of black and mixed heritage boys in the youth justice system. A thematic inspection by HM Inspectorate of Probation October 2021. Accessed <https://www.justiceinspectors.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/10/The-experiences-of-black-and-mixed-heritage-boys-in-the-youth-justice-system-thematic-report-v1.0.pdf>

- Reflect in real time with colleagues about the young person, events, changes and what they might mean.
- Reflect with the young person about their experience.

**Learning Point:** *the practitioners in this review demonstrated some very skilled practice with Andre. There were many enabling factors support good quality practice – values, the context of practice, leadership, communication, clarity of purpose and approach, experience, skills, personal attributes which this account has only briefly touched upon.*

**Recommendation One: Acknowledging and reflecting upon the elements of good culturally competent and anti-discriminatory practice and how to embed it in safeguarding practice in Enfield should be a priority and focus for Enfield Safeguarding Children Partnership over the next year.**

### **Part Two: Working with parental mental health.**

8. Practitioners observed closely the nature of the relationship between Andre and his mother. Practitioners saw the parent's mood and presentation and how it influenced Andre but there was not a shared understanding in the professional network of her mental health diagnosis and how it impacted upon her parenting. This may also have supported more appropriate intervention with her and safety planning for Andre and his family
9. One practitioner who worked closely with the parent evidenced a well-practiced strategy to allow them to engage with services. Whilst acknowledging the capacity to meet basic needs as a good basis for change in families, the focus on simply achieving visits or acknowledging a parent's capacity to provide basic physical care may have fallen short of gripping the more complex and harmful aspects of the inconsistency or unpredictability of a parent in meeting a child's emotional needs.

**Learning point:** *In order to work effectively to support a parent in becoming a consistent protective factor where a young person is facing risk in the community, practitioners have to understand the history, the trauma, of the past risks and current vulnerabilities in the parent's life which contributes to their style of parenting. Curiosity is required regarding where observed behaviours come from. The should be discussed openly with the parent and reflected upon overtly as to how these factors might contribute to their parenting style.*

**Recommendation Two: The partnership needs to ensure that multi-agency assessments and planning of children include an assessment of parenting in that goes beyond the practical capacity to provide care and explores the parent-child relationship in the light of the family's history of vulnerability and risk.**

### **Part Three: Information regarding the new Children's Specialist Service established June 2021: what might be different in terms of intervention for a young person like Andre going forward?**

10. Information shared during the Rapid Review process suggested there was some duplication and gaps in the two statutory processes within which Andre received services. Further inquiry regarding the development of the new Children's Services' Adolescent Safeguarding service as a focus on how to improve the effectiveness of intervention for

young people and a robust use of the available statutory tools so that the young person is at the centre of multi-agency work.

11. The new service is still developing its delivery model and practice approach around extra-familial harm. Areas of current attention include establishing key objectives and challenges are for the service across a range of need and risk; embedding a streamlined route to the intervention in the service; embedding the evidence-based trauma-informed interventions with young people, in the family (especially siblings) and in the community. A useful summary of what the challenge is for the service is to compete successfully with the alternative 'offer' from exploiters and gangs.
12. The identified approach was felt to be 'two-pronged' by working relationally with the young person to fully grasp their lived experience pro-actively enabling young people to access community opportunities, but also to work with young people to develop self-protection skills. and to work with the community to develop as a protective factor. Practical approaches offered included working with young people to recognise themselves and their experience, and to support the young person in identifying where the 'red lines' were for them in terms of the risks they faced. Working practices need to be flexible and creative in order to engage young people earlier and effectively. This echoed the reflection on good practice by those that had worked with Andre as described above.
13. Other priorities were mentioned were particularly relevant getting the information / intelligence sharing arrangements clear and making sure helpful policies and procedures were in place. There was also an emphasis on how to maximise the resources available across the multi-agency system.

**Learning point:** *That relational practice with individual young people needs to sit within a strategic approach of developing community-based assets. The key to this is to ensure effective joint working strategically and operationally to address any potential obstacles regarding the basic of information sharing; shared service pathways; shared approach to engagement and interventions; shared priorities at different levels of need and risk. Some of this is in place and is working well but there appear to be further improvements needed to ensure maximum impact.*

**Recommendation Three: Enfield Safeguarding Children Partnership ensure they have strategic oversight of the operational multi-agency arrangements for responding to this cohort of young people, who experience significant adversity and risk in different contexts. This should be a priority for the partnership in the forthcoming year and activity should include working with the safeguarding ambassadors to understand impact upon outcomes.**

**Recommendation Four: That Enfield Safeguarding Children Partnership ensure that the nature of engagement with families is reflected upon, and that effective engagement is evidenced in changes made in the family.**

14. It is anticipated that the full Local Child Safeguarding Practice Review regarding Andre will be published in summer/ autumn 2022.