

What this review is about & background

A Child Safeguarding Practice Review (CSPR) was undertaken following two serious youth violence incidents in Oldham in 2024, involving three adolescent boys. A 17-year-old was attacked in the street and sustained life-threatening injuries, while in a separate incident a 14-year-old was stabbed at a home address and would likely have died without rapid medical intervention. A 16-year-old witnessed the attack and attempted to save his friend, which had a significant emotional impact on him

Commissioned following Serious Incident Notifications and Rapid Reviews, the cases were combined into one thematic review due to shared patterns of trauma, vulnerability, and risk. The review follows Working Together 2023 and focuses on learning and system improvement, not blame, examining how agencies identified risk, worked together, and how safeguarding can be strengthened.

Reflective Practice – what this means for you

Practitioners should consider:

- Do I understand the impact of trauma and adolescence on this young person’s behaviour?
- Am I seeing them as a child at risk, not just a risk to others?
- How well am I working with other agencies to build a full picture?
- Are we acting early enough, or responding when risk escalates?
- How can I strengthen relationships, trust, and engagement?

What are we doing about it

Serious Youth Violence is being recognised as a strategic safeguarding priority for Oldham Safeguarding Children Partnership, with work underway to strengthen violence reduction and partnership approaches.

Through the Complex and Contextual Safeguarding Subgroup action plan, partners are developing a joint SYV strategy, establishing a dedicated multi-agency forum for at-risk adolescents, improving data sharing and intelligence, embedding trauma-informed and adolescent-focused practice, and strengthening oversight of education placements.

There is now an alternative provision specialist taskforce, led by Kingsland PRU. Driving a coordinated intervention and a reduction in youth violence from youth justice, social care, attendance and behaviour.

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What we see in these cases

All three young people experienced:

- Trauma and adversity (domestic abuse, loss, instability)
- Neurodiversity and/or mental health needs
- Educational disruption (exclusions, reduced timetables)
- Exposure to risk outside the home (violence, exploitation, peer groups)

Adolescents can move between being victims and perceived risks, highlighting safeguarding complexity

Key takeaway:
Serious youth violence is rooted in vulnerability, trauma, and exclusion—effective safeguarding depends on early, relational, and coordinated multi-agency responses

Key Learning for practice

- Serious youth violence is a safeguarding issue, not just criminal justice
- Risk is shaped by trauma, unmet need, and marginalisation
- Adolescence is a period of heightened vulnerability
- Effective responses must be - Early and preventative, relational and trauma informed, coordinated across agencies

What is working well?

Strong professional commitment and persistence
Practitioners are consistently going above and beyond statutory expectations, maintaining involvement even when young people disengage or move between services. This persistence is preventing escalation and sustaining protective relationships.

Positive relationship-based practice
Trusted relationships are proving to be one of the most powerful protective factors. Young people report feeling listened to, respected and understood, which increases their willingness to disclose risk and accept support.

Increasing trauma-informed approaches
More services are recognising the impact of early adversity, exploitation, and community violence. Staff are adapting their language, expectations, and interventions to reduce shame, avoid re-traumatisation, and build emotional safety.

Creative engagement with hard-to-reach young people
Teams are using flexible, youth-centred methods — outreach in community spaces, digital contact, peer mentors, and interest-based activities — to connect with young people who traditionally avoid services.



Where we need to improve

- No unified strategy —** Partners still work in silos, creating duplication, gaps, and weak accountability.
- Fragmented systems —** Inconsistent thresholds and tools across services lead to delays and missed escalation.
- Information not driving action —** Data is shared but decisions, ownership, and follow-through are often unclear; some intelligence is still held back.
- Weak AP oversight —** Monitoring of attendance, progress, and safeguarding is inconsistent, and communication with schools/social care is slow.
- Inconsistent multi-agency coordination —** Roles unclear, partner involvement uneven, and limited shared assessments cause drift and duplication.
- Variable trauma-informed practice —** Practice remains inconsistent, with some responses still behaviour-focused rather than trauma-informed.

