

# It was hard to escape

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**Safeguarding** children at risk  
from criminal exploitation

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# Foreword

**Our children face a number of challenges to their safety and wellbeing today – none more complex and damaging than criminal exploitation. Being drawn into exploitative situations, where children can be both victims and perpetrators of serious harm, can have severe consequences for them and for their families, friends and communities.**

The safeguarding system is facing organised criminal businesses that are skilled at identifying and entrapping children in their activities. Their business model depends on the exploitation of children, using coercion, control and manipulation to push them into criminal activity. Too many children are dying or suffering serious harm as a result of criminal exploitation and this is unacceptable. Investment in helping to protect this group is essential and urgent. Doing nothing is not an option.

The work of the national Child Safeguarding Practice Review Panel draws on the notifications, rapid reviews, practice reviews and serious case reviews that we receive every day. These give us a contemporary and detailed overview of incidents of serious and fatal child maltreatment across England. The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which we believe raise issues that are complex or of national importance. Since we began our work in June 2018, we have seen a worrying number of cases involving children who have died or been seriously harmed where criminal exploitation was a factor.

This, our first national review, aims to identify what might be done differently by practitioners to improve approaches to protecting children who find themselves threatened with violence and serious harm by criminal gangs.

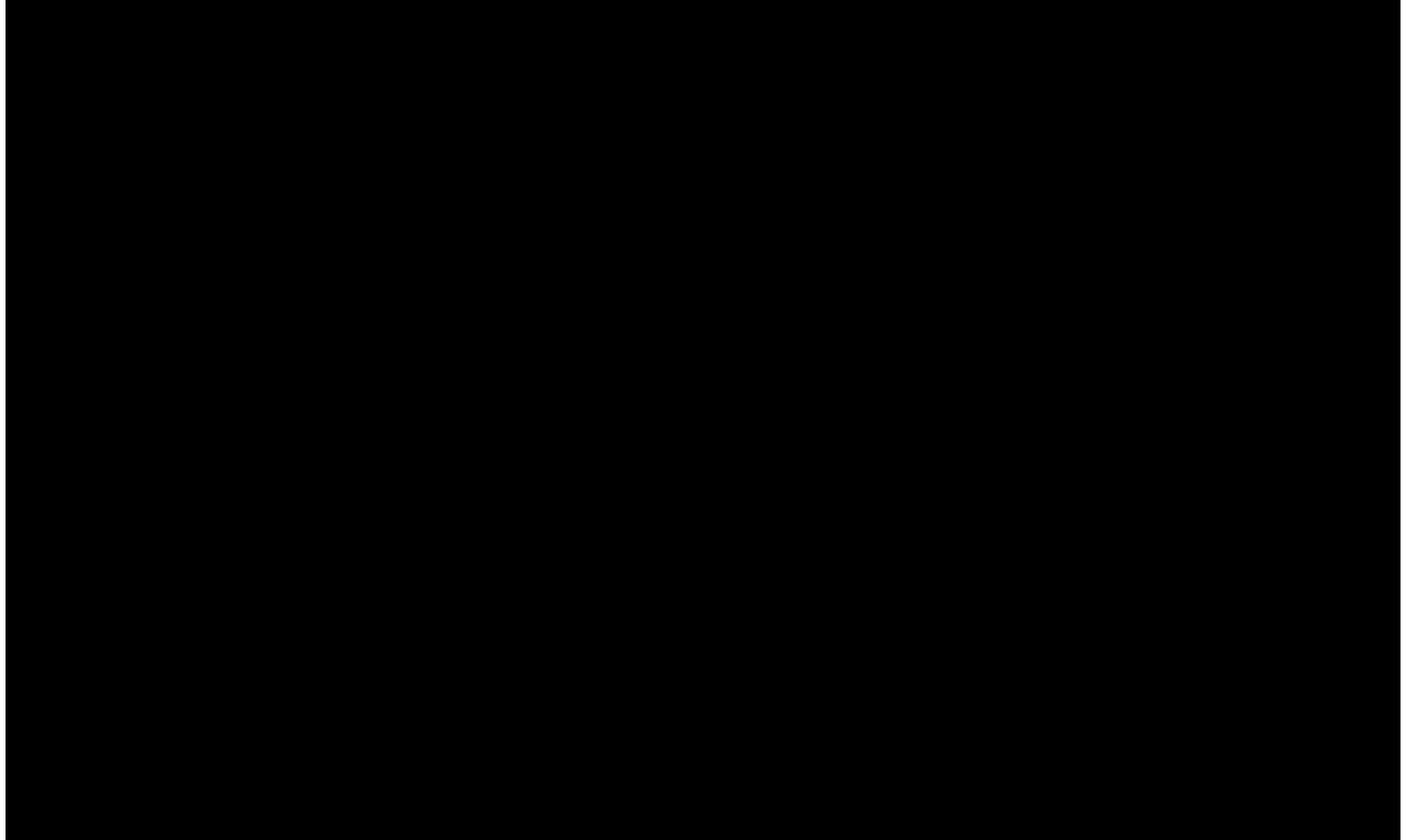
The intention of this report is not to go into the detail of what happened to each of the 21 children whose cases we examined. Its focus is the response of services to the very serious risks they faced. But those children – who experienced violence, fear and exploitation as a feature of their daily lives – are at the heart of this review. We found families torn apart by what had happened and who wanted to talk to us to tell their story and influence the debate. We found local practitioners working hard to understand and respond to challenges which seem to grow and change daily as the operation of gangs and their exploitation of children become ever more sophisticated. We found some evidence about what might help children in these circumstances but also found gaps in local strategic understanding and practice.

In this report we offer a number of key learning points for local leaders, drawing on the evidence we saw from practice. This includes good practice we saw from the fieldwork areas and from visits to areas with innovative emerging practice. We propose a framework for practice to be trialled locally and evaluated and make three further recommendations for change at the national level. This report does not offer all the answers but seeks to add to the body of evidence that is being gathered nationally. The Panel is keen to collaborate in wider debate.

We would like to thank all those who we spoke to as part of the review, in particular the children and their families, the practitioners involved in these tragic cases and those who organised the fieldwork visits. Thanks go also to our two reviewers, Clare Chamberlain and Russell Wate, to the three Panel members who led this review – Dale Simon (Chair), Karen Manners and Mark Gurrey – and to the secretariat team at the Department for Education who have supported us throughout.

#### **Child Safeguarding Practice Review Panel**

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# Executive summary

## Introduction

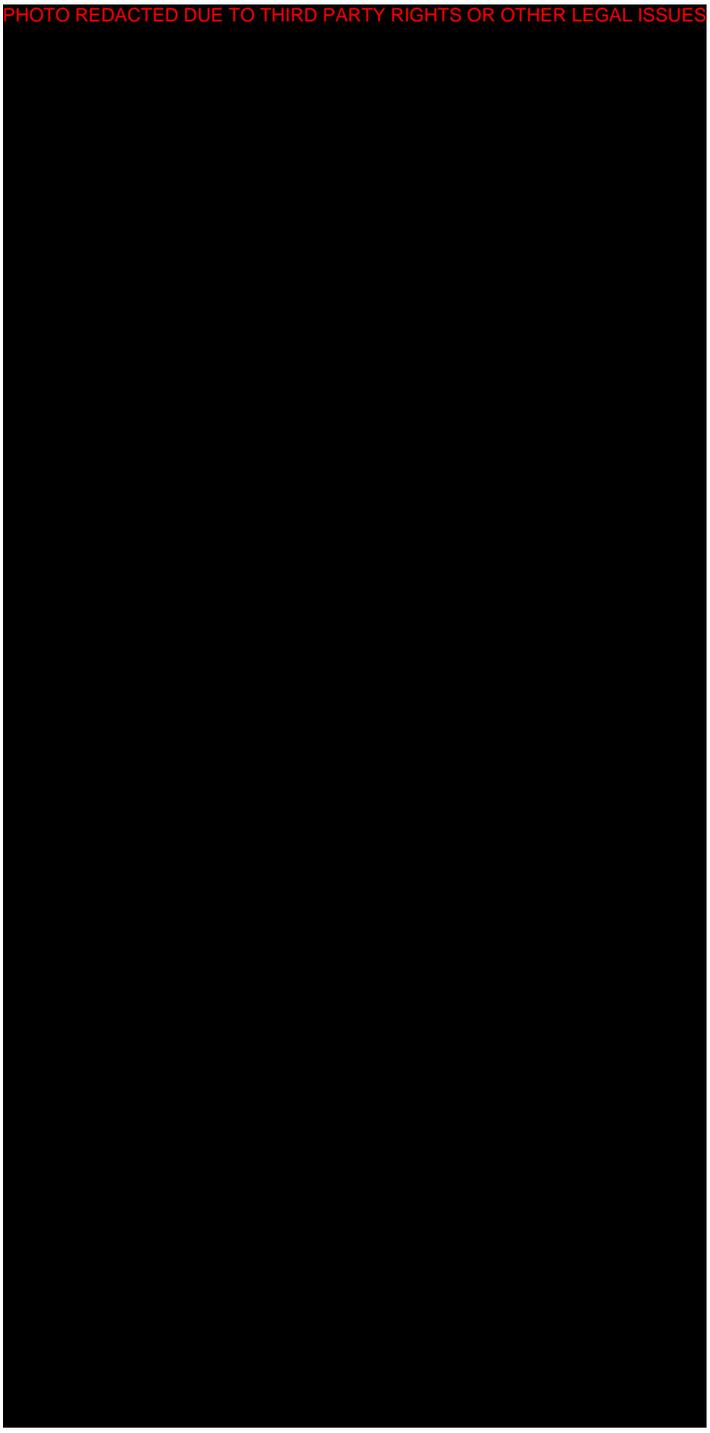
This national review, undertaken by the Child Safeguarding Practice Review Panel<sup>1</sup> (the Panel), asked two connected questions:

- **Do adolescents in need of state protection from criminal exploitation get the help they need, when they need it?**
- **How can the services designed to keep adolescents safe from criminal exploitation, and the way those services work together, be improved to prevent further harm?**

The review found that the answer to the first question is ‘not always’, although there is much good practice to build on. In response to the second question, the review found a number of ways in which services could be improved, including working more effectively with families and responding quickly and flexibly at times when children are likely to be at their most vulnerable.

The specific focus of this review is the service response to children who have already been drawn into criminal exploitation and where high levels of risk of serious harm have been identified. The review focused on what help was available to children and their families at that critical point.

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<sup>1</sup> The Panel is funded by the Department for Education and is accountable to the Secretary of State for Education, but operates independently of government. Part of the Panel's role is to commission national reviews relating to children whose circumstances are complex or likely to be of national importance.

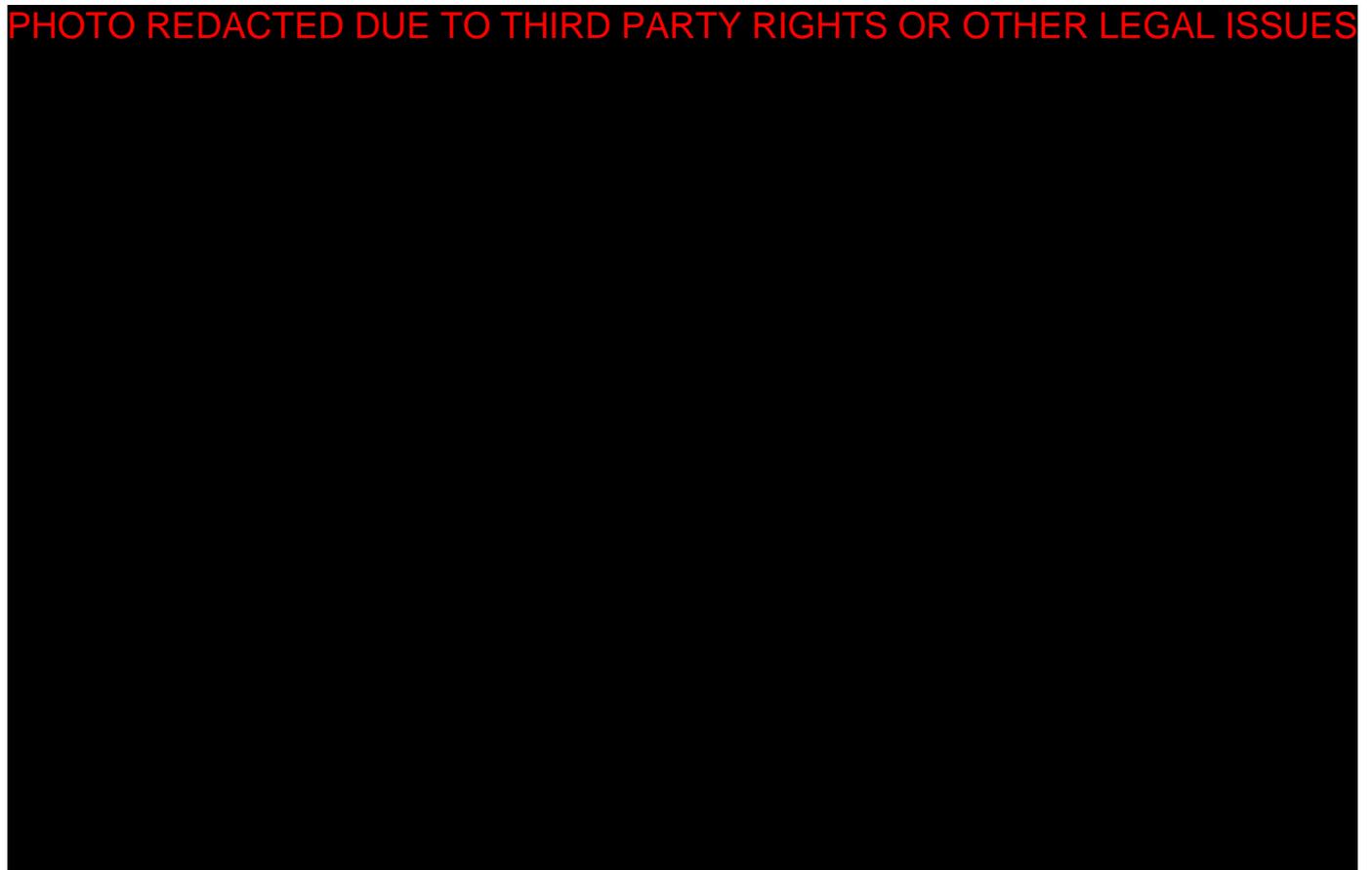
## Method

The review focused on 21 children from 17 local areas who died or experienced serious harm<sup>2</sup> and whose cases were notified to the Panel between July 2018 and March 2019. There were four parts to the review:

- fieldwork in the 17 local areas
- discussions with key professionals and experts
- a literature review
- visits to areas of emerging good practice

This is a qualitative study, based on interviews with practitioners and families and underpinned by factual details from each case. The aim of the review was to look at common patterns, similarities and differences between the approaches taken in local areas to answer the central review questions. The key findings combine evidence from the children's experiences with professional opinion from those who worked with them about the effectiveness of services and approaches available to children who are seriously harmed through criminal exploitation.

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<sup>2</sup> We use the definition of serious harm set out in the statutory guidance Working Together 2018. Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development.

## Key findings

### **Ethnicity and gender appear to be factors**

The review found that boys from black and minority ethnic backgrounds appear to be more vulnerable to harm from criminal exploitation. In the cohort of 21 children, 15 were from a black or minority ethnic background and all of them were male. This is a serious concern.

### **Known risk factors around vulnerability don't always act as predictors**

The common indicators of vulnerability were not present in the lives of many of the children who were the subject of these criminal exploitation cases (the major exception is exclusion from school). For example only two of the 21 children were looked after by the local authority and the remainder all lived at home with parents or extended family. Most of the children (and their families) were not known to children's social care before the problems associated with their potential exploitation surfaced.

### **Exclusion from mainstream school is seen as a trigger point for risk of serious harm**

Seventeen of the children who died or experienced serious harm had been permanently excluded from mainstream education. Permanent exclusion was identified by practitioners and family members as a trigger for a significant escalation of risk. Exclusion has a major impact on children's lives and if it is unavoidable then there needs to be immediate wrap-around support to compensate for the lack of structure, sense of belonging and rejection that exclusion from mainstream school can cause.

### **Effective practice is not widely known about or used**

Even when local areas and practitioners know the children at risk of being drawn into criminal exploitation, many are not confident about what they can do to help them. There are a number of different approaches being taken across the country but little reliable evidence of what works, and no central point where effective evidence is evaluated and disseminated.

### **Trusted relationships with children are important**

We believe that building a trusted relationship between children and practitioners is essential to effective communication and risk management.<sup>3</sup> Establishing such relationships takes time and skill. Above all, persistence, tenacity, creativity and the ability to respond quickly are key qualities required of practitioners.

### **Responding to the 'critical moment'**

There are critical moments in children's lives when a decisive response is necessary to make a difference to their long-term outcomes. Professionals told us that this is likely to include:

- the point at which they are excluded from school
- when they are physically injured
- when they are arrested

More evidence is needed about those key moments, so that service design and individual practitioners can anticipate them and be ready to capitalise on the receptiveness of children at such times. We can then test what interventions can really make a difference.

<sup>3</sup> Currently there is no high-quality research evidence that demonstrates the effectiveness of trusted relationships in supporting children at risk of harm from criminal exploitation, but there is a strong logical link. For further information on trusted relationships see the EIF report: <https://www.eif.org.uk/report/building-trusted-relationships-for-vulnerable-children-and-young-people-with-public-services>

### **Parental engagement is nearly always a protective factor**

Parents and extended family members need effective support in helping them manage risk from outside the home. This is skilled work and requires building good relationships with parents. A number of parents we spoke to felt blamed and therefore alienated from attempts by services to help.

### **Moving children and families works for a short period but is not effective as a long-term strategy**

Moving children or whole families out of the area provides a breathing space and immediate safety but was not effective as a medium or longer term strategy. There must be a clear and consistent plan for supporting the child and managing risk in the new location.

### **More priority should be given to disrupting perpetrator activity**

At the local level, there was little information or working knowledge among safeguarding partnerships of what intervention strategies were being taken against the perpetrators of criminal exploitation. This is a marked contrast with the dual approach taken to children who are sexually exploited (i.e. to both help the victims and disrupt the activity of the perpetrators).

### **The National Referral Mechanism (NRM)<sup>4</sup> is not well understood and is inconsistently used**

Young people who are being criminally exploited are often referred to the NRM in the hope that it will give them protection. The review found that the NRM's original purpose does not always fit well with the circumstances of this group of children and that understanding and use of the NRM was patchy.

### **Comprehensive risk management arrangements can make a difference**

Evidence from the cases reviewed suggested that an intensive risk management plan which includes control measures such as electronic tags, within the context of a good relationship with the child and with parental support, can be effective in reducing risk.

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<sup>4</sup> The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. Further information about the NRM is available here: <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>

## Conclusions and recommendations

The Panel believes there are some clear indicators of a service response which has the potential to reduce the risk of harm to this group of children. Based on the learning from the review, the report outlines a practice framework that should provide a more comprehensive approach at the point when a child has been identified as being at risk of criminal exploitation. The practice framework includes building a relationship with the child, actively engaging parents and providing them with targeted support and an immediate full-time education package to children who are excluded from mainstream school. **We recommend that the government should fund trials of the practice framework and that it is robustly evaluated.**

There are **three further national recommendations** which focus on:

- a review of Working Together 2018 to reflect the specific circumstances of this group of children who are at risk of criminal exploitation
- a review of the use of the National Referral Mechanism
- data collection to improve local and national understanding of prevalence, characteristics and service response

We also set out a number of **key learning points for local agencies**, as well as questions and challenges that we believe every safeguarding partnership should be working on and be able to answer, either now or in the near future. These focus on:

- understanding the nature and scale of the problem and identifying children engaged with and at risk from criminal exploitation
- tailored support for front line staff
- service design and practice development
- quality assurance

# Introduction

# 1. The review question

**1.1** The national Child Safeguarding Practice Review Panel (the Panel) is independent of government, but is accountable to the Secretary of State for Education. It has been operating since June 2018 and meets regularly to consider rapid reviews from local authorities about children<sup>5</sup> who have died or been seriously harmed through abuse or neglect. Part of the Panel's role is to commission national reviews into child safeguarding cases which are complex or likely to be of national significance. This is the first such review, looking at young people who have come to harm through criminal exploitation. There is further detail about the Panel and its membership on GOV.UK.<sup>6</sup>

**1.2** Between July 2018 and March 2019 (when the review began), the Panel received rapid reviews concerning over 300 children who died or suffered serious harm as a result of abuse or neglect. Adolescents were involved in 46 of the cases, comprising a wide range of circumstances, including child sexual exploitation and children who had taken their own lives. The Panel identified the children from this group who died or were seriously harmed within a context of criminal exploitation. This gave us a group of 21 adolescents from 17 localities, including both those who had been harmed (the majority) and those who caused harm to others.

**1.3** The specific focus of this review is the service response to these children who have already been drawn into criminal exploitation and where high levels of risk have been identified. The review focused on what help was available to children and their families at that critical point.

**1.4** The Panel wanted to answer two connected questions through this review:

**Do adolescents in need of state protection from criminal exploitation get the help they need, when they need it?**

**How can the services designed to keep adolescents safe from criminal exploitation, and the way those services work together, be improved to prevent further harm?**

<sup>5</sup> In this report we use the definition of children found in the Children Act 1989 which refers to all under 18s as children. Given the majority of the children who are the subject of this review were between 14 and 18 years old, we also use the terms "young people" and "adolescents".

<sup>6</sup> <https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel>

## 2. Method

**2.1** The findings in this report are based on the 21 cases included in the review. This is a sample of cases notified to the Panel as serious or fatal harm linked to child criminal exploitation. However, it is important to recognise that this does not represent the totality of children involved in or harmed through criminal exploitation. The decision on whether or not to notify an incident rests with a local authority. The decision may be affected by whether or not the harm suffered is considered to be serious, and whether the criminal exploitation is considered to come within the umbrella of abuse or neglect. There will inevitably be other children who are harmed through criminal exploitation, or who are being exploited but have not come to the notice of the Panel.

**There were four parts to this review:**

### 2.2 Fieldwork

Fieldwork was carried out by two expert reviewers from our national pool,<sup>7</sup> who visited 16 of the localities and spoke by telephone to practitioners from the one remaining area.<sup>8</sup> They looked at the detail of each child's circumstances, primarily by speaking to practitioners using a semi-structured interview approach. The reviewers also looked at some 25 cases of comparable adolescents selected by the local area on the basis of similar circumstances and where there were high levels of concern, but where the child had not been seriously harmed or died. In a number of visits, the reviewers spoke directly to children and their families and this gave the review some powerful intelligence. In all, the reviewers talked to well over 100 practitioners, 21 parents/carers and 6 children.

Direct quotes from these interviews can be found throughout the report. For further detail about the fieldwork see Appendix A.

### 2.3 Discussions with key professionals

Roundtable and bilateral discussions were held with experts in this field and with the participating local authorities and their safeguarding partners. In these discussions we set out the emerging findings from the fieldwork to test them against wider experience and understanding and to explore how practitioners are responding to the challenges. Additional stakeholders and experts are listed in Appendix B.

### 2.4 Literature review

The Panel commissioned Cardiff University to conduct a literature review focused on child criminal exploitation in the context of county lines. The purpose of this review was to seek to understand findings from published research and test these against our findings from the fieldwork. This report contains a number of references to the literature review's findings, and the full report can be found at <http://sites.cardiff.ac.uk/cascade/previous-projects/a-systematic-map-and-synthesis-review-of-child-criminal-exploitation/>.

### 2.5 Emerging good practice

Panel members visited areas of developing practice identified during the fieldwork and held discussions with key professionals to explore in more detail the development of effective services to safeguard children at risk of criminal exploitation. Appendix B lists the visits.

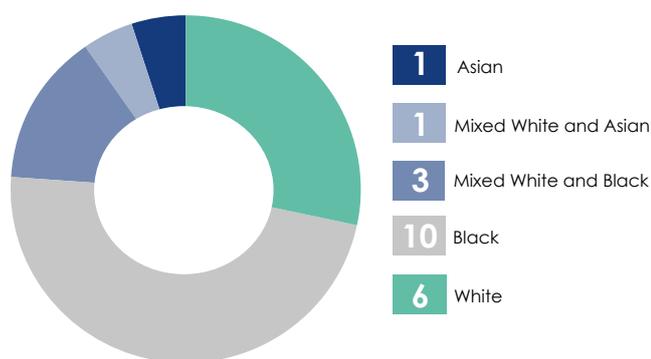
<sup>7</sup> Information on the pool of reviewers can be found at: <https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-pool-of-reviewers>

<sup>8</sup> In one case the child had died in one area but was the responsibility of another area, and a third local authority was also involved. In this case the interview was undertaken by telephone.

# Key findings

### 3. Who we are talking about – common features of the young people in the cohort

Table 1: Ethnicity

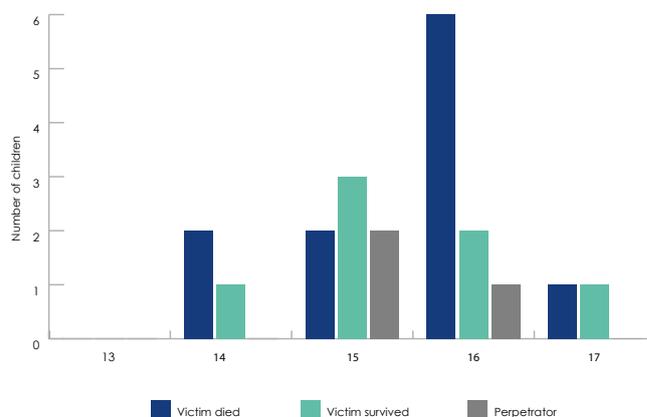


**3.1** The literature review identified a range of risk factors which increase potential vulnerability to criminal exploitation including poverty, abuse, neglect, behavioural difficulties, school exclusions, special educational needs, drug use, children looked after and those with physical or mental health issues. It is of note that in the group of 21 children in the Panel's review, apart from school exclusion, these factors were mostly not present, or not at a level to bring the children to the attention of children's social care or other services. The 21 children did not fit the profile we might have expected, either in terms of demographic groups or individual children's backgrounds. We believe this is important context for further discussion at local and national level.

**3.2** All 21 children were male. Further data and analysis should be collected on this but it is a significant feature to take into account when designing a service response. Only six of the 21 boys were white, so the risk of death or serious harm in our cohort had a disproportionate impact on boys from black and minority ethnic backgrounds.

**3.3** Table 2 details the age of the child (whether victim or perpetrator) at the time of the death or serious incident that prompted the notification to the Panel – although at that point the child may have been involved in criminality or youth violence for some time. Eleven of the children died, seven suffered serious harm, and three inflicted serious harm to others, including – in one case – causing their death.

Table 2: Age



**3.4** The most frequently used weapon in the incident was a knife. During the fieldwork visits the reviewers discovered that a number of the children had been involved in previous assaults (as either victim or perpetrator) where knives were used. We heard that the children felt carrying the knife was for their personal safety, which outweighed any other risk or consequence.

**3.5** In this review, 19 of the 21 children lived at home, most of them with immediate family. Although being a looked after child is regarded as a known risk factor, only two of the children in this cohort were in care. (One because a parent could not cope with her son's behaviour and the other because he was a child seeking asylum in the UK.) When looking at the child's circumstances, we considered whether a decision to look after the child might have kept them safe. From our conversations and our understanding of what the practitioners knew about the child, their attachment to their families and what parents were doing to minimise the risk, we saw no evidence that being in care in the time leading up to the incident would have been a safer option. Indeed, practitioners often cited family as a protective factor.

**3.6** Familial child protection issues were not present in the families (only three children were subject to child protection plans and this was in relation to extra-familial harm). There was evidence of some issues in the families of children in the cohort, including past alcohol and drug use and mental health issues (present in 12 families) and criminality (present in 10 families), but these were not at a level of risk to have triggered concerns to children's social care.

**3.7** Fourteen of the children in our cohort were from families where the parents had separated. They all lived with their mothers, and in some cases, also with a stepfather. In three cases, the boys had experienced an absence of their father in traumatic circumstances (death, deportation, prison).

**3.8** Most of the children were characterised by practitioners as bright, respectful and polite. One child was described as having special educational needs. We often heard words to the effect 'he's very bright but he's putting his skills in the wrong place', as one parent told us. This is not wholly consistent with the findings in the literature review and it is not always the experience of practitioners working in the field.

**3.9** The review did not come to any conclusive findings about deprivation or poverty for this group. There was no common pattern and the boys came from families with working and non-working parents and from a range of areas, not only those with high levels of disadvantage.

### **3.10 Regions and quality of services**

We selected cases from across the country, from both city and shire local authorities. Based on their most recent inspection, Ofsted ratings of the 17 local authorities were as follows:

- six were rated as 'Good'
- nine rated as 'Requires Improvement to be Good'
- two rated as 'Inadequate'.

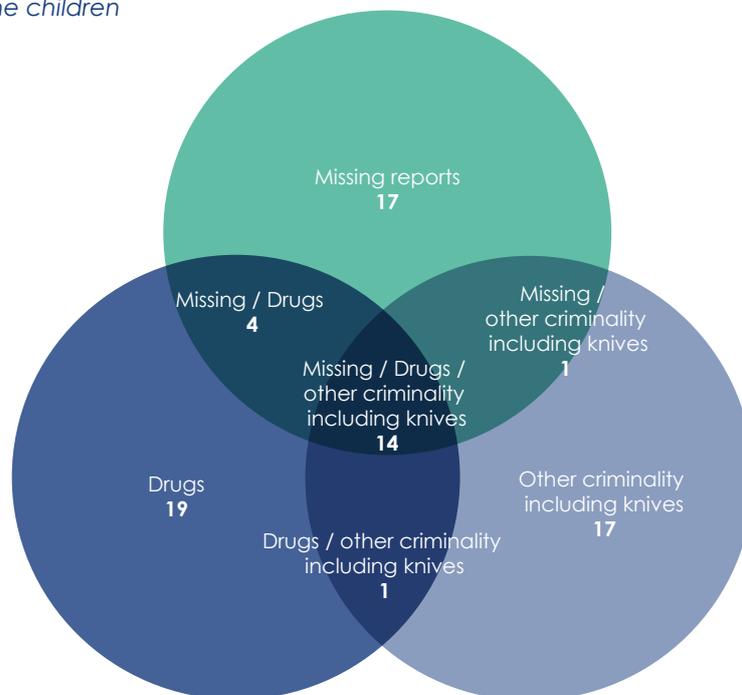
These judgements were made within the last three years and not necessarily at the time of the incident. However, the pattern is not unrepresentative of Ofsted judgements across the country and suggests there was no obvious link between overall quality of service and adolescent harm or death linked to criminal exploitation.

## 4. How do we identify and assess children who are at risk of harm through criminal exploitation?

**4.1** When the reviewers looked more closely at the detailed circumstances of the children in the cohort they found that not all of them came to harm as a direct result of exploitation by a criminal gang. At the time of the incident, 16 of the 21 children were known to be, or believed to be, involved in some sort of group or gang.<sup>9</sup> For 12 of them there was evidence of links to criminal exploitation or being involved in county lines.<sup>10</sup> Agencies had been involved with most of the children in relation to them going missing from home or due to criminality (being found with drugs or a knife).

**4.2** Twelve children were initially referred to the Youth Offending Service in relation to their offending behaviour and became known to other services through this route. A number were then referred on to children's social care for further assessment. Five children were directly referred to children's social care.

Table 3: Vulnerabilities of the children



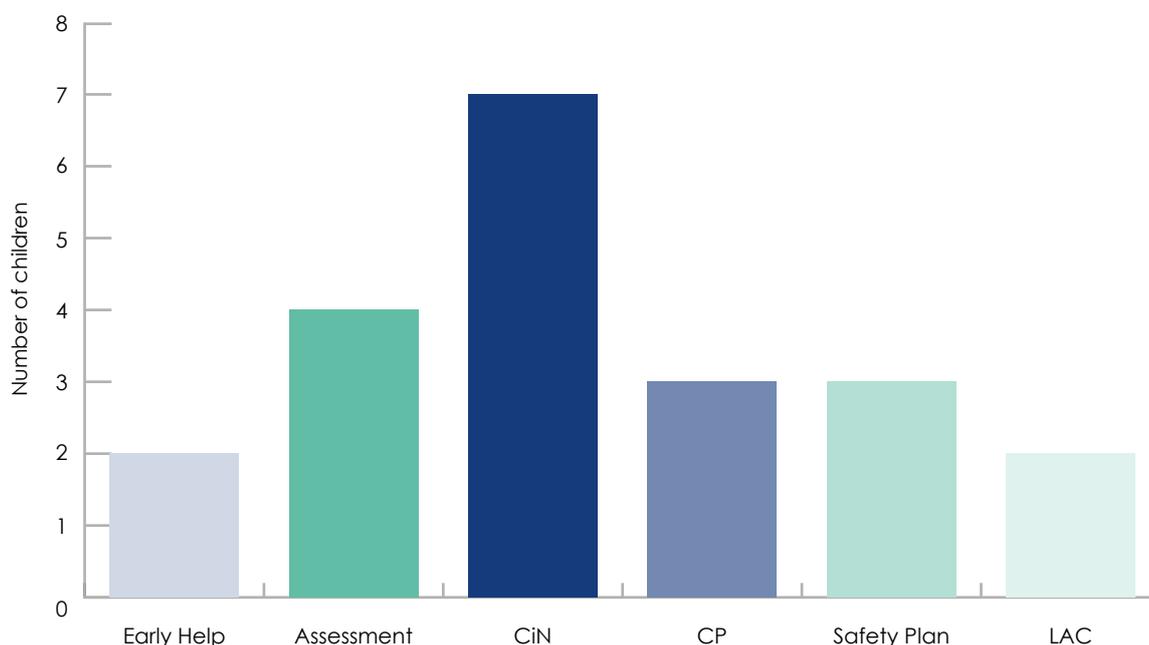
<sup>9</sup> The term 'gang' was used freely in interviews with practitioners and does not necessarily refer to any accepted definitions of gangs.

<sup>10</sup> County Lines is defined in the Serious Violence Strategy 2018 as a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

**4.3** Across the 17 local areas the review looked at, we found a wide range of different practitioners working with the children and at different levels within the system. Some were being supported by early help services, others through children's social care, often as a child in need or as part of a child protection plan. Two young people were looked-after children. We did not find a consistent pattern. As well as an assessment of what was right for the child, local practice and capacity – meaning both the resources available and the quality of the services provided by local partners – were factors in the choice of service. Some of the local areas had a considered approach to working with these children, with investment in services, while others were underdeveloped and did not have clear practice guidelines. Most of the children in the fieldwork cases were involved with a number of agencies. It was common to find engagement with all or some of the following agencies: youth offending service, police, children's social care, Child and Adolescent Mental Health Services (CAMHS) and voluntary organisations.

**4.5** Despite the variation in service categories, the children at risk from criminal exploitation were not difficult to recognise. We saw examples of good practice in the ways local partners shared information and intelligence. Some practitioners knew their local area well and could identify friendship patterns, families who knew each other and school links. In these areas, the practitioners could link children to individuals who were known to have been involved in drug dealing or suspected of recruiting their friends. Such detailed knowledge helped practitioners identify risk early and act on it, both for the child in question and for their peer or family connections. Practitioners also recognised the more obvious signs of criminal exploitation (evidence of drug dealing, unexplained cash or mobile phones, going missing from home and being found in another area) and acted on them.

**4.4** *Table 4: Children's social care involvement*



**4.6** Although it was easy to recognise when a child was being exploited, the detail of their daily lives was much harder to establish and so ascertaining the level of risk and the management of that risk was more difficult. This feature was common for all 21 children. The children were described as guarded and protecting others by not telling practitioners what was happening in their lives. Despite most of the children being described as bright, respectful, likeable and warm, they only engaged with practitioners on a superficial level. Some of the boys were open about not telling practitioners anything, making it clear that to do so would cause them further risk. The phrase used by the children 'you haven't got a clue' was frequently quoted to the reviewers by practitioners.

**4.7** In most cases a considerable number of practitioners were involved with the children (often between four and eight). But from the child's perspective, practitioner involvement might be characterised as being on the surface of their lives. Most of the practitioners, families and children we talked to during the fieldwork said that there was no close and trusted relationship with any of the practitioners. Lots of questions were asked without being able to glean a deep understanding of the complexity and danger within the children's lives.

In one area, the youth offending service team used a youth worker and police liaison officer model to work intensively with a child. The practitioners believed this was effective in getting closer to understanding the child's life but unfortunately it did not prevent his death. Similarly, some voluntary sector partners, youth services workers and gang mentors were able to spend more time with children and to get to know them better. There was evidence of a more relaxed and less formal relationship between these practitioners and the children.

They could be more flexible in their approach, did not have to follow certain processes and were more likely to work outside office hours and in locations closer to the children's communities.

**4.8** In the comparator group of children put forward by the local authorities we visited, we saw more examples of closely managed multi-disciplinary risk management plans with statutory conditions applied as part of court orders. Only a small number of the children who died were being closely monitored in this way. The use of a tag (electronically monitored curfew) which meant the child had to be at home for specified times, usually from 7pm to 7am, was reported by practitioners and parents to be particularly effective. Similarly, children's behaviour could be managed, at least to a degree, by use of strict curfew restrictions including: areas or buildings which the child was not permitted to enter, only being allowed to see one friend at a time, specific named persons they could not see, and not being allowed on public transport without a parent. Such plans demanded a high level of resource and a commitment to multi-agency working to deliver the close monitoring and management and frequent review that is needed. There was variation around the country in such capacity and commitment.

**4.9** Information sharing was cited by practitioners as crucial, particularly soft intelligence from the police. Gangs matrices were often used and there were a number of mapping meetings and frameworks used to share intelligence, understand relationships between individual children and to gain a better understanding of patterns in the local communities. Practitioners felt this was effective in enabling earlier identification of children at risk of criminal exploitation, opening the door to early help for children and families.

## 5. What is the current approach and service response to managing the risk and is it effective?

**5.1** As described in Section 4, recognition of children at risk was not a major obstacle to working with this group. Once identified, finding an effective response to children was much harder to evidence for both the 21 children in the cohort and those in the comparator group. The risk of serious harm to children in this situation is well understood and practitioners and leaders are acutely aware of the dangers they face – and that escalation of that risk can be swift and have serious consequences. However, practitioners openly acknowledge that they are still developing services and interventions which can effectively reduce risk-taking behaviour by children who are subject to criminal exploitation.

**5.2** In this section, we describe some of the more common approaches we saw being taken by local agencies in working with children (from both the cohort of 21 and the comparator group) assessed as being the subject of criminal exploitation. In a later section, we reflect on the efficacy of the current service response and suggest how practice might be developed further.

**5.3** The lead agencies or teams working with children in the cohort were children's services social workers and youth offending team workers. Many areas had also commissioned youth services or voluntary agencies to work with both individuals and groups. Children's services staff took the lead for co-ordinating services in most cases, but while that often involved a significant number of practitioners working with children, few achieved enough depth or trust to influence their behaviour.

**5.4** It is also of note that we heard virtually nothing about work to stop or disrupt the activities of the perpetrators of criminal exploitation. (We saw an exception to this in one of the 'areas of developing practice' we visited – Southend – where a disruption and support plan is developed for each child.) This was a marked difference to the strategies employed by local areas to address child sexual exploitation, where there is often a dual approach to victims and perpetrators. In each of our visits we asked what was happening in the area to tackle the organised crime behind county lines, but very few practitioners knew about any strategies being used. We know tackling county lines and the 'supply gangs' responsible for high levels of violence, exploitation and abuse of vulnerable children is a priority for UK law enforcement and that there is a recently-developed national co-ordination centre. Currently, information is not routinely or consistently shared with those local agencies or departments within policing who respond to the victims of child criminal exploitation. The literature review indicated that a whole system approach incorporating policy, prevention, disruption, protection and support across multiple agencies is likely to be most effective. Our review found a significant gap in the disruption part of that picture.

### 5.5 Relationship with families

When parents and wider family members were actively involved in the risk management plan, we saw evidence of progress. For example, when a father who didn't live with his family took and collected his son from school, the boy's attendance significantly increased. Equally, we saw examples of wider family involvement in enabling children to live with extended family away from their local area where the risk was high. In one area, a family group conference was successful in establishing a shared family plan to manage risk.

**5.6** However, we saw more examples of poor relationships between parents and practitioners. Parents felt helpless to control their child's behaviour, frustrated by the lack of progress, feeling out of control themselves and in some cases wanting a more proactive approach to be taken by the local authority. Practitioners sometimes described parents in these cases as 'not engaging'. This dynamic between practitioner and parent could spiral downwards and create a barrier to effective working.

**5.7** Such negative relationships were caused partly by the agency approach which was perceived by some parents to blame them for the situation. Other parents genuinely felt that the suggested actions would not make a difference and so chose not to participate. In particular, parents reported that they did not see the point of being asked to report to the police that their son was missing every time the child didn't return at the expected time.



**The first one made me feel like I was doing everything wrong, she made me feel small.”**

**Parent talking about a social worker**

**5.8** We saw one example of a small team set up specifically to support parents. This team was staffed by qualified clinicians who understood family dynamics, and whose main purpose was to build an effective relationship. In the case we looked at, the clinician felt she had built a good working relationship with the mother of the boy and that they were beginning to make progress with the family who up until that point had been reluctant to engage. Unfortunately, in this case, this did not prevent the child's death. It is worth exploring whether this approach could have positive outcomes if deployed earlier.

### 5.9 Moving children and families

We found many examples of local authorities facilitating the moving of children and whole families out of the area where the child was considered to be at risk of serious harm and violence. Eight of the 21 children in the cohort were moved. Two were looked after children and the others involved either the whole family moving or the child going to stay with another family member. This was also a strong feature of the comparator group. It was seen as a very effective short-term measure, providing an immediate reduction in risk and a breathing space.

**5.10** However, as a long-term strategy, moving children and whole families was not enough to protect children for a number of reasons. Firstly, two of the children themselves returned to the original areas unbeknown to their families and practitioners and were then attacked and murdered. This confirmed the view that the area was a dangerous place for that young person to be but that simply moving the child or the family does not in itself remove the risk. Communication remains relatively easy through social media and intensive follow up and monitoring is likely to be needed to ensure children do not drift back to those areas.



**I could contact anyone from here as easily as from home. Changing your mindset is what's important, not just moving you out."**

**Child**

**5.11** Secondly, some children became involved in drug dealing in their new areas. Parents reported that initially their children were frightened and stayed home more often than not, but this wore off after a time and old patterns of behaviour re-emerged. Thirdly, moving the family inevitably meant the breaking of relationships with practitioners and changes in school. For some families, it meant younger siblings having to change schools and parents facing problems maintaining employment.

**5.12** None of that negates the short-term benefits of moving a child away from a locality where they are at risk of serious harm. However, a move must be part of a clear and consistent strategy for protecting and supporting that child if it is to have a longer-term impact. Consideration should be given to the needs of parents and siblings so that other important areas in their lives do not deteriorate.

**5.13** Where children's services did wish to move families quickly, liaison with housing departments proved difficult. A number of practitioners felt that local housing policies should be amended to include children at risk of criminal exploitation as a high priority group for rehousing or transfer. One family moved back to the area to prevent the loss of their right to permanent housing. Within months their son was killed.



**We went for three months. It was very helpful for him, but I couldn't work as my work was local to where we lived, and I would have lost my permanent housing – so I decided to come back.”**

**Parent**

**5.14** Some children were assessed as needing care placements to keep them safe in the long term. Where that was necessary, it is of note (and a growing concern nationally) that this review found that suitable, good quality and effective placements for children with this kind of profile are both very hard to source and very expensive when found.

**5.15 Use of the National Referral Mechanism (NRM).** The NRM is a tool for identifying and referring potential victims of modern slavery to the Single Competent Authority in the Home Office so that they can receive the appropriate support. The definition of modern slavery (which covers trafficking and exploitation) means that young people who are being criminally exploited are often referred to the NRM in the hope that it will give them protection. However, our findings from the fieldwork suggest that the NRM's purpose does not always fit well with the circumstances of this group of children.

**5.16** The review found considerable confusion locally about the purpose of the NRM and how it might help. In some areas, there was little or no awareness. Where they knew about it, practitioners saw the NRM as positive in that it treated children as victims rather than offenders and could keep them out of the criminal justice system. However, having a referral to the NRM accepted does not automatically mean that a child will not face criminal charges (depending on the nature and severity of the offence) and there were frustrations among practitioners about the apparent inconsistency in its application by the Crown Prosecution Service and the courts. In some cases, charges were dropped, and in others they were not – but the reasons for these decisions were not clear to local agencies.

**5.17** An unintended consequence of the application of the NRM was the removal of statutory orders which might have been helping to control the child's risk-taking behaviour. For example, a tag was removed for a child as a result of a referral to the NRM being successful. The grandmother looking after the child was concerned because she saw the tag as the only thing that was curbing her grandson's risk-taking behaviour.

**5.18 We recommend that the Home Office, in conjunction with key stakeholders, reviews whether the NRM is an effective mechanism for working with children who are being criminally exploited, both in terms of registering the fact of their criminal exploitation and protecting them from prosecution. In particular, the review should look at:**

- **levels of awareness for those applying to the NRM on behalf of children**
- **consistency of decision making**
- **the impact of positive decisions**
- **any additional controls that could be applied when positive decisions are made**

## 6. Schools and education for children

**6.1** Only four of the 21 children were still on roll at a mainstream school at the time of the incident and three of these were in special units within the school. Only one child had not had at least one fixed-term exclusion and the majority, 17 children, had been permanently excluded or were not attending school.

**6.2** Exclusion from mainstream school and the risks associated with attendance at Pupil Referral Units (PRU) were frequently a source of concern for practitioners and even more so for parents. The literature review identified evidence that PRUs can become an arena for gang rivalries which become dangerous for students and hard for staff to manage. Some parents also felt that PRUs are a place where already vulnerable children get first-hand exposure to criminal activity.



**School is good, they tried to help him, but the PRU doesn't help because of the kids that are there."**

**Parent**

**6.3** Permanent exclusion was seen by practitioners and families as a trigger for significant acceleration of the risk of criminal exploitation. Clearly, exclusion was not the cause of the risk. Risk was already evident and schools were generally working hard to hold on to these boys, even when managing potential risk to peers was challenging. But permanent exclusion was described as a tipping point for these children to encounter greater risk of harm, particularly if alternative provision was not found quickly. Mainstream school, even where things were very challenging, was seen as a protective factor. After exclusion, children were waiting, sometimes for months, for alternative provision and were subject to a lack of daily structure. They were often alone at home while parents were working. We saw examples in the comparator groups when children were placed in a new school very quickly and this was seen as a key factor in keeping them safe.

**6.4** The impact of permanent exclusion on children was a cause of great concern. Parents spoke of their child's feelings of rejection, breaking of friendships and a sense of isolation. They were worried about the loss of peers who might have a positive influence on their sons, and a fear that a placement at the PRU would lead to the likelihood of negative behaviours being reinforced. There were some concerns about the locations of PRUs and that they might be targeted by perpetrators of criminal exploitation. Engagement with parents about placements is crucial.

**6.5** A number of recent reports including the Timpson Review of School Exclusion and Ofsted research on safeguarding children and young people in education from knife crime<sup>11</sup> have highlighted that staying in mainstream education can be a protective factor for children at risk of criminal exploitation. Our intention is not to go over the ground already covered in these reports, but to highlight that at the point of permanent exclusion the increase in risk of harm intensifies for these children and must be matched with a proportionate increase in service response.

**6.6 We cannot emphasise strongly enough the learning from this review about the impact on children of exclusion from mainstream school. Leaders of local safeguarding agencies and head teachers must work together to ensure an immediate response in providing suitable full-time (25 hours) education a week. This is vital in preventing the escalation of risk of harm.**

**6.7** Access to further education was a significant barrier in some areas and not a problem at all in others. In some areas, colleges would not accept children with past offending behaviour because they did not feel they had the capacity to manage the risk to peers. In others, good support was available. In some cases, being unable to access a further education course was regarded by practitioners and families as a significant blow for the child. It was seen to propel them into greater engagement with criminal gangs as no alternative offer was available.

**6.8** A number of areas were able to build relationships with children by use of local resources such as football or music activities. Particularly in the comparator group, practitioners spoke of the opportunities such activities provide to help raise self-esteem and help children feel good about themselves. Access to employment opportunities was also seen favourably by the families.



**He's had a few bad years. It was good having three days at school and two days' work"**

**Parent**

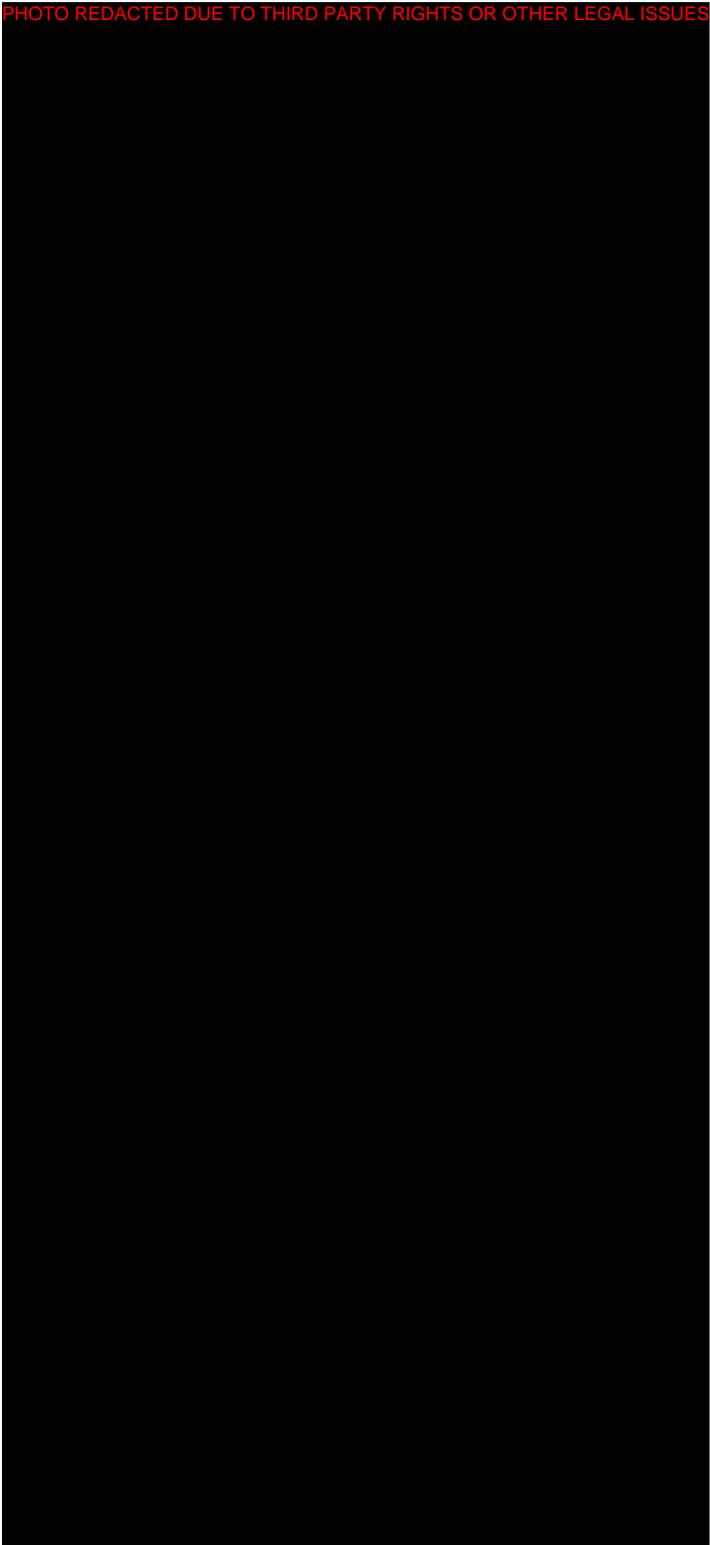
<sup>11</sup> The Timpson review can be found at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/807862/Timpson\\_review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/807862/Timpson_review.pdf)  
The Ofsted research can be found at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/785055/Knife\\_crime\\_safeguarding\\_children\\_and\\_young\\_people\\_110319.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/785055/Knife_crime_safeguarding_children_and_young_people_110319.pdf)

# Reflections and recommendations

On the basis of these findings, alongside discussions with experts in the field, and visits to local areas which are introducing new ways of working with this group of children, this section will focus on reflections and learning points which arise in nine key areas:

- relationships with children
- critical moments
- helping parents and extended families to manage risk
- acknowledging and managing risk
- the child protection framework
- skills and knowledge and the lead agency
- Working Together 2018 and contextual safeguarding
- data collection
- leadership, culture and local partnerships

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## 7. Relationships with children



**You have to build the team around the relationship.”**

**Roundtable participant**

**7.1** A key finding from the literature review was that children who are at risk of, or who are being criminally exploited, require strengths-based, relationship-driven approaches. Building a trusted relationship is crucial to good communication with children – but we acknowledge that it is considerably easier to say than to do. Such children frequently do not want what they see as interference from practitioners. Some of this resistance is based on personal experience, but children also face powerful and persistent pulls away from the agencies that could help them. This is frequently driven by fear of reprisals against them or their families if they fail to repay perceived debts or appear to be ‘snitching’ on associates. These are children who are not easy to reach. Much of their lives are hidden and difficult for us to know (or even imagine) and their need for secrecy is powerful and all-consuming.

**7.2** It remains a frequently and consistently expressed view by those within the safeguarding system and the practitioners we spoke to, that building a trusted relationship is key to any successful engagement with this group of children. It was noticeable that for the 21 children there was very little evidence of significant and trusted relationships with any of the practitioners – even where there was substantial agency involvement and input. We believe that such high-risk situations cannot be managed without good

communication between child and worker and that the most meaningful conversations come within a trusted relationship.<sup>12</sup> Relationship-based practice is increasingly evident in children’s services and the notion that change can be arrived at through the effective use of those relationships is featuring more often in keeping children safe. It is an approach that must be mirrored with this group. Too often children say that agencies are not able to protect them. Agencies have to earn the trust of children if they wish to succeed in protecting them.

**7.3** The building of a trusted relationship does not of course equate to the work falling onto one practitioner’s shoulders – whichever agency they are from. The key concept is of ‘the team around the relationship’, where practitioners from across the system work together to support whoever has the lead relationship with the child. Which agency is in the lead is secondary, but there must be a collective effort to ensure that all those involved are supporting and enabling that relationship. However, local agencies should guard against the tendency to engage more and more different practitioners into the network, especially if they are to have limited involvement.

**7.4 A key learning point for leaders is to ensure that there is sufficient emphasis on relationship-based work and the building of capacity to allow practitioners to have both the skill and time to do this work.**

<sup>12</sup> The Home Office is currently testing ways of building trusted relationships through its Trusted Relationships Fund, drawing on research by the Early Intervention Foundation: <https://www.gov.uk/government/news/boost-for-vulnerable-children-through-trusted-relationships>

## 8. Critical moments

**8.1** There is a concept in systemic theory literature described as a critical moment which changes social worlds. Systemic therapists promote the importance of acting wisely to identify when the words used at a particular critical moment can have a powerful influence on the direction taken after the conversation has ended. In a similar vein, the notion of the teachable moment is well established in education, youth offending and health sectors. They may not happen in the office or between 9 and 5!



**I changed after seeing my mum in tears.”**

**Child**

**8.2** As agencies, we need to find ways of being flexible and responsive enough to be ready to engage in those moments in real time. Days after the event might be too late. Services have to be constructed to be nimble enough to respond in the right moment, in the crisis.

**8.3** We saw a project called ‘Engage’ in Camden that offers a child-centred and child-friendly service at the point at which a child has been arrested. The child often remains in custody for 10 to 12 hours. A worker is available to meet with that child, complete an assessment with them and use it to develop a working relationship with the family, often via a family group conference. We were told that nearly all the children involved in Engage agreed to early help or another intervention and over a third of the families engaged in a family plan of intervention.

**8.4** The voluntary body Red Thread offers a service based in the four major accident and emergency departments across London. They work with children who are brought to hospital at a point when they have been injured. The children are often frightened, might let their guard down and may be more likely to want to change than at other times.

**8.5** There are also other critical moments such as attending the youth court for the first time, or awaiting sentence, or being excluded from school. The challenge to local agencies and partnerships is to identify such critical moments and provide a skilled and flexible response to maximise the chance of influencing behaviour at this time.



**When I was on remand in Feltham I was locked up for 23 hours a day. I had a lot of time to think. Everything bad started happening and I asked myself if I really wanted this. It was awful but it was the reason why I opened up.”**

**Child**

**8.6** The key learning point here is that organisations must be flexible enough to respond immediately to the critical moment when the child is more likely to be open to change.

## 9. Helping parents and extended families to manage risk

**9.1** During the fieldwork, we saw significant resource and energy being directed towards work with the child but sometimes less towards responding to parents' anxiety about their children. This finding from the fieldwork was supported by the literature review, which notes in particular that services may be slow to respond to parental concerns about their child.

**9.2** When parents are active in safety planning and implementation there appears to be a greater chance of success. Many of the young people were facing some level of emotional distress and many found themselves in situations that felt out of their control and were frightening. Some of their resultant behaviour was difficult for those around them to manage. Parents need skilled help in knowing how best to respond to and protect their children in the challenging circumstances they face. Some young people may benefit from a better understanding of the root causes of their own behaviour. This skill set may already be provided by CAMHS, or local safeguarding partners may wish to consider how best to provide alternatives. The offer is likely to require flexibility in approach including a willingness to work outside office hours and office locations. Fundamentally, we need to think differently about how those skills can best be accessed and how they can be of most value to children and their families.

**9.3** We saw one example of parents receiving a skilled clinical service to help them understand adolescent behaviour and how to best influence the direction their children were taking. We also heard about groups where parents could support each other and join forces to address the risk-taking behaviour of their children, one example being the setting up of a WhatsApp group to exchange information about their children's whereabouts. Such groups were greatly appreciated by parents.



**We got to know each other really well. We set up a WhatsApp group, we watched out for each other's kids."**

### Parent

**9.4** We heard of family group conferences being used to develop safety plans and also of one example of a group conference for a number of families. We believe these are promising approaches.



**Report the boy's missing to the police. Put him on Facebook as missing so everyone can look for him. Parents messaging each other is good."**

### **Grandparent**

9.5 The key learning point is that a joint approach between families and practitioners is essential. Leaders should ensure that current frameworks and approaches promote the building of relationships, whole family work and a non-judgemental approach to parents.

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## 10. Acknowledging and managing risk

**10.1** Adolescence is a time of change for all children, part of which is a drive towards greater autonomy. Risk taking is part of the natural progression to adulthood. In adolescence, it affords children new life skills and helps them to develop resilience. In a child protection context, management of the risk of harm and exploitation faced by children is the cornerstone of the work. Understanding the nature and level of risk faced by all children – and particularly adolescents – is key to determining what services should be provided and when.

**10.2** However, an overly interventionist child protection approach to adolescent children can be counter-productive and have the effect of pushing children away from services designed to protect them. Building strong, trusted relationships with adolescents is likely to bring better results in the long-term, but establishing these inevitably takes time. In the interim, agencies and practitioners have to make finely balanced judgements about the risks that the child may still be facing. It is also clearly vital to recognise and address circumstances where there is an escalation of risk, for example when children are excluded from mainstream school (see section 6).

**10.3** There are challenges for national bodies here, in particular the inspectorates. Practitioners and managers told us of their concerns that inspectorates may, either wittingly or unwittingly, push agencies towards a risk-averse approach. This can inhibit the building of trusted relationships, as some practitioners may feel compelled to respond in an over-interventionist way. This is not universally true: some practitioners feel more confident in living with greater risk, and being able to clearly set out and defend, if challenged, the approach that they have taken. As local agencies work towards an effective and consistent approach to risk management for these children it is important that they receive equally consistent advice and guidance from inspectorates. Inspectorates should reflect on this when considering their approach to inspection of services to this group of children.

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**10.4** Of course, there are times when quick and effective intervention is required to protect children, such as those who have been issued with a 'threat to life' warning by the police. We saw from the fieldwork and our visits to areas identified as developing good practice that a comprehensive risk management plan which includes statutory controls can limit the risk-taking behaviour of children. Electronic tags were seen to be particularly effective because:

- they limit the amount of time children are on the streets and accessible to those who are exploiting them
- they allow children to be able to say to peers and perpetrators that they have no choice but to return home at specified times
- criminal gangs may not wish to use children who are so visible

**10.5** Use of tags in conjunction with geographical curfews, limitations on mixing with peers and engagement in training or other meaningful activity can have a positive impact on changing children's behaviour.



**That tag drove him insane! He would run to get home by 7, he flew up the stairs, and then stayed in all night. They dropped the case when he was on the NRM but I would have rather they kept him on the tag. You can keep him on the tag for the next 20 years as far as I'm concerned."**

**Grandmother who was caring for her grandson**

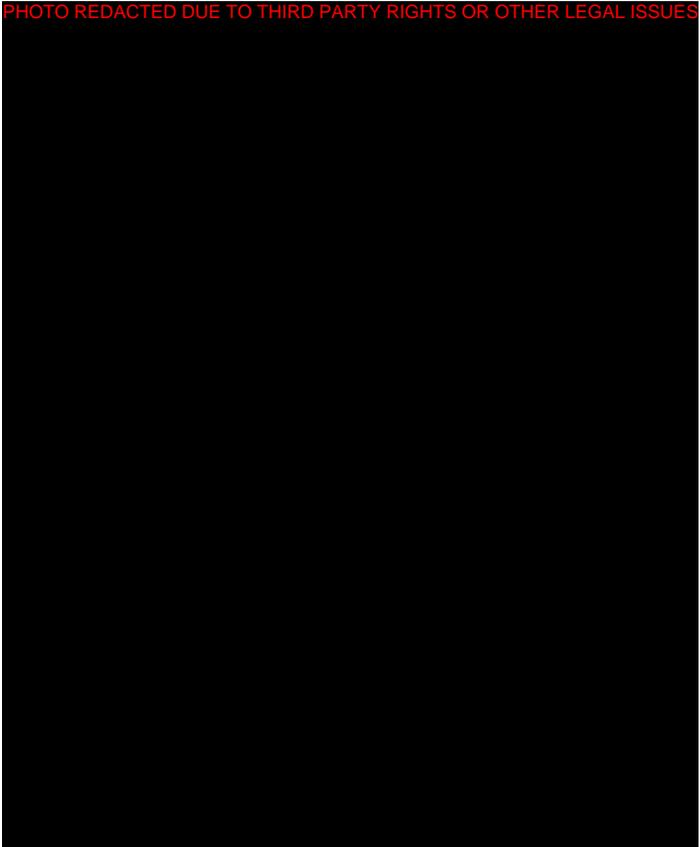
**10.6** A number of areas stressed the need to frequently review and respond to the changing situations of the children. This requires at least daily and sometimes hourly conversations between practitioners and their line managers to enable the agreed response to be tailored and nuanced in response to changing circumstances.

**10.7** This kind of response demands significant capacity, commitment and buy-in from all partners to deliver an effective, flexible multi-disciplinary response. Examples of where such approaches work well are:

- Southend, where the adolescent intervention team offer an 8am to 11pm, seven-days-a-week service. Staff members are able and willing to flex their hours according to the presenting needs of the children they work with.
- Manchester, where the complex safeguarding hub brings together a range of agencies (children's social care, adult social workers, early help services, educational safeguarding, police, probation, youth offending and voluntary sector). A number of these practitioners are physically co-located. The hub team meets every day to review cases and referrals and to share intelligence.

**10.8 The key learning points here are for local partners to look carefully at how individual risk management plans for these children are constructed and whether all local agencies are contributing as needed. They should reflect on how those plans are monitored, and how they ensure they can respond rapidly and flexibly to changing levels of risk.**

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# 11. The child protection framework

**11.1** Should the comprehensive risk management plans used by local agencies be a child protection plan? One of the key themes of our fieldwork discussions has been the extent to which the child protection planning process works for this group of children and these sets of circumstances. We have seen that local areas use different frameworks – child protection, child in need, early help – depending on the presenting needs of the situation.

**11.2** The benefit of the child protection framework is that it is clearly set out in Working Together 2018<sup>13</sup> and is embedded in local practice. Children's social care is the lead agency for risk management and social workers have the skills and knowledge to take responsibility for co-ordinating professional input. The framework benefits from independent chairing, clearly set out decision-making responsibilities, regular and timely reviews, and partner agencies who are familiar with and committed to the process. It also has associated statutory data collection, which allows the system to be held to account. Statutory guidance is followed and decision-making responsibilities are clear.

**11.3** However, the child protection framework is framed around intra-familial threats and the default position for most Child Protection Conferences is to examine and set out what parents need to do to ensure the safety of their child. While parents clearly retain some responsibility for their children's safety, where most of the risk is extra-familial, their experiences of Child Protection Conferences can sometimes feel blaming and unsupportive. If the conference is not chaired well it can lead to a deterioration in the relationship between practitioners and parents.



**Everyone was there to talk about the risk outside the home and everyone else said it was physical abuse, and then the chair said it was my neglect. I felt very judged by her.”**

**Parent**

<sup>13</sup> All further references to 'Working Together' are to Working Together 2018.

**11.4** The formal child protection framework may not always be the best approach to take for children at risk of extra-familial harm. While practitioners and managers generally don't feel that the child protection framework is a barrier in these circumstances, there was an acknowledgement that in some circumstances it didn't facilitate the best interventions. Earlier sections of this report discuss the nuanced decisions required when building a relationship with children and their families, and the importance of applying professional judgement for each individual set of circumstances.

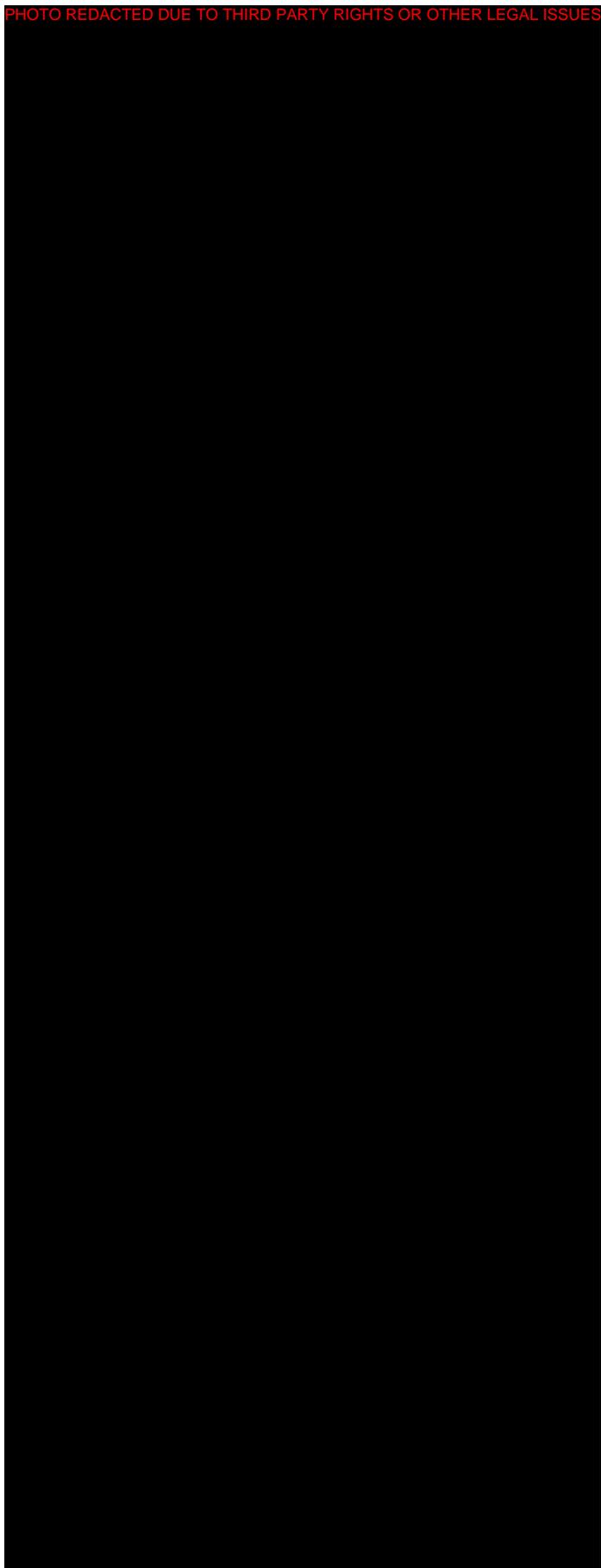
**11.5** The review found that many local authorities are at an early stage of developing their response to children who are at risk of harm due to criminal exploitation. Some are choosing to go down the child protection conference route, and others are taking a less formalised approach. Some areas have developed their own local frameworks for dealing with extra-familial threats, for example, 'disruption and safety planning', 'high risk planning', and 'young person's safety planning'.

**11.6 The learning point is that in all instances a comprehensive multi-disciplinary plan will be the right route as long as it:**

- **reflects the voices and views of the child and the family**
- **is able to flex to meet changing circumstances**
- **clearly sets out agency involvement**

**At this stage, we are recommending that the use of the child protection framework for these children is part of a wider review of Working Together as set out in section 13.**

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## 12. Skills and knowledge and the lead agency

**12.1** We heard a lot about the approach necessary to engage more effectively with this group of children. Services and practitioners who are flexible, able to respond quickly and in the moment, and who focus on strengths and relationships, achieved more trusted relationships with children. We heard about tenacity and persistence as key features of building relationships and of practitioners who are neither rule bound nor role bound.



**Six months ago I felt like I was stuck, it was hard to escape out of it. But I reached out to the social worker. She came to visit me on remand. I really respect her.”**

### Young person

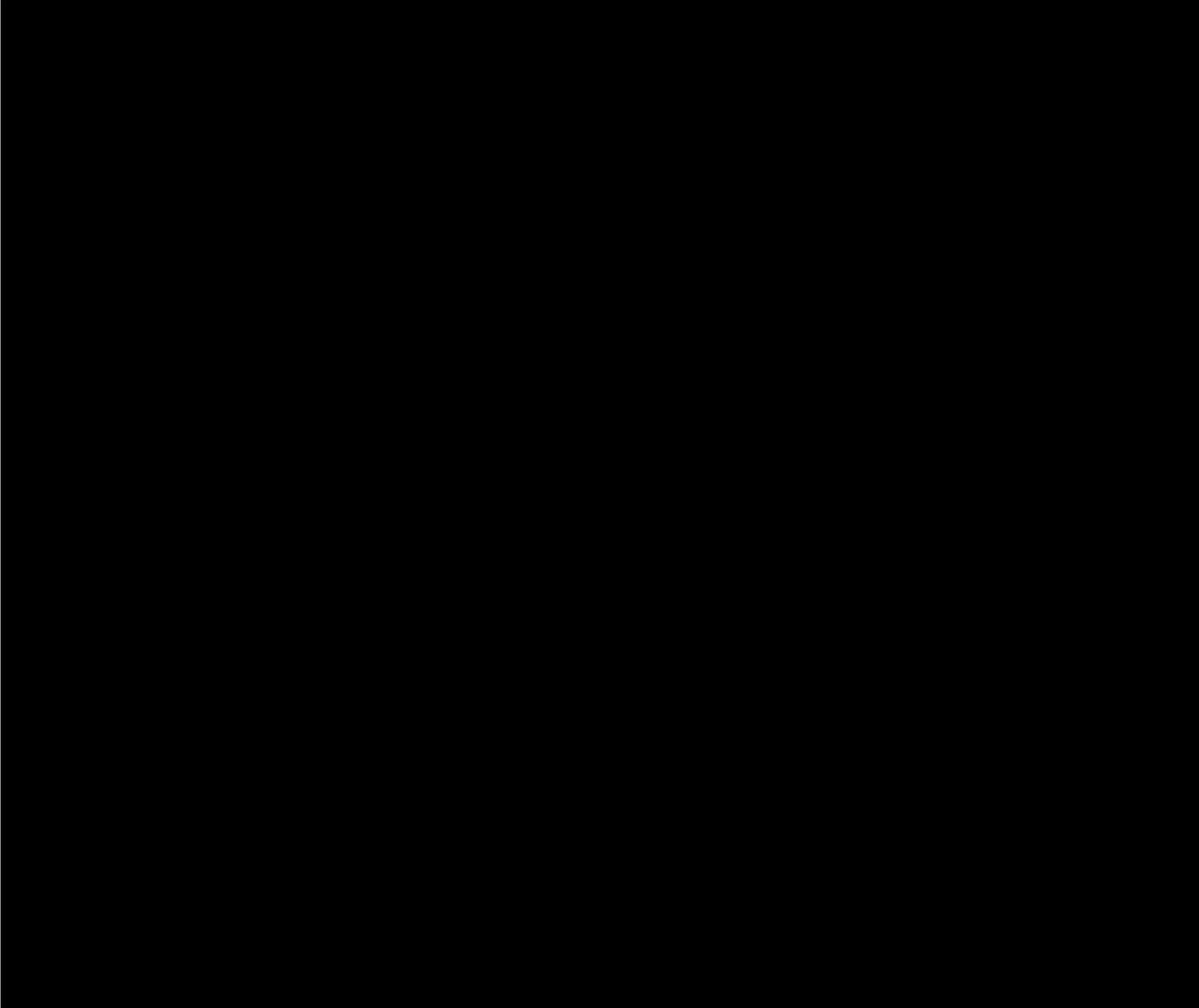
**12.2** Of course it is also important that practitioners have the skills to help children to change, acting with authority, clarity and purpose. Motivational interviewing is an approach that has been robustly tested and there is increasing interest in using the technique in public health and clinical settings. The focus on igniting and intensifying the recipient's internal motivation for change seems highly appropriate in the light of what we heard about these children. It is an approach that could be considered more widely.

**12.3** A theme that featured strongly in the review was the role of children's social care in working with children and families where the threat of serious harm comes from outside the family. We recognise there is an ongoing debate about this issue and how well the statutory framework can flex to support social workers to work with children and families facing extra-familial abuse and exploitation from the wider community. We saw good practice from some of the social work teams who worked alongside partners to provide a strong package of support for children and families. We also heard from a number of parents that they were more confident about the support and interaction provided by youth workers and youth offending teams than they were with social workers and the police. We saw that there was more potential for an adversarial relationship between children and families with police and social workers than there was between children and families and youth workers and youth offending teams. This in part is due to perceptions about the role social workers and police play, with more trust afforded to those working in youth services. Youth offending teams and youth workers tended to have more skills and experience in working specifically with adolescents. The reviewers frequently heard from parents that they had high regard for the staff in youth offending teams.

**12.4** On the other hand, there was an equally powerful view that criminal exploitation is a child safeguarding issue and the responsibility and remit of children's social care. It is in the assessment and management of the risk of harm, which can be uncertain at times, that expert social work skills and experience are required to work with families and other agencies to achieve the best outcomes for children.

**12.5** For these reasons, our view is that the lead agency co-ordinating support for families and children and managing the nature and level of risk should be children's social care. They should do this within a clear multi-disciplinary framework locally which sets out accountability and roles and responsibilities. Above all, local agencies need to be clear on the skills and knowledge needed to make effective interventions with children and families and the community.

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## 13. Working Together 2018 and contextual safeguarding

**13.1** For the purposes of this review, we are using the term 'contextual safeguarding' to refer to the model developed at the University of Bedfordshire.<sup>14</sup> Members of the review team visited Hackney as the main development site of contextual safeguarding. We are also aware that a number of other areas are now working with the University of Bedfordshire to develop similar practices and responses in their areas. The contextual safeguarding work in Hackney is due to be formally evaluated by the University of Sussex over the next two years, and Coventry University is similarly evaluating work underway in Ealing. It would be wrong therefore for this review to comment in too much detail in advance of those evaluations.

**13.2** However, it is clear that the response to children who are at risk of significant harm and exploitation from within their communities must be formulated in the light of that wider context. It cannot be solved by focusing on the family unit alone. Work to develop effective ways of working at a community level should continue and we should recognise that this may challenge the current approach from local agencies and require a deeper look at the skills required in multi-disciplinary teams. Consideration of the approaches needed from different agencies – both individually and collectively – to understand context and deliver interventions successfully is an important element to build into this work.

**13.3** Referring concerns relating to a number of children rather than an individual is a challenge to the more traditional route into social care. There are issues about parental consent and about how children's social care implements the current legislative and statutory requirements around the process for assessment as set out in Working Together. We believe that the current narrative and requirements in Working Together are not clear enough about how the guidance should be applied to children who are subject to risks from outside the home.

**13.4** We are aware that Working Together was constructed before the nature and complexity of extra-familial risks were fully understood. This report will add to the growing body of knowledge in this area. At this stage, we do not think it right to attempt to set out specific changes to be included in the next iteration of Working Together. However, we believe that while the sector is still working through best practice responses, the areas set out below need to be considered as part of any re-working of the guidance and that work should begin immediately.

<sup>14</sup> Further information on the contextual safeguarding model can be found at <https://www.contextualsafeguarding.org.uk/en/about/what-is-contextual-safeguarding>

- In Chapter 1 of Working Together, paragraphs 33 to 34 set out some of the issues relating to extra-familial harm. Paragraphs 35 to 37 go on to describe the circumstances of those subject to Channel panels and the impact of the Counter-Terrorism and Security Act 2015 on safeguarding. It is our view that in future, Working Together should make explicit the difference between 'contextual safeguarding' as a very specific approach developed by the University of Bedfordshire and the more general issues associated with extra-familial harm. They are not the same.
- Paragraphs 38 to 52 cover the nature and focus of assessments required to best understand the needs of a child and their family. It will always be the case that the needs of individual children must sit at the heart of any assessment. But understanding the complexity of the wider relationships for those children who are subject to criminal exploitation needs further consideration within the assessment process. It is also important that the text recognises the time that may be needed in developing that understanding and the relationship with the child or (in some cases) group of children.
- Pages 46 to 52 of Working Together cover the commissioning and conduct of child protection conferences. It is not our view that a uniform model of planning should be imposed. We know many local areas are using these processes flexibly to meet the needs of the individual circumstances. However, it is our view that models of multi-agency planning should be explored and examples of best practice evaluated and disseminated appropriately with a particular focus on the engagement of parents and wider family members.

### **Multi-agency safeguarding arrangements and reviews**

**13.5** There is a duty on local authorities to notify the Panel of child safeguarding incidents in their area involving serious harm to, or death of, a child. This Panel has seen different interpretations of that duty, in particular in relation to children where extra-familial harm is the key feature. It is our view that the government should consider how it can strengthen guidance to ensure that all local areas understand when and how to notify a serious incident and how they review and learn lessons from any local safeguarding practice review where extra-familial harm is a feature.

**13.6 We recommend that government moves at pace to review Working Together. The Department for Education should bring together the relevant stakeholders to explore how best to ensure the narrative and requirements of Working Together reflect the risk of harm from outside the home, with a view to agreeing amendments to the current guidance.**

## 14. Data collection

**14.1** The literature review highlighted that there is a lack of reliable data which can tell us about the extent of criminal exploitation in different areas. There is no systematic data collection about children who are at risk of harm as a result of county lines and drug dealing. There is also no accurate national mechanism to know the size of the problem, or whether it is growing or reducing. Furthermore, the issue of arriving at genuine outcome measures is difficult in all child protection work and none more so than in this area.

**14.2** It seems to us completely incongruous to state that criminal exploitation (and the wider range of extra-familial risks) represents one of the most significant challenges to our children and to those agencies who are responsible for their safeguarding and yet nationally we remain unaware of the numbers and characteristics of those involved. Many, but not all, of the local areas we visited are developing their approaches to collecting this information. We believe this must also be addressed at a national level.

**14.3** In section 17, we set out a series of challenges to local safeguarding partners that we believe they should be tackling head-on. The first is an expectation that they know the size and nature of the problem in their area. Most areas are now able to report on the numbers of children subject to and at risk of sexual exploitation. The need is to replicate that for those children subject to criminal exploitation.

**14.4** Simply counting them will not be enough. There is a need to better understand their histories and family backgrounds. We are also aware that the networks of both victims and perpetrators are often complex. The need to map those networks and to understand them both systemically and geographically is, in our view, crucial to ensure interventions are well targeted. It also enables practitioners to more fully understand the lives of the children they are working with and therefore aids in building the trusted relationship.

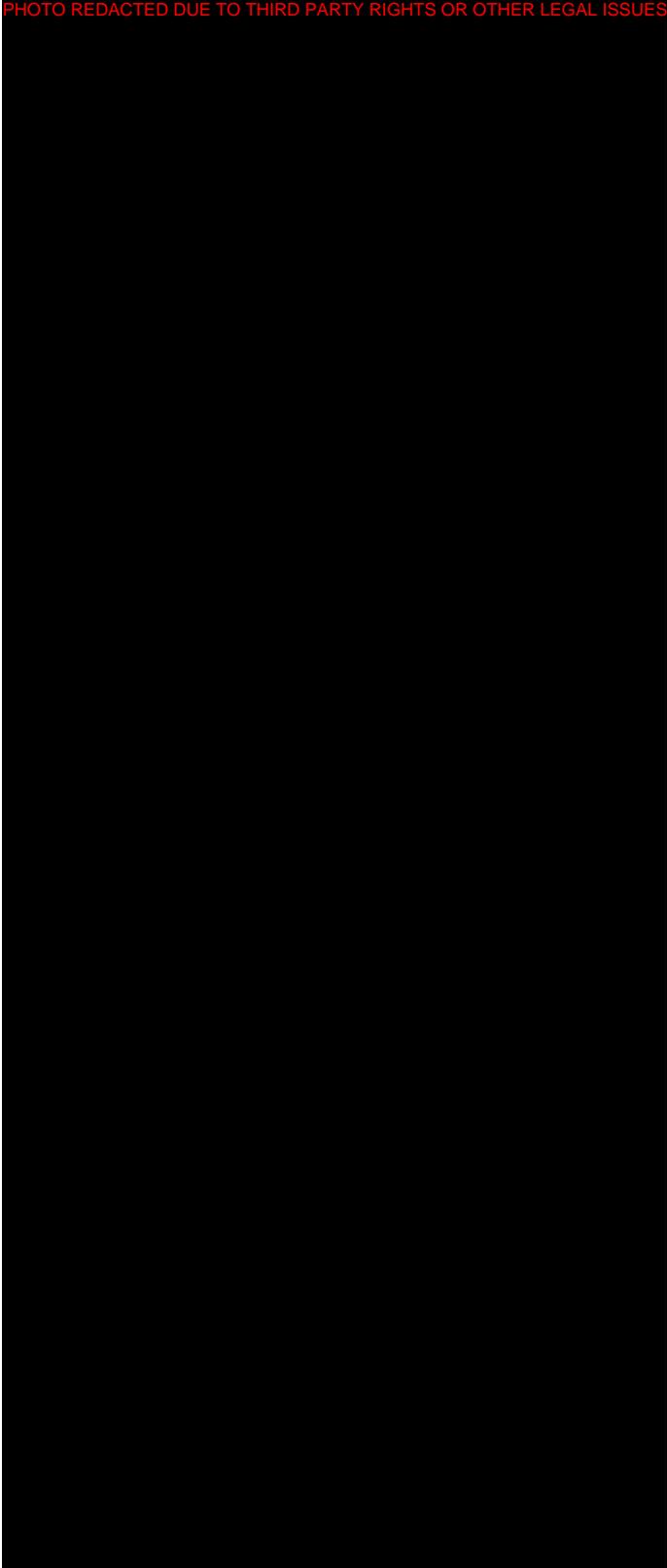
**14.5** Many local areas have developed their mapping activity. We saw good examples both in the fieldwork areas and in the areas of developing practice we visited. To give just one example, Wiltshire has appointed a specialist data analyst and can now generate informed and informative maps setting out how different children and groups of children are involved with each other. Local partnerships are able to highlight geographic hotspots where children are recruited and where there are threats of exploitation. This focuses the work of the operational teams, aids disruption work and makes it easier to engage specific local agencies (such as schools) in the work.

**14.6** We believe there needs to be a national response to aggregating data. We know a lot about children in need, children subject to child protection plans and even more about children in care (by area, by region and nationally). Some of what is reported on is counting the numbers – number of children, gender and ethnicity breakdown, categories of risk – while other data offers commentary on performance: repeat and lengthy protection plans, reviewing timescales, placement moves, health and education outcomes.

**14.7** We are anxious not to promote the collection of unnecessary and unhelpful data and add to the burden placed on agencies in this regard. However, it is our view that an essential prerequisite for continuing to respond to the needs of this group of children is coherent data collection that can define the size and nature of the problem locally, regionally and nationally. We believe the relevant data will mostly be held by the police and local authority children's services.<sup>15</sup>

**14.8 We recommend that joint work is undertaken by the Department for Education, the Home Office, the Department for Health and Social Care, the Youth Justice Board, the Association of Directors of Children's Services and the police to agree a simple dataset for local collection, which can be incorporated into existing national data collections. The purpose would be to identify the extent, particular features and changing trends and patterns in relation to the criminal exploitation of children.**

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<sup>15</sup> The recent Home Affairs Committee report on serious youth violence also points to the lack of national data on the numbers of children at risk of involvement in serious youth violence <https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/1016/1016.pdf>

## 15. Leadership, culture and local partnerships

**15.1** The key to effective safeguarding lies in the quality of the local leadership, the culture those leaders develop within and between their organisations, and the effectiveness of joint working both on the ground and strategically.

**15.2** It is clear from our fieldwork that examples of more effective practice have been led, enabled and developed by local leaders willing to find different and creative ways of addressing what can often seem a set of intractable problems. They have understood that the threat of criminal exploitation of adolescent children is something both potentially overwhelming and outside the routine range of safeguarding work and that it requires a different set of responses.

**15.3** There is learning from this report which will need to be taken forward nationally. However, there is much in what we have seen from the scrutiny of the children's circumstances and the practitioners we have spoken to that can and should be addressed locally. All areas will have now moved to their new multi-agency safeguarding arrangements. All areas continue to host adult safeguarding boards and many have retained community safety partnerships. It is clearly a matter for those local agencies and partnerships to decide how and where this work should be best driven and where accountability lies.

**15.4** The review also heard about the need for and the benefits of tackling some of these problems sub-regionally and regionally. Victims and offenders move across borough boundaries, families and extended families can live in different authority areas, and police forces (and health bodies) can cover a number of different local authorities. There needs to be some uniformity of approach to maximise effectiveness, especially when children and their families are sometimes moved out of their area to places of safety.

**15.5** It was not the subject of this review because of the age of the children in the cohort but a number of professionals we spoke to talked about the vulnerability of individuals aged over 18. Once the adolescents turned 18, children's services were no longer involved (unless the young person was in care). Those young people continue to be at very high risk of harm and yet do not always receive the same level of attention from services. If a trusted relationship has been established, there may be some flexibility for continued working over a transitional period. It is suggested that Safeguarding Adults Boards consider their interaction with the local child safeguarding partners and how local services should respond to young adults who are at risk of criminal exploitation.

## 16. Local learning points

**16.1** Rather than a long list of recommendations, we have chosen to highlight important local learning points from the review. We then go on to make four national recommendations, which we believe will provide the necessary structural support for change.

**16.2** No local area or safeguarding partner can afford to disregard the extra-familial safeguarding risks experienced by children. It might be more prevalent in some areas than others, but it exists to some extent everywhere, and local agencies need to respond quickly and effectively. We know there is a considerable amount of policy and service development in this area and we further acknowledge the pressures on safeguarding partners and relevant agencies' budgets. There is a sense that there is a pressing need to find the 'right' solutions and an equally pressing need to be able to invest in them as needed.

**16.3** We recognise that many safeguarding partnerships are already constructing their responses to the issues, although some are further ahead than others. Through this review, we have identified a series of questions and challenges in four key areas that we believe every partnership should be working on and be able to answer.

### 1 Problem identification

- Do you know the size and nature of the problem in your area?
- Do you know which are the most vulnerable neighbourhoods and community spaces?
- Which children are predominantly affected in your area? Are they all boys? Are BAME children disproportionately affected? What is your response to your local dynamics?

### 2 Supporting your staff

- Do you know the levels of risk your front-line staff are routinely managing?
- Do you know how well they are supported and supervised in this work?
- Have you articulated an approach to risk management that is shared across all agencies?

### 3 Service design and practice development

- Are your services flexible enough to respond to the critical moments in children's lives?
- Is there sufficient emphasis on relationship-based work and on the value of trusted relationships?
- How are individual risk management plans for these children constructed? Are all local agencies contributing as needed?
- Are risk management plans regularly monitored to respond to changing levels of risk?
- How well are families being engaged in the joint protection of their children?
- How is the balance between understanding these children as both victims and perpetrators understood locally?
- Are adult and children's services working together where needed?
- Are you satisfied with the approach in your local area to prioritising housing for families who face a serious threat as a result of criminal exploitation?
- What is the pattern and trend in school exclusions? What is the nature of alternative provision available?
- Is there a sufficient focus on disruption of criminal activity as well as support for victims?
- How well co-ordinated are you with your neighbouring partnerships? If your police service covers more than one area, are you as integrated with those other areas as possible?
- Are you confident that information follows children and families who are moved out of your area for their own safety and that there is continuity of support?

### 4 Quality assurance

- How are your independent scrutiny arrangements focused in this area of work?
- Have you developed a sense of what 'good' looks like in this work?
- Are the voices of children and their families helping inform your responses and your quality assurance?

## 17. National recommendations

**This review makes four national recommendations we believe will help to improve the context for the continuing development of services to this very vulnerable group of children.**

### 17.1 Recommendation 1: Trial a practice framework which can respond to children at risk of serious harm from criminal exploitation.

The Department for Education should fund and evaluate a trial of a practice framework. This should involve sufficient areas and be of sufficient length to be able to measure meaningful outcomes. Key features of the practice framework are set out below.

**17.2** As we have stated throughout this report, local leaders are acutely aware of the levels of risk faced by children in this group. Some are taking a whole-system approach which comprises, for example, prevention and early intervention strategies, work with local communities and schools, and introduction of contextual safeguarding processes. We commend the commitment and dedication of local leaders to make some headway in protecting this very vulnerable group of children.

**17.3** We are aware of a significant number of initiatives and funding sources which have recently come on stream with a focus on criminal exploitation of children. These include a long list of Home Office initiatives<sup>16</sup> which incorporate a huge range of activities designed to reduce youth violence, for example:

- changes to the law regarding weapon possession
- extension of police powers
- the establishment of national bodies such as the National County Lines Co-ordination Centre

- raising awareness in schools
- summits, strategies, high-profile roundtable discussions

The number of initiatives reflects not only the huge levels of concern of both national and local leaders, but also our lack of an evidence base about effective responses to children at very serious risk.

**17.4** There are newly funded projects addressing serious youth violence which are supporting new multi-disciplinary approaches and ways of working with this group of children. As an example, the list of successful bids to the Early Intervention Youth Fund<sup>17</sup> outlines a variety of teams and projects to work specifically with this group as well as broader prevention and awareness raising projects.

**17.5** Similarly, the newly established Youth Endowment Fund, whose overall aim is to prevent young people getting drawn into crime and violence, is sponsoring different approaches with this group. The fund has recently announced grants for a variety of projects, some of which will be subject to evaluation to establish their effectiveness. The projects include both prevention, early intervention and work with children and their families when they have already become involved in offending and knife crime. The first round of grants<sup>18</sup> includes some projects which will test out different models of intervention, for example trauma informed approaches, cognitive behavioural therapy and multi-systemic treatment.

<sup>16</sup> <https://homeofficemedia.blog.gov.uk/2019/06/18/what-is-the-government-doing-to-tackle-violent-crime-2/>

<sup>17</sup> <https://www.gov.uk/government/publications/early-intervention-youth-fund-successful-bids/early-intervention-youth-fund-successful-bids-2019-20>

<sup>18</sup> <https://youthendowmentfund.org.uk/wp-content/uploads/2019/10/Details-of-YEF-first-grantees-.pdf>

**17.6** We have examined these various initiatives and none is in conflict with our findings. Some are more closely aligned depending on the specificity of the project, others are much broader. However, we would want to emphasise again the practice focus of this review and the particular response required to help and protect children who are at very serious risk of harm from criminal exploitation. Having identified that a child is at very high risk, what could be done to work with the child and their family to reduce the level of danger they face?

**17.7** This review has given us some clear indicators of what could work. The features of a service response which could incorporate these lessons are described below. Such a response would need to be properly evaluated, looking at both service design and the skills and knowledge practitioners need to work effectively with these children.

### **17.8 Key features of a practice model to respond to children at risk of serious harm from criminal exploitation**

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

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

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

**17.8.4** Members of the team who can work closely with parents and provide dedicated support to help them manage the risk in a way which is perceived to be supportive and empowering. Family group conferences and group work with parents are a strong feature of this work.

**17.8.5** Use of a shared practice model which is known to be effective, such as systemic practice. The seven features of practice described in the evaluation of the Innovation Programme outline the key factors which have been found to be associated with positive outcomes.<sup>19</sup>

<sup>19</sup> Seven key features of an effective practice system:

1. Using a clear strengths-based practice framework
2. Using systemic approaches to social work practice
3. Enabling staff to do skilled direct work
4. Multi-disciplinary skill sets working together
5. Undertaking group case discussion
6. High intensity and consistency of practitioner
7. Having a whole family focus

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

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

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

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

### **17.9 Recommendation 2: Changes to Working Together and inspection regime**

We recommend that government moves at pace to review Working Together. The Department for Education should bring together the relevant stakeholders to explore how best to ensure the narrative and requirements of Working Together reflect the risk of harm from outside the home, with a view to agreeing amendments to the current guidance.

### **17.10 Recommendation 3: Improve the working of the National Referral Mechanism**

We recommend that the Home Office, in conjunction with key stakeholders, reviews whether the NRM is an effective mechanism for working with this group of children, both in terms of registering the fact of their criminal exploitation and protecting them from prosecution. In particular they should look at:

- levels of awareness for those applying to the NRM on behalf of children
- consistency of decision making
- the impact of positive decisions
- any additional controls that might need to be applied when positive decisions are made

### **17.11 Recommendation 4: Data collection**

We recommend that joint work is undertaken by the Department for Education, the Home Office, the Youth Justice Board, the Association of Directors of Children's Services and the police to agree a simple dataset for local collection, which can be incorporated into existing national data collections. The purpose would be to identify the extent, particular features and changing trends and patterns in relation to the criminal exploitation of children.

## 18. Conclusions

**18.1** This review is centred on the circumstances of 21 children who were either killed or seriously harmed and where criminal exploitation was potentially a factor. Since the review began, we know more children have been harmed or killed (we have seen over 30 more potential cases since April 2019) and yet more have been brought into a world of risk and danger by cynical and calculated criminals.

**18.2** As we have referenced in this report, there is already considerable work underway in this area and investment in initiatives designed to reduce the risks we have highlighted. The level of understanding about the size and nature of the risk is developing all the time. We hope that the insights within this review will be added to that growing body of knowledge.

**18.3** We do not pretend that we have the answer to this complex and complicated safeguarding issue. Our collective response to the challenge must be to recognise and then respond to the complexity within it and ensure that, as agencies, parents and carers, we work together to protect our children from what are often unimaginably dangerous circumstances.

# Appendices

## Appendix A: Fieldwork report

This brief report summarises the information about 21 children from the 16 fieldwork visits and one phone call. This report does not seek to repeat all the findings contained in the main report.

### Areas

The local areas visited were based on the sample of children as described in the main report. In alphabetical order:

- Barking and Dagenham
- Bedford (two children)
- Bristol
- Cheshire East
- Croydon
- Devon
- Durham
- Hammersmith and Fulham
- Kingston (two children)
- Lambeth
- Newham (two children)
- Norfolk
- Oxfordshire
- Thurrock
- Tower Hamlets
- Waltham Forest
- Wolverhampton (two children)

### Children

Table 1: Ethnicity

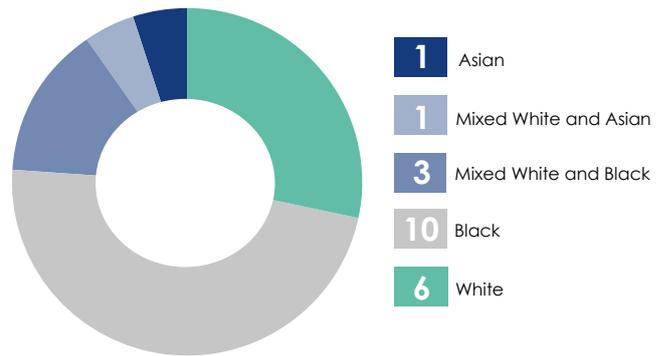


Table 2: Age

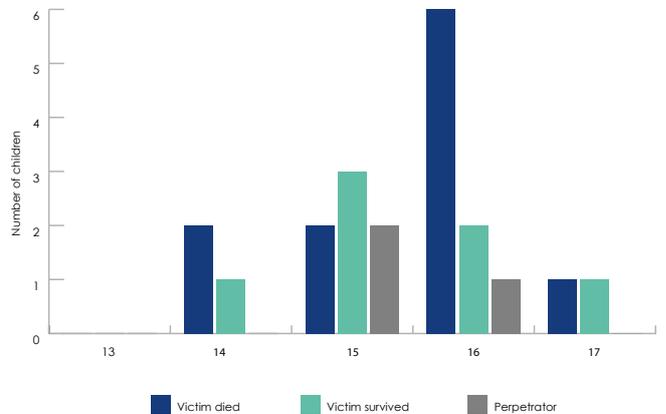


Table 3: Weapon used

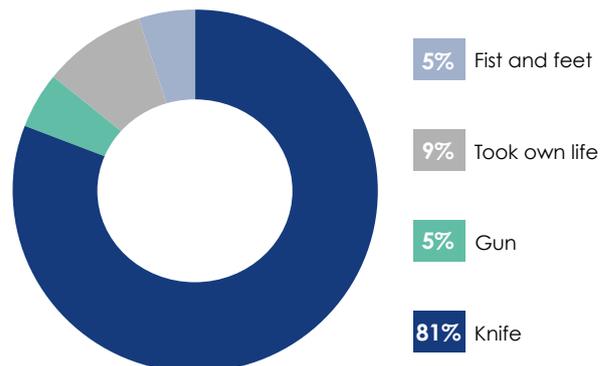


Table 4: Vulnerabilities of children

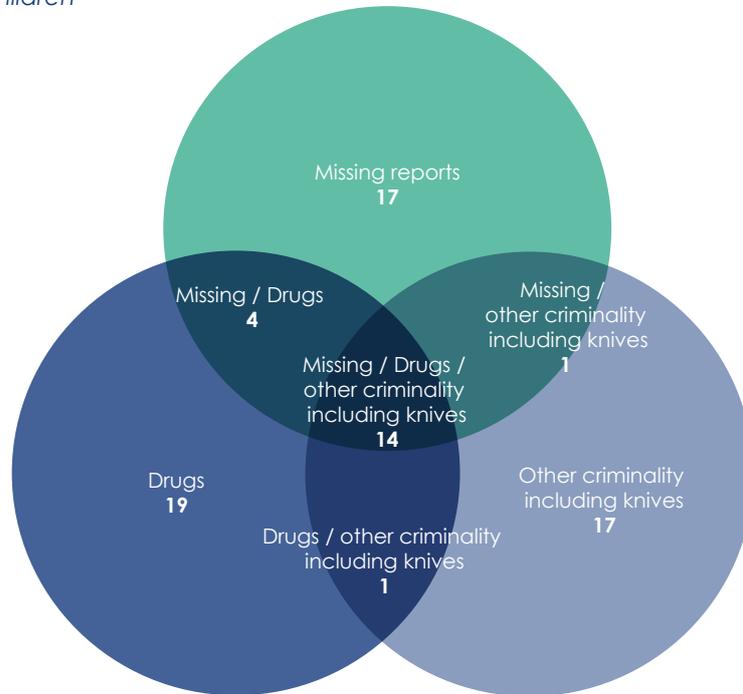
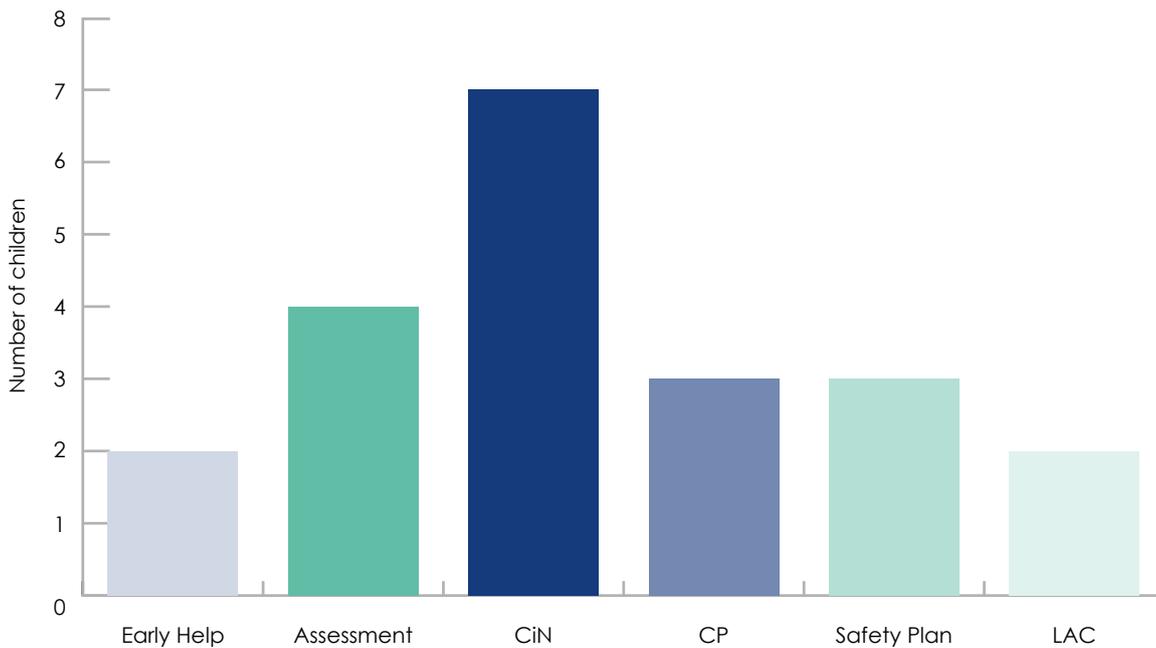


Table 5: Children's social care involvement



## Referral route

Referred to Youth Offending Services Offences included robbery, carrying a knife or offensive weapon, drug possession, gang activity	<b>12 children</b>
Referred to early help or children's social care by parents	<b>2 children</b>
Referred to children's social care by other professionals concerned about gang activity or county lines involvement	<b>2 children</b>
Referred to children's social care following an injury from an attack	<b>2 children</b>
Looked after child – parents unable to cope and an asylum seeker	<b>2 children</b>
Limited involvement with services and no recent referrals	<b>1 child</b>

## Links to drug dealing and criminal exploitation

Strong indications of a link to county lines such as being found with large quantities of drugs on their person in areas not local to their homes, or frequent change of phone numbers	<b>12 children</b>
Links to gangs but more territorial rather than county lines	<b>4 children</b>
The incident appeared to be more of a random stabbing in a fight, or in another case to do with a row about a girlfriend, or a careless act	<b>5 children</b>

## Appendix B: List of those consulted

As well as our fieldwork, during the review we spoke to a number of experts and academics in this field, and visited some areas developing promising practice. We are grateful to all those who gave their time to help us think about these complex issues and how best to safeguard children at risk from criminal exploitation.

### We held a roundtable event with representatives from areas developing innovative practice and organisations with expert knowledge:

Bradford  
 Ealing  
 Camden  
 Hertfordshire  
 Islington  
 Kent  
 North East Lincolnshire  
 Oxfordshire  
 Sheffield  
 Wiltshire  
 Association of Directors of Children's Services  
 The National Working Group  
 St Giles Trust  
 NSPCC  
 The Metropolitan Police service  
 The University of Bedfordshire

### We had individual meetings with:

Simon Bailey: Chief Constable for the Norfolk Constabulary and NPCC lead on child protection  
 Carlene Firman: The University of Bedfordshire  
 Dez Holmes: Research in Practice  
 Annie Hudson: Strategic Director – Children's Services Lambeth  
 Florence Kroll: Director of Children's Services Greenwich  
 Alice Miles: Office of the Children's Commissioner  
 Richard Smith: Metropolitan Police Service  
 Yvette Stanley: Ofsted  
 Charlie Taylor: Youth Justice Board  
 James Thomas: Association of Directors of Children's Services

### The areas of developing practice we visited were:

Manchester Complex Safeguarding Hub  
 Hackney  
 Lambeth  
 Southend

**In addition, Richard Smith (Metropolitan Police Service) kindly organised a multi-agency London focused roundtable, to explore developing practice in the capital, attended by:**

Liz Balfe, National Co-ordinator for Health

Phil Brewer, Metropolitan Police Service

Nicky Brownjohn, NHS England

Carlene Firmin, University of Bedfordshire

Paul Furnell, British Transport Police

Dave Musker, Metropolitan Police Service

Lorraine Parker, National Co-ordinator for Policing

Martin Pratt, Association of London Directors of Children's Services

Jenny Shaw, Home Office

Richard Smith, Metropolitan Police Service

Sharon Stratton, College of Policing

Laura Watson, Home Office

