Joint Living in Hackney and CYP Scrutiny Commission

June 2022

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1. Introduction and Background

1.1 In December 2020, Child Q, a Black female child of secondary school age, was subject to a strip-search by female police officers from the Metropolitan Police Service. The search, which involved the exposure of Child Q's intimate body parts, took place on school premises, without an appropriate adult present and with the knowledge that Child Q was menstruating.

1.2 As a result of this incident and in my capacity as the Independent Safeguarding Children Commissioner of the CHSCP, I made the decision to instigate a Local Child Safeguarding Practice Review (the review).

1.3 The review report was published in March 2022. Rory McCallum, the CHSCP's Senior Professional Advisor, was its co-author. The review was also supported by a reference panel that included Black and Global Majority Ethnic safeguarding professionals.

1.4 I will be publishing an update report covering the progress made in response to the Child Q review in December 2022. This briefing sets out my written response to several questions raised by the joint Living in Hackney and Children and Young People's Scrutiny Commission.

2. An outline of the timeline of events leading up to the review

2.1 The report describes the relevant circumstances leading up to the search of Child Q and the instigation of the review. Beyond the immediate events of the strip search at Child Q's school, the review kept information relating to the background and context of Child Q's lived experience to a minimum. The reasons for this were three-fold.

- Firstly, to protect Child Q's identity and that of her family.
- Secondly, to allow for the report's publication and.
- Thirdly, because the review considers much of this information to be largely irrelevant. In this respect, the review was mindful not to detract from the incident itself. It was careful not to introduce a perception that there might be a 'rationale' to excuse the actions of some professionals based on who Child Q is, where she lives or what her family circumstances are.

2.2 In terms of the overall timeline for the review, Child Q first came to my attention on 11 January 2021 and a Rapid Review meeting was convened two days later.

2.3 The Rapid Review report and my decision to instigate a review was submitted to the National Child Safeguarding Practice Review Panel (the national panel) on 15 January 2021. The national panel considered the case on 26 January 2021 and responded on 2 February 2021.

2.4 This response encouraged us to '*think carefully*' about whether a review was necessary as the national panel felt the case was not notifiable and did not meet the criteria for an LCSPR. This advice was noted but ignored.

2.5 Across February and March 2021, the authors were confirmed, a reference panel identified, and a forward plan of key interviews developed. We were mindful of the impact on Child Q and whilst the family were quickly notified of the review, it was right not to interrupt the immediate support services being provided.

2.6 At the outset, we worked with the Council to facilitate communication and ensure that support was wrapped around Child Q and her family. We were aware that formal complaints had been made and we were mindful not to impede or undermine any of these processes.

2.7 Interviews with Child Q, her family and the school teachers were completed by mid-April 2021. The headteacher and Local Authority Designated Officer were

interviewed in May 2021. However, the review continued to be frustrated by its inability to access the police officers involved in the search. This was due to the internal investigative processes of the MPS and the requirement not to undermine their investigation.

2.8 Over the next three months, I continued to press the MPS for access to the officers involved, or at the very least, their statements. Due to the nature and range of complaints, the Independent Office for Police Conduct (IOPC) had become formally involved.

2.9 On 6 July 2021, I wrote to the Director General of the IOPC explaining the situation and asking if he could reconcile the issue of access. This resulted in the CHSCP being designated an 'interested party' to the IOPC's investigation. This allowed for the lawful sharing of relevant information which was received in October 2021.

2.10 Whilst eventually resolved, the difficulties encountered are exactly why the review made its first recommendation for the national panel and the IOPC.

2.11 Other work followed and advice from the reference panel, research and data helped us come to a position whereby the findings and recommendations could be focused and developed.

2.12 In the New Year, fact checking was completed, and final rounds of engagement undertaken, including with the family (and their solicitor), the reference group, the MPS and the IOPC. Throughout the review process, safeguarding partners and relevant agencies of the CHSCP, LA leaders / officers and key agencies were routinely briefed.

2.13 The report took 14 months to complete. On 22 March 2022, in response to public questions about the time it took to complete the review, I published a third statement that addressed the timeline.

3. Overview of key findings and recommendations

3.1 The Child Q report speaks for itself and makes eight findings and fourteen recommendations for practice improvement. It concluded that Child Q should never have been strip searched and found across many of the professionals involved that day, there was an absence of a safeguarding-first approach to their practice. The report also concluded that racism was 'likely an influencing factor' in the strip-search and that there was a high level of probability that practitioners were influenced by 'adultification' bias.

3.2 The report details an analysis for each of the findings set out below:

- **Finding 1:** The school was fully compliant with expected practice standards when responding to its concerns about Child Q smelling of cannabis and its subsequent search of Child Q's coat, bag, scarf and shoes. This demonstrated good curiosity by involved staff and an alertness to potential indicators of risk.
- **Finding 2:** The decision to strip search Child Q was insufficiently attuned to her best interests or right to privacy.
- **Finding 3:** School staff deferred to the authority of the police on their arrival at school. They should have been more challenging to the police, seeking clarity about the actions they intended to take. All practitioners need to be mindful of their duties to uphold the best interests of children.
- **Finding 4:** School staff had an insufficient focus on the safeguarding needs of Child Q when responding to concerns about suspected drug use.
- **Finding 5**: The application of the law and policy governing the strip searching of children can be variable and open to interpretation.
- **Finding 6:** The absence of any specific requirement to seek parental consent when strip searching children undermines the principles of parental responsibility and partnership working with parents to safeguard children.
- **Finding 7:** The Covid-19 restrictions in place at the time appeared to have frustrated effective communication between school staff and the Safer Schools Officer.

- **Finding 8:** Having considered the context of the incident, the views of those engaged in the review and the impact felt by Child Q and her family, racism (whether deliberate or not) was likely to have been an influencing factor in the decision to undertake a strip search.

3.3 In terms of the review's 14 recommendations, these centre of the following practice areas:

- The review process x 1 (National Panel & IOPC)
- Data and the recording of stop and search activity x 1 (MPS)
- School guidance on searching, screening and confiscation x 2 (DfE)
- Policy & Guidance relating to searches x 4 (MPS / Home Office / NPCC / College of Policing)
- Awareness raising / training x 4 - (CHSCP)
- Monitoring / Oversight of safeguarding as part of stop & search x 1 (MPS)
- Anti-Racism x 1 (CHSCP)

4. Accountability and Monitoring

4.1 The responsibility for how the system learns the lessons from reviews is set out in the statutory guidance, Working Together 2018. At a national level, this lies with the Child Safeguarding Practice Review Panel and at local level with the safeguarding partners – the Local Authority, Police and Clinical Commissioning Group. All three safeguarding partners have an equal and joint responsibility for the CHSCP's overall safeguarding arrangements.

4.2 Statutory guidance is also clear that safeguarding partners should consider how identified improvements should be implemented locally, and that they should regularly monitor / audit progress on the implementation of recommended improvements.

4.3 In terms of this monitoring, the CHSCP has convened a defined 'Core Group' to undertake this task. Review Core Groups are an embedded part of the CHSCP's usual response to local reviews. They allow for the routine oversight,

challenge and monitoring of review recommendations whilst collating evidence of impact. I am chairing the Child Q Review Core Group, with membership comprising safeguarding partners and other agencies represented on the CHSCP's case review sub group.

4.5 The remit of this group is focused on the 14 recommendations of the review, although it is sighted on other strands of related activity for which Child Q has been a catalyst. There are clear mechanisms in place for reporting to the CHSCP's Case Review Sub Group, the CHSCP Hackney Executive and the CHSCP's Strategic Leadership Team. Further commentary will be made on in my update report and will similarly be referenced in the next annual report of the CHSCP.

4.6 The arrangements in place covering the MPS and planning for the publication of the IOPC report are set out in the submission from the Council's Head of Policy and Strategic Delivery.

4.7 In terms of wider issues of leadership and accountability, the Senior Professional Advisor and myself recently met with the chair of the national panel to discuss the Child Q report. I set out my concerns about the panel's failure to recognise the significance of Child Q's experiences and its response that actively discouraged us from undertaking a review.

4.8 Whilst they acknowledged their errors to us, I remain surprised at the lack of public acknowledgement that their judgement on this matter was flawed and that they too are taking time to reflect on why the national panel failed to recognise the significance of this incident and the likely attitudes that facilitated it.

Jim Gamble QPM
30 May 2022