Multi-Agency Learning Review

Child Sam

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This report is written for publication in line with statutory guidance. In order to preserve anonymity, as far as possible the author has:

- made limited reference to the gender of persons, other than where not to do so would compromise the reader's understanding of the report
- restricted the use of exact dates.

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Introduction

What is this review about

This multi-agency review concerns a young person known for the purposes of this report, as Sam.

In the summer of 2019, Sam was the victim of a targeted attack, in which he sustained serious, non-life threatening injuries. He was later admitted to hospital.

Local services have been in contact with Sam and his family from an early age. There exists a history of domestic abuse, some of which he has witnessed. His mother and father have been separated for some time, leaving him for periods without a male present.

His mother met a new partner, with whom she had two further children, sadly one of these siblings died of natural causes. This relationship has also now ended. Care and residence for Sam has been split between his mother and her parents. However, whilst still close to his grandparents he now stays there overnight infrequently.

He has come to the attention of the local Police on a number of occasions including being arrested several times. Predominantly for allegations relating to the misuse of drugs. However, he has limited criminal convictions or other sanctions. Notably during 2018 he was arrested outside the county where he resided for suspected 'county lines' drug supply.

In autumn 2017, a close friend of Sam was the victim of a homicide in the local area. There followed a separate, seemingly unconnected murder again within the local area. Sam was arrested for suspected involvement in this offence; he remains under investigation in relation to this.

There are clear signs that Sam is associating with those involved in serious and organised crime, police are in possession of intelligence suggesting he is to some extent involved in such crime. In effect he left education at 15 years of age and was undoubtedly at significant risk of exploitation, but he denies being in any way a victim and hasn't supported investigations. This group of young people present significant and unique challenges to local services.

The local safeguarding children partnership agreed that this case meets the criteria established in *Working Together to Safeguard Children 2018* for a multi-agency learning review to be conducted.

Why was this review conducted?

A rapid review was held on 14 August 2019, the local safeguarding partners agreed with a recommendation of the Rapid Review Group that the case should be subject of a multi-agency reflective review. As required by *section 16c (1) of the Children Act 2004,* The Child Safeguarding Practice Review Panel have been notified and subsequently approved this approach.

The statutory basis for conducting reviews and the role and function of a Local Safeguarding Children Board is contained in: *The Local Safeguarding Children Boards Regulations 2006, Statutory Instrument 2006/90.*

Regulation 5 of *Local Safeguarding Boards Regulations 2006,* requires local safeguarding children boards to undertake a review where -
abuse or neglect of a child is known or suspected; and

(a) either –
    (i) the child has died; or
    (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Guidance for local safeguarding children boards conducting case reviews is contained in chapter four of *Working Together 2018*. The purpose of this multi-agency learning review is to establish the role of services and their effectiveness when caring for Sam. Whether information was fully shared by professionals involved and whether child protection procedures were appropriately followed.

This process ensures that any deficiencies in services can be identified and any lessons learned, minimising the risk to other children or young people.

The terms of reference

This review has looked at the period of Sam's life from 4 November 2017 to 22 August 2019. These parameters were agreed at a panel meeting and are sufficient to include key episodes and the relevant engagement of agencies with him. However, when appropriate reference is made to other incidents, periods of his life, or other relevant information.

Draft terms of reference were agreed as follows:

Aims

- to learn lessons concerning how local professionals and organisations worked to individually and together to safeguard and protect Sam from harm;
- make recommendations to address those lessons, both within and between agencies; and
- were appropriate identify key outcomes for any proposed change.

Objectives

- to establish whether an effective, coordinated multi-agency approach was adopted that focused on improving outcomes for the child; and
- to establish the effectiveness of agencies in identifying, assessing and responding to any safeguarding risks present.

Specific agencies and services that have contributed to this review are as follows:

- Children's Social Care;
- Health Services;
- Education;
- local Police force
- local child exploitation (CE) team
- Early Help/Family First;
- CAMHS; and
- Youth Offending Service.

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Main lines of enquiry

In considering the issues this review will take into consideration:

- Were thresholds applied appropriately to manage the risk of the child;
- Was information concerning the risk of criminal exploitation identified, assessed and managed effectively;
- Was information effectively shared with other agencies;
- How did the voice of the child influence child protection measures that were put in place for the child or to mitigate the risk within the community; and
- Were there any organisational or contextual obstacles or difficulties in this case that prevented agencies from fulfilling their duties.

Methodology

Agencies that are involved in child safeguarding are required to follow statutory government guidance called *Working Together*, it contains all the processes that agencies are required to follow. The guidance has been through several iterations, this review benchmarks against the 2018 version. This being the guidance that professionals were working with during the timeframe of this case.

This multi-agency learning review has been conducted using a methodology adapted to suit the circumstances of this case and is consistent with *Working Together*. It sought to establish how well systems have worked and if any improvements can be made. It is not a disciplinary review designed to attach any blame to individuals.

The methodology agreed by the local Safeguarding Children Partnership ensures that the review was conducted in a way which:

- recognised the complex circumstances in which professionals work together to safeguard children;
- sought to understand precisely who did what, and the underlying reasons that led individuals and organisations to act as they did;
- sought to understand practice from the viewpoint of the individuals and organisations at the time, rather than relying on hindsight;
- was transparent in the way data is collected and analysed; and
  made use of relevant research and case evidence to inform findings.

This methodology is intended to capture the practitioner view and a wider systematic understanding of how effective individual agencies processes were in safeguarding the interests of Sam.

Chronology and management reports

All relevant agencies produced reports detailing their contacts with the subject of this review, these included chronologies, incident reports and records of meetings, where appropriate these included material outside of the agreed time parameters. These assisted in the creation of a combined chronology of events. Additionally, each agency was asked to highlight any areas of concern or good practice. When further clarification was required agencies responded in an open and honest manner, some by means of individual interviews.

This review is intended to establish why events occurred and not simply to create a commentary of what happened. Having access to the views of front-line staff was essential to achieving this. Whilst details of discussions with staff were recorded, the comments made by interviewees are non-attributable and no comments are quoted directly in this report. Staff being able to frankly discuss their engagement with Sam was pivotal to ensure future learning from these events.

Voice of the child

At the time of this report, Sam remains a person who is subject to an ongoing criminal investigation. As a result, the author was unable to speak directly to him during the early stages of the review. Then the restrictions imposed to deal with the Covid 19 pandemic, made it impractical and potentially unsafe.

Enquiries were made with Sam's mother who indicated that her son was reluctant to speak to the review, due to his mistrust of authority. She agreed to speak on the telephone to the author and facilitate a conversation between the review and the child. No issues were raised from a safeguarding perspective.

The author will make further contact with the child's mother at the conclusion of the review to discuss the findings with her and her son, if he wishes.

Background

To assist with understanding, background information on significant areas is included at this point.

Child criminal exploitation

Child exploitation, whether sexual or criminal presents huge risks to the well-being of children. Criminal exploitation of children is widespread and presents unique challenges to professionals working to protect them. Whilst there is no statutory definition of child criminal exploitation HM Government have published the following:

Child criminal exploitation is common and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

Whilst such exploitation can occur in many circumstances, the rise in the 'county lines' drug supply model is high in the national conscience. Dealing with it effectively requires a fundamentally different approach from professionals.

They must work with partner agencies, not just locally but often many miles away. The challenge can be further complicated as those at risk often do not see themselves as victims and may be unwilling to immediately engage with any services offered. A cultural change may be necessary to ensure that those who previously were likely to face prosecution, should now be considered as potential victims of exploitation.

Contextual safeguarding

Traditional approaches to protecting children and young people from harm have focused on the risk of violence and abuse within the home. Contextual safeguarding seeks to understand and respond to young people's experiences beyond their family, understanding the influence of peers on their development and safety. Parents and carers may find it difficult to influence these experiences. Professionals therefore, need to adopt different approaches. By engaging with individuals and sectors with influence outside the family, positive outcomes can be achieved.

Local response to CCE

Considerable progress has been made nationally in recent years to better protect victims of child sexual exploitation (CSE). Similarly, as the recognition of child criminal exploitation (CCE) increases, that response is also improving.

The Police and the Safeguarding Children Partnerships in the county have published a *Multi-Agency Child Exploitation Protocol* for professionals, it includes:

- principles for combatting child exploitation;
- definitions of sexual exploitation, criminal exploitation and 'county lines';
- definition and terms of reference of multi-agency child exploitation meetings (MACE);
- the roles of key agencies;
- warning signs and vulnerabilities checklist; and
- screening and assessment tools.

Additionally, the local Safeguarding Children Partnership have published *Inter-Agency Safeguarding Children Procedures*, written in line with '*Working Together 2018'*. Contained within it is a section dedicated to tackling criminal exploitation of children, which it defines as follows:

'involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them completing a task on behalf of another individual or group of individuals; this is often of a criminal nature. Child criminal exploitation often occurs without the child's immediate recognition, with the child believing that they are in control of the situation. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.'

To compliment these procedures the partnership published in January 2019 *Multi-Agency Child Exploitation Policy and Guidance* to replace 2017 procedure. Its aim is to unify a process of recognition, risk assessment, referral and discussion amongst

professionals. Setting out a pathway to ensure all organisations work together to provide the best service possible for all children at risk of exploitation.

When there is concern that a child is at risk of criminal exploitation, a procedure including a threshold matrix and completion of a measurement tool is explained. The measurement tool should, when possible be completed within a multi-agency context, including input from caregivers and relevant neighbourhood police officers.

The Multi Agency Safeguarding Hub (MASH) co-locates agencies that have contact with children and vulnerable adults to make the best possible use of their combined knowledge, to help keep them safe from harm.

Locally there is an established MACE meeting, it seeks to tackle child exploitation by information sharing and action planning. There is also a Multi-Agency Response to Threat, Harm and Risk (MARTHR), which is responsible for considering the perpetrators of exploitation as well as vulnerable locations, developing plans aimed at reducing risk.

A multi-agency team was formed in 2015. Its aim was to protect children from exploitation, Assuming responsibility for criminal exploitation in 2017. 'Catch22' is a social business operating nationally. With support from a grant awarded by the Police and Crime Commissioner they offer a child exploitation service across the county.

The local Threshold of Need guidance was published by in 2018[1]. It is designed to help identify when a threshold or trigger has been reached, indicating when a child or family might need support and then to identify where best to get this support from.

Four levels are explained:

1. Level 1 - All children accessing mainstream services with low-level need that can be met by a single agency.
2. Level 2 - Children with emerging needs or low-level concerns that can be met with the support of a multi-agency early help assessment and plan.
3. Level 3 - Children with multiple or complex needs have to be met by targeted services or by a multi-agency early help assessment or by other specialist assessments e.g. education health care plan.

[1] Outside the parameters of this review the partnership has replaced Threshold of Need Guidance with 'Helping Children Thrive 2020'

4. Level 4 - Children who present with acute needs/risk. This includes those at risk of abuse or neglect. They will require a response by Children's Social Care.

The author has been made aware of a new document, 'Helping Children Thrive 2020' this is to replace the 'Threshold of Need Guidance', which was in operation during the time relevant to this review.

Serious and organised crime

Sam was undoubtedly at risk from criminal exploitation. He was not in full time education, and appears to associate with others, including adults involved in serious and organised crime. He may also be involved in the supply of illegal drugs, including possible 'county lines' activity away from the area He has been the victim of serious violence and is currently under investigation for a local murder.

Police hold intelligence that supports his involvement in such activity, he is in fact believed to be a member of an organised crime group. Law enforcement throughout the UK utilises a process known as 'organised crime group mapping' to assist them identify and prioritise criminal groups for intervention.

Once a group is identified, available intelligence from a wide variety of sources is examined to assess their capability then allocate a score. In turn this score is used to band them and allocate appropriate levels of response.

Responsibility for each group is then assigned to a 'lead responsible officer' (LRO) these are usually, but not necessarily police officers. Their function is to manage the response to these groups using a variety of strategies. They will work with private sector bodies and all relevant local agencies.

It is usual for a strategy known as a '4P plan' to be developed for each organised crime group:

- **Pursue** - prosecuting and disrupting serious and organised crime;
- **Prevent** - preventing people from engaging in serious and organised crime;

- **Protect** - increasing protection against serious and organised crime; and
- **Prepare** - reducing the impact of serious and organised crime.

Children forming part of these groups present particular challenges, it is imperative that LRO's consider safeguarding as a priority when dealing with intelligence and developing their strategies.

The story of Sam

Introduction

This section sets out the facts in the case. It begins with the background of Sam, his family and close associates. It is designed to provide an insight to the type of child he is, and the challenges faced by various agencies.

His parents have been separated for a considerable time and now have little contact. Occasional telephone contact is maintained between Sam and his father who is currently in prison custody.

His mother had two further children from a different relationship which has also now ended. Tragically, one of these siblings died in infancy, they had been suffering with a known heart condition. It appears that currently Sam doesn't like this partner and wants him to have nothing to do with him or his family.

Parental responsibility has at times been shared between his mother and her parents. Whilst he retains a close relationship with his maternal grandparents, he now predominantly resides at home.

From an early age he has witnessed incidents of domestic abuse in the home involving his mother and her partners. He has a complex relationship with his mother, it is reported that he can at times be abusive and violent, also attempting to prevent her having new partners. Conversely, she reportedly struggles with being his mother and at times treats him more as a peer. There have been suggestions of disguised compliance in some of her dealings with local services. He is though very focused on protecting his young sibling.

He was referred to a pupil referral unit at 13 years of age by the local Access Provision Panel due to his disruptive behaviour and being found on school premises in possession of cannabis. By the age of 15 he had in effect left education.

He has sought close relationships with girls of a similar age. During the period relevant to this review he had a partner, she was believed to have had a stabilising effect on his lifestyle, it does though seem that this relationship has since ended.

He has had contact with key agencies for most of his life, including several contacts with local police. He associates with adults involved in serious and organised crime, placing him at significant risk of child criminal exploitation. This presents complex challenges to agencies working with him.

Overview of what was known to agencies

In May 2007, just before Sam's fifth birthday, concerns were raised that he was witnessing incidents of domestic abuse involving his parents. In 2009, whilst at school he reported that his face hurt after his father had hit him. He also spoke at this very young age of knives and killing himself. As a result, he was referred to educational psychology and his mother attended a parenting course.

Tragically when Sam was about ten years old, his young sibling died in infancy from a known heart complaint. The family received subsequent bereavement support.

When he was 12 years old an allegation of child sexual exploitation was investigated by the police. It was believed that a male may have been enticing a number of children, including Sam to engage in sexual activity. Ultimately no action was taken in this case.

In September 2015, when 13 years old he was referred to a pupil referral unit. Initially he struggled to settle and was provided with one to one support. He was verbally and physically confrontational to both staff and other pupils.

Police reported that that the father of Sam's siblings may have been responsible for assaulting someone he believed to be having a relationship with Sam's mother. A single assessment was completed, no action was taken as any risk to the children was

considered low as he was in prison custody. His mother wanted the relationship to continue, at that time, Sam also seems to have had no concerns about him. The relationship has since ended, and Sam now appears to dislike him.

In December 2016 he left the pupil referral unit and was placed on the local authority nominal roll. With ongoing support from the unit, he was offered several alternative provisions but was reluctant to accept any. There were some reported issues of lack of engagement and negative attitude as well as clashes with other learners. Between September 2016 and April 2017, he did attend some alternative provision.

Staff believed there was an unidentified learning need, so he was referred for assessment. This was conducted in May 2017, concluding that he was working significantly below age related expectations. In September 2017, Sam was removed from the nominal role and he returned to the pupil referral unit.

In 2017, a close friend of Sam was murdered. This appeared to be a targeted attack. A criminal trial was subsequently held resulting in two males being convicted of manslaughter and firearms offences.

Although Sam was close to the victim, he did not feature significantly during the investigation. However, it does appear that he has suffered emotionally because of this trauma. It may also indicate that he was at that time at risk of harm and exploitation. His mother requested further assessment of his emotional wellbeing by his GP.

A short time after the death of his friend, a male was murdered, no evidential links between these two killings have been established. However, Sam has been arrested and interviewed in relation to this murder and his home address searched. During the search, items potentially linked to the supply of drugs were seized. The investigation is ongoing, and he remains ‘released under investigation’,

Following this a single assessment was undertaken. His engagement with Children’s Social Care was minimal and no referrals appear to have been made. He found intervention stressful and felt that people were judging him, considering him guilty of a crime he states he did not commit. The case was closed on 8 August.

From discussions with professionals it seems that being subject to this ongoing investigation was having a significant effect emotionally and practically on Sam. His

arrest was known within the community which it is suggested contributed to him finishing education early.

Youth Offending Service (YOS) were subsequently notified of his arrest in relation to the murder. They attended subsequent strategy meetings. Section 47 enquiries were initiated, due to the ongoing investigation there was no further YOS involvement at this time due to ongoing criminal investigation. A high profile/media report was completed and sent to YOS managers for information purposes.

Education provision for Sam continued to prove difficult, a further short placement with an alternative provider was unsuccessful. In November 2017 he returned to the referral unit but was then excluded following a violent incident. It seems that parents of other children in the local area were also raising concerns about his attendance, following the arrest for murder. He has not then returned to education at all.

A mentor continued to visit Sam at home, but he refused to come downstairs to meet with them. He officially left education on 29 June 2018, achieving some AQA award scheme certificates.

In June 2018 Sam was referred to YOS in relation to possession of cannabis, he received a community resolution and was allocated a case manager. An ‘Early Help’ assessment was completed, this identified peer associations, regular cannabis use and parental offending behaviour as the main concerns. A number of Interventions, including voluntary CE work were put in place, they were only partially completed before he re-offended.

Between June and July 2018, Sam was subject of second community resolution, again for possession of cannabis, as well as drunk & disorderly. Some of the earlier incomplete interventions were rescheduled and successfully completed, overall engagement was good, and details of work completed were handed over to Children’s Social Care.

On 21 June 2018, Sam and his mother completed a ‘strength and difficulties questionnaire’. Whilst his answers did not identify ongoing concerns, his mother did report emotional symptoms and hyperactivity. Overall, results were borderline but didn’t meet the threshold for referral to child and adolescent mental health services (CAMHS.) It was also noted that around this time he was staying out 3-4 nights per week.

In July 2018, he attended at an appointment with YOS CAMHS worker and YOS substance misuse worker. During this meeting he accepted that he was regularly misusing controlled drugs, namely cannabis and ketamine. He was taking these mainly as a means of coping with the issues he was facing. He was assessed as not presenting with low mood or expressed anxiety. It is not possible to establish definitively the reasons for his use of controlled drugs. It may as he suggests, be a way for him to deal with the challenges he has faced, alternatively it may be a consequence of peer group associations.

In August 2018 a referral was made to 'Career Connect' however, Sam failed to attend any of the appointments made for him. He expressed his view that he was willing to access a service but was unsure if anything could be found in view of earlier issues in the community after his arrest for murder.

In the autumn of 2018, when 16 years old he was arrested in another county, in the home of a vulnerable drug user. He was with others from the area he resides, some were known to the police. It was believed they were involved in 'county lines' drug supply. He was released on bail with conditions not to enter the area of arrest. No criminal charges have followed this arrest.

Police in the area he was arrested correctly shared details of this incident with the local police, a referral to the National Referral Mechanism (NRM) also followed, they subsequently returned a negative decision. The police have also recorded a crime report under Modern Slavery legislation. YOS again were involved and attended strategy meetings section 47 enquiries commenced but due to ongoing police investigation there was no further YOS involvement. It was following this incident that he was first referred to MACE.

The levels of service offered to child Sam and his family are a significant feature of this review. To assist the reader fully understand decisions and rationale for them a chronological summary is included at the end of this section.

During April 2019, Sam was visited by 'Family First' & 'Career Connect', at this time he was expressing the view that he preferred employment to a returning to education. However, he was not willing to travel far. It was felt other than financial benefit he was not genuinely interested in employment.

Also, in the spring of 2018, a significant breakdown in his domestic relationship was noted. During a home visit, his mother reported to the school nurse and 'Family First' case manager, that unknown adult males had been accessing the home throughout the night. There was alleged drug use and damage being caused to the property and contents. She initially stated that was unable to cope and wanted him to leave the house, but agreed he could remain if the males stopped visiting.

Sam was reportedly becoming increasingly volatile. He was threatening extreme violence to his mother and her partner. Throughout this his sibling was present and as a result mum became concerned for their safety.

At around this time a request was made by the ex-partner of Sam's mother, for mediation and increased contact with the younger sibling. This caused Sam considerable anxiety, 'Family First' worked with the Probation Service to ensure that an exclusion zone was in place.

In the summer of 2019 Sam was the victim of a targeted attack, in which he sustained serious, not life-threatening injuries He was taken to a local hospital by an associate, and the police were informed. He underwent surgery before being discharged some days later.

The police investigation is still ongoing, at this stage he has refused to engage with officers or assist the investigation as have other witnesses. At the time of this incident he was found to be in possession of a knife, he has since been convicted for this, referred to YOS and ordered to pay £85 in costs.

Threshold of need

Decisions relating to level of need for Sam and his family are significant to this review. To assist with understanding, some key milestones are recorded sequentially at this point to assist the reader understand the chronology and rationale.

Following the arrest outside of the area in the autumn of 2018 children's services had a strategy discussion with the relevant other local authority. Section 47 enquiries concluded that that he was at continuing risk of harm. A single assessment was then

conducted, the social worker used a contextual safeguarding framework to assess his needs and present risks. They also supported the view that he was a vulnerable young person.

He denied being criminally exploited and did not see himself as being at risk. He was also unwilling to engage with any intervention from Children's Social Care. Support that was available was identified that both Sam and his mother were prepared to engage with. This was identified as an opportunity for positive engagement. As a result, a decision to 'step down' the case to early help at level 3 was made. He was added to the Child Exploitation (C.E) team cohort.

On 3 January 2019, he was discussed at the local Multi-Agency Child Exploitation Meeting (MACE). He was assessed as being a high risk of child criminal exploitation, based on the scores from the risk assessment completed in October. The decision to 'step down' and allocate to level 3 & 'Family First' was approved.

Following the breakdown in his domestic situation in April 2019 discussions involving a range of professionals and managers considered whether Sam was best managed at level 3 or 4. 'Family First' submitted documentation formally requesting that he be 'stepped up' to level 4. A meeting was scheduled for early May.

The request for escalation to level 4 was considered at the MACE meeting in May. However, following discussion it was agreed that; there was no evidence of immediate risk or likelihood of risk to Sam or his sibling. Therefore, it did not warrant a strategy meeting, a single assessment or social work intervention.

It was decided that their (the children's) needs could be properly assessed and addressed by 'Family First' and 'C.E Team' case managers, consequently it would not be in their best interests for another professional to become involved in the case. Therefore, it was agreed not to transfer the case to Children's Social Care. It does not appear that this decision was challenged or escalated.

Attempts to engage with him regarding ongoing child criminal exploitation continued unsuccessfully, due to mental health and family concerns. A case consultation was then held on 15 July 2019 involving 'Catch 22', 'Family First' & CE', to establish the best way

of supporting the family. It was agreed that ‘Family First’ should continue to support Sam in accessing health services. ‘Catch 22’ would continue to support mother.

Child and Adolescent Mental Health Service (CAMHS)

On 19 June 2019 Sam attended a medical appointment with his doctor, accompanied by ‘Family First’ case manager. He reported the significant events that had been encountered and the resulting low mood that was being suffering. He explained having graphic and vivid dreams, and a lack of concentration and motivation. It was agreed that he should be referred to CAMHS.

Following this referral an assessment appointment was arranged for 19 August 2019. This appointment had to be cancelled because he was in hospital after being injured in the shooting. A number of further requests for appointments were then made by various professionals. These were often cancelled, sometimes at short notice for a variety of reasons mainly by the family. A schedule of key dates all in 2019 has been provided by CAMHS. He did eventually attend an appointment in the autumn of 2019 accompanied by his grandmother.

Analysis of significant issues

This examination of the chronology of events set out in the previous section is supported by brief single agency reports and chronologies, individual meetings with relevant practitioners and the examination of relevant documents and policies where appropriate.

Criminal exploitation and police contacts.

Throughout the chronology of events a number of contacts between the police and Sam are recorded. The frequency and seriousness of these events may indicate the activities he was becoming involved, in and the increasing risk of exploitation he was at. Significant areas are dealt with at this point.

Proper and effective sharing of information between agencies is important and can assist in reducing safeguarding risks to children and vulnerable people. Intelligence relating to young people involved in organised crime including ‘county lines’ presents

agencies with particular challenges. When police find themselves in possession of such sensitive intelligence, it should where possible be shared expeditiously to ensure

effective protection. However, professionals receiving it must have the skills and confidence to respond accordingly.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) recently published a report focusing on the response to 'county lines.' The problems of information sharing are considered, they make the following observation;

"*Systems for collating and sharing intelligence and information between the police and other agencies are crucial to preventing exploitation efficiently and effectively. '*

There are a number of instances involving the sharing of police intelligence relevant to this review. The local police have provided sanitised summaries of available intelligence and access to other documentation, to assist the reviewer prepare this report.

Relevant local agencies work together in a shared location, this is called the Multi Agency Safeguarding Hub (MASH) and is the forum used to share case information to assist with decision making around welfare and safety. This would include police intelligence, there is in existence a multi-agency information sharing agreement.

As already noted, the cohort of young people susceptible to criminal exploitation can be particularly challenging. Police will often find themselves in possession of intelligence that is sensitive or of low grade. Evaluation of such intelligence is resource intensive and dynamic responses may at times be required. Such issues can be exacerbated, when the intelligence originates from outside the area,

It is clear that intelligence has been shared in this case. However, concerns were raised during some interviews that this was not always as complete or as expeditious as was desirable. Changes in police personnel within the MASH were identified as possibly contributing to this. At times these concerns were felt more acutely when professionals were visiting Sam, or other young people in the community or private dwellings.

Professionals spoken to understood the problems faced by the police. Further, they recognised that they may lack the skills, experience and confidence to effectively manage the receipt of such intelligence. There is, they accept a difference between intelligence and evidence and at times responses need to be tempered accordingly.

Learning point 1

Safeguarding partners need to be assured that they are sharing key information and that they are doing so securely in compliance with regulations. The effective and timely sharing of police intelligence between safeguarding partners provides agencies with an important source of information that can enhance their capability to safeguard and protect children. When such intelligence relates to involvement in organised crime and/or is sensitive in origin then distinct challenges are involved.

Learning point 2

Professionals in all agencies need to know that they are sharing key information and have confidence that it won't be mismanaged. An enhanced awareness of sensitive police intelligence processes for all professionals is required. This will better equip them to manage and respond proportionately to the receipt of such material without compromising other ongoing activity.

Recommendation 1

The local safeguarding children partnership should seek reassurance from the local Police of the steps taken to review their processes for the assessment and dissemination of intelligence for the purposes of safeguarding. In particular when such intelligence relates to young people and serious and organised crime. This should ensure that such intelligence is shared in a timely manner.

Recommendation 1a

Safeguarding partners should ensure that relevant information including contextualised material is effectively shared between agencies and that they have confidence in each other's abilities to handle and manage such information appropriately. In support of this a multi-agency audit should be conducted to review available information and how it has been managed and shared.

Recommendation 2

The local safeguarding children partnership, working with the local Police should develop a communication plan to raise professional's awareness about intelligence processes. In particular the dissemination, grading and sensitivity of reports.

Sam is linked to a known organised crime group (OCG), with a nominated lead responsible officer (LRO) responsible for managing a coordinated response. This process of crime group management has been explained earlier in this report. It is important that when children and vulnerable adults are identified as part of active crime groups safeguarding is a primary consideration.

It is suspected that Sam has become involved in the supply of illegal drugs, including 'county lines' supply away from the area he resides. He denies being a victim of exploitation and declines offers of support, which is not unusual. He described being away on a 'little holiday' with his friend at the time and expressed the view that he was old enough to make that decision. He has refused to share his mobile telephone number with professionals, insisting that any arrangements are made via his mother.

The local police provided access to documents relevant to the management of this OCG, dated January 2020. Whilst the date is outside the parameters relevant to this review, it still provides a useful insight into the approach that is being taken. They are structured under '4P' headings and will be updated following regular progress meetings.

UK law enforcement has understandably tended to concentrate on 'Pursue' activities. In order to effectively disrupt OCG activity, protect communities and reduce exploitation it is recognised that a more coordinated use of 'Prevent, Protect & Prepare' is necessary.

Strategies under the 'Prevent' section are the most relevant to safeguarding vulnerable young people. The local area has a process called the, Multi Agency Risk Threat & Harm (MARTH.) This is designed to challenge people and locations most relevant to the exploitation of young and vulnerable people. It is therefore important that LRO's utilise the MARTH to target exploiters within OCG's, in relation to Sam or those associated with him there is no apparent use of this process.

Learning point 3

Local police have well established processes to manage the response to organised crime. Ensuring that they are fully integrated with local safeguarding processes will assist protecting vulnerable people, as well as building confidence and trust between safeguarding partners. Information around family and peer associations is particularly relevant for contextual safeguarding. This should be applied to all OCG's even those managed at tier 3 & 4.

Recommendation 3

The local safeguarding children partnership should seek reassurance from the local Police of the steps taken to develop their OCG management processes to ensure that when appropriate they are fully integrated with local contextual safeguarding.

As noted in the chronology, Sam has been arrested as part of a 2017 murder investigation. He has been interviewed and is currently released under a legal provision called 'released under investigation.'

The Policing and Crime Act 2017 introduced changes to how police deal with people that they are not in a position to charge with an offence but are still actively investigating their involvement. A response, in part at least to concerns around the use of police bail, often for extended periods.

It has been noted during interviews with professionals and in written submissions that Sam felt continuing to be subject to this status was adversely affecting him. Knowledge of it was widespread in the community, which, was a cause of concern for parents of other children. Also, it certainly appears to have caused him stress and anxiety being under continuing investigation for this serious offence. He disliked the police and believed that his house may be under surveillance. He has told professionals that they are 'pinning' him to a murder he wasn't involved in.

The local police have policy and guidance covering the use of this legislation and its provisions in place. When a person is released from custody in this way, an investigation plan is to be prepared, including the use of a risk assessment tool called 'Thrive.' This includes consideration of vulnerability, however, whilst victims of crime and suspects are both included, emphasis is mainly on the victim.

As an investigation progresses continued use of the provision must be periodically reviewed with supervisors. The seniority of these reviewing officers increases as time goes on, eventually after 48 weeks such reviews must be conducted by a superintendent.

This investigation has been discussed with the Senior Investigation Officer (SIO). They confirmed that the circumstances of the investigation meant that the initial decision to

release Sam in this way was appropriate, and that subsequent reviews have been properly completed.

Quite properly victims of crime are central to the policy. This case though has highlighted potential implications for the wellbeing of young people remaining subject to these provisions. It is not suggested that the Police have acted in any way inappropriately, however, the policy should be reviewed to ensure that vulnerability of suspects is properly recognised and documented. Managers conducting periodic reviews should take cognisance of a suspects age and vulnerabilities when considering the investigation and continued necessity of this provision.

Learning point 4

There are potential implications for children and vulnerable people who are 'released under investigation' especially when this is for an extended period. It is important that these are properly considered, documented, and subsequently reviewed periodically by managers.

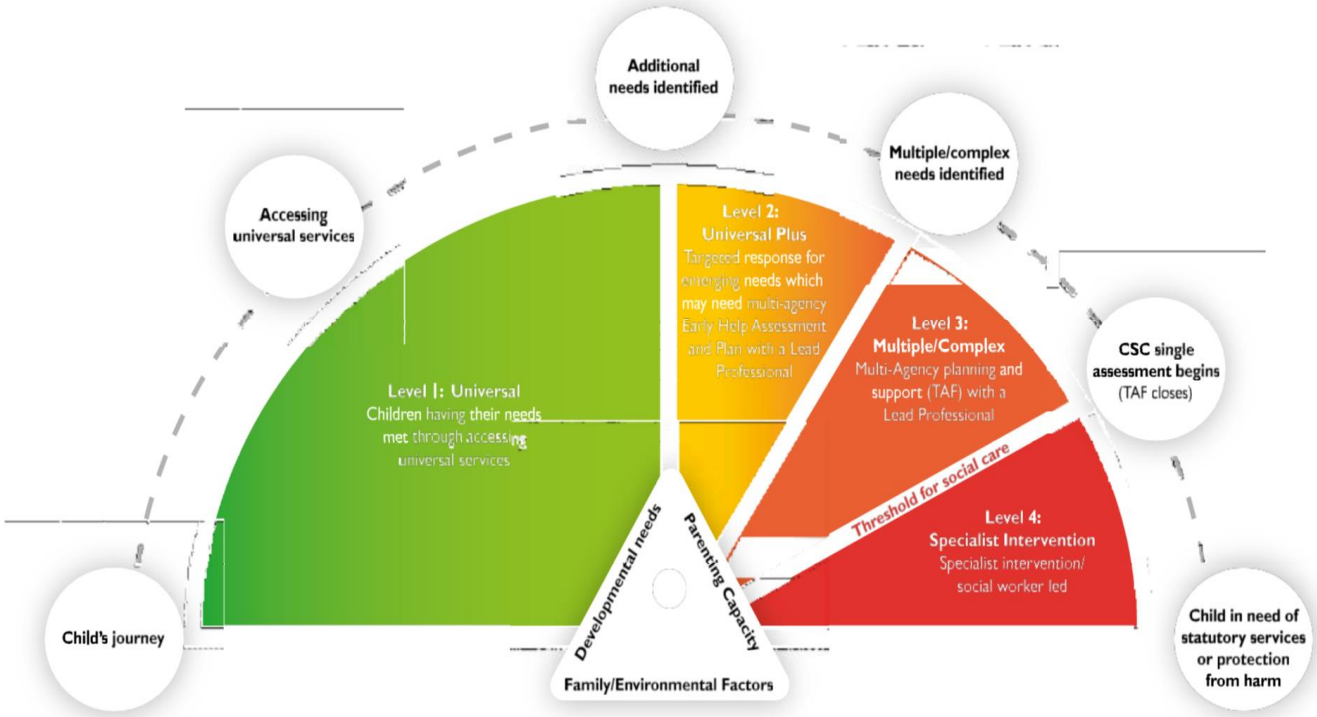
Recommendation 4
Local police should review its 'Released Under Investigation Framework' to ensure that investigators and managers conducting reviews take cognisance of a suspects age, vulnerabilities and any safeguarding risks.

Levels of need

The appropriate level of need for Sam and his family is a significant feature of this review. Relevant events and decisions are summarised together in the previous section, concentrating from October 2018 when he was arrested outside the local area.

The below chart is taken from the local 'Threshold Hold of Need' guidance and is known as the 'windscreen model.' It illustrates the four available levels and the appropriate responses. This guidance has recently been replaced by 'Helping Children Thrive 2020' but was in use during the relevant period.

Figure 1. Threshold of Need
The Windscreen Model



As needs change children can move from one level to another, as they do supplemental services will increase or decrease. Movement should happen smoothly, information be shared appropriately, and involvement recorded systematically. 1

Level 3 – Is for children with multiple or complex needs which have to be met by targeted services, a multi-agency early help assessment, or other specialist assessments such as education or health.

Level 4 – Is for children who present with acute needs or risk. Including those at risk of abuse or neglect. They will require a response from Children's Social Care.

Indicators of need are included in the guidance, the below are taken form the crime and anti-social behaviour category;

- **Level 3** - Offending or regular anti-social behaviour.
- **Level 4** - Regularly involved in anti-social or criminal activities;

- Failure or rejection to address serious offending or anti-social behaviour;
- Puts self or others in dangers; and
- Participates in gang activity or involved with serious or organised crime.

Locally a young person and their family can expect the following in terms of support at levels 3 & 4.

- **Level 3** - Early help & Family First.
- **Level 4** - Children's Social Care services.

For the purposes of this review it is important to set out the following:

Children in need of protection - Level 4

The Children Act (1989), section 47 states that where a local authority has reasonable cause to suspect that a child who lives or who is found in their area is suffering or likely to suffer significant harm. '*The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take action to safeguard or promote the child's welfare.'*

A strategy discussion involving the local authority, police, health and other relevant agencies must take place to decide if a section 47 enquiry is required. This enquiry is undertaken by the authority with the help of the other organisations to establish what is happening and consider any protective action necessary, including the need for legal action.

The local area has a 'step down process' to manage movement between levels of service. It recognises the importance for keeping children safe when moving between Early Help and Children's Social Care. 'Safeguarding' processes must take precedence, and if a child is believed to be at risk nothing should delay seeking help and support. It is further stated that decision making should always be family focussed with the child's needs remaining paramount.

Where a family is being supported by ‘Family First’ and there is concern that needs are increasing. The lead practitioner should, following consultation with a manager complete a ‘step up’ form for Children’s Social Care, including a risk analysis.

The lead practitioner will attend a Team Around the Family (TAF) meeting, with multi-agency colleagues. Along with the attending social worker they will review the available evidence against the ‘Threshold of Need’ document. Ultimately the social worker will be responsible for making the decision as to whether the case should step up to CSC or remain with Family First 0-18.

The outcome of the meeting, and the rationale for the decision, should be clearly and accurately recorded in the minutes/notes of the meeting and as a case note in relevant IT systems. If the case moves to level 4, support from ‘Family First’ will continue, including joint working to cover transition periods. Decisions will also be considered at MACE meetings.

Cases were concerns persist, following a decision to leave at level 3 can be escalated to the MASH team manager. They will also monitor adherence to process, persistent issues will be brought to the attention of the Children’s Social Care Head of Service who will liaise with the Head of Service for Early Help and Protection.

For conciseness this report has concentrated on decisions taken following the ‘county lines’ arrest in October 2018, a single assessment was completed, and level 3 support was ultimately agreed. Earlier incidents or the effects of them taken together could arguably have reached the threshold for level 4.

Sam was to work with ‘a local support agency’ to help rebuild family relationships, reduce offending and engage him in education and training. Mother was to be supported by ‘Family First’ concentrating on, parenting, keeping Sam safe, and helping her understand the risks of exploitation. Engagement remained problematic and little progress was made.

The case manager from ‘Family First’ maintained visits, liaising with mother and observing the younger brother. It was during these visits that a positive relationship started to develop with Sam. This improved relationship was consistently noted as a good example of what can be achieved by maintaining contact and building trust. In effect, it led to the roles and responsibilities of the local support agency and ‘Family First’ being reversed.

In April 2019 the breakdown in domestic circumstances was observed, this was significant and caused concern for the lead practitioner. Discussions within MASH followed involving relevant professionals. Culminating in the submission of a ‘step up’ request by the case manager from ‘Family First’, the author has been provided with access to this documentation. It is a comprehensive document outlining relevant information and concerns present at the time.

It was decided by a social worker that remaining at level 3 best served the interests of the children. This decision was approved at the MACE meeting in May, ‘Family First’ and ‘CE’ case managers were to continue their involvement. It does not appear that this decision was subject of any challenge or escalation, this may have been a missed opportunity.

It is the view of the author that the circumstances relevant to Sam reached the threshold for level 4 support. This may have been the case after the arrest outside the area he resides in October 2018, but certainly after considering the subsequent deterioration in his circumstances by April 2019.

The decision to leave the case at level 3 would therefore appear flawed. However, what is in the best interests of the child must be paramount. The complexities of dealing with young people at risk of criminal exploitation have already been referenced. Opportunities to positively engage may be limited, bearing this in mind the decision to maintain the involvement of the case manager from ‘Family First’ can be understood. To risk losing positive engagement by introducing someone new may have been detrimental. It is worth noting that the case manager from ‘Family First’ was a qualified social worker, this may not always be the case.

The response and support received is more important to a child’s best interests than a threshold level being assigned to them. Would there be any benefit in removing a case manager who has achieved positive engagement because a threshold has been crossed? A further danger is created with a high turnaround in staff, one interviewee observed that there had been five assigned workers in less than a year.

This is not to suggest that a child should not be moved to level 4 when appropriate just to avoid introducing new case managers. The ability to adopt a flexible approach is necessary, under current arrangements decisions are made by Children’s Social Care. A multi-agency approach to such decisions is needed, but with sufficient flexibility to ensure that appropriate staff are involved to best protect the young person and their family. Comment was also made that in this case the decision took three weeks, this

was felt too long. It is recognised that ‘Helping Children Thrive 2020’ has now replaced the Threshold of need Guidance, which may assist management of individual cases.

Learning point 5

Effectively managing the response of safeguarding partners is vital for vulnerable young people. They should receive support from appropriate professionals, in a timely manner. This should reduce the turnover of staff and encourage the building of positive relationships. A multi-agency approach to decision making will also ensure smooth transitions when new professionals are introduced.

Recommendation 5

The local safeguarding children partnership should review the ‘Step Up & Step Down’ procedure to ensure that a multi-agency approach is taken when making decisions relating to levels of need. This will assist in providing the timely and appropriate response to children at risk and manage the turnover of professionals involved. At all stages any disagreements and opportunities for escalation should be considered and documented.

Recommendation 5a

The local safeguarding children partnership should commission a review of current training delivered to practitioners to ensure that it is relevant for the roles of those attending and has improved outcomes for children.

It was acknowledged that the best interests of child Sam’s younger sibling were not fully considered, the decision not to ‘step up’ to level 4 may have contributed to this. Clear risks were obviously present, some in fact created by the circumstances pertaining to Sam. The home address being used by unknown adult males, causing damage and misusing drugs being an obvious example. Problems caused by contextual safeguarding issues relating to Sam, should not have prevented professionals considering the best interests of his sibling, this may represent a missed opportunity. There is a danger of seeing such challenges as being primarily criminal justice issues.

Learning point 6

Safeguarding partners must recognise inherent risks faced by families of young people at risk of exploitation and becoming involved in organised crime. In particular it is important that younger family members receive levels of support and intervention from all agencies that would ordinarily be expected.

Recommendation 6

The local safeguarding children partnership to review processes to ensure that due consideration is given to any risks present for siblings and the wider family. This will ensure these risks are properly mitigated.

Education

It is widely recognised that being out of education leaves young people at high risk of exposure to drugs and violent crime as well as increased susceptibility to exploitation by criminal gangs.

A correlation between significant events in Sam's life and his education breaking down completely is obvious from any examination of the chronology. It is of course much more difficult to understand this or draw any positive conclusions. There is no firm evidence confirming that not being in school led to him being exploited or becoming involved in crime. Neither can it be said that his lifestyle and circumstances contributed to him leaving education. Having no daily structure though has unequivocally increased his susceptibility. It may be worthy of note that during the same period concerns around his mental health were also being raised. Interviews with professionals also raised the lack of alternative youth provisions available to offer. This, it was felt reduced their ability to divert young people from crime and anti-social behaviour and protect them from exploitation.

Sam officially finished his education in June 2018 at the age of sixteen. He had in effect not been in receipt of any education provision since the previous November. There is history of aggressive and disruptive behaviour in school as well as use of cannabis, he first attended a pupil referral unit when only thirteen years old. Sadly, experience suggests a trajectory between children in pupil referral and those drawn organised crime.

There were concerns that unidentified needs were affecting his learning, he was though not assessed until 2017 when he was nearly fifteen. Education professionals expressed the view that he may have benefited from being assessed for ADHD at an earlier age, they also had concerns about parental support with some suggestion of 'disguised compliance.'

Sam's arrest in relation to the murder in November 2017, appears to have been known widely in the community. Anecdotal evidence suggests that parents of other children had raised concerns about his continuing attendance. It doesn't though appear that this has prevented him going to school, in fact he was shown several alternative providers but refused to attend any of them. Professionals did though suggest that there was actually little available for Sam. Most interviewees explained that Sam felt that what was being offered to him was not supportive, more it was being 'done to' him.

Professionals suggested that following high profile incidents, the local community would benefit from a 'drop in' service to support young people. Providing them with support and guidance, it may also help reduce unhelpful speculation and rumour.

The author believes that adopting this approach would have many potential benefits. It would increase contact between young people and professionals in a community at key times immediately following significant incidents. Presenting opportunities to harvest and understand the opinions of local communities and raise awareness of services available locally. It may be appropriate for the ' C.E ' Team to develop such an approach.

Learning point 7

Following any high-profile local incident community tensions and anxiety are likely to be heightened. Misinformation and speculation can be damaging and increase risks. The introduction of a localised 'drop in' service may assist professionals to reduce their impact on communities. Developing a dynamic response to such incidents would allow professionals to contact affected young people with many potential benefits.

Experience suggests that there is a common trajectory of children attending PRU's being drawn into organised crime. The Local Authority have an opportunity to work with

staff from PRU's and partners to audit available data and establish the true scale of the problem locally. This will support more focussed interventions within PRU's.

Recommendation 7

The local safeguarding children partnership to liaise with the local community safety partnership to consider introducing localised 'drop in' services following high profile incidents in an area. These could provide support and guidance for young people in the area, reduce speculation in the community and increase community intelligence.

Recommendation 8

The local safeguarding children partnership to work with safeguarding partners and staff within PRU's to establish the true extent of children within PRU's being drawn into organised crime. Results from such research can be used to deliver focussed interventions within local PRU's.

Child and Adolescent Mental Health Service (CAMHS)

Mental health issues are acknowledged to represent a significant threat to children. The majority of adults suffering mental health problems were diagnosed before the age of 18. Less than half had received the correct treatment or support. A study has concluded that juvenile disorders should be targeted, in order to reduce such disorders in the adult population. (Kim-Cohen, Moffat T.E et al 2003)

Sam has been exposed to significant trauma from a very early age. Including, the death of a sibling, exposure to domestic abuse, the killing of a close friend, injuries sustained when he was shot, as well as his own arrest in relation for murder. Additionally, his sleep pattern was disturbed, he was misusing controlled substances and had lost weight.

Taken together these incidents have without doubt impacted on his emotional well-being and mental health. Concerns have been raised on several occasions by family and professionals:

Locally, CAMHS provide support and therapeutic intervention to children, young people and their families when experiencing complex, persistent and sever emotional and psychological problems. Referrals can be made by anyone and will be graded as routine or emergency. at the time of referral there was a waiting list of approximately eight weeks for an appointment.

The chronology contains a summary of events commencing with the routine referral made in June 2019 after Sam visited his GP. It has been confirmed that he was not known to CAMHS prior to this. Concerns though are noted in April by his 'Family First' case manager who recommended that he be assessed. Mother also expressed concerns about his mental state and increased paranoia. Sam declined any appointments and admitted self-medicating with cannabis.

It was nearly five months post referral before he attended an appointment. Concern around this delay was raised during interviews with professionals working with Sam. The date for the initial appointment was just over eight weeks after the referral, commensurate with the waiting list at the time. He was at that point being treated in hospital after being injured in the shooting and the appointment needed to be cancelled. A further appointment was arranged approximately six weeks after his discharge from hospital.

A number of appointments were then cancelled on his behalf by the family. It was almost 19 weeks after initial referral before he attended an appointment accompanied by his grandmother. This was a significant period for him, coinciding with him being out of education. It was felt that it was unlikely he would have benefited from referrals after earlier incidents.

There is a considerable break between the initial referral and Sam actually attending an appointment. Services are in high demand and it appears that policies were followed. Appointments offered were within normal parameters at the time and several appointments were cancelled by his family, contributing to this delay. It is though regrettable that it wasn't possible to see him any earlier. A young person suffering with physical symptoms or injuries would likely be able to access treatment faster than if suffering with mental health issues.

Learning point 8

The introduction of a process allowing professionals to expedite CAMHS appointments in high risk cases may benefit young people. Any process should identify any pattern of family cancellations which may in itself may highlight medical safeguarding implications. Mental health is widely recognised as a threat to the wellbeing and development of children, early identification and professional support has many potential benefits.

Recommendation 9

Local NHS Foundation Trust to undertake a review of CAMHS referral and appointment process They should seek to develop a 'FastTrack' pathway or escalation process for high risk cases.

Conclusion

This review was commissioned as a result of Sam being injured during a firearms incident. He was out with a friend when they were attacked by a group of unknown males, as they ran, he was shot sustaining serious injuries. Throughout this review professionals from all agencies have engaged with the author in an open and supportive manner.

Sam has already faced many challenges in his life and has been known to local agencies for some time. He has had witnessed domestic abuse in the home with no male present for the majority of time. He suffered the loss of an infant sibling when he was only ten years old himself, a close friend was also the victim of murder when Sam was only 15.

His education has been challenging, he started attending a pupil referral unit when he was 13, due to disruptive behaviour and being found with cannabis on school premises. He stopped attending school completely when he was 15, approximately six months before officially leaving. He was assessed just before this time and it was established that he was working significantly below age related expectations.

During the period covered by the chronology he has had increasing contact with local police. As well as the loss of a close friend who was unlawfully killed, he has himself been arrested in relation to a separate local murder. He admits to regularly using illegal

drugs and it is possible that he may be involved in their supply. He has been arrested away from the area he resides in the home of a vulnerable drug user for possible ‘county lines’ drug supply.

He dislikes the police and is distrustful of other professionals who have been involved with him. Intelligence suggests that he is associating with others including adults involved in serious and organised crime. He is believed to be part of a known organised crime group. The motive for the shooting incident he was injured in is unclear, however there is a suggestion the victims were themselves trying to steal drugs from other dealers.

He is a young person who has been at significant risk from criminal exploitation, this cohort presents unique challenges to local agencies. Victims often do not see themselves as such and traditionally they are likely to have faced prosecution with little consideration of them being a victim. Criminal exploitation such as ‘county lines’ can see young people being moved many miles around the country, further complicating these challenges. The response to child criminal exploitation is improving nationally but it is not yet as mature as the response to child sexual exploitation. The earlier potential victims are identified the more effective intervention is likely to prove.

Sam and his family have been subject to multi-agency support for many years. The relationship with his mother is complex and not always helpful, there are suggestions of disguised compliance on her part. As he has got older, so his behaviour appears to have become more challenging, culminating in the breakdown in their relationship in April 2019. He has presented professionals with many challenges, on occasions being unwilling to engage at all.

The local area is one of the most deprived boroughs in the country, with a number of factors present that may increase the risk of child criminal exploitation. There are well established relationships between agencies working together, it was apparent throughout this review that professionals are committed to protecting young people.

Considering the specific questions contained within the terms of reference. There is considerable evidence of professionals working hard to engage with and support Sam. Generally, incidents and risks were identified and responded to appropriately. Locally

there are effective structures, including the C.E' team who aim to protect children and prosecute those responsible for their exploitation.

Professionals and processes have at times struggled defining the appropriate level of need for Sam and his family. The request to step up to level 4 should have been approved. Whilst there exists a potential for decisions to be made based on availability of resources, there is no evidence of any bad faith in this review. Decisions seem to have been made in the best interests of Sam. It appears that no challenge or escalation of these decisions was made, which may represent a missed opportunity and worth considering. Consistency and flexibility are important when developing effective engagement with young people. Decisions need to be made quickly with input from all agencies.

There appears to have been a missed opportunity in relation to Sam's younger sibling. Decisions and resource allocations did not take full cognisance of them or the risks they were exposed to.

Being out of education is known to increase the risk of exploitation, it is of note that Sam was out of education at significant times. There is also a reported lack of available youth provision.

There is evidence of agencies working together and sharing information within the MASH. However, on occasions they have struggled to respond and adapt to the unique challenges created by young people who are associated with criminals and organised crime. Dissemination of police intelligence, at times sensitive is an example of this.

Contextual safeguarding aims to tackle risks encountered away from the home and target those responsible for exploitation. Closer alignment of safeguarding and organised crime group management processes will improve this response.

This review has identified learning and made recommendations to assist further development. The author invites the local partnership to continue to develop its approach in respect of children susceptible to all forms of exploitation. Professionals face unique and complex challenges in this area, Early identification coupled with an effective and coordinated multi-agency response are vital to success. The

recommendations contained in this report aim to support this work, ultimately reducing risk and protecting young people.

Table of Recommendations

Recommendation 1

The local safeguarding children partnership should seek reassurance from the local Police of the steps taken to review their processes for the assessment and dissemination of intelligence for the purposes of safeguarding. In particular when such intelligence relates to young people and serious and organised crime. This should ensure that such intelligence is shared in a timely manner.

Recommendation 1a

Safeguarding partners should ensure that relevant information including contextualised material is effectively shared between agencies and that they have confidence in each other's abilities to handle and manage such information appropriately. In support of this a multi-agency audit should be conducted to review available information and how it has been managed and shared.

Recommendation 2

The local safeguarding children partnership, working with the local Police should develop a communication plan to raise professional's awareness about intelligence processes. In particular the dissemination, grading and sensitivity of reports.

Recommendation 3

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