Enfield
Safeguarding
Children Board
...because safeguarding children is everybody's business

Local Safeguarding Children Board
LSCB
Haringey

SERIOUS CASE REVIEW OVERVIEW REPORT

Child 'CH'

Alyson Leslie - Independent Overview Author

May 2015

Contents

Incident Leading to the Serious Case Review

1. On 31 August 2011 CH, then aged 15 was with another male and two female teenagers in a residential street in North London. It was around 7pm and daylight. They were generally playing around with each other and then started targeting a passer-by, Mr Z, a 21-year-old student who was unknown to any of them. The facts established in court were that Mr Z remonstrated with CH who, egged on by his friends, confronted him. A heated argument ensued during which Mr Z was seen trying to placate CH. The other male youth joined CH in lashing out at Mr Z, punching and kicking him. Mr Z raised a skateboard he had picked up. A knife was produced and CH stabbed Mr Z with a single wound to the chest. Mr Z collapsed and residents who had witnessed the events summoned assistance. Despite prompt medical attention and emergency surgery, Mr Z died the following day.

2. CH later claimed he acted in self-defence by punching Mr Z after Mr Z attacked him with the skateboard and claimed that the fatal blow was struck by the other male youth present. CH was identified by witnesses as the assailant by his distinctive clothing which was captured on CCTV and by his street name which a female companion had used.

3. On 13 June 2012 CH was sentenced to life imprisonment with a minimum term of 10½ years. The sentence was increased to a minimum term of 12 years imprisonment by the Court of Appeal on referral by the Attorney General on 9 October 2012.

4. In his sentencing remarks, the trial judge described Mr Z as "an outstanding human being" and he was described by his mother as "caring and respectful". Mr Z was due to have enrolled at university the following day to study architecture and was on his way home from collecting the passport he needed for matriculation, from his grandmother's home, when he encountered CH and his companions.

5. Both Mr Z and CH came from families which had migrated to the UK. Both had spent time growing up in North London and their lives shared some common features. One of the purposes of this review is to gain an understanding of how CH came to be on the trajectory which led to the events of 31 August 2011, culminating in the profound tragedy of Mr Z's death and the ruinous consequences for CH. Other objectives of this review are to understand how public services interacted with CH and his family and to determine the extent to which his actions could have been prevented or predicted. The loss of Mr Z's life was a devastating and unnecessary tragedy. Part of its legacy must be turning a better understanding of how an adolescent boy can become a lethal threat to a stranger on a quiet London street, into effective interventions for deflecting other young men from similarly dangerous trajectories.

6. CH admits to being present when the altercation with Mr Z took place but maintains he was not carrying a weapon and that the fatal blow was struck by the other male. His appeal against conviction has been heard and was turned down at the end of 2014.

Summary of Critical Failings

7. Any detailed scrutiny of a case going back over ten years will inevitably find shortcomings in systems and practice, some of which may be reflective of policy and attitudes of a different time. In some cases it is no longer relevant to focus on the issues as law, guidance, policy and practice have changed. This case has highlighted a number of general issues, such as the unrealistic expectations of case conferences and a lack of awareness of the significance of emotional neglect, which impacted across both single agency and inter-professional working.

8. Individual agency shortcomings are addressed in the recommendations made by individual agencies in IMRs, along with proposals and timescales for addressing them. Overarching recommendations for the Boards are made at the end of this report.

9. There are, however, a small number of "critical failings" at individual practitioner or agency level, from various stages of this case, which had a significant or potentially significant impact on the quality of service provided or outcomes for family members. These are summarised in Table 1 below.

10. Table 1

PERIOD/AGENCY	FAILINGS	REASON (if known)	COMMENT
Early 2004 **Sheffield Children's Services**	Continuing vulnerability of family in period after withdrawal of intensive support and ending of care order was not fully addressed. After loss of contact with family, Agency then did not follow-up and confirm family whereabouts resulting in loss of professional continuity when family moved within South Yorkshire and then to London.	Agency was influenced by letter from UKBA advising that family was being deported to Jamaica. Family was keen to disengage from contact with social services agencies and avoid further involvement.	Families must be considered vulnerable for a pre-determined "amber" period following cessation of registration/care order. This must be agreed prior to expiration of order/registration and must be recorded and notified to any agency making child protection related inquiries. Move of vulnerable families overseas should be followed-up with the same thoroughness in transfer of information as within the UK and contact made with authorities in country to which they move. Importance of follow-through in child protection work.
2004 onwards **Most GPs**	Failure to identify and communicate history of child protection concerns which were recorded in medical records of Mrs H and AH when invited to contribute to assessment of children's needs / requests for information by social services. Resulting in superficial and/or inaccurate information and reassurances being conveyed to case conferences and to social workers undertaking assessments. Failure to be pro-active in relation to child welfare in light of knowledge of Mrs H and AH's psychiatric conditions, Mrs H, AH, GK	Reliance on self-reported patient information which was not checked against records. Failure of GPs to familiarise themselves with family history. Over a period of 10 years GPs received presentations and notifications of clinic attendances for CH's health yet no-one made the link with stresses in his home environment. Similarly, regular A&E attendances for trauma injuries, including a bullet wound and burns, were not explored in relation to child welfare.	GP records had information about Sheffield child protection concerns that was otherwise unavailable to social workers but was never shared in the period before Sheffield records were obtained. The attitude of London GPs contrasted sharply with that of Sheffield GP1 who was proactive in identifying potential child protection issues in relation to parental health issues and who liaised closely with health visitor. Individual presentations at surgery or notifications from A&E/clinics were not

	and CH attendances at A&E and clinics. Failure to link GK into health visiting system.	Insufficient clarity about statutory child protection responsibilities and need to be proactive in evidencing that no child was at risk.	contextualised and the worrying picture of family violence and stress was not acknowledged.
Late 2006 - early 2010 **Haringey CYPS**	Failure by Haringey CYPS to respond to repeated referrals and requests for investigation, initiation of multi-agency case conferences and intervention in the light of multiple and escalating concerns about the care of CH and about the children of AH. Assessments were used as a form of intervention that ultimately delayed intervention and failed to grasp the significance of the family's history, the patterns of violence or the likely impact on the children of years of emotional abuse and neglect.	The context of the prevailing culture, inconsistent standards of practice (particularly in relation to assessment) and failures of leadership in Haringey 2006 onwards have been highlighted above. Staff appeared sometimes to treat each new referral about the H family as a new referral rather than contextualising it within an extensive history. Staff had inadequate management support and management oversight of the case was poor.	Management of the department was woefully inadequate, allowing poor standards of practice to prevail. Poor assessment skills resulted in inadequate assessments which were not subject to proper oversight or challenge. Even when circumstances began to improve in Haringey under new leadership, the oversight of the case was inadequate.
2010-2011 **Haringey CYPS**	Poor case management by Haringey CYPS. Failure to follow up actions from case conferences in core groups or through review meetings and allowing the case to drift, compromising the welfare of CH and GK in particular.	There was a failure throughout to envisage what experiences of "emotional abuse/neglect" meant for the children and what measures were needed to mitigate them. The complexity of the case was too much for one worker to handle and a different approach could have been adopted that allowed sufficient attention to be given to the differing needs of each child.	See above
2010 -2011 **Core Group**	The Core Group did not meet sufficiently regularly and were not always well-attended. The Core Group failed to	Poor management and oversight of the Core Group meetings and insufficient challenge and follow-through by CYPS	Poor channels for accountability for Core Group and lack of clarity about who should be monitoring efficacy and how this should

	recognise that it was overwhelmed by the complexity of the case and unable to give sufficient attention to the diverse needs of the children of Mrs H and of AH. The Group allowed its agenda to be dominated at times by issues of Mrs H's sexuality and her immigration worries. The Group put forward a poorly formulated request for secure accommodation for CH in May 2010, as a response to escalating concerns about his behaviour and well-being. When this request was rightly rejected, no alternative was considered, although the Group was concerned that CH was at risk of harming or being harmed if he continued on the same trajectory.	supervisor who should have been alert to drift in the case.	be done. Clearer protocols needed for overseeing/auditing work of core groups.
2010-2011 **Haringey CYPS**	Failure by HSW1 to transfer the case to Enfield CSC after the family moved in August 2010 caused difficulties for multi-agency working and resulted in Enfield professionals who encountered CH to have an incomplete history on which to base their assessments of risk.	Poor practice combined with insufficient supervision and oversight. Failure to recognise the need to plan and implement a careful transfer of a volatile and complex case.	New protocol for transfer of cases with CPP in Haringey needs to be devised and strictly monitored for agreed period.
2010 -2011 **Haringey YOS**	Retention of CH's case by Haringey YOS after CH moved to Enfield was initially justifiable but as time passed became a barrier to effective integrated working and added to the confusion over curfew orders and breaches, and affected case planning and management.	Original decision to retain till end of order was understandable but once a second court order was made, case should have been transferred. YOS officer seemed to lose track of what was happening.	Protocol should be established to ensure timely transfer of cases where offender has moved between authorities. Transfer should be made for cases with more than two months of order to run and cases where a new order comes into force before the end of an order with less than two

			months to run.
March-June 2011 **Haringey CYPS**	Failure to respond to referrals and information, including the report of 60+ injuries, suggesting GK was at risk of physical and emotional harm. Failures to follow safeguarding procedures in relation to investigation compromising criminal investigation and resulting in GK being placed with Mrs H who was known to have physically abused a child previously and who was a potential suspect in relation to the injuries to GK	Emphasis appears to have been placed on GK's retraction of allegations rather than the physical evidence of non-accidental injury. There was an inexplicable failure of management and professional standards in the handling of this case. One possible explanation is that CYPS staff had come to accept high levels of violence in this family as normal.	Mechanism is needed for professionals other than CYPS to initiate a case conference.
July 2011 **Haringey CYPS**	Failure to follow through on actions of review case conference and legal planning meeting in relation to accommodating GK and securing supervision orders for CH and DH.	No obvious explanation apart from a lack of diligence and absence of a mechanism for identifying and monitoring significant actions from case conferences and legal planning meetings.	Mechanism needed for identifying and monitoring key actions from case conferences and legal planning meetings.
August 2011 **Enfield YOS**	Insufficiently robust case management and oversight by EYOS2 meant CH was not seen sufficiently frequently, that he was not assessed at a high level of risk of harm and that the confusion about orders, breaches and curfews was unresolved.	The standard of the case officer's practice was not sufficiently high. Case officer did initiate a number of actions, including referral to psychologist and support agencies with potential to assist CH. Some of the shortfalls arose because of the timing of the order at the end of July with several staff including EYOS2 being on leave in this period	This was an unusual departure from Enfield YOS's usual good standard of practice and robust oversight systems.

Failings in Context

11. While some of these failures are particularly grave, notably the poor assessment practice in Haringey CYPS over a prolonged period of time, it is important to note that none of the deficits noted above contributed directly to the death of Mr Z. It can be argued that had CH been removed from the community and accommodated elsewhere, he would not have been present at the fateful encounter with Mr Z on 31 August 2011. CH, however, maintains he was not carrying a knife that evening, and the court determined that it could not be proved otherwise, leaving open the likelihood that the knife was being carried by one of the other young people present. Even if CH had been absent, there is a possibility therefore that Mr Z would have encountered the other young people, one of whom may have had a lethal weapon.

12. Even if CH's presence alone did not guarantee the development of events that led to Mr Z's death, the above failings are still significant. CH was a troubled, displaced and stressed young man with a growing history of aggressive actions and criminal behaviour. He was adjudged, in keeping with his history of emotional trauma, to have little concept of the link between actions and consequences. He had a particularly disrespectful attitude to females and had been alleged to have subjected girls in school to aggressive, sexualised assaults; he consorted with youths who had histories of violent crime, and had allegedly been implicated in crimes involving knives and guns. Aside from his convictions for burglary and assault, he had been arrested or interviewed by Police in relation to 14 other incidents, including drug-related incidents, theft of property, assaults, and crimes involving guns and knives. He had run away from home several times and in early March 2011 had deliberately injured himself, following an incident in his home. He was vulnerable, unstable, and rootless. Without the kind of rigid, structured, intensive programme advised by the Enfield YOS psychologist, CH was in a highly vulnerable state and in all likelihood was going to harm someone or be seriously harmed.

13. Had the events of August 31 2011 not happened, or had CH's case been transferred earlier from CYPS and from Haringey YOS to Enfield CSC and Enfield YOS, the more structured, co-ordinated support and more insightful assessments evidenced by Enfield services might have secured CH the intervention he needed. Much would have depended, however, on the cooperation of CH and the ability of professionals to persuade him to separate from his destructive peer group, and to provide him with a more stable living situation than with his mother. While Mrs H's view is that her son should have been removed from the family home and sent to a boarding facility with a "strict discipline" regime, CH's own view is that nothing would have persuaded him voluntarily to leave his home and family, that he had no desire to lose his social group and that no professional had ever been able to help him.

14. Two further issues are important to consider in looking at the history of professional contact with this case. First, Mrs H and AH were serial offenders over many years. Their offences related mainly to shoplifting but also included acts of violence. Despite frequent court appearances, only once did either of them receive a custodial sentence. Mrs H's role as a mother, her anxieties about her immigration status and her health were regular factors put forward in mitigation when she was in court. CH was also questioned about or suspected of being involved in over a dozen crimes for which he was not charged or brought to court. The

SCR panel did invite the Crown Prosecution Service to contribute to this Review, but they declined to do so. Their contribution might have helped explain why members of this family avoided more robust prosecution of offences and more serious consequences.

15. Second, it is not clear whether the serial offending by Mrs H and AH, and the catalogue of over 40 incidents of household violence and violence against others in which they were implicated, have been fully considered in relation to their applications for asylum. The delay in resolving Mrs H's asylum case meant the family were able to accrue further periods of residence in the UK by default. The UKBA IMR does point out however, that, in the light of the features of the case and the capacity of UKBA to manage it, had a final decision been concluded earlier it would not necessarily have led to steps to enforce the removal of the family from the UK. The UKBA's opinion was provided before the collation in this review of information that later emerged which calls into question some of the narrative which was the basis of Mrs H and AH's original application for asylum which has not, prior to this review, been available to UKBA or its predecessor agencies.

The SCR Process

Terms of Reference

16. The terms of reference for this Serious Case Review are set out in Appendix A.

The Serious Case Review Process

17. At the time of Mr Z's death, CH and his family were living in Enfield. Enfield Council was responsible for his educational provision and he had been supervised by criminal justice services in Enfield for just over a month. His family had moved to Enfield one year previously from neighbouring Haringey where they had lived for over five years. CH was subject to a child protection plan and his case was open to and being coordinated by Haringey CYPS because, although Enfield had been alerted to the family's presence in their area, a transfer case conference had never been arranged by Haringey.

18. Following discussion between the LSCBs from Haringey and Enfield it was agreed that a joint Serious Case Review (SCR) would be undertaken. The Review was chaired by the independent Chair of Enfield LSCB, Geraldine Gavin, while the administration of the process was undertaken by Haringey. The review commenced on 4th December 2012.

19. CH's family moved to Haringey in 2005 from the Sheffield area where they had lived for over four years. Sheffield LSCB undertook a review of the family's time in Sheffield and provided a comprehensive overview report. The family spent several months in Barnsley between living in Sheffield and moving to Haringey. Barnsley were invited to contribute to the SCR process but decided not to do so, Children's Services there having had no contact with the family, although the family did access housing and health services

20. IMRs have been prepared by a mixture of independent writers and senior staff from within the agencies.

Elements of Independence /Overview Report Writer

21. The SCR Panel comprised members of Haringey and Enfield Local Safeguarding Boards and was chaired by Geraldine Gavin, Independent Chair of Enfield LSCB since 2010. The Overview Report has been written by Alyson Leslie of the University of Dundee, working in an independent capacity.

Approach to this Serious Case Review

22. Setting the parameters and making arrangements for the review across two Boards, with the involvement of over twenty agencies, was a complex task. Slippage occurred initially in arrangements, meaning IMRs did not get underway until around March 2013. There were difficulties for the production of the Overview Report when the original schedule changed from spring to autumn 2013, and the availability of the writer has been a delaying factor. Other considerations have been the participation of family, which was secured late in the process (July and November 2013) and CH's appeal against conviction which was rescheduled from October to December 2013 and was finally heard at the end of 2014.

Scope and Timescale of the SCR

23. This review covers the history of CH and his family from the arrival of his mother and sister in the UK in July 2000 up until the death of Mr Z. Originally it was intended to review the family history from November 2001. In order to contextualise material from that time, it was necessary to start the review period just over a year earlier, when family members first arrived in the UK.

Structure of Overview Report

24. The family history falls into four periods:

- The early years (2000 - 2004) from Mrs H's arrival in the UK until the family left Sheffield
- The "missing" years (2004 - 2005) when the family moved around and had intermittent contact with statutory agencies
- The London years early phase (2005 - 2008)
- The London years gang phase (2009 - onwards)

25. Within this report and within the chronology is sensitive information about individuals in the family group which has been disclosed by them about themselves or other family members in confidence to health and social work professionals. Some of this information shared with professionals has not been more widely shared by the individual disclosing it. It is imperative that in sharing the contents of this report and in its publication, safeguards are in place to protect the privacy of the persons affected.

26. The events discussed cover a period of eleven years. Significant changes have taken place in policy, practice and leadership in fields and in agencies. For example, when the first Initial

Child Protection Conference took place in Sheffield, the new *Working Together* guidance had only been published a few weeks earlier and new assessment frameworks and practice guidance were unavailable to professionals. In the early period, therefore, professionals were sometimes working in the context of processes which were unfamiliar and not fully bedded in.

27. A crucial period in the family's contact with Haringey CYPS came in 2006-2009. This is the same period that staff in Haringey were working with the family of 'Child A' (Peter Connelly) and dealing with the aftermath of that case. Three reviews of the Child A case have documented the apparent lack of leadership, evidence of poor standards, insufficiencies in supervision and under-resourcing in children's social care services in Haringey at that time. In that context, it is unsurprising that subtleties and complexities of CH's circumstances and the potential risks within them were not recognised or addressed. As the situation in Haringey stabilised during 2009, engagement with the family did increase and Mrs H speaks highly of some of the involvement and people from CYPS, particularly HSW1, in that period. The case, however, was only intermittently seen as a high priority.

Discussion of Key Themes and Going beyond Learning Lessons

28. In a case of this complexity, the traditional concept of "learning lessons" is not helpful. It suggests professionals and agencies finding out things of which they were unaware or being reminded of things they had forgotten. The traditional approach to "learning lessons" also creates a danger of particularising issues at the level of individual professionals or agencies and reducing outcomes of the exercise to remedial actions that can be check-listed. As a result, systemic and wider policy issues can be overlooked and no room left for truly creative and pro-active initiatives.

29. Agencies completing IMRs have made recommendations in relation to areas of practice and administration where these are still relevant. These are adjudged by the people who know the agencies, their management and systems best, to be sound, achievable and relevant. It is suggested that individual agencies should develop and implement action plans in relation to these recommendations and that the Haringey and Enfield Boards should focus on addressing a small number of broad policy areas which can have a wider impact on safeguarding complex families and which are discussed below.

Issues of Communication, Information Transfer and Assessment

30. Given the distance of many of the events in this case, it is not particularly helpful to engage in a detailed critique of all the issues of communication, information transfer and conclusions of assessments arising from professional engagement with the H family. These are covered in detail in IMRs with particularly thorough and detailed analysis in the Health Overview and the CYPS IMR.

31. The broad lessons to emerge are extremely familiar to everyone involved in safeguarding children and do not need elaboration:

    - Assumptions must be avoided in child protection work as they only introduce more uncertainty into an already uncertain situation;

- Professionals can readily mistake parental participation for co-operation and engagement;
- Focus on a child can be easily lost due to parents employing deliberately distracting techniques or due to parents being so pre-occupied with their own concerns and demanding of professionals' attention;
- Follow-through is critical when dealing with information, responsibility or concerns in child protection cases: a good metaphor is the transferring of a baton in a relay race, it should only be released when its secure reception has been acknowledged;
- Safeguarding is everyone's responsibility. There are some good examples of professionals who were working with the adults in the H family being sensitive to the impact on the children of AH's and Mrs H's health and lifestyle, and many examples of this being overlooked.

Thinking Differently about Capturing Children's Experiences

32. The most important theme to emerge from the extensive documentation of this review is the importance of **understanding and responding to the child's perspective**. This is perhaps a more helpful way of thinking about "listening to the voice of the child".

33. The term “listening to the child's voice" has three limitations. First, it puts undue onus on the child to do something difficult and counter-intuitive and speak out (by implication within earshot of an adult). Second, it implies a conversational context. Children do not find it easy to articulate their worries and fears, particularly when talking might make things worse or hurt a parent about whom they have confusing feelings of affection and fear. Children are also unlikely to express their feelings, fears, needs and wishes to an unfamiliar adult. Third, the term can suggest passivity by the hearer and does not capture the necessity of a response to what the child is saying.

34. In all the documentation available to this review, the "voice" of CH on his home circumstances was rarely heard. The only direct examples are from the Sheffield period where his voice is directly heard three times, and each time he is saying that someone has hurt him, that his home is a scary place or that he wants to leave it. The courage that it took him and BH to confide these things to an adult cannot be underestimated. Each time CH said these things it was to a trusted, friendly and familiar adult at school. Each time there was an immediate response and steps were taken to keep him and his brother safe in the short term. In the longer term, little changed in a house where people sometimes hit him, hit each other, harmed his mother, and came into and left his life in a bewildering way. A child inevitably becomes dispirited when the supreme and frightening effort he has made to get adults to change something he cannot, ultimately makes no difference.

35. In Sheffield CH and BH told adults about their home life and how it affected them and that they wanted to leave there. The adults who listened then appeared to do the opposite of what the boys asked. BH only succeeded in his attempt to get away from the unpleasantness at home by displaying more forceful and distressed behaviour. For CH who was younger and quieter, nothing changed except that he no longer had the comfort and companionship of his

older brother for a period. Later the children rarely responded to inquiries about their home life.

36. In safeguarding, the occasions when children directly articulate abusive experiences, worries, fears or needs to professionals are relatively rare. Opportunities for busy professionals to build the quality of relationship and level of trust necessary for a young person to feel safe and confident talking about their lives and feelings can be equally rare. Professionals cannot overly rely on these rare occurrences to deliver a child's perspective on events. A child's story, experiences and needs can more often be deduced where they cannot be voiced.

37. The Health Overview Report argues that throughout CH's life there is little evidence of professional curiosity about or response to the impact of events and traumas on the children, including the level of violence witnessed by the younger family members, the verbal and physical abuse they endured and the effect on them of their mother experiencing unstable and sometime violent relationships.

38. Professionals must be attuned to understanding the impact on a child's experiences of the places where and people with whom they spend most of their time (household, school, gang activities, online).

39. When CH or BH found their voice, they described a chaotic existence, severe physical punishment, unpredictability and the fear of violence in their household. Some of the underlying causes of these traumas, such as Mrs H's dangerous lifestyle and health issues did not change; professionals, therefore, could reasonably deduce that these elements continued to cause distressing experiences, even when BH or CH were not complaining of them.

40. It was accepted that the children were exposed to unpredictable incidents of violence, family instability and emotional unavailability. Children cannot be expected to articulate the physical, emotional and cognitive impact of living long-term with such stresses, though they will express it through distressed, aggressive or overly-compliant behaviour. Professionals need to be alert to the severe and enduring impact of the continuous stress of emotional neglect, exposure to violence and chaotic family systems on children and anticipate and articulate it. On-going emotional trauma experienced by children requires as careful assessment and as clear a response as the episodic traumas of physical abuse.

41. Since their arrival in the UK, nothing in the H family situation has improved for the children. A new generation is now enduring the same abuse and turmoil with which their uncles and aunt grew up. There are now three more children in the household, AH's sons and daughter, GK, EJ and FJ (11, 5 and 4). History suggests they may face a bleak and traumatic childhood. The pattern of instability, the impact of severe health problems, criminality, violence and aggression, transient and volatile relationships and lack of emotional nurture has continued to dominate the children's lives.

42. Extraordinary levels of violence, emotional and physical abuse and criminality were accepted by many professionals as the norm for the household with no consideration of its long-term impact on the children. In particular, incidents of domestic violence made known to police, medical and social work professionals were not followed-up in terms of child welfare as they should have been. Because several incidents involved Mrs H and a female partner or

girlfriend, there seems to have been an assumption by professionals that they were less serious and less harrowing to the children than heterosexual partner violence.

43. Despite thousands of professional hours provided by nearly 70 people, and provision of multiple forms of support to different family members, little changed for CH or his siblings over their time in the UK. Assessments and reviews confused activity with progress and failed to address the basic questions of "What is changing and to what end?" and "If nothing is changing, what must we do instead?" Review processes throughout became activity planning sessions and failed to address the quality or effectiveness of interventions or take stock of how and whether the children's lives were improving.

44. There was clearly no lack of innovative schemes to support and assist CH, from Boxing Academy as a school alternative, to mentoring schemes that would give him positive black male role models. When one form of intervention was unsuccessful it tended to be replaced with another solution without the underlying issues that it was intended to address having been fully identified and quantified. There was no objective way, therefore, of monitoring the effectiveness of intervention and no sense of coherence, integration, or clear purpose.

45. What is evident in this case is the absence of a mechanism for recognising the futility of approaches and activities which are not making a difference to children and replacing them with something that will. Reviews had become so formulaic that they missed the obvious and did not deliver what was required to make a difference. In this case, none of the resources being committed to the case were improving the children's situation; removing them from that situation should have been a serious consideration from 2006 onwards.

"The Child's Needs v the System's Needs"

46. The reluctance to consider residential options for CH may have been in some part attributable to external pressures rather than the child's needs determining available options. There is considerable pressure on YOS teams not to recommend custodial sentences. Some of the performance measures of YOS teams are linked to securing non-custodial outcomes. This means that the specific needs of some young people, such as CH, for whom a psychologist had recommended a structured environment with strong routine, may be subsumed by policy imperatives. As the government's emphasis on restorative justice initiatives is developed, this dilemma may become more pronounced.

47. Some of the assessments of CH undertaken in the youth justice system, using standardised tools, failed to identify the high level of risk he presented. On each occasion this happened, the professional judgement of staff tended to recognise the levels of risk present, which the national measures they used failed to capture. It has now been recognised nationally that tools, such as those used in this case, are not fit for purpose. A new framework of standardised assessment is being introduced in criminal justice which places more emphasis on the judgement of professionals.

48. While recognising that a residential placement or custodial outcome might have been the most appropriate recommendation for CH at various times in 2010-11, given the risks he presented to himself and others, the risks attendant on such placements must be recognised.

The rate of reconviction of offenders sentenced to custody in England is over 70%. Young people who have spent time in residential institutions have some of the lowest levels of educational attainment and highest levels of homelessness, destitution and mental illness in our society. This is not an inevitable outcome of removing a young person from their unsatisfactory home environment but rather reflects the features of the residential/youth custody system in the UK. Countries such as Norway, for example, have less than half the UK's reconviction rate.

Summary of Good Practice

49. This review has of necessity focussed on the deficits in the handling of in this case in order to identify gaps and learn lessons. The summary of critical failings has been set out at para 10. Exceptional practice has been noted also in a number of instances:

- The proactive work and responsiveness of GP1 in Sheffield who recognised the implications of Mrs H's and AH's health for the welfare of their children;
- The intensive work carried out by family support staff in Sheffield in the autumn of 2003 which provided a settled period for the children;
- The diligence of CP2, the consultant who quickly identified safeguarding issues in relation to Mrs H's parenting capacity and took steps to ensure these were followed through;
- The exceptional practice of TSW1 whose assessments were thorough and insightful and who made sustained efforts to secure the engagement of Haringey CYPS in relation to the children's well-being;
- The diligence of probation officer, PO18, in sharing assessments and concerns with health and other agencies in the absence of CYPS intervention;
- The exemplary practice of staff at NMT A&E in following child protection protocols and identifying the children of Mrs H and AH as subject of child protection plans and following through their concerns;
- The thoroughness of the documentation by CPaed1 of Whittington Health of over 60 injuries to GK and the clarity of recommendations for follow-up;
- The work of School 1 which recognised and tried to address CH's deteriorating behaviour and engagement and were responsive to child protection concerns;
- The accurate and detailed assessment by SnPr2 of Haringey CYPS of the risks and concerns in the family situation and her persistence in attempting to alert senior managers to the dangers of the case being left unallocated;
- The responsiveness of Haringey FIP to concerns about gang related activity and, in conjunction with Housing, the swift intervention when Mrs H and AH were perceived to be at risk following their altercation with gang members in July 2010.

- The insightful and thorough PSR compiled by EYOS1 despite considerable lack of engagement from the H family and extremely short timescales.

Perspective of Mrs H and of CH

50. Mrs H's view is that all the issues relating to child protection concerns over many years arose from a single misunderstanding and from BH's misbehaviour. Mrs H's states that the allegations made by BH in Sheffield about her lifestyle and physical abuse of BH and CH were untrue. She says they were fabricated by BH because she would not allow him to have a dog and that they set off a chain of events which meant that for many years she and her family were pursued and scrutinised. She asserts she loves her children and would not harm them. Mrs H acknowledges that her lifestyle was previously unsettled and that she had a serious drink problem but she feels she has not been given enough credit by professionals for having tackled her alcoholism and stopped drinking and for having ceased offending behaviour.

51. In Mrs H's view, her contact with social work services has never been satisfactory in relation to her children. Either she was being pestered unnecessarily about their welfare and living under, what she saw as, the threat of them being removed, or when she sought help about CH being caught up in gang culture, she was not given sufficient support. Mrs H does have a high regard for HSW1 whom she said spent a lot of time with the family and tried to help CH. She believes, however, that CH should have been "sent away to a boarding school" to break his links with the area and with the people with whom he was offending.

52. CH, in contrast, states that nothing would have persuaded him to move out of his home. His loyalty was first to his family and he feels the need to protect his mother and would not have willingly left her and his siblings. He does not think he would have settled anywhere else like a residential school or foster care. CH has a strong affection for his family and a need to feel part of them. He remembers his time in Sheffield at school as being happy, although things were more unhappy and unsettled at home then than they were in London. His perception seems to be linked to the presence and absence of people who hurt his mother.

53. CH does not feel anyone he encountered understood his life and he did not feel confident talking to anyone. He did not like the ethos of Boxing Academy. He does not like boxing and felt the regime there was oppressive. At times his life seemed full of professionals who came and went but nothing changed and he wanted to be free of them. His view is that what are needed to divert young men from crime and gang activity is lots more structured sports and leisure activities to fill up their time. CH denies he has ever been involved in knife crime and maintains his innocence of Mr Z's murder.

Findings and Conclusions

54. The following is a summary of the findings and conclusions of this review.

a) At the time of Mr Z's death, CH was on a worrying trajectory of violence, offending, disengagement and rootlessness and he was seeking increasingly to identify with gang culture. He was at risk of harming someone or of being harmed.

b) The circumstances of the death of Mr Z, and CH's involvement could not have been predicted.

c) CH was not breaking curfew when he had a dispute with Mr Z and fatally stabbed him. CH was on a curfew order covering the period from 9 pm to 7 am on the day Mr Z died. The incident which led to Mr Z's death happened just before 7pm in the evening.

d) The seeds of the recklessness and inability to conceptualise consequences which appear to have influenced CH's actions on 31/8/11, were sown over a decade earlier and flourished in the atmosphere of poor nurture, inconsistent parenting and emotional trauma he endured from early childhood to adulthood.

e) An opportunity may have been missed in Sheffield to remove the children from the care of Mrs H and provide them with stable environments, while allowing her to be helped to sort out her own overwhelming difficulties and needs. The main factors in Mrs H retaining care of her children were her successful challenge in court to the local authority request for a care order, her subsequent short period of intense compliance with parenting support programmes and the deregistration of the children's names and premature closure of the case in the erroneous belief the family were returning to Jamaica.

f) Families subject to child protection plans and measures do not recover stability or safety quickly. The H family should have been considered vulnerable and at some risk for a period of two years after deregistration and liaison made with whichever location they moved to, including if necessary with Jamaican authorities.

g) Professionals frequently failed to recognise the patterns of Mrs H's behaviour, her constant need to move house, her manipulation and her placing of her immigration status needs and other issues before her responsibilities as a parent

h) The failure by Haringey CYPS to respond to the repeated requests by TSW1 and others for intervention was an unacceptable level of performance and put CH and other children in the family at risk.

i) The failure by Haringey CYPS to follow safeguarding procedures and to ensure the safety of GK in March 2011, after he was found to have suffered a large number of non-accidental injuries, put the child at unacceptable risk and was woefully inadequate and unsafe practice.

j) Assessment appeared to be used at times as an alternative to action / decision-making, even in the face of evidence of risk of harm to the children

k) The case conference process delivered mainly general aspirations rather than workable strategies linked to key outcomes. There was a lack of follow through of key decisions and few systems for monitoring them in place.

l) Astonishing levels of violence perpetrated within and against the H household were normalised and tolerated unchallenged. Same sex intimate partner violence appeared not to have been evaluated and responded to as robustly as similar violence might be in a heterosexual relationship.

m) CH should have been removed from the H household at least two years before the tragedy of Mr Z's death. This could have been achieved by a number of approaches including residential schooling and need not have necessitated secure accommodation. GK should not have been allowed to remain in the care of Mrs H or AH following CPaed1's report of a series of non-accidental injuries in March 2011.

n) DH's compliant nature and near invisibility in the H household narrative may mask equally significant levels of emotional trauma occasioned by her upbringing.

o) Despite some improvements in aspects of the family situation it is unlikely that life in the H household will be any more stable or safe for the current generation of children.

Recommendations from this Serious Case Review

Introduction

55. These recommendations to the Board reflect the key lessons to be learned from this review. They draw on the views of the SCR Panel and the author of this report.

56. The review does not make a recommendation for every point of learning that has been identified. These recommendations are complemented by more detailed recommendations, specific to each agency, contained in the IMRs from those agencies.

57. It is over three years since the events leading to this Serious Case Review. Agencies have not awaited the completion of this review in order to tackle issues arising from these events. Many of these recommendations, or aspects of them, have been identified and addressed already.

Recommendations to the Haringey and Enfield Safeguarding Children Boards

58. The Boards should explore through discussion, debate and professional development initiatives ways of improving professional competence in assessment. One of the mechanisms used should be the sharing of good practice. In this case, the work of TSW1, SnPr2 and EYOS1 are commended for discussion and learning.

59. The Boards should explore and devise local arrangements for reviewing decisions by Children's Services not to progress to S47/ICPC potential child protection cases referred by partner agencies.

60. The Boards should draw on learning from Troubled Families and TAF work to establish models of working with families with complex needs, specifically families where there are both mental health and child protection issues. The key elements of the models should be that professionals have time and scope to deploy their professional skills, that a discrete team work with the family and that an information co-ordinator be appointed from within that team, whose role is to compile and understand the family history and to facilitate the flow of information amongst professionals.

61. The Boards should look to establish a Practice Working Group to look at creation of a simple chronology tool that could be completed across agencies.

62. The Boards should support efforts to review YOS national performance indicators to ensure they do not risk compromising outcomes for individual children.

63. The Boards should support efforts to explore custodial and residential approaches which have low rates of reconviction.

64. The Boards begin a dialogue across professions about shifting the emphasis from "listening to the voice" to "capturing the experience" of the child, with particular consideration of what a child's behaviour tells us about their experience.

Appendix A – Terms of Reference

The following terms of reference (TOR), covering 13 areas of professional activity were agreed at the start of the process

Terms of Reference	
1.	An examination of any issues, in communication, information sharing or service delivery, within or between services. To include those with responsibility for working out of hours as well as those working in normal office hours and with particular reference to their knowledge of the process of escalation on intra and inter agency concerns in accordance with paragraph 18.5 of the London Child Protection procedures.
2.	Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children and with wider professional standards?
3.	What were the key relevant points/opportunities for assessment and decision-making and effective intervention in this case in relation to the children and family? What was the quality and timeliness of decision-making and did subsequent assessments and decisions appear to have been reached in an informed and professional way? What was the quality of multi-agency risk assessments?
4.	Did actions accord with assessments and decisions made, taking into account the previous court intervention? Were opportunities for effective intervention, such as Section 47 investigations, multi-agency strategy meetings, Family Group Conferences, Child Protection conferences or effective Looked After Child reviews taken? Were appropriate services offered/provided and/or relevant enquiries made, in the light of assessments?
5.	What did each agency know about the history of each of the parents and or any other significant adults in the household? Consider whether both the mother's and the fathers' presentation and experiences in the light of their childhood and previous relationships was appropriately identified, acted upon and has any relevance.
6.	What training has been provided in adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done with regard to the duties to safeguard and promote the welfare of children?
7.	Were practitioners aware of "what it was like to actually be that child", sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse, specifically physical abuse or neglect and about what to do it they had concerns about a child's welfare?
8.	Did practice in the period show any lessons learned from previous Serious Case Reviews? If not, what were the barriers?
9.	Was practice sensitive to and/or influenced by the racial, cultural, gender, sexuality, linguistic and religious identity and any issues of disability of the child and family, and were they explored, taken on board and recorded?
10.	Was there sufficient management accountability for decision-making? What was the quality of supervision? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

11.	How effective was management support and supervision in countering the impact of parental hostility and deflection. What evidence is there of reflective and authoritative practice of both supervisors and supervisees?
12.	Evaluate the impact of any organisational change and challenge over the period covered by the review and establish the capacity of front-line services for effective response.
13.	In addition to the above, IMR writers are asked to comment on any other children in the household.