Local Child Safeguarding Practice Review
Child Joe

Contents

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[2] There is no legal definition of CCE The Children's *Society states whilst it takes many forms "ultimately it is the grooming and exploitation of children into criminal activity. Across each form that CCE takes, the current reality is that children who are coerced into criminal activity are often treated as criminals by statutory agencies rather than as victims of exploitation. This is in part because safeguarding partners have different understandings of what constitutes criminal exploitation. Recently, CCE has become strongly associated with one specific model known as county lines"* https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines

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1: Introduction and context of the review

1.1 This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Hartlepool and Stockton-on-Tees Safeguarding Children Partnership (HSSCP) to consider the multi-agency safeguarding responses in relation to child criminal exploitation (CCE) in respect of a young person who was involved in a serious and violent incident where he severely harmed a male as part of a robbery. The rapid review recommended that the LCSPR take a longitudinal perspective and consider Joe's earlier childhood experiences which would include cross-border understanding as he spent most of his life living in a neighbouring authority.

1.2 Alongside the lead reviewer HSSCP commissioned Sarah Pritchard, consultant social worker and trainer, Barnardo's to provide specific local practice expertise in respect of CCE.

1.3 It is also of note that the neighbouring Safeguarding partnership where Joe lived for much of his life has just completed a Thematic LCSPR concerning CCE in relation to a group of young boys. The Partnerships share the same Strategic Exploitation Group and police force, both reviews were undertaken by this lead reviewer affording an understanding of the shared systems and practice across both partnerships.

1.4 The region has long-standing issues of poverty, significant deprivation, and wider criminality with high levels of substance and alcohol misuse resulting in poor health outcomes for its population. All of these societal problems transfer into specific challenges relating to extra familial harm. Children are at risk of, and experiencing child exploitation (criminal and sexual), there has been a rise in incidents of serious youth violence where children are reporting feeling a need to carry knives "for protection." Children are trafficked in and around the region, also been taken further afield by organised crime gangs. The region was rated by the Office of National Statistics in March 2023 as "the most dangerous place to live for violence and sexual violence in the UK".

2: Relevant background

2.1 Joe was 17 years old at the time of the significant incident, he was a cared-for child living at home with his mother and sister. His father and elder siblings lived in a neighbouring authority; Joe is the youngest of 4 children. The family were historically known to a neighbouring authority.

2.2 Concerns over his friendship groups, periods of missing, worries about exploitation, antisocial and criminal behaviours, and disengagement from education escalated. Joe was made subject to a Protection Plan for Neglect and was identified as High Risk by the Vulnerable Missing, Exploited and Trafficked Group. The family moved to a neighbouring authority in an attempt to move away from peer pressure and influences.

2.3 Following the move responsibility for the Protection Plan and the VEMT risk management process was transferred and overseen in the new local authority by one of two Multi-Agency Child Exploitation (MACE) Hubs in the Partnership) By the age of 15 legal plans to secure his safety and well-being were made and a residential placement secured. He was made subject to Police Protection and the matter was put before the Courts. The seriousness of the matter and the risks to Joe were so high that a Secure Order[4] was made.

2.4 After two months Joe was returned to his mother's care, within days he was reported missing and subsequently associated with an incident of Grievous Bodily Harm. A further application for Secure was made but the grounds were not met. A full Care Order[5] was made, Joe was now 16.

2.5 Over the next six months he was then removed from the MACE process due to a reduction in reported concerns and services ending their involvement. Subsequently, the Local Authority approved the decision to revoke the Care Order.

2.6 Within four months a Strategy Meeting was held when Joe had been missing for a significant period of time, he was associated with a number of burglaries including aggravated burglary and was sighted as carrying a knife. There was an increased association with burglaries and stolen cars with groups of elder males.

Within two months of this Strategy Meeting, the significant event occurred

2.7 A high-level Timeline has been developed to support analysis of the full agency chronologies requested by the Partnership, this has been used to support key episodes where both practice and systems have interacted and enable a longitudinal analysis of some key events and circumstances in Joe's narrative. Using a systems methodology such as the Pathways to Harm, and Pathways to Protection (Brandon, Sidebotham et al)[6] enabled evaluation and discussion at the learning events to consider how services practitioners and family responded to his needs and the harm he experienced.

2.8 Summary learning

Learning is detailed and analysed throughout the report and key learning is summarised below

- Recognising and understanding CCE. Strengthening knowledge, skills, and confidence in working with children and the family network affected by extra-familial harm and criminal exploitation
- Appreciating the significance of predisposing vulnerabilities, adversity, and developmental issues such as cognitive ability
- Robust advocacy for children cared for by the local authority missing from education and in need of additional support for their learning needs
- Recognition and challenge of victim-blaming language as a barrier to protecting children
- Understanding the impact of trauma on behaviour and engagement and the importance of interdisciplinary support

[4] Secure Order allows a looked after a child under the age of 16 to be placed in secure accommodation on welfare grounds, based on one of the following conditions: they may run away from another type of placement and likely suffer significant harm if run away or the child is likely to injure themselves or someone else if in another type of placement

[5] Care order – where a local authority is given parental responsibility which is shared with those with Parental responsibility

[6] Figure 2 Pathways to harm, pathways to protection https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

- Joint risk management collaboration where children are moving between local authorities, at risk of /or being criminally exploited and missing. Including how information from the police is triaged and shared with VEMT and MACE.
- Increased understanding and use of techniques that support the identification of risks for CCE (Tees wide screening tool and NRM)
- Where children's multi-agency plans are co-ordinated by MACE there have to be clear multi-agency evidence-based decisions to remove children from risk management systems. Clear pathways to MACE should be established for children who are cared for.
- Appreciating and responding to 'reachable moments' to engage with children where they may be more receptive to engagement and change.

7

Timeline Joe

Possible early indicators of CCE

This is a critical year for Joe

Significant welfare decisions made for Joe

Risks to Joe misunderstood

Patterns of CCE extra familial harm, associations with groups of adult males, increasing violence

Age 0-10

Early identification of neglect.

Parental issues including alcohol and mental health needs.

Family identified as part of the Troubled Family Programme [1]

Early indication of learning needs.

Anonymous referral regarding Neglect. No concerns identified.

Aged 12

Reports of anti-social behaviours including, peer group threats targeting local shops, houses and parks, nuisance, racial abuse, fire setting, assault, off road bikes and theft.

Juvenile Triage. Youth Justice Service interventions.

A & E head injury.

Transition to secondary school problematic. Permanently excluded within a year.

Aged 13

Continued anti-social behaviour.

Reports of involvement with 'street gangs' Smoking cannabis and reported nuisance in stairwells of flats.

Further head injury, hospital admission.

Gang related Public Order offence for theft of phone. Caution, Youth Justice Service involvement but unable to engage.

Out of education for some 6 months.

Aged 14

Mother self-referred to Children Social Care (CSC) Joe aggressive at home. Threshold not met, step down to Early Help.

Referral from education, extended period out of education unable to engage family, concerns highlighted about home conditions. **First identification re risk of exploitation**. Mother struggling with own anxiety, worries about her son and debts. Outcome to continue with early help

Case closed due to non-engagement.

CSC Referral. Joe reported Missing, found sleeping at flat. Links to young males/friendship groups known to services and associated with CSE, CCE, domestic abuse, drug, and alcohol use. Initial Assessment commenced. Repeated Missing.

Child Protection referral and Strategy Meeting. Joe stole a car and phone from a relative and was involved in a crash.

Seen as high risk of CCE and death by misadventure.

In the same period Joe handed himself into the police regarding an alleged stabbing.

Further periods of Missing. ICPC held Joe subject to a **Protection Plan** category of Neglect.

COVID NATIONAL LOCKDOWN March 2020 – March 2021

Discussed at VEMT, accepted under category of **CCE VERY HIGH RISK**

Twelve periods of missing, Strategy Meetings held. Information of cannabis use.

Joe was discussed at a **Complex Strategy Meeting** triggered by police and social care intelligence and links to several individuals/families. Outcome for Joe-information sharing.

Family moves to neighbouring authority, **Transfer-in** Child Protection Conference requested.

VEMT transfer made to neighbouring authority

Aged 15

Family moved. Transfer of responsibility for CP and VEMT process (MACE).

Offending behaviours increased in seriousness and frequency. Association elder males, burglary, drug taking, attendance at A & E injury and drug /overdose issues. Polydrug use.

Arrested for possession of large knife.

Continued Missing episodes and not in education. Further **Strategy Meeting** held.

Legal Gateway Meeting held. **Threshold for Section 20 met.** Residential placement secured but absconded from placement.

Police Protection taken

Secure Order granted. Cognitive Assessment undertaken

Retuned to mother's care after two months. Mother positively assessed and support put in place.

Within days of return Missing overnight. Missing continues. Referral for drug use.

MACE risk assessment completed high risk of CCE, subsequently reduced to medium risk.

Missing and arrested alleged GBH knife use.

Further Secure Order not granted.

Full care order made.

Police undertake welfare visit, mother highly stressed over debts and Joe's continual Missing.

Aged 16

Continued Missing and Curfew infringement.

Joe removed from MACE process due to reduction of concerns from services after some five months.

Decision made to revoke Care Order.

Within four months reported Missing for an extended period, associated with aggravated burglary, and carrying a knife.

Strategy Meeting held, shared significant concerns about Joe,' criminal activity, drug use and use of weapons. Seen at risk of exploitation in Strategy discussion No referral to MACE made.

Joe attended A & E alone following a fall from a bike under the influence of substances.

Referral and Community Order made.

Aged 17

12-month Rehabilitation Order. Involved with commercial burglaries and car theft.

Police call outs to home re Joe's behaviour and allegations of overdose, neighbour disputes, assaults, and theft.

Joe identified as habitual knife carrier, increasing instances of arrest involving burglaries with elder males. Threats to officers and families by Joe.

Plan changed regarding revocation of Care Order.

Joe receives conditions not to enter areas of his previous local authority.

Associating with groups of elder males concerns re cuckooing [2], intelligence re a 'graft house' [3]

MACE /VEMT risk assessment completed due to escalating concerns and risks.

Strategy Meeting following period of missing for two weeks. Reports of criminal activity arrested for breach of bail placed before the Courts.

Numerous notifications from MACE regarding Persons of Concern around Joe.

Within two months of the strategy the significant incident occurred.

1 Troubled Family Programme - Government scheme aimed at helping families experiencing multiple social and economic problems.

2 Cuckooing is a practice where people take over a vulnerable person's home and use it to exploit the vulnerable person and undertake criminal activity. It comes from the behaviour of cuckoo birds who take over the nests of other birds.

3 A 'graft house' is a place where criminals meet to plan and execute illegal activities. Can also be known as a 'safe house' or 'stash house' where criminals store stolen property, drugs, and weapons etc

3: The review methodology

3.1 The LCSPR has been undertaken in two phases, firstly a deep dive of full multi-agency chronologies and relevant documentation, the initial findings were presented to the Executive Group.

3.2 The second phase involved engagement events with front-line practitioners and strategic leads across the relevant authorities. The work has included direct engagement with Joe whose voice is captured both directly through his direct feedback and indirectly through understanding his narrative. Attempts to engage with the wider family continued throughout the process but to date have not been successful.

3.3 The review considered the systems and practice across the partnership in relation to CCE and identified learning from both a practice, partnership (systems) and cross-boundary perspective. They relate in particular to how vulnerability and harm were understood and specifically how Joe was heard and appreciated, how the risks around child criminal exploitation and extra-familial harm were understood, the level of critical reflection and professional challenge within and between agencies and a whole system response to extra familial harm and exploitation across safeguarding, enforcement and criminal and welfare systems.

3.4 The following practice themes were identified and formed a framework in which to analyse the findings, enquire and develop an understanding of what was happening and what it meant in the circumstances for Joe. Practitioners and Strategic managers, including representatives from the local authority where Joe had lived, attended the learning events, and reflected on the key findings in relation to systems and practice and considered; *what was helpful. what got in the way? and specifically to highlight Joe's voice and experience.* These were positive and helpful sessions which have directly informed this report and supported wider learning and single-agency learning and improvements.

Key Themes
1. Understanding extra-familial harm
2. Cross-boundary working and information sharing
3. Multi-agency responses to managing risks
4. Underpinned by understanding Joe's voice and experience

4: Thematic analysis and Key learning

1 Understanding extra familial harm.

Why was Joe not seen as an exploited child?

4.1.1 This section explores how child criminal exploitation was identified across the partnership and the challenges for systems and practice in understanding the harm Joe experienced. It is a concern that Joe was consistently being blamed in the documentation for placing himself at risk and therefore 'choosing' to engage in criminality and placing himself in danger. This meant his own needs were not fully understood and prioritised. Language can contribute to how children are perceived.[8] There are indicators that Joe was exploited as early as 12 years old, these do not appear to have been recognised or acted upon. (See timeline)

4.1.2 Joe's narrative clearly shows indicators of neglect, adversity, and harm. He showed developmental and communication delays and learning difficulties. He was not brought for many health appointments and wider systems identified the family as sharing the key indicators of a 'Troubled Family' in need of targeted support.

4.1.3 Joe has directly shared with the review his own experiences of a number of Adverse Childhood Experiences (ACEs)[9] that included knowledge of abuse and exploitation.

4.1.4 Joe aged 12 was assessed by Youth Justice Services, the assessment did not reflect the evidence at the time regarding his lived experience, there is a risk that this then becomes a misleading written record. This was a period of several ASB (Anti-Social Behaviours) incidents in local parks, neighbourhood shops, and associations with peer groups. Our knowledge of CCE is now more developed and with the benefit of hindsight and increased knowledge we can now consider that some of the incidents he was involved with were possible signs of early gang initiation. This is supported by Joe's surprise and acknowledgement in direct conversation that this had been considered; "***how the hell do you **** know that!"***

4.1.5 Reviewing the history (see timeline) when Joe was 14 this was a critical year, his mother asked for help from Children's Social Care (CSC) with his behaviour, he was reported to be punching holes in the walls of the house clearly evidencing distress. He was not in education and the timeline shows early indicators of CCE and the context of his life at the time. There were a number of attempts to engage Joe in education over the years, and working with his mother there were brief periods of attendance around activities he was interested in. Education can provide an important protective factor for vulnerable children and those children missing from education and/or excluded are at greater risk of exploitation.[10] Joe was missing from education for extensive periods including Years 9 and 10 and thereafter there

[8] Children's society Child Exploitation Language Guide | The Children's Society (childrenssociety.org.uk)

[9] Adverse Childhood Experience (ACEs) Current definition includes as experiences which require significant adaptation by the developing child in terms of psychological, social, and neurodevelopmental systems, and which are outside of the normal expected environment (adapted from (McLaughlin, 2016). ACEs may include other adversities not included in Felitti et al.'s 1998 study, such as bullying victimisation, parental death, and community violence. https://www.acamh.org/topic/aces/

[10] It was Hard to Escape Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf (publishing.service.gov.uk)

was intermittent engagement with any educational provision. His violent behaviour, motivation, COVID-19, and difficulties in engagement were cited as the reasons for this at different times. His learning needs were not questioned.

4.1.6 For Joe, the risk was compounded by the limited understanding of his cognitive ability and then, once this was assessed and known, the lack of a coordinated approach to apply suggested strategies to engage with him. It is difficult to understand that until he was in Secure, aged 15, his cognitive ability and functioning were not raised as a concern, this meant his needs were not accurately assessed or understood. This was critical to helping and understanding Joe to ensure he got the right support and services. The cognitive assessment undertaken showed significant differences between his chronological age and ability. For Joe, this meant his ability to communicate, process and retain information and express himself was significantly below the average for a similar child. His lack of education will have meant his ability to develop the skills needed to enable him to think, learn, remember, listen, communicate, and solve problems will have been further compromised. The assessment of his cognitive needs and strategies to help was critical information that was known. Professionals shared that they either did not know about this assessment and/or did not use it to inform practice and engagement. This is a significant document that was not used to support engagement work with Joe and importantly ensure his educational needs were fully assessed. It is clear that more could have been done to understand and meet Joe's learning needs. Efforts were made to progress an Education Health Support Plan (EHCP) for Joe on his return from Secure initiated by his Secure placement. This would have enabled additional support to be provided to meet his needs, however, the EHCP Panel decided that his needs could be met without a plan and that the cognitive assessment did not change the outcome. Joe was at this time a cared-for child, this was not challenged and did not seem to consider the complexity of his social, emotional, and learning needs.[11] This is likely to have left Joe more vulnerable and compromised without the additional support and approach he needed to provide him with the best opportunity to learn and be helped to engage in learning activities.

4.1.7 A referral to Forensic CAMHS was made to support Joe's return home from Secure this was good practice. After discussions, it was decided that there was no role for FCAMHS, there were other agencies involved and no concerns were raised about his mental health. This shows a limited understanding of Joe's lived experiences, being in Secure and the impact of this and his experiences of being exploited. Even if FCAMHS were not directly involved their specific expertise could have supported the other professionals trying to engage and manage the risks for Joe. Joe spoke about his mental health including times when he did want to die, and his use of drugs and constant 'keeping busy' to manage when things were too difficult. *"I didn't sleep, I was always out with my mates*" (Joe talking about how he coped with exploitation) Support and expertise from child mental health services could have been provided to help professionals understand and look beyond the behaviour using a more trauma-informed approach looking to explore a 'what had happened' rather than a 'what was wrong' perspective. This was professional expertise that could have been provided for consultation and peer reflection, this meant Joe's emotional needs and trauma as a result of his exploitation were not fully attended to.

4.1.8 Joe's vulnerabilities and adverse childhood experiences did not seem to inform the referral to CSC historically which would have been evident in the records so understanding of his needs was not seen as a causal link or predisposing vulnerability factor. The earlier threshold decision was that Joe and the family's needs could be met by Early Help.

[11] cc-lac-not-in-school.pdf (childrenscommissioner.gov.uk)

4.1.9 At the learning event it became clear that at the time the history was not accessible to early help services as they used a different recording system. This would have meant they were not fully informed of all the family's circumstances that were known at the time. (see timeline) In the same time period, there was the first referral for possible child criminal exploitation. This was good practice from the education inclusion team but did not inform the decision-making to close the case.

4.1.10 There is no evidence of any challenge regarding this, and it is simply accepted, professionals felt a barrier to this was information not being available to all agencies, held in isolation and assumptions that other agencies hold key information. A more enquiring and curious approach could have led to wider multi-agency discussions. Early Help was not able to engage with the family and the case was subsequently closed due to 'non-engagement.' This was a missed opportunity to consider stepping the case up to social care at an earlier opportunity if all the history had been known and triangulated. There are continual comments about the lack of 'persistent' engagement and 'avoidance' to involve Joe in any meaningful work throughout the case information.

4.1.11 The period following case transfer when the family moved to the current local authority areas saw accepted acknowledgement of the risks for Joe, he was maintained on the Child Protection Plan and VEMT/MACE processes to co-ordinate the multi-agency plan.

4.1.12 Joe's offending behaviours increased in seriousness and frequency, by the time he was 16 he was found in possession of a knife leading to a conviction, associations with groups of elder males, burglary, polydrug use and the use of items (i.e., screwdriver) as weapons. There was a clear acknowledgement of the risks for Joe and that he could not be kept safe at home and a legal threshold decision was agreed for him to become a cared-for child, a Secure placement was subsequently needed. Joe was made safe, and this was supported across criminal, safeguarding and care processes he was placed in a secure residential setting and received assessment and support in the short term. This was a critical period for Joe in terms of assessments, planning and identifying trusted relationships.

4.1.13 Discussions with local Court representatives highlighted wider systemic challenges in ensuring that clear evidence of risk and planning is presented, and longer-term planning was fully considered. Weak assessment and planning seemed to lead to reactive practice here. Work is underway within the courts to pilot an Adolescent Pathway based on the learning from Family Drug and Alcohol Courts[12] . This is an opportunity to collaborate across criminal, welfare and safeguarding systems to ensure the complexity of needs, vulnerabilities, risks, and plans for young people such as Joe caught up in the web of criminal exploitation.

4.1.14 There was a reference in the Care planning documents to a referral to the National Referral Mechanisms (NRM)[13] however this was never given a timescale, any update or progressed but remained cited within the Care Review and Planning documents. This shows that Care Planning documents were not updated and reviewed appropriately which had a direct impact on ensuring he was clearly identified as an exploited and vulnerable child. Other opportunities to

[12] FDAC are problem-solving courts adopting a multi-agency approach National Website for Family Drug & Alcohol Courts | FDAC

[13] National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive appropriate support. https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales

consider a referral to the NRM were not considered. This meant his vulnerability, support needs and risks were not fully identified or acted upon.

4.1.15 The decision to remove Joe from MACE risk management and to revoke the Care Order within months of the second secure order application is questionable and suggests the risks to Joe regarding CCE were misunderstood. (see timeline) The decision to revoke the Care order was subsequently reversed and removing Joe from MACE risk management effectively said he was no longer seen as being exploited. Given the history, level, seriousness, and continued patterns of CCE known it is not evidenced how this change had occurred. Moreover, most of these decisions were made by professionals with no direct or significant contact with Joe and his family or indeed discussion with them for example the child in our care review where this decision was made to revoke the care order did not include the child or either of his parents.

4.1.16 The rationale for removing him from MACE was based on no reports of criminal activity or police intelligence in the five months. Services were reported to be closing their involvement. However, no one was seeing or engaging with Joe and because he was 'Hidden in plain sight'[14] assumptions seem to have been made. Practitioners reflected that he was anxious about being returned to secure so was staying out of the way, Joe identified that his time in secure was "not that bad," the person who had helped him most amongst all professionals was "…. from (the secure home) as I could have conversations with her." Our knowledge of gang dynamics is that during this period of perceived calm, was in fact when Joe was being given greater responsibility within his exploitation tasks from his exploiters. He was moving up the gang hierarchy from a 'runner' to a 'younger' where he was expected to complete more serious criminal activity and take more of an active enforcer role which removed him from the more visible activities of what can be understood as anti-social behaviour and lower level CCE. Within the exploitative relationships, he will have been supported to keep off service radars.

4.1.17 Joe agreed he was exploited "in the beginning." Exploring what he was experiencing during his period of grooming, he shared "*I wanted to impress older people, they were my mates, I got compliments from them. I was good at it; it was a good laugh*." He refers to his exploitation later as *"going out to work"* and as the responsibility and expectation on him increased when he was given the role of a "younger," this period he refers to as "*really bad when things got really bad."*

4.1.18 Joe attended the emergency department on nine separate occasions for a range of injuries and suspected drug overdoses. Self-harm was not fully explored but dealt with episodically or seen as a method to avoid or delay being questioned by the police. There was limited critical reflection about these attendances and the risks and likely trauma he experienced, reports of these events were largely descriptive and reported his 'lack of cooperation'. There was no information to say this was followed up with child mental health services. Joe was subject to physical injuries and emotional harm as a direct result of his exploitation, given his level of understanding and capacity to understand what was happening or being asked to do there was elevated risk around the use of weapons, drugs, burglary, theft, and the use of vehicles placing him in great danger. The Child Safeguarding Practice Panel Annual Review 2020[15] reflected that practitioners should be aware that challenging or help-seeking behaviours may reflect harm and distress.

[14] COYL-FINAL-REPORT-FINAL-VERSION.pdf (thecommissiononyounglives.co.uk)
[15] Child Safeguarding Practice Panel 2020 annual Report

4.1.19 Recent proposals to introduce Accident and Emergency navigators[16] into local hospitals to support young people with violence-related injuries, this is a positive strategy supported by the evidence into 'reachable and/or critical moments and supports good relational practice.

Why does it matter?

Reflecting on the findings here increases understanding of why Joe was not seen consistently as an exploited child and these findings therefore matter in understanding how exploited children like Joe are identified and how help could be improved. This is supported by national research and local evidence and learning about other children who share similar experiences.

Appreciating the significance of pre-disposing vulnerabilities and risks. There are a number of predisposing vulnerabilities, adverse experiences, and developmental issues such as cognitive ability, which can make children like Joe more vulnerable to grooming and exploitation. As Joe's exploitation continued, he experienced more trauma, risks, and harm. There was limited protection identified or strengthened apart from his short stay in Secure.

Missing from education and cognitive ability. The increased risks associated with children persistently missing from education are clearly highlighted in research and statutory guidance[17]. An inability to see Joe and understand his cognitive ability is highly likely to have made him more vulnerable to grooming and exploitation and therefore disproportionately susceptible to becoming more entrenched in organised crime at a much quicker pace. Children with SEND needs are more likely to be living in vulnerable situations[18] and less likely to access the support they need. Knowing this, services and practitioners need to ensure they follow up robustly when families disengage and use established multi-agency systems to ensure the impact and solutions are fully considered. Joe's situation was made more difficult as his additional needs were not recognised and therefore plans put in place did not meet his needs. As a cared-for child, this should have been challenged.

Victim-blaming language Joe was not viewed for much of his life as an exploited child and despite the risks of harm was 'blamed' for his behaviours, this was across all agencies and both local authorities involved with Joe. This does not provide an accurate narrative of Joe's life story or consider the risks he was exposed to. Young people must not be blamed for putting themselves at risk and therefore 'choosing' to engage in criminal behaviours. Practitioners, managers, and leaders need to challenge victim-blaming language. This is a barrier to protecting children.

Knowledge of CCE In the earlier years, practitioners reflected that contextual safeguarding was underdeveloped. However, knowledge of adversity, vulnerabilities cumulative harm and neglect **was** well known and for much of his life the accelerated knowledge and research about extra familial harm and exploitation has been given high precedence in national and local research across all services and professionals. This includes a recent LSCPR Riley[19] which identified similar indicators of vulnerability, harm, and learning difficulties The findings from this review did not appear to show an informed knowledge about the nature of CCE, exploitative relationships, harm, and behaviours. Contextual safeguarding

[16] Hospital Navigators are part of a national public health approach to tackling violence. Here Barnardo's will support young people and seek to build trust and relationships with the aim of trying and divert young people from future harm and violence.
[17] Keeping_children_safe_in_education_2023.pdf (publishing.service.gov.uk)
[18] Hidden in plain sight 2022. https://thecommissiononyounglives.co.uk/wp-content/uploads/2022/11/COYL-FINAL-REPORT-FINAL-VERSION.pdf
[19] d0458ef0a0285fd0c7f5822da7cce5e0.pdf (hsscp.co.uk)

is an identified priority for the Partnership supported by training and awareness raising and the development of Multi Agency Child Exploitation teams. (MACE) The findings here highlight important learning for the partnership to consider and reflect on how previous and current learning is being applied to practice and what's getting in the way. It is reasonable to suggest this is linked to a fixed focus on behaviour and a lack of confidence (see below) which is evident in the analysis of information for his review.

Nation Referral Mechanism (NRM) The significance of making a referral to the NRM is that children who are exploited can receive appropriate care and support and are not treated as criminals. It also supports wider evidence to inform wider practice and intervention(disruption) Assessment, supervision, and multi-agency discussions are all opportunities where a referral should be considered and triggered where there are indicators of exploitation.

Practice skills Supporting practitioners to think about the possibility of criminal exploitation at points of contact with young people is prevalent in much of the research regarding safeguarding children at risk (It was Hard to Escape [20]) and it recognised that for many practitioners even when they identified children as exploited, they struggled to know how they could help. Building workforce confidence requires access to current knowledge and evidence-based tools to develop skills and then to be supported in their practice by a multi-disciplinary group that brings together aspects of child, family, and community providing a system-wide contextual safeguarding response. The agreed response needs to be consistent and clear.

Limited curiosity and assumptions made Professionals showed limited curiosity about what was happening to Joe. Assumptions reflected a poor understanding of CCE and extra-familial harm Professionals focused on Joe's behaviours and whilst they worked hard to keep him safe this clearly narrowed their focus. This would have been a constant worry and contributing factor in the blaming language. There was an inability to think wider and deeper. Joe told us "*I didn't sleep, I was always out with my mates"* when talking about how he coped with the exploitation. Professionals saw this as problematic behaviour rather than part of his coping strategies.

Rules of engagement Professionals did not consider '*why*' there were difficulties in engagement. Given what was known about Joe, particularly more recently it was difficult to appreciate professionals' continued frustrations. This appeared to be 'accepted' behaviour from Joe and his family. Joe's voice was silent when professionals and agencies withdrew because they were unable to engage with the family. Opportunities to develop helpful and 'trusted relationships' for Joe were evidenced. *" I could have a conversation with (name)" " Being in Secure "was not that bad"* There is evidence of new initiatives through the use of 'navigators' in the hospital and police custody to seek to maximise reachable moments for young people. Responsibility for engagement with children rests with the professional, children and young people should not be blamed for their lack of cooperation.

Understanding underlying trauma and its impact on behaviour and mental health is essential when working with vulnerable young people. Skilled trauma-informed approaches can strengthen trust, develop relationships, and support interventions to build resilience and recovery and can provide practical strategies to help.[21] Joe shared he used pregabalin and other drugs to *"manage the anxious feelings when things get really bad"* Joe's behaviours and incidents

[20] Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf (publishing.service.gov.uk)

[21] PHW-WHO-ACEs-Handbook-Eng-18_09_23.pdf (phwwhocc.co.uk)

of self-harm were not seen as a form of communication related to the trauma he had experienced; he was described as 'un-cooperative' consequently this resulting in a lack of understanding of any underlying reasons for the behaviour.

What needs to happen - learning points	
1	Improvements to the workforce knowledge and skills in recognising and understanding child criminal exploitation and extra-familial harm. This requires an evaluation of the current training needs in relation to this subject and the current learning transfer into practice. This will be supported by critical thinking across multi-agency groups, and this could take the form of a 'community of practice' to share effective multi-agency practices, challenges, and knowledge updates. (see also point 7)
2	Multi-agency assessment and intervention with children to include an appreciation and understanding of how children's experiences can impact them adversely and make them more vulnerable to harm and abuse. This needs to include strategies for how interventions can build resilience and safety. The use of multi-agency chronologies is a tool that can support analysis.
3	Recognition of corporate parenting responsibilities, including the need to ensure the right support is in place to meet educational and learning needs. Where there are indicators of cognitive need and vulnerability this must be actively pursued and inform educational assessment and support through EHCP. Advocacy and challenge on behalf of children cared for should be robustly applied evidenced and scrutinised via Care Planning oversight.
4	Practitioners, managers, and leaders need to challenge victim-blaming language within and across agencies in case records, supervision, and discussions. Young people must not be blamed for putting themselves at risk and therefore 'choosing' to engage in criminal behaviours.
5	Understanding underlying trauma and its impact on behaviour and mental health is essential when working with vulnerable young people and must inform engagement with young people. Developing skilled trauma-informed approaches can strengthen trust, develop relationships, and support interventions to build resilience and recovery. Practitioners and services to consider how they can embed and follow best practice guidance for trauma-informed practice and care.
6	Assessment of parents and the family network can form a key protective factor for exploited children and are often the most enduring relationships. When undertaking assessments and interventions with family members practitioners should consider and identify that parents are highly likely to need additional support in their own right to enable them to provide the necessary care and safety.
7	Professionals and agencies need to find opportunities to listen and learn about the experiences of young people like Joe to increase understanding about CCE to support multi-agency practice and service delivery.

2: Cross-boundary working and information sharing

How was information shared across the two local authorities?

4.2.1 This section examines how CCE was managed and how information was shared across partnership boundaries. Joe's pathway involved work across two Local Authorities, two Safeguarding Children Partnerships and varied operational systems to manage child exploitation with four operational exploitation teams. The two Safeguarding Children Partnerships share a Strategic Exploitation Group and Child Exploitation Team led by the Police and all four local authorities utilise a Tees Wide Child Exploitation Screening Tool.[22]

4.2.2 The family's move and the responsibility for the multi-agency Protection Plan happened in a critical period for Joe in terms of CCE and extra-familial harms. The move was an attempt by mother to sever some of the criminal associations that Joe was becoming heavily involved with indicating her worry about her son and the influences on him.

4.2.3 It also coincided with the National Lockdown due to COVID-19, which led to some changes to service delivery, and this meant Joe and other vulnerable children a reduction of many normal protective services, for example, Joe's education setting was closed and there was no alternative provided as a vulnerable child. Research shows vulnerability to exploitation increased during COVID-19 when young people were isolated from the usual support networks. Thematic analysis of Rapid Reviews by the Child Safeguarding Practice Review Panel highlighted the situational risks of COVID-19 on vulnerable children and families where "the potential to exacerbate pre-existing safeguarding risks and bring new ones"[23] was a factor in their findings.

4.2.4 This necessitated in this instance that the case transfer conference was undertaken online, this followed local practice guidance for a 'transfer in'[24]. Whilst there were no identified issues with the process the change of services, professionals and systems was raised as something that got in the way of making sure information was shared and appreciated across the local authorities at the learning events. This related to several aspects

1. Receiving information through online meetings or more frequently by email was not seen to be best practice in understanding the features of the case. Professionals reflected that an active discussion was more rigorous and helpful.
2. New systems and processes would need to be created starting from the point of case acceptance with the risk that historical information may be lost or lose its significance.
3. Handover meetings were dependent on staff availability and at the time Covid measures
4. Whilst child Protection procedures were well understood and continued other risk management systems (VEMT/MACE) were authority specific.

4.2.5 Positively the transfer from one authorities VEMT risk management to the receiving authorities MACE was accepted. This transfer was done via email which, given the nature and level of the extra-familial harm, exploitation and Missing was a limited response. It was therefore surprising that a cross-boundary handover meeting was not held; this would have been best practice and demonstrated a **child-centred system** (Munro 2011) There is information to indicate

[22] Child Exploitation - Tees Safeguarding Children Partnerships' Procedures (teescpp.org.uk)
[23] The Child Safeguarding Practice Review Panel Webinar January 2021 Thematic analysis of rapid reviews featuring Covid -19
[24] 13. Transfer In / Out (Child Protection) - Tees Safeguarding Children Partnerships' Procedures (teescpp.org.uk)

a request to arrange a joint risk management meeting was made by the new local authority, which was good practice, but there is no challenge to the non-response to this request and is a significant missed opportunity to coordinate a child-focused response.

4.2.6 Furthermore, it very quickly became clear that Joe's continued ties to his previous authority remained strong, his family still resided there as did his support networks and associations. Criminals and exploiters are not bound by local authority or professional boundaries.[25] Safeguarding children at risk from criminal exploitation is complex and challenging beyond the local level and requires a good understanding of extra-familial harm and information pertaining to drugs, gangs, youth violence, sexual and criminal exploitation, and a multi-agency Contextual Safeguarding approach[26]

4.2.7 Missing episodes do not appear to have been understood in the context of Joe's exploitation and therefore given the significance they needed. All his missing was to his previous authority it seemed the rationale was this was simply Joe returning to be with his friends and family and whilst these episodes were discussed appropriately at Strategy Meetings there was no analysis of this data or consideration of what this meant from a wider contextual safeguarding perspective.

4.2.8 Information sharing regarding Joe's missing, criminal exploitation and criminal behaviours and associations is an issue for both local authorities given all the harms, exploitation and criminal behaviours occurred in one area whilst responsibility sat within the neighbouring authority where Joe now lived. This was managed through the perspective of the local authority with case responsibility. Whilst this was the correct procedure in terms of statutory processes this prevented a wider contextual safeguarding response that could have included a collaborative cross-boundary and multi-agency response in order to safeguard Joe and intervene to disrupt his exploiters and adult criminal associates and link it directly to the impact on Joe. The reason given for the single authority response was the different systems and pathways established across all areas of the Safeguarding Partnerships. However, the police as a Safeguarding Statutory Partner have a key leadership role here particularly as their footprint and specialist knowledge of criminal activities is across both Child Safeguarding Partnerships and hold important information and intelligence about Joe and the adults around him.

Why does it matter?

Reflecting on the findings for Joe here considers the understanding and effectiveness of the multi-agency risk management systems for children at risk of and/or being exploited criminally. A complicating factor was that Joe moved to a neighbouring authority at a critical point in terms of the escalation of his exploitation and at the start of the national lockdown due to COVID-19 will have had some impact in terms of managing the risks.

[25] *CCE has become strongly associated with one specific model known as county lines"* https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines

[26] Firmin, C, 2020 Contextual Safeguarding and Child Protection: Rewriting the Rules Routledge Group. An approach to understand and respond to young people's experiences of significant harm outside the home beyond their families. It recognises the impact of the public/social context on young people's lives and consequently, their safety. Intervention focuses on the places and spaces where young people spend their time.

Cross-boundary working. Safeguarding children at risk of exploitation is complex and requires a wider awareness of harm to appreciate wider Contextual Safeguarding approaches (Firmin 2009)[27]. Given the nature of CCE and what was known about Joe's history, exploitation, Missing and offending behaviours and adult associations a cross-boundary response to manage the risks should have occurred. Criminals do not respect local authority boundaries; therefore, systems need to work collaboratively where there are identified high risks of child exploitation and young people are moving between local authority boundaries. Sharing information underpins effective multi-agency practice and remains a significant feature in all LCSPRs. Where children are subject to VEMT/MACE risk management procedures and are transferred to another authority it is important information is shared directly to enable interactive discussion, reflection, and critical challenge.

VEMT /MACE The first finding of significance here (see also page 20) relates to cross-boundary collaboration where joint risk management with clear responsibilities, accountability and information sharing would be good practice and ensure effective cross-boundary practice. Successfully safeguarding children through multi-agency working makes it clear that "*it's not about structures it's about making it work out there for children"* Laming 2009[28]. It is important that the systems and processes established to identify and manage exploitation do not get in the way of ensuring there is a collaborative child-centred response to extra-familial harm and criminal exploitation. There can be confusion for practitioners and managers working within the different operating structures across local authority boundaries.

Missing is a significant vulnerability and risk factor for exploitation. It is therefore important that these episodes are collated and analysed to evaluate and understand any patterns and thereby inform risk management and disruption work to keep children safe, particularly where this is occurring cross-boundary.

What needs to happen - learning points	
8	Joint risk management collaboration is required where there is an identified risk of a child at risk of /or being criminally exploited and children are moving between local authorities and should establish clear responsibilities and accountability covering information sharing, missing and disruption work.
9	Missing is a significant vulnerability and risk factor for exploitation. These episodes should be collated and analysed to evaluate and understand any patterns and thereby inform risk management and potential disruption work to keep children safe, including where this is occurring across local authorities.
10	Increased understanding and use of the identification of risks (Tees wide screening tool and NRM) for CCE and extra-familial harm.

[27] Firmin, C, 2020 Contextual Safeguarding and Child Protection: Rewriting the Rules Routledge Group
[28] The Lord Laming 2009 The Protection of Children A Progress Report in England Chapter 4 Interagency working

3: Multi-agency responses to managing risks (assessment, intervention(disruption) and building safety)

How did agencies understand what Joe needed?

4.3.1 This section considers the multi-agency responses to assessing and managing the risks to Joe and multi-agency interventions with Joe to keep him safe and meet his needs. There was a delay in identifying vulnerabilities for Joe and associated risks early in the problem, the timeline evidence known information about the family's early history. Joe reports strong relationships with his family members although there is limited information about these relationships. Joe's parents were separately assessed as possible carers during the Care Proceedings. Father does not appear to have been included after this and is not visible in key assessment, planning or review information. This is a gap, particularly when father (and brother) has provided a safe place for Joe to stay temporarily. What was evident was the lack of any information about any support networks for the family particularly when they moved. There was no sense of the circumstances of his exploitation his lived experience and the influences upon him and how they might be managed.

4.3.2 There were clear earlier indicators of exploitation but not identified and acted upon preventatively and exploitation and risk management processes were not triggered until the matter had escalated to Child Protection. Positively the Child Protection Conference clearly identified that Joe was at risk of CCE and recommended a risk assessment, safety work with Joe around exploitation and mother's ability to keep him safe. This was a good start it would have been strengthened if father was included and there was exploration /mapping with Joe around his friendship groups (risks and strengths) and support networks.

4.3.3 Within three months of the family's move events had heightened to such a point that a residential placement was being sought evidencing the escalating level of risk and harm he was being exposed to as he continued to associate with criminal influences in the previous authority and go missing from his home address. This was positive practice to try and keep him safe.

4.3.4 Assessments seen were largely descriptive with limited analysis and understanding of the impact of cumulative harm and neglect, his developmental needs and identification of extra-familial harm. Some direct work was done with Joe to look at his drug use and knife crime, but it did not inform a wider multi-agency assessment. Language continued to be victim blaming and whilst his behaviours and behaviour were problematic particularly when he displayed significant violence and abusive language this meant he was seen as a perpetrator. The language used to describe Joe's criminal behaviours is also problematic, he was described in police records as a 'habitual' knife carrier and whilst the risks to others of knife carrying are great there is no exploration of whether this is seen by Joe to be for protection or to actively harm others. This is an important distinction and can lead to a belief that Joe was an active preparator of violence as opposed to a victim carrying a knife for protection. Research shows victims and perpetrators are not distinct groups, and many violent offenders are also victims at the same time and should be seen first as vulnerable children.

The Violence and Vulnerability Unit (2018) noted that criminally exploited children did not always meet the threshold for support. Instead, there was "a tendency to view these young people's behaviour, especially in the case of boys, as a sign of criminality, almost a lifestyle choice, rather than evidence of a vulnerable child in need of protection." (Crest 2021)

4.3.5 Parenting assessments were appropriately undertaken to consider plans for Joe leaving secure and these were key assessments. They are limited as there were only a few face-to-face sessions in the home, they were completed at the end of the COVID period and most of the sessions were undertaken online, no observations were incorporated or planned, and they are mainly based on self-report and summary police information. The reports are largely descriptive and contain no analysis of the family functioning capacity risks and strengths and significantly it is not clear how mother (who was assessed positively) would change her parenting and address and mitigate against some of the neglect Joe has experienced and the risk he was likely to continue to experience around exploitation. There was no exploration of mother's own needs and adversity and how she would balance these against providing strategies and boundaries for Joe. She had previously shared her fears about his behaviour and her understanding of contextual safeguarding was not explored. It did acknowledge that some sort of bridging placement would be helpful, and this would have provided an opportunity to test out safety for Joe. There was no contingency planning meaning the plan to return home immediately was simply accepted.

4.3.6 It is evident that once Joe became a cared-for-child the multi-agency risk management around exploitation was less effective. Reviews and Risk Assessment and Management Plans (RAMP)appeared to be used mainly as a means of sharing or updating colleagues. There are limited or no actions or outcomes. These meetings were not fully multi-agency and significantly did not include colleagues from the police health or education. This did not therefore take account of the reason Joe was in care, and this meant for Joe that his needs and risks were not fully understood through wider exploitation systems. This was further compounded when Joe was removed from the MACE risk management system. The history, seriousness and levels of risk and harm around CCE demonstrate misplaced optimism in the circumstances and context of the case history. This meant that Joe was less visible to the multi-agency systems and services that were in place to assess, monitor and reduce the risk of exploitation to him.

4.3.7 Joe's criminality became visible and increased rapidly over the next 18 months, this included extended periods of missing, arrest for possession of a bladed article, burglary, theft, and multiple intelligence about drug dealing and associations with adult males and criminal activity (see timeline) The criminal activity happened in the neighbouring authority and whilst PPNs [29] were shared with the responsible social worker this was indirect via two authorities respective 'front doors'[30] and significantly it was not, or any associated intelligence, shared with the MACE as Joe was not open to them. A referral was not made to MACE until a few weeks before the significant incident, then MACE started to gather information about the networks of adults around Joe. This was positive strategy planning however was

[29] Public Protection Notification is the information sharing document from the police regarding safeguarding concerns about a child
[30] The arrangements that local authorities have to respond to initial contact from a professional or member of the public with concerns about a child

significantly late in the path of Joe's exploitation meaning there was no agreed confirmation that Joe was being criminally exploited until he was deeply entrenched in criminal exploitation.

4.3.8 Whilst information was shared it was not effective in keeping Joe safe or raising concerns about exploitation partly because no one agency held all the information and there was no multi-agency discussion earlier on in the problem about what could be going on for Joe. MACE would have been the place to make a referral raise some enquiry and develop some reflective discussions. There was evidence of exploitation and harm and some agencies such as the police, youth justice, and social care all held critical information that showed clear evidence of exploitation. The multi-agency Strategy Meeting in late 2021 clearly identified there were 'risks of exploitation' but no identification that he **was being** exploited, NRM considered or a referral into MACE. This indicates a differing understanding about what constitutes criminal exploitation from partners, both of these processes could have supported intervention for Joe. This was not a fixed opportunity, and there was no critical thinking or challenge about these from a contextual safeguarding perspective over a significant period of time (see timeline).

4.3.9 A significant amount of resources contributed to supporting Joe to stay at home, this included several daily contacts and/or visits from a team of staff. This 'intensive' support appeared in the main to provide daily welfare visits and 'monitoring' where Joe was. This visibility is likely to have contributed to the optimistic view that Joe was at reduced risk. Furthermore, it is not clear if any specific therapeutic and/or safety planning work with the family was achieved as no meaningful engagement was made with Joe. Furthermore, professionals are at risk of taking on a policing role to manage their understandable worries about where Joe was and with whom, however, seeing Joe or having telephone contact was only ever going to provide limited safety. The challenges of engaging with young people like Joe are fully acknowledged however there is evidence[31] developing around the effectiveness of a "trusted person" [32] in supporting children at risk of harm from exploitation. Joe was able to identify key staff that he saw as helpful indicating there were opportunities to develop relationships. Research shows strategies to engage with children need to be relational and trauma-informed in order to develop relationships that can support interventions to build resilience and recovery. Joe's reflections of this time and intervention are "social workers just make everything worse; they just cause more stress and don't help." Joe stated, "*Things aren't as bad as what social workers think they are." "They just come in your house, you have to be in for a time, they just want information off you, they don't try and change things. If you are not in, then they have a go at me mam and she have a go at me and then we are fighting."* This type of monitoring or 'policing type' intervention is counterproductive and pushes children away as we can see from Joe's feedback. This evidence is supported by wider research (ref 22) and advocates for a relational more therapeutic approach needed to develop relationships.

4.3.10 The learning event highlighted the number of times that Joe had been seen in custody by the Arrest Referral Scheme[33] in a three-year period. This totalled 22 times. This is significant for a number of reasons and presented 22 opportunities for practitioners to engage with Joe and this was one agency of many involved with Joe. Research shows there are a number of critical[34] or 'reachable' moments in young people's lives that require decisive action to make a difference particularly early in the problem. Services and practitioners need to be vigilant and curious about these

[31] Building trusted relationships for vulnerable children and young people with public services | Early Intervention Foundation (eif.org.uk)
[32] Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf (publishing.service.gov.uk)
[33] Arrest Referral schemes are based in police stations and provide an opportunity for advice, information and assessment relating to drugs and can support referrals to drug services.
[34] Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf (publishing.service.gov.uk)

opportunities and indicators of risk and harm. Arrest and Custody, hospital attendance and returning from a Missing episode are potential opportunities to engage. Recent developments have seen a Custody Navigator pilot in the police main custody suite where non-police officers will work with young people when they have entered into the criminal justice system via police custody to engage in 'reachable, teachable 'moments in their lives. This is part of a national best practice initiative.

4.3.11 Safeguarding children at risk of or being exploited as Joe was, is complex and requires systems and the professionals working within them to consider alternative frameworks and have access to the skills of a wide range of expertise and knowledge sometimes outside the more traditional multi-agency safeguarding frameworks. For Joe using approaches that consider extra-familial harm out of the family home and places the focus of professional assessment and intervention towards the places and spaces where adolescents inhabit.[35]

Why does it matter?

It is important for practitioners and managers to understand that child criminal exploitation is a form of child abuse and children should not be blamed for this. Multi-agency assessments, interventions, and plans need to identify exploitation and harm to ensure children can be protected and make use of a range of professional disciplines. This needs collaboration and joint work.

MACE risk management Decision making to move young people from MACE risk management processes should be considered in the full context of the case history and knowledge about the nature and context of CCE. There needs to be clear evidence of protective factors including a good safety network. Plans need to be clear about the risks, what needs to change, what support is needed and what safety and intervention looks like. Decision making relating to assessing the reduced risks of exploitation and therefore removal from any risk management system needs greater scrutiny and rigour informed by understanding about the nature of exploitation. Once Joe was removed from the MACE risk management systems, he was less visible to the multi-agency systems and services in place to manage and reduce the risks of exploitation. An unintended consequence of this for Joe as a cared-for-child meant there was then no clear pathway to ensure police information was routinely shared.

Referrals to MACE Early identification of extra-familial harm and exploitation is critical to prevent and address the harm caused by the grooming and exploitation of vulnerable children into serious crime this is important at every level of exploitation. The escalating patterns of criminal exploitation and extra-familial harm were evident through the increase of serious criminal activity, associations with groups of adult males, Court Orders, curfew, Missing, drug use and the use of weapons. Strategy Meetings that are the result of identified risks of CCE and harm to a child should require an automatic referral to MACE and the NRM to ensure a wider contextual safeguarding response.

Opportunities to engage There are a number of critical or "*reachable"* moments or events in young people's lives, particularly **early on** in the problem where they may be more receptive to change. Services and practitioners need to be vigilant and curious about these opportunities, including early indicators of risk and harm. These include disclosures of harm, exclusion from school, hospital admissions arrest and critical incidents such as the making of the 12-month

[35] Firmin, C, 2020 Contextual Safeguarding and Child Protection :Rewriting the Rules Routledge Group

Rehabilitation Order[36]. There are new Navigator initiatives that can support this learning. Practitioners require a good understanding of how children communicate and consideration of their developmental age and understanding.

Cared-for-children It is important that the interface between the multi-agency risk management systems around extra-familial harm and child criminal exploitation and children cared for is strengthened to fully protect children like Joe placed at home. It is critical that children who are cared for because of risks around exploitation have a clear pathway into the MACE risk management process so it informs planning and decision making. This is particularly relevant for children who are placed at home and back to the places and spaces where they experienced harm and exploitation.

Strengths and safety within the family Parents can be a key protective factor for exploited children and are often, like in Joe's situation, the most enduring relationship. Parents are highly likely to need additional support in their own right to enable them to provide the necessary safety. Robust parenting assessments can support transition home. Plans need to understand, appreciate, and be informed of the risks around exploitation through a contextual safeguarding lens and be managed across a multi-agency group that encompasses a contextual safeguarding approach that assesses risk outside of the home[37] Work with Joe and his family took on a monitoring or policing role which Joe saw as interfering and not helpful.

What needs to happen - learning points	
11	Where children's multi-agency plans are co-ordinated by MACE there have to be clear multi-agency evidence-based decisions to remove children from risk management systems. There needs to be clear multi-agency safety plans /exit plans for children who are no longer seen to be at risk
12	Clear pathways should be established to/from the MACE for children who are Cared for to strengthen and inform multi-agency risk management plans.
13	Practitioners should identify professional(s) who have started/have the opportunity to develop relationships build on these and be flexible. Services and practitioners need to be vigilant and curious about possible 'reachable' opportunities where children may be more receptive to engagement.
14	Work with children and families should be relational and risks managed via multi-agency safety planning inclusive of the family. Intervention work with children and families is most effective when it is relational and non-blaming, monitoring-type interventions can be counterproductive and increase resistance.
15	Strategy Meetings that consider extra familial harm and exploitation should require an automatic referral and inclusion of the MACE team. Consideration of a referral to the NRM or an explanation of why it is not needed should be part of the discussion to identify local children and identify support and intervention needs.

[36] A Rehabilitation Order from the court that sets out a contract of work to be completed often for young people who continue to commit offences after completing a Referral Order

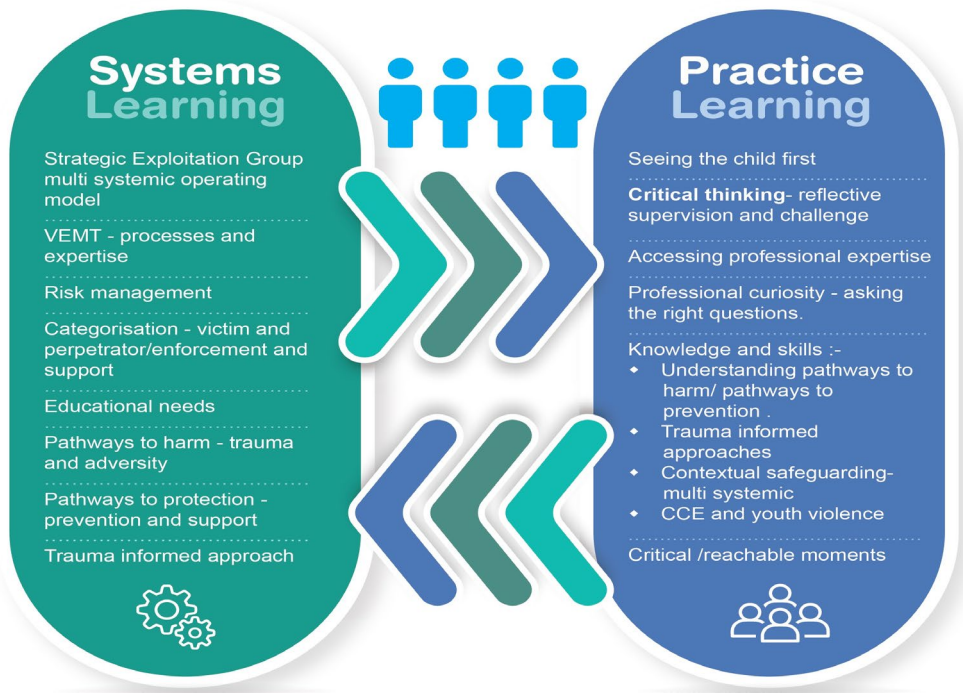
[37] Contextual Safeguarding Research Durham University
Working_together_to_safeguard_children_inter_agency_guidance.pdf (publishing.service.gov.uk)

6: Summary and Recommendations

6.1 This practice review has identified a number of key themes for the partnership to consider and reflect upon regarding current systems and practice regarding child criminal exploitation. There are also some single-agency practice improvements that need attention highlighted within the review process. Some of these are related specifically to understanding exploitation and harms outside of the home and these are identified. There is also learning in relation to wider assessment demonstrating critical reflection and analysis, pattering information, and understanding what this means for the child through chronologies and repeated agency contacts. The ongoing assessment of Joe's developmental and emotional needs is likely to have had a significant impact not only on his vulnerability to exploitation but contributed to his poor outcomes. This is a cumulative impact and involves a wide spectrum of services trying their best from their own agency's perspective.

6.2 It is clear that once the risks were identified professionals acted quickly to make Joe safe and significant resource was put in place to try and keep him safe. However, the required knowledge and skills in engaging with young people like Joe meant professionals started to blame Joe and make assumptions about his behaviours and engagement. Cross-boundary working was a clear issue specifically regarding sharing information and coordinating risk management plans in relation to his criminal exploitation and how Joe was managed through different structures and processes. This meant that Joe was not seen consistently as an exploited and vulnerable child until the impact of his criminal behaviours intensified in severity leading to the significant incident.

6.3 There are clear parallels with the recent Thematic Review regarding CCE in the neighbouring Child Safeguarding Partnership where Joe lived for much of his life and shares a similar trajectory. There is an opportunity to learn and improve services and practice across a wider footprint led by the shared Strategic Exploitation Partnership. The overarching system and practice themes from this review are represented below and mirror much of the learning here.



Recommendations for the partnership

Practice

1 HSSCP to evaluate the effectiveness of the learning transfer in relation to CCE and extra-familial harm. In addition to the learning from this LCSPR, it should include the learning from Riley[38] and the Thematic Review of Child Criminal Exploitation undertaken in the neighbouring Safeguarding Partnership to strengthen knowledge, skills and confidence regarding the risks and impact of CCE.

2 The statutory partners to provide clear leadership and challenge about victim blaming culture and response when working with children involved with CCE.

3 HSSCP to consider the long-term impact on the mental health of children involved in CCE and ensure services are in place to support trauma and also identify possible Post Traumatic Stress Disorder as these young people transition into adulthood.

4 HSSCP to consider the development of multi-agency reflective practice forums (community of practice) facilitated by subject experts/operational leads for exploitation to share knowledge, evidence, tools, and risk factors around criminal exploitation. This should be informed by the voice of young people to support practice, form critical reflection, and share best practices.

Systems

1 HSSCP to seek assurance from the Police (as the strategic safeguarding partner leading the Strategic Exploitation Group) that there is a clear and unified risk management framework that is arranged around the child, built on evidence-based practice[39] and has clear operational and information sharing pathways understood across the partnership.

2 HSSCP to establish clear direction around shared accountability and responsibility when children subject to VEMT/MACE are transferred to another authority and where harm and CCE occur across local authority boundaries

3 Multi-Agency Criminal Exploitation Team (MACE)

- HSSCP to seek assurance that MACE's decision-making is evidence-based, and is informed by the history
- Strategy Meetings that highlight the risks of CCE should involve the MACE team, and require a direct referral and consideration of an NRM referral

4 Children Cared for by the local authority-

- HSSCP to seek assurance from education strategic leads to ensure appropriate services and support are provided for vulnerable children missing education and with additional needs.
- HSSCP to seek assurance that its cared-for children have a clear pathway into/from the MACE risk management systems.

5 HSSCP to reflect on the development of the Local Family Justice Court's proposed Adolescent Pathway pilot and consider how this could form part of a broader pathway or framework across criminal, welfare and safeguarding systems in relation to CCE. This has the potential to inform service development and practice improvements.

[38] Hartlepool and Stockton-on-Tees Safeguarding Children Partnership (HSSCP) CSPR Riley 7-minute briefing
[39] Tackling Child Exploitation Support Programme extended | Research in Practice