Children's Safeguarding Assurance Partnership
Blackburn with Darwen - Blackpool - Lancashire

Lessons Learned: Child F
Child Safeguarding Practice Review

What Happened?

Child F (henceforth known as 'F') was 16 years old child when he was murdered in December 2020. Two young people, G (16 years old), H (18 years old) were convicted of his murder. A further young person, J (17 years old) was convicted of a lesser offence.

Although the young people were known to several public agencies in Lancashire what was known about their lives was limited. Reports indicate all four young people knew each other and were involved to varying degrees in the supply of drugs, in using drugs or in violence between local gangs. There were adults involved in supplying these drugs, who must have played a significant role in the lives of the young people.

F was known to numerous agencies including, the Lancashire Child and Family Wellbeing Service, Lancashire Constabulary and the Child and Youth Justice Service. G, H and J were known to Lancashire Children's Social Care (CSC). G and H had considerable contact with CSC and were identified of being at risk of Child Criminal Exploitation (CCE). G, H and J had experienced exposure to serious domestic abuse in early childhood.

All four young people presented with behavioural difficulties in school. H and G had additional vulnerabilities that required Education Health and Care Plans (EHCPs). F and G had not been able to be supported by mainstream school.

What Have We Learned?

What was known and understood about the Child Criminal Exploitation (CCE) risks to F, G, H and J: Information about the risks posed to each young person was limited across agencies. The information that was known primarily focused on agency needs whereas more rounded thinking about the young people's lives is required. The review identified that critical moments were present in the lives of all four young people but the way in which agencies made sense of these moments was limited.

G and H were identified as at risk of CCE by agencies and there should have been more probing work to gather information about the risks posed to F and J. Agencies did not give due consideration to race and culture in their work.

Agency Information sharing:
Formal mechanisms to share information, i.e., strategy meetings were used but not all relevant information was shared; information sharing, and the sharing of intelligence was inconsistent. Weaknesses in information sharing was considered in the report (to what degree agencies did not know or what they might infer from the limited information available). These weaknesses led to an optimism that levels of risk were reducing or a view that having completed the assessment; processes would have reduced the risks without affirmative evidence that this was the case.

Agency communication and development of joint plans of intervention:
The report highlights that there were no joint agency plans of intervention outside of Child Protection (CP) Plans, no systematic view of the young people's lives and no peer group mapping or contextual safety planning.

Service intervention offers and their impact:
All four young people were subject to some level of intervention. Child Youth Justice Orders and CP Plans had little impact. CCE interventions happened too late and there was a need to focus on early intervention.

Where there was continuity of schooling, this allowed positive relationships to develop. However, early warning signs of exclusion could have been a chance to target help earlier.

Young People's Lived Experience:
Little was known about the young people's lived experiences and there was little reflection on how the world looked to them and what and who influenced their lives. For example, agencies did not consider relationships with adults in their extended family and neighbourhood networks who drew them into offending including drug dealing and associated violent norms of behaviour.

The impact for three of the four young people of adverse childhood experiences and trauma earlier in their childhoods such as exposure to serious domestic abuse was also not considered.

The CCE team did establish a positive relationship with H's family, enabled by a persistent and non-judgmental approach. However, there was also a lack of trust of agencies and relationships between the young people and agencies had not developed. This is not uncommon when working with children and young people who have experienced trauma and have experienced school exclusion and contact with the police. There is a need to adopt a trauma informed, trust based, relational approach when working with children at risk of serious violence.

Young people's material difficulties:
A learning point to consider is the role of poverty and inequality as a driver for harm and adversity. All the young people lived in deprived communities. The desire for material gain was important but families did provide for the young people.

Conclusions:

- There is a great deal in common between the findings from academic work, the national review, the triennial review of serious case reviews and this review. This is reflected in the Pan Lancashire Contextual Safeguarding Strategy and the work of the Contextual Safeguarding Operational Groups. It is recognised that more work is needed to adopt a Contextual Safeguarding approach to multi-agency practice
- There were opportunities to intervene earlier and more effectively with all the young people
- Agency effort focused on their own responsibilities and accountabilities
- Too much work was transactional and of short duration
- The young people's exploitation and involvement in drug dealing was entrenched
- Parents were engaged to some degree and for one parent this was helpful and made a difference. Families can help

What Do We Need To Do?

Read and familiarise yourself with the following terms and practice guidance:

CSAP 7MB on Contextual Safeguarding highlighting an approach to understanding, and responding to, young people's experiences of significant harm beyond their families:
7MB Contextual Safeguarding

CSAP's Contextual Safeguarding Strategy 2022-2024:
Blackburn with Darwen, Blackpool and Lancashire Contextual Safeguarding Strategy 2022-2024

CSAP's 7MB on the Contextual Safeguarding Strategy:
7MB Contextual Safeguarding Strategy

CSAP's 7MB and your role within it:
What is your role in the Contextual Safeguarding Strategy

National Multiagency Practice Principles for responding to child exploitation and extra-familial harm:
Multiagency Practice Principles for responding to child exploitation and extra-familial harm
Supporting resources developed alongside the Multiagency Practice Principles

Lancashire Violence Reduction Network - https://lancsvrn.co.uk/

Adverse Childhood experiences and Little Book of Aces https://lancsvrn.co.uk/resources/

Violence Reduction Network Trauma 7mb's series https://www.safeguardingpartnership.org.uk/learn/7mbs/

Contextual safeguarding and Child F Learning from Review Event Presentations Local Learning Reviews - Children's Safeguarding Assurance Partnership (safeguardingpartnership.org.uk)

Keep in Touch

Further learning and resources can be found on the Children's Safeguarding Assurance Partnership website
For queries or feedback please contact the Joint Partnership Business Unit Team jpbu@lancashire.gov.uk