KENT COUNTY COUNCIL

SELECT COMMITTEE - KNIFE CRIME IN KENT

MINUTES of a meeting of the Select Committee - Knife Crime in Kent held in the Medway Room - Sessions House on Monday, 17 June 2019.

PRESENT: Mr P V Barrington-King (Chairman), Mr I S Chittenden, Mr A Cook, Mr P C Cooper, Mr D Farrell, Mr A R Hills and Mr K Pugh

IN ATTENDANCE: Dr A Duggal (Deputy Director of Public Health), Ms J Mookherjee (Consultant in Public Health), Mr G Romagnuolo (Research Officer - Overview and Scrutiny) and Mr A Tait (Democratic Services Officer)

UNRESTRICTED ITEMS

1. Allison Duggal (Deputy Director, Public Health, Kent County Council) and Jessica Mookherjee (Consultant in Public Health, Kent County Council)
(Item 2)

(1) The Chairman welcomed Dr Allison Duggal and Ms Jessica Mookherjee to the meeting. Dr Duggal was the Deputy Director of Public Health for KCC whose remit included place-based health care (mainly in new towns), the quality of public health, emergency planning and domestic abuse.

(2) Ms Mookherjee was a public health consultant whose work on substance abuse included the development of Drugs and Alcohol Strategy with the Police. She also worked on STP Groups such as Mental Health, the development of the Suicide Strategy, Health Equalities and represented KCC on the Kent Crime Partnership.

(3) Dr Duggal tabled a report from the Kent Public Health Observatory entitled "*Assault by Sharp Object*". This report can be found in the agenda papers on the KCC website. It covered the period from April 2014 to November 2018 and provided a summary of the volume and nature of admissions to acute hospitals where a cause of injury had been identified by "assault by a sharp object."

(4) Dr Duggal explained that the figures within the report omitted those who had died before they could be admitted as well as minor injuries. The sharp object could be a knife but might also be glass or a needle.

(5) Dr Duggal went on to highlight the main themes identified in the report. There had been approximately six admissions to hospital every month of victims of assault during the period covered. The majority of victims were under the age of 35 with the greatest number aged between 20 and 24. The greatest number of admissions occurred amongst people who lived in the Gravesham local authority area. High rates also occurred in the local authority areas of Dartford, Swale, Thanet and Shepway. The total number of admissions was 324 (including some admitted on more than one occasion. Some 86% were males.

(6) Ms Mookherjee said that many stabbing incidents would not be reported, especially by young people. There was a link between knife crime, mental health and drugs and alcohol. Another major contributor was Kent's proximity to London, which made it susceptible to the "County lines" practice where drug dealers exploited vulnerable people to traffic drugs into rural areas. The same problem occurred in Essex and Norfolk. The fact that young vulnerable people were being groomed into County lines demonstrated that perpetrators could simultaneously be victims.

(7) Ms Mookherjee moved on to explain that Studies by the University of Kent and by the psychologists Martin Daly and Margi Wilson had established reasons that caused people to carry knives. People who had experienced knife crime were more likely to carry knives themselves. There was also a link between health inequalities and homicide. Growing up in a concentrated area of poverty often led to drug taking, fighting and, on occasions, killing. The solution lay in community activism, engagement and empowerment.

(8) Dr Duggal then outlined the Public Health approach to reducing violence. She said it involved using data to establish an in-depth understanding of the nature and causes of the problem. This included the inequalities, the type of sharp object generally used by the perpetrators, the localities where perpetrators came from and where incidents took place and identifying those factors which could be addressed in order to modify the problem. This enabled consideration of the most effective form of intervention. An example of this might be identifying the young people in a particular area who had undergone an adverse childhood experience and the type of support that should be provided. The next steps were the implementation of the Initiative and its evaluation. The two purpose of evaluation were to prevent a repetition of any mistakes and to inform other agencies.

(9) Ms Mookherjee explained the three levels of violence prevention. The Primary Level consisted of taking steps to prevent violence before it could occur. Examples of actions that could be taken were those which reduced inequalities and increased well-being. The Secondary Level involved responding once a problem had begun to manifest itself. This involved working with people at risk as a result of, for example, County lines or homelessness. Secondary Level work included early prevention youth offending programmes, youth programmes, CAMS and the Kent Drug and Alcohol Partnership. The Tertiary Level entailed intervention once the violence problem had become evident and was causing harm. *"ACE Aware*" was an action programme designed to use the data gained from a variety of sources (such as A&E admissions for assault with sharp weapons) to intervene amongst those who had gone through Adverse Childhood Experiences. *Blue Light Leadership* was an action programme which enabled the Emergency Services to take a Public Health approach. Work was being undertaken to address issues within the Section 136 (Mental Health Act 1983) Concordat.

(10) The Chairman asked the speakers whether they could set out an aspiration list. Dr Duggal said that the Domestic Abuse Strategy had a great influence. If this Strategy could be implemented to its full potential, it would be a very significant component of early intervention.

(11) Ms Mookherjee said that Kent needed to develop a place-based approach to tackling Health Inequalities. KCC took a leading role on domestic violence and suicide prevention which would be greatly enhanced if it could take the same approach to social cohesion. Problems for young people arose if they lacked hope or respect. A Wellbeing Strategy, particularly in respect of mental health would be invaluable, and probably best delivered by using a Roadshow approach.

(12) Mr Pugh asked why knife crime had increased in Kent. Ms Mookherjee replied that there had been an increase in Health Inequalities leading to an increase in despair. She referred to a publication entitled "*Respect"* by Richard Sennett which detailed how disempowerment led to domestic violence and knife crime. This process was exacerbated by County lines. When she had worked in LB Lewisham, there had been an enormous investment in Youth Workers. This funding had then been greatly reduced, leading through social inequality and Adverse Childhood Experiences to drug gangs and accompanying violence. Kent itself did not have homogenous gangs. Vulnerable young people in the County were, however, being groomed and co-opted. It was nevertheless true that although Kent had seen a 152% increase in knife crime, the actual number of incidents was still far lower than in most o the UK.

(13) Dr Duggal replied to a question from Mr Chittenden by saying that there were governance issues preventing Police data being fully integrated into the Kent Integrated Database. This was a systems problem and had nothing to do with GDPR. It was proving to be difficult to bring Analysts from the Police and A&E together effectively.

(14) Ms Mookherjee said that it was vital to share information about individuals. GPs were asked to flag up suicide attempts but tended not to do so. Children who were involved in knife crime were quite possibly well known to the Mental Health Service, the Youth Service or the Sexual Health Service.

(15) The Chairman summed up the points for the Select Committee to consider. The principle theme had been the need for an information sharing approach to be adopted. Any further information on this theme that the speakers wished the Committee to consider would be welcomed. The second theme was what KCC should be doing to promote Public Health.