Serious Case Review

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On behalf of an unnamed local safeguarding children board

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Adam
Local Child Safeguarding Practice Review

1. Background and Introduction to the review

1.1 Background

This child safeguarding practice review was commissioned by a Local Safeguarding Children Partnership (LSCP) in November 2020 following a Rapid Review of Adam's case. Adam died tragically in a road traffic collision.

Adam was believed to have been at risk of criminal exploitation at the time of his tragic death. He was suspected of being involved in criminal activity but this had not resulted in any formal outcome or charge and was being investigated. Adam and his family received support from a number of services including Children's Social Care and the Complex Safeguarding Team and there were concerns about how partners worked together to identify and provide timely support in response to the risks of child criminal exploitation.

1.2 Methodology

A case discussion tool, developed by Salford Safeguarding Children Partnership was used by a Practice Review Panel to review the effectiveness of multiagency work which had been undertaken with Adam and his family. This required the gathering of a multiagency chronology of events from agencies and the identification of key lines of enquiry by the Panel for further analysis.

The following themes have been identified:

- Gathering, analysing and sharing of information
- Delayed Service Offer
- Poor Engagement
- Child Criminal Exploitation and Contextual Safeguarding

1.3 Practitioner Involvement

A learning event was held with practitioners and team managers that had direct involvement in the case. The views of practitioners gained from the respective multi agency chronologies and the Practitioner event have been included within the report and analysed by the Practice Review Panel.

1.4 Family Involvement

At the time of writing this report several attempts had been made by the Local Children's Safeguarding Partnership to contact Adam's family, inviting their involvement with the Practice Review. To date the family have not responded to these requests and so we have been unable to include their views and experiences in the practice review.

2. Key Findings

Through multi-agency examination of events in Adam's life the Review Panel found four practice and system themes. These are briefly summarised below and examined in further detail in section 5 of the report.

2.1 Gathering, analysing and sharing of information

Adam appeared to be viewed by agencies as a criminal rather than as a child who may have been demonstrating learnt behaviour and who was vulnerable to criminal exploitation.

As a result agencies had not considered his increasing involvement in criminal activity as a safeguarding matter. As a result the multi-agency approach was used to gather information about him which could be used primarily to assist with criminal investigation.

2.2 Delayed Service Offer

A referral was made to the Complex Safeguarding Team at the point when there was clear evidence that Adam was actually involved in criminal activity. This was despite potential indicators of criminal exploitation having been identified some months earlier by agencies. The perceptions of some level of risk which some indicators of child criminal exploitation may or may not have had to Adam's safety was not consistent between multi agency partners. This meant that there was a delay in making referral to the Complex Safeguarding Team. Child Criminal Exploitation was not being perceived to require the same urgency of risk as that of intra familial child abuse. Exploitation was not necessarily being perceived to be a safeguarding issue.

2.3 Poor Engagement

The Practice Review panel identified that there was limited engagement of Adam and his family with services. This should have led to a re-assessment of the level of safeguarding risk including the likely impact on Adam's daily lived experience; significantly in the context of living in a family where adult care givers had criminal convictions. Because Adam was being viewed as a "perpetrator of crime" the need for him to be protected from harm appeared to have been missed with agencies being slow to make due assessment and intervention.

2.4 Child Criminal Exploitation and Contextual Safeguarding

The risk to children and young people of the impact of criminal exploitation is ongoing and has been widely identified nationally. The Practice Review Panel identified that practitioners do not necessarily perceive exploitation of children, through various routes, as being synonymous with accepted definitions of child abuse. Children are viewed as being part of the problem rather than demonstrating learnt behaviours from the context in which they live their lives.

Practitioners in this case had identified the early indications of child criminal exploitation. However, unlike CSE indicators these are not a widely known and therefore not embedded in practice. Practice does not reflect the magnitude of the push pull factors in relation to Child Criminal Exploitation or that they warrant a safeguarding referral and intervention.

3. Strengths in Practice

Adam had attended school with roughly 90% attendance in years 7-10. Only in year 11, and with the closing of schools to many pupils due to Covid-19, did Adam's attendance drop to 47%. As a 'vulnerable child', due to Adam's Child in Need status, efforts were made to get Adam to attend school as normal. His school made good attempts to support Adam and they also tried to transition Adam into further education.

Social Workers in particular were persistent in the efforts to engage with Adam and his family. In addition they did consult with a Clinical Psychologist about alternative forms of engagement. Assessments were completed and it was noted that the social worker was able to capture Adam's wishes and feelings as part of the Child and Family Assessment.

The multi-disciplinary Complex Safeguarding Team has brought the working arrangements of Children's Social Care, Police, and Health colleagues closer together. Those partner agencies had already begun to map out community issues and local associates.

4. Learning Points

4.1 Learning Points for Practitioners

- Always follow safeguarding procedures to assess and manage the risk of harm to a child in parallel with any criminal investigation.

- Utilise the Early Help Assessment and Team Around the School approach at the earliest opportunity when responding to signs of criminal exploitation.

- Remember to professionally challenge and escalate any decisions that you do not agree with and;

- Refer to the District Safeguarding Procedures for guidance on a wide range of safeguarding issues including child criminal exploitation and resolving professional disagreement and escalation.

4.2 Learning Points for Managers

- Support your staff to escalate concerns when there is professional disagreement.

- Promote and check your staffs awareness and compliance with the District Safeguarding Procedures.

- Ensure the risks and the impact of non-engagement to the child have been assessed before closing a case and consider escalating the concerns if those risks are still prevalent.

4.3 Key Messages for the Safeguarding System

- LSCP should be assured that partner agencies utilise the Early Help Assessment and Team Around the School approach at the earliest opportunity when responding to signs of exploitation.

- LSCP to seek assurance that the 'Understanding Exploitation' training course provides guidance on how services should respond to the early signs of exploitation and promotes the complex safeguarding offer.

- LSCP to host a Practitioner Forum on the topic 'developing trusted relationships' so that professionals can share good practice and develop alternative ways to engage families.

- Strategic partnerships should undertake a strategic need assessment so they have an understanding the nature and scale of the problem and are able to identify children engaged with and at risk from criminal exploitation.

- Strategic partners (LSCP and Community Safety Partnership) to agree and implement a contextual safeguarding response that will engage and empower members of the community.

5. Analysis & Findings with Key Recommendations

The Review has found four system and practice areas that are significant in Adam's story and these are analysed in greater detail with key recommendations for the partnership in this next section. This Review has found some similar themes to the National Panel's Report into child criminal exploitation 'It was hard to escape' and these specific points are referenced below.

5.1 Gathering, Sharing and Analysing Intelligence

Information collated as part of the review showed that professionals had a lot of information about Adam and his family. Although this might not have been sufficient to secure a conviction in relation to criminal activity the level of risk to Adam was enough to warrant an earlier statutory child protection intervention. School were contacted by Police in 2019 regarding an investigation into vehicle theft but were advised at that point not to inform Adam or his parents so as not to prejudice the police investigation as per their standard practice. The school then became aware, through 3rd party information, of a snapchat post which indicated that Adam was driving a car. The school contacted Adams Mother about the information that they had received who stated that it was Adams Uncle driving the car. According to school records they shared that information

with the Police, sought advice from the Multi-Agency Safeguarding Hub and subsequently made a safeguarding referral that was then rejected due to a 'lack of consent'.

Partner agencies did not adopt a child 1st, offender 2nd approach and therefore did not see Adam as a vulnerable child that needed safeguarding. There was also no further referral to Youth Justice Services. The Panel agreed that the Police position could have been challenged rather than accepted and that partner agencies should have other means to discuss their concerns when some of the information couldn't be shared with the family. For example an early help platform such as the Team around the School approach would have enabled those discussions to take place and for information to be shared with partner agencies. In addition effective triaging must take place within the MASH regardless of whether or not information can be shared with the family.

Recommendation 1

LSCP should be assured that safeguarding partners effectively invoke safeguarding procedures even when some information cannot be shared with the family due to a criminal investigation.

It was the schools understanding that their safeguarding referral would be kept on record in case any further concerns were raised. However, Children's Social Care have no record of that referral on their system. The review panel agreed that this could have led to a strategy meeting or professionals meeting. The effectiveness of the strategy meeting process and its alignment to 'Working Together to Safeguard Children' (2018) has already been identified and actioned in another Local Child Safeguarding Practice Review.

There is evidence of multi-agency sharing of information within the child and family assessment, of multi-agency representation and information sharing at a strategy meeting in 2020, and at subsequent child in need meetings. However, Children's Social Care noted in their analysis that there is conflicting information about whether a S47 enquiry was agreed or not. Following the strategy meeting a form is completed 'record of outcome of s47' where Child in Need (CIN) is determined as the threshold. It's unclear whether this was a single agency or joint agency decision and there is a lack of clarity regarding the actions that were agreed as part of the CIN plan. In addition Children's Social Care have acknowledged that Child in Need meetings were not held in line with procedures. CIN meetings should be held a minimum of every 3 months and locally best practice would state 6 weekly. The recording of the strategy meetings and compliance with the frequency of CIN meetings have been identified as areas of learning for Children's Social Care.

Recommendation 2

LSCP seeks assurance from statutory partners that they are working in accordance with Working Together to Safeguard Children 2018.

Practitioners didn't feel that they could record and share information because it was based on hearsay rather than evidence. There was a lack of information sharing between partner agencies and evidence of those partners adopting a silo mentality rather than working together to identify and respond to risk at the earliest opportunity. Intelligence was not recorded as a safeguarding or vulnerability concern and there is no evidence that a referral to the Complex Safeguarding Team was considered at that point.

Recommendation 3

Practitioners needs to be able to distinguish between factual information and hearsay evidence that needs to be utilised to inform a risk assessment.

5.2 Delayed Service Offer

Professionals compartmentalised Adam's circumstances as criminal behaviour which had to be investigated by the Police as oppose to showing more curiosity regarding the family history and lived experience. A referral was only made to the Complex Safeguarding Team when there was clear evidence that Adam was involved in criminality and yet some of the indicators of potential Child Criminal Exploitation (CCE) had been known about several months prior. The response from partners to indicators of CCE and to the families criminal history were not the same, or provided as early, as they might have been for other types of intra-familial abuse where they would act to safeguard children when they have reasonable cause to suspect that abuse or neglect. In particular there was no early help offer. The Child Safeguarding Practice Review Panel found in their review into criminal exploitation that *"Effective practice is not widely known about or used. Even when local areas and practitioners know the children at risk of being drawn into criminal exploitation, many are not confident about what they can do to help them. There are a number of different approaches being taken across the country but little reliable evidence of what works, and no central point where effective evidence is evaluated and disseminated."* (The Child Safeguarding Practice Review Panel, 2020).

While evidence of what works in relation to child criminal exploitation specifically might be a gap practitioners should not forget what we know to work in relation to the wider safeguarding system most notably parenting support and family safeguarding (Evidence Store - What Works for Children's Social Care (whatworks-csc.org.uk). In relation to this case there was no Early Help Assessment, referral to the Early Help Access Point or Team Around the School meeting which might have led to earlier family support. Despite the view that Adam was an 'offender' there was also no referral to the Youth Justice Service for preventative services.

Recommendation 4

LSCP should be assured that partner agencies utilise the Early Help Assessment and Team Around the School approach at the earliest opportunity when responding to signs of exploitation.

National research based on many types of exploitation of children has identified that factors within the family, especially early childhood experiences, may have some influence on the susceptibility of young people to have increased risk of both intra and extra familial exploitation in later childhood. Multi-agency risk assessments of both intra and extra familial exploitation should incorporate the child's earlier life experiences and assessment as to how these may impact on the child's present level of safeguarding risk.

Recommendation 5

LSCP consider ACES and trauma informed practice as a strategic priority together with the need to provide training on the impact of ACES on children, including where there has been a history of criminality.

Recommendation 6

LSCP to seek assurance that the District 'Understanding Exploitation' training course provides guidance on how services should respond to the early signs of exploitation and promotes the complex safeguarding offer.

5.3 Poor Engagement

Adam was referred to the Youth Justice Service, Substance Misuse Service (CGL) and then later to Children's Social Care and Complex Safeguarding. All of those referrals were appropriate but based on limited information that restricted the remit of those services and led to a limited service offer, largely due to an inability to engage with the family. The case was allocated as Child in Need so the family still had to be engaged with their consent. This combined with the referral to the Complex Safeguarding Team might have been successful but partners' efforts to engage the family were ineffective.

The Child and Family assessment was completed and the complex safeguarding assessment appropriately identified Adam as medium risk of CCE. While the family refused to work with the Complex Safeguarding Social Worker they did agree to continue work with the social worker that was coordinating the child in need support. This suggests that the parents were influencing the level of service intervention and not the professionals. The limited engagement should have led services to re-assess the level of risk and the likely impact of that limited engagement on Adams daily lived experience. If the known risks associated with CCE had been linked with the potential impact of the families criminal history then child protection thresholds could have been applied sooner. The lack of engagement from Adam and his parents with the Complex Safeguarding Team could have been viewed alongside a history of poor parental engagement with other services and escalated the concerns from practitioners which could have warranted consideration at an initial child protection conference.

Professionals at the Practitioner Learning event recognised the need to engage with the parents, in order to engage Adam. This was despite concerns that his parents could potentially be encouraging, or even implicit in, Adams criminal behaviour. Engaging the family would have opened up a dialogue about those concerns, the potential risks and how to manage them. The Panel concluded that one of those partner agencies needed to establish a 'trusted relationship' not only with Adam but also his parents to improve their engagement. The national Child Safeguarding Practice Review Panel identified trusted relationships as being essential to effective communication and risk management. Whilst there was some evidence of practitioner's persistence and considered alternative forms of engagement it was apparent the family were referred too soon to other services when practitioners experienced difficulty in engaging the family, which impacted the ability of developing trusted relationships.

Recommendation 7

LSCP to host a Practitioner Forum on the topic 'developing trusted relationships' so that professionals can share good practice and develop alternative ways to engage families.

Professionals from the Practitioner Learning Event believed that there was 'disguised compliance' from parents that kept them at arms-length. This meant that no direct or meaningful intervention was ever delivered to Adam. The panel debated whether this was disguised compliance or just non-compliance and considered whether practitioners lack confidence in challenging families and escalating concerns. There is guidance for practitioners on 'Dealing with Persistent Non-Engagement with Services by Uncooperative Families' which advises that persistent non-engagement with a service should trigger a review and impact assessment in respect of any children within a family.

Recommendation 8

LSCP, via the Learning and Improvement Group, should raise awareness of the District Safeguarding Procedures.

It was the view of the Panel that ending an intervention that wasn't achieving positive outcomes while the risks are still prevalent minimises the perceived risk by the family and gives the impression that those services are not required. This impacted on the ability of the next service to provide credible support or intervention.

Recommendation 9

LSCP should be assured that a decision to close a case to one service (due to persistent non-engagement or dis-engagement) is informed by a child focused multi-agency risk assessment and agreed upon by those services that are involved in working with the family.

5.4 Child Criminal Exploitation and Contextual Safeguarding

There is concern that safeguarding partners are not adequately equipped to protect those at risk of harm from child criminal exploitation. While successfully engaging with the family might have helped to reduce some of the risks to Adam there were also extra familial risks to Adam that were identified by practitioners involved in the case. Adam was suspected of dealing Cannabis in the local community, he was suspected of driving illegally and he was linked to known associates who were involved in criminal activity.

Professionals at the Practitioner Learning Event recognised that many young people in the local area will experience push factors such as poverty, neglect or abuse, lack of opportunities or positive activities as well as pull factors; such as the glamorisation, status and financial gain; toward criminal associates and activity. Those push and pull factors could cause other young people to become involved in crime and anti-social behaviour. Due to the lack of early identification of indicators we do not know or understand the scale of the problem or what our profile is. The Panel were concerned that some of those young people living in 'at risk' communities could be disguised by ward level data where neighbouring areas are more affluent or less isolated.

Recommendation 10

LSCP adopt the following recommendation;

The Child Safeguarding Practice Review Panel recommend that all safeguarding partnerships have an understanding the nature and scale of the problem and are able to identify children engaged with and at risk from criminal exploitation.

There are extra-familiar factors that safeguarding partners and community safety partners need to work together on to address. LSCP, via the Complex Safeguarding Strategic Group, has already undertaken further consultation with partner agencies from Adams local community and liaised with the relevant local councillors. Issues such as service withdrawal and increased community isolation over the past 10 years have been raised at a Neighbourhood Learning Circle, a multi-agency forum to identify and discuss place based concerns. As a result the risk of other young people being exploited, within this particular community and more generally across the Local Authority area, has been identified and raised with the statutory safeguarding partners, education, and with the Operations and Neighbourhoods Service which encompasses the Community Safety Partnership and Youth Services. A multi-agency group of senior leaders will be convened to agree a strategic response to those place based issues. The Panel recognised the impact that Adams death had on the community and the need to consider community relationships with this work.

Recommendation 11

Strategic partners (LSCP and Community Safety Partnership) to agree and implement a contextual safeguarding response that will engage and empower members of the community.

References

"It was Hard to Escape": The Child Safeguarding Practice Review Panel Report 2020 DfE: HMO: London. The Child Safeguarding Practice Review Panel - It was hard to escape - report (researchinpractice.org.uk)

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