Child Safeguarding Practice Review

Overview Report: Child F

Author: Colin Green

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1. Executive Summary

This review is about F and the three young people involved in his murder. Two, G and H, were convicted of his murder and J of a lesser offence. All four young people had a history of involvement in either drug supply at street level and or involvement in anti-social behaviour and violence between young people. This history started in early adolescence. Three were being criminally exploited from age 11 to 14 years to deal drugs primarily cannabis but H was involved in dealing crack cocaine and heroin. None of the young people recognised that they were being exploited at the time but do so now.

Three of the four came from families where they were exposed to domestic abuse at a young age and had other adverse childhood experiences.

All four had difficulties at school and underachieved educationally. H attended the same school for the whole of his secondary education and J the same secondary school from year 8. They both benefited from the continuity this provided and the consistent interest of the adults at school, offering care, support and advice to themselves and their families. Conversely the secondary education of F and G was disrupted. They were permanently excluded from mainstream schools and once placed in a pupil referral unit did not have consistent educational input. For G his involvement in education was limited for all of years 10 and 11.

All the young people had some involvement with statutory services. For G and H this had been considerable at various points in their lives. These two young people had Child Protection Plans (CPP) for Child Criminal Exploitation (CCE) which came at a late stage in their involvement in exploitation. For G this involvement made little difference for him or his family. For H the involvement was welcomed and found helpful by his family who also used their own resources to try to help H move away from the lifestyle they saw as harmful to him.

The families of F, G, H and J were all expressing concern about their young people in different ways. The families felt at a loss as to what to do. They felt under threat themselves from those exploiting their children and did not have confidence that statutory agencies could protect them if they shared all they knew with those agencies.

Professionals working with the young people also felt uncertain as to what they could do to make a difference. They undertook their discreet roles as best they could but were aware that what they had to offer was not enough to change how the young people behaved or draw them away from being exploited. In retrospect they could see there was little effective coordination between the work of the different agencies and practitioners.

The conclusions and learning from this review are similar to 'Safeguarding Young People – risks, rights, resilience and relationships' edited by Dez Holmes[1] and other reviews primarily the 'National

[1] Safeguarding Young People – risks, rights, resilience and relationships edited by Dez Holmes. Jessica Kingsley 2022

Review – It was hard to escape Safeguarding Children at Risk of Criminal Exploitation'[2] and the '2014 to 2017 triennial analysis of serious case reviews'[3][4].

The recommendations are to take forward the learning from those reviews adapted for the local context in Lancashire including the commitment to implement the national exploitation principles when published.

In addition the importance of the following needs to be recognised:

- Developing a range of early intervention services to support children and families at risk of or in the early stages of CCE
- Ensuring that practice always explores the strengths within the immediate and wider families of children at risk of or being criminally exploited
- Recruiting staff with the personal skills to undertake relational work with children and families and give them both the training to develop those skills further and time to develop relationships with the children and families they are supporting, which do not preach or judge.

2. Reason CSPR Undertaken

F was murdered on 23rd December 2020 and was 16yrs and 5 months old when he died. At the time of the murder, G was 16ys and 4 months, H 18yrs and 11mths and J was 17yrs. G and H were convicted of his murder and J was convicted of conspiracy to commit section 18 assault.

All four young people had contact with a number of statutory services in the period prior to F's murder and earlier in their childhoods including consideration of whether they were subject to CCE. Lancashire Safeguarding Children Partnership agreed that the criteria for a CSPR had been met on the grounds that this case exposed gaps in partnership working across Lancashire when responding to CCE. It was agreed that carrying out a CSPR focussing on CCE would support and direct the work already taking place.

3. The Murder of F

F was murdered in a planned attack over a drug debt of £25. Reports indicate that all four young people involved knew each other and were involved in street level supply of drugs. The Police had information of previous violence between F and G and H. Following the convictions of G, H and J, F's parents said in a statement that "Their son died at the hands of 'three heartless cowards' in an 'unprovoked attack'. We will remain incomplete without F. His cheeky laughter will never again be

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2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf

3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

4 https://seriouscasereviews.rip.org.uk/local-safeguarding-partnerships/ #lscb_vulnerable

heard in our home. The sentences given today will never reflect the pain and devastation with which we are living each day."

4. Context of Adolescence

4.1 At the time of F's murder H, aged 18 was an adult, F and G were 16 yrs and J was 17yrs. Convention would be to describe them as young people. This term allows for consideration of emerging adulthood. The term 'youth' refers to a 14–25-year-old reflecting the UN definition and takes account that the adolescent brain continues to develop until the mid-twenties for many people (Sawyer et al, 2018)[5].

In thinking about their lives and how services might respond to their needs it is important to consider the life stage they were in. Being a young person or adolescent is a time of profound change[6]. There are major alterations in biological, emotional, and social spheres of human development.

There are specific vulnerabilities which may link to previous adverse experiences. These adversities may extend beyond the '10 Adverse Childhood Experiences (ACEs) commonly identified, based on Felletti et al's original ACEs study[7]. The study focused on intrafamilial adversity and did not include structural trauma, inequalities and situational vulnerability due to housing, poverty etc.

Being a young person is a time of experimentation, separation from family, the establishment of a life centred outside the family, the development of close friendships and when first romantic and sexual experiences occur. There are few people who do not experience highs and lows as a young person or who did not take part in activities they later regret or would later see as foolish or risky. An issue for this review is considering how being a young person was potentially different for F, G, H and J in ways that led to the tragedy of F's murder. How could services have responded better to their needs as young people so that their lives were more like their peers?

5. Information Available to the CSPR

5.1 While all four young people who are the subject of this CSPR were known to a number of public agencies in Lancashire, what was known about their lives by those agencies was limited. Adolescence is a time when children develop their lives outside the family which may include new relationships not known to their family. Young people will decide what they will or will not share with adults whether within their family or when they are in contact with agencies. They exercise greater autonomy over their own information, compared to younger children.

[5] Sawyer S, Azzopardi P, Wickremarathne D and Patton G (2018) 'The age of adolesence'. The Lancet Child and Adolescent Health. 2(3): 223-228

[6] Coleman and Hagell in Safeguarding Young People edited by Dez Holmes. Jessica Kingsley 2022

[7] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D., Spitz, A. M., Edwards, V., … Marks, S. J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. American Journal of Preventive Medicine, 14(4), 245–258.

5.2 All four of these young people were involved to various degrees in the supply of drugs in their local area, in using drugs and in violence between local gangs. What public agencies knew about this will be described later but what is certain is that public agencies only knew about a fraction of what was going on. This was also almost certainly true for the families of the four young people.

5.3 There were adults involved in supplying drugs to these young people who were not visible to public agencies, with the exception, to some degree, of the Police. These adults must have played a significant role in the lives of the young people both in terms of the trade in drugs as dealers and suppliers and in setting the "culture" within which the young people operated as street level dealers.

5.4 This would have included the commitment to secrecy, hostility to the Police and the use of violence to enforce norms of behaviour within the dealing/supplying network. It was known that there were members of the young people's extended families who were part of organised crime groups or who had a history of involvement in drug use and dealing. What role these people played with the individual young people was not known to agencies.

5.5 The aspects of these young people's lives which were unknown or unseen to public agencies were very significant and important in considering what might have provided a better response to the needs these young people presented, including how to keep them safe.

6. Family Contexts

6.1 F lived with his mother and two younger brothers. His father lived nearby and was in regular contact with F. F's parents were from the middle east. F was born in the UK. F was a healthy child. The only significant area of contact with specialist health services was an assessment for whether F had Attention Deficit Hyperactivity Disorder (ADHD). This was assessed by the local Child and Adolescent Mental Health Service (CAMHS) in October 2019 and in March 2020 it was concluded there was not enough evidence for a diagnosis of ADHD. F's mother was seeking an explanation for his aggressive behaviour but once ADHD was not evidenced, what lay behind F's behaviour and his mother's concern about this was not followed up. The Family had no contact with Children's Social Care or other specialist services prior to July 2019. F's murder has traumatised his family. He was a loved and cared for child.

6.2 J lived with his mother and an older sister. J's family were of South Asian Pakistani heritage. J was born in the UK. His father lived separately from the family and his parents were divorced. There was a considerable history of domestic abuse in the family of which J's mother was the victim. In 2017 this led to a child protection plan for J. J was upset by his parents' divorce. There are indications that the family experienced a sense of shame in their community about the divorce. The Family would also have placed a high value on maintaining privacy about family matters including from public agencies.

6.3 G lived with his mother and an older sister and younger half-sister. G's father was of black Afro-Caribbean heritage and his mother white British heritage. He was born in the UK. His father lived in Lancashire and was in regular contact with G through most of his childhood.

6.4 G's family had had extensive contact with children's services from when he was 6yrs. This related to extensive domestic abuse where G's mother was the victim. His father was not the perpetrator of the abuse to his mother. This abuse was sufficiently serious to lead to three Child Protection plans over the years. G's mother loved and cared for him and although G loved his mother, he did not take notice of her or his older sister's concerns about his behaviour or the risks associated with his drug dealing.

6.5 H lived with his mother and her partner and four younger half siblings. H's parents were white British heritage and H was born in the UK. H also lived with his father and his father's partner for a time away from his hometown and with his maternal grandparents from early 2020 in his home town in Lancashire. There was a history of domestic abuse where his mother was the victim, but this did not lead to child protection or child in need plans for H and his half brothers and sisters. His Family were aware of his involvement in drug supply and wanted to help him change his life, which was why he went to live with his father and then his maternal grandparents.

7. Educational Contexts

7.1 Within national reviews of young people involved in violent crime there is a strong association with exclusion from school[8][9], school absence and being in a pupil referral unit. With this context it is worth considering the educational history of these four young people.

7.2 **F.** F completed his primary education and there are no indications of serious difficulties while he was in primary school. He transferred to a local comprehensive school to start his secondary education. During F's time in Year 9, he was getting into difficulties at this school and a managed move to another secondary school was tried but failed, and he returned to his original school. He was placed for "respite" at a Pupil Referral Unit (PRU). He remained on roll at his school and returned there at the start of Year 10, September 2018. His attendance in the school year 2017/18 was 95%.

7.3 F's behaviour at his school in Year 10 deteriorated and he was permanently excluded because of drug related issues. He was found in school with a quantity of cannabis. He returned to the PRU in March 2019.

7.4 F was unsettled at the PRU and was for the rest of Years 10 and 11. He was on a personalised timetable. The PRU arranged external provision with a local vocational centre. F was not identified as having any special educational needs.

7.5 The PRU opened a Common Assessment Framework (CAF) to support the family in June 2019. At the PRU, F sometimes arrived under the influence of cannabis and was very aggressive towards staff but not to other young people. On one occasion, he took drug paraphernalia to an off site activity. His mother worked with the school but did not believe what she was told about her son. She found it hard to accept the negative information the school provided

[8] Irwin-Rogers, k., Muthoo, A., Billingham, L. (2020) Youth Violence Commission Final Report

[9] Longfield, Anne, Commission on young lives

about F's behaviour and what he was involved in. The PRU described F as alternating between fight and flight modes of behaviour and that his dysregulated behaviour was not helped by his cannabis consumption. He could be polite and respectful.

7.6 When Covid lockdown started, F's mother contacted the PRU for advice as F was still going out and not following the guidance in place at that time. The Headteacher of the PRU spoke to F, who his mother had reported to and then he adhered to the Covid rules. By June 2020, F was considering college applications and seemed to be making positive choices about this. F gained level 3 in GCSE Maths and English. His Cognitive Ability Test (CAT) and Academic Achievement Battery (AAB) scores were very variable which is usually an indication that a student has missed education and in some areas is working well below what they are capable of. For example, F had an expressive communication score of 104 and Math reasoning score of 102, whilst also having a Reading score of 69 and Reading comprehension score of 88. The GCSEs, AAB and CAT scores suggest F had the ability to do much better in education. He could have accessed a normal secondary education curriculum, if his needs could have been better met in the educational setting/mainstream school.

7.7 J. J completed his primary education and transferred to a local secondary academy school in September 2015 to commence Year 7. At the start of the next academic year, in September 2016, his parents selected to move him to another academy school as they wanted him to attend an Islamic ethos education establishment. He completed his secondary education at this school in June 2020 at the end of Year 11. J had no identified special educational needs.

7.8 J was temporarily excluded three times in Years 10 and 11 for a total of 11 days following assaults on other pupils. He was never at a point where he was considered for permanent exclusion or a move to another school. A total of three exclusions, including one for five days, was unusual within this school's pupil population.

7.9 J was an able pupil, when he attended and worked well, he got good results. In Year 11, his attendance was 82% which indicates persistent absence. He left school with eight GCSEs or equivalents which included achieving grades 7 and 6 in Science, 6 in English Literature and 5 in English Language and Maths. J had good relationships with most teachers and in particular with his Head of Year and his English teacher. He responded well when people put in time and effort with him.

7.10 J's school saw that they were providing 'normality' for him. There was routine and stability at school. J's school were aware that this was different to his life outside school. They were aware of his negative behaviour outside school and that he was involved in street level crime and what his school described as gang related activity[10]. The school was never told specifically about any of J's drug related offences. There were never any indications of J dealing drugs in school or that he ever smelt of cannabis at school.

[10] Caution is needed in the use of 'gang' terminology. It is not clearly or consistently defined, which can drive racialised interpretations.

7.11 The school had most contact with J's mother and some contact with his father. They had contact with an older brother who they saw as a positive influence. The school held a Team Around the Family (TAF) meeting as there were issues at home related to J not accepting his mother's authority. His older brother tried to help with this.

7.12 School was not aware of J being involved in any structured positive activities outside school. He was a good athlete, but he did not follow this up.

7.13 **H.** H left school in July 2018. H had been permanently been excluded while at primary school aged 8 years old and subsequently attended a special primary school. He attended a special school for children with Social, Emotional and Mental Health (SEMH) needs for the whole of his secondary schooling. He had an Education Health and Care Plan (EHCP) that reflected his additional educational needs. H's special educational needs were primarily related to his behaviour. His academic attainment was poor, but this reflected on him missed schooling and/or his behaviour was a reflection of his frustration at not being able to learn. He would have been able to access the secondary curriculum. H was literate and numerate. He was good at sports, in particular football.

7.14 H did present difficult behaviour in school, but he could also be engaging and charming with staff. H could be quick tempered and aggressive in school. He had a number of fixed term exclusions for aggression to staff including assaulting the head teacher. He was remorseful after these aggressive episodes. His school were able to manage his behaviour and he was not excluded.

7.15 H's school was aware he was involved in the supply of drugs outside school and saw that H was pulled towards this more than being in school. They observed he "had" to answer the phone he used when involved in supplying drugs. His mother worked well with the school and was keen for H to do well. She supported the school in trying to ensure he did access education and took the opportunities the school offered. The school's view was that H could manage further education or an apprenticeship. H could talk to staff and explain what the matter was including why he lost his temper, and he did respond to a restorative approach.

7.16 School made a number of referrals to Multi Agency Safeguarding Hub (MASH), Early Help and initiated a Common Assessment Framework (CAF). They referred H to the school's Family Support Worker.

7.17 **G.** In Year 6 of his primary school, G's behaviour meant school was struggling to meet his needs due to his complex emotional, social and educational needs. He had 1 to 1 support from a teaching assistant. He transferred to a local secondary school. He was permanently excluded from that school in the Easter term of Year 8, when he was 12 yrs old. The permanent exclusion was for bringing cannabis into school, and threats made to the school headteacher.

7.18 G was dyslexic and struggled with basic literacy. He was thought to have difficulties with speech and language. His difficult behaviour in school included sexually explicit and abusive language within the school environment. However, G's CAT and Wide Range Achievement

Test (WRAT) scores suggest he was of low average ability and that he could access a normal secondary curriculum.

7.19 Following exclusion, G moved to a PRU where he was initially settled, and an effort was made to reintegrate him into another mainstream secondary school which failed. He returned to the PRU. Staff in the PRU felt that after this 'failure' G seemed to give up. Following the unsuccessful attempt to reintegrate him into a mainstream school, G struggled to settle back into education within the PRU. The PRU asked for a statutory assessment for an EHCP, which was undertaken and recommended specialist provision. G was in Year 9 when this request was made. The category of need identified for G in the EHCP was Specific Learning Difficulty (SPLD) and SEMH.

7.20 The EHCP was completed in October 2018 near the start of Year 10. The EHCP noted that G was hypervigilant. Research shows that hyper-vigilance (along with other Post Traumatic Stress Disorder related symptoms) in children is linked to experiencing domestic abuse, which was a feature of G's childhood.[11] He struggled to maintain attention in a classroom environment as he had such high levels of alertness and found being seen on a 1 to 1 basis, in a quiet room, easier.

7.21 Before the specialist provision was identified G was referred to an unregistered provision, found by the Lancashire Special Educational Needs (SEN) team. This was not acceptable to the PRU, where he was still on roll, as they could not quality assure the provision themselves. The disagreement about what provision was suitable for G between the PRU and the SEN team must have been confusing for G and his mother. The back and forth about this educational provision caused relationships between education services, G and his mother to deteriorate. Responsibility for the problems in finding him a suitable educational placement lay with the 'system'. G experienced this as another educational failure. G was then offered a place at a special school.

7.22 Following this episode, G did not engage well at the PRU. He had a 1 to 1 timetable. He regularly came into the PRU, got into trouble and was sent home. G had good days, where he was reported to be delightful by staff, other days when he was verbally aggressive and his behaviour was unregulated. G was well presented, liked to look good and appeared well cared for. G liked Food Technology and was good at Sports and other physical activities such as Jujitsu but did not always engage well with sports.

7.23 In May 2019, towards the end of Year 10, G was on roll at a local special school. It appears his attendance from this point forward was very poor. By his own account, G said that he hardly attended school in Years 10 and 11, as he was out in the community dealing drugs. G had no educational provision after he left school in July 2020. There seems to have been no post 16 tracking, even though G had an EHCP. It appears no agency, other than perhaps the Police, had 'eyes' on G.

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193214/

7.24 **Education summary and analysis**. F, G and H all had significant difficulties in engaging and settling in education due to their complex needs/difficulties, which were expressed in their behaviour and educational settings being unable to meet their needs. G and H had EHCPs. H spent most of his education in special schools. H benefited from the continuity of attending one secondary school, he and his mother were able to develop relationships with the staff from which H benefited.

7.25 G and F were permanently excluded from their secondary schools and attended the local PRU. The reasons for their permanent exclusions were serious matters and it is simplistic to think that their schools had any very clear alternative. The issue is what is the response to such exclusions. Their educational experience was fractured. They did not build up positive relationships within their educational provision. For G, the changes of provision and 'failures' of new provision often undermined his already tenuous engagement with education.

7.26 J stayed in his secondary school and left with some good GCSEs and good prospects for his future. His school believed they were a haven for him, and he found in school positive relationships with adults he saw as wanting to help him. The evidence for this was in the progress he made in school and the positive relationships he had with a number of staff.

7.27 The educational experience of these four young people emphasises the importance of school as a place for positive relationships and continuity of care (for J and H) and how for F and G the absence of these qualities led to further disengagement from education and missed opportunities for positive relationships with adults and peers.

8. Contact with Services of Each Adolescent

8.1 All four young people knew each other and were connected through friendship, in the case of G and H, and through their involvement in the supply of drug and related street gangs. They lived relatively near each other. F and G had both attended the same PRU. The agencies who knew them were not aware of their connections or did not focus on the possible connections between them. The approach of the agencies was to work with each adolescent as an individual. Good practice in contextual safeguarding emphasises the need for group work where safe to do so.[12]

Summary of Agency Contact:

8.2 **NHS services:** F, G, H and J were all physically healthy young people with limited contact with NHS services including their GP. Much of the information from NHS agencies reflects their participation in multi-agency forums, which discussed the four young people e.g. Child Protection conferences. The GP referred F to CAMHs as noted in paragraph 8.3. The GPs were aware of the Child Protection Conferences (CPCs). There were one off contacts, such as, J being seen by Liaison and Diversion while in Police custody in July 2019 and G's attendances at A&E in September 2020, when he was found unconscious in a hotel room. He was with others who called an ambulance. G was 15yrs at the time. All four young

[12] https://www.contextualsafeguarding.org.uk/blog/spotlight-5-building-on-friendships-to-create-safety/

people had a number of health professionals involved in their care. They did not receive a holistic assessment from these health professionals in relation to their physical, social and emotional needs at the points where concerns about their involvement in criminal exploitation were emerging.

8.3 Child and Adolescent Mental Health Services (CAMHS): CAMHS assessed F for ADHD in 2019, concluding there was insufficient evidence to make a diagnosis in March 2020. The request for assessment came from F's mother reflecting her concern about his behaviour. His mother wanted an explanation for his anger. When ADHD was not diagnosed, this was the end of any exploration of F's behaviour and needs. CAMHS answered the question they were asked, but did not explore F's difficulties any further. H was referred in July 2019 about his difficulty managing anger and attended with his mother for an initial contact, but there was no further contact.

Children's Social Care (CSC) and the Children and Family Wellbeing Service (CFWS).

8.4 F had no contact with CSC. He was referred to the CFWS in July 2019 by his school due to the unsafe situations he was finding himself in and his anger, aggression and drug use. He was closed to the service after anger management sessions were completed. His mother said nothing had changed. There was a request from CAMHS to the CFWS for support, but the service was unable to engage him into any work.

8.5 J's family had a history of domestic abuse and there was a CPP for this reason from July 2017 to July 2018. In June 2019, concerns were raised about J being criminally exploited, but his mother declined an assessment which led to no further involvement.

8.6 G and his family had an extensive history of involvement with CSC from when G was in primary school. This was mostly related to domestic abuse and the consequent impact of this on G and his siblings. In August 2019, G had a CPP because of emotional abuse and physical abuse related to criminal exploitation and the high risk of harm to him from this. Those working with G while on the CPP found he was very guarded. G was reluctant to engage in any conversations. He was distressed when professionals came to his home. He saw himself as protecting his family and taking on their burdens. There is no evidence that G was providing financial help to his family from his illegal earnings. Contact was on G's terms and reflected his level of distrust of public agencies, their staff and possibly his fear from those who he was supplying drugs. Professionals cannot guarantee the safety of a young person who discloses illegal activity. A failure to engage may be a young person keeping themselves safe from reprisals for being seen as a 'grass'.

8.7 G was closed to CSC in May 2020 when the risk was assessed as low, and the case transferred to the CFWS from the CSC exploitation team. Red Amber Green (RAG) or scored risk assessments are deeply flawed. They are applied inconsistently, based on variable evidence, can screen out some young people and can be used as a gatekeeping mechanism for services.[13] The aim of the work with the family wellbeing team was to support G to be ready for college in September 2020. G did not engage with this support, his mother did and

[13] https://tce.researchin practice.org.uk/risk-assessing-child-sexual-exploitation/

completed a parenting programme. In November 2020 there was a further CSC assessment due to the family, G's older sister, expressing serious concerns about the risk he was at, with indicators of CCE such as carrying knives. G denied he was engaging in or ensnared in high-risk activities. This led to a strategy meeting to consider what to do next to protect G. G's mother and sister felt dissatisfied with the response recevied from CSC and Police with regards to protecting G.

8.8 H and his family had considerable contact with CSC, with fourteen contacts and referrals between 2003 and 2019 of which, four led to assessments. These contacts and assessments were domestic abuse related. H was first identified as being involved in the supply of drugs in February 2019. In February 2019, there was a further incident of child to parent abuse between H and his mother. While the case was open, information was given about H's criminal associations and he was assessed as at risk of CCE and risk of serious violence. This led to a CPP for H. The information made clear that for some time, H had been subject to pressure from adults in relation to dealing drugs and felt under threat in the community including from people in his wider family. His mother was concerned about him carrying knives and his selling drugs. She had reported him having drugs in the house. This indicates the importance of taking opportunities to treat protective parents such as H's mother, as partners in work with their children.

8.9 While H was reserved and did not always feel safe enough to trust professionals, he did confide in those working with him and his mother shared important information about H and her concerns about the risks to him.

8.10 In October 2019, H was assessed as at high risk of CCE and that the CPP was not working in helping protect him. In January 2020 H moved to his grandparents in the same town and this together with him being in regular work he liked was seen to have reduced the risks to him and the case was closed in March 2020.

Youth Justice Service (YJS)

8.11 F was sentenced to a six-month referral order for affray in September 2019. The offence was committed in November 2018. The affray was an arranged fight between groups of youths. F was assessed as at low risk of reoffending, low risk of serious harm and medium risk for safety and wellbeing. The comments made in paragraph 8.7 about the weaknesses of scoring or RAG rating systems apply to the way the risks to F were assessed. F completed the referral order successfully in April 2020. His compliance reduced towards the end of the order. He had no further contact with the YJS. The work done with F while on the referral order did not give any indication of his being involved in drug dealing and related activities. This became clear after his murder. On face value F engaged well, was polite and pleasant. He seemed to like to please and keep people happy.

8.12 J had his first contact with the YJS in November 2020 following a charge of theft in July 2020. J was referred to the Out of Court Panel and a Community Resolution was issued. J said he wanted to distance himself from a gang lifestyle when seen for assessment prior to the Out of Court Panel. This was an important statement from J and should have led to an active response.

8.13 G had no contact with the Youth Justice Service.

8.14 H had a referral order in February 2016 for lighting a firework in a public place. H was open to the YJS from September 2019 to June 2020. He had two convictions for intent to supply heroin and crack cocaine in February 2019 and three convictions for possession and intent to supply crack cocaine, heroin and amphetamine in May 2019. In September 2019, H was sentenced to a referral order which he completed.

8.15 H reported he started to use cocaine at the age of 14 years, which was in 2016. He was given cocaine instead of money for dealing drugs. He was identified as at risk of CCE in May 2019 and that he was groomed by an Organised Crime Group (OCG) member. H's compliance with the referral order was described as good. His move to his grandparents was positive as was his working in a job he liked. Assessments from the midpoint of his order showed reduced risk of serious harm to others and of reoffending.

8.16 The relatively limited or no contact with the YJS for all four young people is in contrast to the extent of their contact with the Police.

Police

8.17 F had continuous involvement with the Police from March 2018, when he was 13yrs, to his murder in December 2020. The involvement was initially about assault and bullying allegations made by F at his school, which were resolved by community resolution. F was arrested four times between November 2018 and April 2020. F was arrested for attacking, with others, victims with a baseball bat and metal poles. In October 2019, his phone number appeared on an analysis of a drug dealers phone records. F was spoken to at home by a member of the CCE team with his mother. F denied being involved in dealing drugs. F should have been seen alone. He said he was not under threat. In January 2020, Police intelligence indicated F was a main dealer heavily involved in the supply of drugs in a particular area and was carrying knives. In May 2020 he was found close to controlled drugs, which could not be attributed to him. The Police concluded F was involved with drug users and placing himself in an extremely vulnerable position. The framing as 'placing himself at risk' suggests F was seen as responsible without considering the pressures there may have been on him or how far he was the subject of exploitation. In October 2020, F was found with cannabis and this was dealt with by Police resolution.

8.18 J was recorded as throwing stones at taxis and smashed a neighbour's window between November 2018 and January 2019, he was 15 yrs old. Police also recorded J being assaulted by a gang of males. Police submitted a youth referral to the Youth Justice team. In June 2019, he was seen in the company of an adult known to be part of an OCG. He was arrested twice in 2020, for a fight and for theft, but no charges resulted until the charge of theft leading to the Out of Court panel in December 2020. These contacts did not lead to a safeguarding alert.

8.19 G was reported missing three times in 2016, he was 12 yrs in August 2016. The police records show a first link with drugs in September 2018, when G was 14 yrs. His mother reported him missing and found evidence of G dealing crack and smack (heroin). The Police knew G was

involved in numerous incidents of violent behaviour in 2018/19. He was recorded as assaulting others three times and being assaulted four times by gangs of youths. The Police believed these incidents were gang and OCG related. These incidents led to a strategy meeting with CSC in July 2019 and G being placed on a CPP.

8.20 In August 2020 G was reported missing several times and that he was carrying knives. In November 2020, G's sister was very concerned about his drug dealing and that he was carrying knives and a machete for his own protection. This led to a further strategy meeting in December 2020. His sister, though a young adult, was another potential ally for those working with G.

8.21 H was 13yrs when he was dealt with by a community resolution for pushing the Deputy Head of his school and damaging his school. In March 2019, there was an Initial Child Protection Conference (ICPC) related to concerns about H's behaviour and his identification as a victim of CCE. He had been arrested in February 2019 for possession with intent to supply crack, cocaine and heroin. He was arrested in May 2019 for intent to supply crack, cocaine and heroin. The offences were linked to a wider investigation of an OCG. H said he was being groomed to sell drugs and both H and his mother reported threats to his life. Police recorded CSC as believing H was being exploited by adult males. There was conflict between H and his mother about his drug use and this was part of the reason he moved to his grandparents in January 2020. The concerns about H's links to an OCG and him being exploited were again recorded in July 2020. In July 2020, H received a serious stab wound to his hand and would not tell the Police about this assault. H had been chased by males with a machete.

8.22 The Police were working to disrupt the OCGs but it is not clear that there was a systematic effort by the Police to disrupt the street level drug supply networks that these young people were part of.

9. Family and Young People's Contributions to the Review

9.1 The parents of the four young people who are the subject of this review were all written to about the review and offered the opportunity to talk to the reviewer. Two mothers have taken up this offer. The report summarises the key points from the discussions with the mothers and in one case with maternal grandparents.

9.2 The mothers and one child's grandparents talked warmly about their child and their place in the family. They recognised the troubled aspects of their behaviour and the difficulties they had brought to their families, but they were loved and valued members of their families.

9.3 The Mothers of G and H were clear that their children were being exploited from early adolescence. Their views were that both young people had been groomed from early adolescence and that this was known to CSC and other agencies. For example, H was hanging around from age 13 yrs with older males. G's mother was also aware he was carrying weapons. G and H's mothers knew of incidents, where G and H were injured in assaults or when running away from those attacking them. For both mothers, their sons did not listen to them and

their mothers' distress when they were injured or under threat seemed to make no impression on the two young people.

9.4 Both mothers saw changes in their children's appearance and demeanour, which they attributed to drug use, principally cannabis. They were aware of the money their children had and what they were buying with this, which was beyond what their families could provide. Both Mother's said they could make adequate material provision for their children, though money was always tight.

9.5 G's mother knew G was under threat, but recognised that G was in too deep to the lifestyle, to get out on his own. She was aware that the focus of his life was his life on the streets. G's mother wanted him to be moved out of his hometown by CSC.

9.6 G and H's mothers knew their children were scared at times. They were aware of serious consequences for their children and for their families, if either their children, or they told the Police or other agencies about their offending. Both families felt under threat and intimidated at times and had little confidence that the authorities could effectively protect them in their homes. H's mother described how those exploiting H climbed through windows of her house and threw stones at the house. At times H's mother paid his drug debts to try to reduce the risk to H. H's family tried to get him out of his local town, and this was why he went to live with his father for a period when he was 16yrs old.

9.7 For G's mother, the CPP made no difference as by that stage G was unwilling to work with services, though there were times he would sit and talk to his key worker and ask to be moved from his hometown. This was an opportunity to consider what disruption activities or wrap around service could have helped protect G. G was also not sharing what was happening in his life with his mother. It was evident that G's mother had little influence on his behaviour.

9.8 For H's family their experience of help following H's two convictions for drug possession in 2019 were more positive though they did not see the CPP as making a difference. The Family felt the help they received was valuable, including helping the family move to a neighbouring town. This was even though the move of home meant the younger children in the family changing schools and disrupted their local friendships. H moved to his grandparents. He got a job which he liked, and which paid a reasonable wage. His grandfather tried to instil in H positive work habits including making sure he got to work on time and taking on any overtime that was available.

9.9 The support workers from the exploitation team and Youth Offending Service (YOS) were valued as people who listened, showed genuine concern for H and his family, and were trying to make a difference. The regular and frequent time spent with H and his family by these workers was valued and made a difference.

9.10 H's family saw how this positive progress was disrupted by H suffering a hand injury in a machete attack and he then gave up his job. This disruption to his life made him more vulnerable to getting reinvolved in drug dealing again, the friends who were involved in this

and related behaviours. H's family see a direct connection between the injury, not keeping his job and H getting involved in the murder of F.

9.11 Parents were positive about the efforts their children's schools made to engage them in education and keep them in school. H's school kept in touch with his mother who felt they did well with him. For H, support from CSC in 2019 and 2020, including the exploitation team and YOS, was good.

9.12 H's mother contrasted this experience with previous experience with social workers who she felt tried to tell her what to do and judged her. This was also how G's mother felt about some previous social workers. The parents felt they could not contact the Police or help them because of the potentially serious consequences for them and their other children.

What could have made a difference?

9.13 The parents said they felt very stuck when they knew their children were dealing drugs and working for the older men. They could not tell on them directly because of the potential consequences for their children and their families. Both children were violent to their mothers and homes when high or could not get cannabis. Both mothers tried to protect their children as best they could with limited resources and choices available. H's mother thought availability of workers, like those she found helpful from the exploitation team earlier, might have helped. People to talk through the dilemmas she faced and who she felt were sympathetic to her and liked H would have helped. These practitioners needed to not judge or preach.

9.14 Both parents thought earlier involvement would have helped, especially when their children were younger, such as, when they were just starting to get involved in drug dealing. They thought more help with taking them out and trying to engage them in positive activities might have helped.

9.15 The three young people involved in F's murder were written to and asked if they wished to contribute to the review. G and H agreed to meet the reviewer.

G

9.16 G was seen in April 2022 with his social worker at the Young Offenders Institution (YOI) where he has been since being sentenced. G described himself as very closed and not willing to tell, even those he had trust in, such as his mother and father what was happening. He did not want to "put weight" on them. G described himself as a "tight person", "a proper confidential child". He knew his family were concerned about him, but he thought that anything major he shared would be passed on. He felt his family had not been in his situation and had not learnt to handle what he was now handling. G contrasted his adolescent life with what was happening when his father was his age.

9.17 G said he would have felt weak if he had told people his problems, even at age 13yrs. G said he did not see himself as having choices, he just acted. This was linked in his mind to his view

that no one groomed or made him do things that he did not want to. G saw himself as making his own destiny. G said he was never "battered" by those higher up.

Social Workers

9.18 G felt social workers did nothing for you and tried to force something out of you. There was an expectation that you would share information with them "full whack – like no tomorrow" from a first interview. G contrasted this with the approach of a social worker he had known when he was younger, who worked with the family when he was 10/11 yrs old, who took it slowly and spent time with him. G recalled this social worker was with the family for three years and did help. This social worker was with the family following G's mother being beaten up. G said he has flash backs of his mother being beaten up.

Education

9.19 G recalled choosing the friendship group at his secondary school who got into trouble. He was the class clown. G recalled stopping going to the PRU and related provision in Years 10 and 11 as he was making money dealing drugs. This was his daytime activity.

Involvement in drug dealing

9.20 G linked his making money to not wanting to ask his mother for money and that the dealing gave him access to material things he wanted. He was making more money than anyone he knew in a regular job, which made a regular job unattractive. G said, he knew nobody with a regular job.

9.21 G said the violence was about jealousy and territory. There were fights, where he inflicted injuries, and where he was injured. His mother's distress at his injuries seems to have had no effect on him. There was a normalisation of violence. G felt he needed knives and a balaclava to protect himself when dealing drugs.

9.22 G said he smoked cannabis every day and this removed his feelings. He described himself as like a fizzy bottle shaken and about to explode and the cannabis helped him manage these feelings. He did not care about anyone except himself, and this lack of feeling, G attributed to his cannabis use. This suggests G's drug use was a form of self-medication.

9.23 G said that when we was 15/16 yrs old he began to process more of what he had gone through and was going through and became more future orientated. Up to that point, he lived in the moment. As a 15 yr old, he felt he was already independent and had already grown up. G was very clear, he saw himself as in charge of his own destiny at this time. G saw himself as having earned all he had got. When G said he was ready to leave his hometown to his social worker, he meant it, but he could not tell the whole story of why he needed to leave. He provided no detail of what was going on to enable the social worker to justify such a move.

9.24 G did recognise that there were those who were bigger than those like him selling drugs on the street. He noted that it was not the 'kids' who started it. He implied, these were the people who supplied weapons to young people like him.

H

9.25 H now sees that at aged 12/13yrs old he was "groomed" to sell drugs. This was not how he saw it at the time, but he can see this now. What happened to H was described as grooming by Police and his solicitor following his arrests for possession of drugs in 2019. H told Police he was forced to sell drugs. He said when younger, he was oblivious to what was happening. He did not care, including the impact on his mother of his selling drugs. H described falling asleep in school and the use of two phones in school, one of which was his drugs phone. What H described matched what his school had described about this behaviour in years 10 and 11. H, when younger, was hiding drugs for older people. He did not listen to his mother, who was trying to deal with what she saw H involved in. H's mother forced him to go to school and he would "kick off" and resist her efforts to get him to school or otherwise behave better.

9.26 H described himself as a well-known kid, who hung around the local shop. People he met there, some of whom were from outside his local town, led him into drug dealing. H said that at 13 he would do anything he was asked to. He did not see it as exploitation, but more being looked after by older mates. H said that when dealing, he made £1000 a week, which was shared with G.

9.27 H described being in and out of selling drugs. He would stop and then get drawn back in. He found cocaine addictive and he was given cocaine in exchange for selling drugs, which drew him back in and meant he had drug debts he had to repay through dealing. After his convictions for possession in 2019, he and his family were harassed and his mother moved out of his local town. H said it was hard to get out of dealing and he did not listen to others. He did not know what prison was like. His family were all people who worked in regular jobs. His mother tried to put boundaries in place.

9.28 When asked about why he had got into drug dealing, H said he saw older people leading a good life. They could buy what they wanted, however, H said that his mother always got him what he needed, and he was provided for, but he wanted more.

Family relationships

9.29 H is close to his maternal family. After a period of living with his father, H returned to his mothers' home, but felt the house was very full and his grandparents agreed to help by taking him in as long as he worked. His maternal grandparents had always been part of H's life. This family support was important for H and was helping him break away from his involvement in drug dealing.

School and education

9.30 H recalls being excluded from primary school aged 7/8 yrs old, when he threw a chair. He then went to a 'behaviour' school. H liked it and saw it as good for him. He had anger problems and liked the 1 to 1 attention. At school, H loved Maths and PE. In Years 10 and 11, H was a peer mentor at his school, which he liked. In Year 11, he was quiet in school, but was only there 60 to 70% of the time. He liked Science, as it was a hands-on subject. He liked Food Technology for the same reason. At H's secondary school, H said he tried to be

respectful. He liked two staff members that were involved in professional football and he listened to them more than female staff.

Child Protection Plan (CPP) and involvement with YOS 2019

9.31 H did recall the time there was a CPP and the meetings he attended as part of this. He had no distinct memory of the social work involvement with him and his family. H described what was said as going in one ear and out the other. H agreed that social care and others were right that he was being exploited. However, he saw the money being made and as he got older, thought he knew it all. H recognised he did not listen to others but also saw that some of the people he associated with were scary as he knew what they were capable of. H could see his mother was worried about him and her ex-partner was angry with him because of H's behaviour. H saw his mother as being on her ex-partners side not his.

9.32 H did recall his involvement with the YOS. The YOS worker did check up on him and worked with his mother.

Contact with the Police

9.33 H said the Police knew he was involved and he did not cooperate with them. H could not say what was going on. He did get stopped and searched but only found with drugs twice. These two occasions when he was caught led to him having a drug debt.

Carrying a knife and experience of violence

9.34 H said until F's murder he never carried a knife. He said knife carrying was common amongst those involved in selling drugs and that it hyped everyone up. H was aware of violence on the estate where he was brought up. There were men with guns and knives. Those involved seemed to get an energy from this behaviour. H said he has been attacked a few times.

What might have made a difference

9.35 When asked what might have made a difference, H identified the absence of his father in his life when younger. He contrasted this to the role that the father of his brother has played. For example, the consistent interest of his brother's father in his brother playing football. H's brothers father was there to support H's brother while H's father was absent and when H stopped playing football at 12 or 13 yrs of age, there was no one to get him back into playing.

10. Practice Learning Event

10.1 The practice learning event provided an opportunity for the practitioners who had worked with F, G, H and J to share information about this experience and reflect on what might have made a difference. The information shared is included in the account of agency work with F, G, H and J. It was evident that practitioners had thought carefully about their work with the four young people. There was a shared conclusion that all four young people were very entrenched in the situation they found themselves in and that the interventions, the practitioners had delivered had not been effective in addressing or identifying their needs.

10.2 Practitioners noted the lack of power of their offer compared to the material rewards drug dealing offered alongside the unseen people with influence on the young people's lives who are members of their community and in some cases of their wider families.

10.3 The discussion of what might have made a difference included the following points:

- The importance of the young person having ownership of the plan for them and the related issue of how to engage them sufficiently in developing their plan
- Earlier intervention, including when there are difficulties in school, trying to maintain children in mainstream school and when this cannot be done providing continuity of education and school placement.
- The importance of community engagement and the role that community and youth workers could play in this work.
- How to engage fathers.
- Using trauma informed approaches at every stage.
- Flexibility and autonomy for family support workers to adapt programmes to the child and family circumstances. Time to try to get to the underlying issues for the young people.
- Services are too targeted – need workers who have no agenda, who have time to get alongside young people without having to deliver a programme or intervention. Structures that allow the development of relationships over time - 6 to 12 months.[14]
- Addressing the needs of and providing containment for parents who feel overwhelmed by the behaviour of their children and the risks their children face and by their own issues.
- Long term impact of domestic abuse
- Recognising the importance of family values, including desire for privacy, sense of shame and how a family may fear being seen in their community as a result of their children's behaviour or adult problems such as divorce or separation. There was a lack of evidence of how cultural and family values had been considered in practice with these four young people.

10.4 Practitioners' views of what needs to change:

- Earlier intervention – the CCE service is only working at level 4 when behaviour and involvement in CCE is very entrenched. Need an earlier assessment and services that can be offered in response.
- Education provision that does not meet needs or sufficiently engage or address difficulties early enough or with sufficient intensity of intervention.
- Unassessed health needs and ensuring there is a lead professional for health needs.
- Ensuring A & E attendances are recorded within wider interagency system.
- Communication and access to a central record held by the GP for the multi-agency system.
- Lack of suitable placements if a child needs to move out of the area
- Benefits of open access youth services. Everything is now too targeted. Open access provides greater insight into communities and helps provide access to trusted adults.
- Are CPPs useful for young people facing CCE given the parental deficit model the CPP is based on? What alternatives could work better?

[14] https://tce.researchinpractice.org.uk/slowing-down-for-stronger-momentum-in-tackling-child-exploitation/

11. Analysis and Response to the Key Lines of Enquiry

What was known and understood about the risks to F, G, H and J by each agency individually and collectively across agencies?

11.1 While a considerable amount of information was known about each of the young people who are the subject of this CSPR, this information was about a small segment of their lives. The information that was known to public bodies was shared through mechanisms, such as, the CPC that were held for H and G and when J and F were involved with the Youth Justice Team, but none of this amounted to a full bringing together of all the information, potentially available from all agencies. The risks to H and G were recognised through their being subject to CPPs, but the CPPs were of relatively short duration and in retrospect, it is hard to see that when G's ended, any significant change had been made to the underlying risks he faced.

11.2 The sense is of quick, transactional 'throughput' type work, which was not sufficiently purposeful, or thoughtful or young person centred enough. For H it appeared risks had reduced, but this did not recognise the limits of what was known about his life and his relationships with those who placed him at risk or might lead him into further serious offending. The risks to F and J were not well articulated, F and his family declined assessment by CSC and the level of risk he faced was not fully understood. This was also true for J. This raises an important dilemma about how to reconcile working with parents as partners with situations where the child's best interests invite assessment without parental consent.

11.3 G and H's families were very concerned about the risks they faced and shared information with Police and CSC. A question for the review is whether this information was given sufficient weight or acted upon or whether professionals recognised how difficult it was for families to share such information or the risk they might be taking in doing so. J and F's families were less engaged but neither of their cases escalated to the formal mechanisms of CPP which might have provided a means for sharing information.

Were F, G, H and J identified as at risk of CCE in each agency and collectively?

11.4 G and H were identified as at risk of CCE. This was clearest for H who with his mother talked about the exploitation he had experienced and was experiencing. G disclosed nothing about his relationships, but the information from the Police and his family made clear that he was being exploited even if he did not identify with this description of his circumstances.

11.5 For F and J, they denied being exploited and were not identified as being subject to CCE. This judgment rested on the absence of evidence of them being pressured to be involved in drug dealing and youth violence. Given their ages at the time and that they were involved in drug dealing with the drugs supplied by adults not identifying them as exploited suggests a degree of control and volition which does not recognise that the adults were exploiting them whatever J and F's views were.

11.6 Though G was identified as being at risk of CCE he saw himself as involved in dealing drugs as a choice. Given his age and circumstances, it would not be appropriate to see him as in

control of his destiny in this way. A young person does not need to self-identify as a victim of exploitation to be treated as one. Asserting to a young person like G that they are a victim or being controlled could be upsetting to a young person who has built a mental model where they are a tough seasoned adult in charge of their own destiny. This sense of agency, however misguided, can be an important part of the scaffolding they build to feel safe and have some control. All four young people were being exploited whatever their views of the level of control they had of their situation.

Was information shared about F, G, H and J who were at risk of CCE in a timely and effective way?

11.7 The formal mechanisms of strategy meetings, CPCs and Multi Agency Child Exploitation (MACE) discussions were used with these young people. There were weaknesses in what was shared. On occasions, the Police did not share information provided to them anonymously and which was not otherwise evidenced. This is a sensitive judgment to make about when to share information which cannot be substantiated. It may be useful for the Partnership to offer guidance on what constitutes information or intelligence and why and when it needs to be shared. The schools seem to have been included some of the time but not always and it is not evident that consideration of how these four young people were at school was given sufficient weight or what might be learnt from their educational history fully considered. The weakness in information sharing was the consideration given to what agencies did not know or what they might infer from the limited information available. This led to an optimism that levels of risk were reducing or a view that having completed the assessment, YOS and CP processes this would have reduced the risks without positive evidence this was the case. For example, for H, G and F simply because there was no new offence or nothing new known, their risk was assessed as reduced without a deeper reflection about whether anything had changed for the young people and what might have been hidden from view.

What interventions and offers of help were tried with F, G H and J and what if any was their impact?

11.8 F, G, H and I were all subject to some level of intervention which perhaps provided a level of reassurance which was not substantiated by evidence of change in the young people's lives. F, I and H had interventions from Youth Justice which focused on their offending. They completed their orders successfully and were believed to then be at lower risk. G and H had considerable contact with CSC when on a CPP and with specialist CCE team workers. These workers completed programmes with H and G, but subsequent events suggest this work made minimal change in their outlook or was superficial relative to the other more powerful influences on their behaviour and views of their world. For example, when the CPP ended for G in May 2020, and he was stepped down to the Children and Family Wellbeing Service, G did not engage with the service at all. H did appear to do better after the end of his CPP, but this seemed related to actions his family took when he moved to live with his grandparents. By the time G and H were subject to CPP because of CCE, their behaviours and levels of distrust of agencies were entrenched. The CPPs did not last long enough for relationships to develop with young people who may feel under threat from adults in the community, they will see as much more influential than the professionals they were engaged with.

11.9 The interventions with F and J were only touching the surface as the nature of their involvement with inappropriate adults and the supply of drugs or the nature of their exploitation in drug dealing and street activities was much deeper than was seen by the services working with them and their families.

11.10 It is hard to see that the specific interventions aimed at reducing risks from CCE were effective. They were not early enough or powerful enough to outweigh the other influences on these young people's lives which drew them into offending and violent behaviour placing themselves and others at risk. The kind of work that might have made a difference is described in the evaluation of service for children who are at risk of sexual exploitation in Wigan and Rochdale.[15]

Education Interventions.

11.11 J had stable schooling and seemed to have benefited from the support he had at school. He had academic and social support from school which was available to all students who might at some point be struggling.

11.12 F was at the PRU following his permanent exclusion and efforts were made to provide a tailored programme to meet his needs.

11.13 H had stable schooling at his special school and while there were regular difficulties there was a good partnership between the school and his mother and they were able to maintain his place.

11.14 G's secondary education was disrupted and from Year 10 it is not clear if he was in school. His needs were not met, and he moved away from school and education in Year 9 and never reengaged.

What contact was made with F, G, H and J's families and what work was undertaken with them? What did their Family's understand about the risks to their children?

11.15 There was contact with all the families which was almost exclusively with the mothers of the four young people. F's mother was concerned about his behaviour which she attributed to ADHD. This was not confirmed in an assessment by CAMHS which disappointed her and there was no further exploration of what lay behind F's aggressive behaviour. F's mother did work with the CFWS on risk taking behaviour, anger and aggression and F's drug use but felt nothing changed.

11.16 J's mother declined an assessment for CCE and there was very little contact with her. The declining of the offer could have been responded to with a more tenacious and curious response.

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15 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/601976/Child_sexual_exploitation_project_Wigan_and_Rochdale_evaluation.pdf

11.17 H's mother was actively involved in work with his school and was an important source of information about the risks to him. Her conflict with H arose when she tried to set limits to his behaviour. H's mother valued the relationships with workers from the YOS and child exploitation team. These workers were persistent and had time to get to know H and his mother and were felt to have made a difference.

11.18 G's mother was actively involved in the CPP and with his sisters in providing information about the concerns for G. She reported him missing and his drug dealing. G's mother took part in parenting programmes with CFWS.

11.19 For each adolescent there were opportunities to engage with their mothers. There were efforts to help the mothers understand the risks to their child. G and H's mothers were very aware of the risks to their child. The lack of engagement with F and I's mothers makes it harder to judge how far they appreciated the risks to their child. J's mother's English was limited and the one more substantial interview with her used J's sister to interpret. This was not appropriate, to have the kind of conversation needed to fully explore J's mother's understanding of the risks J faced. F's mother's concern about his behaviour was explored with a limited focus on ADHD as a possible cause and when that was not confirmed nothing else was offered to engage F's mother or address her worries about F.

Was contact made with F, G, H and I's fathers and what if any role did they play in their lives?

11.20 All the father's played a role in the lives of their sons. H went to live with his father for a time which seemed to be part of his family's efforts to keep him safe and out of his local town. G saw his father and his father tried to engage him in some constructive sports activities. F at times worked with his father in his father's business. J was in conflict with his father over his father's behaviour. None of the professionals had any significant contact with the fathers. Some efforts were made to contact them, but it appears they left contact with agencies to the mothers. Whether more persistent efforts to engage the fathers would have worked is unknown. No father has responded to the efforts made to involve them in the CSPR.

How well did practitioners working with F, G, H and I and their associates communicate and develop joint plans of intervention? Did they take a systemic view of their work with F, G, H and I?

11.21 There were no joint plans outside the CPPs. There is no sense of their being a systemic view which looked at the wider context of these young people's lives or how they might connect together and connect with the other young people engaged in negative behaviour. They all lived and socialised within a limited geographical area. There was no peer-group mapping or contextual safety planning.

What was understood about F, G, H and J's lived experience including how they saw themselves in their community, their emotional and mental health, their motivations and their experience of agencies?

11.22 The agency reports suggest very little was known about the lived experience of the four young people. There is little sense of reflection on how the world looked to these young people or of curiosity, tenacity or creativity in thinking about their lives. For example, how did they see the 'choices' they made and how they might respond to or describe pressures on them to deal drugs. There is little reflection on their relationships with adults in their extended family and neighbourhood networks who drew them into offending, including drug dealing and associated violent norms of behaviour. There is no consideration of how they saw opportunity or lack of it. There was little consideration of what was changing, if anything, as a result of any intervention. The impact for three of the four of adverse experiences and trauma earlier in their childhoods, such as, exposure to serious domestic abuse is not given significant consideration.

11.23 Their experience of agencies was largely transitory and transactional. Apart from school, their relationships with agencies were over relatively short periods of time and not ones where relationships of trust and depth could easily develop when the starting point is one of deep distrust. Where there was continuity of schooling, this did allow positive relationships to develop. Conversely, where continuity was broken this made disengagement from schooling much more likely. The experience of their familiess was also of episodic involvement with social workers or YOS workers. Persistence was limited and it is hard to see evidence of the families feeling they or their children had been helped.

11.24 All four had deep distrust of the Police likely to reflect family and community views of the Police. There was more positive contact with PCSOs but with the warranted officers contact was about enforcement. Those who worked closely with the Police, such as, Youth Justice and CSC will have been seen as people with whom sensitive information could not be shared.

Did any practitioner form a relationship of any depth with F, G, H and J and if so, what enabled this?

11.25 There is no evidence that any practitioner had a depth of relationships with any of the four young people. J had several positive relationships reported by his school. These were school focused and did not mean J shared what was happening in his life outside school with these adults. H's school saw him positively and had a good relationship with his mother. These relationships helped keep H and J in school. G was very guarded and by the time he was being seen by a practitioner from the CCE team, he was very unwilling and possibly felt unsafe to disclose anything of consequence about his life. This is why engagement needs to be early before an entrenched sense of fear or loyalty to those exploiting a young person has developed. H was less guarded, but the 'rules' the young people lived by would not have allowed significant disclosure about their offending behaviour or about harms they had come to as a consequence or threats they felt they were under.

What were the key factors in F, G, H and J's educational difficulties and how were these difficulties addressed?

11.26 All four young people presented behaviour difficulties in school. J's were the least acute and he stayed in his secondary school and achieved reasonable GCSEs at the end of key stage 4. With more application he could have done significantly better.

11.27 F was permanently excluded and went to the PRU where he had a one-to-one programme due to his continuing behavioural difficulties. He could access the secondary curriculum. What was driving his behaviour was not explored beyond the assessment for ADHD which concluded there was not enough evidence for a diagnosis. This gives a sense of gatekeeping rather than needs-meeting and is an indication of overstretched services.

11.28 H had an Education Health and Care Plan (EHCP) and was attending a special school. His behaviour and emotional regulation were the primary issues which inhibited his being in mainstream school and making better educational progress. There was limited thinking about why he behaved as he did.

11.29 G started his secondary education in mainstream school but was excluded, went to the PRU and then had a failed reintegration to mainstream after which his engagement with education was limited. He had an EHCP. As for F and H, there was very limited thinking about what his behaviour meant including his emotional dysregulation and what might help him with his behaviour. His fractured secondary education meant he did not develop any positive relationships with his teachers or schools.

Did F, G, H and J and their families face any material difficulties that may have affected their health and development and if so, were these addressed by any professional?

11.30 The records do not suggest that any of the families had serious material difficulties, but it is not clear whether this is because the issue was explored, and a conclusion reached there were no issues or the issues were not explored. They all lived in relatively deprived areas of their hometown. They appeared to have stable housing. H and F's families were in work. G and J's mothers were not in work and their fathers were not part of the household. These families were dependent on benefits. G in his account says that desire for a better material life and not having to ask his mother for money was a motivator for his involvement in drug dealing.

Did practitioners consider issues of identity, race and culture in their work with F, G, H and J and their associates?

11.31 This is not evident in the Individual Management Review (IMRs). The ethnicities of the four young people were diverse. The family norms of J and F may well have influenced the willingness of their mothers to share information with those working with their children but the implications of this are not explored in the IMRs. The use of J's sister as a translator suggests weak consideration of issues of identity and culture.

How was practice with F, G, H and J and their associates and family affected by Covid 19 and related changes in working practices?

11.32 The Covid 19 pandemic limited face to face contact with practitioners during the lockdown phase. This had an impact on how the later stages of the referral order programmes for F and H were conducted – they went online. F's mother sought advice from his school about this not keeping to Covid restrictions. This was another aspect of his behaviour and demonstrated that F did not appear to respect his mother's authority.

Were practitioners effectively supervised and managed when working with F, G, H and J and their families and associates?

11.33 The IMRs and timelines do not suggest there were any gaps in supervision and management of those working with F, G, H and J in terms of whether standards for supervision and management were met. The gap was in whether supervisors and managers were able to help practitioners move beyond meeting their own agency expectations to take a wider view of each young person and consider the wider system within which they lived, their lived experience and what this might mean for the intervention from their agency and for the agencies working together.

11.34 Practitioners might have been having 1:1s with managers of a frequency that meets standards, but it is hard to see how 'effective' supervision could have been in place. 'Effective' suggests there was a space for hypothesis forming and testing, thinking deeply about anti-discriminatory practice, case formulation, being challenged to think creatively about options, using family feedback to inform planning, reflecting on gaps in knowledge, processing fears and anxieties, etc… Crucially, this kind of supervision would have needed to extend beyond social work. This issue of how to supervise and reflect with the multi-agency professionals who are holding the family could be a key one for the partnership to grapple with. If extra-familial harm is a multi-agency issue, then what is the multi-agency offer to support ethical, informed practice?

12. Partnership Learning

12.1 In considering partnership learning, it is worth reflecting on how far the circumstances of the four young people who are the subject of this review and their involvement in CCE are similar or different to findings from academic work on safeguarding young people, notably '*Safeguarding Young People – risks, rights, resilience and relationships*' edited by Dez Holmes[16] and other reviews primarily the '*National Review – It was hard to escape Safeguarding Children at Risk of Criminal Exploitation*[17] and the '2014 to 2017 triennial analysis of serious case reviews'[18][19]

12.2 It is not surprising 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. From

[16] Safeguarding Young People – risks, rights, resilience and relationships edited by Dez Holmes. Jessica Kingsley 2022
[17] National Review – It was hard to escape Safeguarding Children at Risk of Criminal Exploitation 2020
[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf
[19] https://seriouscasereviews.rip.org.uk/local-safeguarding-partnerships/#lscb_vulnerable

Safeguarding Young People, the key learning points to consider are:

1. Understanding safeguarding within adolescence as a developmental life stage
2. The link of individual development and structural factors in promoting healthy development and behaviours
3. The importance of considering the dual identities of young people as victims and perpetrators of harm i.e. not making a criminal justice response to a welfare issue
4. Practitioners needing to hold the concepts of the autonomy of the young person and their dependence in healthy tension. This in turn enables practice to integrate protection and participation.
5. The role of poverty and inequality as a driver for harm and adversity.
6. The importance of providing a personalised and tailored response. There are no typical victims and perpetrators.
7. The role of adultification – seeing children as older and more responsible than they are chronologically or developmentally.
8. Whether the current legal and policy framework facilitates or inhibits effective responses to extra familial harm.
9. The importance of a trauma informed approach to working with young people where practitioners look for what lies beneath a young person's behaviour.
10. The impact of early attachment and later experiences of risk and harm.
11. The connection between young people's trauma and unmet developmental needs
12. That viewing trauma through developmental and relational lens enables better sense making of young people's worlds and the impact of their experiences.
13. That attachment experiences and trauma are not hard wired or destiny. Change and development are possible, but this needs practitioners who feel safe and able to develop relationships with young people.
14. That participation and empowerment focused approaches are essential features of safeguarding for young people. They need to own their plans if they are to be effective. Professionals should avoid mirroring the coercive dynamics that young people may have experienced as part of being exploited in how they seek to protect young people.

12.3 From the National Review the learning points were, together with reflection on how far they apply to this review:

1. Boys from black and ethnic minority backgrounds were more vulnerable to CCE – 3 of 4 young people involved in this review were from ethnic minority backgrounds. Was the practice sufficiently culturally sensitive and were opportunities taken to involve the voluntary sector where there was reluctance for families to engage?
2. Known risk factors except for exclusion from school were not always good predictors of CCE. Most in the national review sample were not know to CSC. This was not true for this review where 3 of 4 were known to CSC and 2 had long histories of CSC involvement.
3. Exclusion from mainstream school was a key trigger point for escalation of risk. The National Review identified the need for immediate wrap around support to compensate for the lack of structure and sense of belonging and rejection that exclusion from mainstream school can cause. 2 of 4 in this review were excluded from school and 1 was

at a special school. Early warning signs of exclusion could have been a chance to target help earlier.

4. There was a lack of confidence about what to do to help and little reliable evidence of what works. In this review, the efforts to address CCE were ineffective. Staff need a comprehensive professional development offer that includes group supervision, case clinics, 'I've got stuck panels', co-working and that is open to all partners.
5. Trusted relationships are important. Building a trusted relationship between the child and a practitioner was essential to effective communication and risk management. This takes time and skill with persistence, tenacity, creativity and the ability to respond quickly being the key qualities required form practitioners. No one had this kind of relationship with any of the four young people who were subject to this review with the possible exception of staff at J's school but this relationship was school focused and did not encompass what was happening in his life outside school.
6. Responding at critical moments can make a difference e.g. school exclusion, physical injury and arrests. There was no vigorous response at such critical moments for the 4 young people who are the subject of this review.
7. Parental engagement was nearly always a protective factor. Parents and extended family need effective support in helping manage risks. The parents of all four young people were engaged to some degree and for one parent this was helpful and made a difference. In retrospect there was not sufficient energy and persistence in engaging parents and wider family.
8. Moving children and families to somewhere else works in the short term but is not an effective long-term strategy. This is pertinent to considering whether G's request to be moved should have been responded to. For this to be successful would have meant putting in place a supporting strategy to make the move a success and help G and his family with what would come next.[20] Moving H was helpful and his time living with his grandparents was positive.
9. More priority to disrupting perpetrator activity for these four young people, the Police were engaged with them, but it is not clear how far there was a wider strategy to disrupt the criminal networks they were part of. The Police have powers to help disruption.[21]
10. Comprehensive risk management arrangements can make a difference. In this case, the CPPs for G and H did not make a difference. The risk management arrangements were not effective.

12.4 The National Review recommends a practice framework. The key features of this are:

1. Identification of individual children who are at risk of serious harm through use of data, mapping exercises, local practitioners' knowledge and work with communities to get a detailed picture of those at risk. This group of children would be those who are identified as being at the most extreme risk, where criminal exploitation is known to be a feature and they are involved in county lines and gangs.

[20] https://www.contextualsafeguarding.org.uk/our-work/research-projects/securing-safety/

[21] https://www.gov.uk/government/publications/child-exploitation-disruption-toolkit/child-exploitation-disruption-toolkit-accessible

2. Intensive and dedicated work with individual children and their families to build good relationships. A specialist team (perhaps part of an existing service) comprising practitioners from a mix of disciplines and with significant experience of working with young people. The important qualities are persistence, tenacity, creativity, flexibility and ability to respond quickly.

3. Team make-up will vary, but could include both part-time and full-time staff from the following disciplines: police, youth offending, social work, clinical expertise, voluntary sector, youth work, teachers, family support workers.

4. Members of the team who can work closely with parents and provide dedicated support to help them manage the risk in a way which is perceived to be supportive and empowering. Family group conferences and group work with parents are a strong feature of this work. They should be applied from early help and not just as a part of high-risk response.

5. Use of a shared practice model which is known to be effective, such as systemic practice. The seven features of practice described in the evaluation of the Innovation Programme outline the key factors which have been found to be associated with positive outcomes. These are:

    - Using a clear strengths-based practice framework.
    - Using systemic approaches to social work practice
    - Enabling staff to do skilled direct work
    - Multi-disciplinary skill sets working together
    - Undertaking group case discussion
    - High intensity and consistency of practitioner
    - Having a whole family focus with a proactive approach to helping the family be active partners.

6. A dedicated budget for the team and permission for them to work flexibly. This will enable practitioners to step outside routine procedures so they can respond to individual characteristics of the family, be more creative and make decisions which are not risk averse. Confidence and autonomy are key factors. These practitioners need to be able to respond at speed to critical moments.

7. Comprehensive risk management plans which are reviewed frequently and in response to changes or heightened risk. Work with the courts to facilitate the use of electronic tags and curfews and intensive supervision arrangements.

8. Members of the team are available in the evenings and weekends to respond immediately if they are alerted to an incident or information which indicates a heightened level of risk. For example, they may need to remove a child immediately from a location and take them to a safe place. We have heard of examples of this being done, with the child's consent, and where it has enabled a breathing space and time for the child and family to consider their situation and options.

9. Capacity to provide an immediate, high quality, full-time timetable for children who are permanently excluded at the point of exclusion, with no time lag. This will involve working with head teachers before the point of exclusion. The timetable could include employment or activities such as music or football which are known to be popular with young males.

13. Recommendations

13.1 Given the common features between this CSPR and the National Review Findings, a good starting point for considering recommendations is to consider whether the National Review recommendations provide a template which with local adaptation should be implemented in Lancashire.

13.2 A recommendation of the National review was the development of exploitation principles. These are being developed now and the Partnership could commit to their implementation when published. [Note: The current draft of the principles is now available to the partnership.]

13.3 Recommendations for the Partnership:

a. Commits to the implementation of the national exploitation principles when published.
b. Develops a range of early intervention services to support children and families at risk of or in the early stages of CCE
c. Ensures that practice always explores the strengths within the immediate and wider families of children at risk of or being criminally exploited
d. Recruit workers with the personal skills to undertake relational work with children and families and gives them the training to develop those skills further and time to develop relationships with children and families which do not preach or judge.