# Oldham Local Safeguarding Children Board

## Serious Case Review

# Child M

## 1 The circumstances which led to a Serious Case Review (SCR)

1.1 Child M was remanded to custody on a charge of attempted murder aged 15 years old. He is one of the younger children of a sibling group who were parented by their mother since the early death of their father when Child M was 5 years old.

1.2 Child M was born in the UK to parents of South East Asian heritage, for whom English is a second language. Child M's mother MM had little spoken English and relied on extended family members and the children to communicate outside of the family.

1.3 Aged 12 years old, Child M became the subject to a Child Protection Plan for seven months due to concerns that Child M and siblings were regularly missing from home until the early hours of the morning and associating with a person who was believed to be a risk to children. Professionals were concerned that the children were at risk of grooming in relation to sexual exploitation or criminality coupled with a lack of parental boundaries and low levels of supervision.

1.4 Shortly after the cessation of the Child Protection Plan, Child M was frequently missing from school. The school worked closely with MM and extended family members to try to focus Child M on education. However, attempts to exert controls and consequences were frustrated by MM's unwillingness to report Child M missing to the police. Child M's behaviour whilst at school became increasingly anti-social and at times aggressive towards peers, and in order to maintain a continued education, the school introduced resources both on and off site to increase teaching support.

1.5 Through an active police investigation, Child M was identified as a potential victim of child sexual exploitation aged 14 years. Child M was subject to joint police and Children's Social Care investigation where no crime was established, and no further actions taken by Children's Social Care.

1.6 Due to increasing incidents of anti-social behaviour in the community Child M was referred to the Community Safety Partnership who organised intervention meetings. The anti-social behaviour continued in frequency and severity, and by the age of 15

years, Child M was involved in a series of violent assaults on adults within the community. This culminated in a very serious assault for which he was charged with attempted murder.

1.7 Child M was convicted of Section 18 Assault, Causing Grievous Bodily Harm with the Intent to Cause Grievous Bodily Harm and received a custodial sentence of six years.

1.8 This Serious Case Review was agreed by the Chair of the Oldham Local Safeguarding Children Board (OLSCB) following consideration by the Serious Incident Review Group. The rationale to progress to series case review for Child M was based on a view that:

- there was clear evidence of significant harm that was not recognised by organisations or individuals in contact with the child, not shared with others or not acted on appropriately.
- there might be indications of failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of the specific case.
- the child was the subject of a child protection plan, or had previously been the subject of a plan or on the child protection register.

## 2 Methodology

2.1 Working Together 2015 requires that Serious Case Reviews are conducted in such a way that they:

- recognise the complex circumstances in which professionals work together to safeguard children;
- seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- are transparent about the way that data is collected and analysed;

- make use of relevant research and case evidence to inform the findings.

The statutory guidance of 2015 was followed because at the point of commencing the review, the new arrangements contained in the 2018 guidance were not yet in place.

2.2 The local partnership committed to the review by taking a genuinely enquiring approach to understanding the journey of the child and the impact on community safety, so that important lessons could be learnt about how services can be more responsive to preventing the escalation of risk by children who present a risk of harm to others. The Board appointed an Independent Reviewer experienced in undertaking Serious Case Reviews to facilitate the process and write an overview report.

2.3 A Review Panel of senior officers representing the agencies that had been involved with the family was established. The Review Panel members coordinated and maintained their agency engagement by providing brief reports which gave an overview and analysis of their agency contacts with Child M and by supporting the professionals involved with the family to contribute directly to the review. The Review Panel considered each of the Agency Reports supporting the appraisal of the practice from which the issues key to this review emerged.

2.4 The review set out to involve those practitioners who had worked directly with the family, and several attended a one-day practitioners meeting held as a multi-agency group which together considered the strengths and areas of weakness in supporting Child M throughout his adolescence years.

## 3 Scope and Terms of Reference

3.1 At the beginning of the Review, each agency submitted a chronology of interventions and this was collated to outline the multi-agency activity around the child and family. It was agreed that the general timeline for the Review would commence at the point of an Initial Child Protection Conference until Child M was remanded to custody aged 16 years. This was a period of 2 years and 7 months. Agencies were also asked to

provide any contextual information that may have had relevance to the review prior to this period.

3.2 The panel meeting, with the multi-agency chronology identified four key areas to be explored. These included the following:

- The extent to which the risks associated with gang culture/youth violence in the community is reflected through strategic planning
- The effectiveness of partnership arrangements in relation to risk of youth crime across council services
- The extent to which vulnerability factors were identified and addressed in planning for Child M
- The extent to which specific issues of diversity were identified and addressed through service delivery

Each of these issues were considered in detail at the practitioners meeting.

## 4 Parallel Proceedings

4.1 During the process of the review, Child M was subject to criminal trial.

4.2 The criminal proceedings had no impact on practitioner's availability.

## 5 Overview of what was known to Agencies

5.1 The Initial Child Protection Conference (ICPC) was precipitated by an incident between siblings, the investigation of which revealed that Child M and Sibling 3 were regularly missing from home until the early hours of the morning and associating with an older male. MM's response to the management of the children indicated a lack of parental boundaries and low levels of supervision. MM attended the ICPC with a family member who was used as an interpreter, whilst the Children's Social Care report was made available to MM translated into her spoken language. The ICPC concluded that

Child M and Sibling SM should become subject of a Child Protection Plan. A Child Sexual Exploitation Risk Measurement Tool was completed in respect of Child M by a social worker in a specialist CSE Team Phoenix. This concluded that although the lack of parental supervision and missing from home episodes made Child M vulnerable, particularly in light of MM failing to report him missing, there was no evidence that Child M was being sexually exploited. The assessment concluded a medium risk of child sexual exploitation.

5.2 In the three-month period between the ICPC and first review child protection conference (RCPC 1) Child M was introduced to a support worker from an Adolescent Support Unit (ASU) who he met with on nine occasions. ASU undertook an assessment, and devised an outreach intervention plan with Child M, focusing on helping him to understand how his behaviour impacted upon himself and others, his family relationships, providing him with tools to keep him calm, and helped him understand safe relationships. In addition, a Family Worker was allocated to work with MM. The social worker made four visits to the family home and Child M was seen twice by the school nurse who completed a health assessment using the Strengths and Difficulties Questionnaire. The assessment concluded that no emotional health difficulties were present. Other sources of information were inconsistent with this finding, as Child M was demonstrating disruptive and aggressive behaviour in school, and at times during interactions with other professionals he had been tearful and reported feeling scared at night.

5.3 The social worker shared with the police that Child M's behaviour had deteriorated and that he had been seen getting into cars with older males. The CSE Risk Measurement Tool was reviewed. The risk measurement score was slightly lower due impact of the support systems then in place, and the case was closed to the Phoenix Team on the understanding that ASU would complete CSE risk reduction work with Child M.

5.4 Three core group meetings took place between the ICPC and RCPC1. There are no minutes available of these meetings. Initially MM declined support from the Family Worker, stating that the children only had issues with their behaviour when at school and were compliant with her boundaries and curfews in the home. In school, Child M was assigned a learning mentor to work with him in a smaller group with the purpose of building a relationship as the route to best supporting Child M's areas of vulnerability. The social worker recommended to the RCPC 1 that Child M and SM3 should be stepped down from the child protection plan to a child in need plan. Neither the school nor school health advisor agreed with this because they considered MM had not been able to sufficiently understand what change was needed. Police were not in attendance. The Child Protection Plan continued, and it was agreed that ASU would support Child M for a further six weeks. When ASU ceased their work, they had completed work on anger management and parenting strategies. A second Family Worker was allocated who was able to converse in MM's spoken language. MM engaged in three sessions of work which focussed on house rules and consequences. Although MM expressed some concern in respect of her children's associates, within a short time she advised that the children were coming home on time and declined any further support.

5.5 At the point that ASU were ceasing their work, school reported that behaviour and attendance was an escalating concern for Child M. In order to refocus Child M on education, it was agreed that he would attend a small facility off site for students with additional support needs. GMP received information that Child M and SM3 were visiting the address of a person known to be a sexual risk to children and was being given cigarettes and alcohol. Child M was spoken to by an officer from a specialist CSE team and stated that no abusive activity had taken place. No further action was taken in relation to Child M. Records in Children's Social Care note that no evidence was found to substantiate the concern.

5.6 At the start of 2016, the school was working towards an integration back to mainstream schooling for Child M. Some missing episodes continued although they

were less frequent and tended to occur between leaving school and arriving home. On these occasions MM did not report Child M as missing as advised. The school organised for Child M to have preventative youth justice direct work sessions. However, this ceased after two meetings as Child M did not commit to attendance.

5.7 The RCPC 2 noted that 'the children's behaviour has improved' and they are now coming home at a reasonable time. Initially MM had no routines or boundaries in place, and she had no strategies in place about dealing with the boys' behaviour. There has been a great improvement in their behaviour, and work has been completed with the Family Worker. MM has been co-operative throughout, making herself available for home visits, and the family have helped'. The RCPC reached a unanimous decision to cease the child protection plan and step down to a Child in Need Plan. Three days later a Child in Need meeting agreed that Children's Social Care would cease their involvement.

5.8 The school continued to work closely with Child M. They noticed that the continued missing episodes coincided with the days he was in mainstream school and subsequently it was agreed that when not in the offsite unit, Child M would access lessons in the supported learning centre. By the summer, the school made a referral to Youth Justice Service because of aggressive conduct in school coupled with their knowledge of involvement with the police within the community. A worker was allocated but closed the case after two abortive home visits where engagement with Child M was not achieved.

5.9 In July 2016, Child M was identified as a target offender along with a number of associates as part of a priority crime group for anti-social behaviour. Child M was involved in a burglary of a mosque and the first of a series of assaults against members of the public. There was no prosecution for this assault due to insufficient evidence. Difficulties in school continued, and Child M experienced internal and external exclusions.

5.10 In October 2016 information was received by the police that Child M and sibling were victims of CSE by a person who was a known risk to children. A Strategy Meeting took place. Child M was spoken to by a police officer and a Family Worker from the Phoenix CSE Team and restated that he was not the victim of sexual abuse. Child M was further spoken with by the social worker on two separate occasion. Child M stated he knew the male and had received cigarettes from him but had never been alone with him. The completed Child and Family assessment indicated that MM did not appear to understand the safeguarding concerns and did not appear to have made many changes in terms of being able to manage the children's behaviour. The case was then closed to Children's Social Care.

5.11 GMP referred Child M to the Community Safety Partnership following several complaints of verbally abusing residents and shopkeepers, causing damage, and throwing missiles at residents. Child M accompanied by an older sibling met with a representative of the community safety unit, the police and Positive Steps to discuss his behaviour in the community and at school. Child M agreed that the behaviour was unacceptable and agreed to change his attitudes and associates.

5.12 Child M twice in six months attended accident and emergency with a hand injury, the first being a broken finger, the second an injury to the fist which he indicated he had hit a wall with when play fighting with friends.

5.13 In January 2017 Child M became involved in an argument with another child described as a lifelong friend. Child M left the scene and returned five minutes later carrying a knife and stabbed his friend to the abdomen, the knife passing through clothing and penetrating the body. Child M was arrested for section 18 Assault when he admitted being involved in the fight but denied stabbing the victim. Child M was placed on police bail, but the charging decision was delayed, and it took nine months from arrest to charge. By the time Child M appeared before Court, he was remanded to custody for the subsequent attempted murder charge.

5.14 In response to the stabbing, a referral was made to the MASH and a strategy meeting was held. It was agreed that Children's Social Care would undertake a single assessment in respect of Child M who was fourteen years and two months old at this point. A Child and Family assessment were completed, MM stated that she was well supported by a friend of the family and declined professional support. The assessment noted that MM struggled to make changes and recommended that the school should refer Child M to the Youth Justice Service to help him make better choices. The case was closed to CSC. The school challenged this outcome with the social worker and recorded that the social worker agreed to raise the challenge with the manager from MASH. There is no further action by either Children's Social Care of the school with regards to this challenge.

5.15 A further referral to Youth Justice Service was made by the school. The case was re-opened and allocated to a case manager and trainee case manager. An assessment using the ASSET plus model was completed which recommended a series of interventions including:

- referral to OASIS for support with substance misuses,
- work with a therapeutic coach around managing emotions
- support with attending education,
- consequences of offending/positive choices, negative peer influence/power mapping
- Identifying positive and constructive activities, self-esteem work.

5.16 In May 2017 Child M was arrested for Section 5 Public Order offence, he was seen on CCTV in the town centre waving a belt in an aggressive manner. Whilst detained for this offence, Child M was also identified as being responsible for the robbery of a young person who was punched and had a mobile phone stolen. Due to difficulties in identification and lack of corroboration Child M was not charged with the robbery but he was charged with the Public Order offence and appeared before Court. At Court, the CPS withdrew the charge and returned him for a second youth caution.

5.17 Child M was further referred to community safety, and this time a warning letter was issued under the provisions of the Anti-Social Behaviour, Crime and Policing Act 2014. The purpose of the letter was to advise Child M's parent about the concerns relating to his behaviour and to offer information on more positive diversionary activities he could engage in.

5.18 In September and October 2017 Child M was named in a series of Crime stopper intelligence submissions as being groomed by older boys to carry drugs and weapons, being involved in two public order offences and an assault. Child M was interviewed about them and admitted being present with others. However, he denied being responsible for the actual assaults or damage. Due to identification issues and in agreement with the victims the crimes were not prosecuted. In November a warrant was executed by the police at Child M's home address in response to information. No drugs or weapons were seized. However, a quantity of cash was taken from Child M's room. MM stated that this money had been given to her by a relative.

5.19 As the autumn school term progressed, Child M's behaviour continually deteriorated. He was abusive to teachers, alleged to be dealing cannabis, disruptive to school life and now openly defiant with the head teacher. He was given a 4-day exclusion after refusing to be searched and leaving the premises. The Youth Justice Service made a referral to Children's Social Care which gave the following information:

- That Child M had lost all interest in school
- That MM could not exert boundaries, nor speak English
- It noted previous parenting inputs but identified that MM currently needed help to manage her children's behaviour and put appropriate boundaries in place.
- Requested further work with the children to help them adhere to the rules and boundaries put in place
- Possible support from mental health service to help MM reduce her anxiety levels.

5.20 A strategy meeting was held which confirmed the need for an investigation under Section 47 Children Act 1989. The investigation concluded with no further action. Child M denied using drugs or having brought drugs/firearms into the family home.

5.21 Children's Social Care progressed the matter to a single assessment. This noted that Child M advised that he believed that the information received by the police was malicious but did comment that he would have to be more careful with his friends in order to stay out of trouble. MM blamed school for the behaviour exhibited by Child M within the school environment and did not want support in the home other than from family. The Team Manager concluded that CSC could not force the family to engage with a Child in Need Plan and deemed that threshold had not been met for a further ICPC. As such, the recommendation was that school would undertake a piece of restorative justice work with Child M. The case subsequently closed to CSC.

5.22 Anonymous information was received three times through crime stoppers that Child M was driving high powered vehicles around the town and transporting drugs in them. In early February Child M was named as being involved in a serious assault of a 17-year old with three accomplices. The investigation was not completed before Child M committed the offence for which he was remanded into custody.

5.23 Child M was then involved in a series of public order incidents that were collated by the Metro Link Travel Safe Police team. He was not identified until after the attempted murder offence. These included

- Lying on a tram line and verbally abusing and simulating masturbation to a PCSO when approached
- Spitting saliva at a PCSO when she approached him in a group of youths at the tram stop
- Using a belt as a weapon in a fight on a tram

5.24 The incident which lead to the conviction for Section 18 assault involving an adult male whereby Child M and two others kicked and stamped on his head a total of 93 times

prior to them running off and leaving the victim lifeless. Child M was identified through CCTV footage and arrested 16 days later. He appeared before the court and was remanded to secure accommodation. In the intervening period, Child M presented at hospital with a further hand injury which he said was caused by hitting a wall in a temper tantrum.

## 6 The Child Perspective

6.1 MM was advised of the convening and purpose of an SCR by a support worker with whom she is familiar and is able to converse in her first language.

6.2 The Independent Author sought to meet with MM and a family member. After consideration MM decided she did not want a meeting to go ahead unless it could influence Child M having a sentence reduction. As this was not possible, the proposed meeting did not go ahead.

6.3 MM agreed to meet the Independent Reviewer along with his Youth Justice Worker.

6.4 In reflecting over his adolescent years, Child M said that in his view, the main reason that his life spiralled out of control was because he was drinking alcohol on a daily basis. He recalled that he spent time at Oasis but did not listen. Child M said that within his culture, alcohol is forbidden, this meant he could not own up to this.

6.5 When discussing his anger, child M said that he carried anger about the loss of his father, and although unable to discuss any references to sexual exploitation, accepted the reviewer's hypothesis that he was at risk from a person in the community.

6.6 Although many professionals worked with Child M, he was unable to recall any that made a particular impact on him. He recalled liking one man who shared his religion but stated that whilst he believed that many people tried to help him, he was 'in my own world'.

6.7 Child M said that he lost interest in school, he felt humiliated by being placed outside of mainstream classroom and felt if unfair at he was placed on a part time timetable. Child M advised that the impact of this was that he fell behind with learning which

contributed to his disassociation with school and that he lost motivation and slipped into anti-social behaviour with too much time on his hands.

6.8 Child M said that young people need to be kept busy, need activities and somewhere to go. He said that it was hard for his mum to bring up children alone.

6.9 Child M advised that he wants to be a person with a good job and a family, not someone who 'brings tears to their mothers' eyes'. He recognised that he had responded to the very firm boundaries in the custodial setting and was using the time to complete all the education and programmes he can. He was proud to report that his good behaviour had been recognised and rewarded and to realise that it is possible for him to be that person.

## 7 Analysis

The examination of single and multi-agency working leading up to the precipitating incident of this Serious Case Review has facilitated agencies and practitioners to come together to review the effectiveness of practice and infrastructures in respect of responding to a child who posed a risk of significant harm to others. Inevitably the pathway of interventions also leads the review to consider how services responded to Child M as a child in need of protection. The analysis is structured to reference the key areas of interest as they arise throughout the chronology of events. The analysis is drawn from the agency's written contributions to the review, the reflections of practitioners, and the discussion and challenges that occurred within the review panel as well as the Reviewers own contributions.

7.1 This timescale for this review commenced when Child M was made subject of a Child Protection Plan aged 12 years and 8 months. The ICPS noted that Child M was the subject of a child protection investigation aged 7 years, which indicated that MM was using physical chastisement to manage behavioural problems of Child M and sibling SM3 who was 17 months older. The information references the children smoking, stealing and fighting and being involved in setting a fire at a sub-station. A petition was drawn up by the neighbourhood seeking eviction of the family because of anti-social behaviour. An assessment was undertaken which outlined that MM refused to

accept any responsibility for the concerns about her sons, which included the children's not engaging in school and arriving unkempt, hungry and late, missed health appointments and emerging criminal activity. The assessment concluded unequivocally that the children were not afforded guidance and boundaries at home and that MM was not accepting the need for change and a decision was made to transfer the matter to a long-term team for a structured intervention under child in need procedures. Despite the high level of concern, within two months a decision was made in social work supervision that a child in need meeting should be held to step the case down to a CAF level. The information available to this review is Children's Social Care focussed, with little sense of the role of the multiagency partnership in respect of a plan around the child or activity with regards to decision making.

7.2 This period of intervention is highly significant to later points of decision making. The social work assessment identified that the children needed their parent to make changes in order to safeguard and promote their welfare, and that this would require a long-term piece of work to achieve. It was at this point that the case was transferred to a long-term team. Within a cycle of change management, MM was not demonstrating a prognosis for change. MM could not accept that her children needed a different style of parenting and the children's behaviour in the face of this became increasingly oppositional. Whilst the review has not covered this period, it noteworthy that although Children's Social Care identified the need, it did not clearly enough specify the risks that would result from unmet need. The unmet need continued to be highly problematic, and by the next point of significant intervention some four years later, Child M was considered to be at risk of significant harm.

7.3 When the child protection plan commenced Child M was not yet 13 years old. The preceding Section 47 investigation commenced when an older sibling was alleged to have physically assaulted Child M because he had not come home on time. The ICPC noted that Child M and sibling were missing from home on a regular basis up till 2 a.m., but MM refused to report them missing because she thought it would criminalise them and affect their future. Local information suggested that when missing, Child M and sibling were associating with an older male reported to be giving them money and cigarettes. A recommendation to cease the Child Protection Plan was

made by Children's Social Care to the RCPC 1 after just 3 months. The confidence that good progress had been made was predominantly based on Child M's engagement with the ASU worker, and it would appear that Child M did enjoy and respond to the mentorship of this worker. The focus of the ASU service was however to children on the edge of care, to prevent inappropriate and unnecessary admission. Other than through a criminal route, once the whole situation was assessed, Child M was not at risk of becoming looked after. The intervention of the ASU team in all instances was to undertake an assessment and deliver a programme of work to a child that would reduce escalating risk, however, of significance was the parallel role played by a Family Support Worker who was less successful in attempts to work with MM.

7.4 The assessment that led to recommending the end of the plan was superficial, and, in particular did not address the impact of MM's parenting style on Child M. Baumrind (1991) defines three parenting styles as authoritative, authoritarian and permissive, permissive being highly responsive to the child but also undemanding. A permissive style of parenting is associated with insecurely attached children who have ambivalent and avoidant attachments styles. Generally, permissive parenting is viewed as either indulgent or negligent but of course both can be co-existent. The definition of neglect in Working Together 2018 includes a parent failing to provide protection from physical and emotional danger or adequate supervision. There was good evidence that the impact the parenting style resulted in the children having autonomy inconsistent with their age and stage of development and resulted in the children developing a greater tendency towards impulsive behaviour. Commonly children of permissive parents' disregard rules and social norms because they are used to getting their own way, they lack the social skills of their peers and are the children more likely to get into trouble through high risk behaviour.

7.5 The recommendation to cease the child protection plan at RCPC1 suggests that Children's Social Care had adopted an early mind-set that the issues facing Child M had quickly been resolved, when in reality this was far from the truth. Taking into account the family's history of working with services, a further period of intervention was necessary given that the core factors associated with risk had not changed. Although by the RCPC 2 all multi-agency professionals accepted that sufficient change

had occurred to reduce the level of risk, this was not rooted in a model of change that evidenced a reduction of risk or that necessary changed had occurred. If change is considered as a five-step process (Prochaska and DiClemente) then at best MM was in the stuck in stage 2 that being the acceptance of the need for change before implementation can be achieved. Certainly, there was no reason for professionals to be confident that change had been embedded or could be sustained. Despite the multi-agency agreement that risk had reduced by RCPC2, in the three-month prior following RCPC 1, the following events had occurred:

- MM had stated that she struggled to control the children when they are negatively influenced by their friends and did need help. MM undertook two sessions of work with a Family Support Worker
- MM never reported Child M missing when he was home late
- Child M had become educated off site due to behavioural challenges
- The Family Worker raised concerns about MM's ability to understand and retain information.
- ASU concluded their involvement noting they had undertaken anger management work and had helped to maintain Child M at home.
- Information received that Child M was visiting the address of an older male and being given cigarettes and alcohol in return for sexual acts. No section 47 investigation was undertaken

The practitioners recalled that the core group meetings as the vehicle to support multi-agency working were poorly organised and attended with no shared outcomes or updates to the child protection plan. The Conference did not create suitable challenge to the partnership, and to this extent permitted an over optimistic view of what had been achieved within a short period of time in respect of a family with longstanding and complex difficulties.

7.6 Through the practitioners' meetings, there was a sense that MM's parenting style was understood but that it was rationalised in the context of Child M's loss of his father

and accepted as her need to console her children through the empathy and dedication of one parent. This acceptance of the status quo for what was considered to be understandable reasons did not however make the link that indulgent parenting is more likely to result in children who are more vulnerable to misconduct and addiction (Milevsky et al. 2007). There are questions about MM's ability to work towards change in the light of several possible hurdles which included whether there was a cognitive limitation, how the partnership enabled MM to access services and people due to a language barrier and her willingness to accept that her children needed this from her. Although questions were raised about MM's cognition, this was never explored with MM directly, and there was no recourse to assessment models such as the PAMs assessment to determine what assistance and support might be needed by MM. Although there are instances where interpreters were used to support meetings or conversations with MM, this was not consistent and not determined by any particular rationale. Often, a family member was used to interpret, which professionals were aware was not acceptable practice, but accepted in the context of finding it difficult to arrange translation.

7.7 The biggest barrier to change was the limited success in help MM to understand that Child M needed a more authoritative style of parenting to safeguard his welfare. The attempts to work with MM were short-lived, and the potential barriers to engagement were not explicitly explored through the period of child protection planning or at subsequent points of intervention. Without achieving progress with MM, in the efforts to unconditionally support Child M, he experienced neglect of his need for boundaries and control.

7.8 Throughout the Child Protection Conferences there is reference to the child's views being unknown, there is no explanation for this but given his age, this is a significant omission to the process of a planning for his safety. Child M's own views are not often referenced, but he was clear that he enjoyed the work with the ASU worker and wanted this to continue. The ASU worker made an impact on Child M, and his presence over a prolonged period could well have helped Child M develop greater self-awareness and empathy for others. Child M was referred for a range of services, but, he did not have an enduring relationship with a professional.

7.9 Research suggests that neglect in adolescence leads to worse outcomes than neglect that takes place only in earlier childhood, yet many professionals fall into a pitfall of thinking that neglect is less damaging than other forms of abuse. Coupled with a mind-set that adolescents by virtue of their age have a 'natural resilience', it becomes very easy to overlook and specify the presence of neglect for older children. In the case of Child M, he remained the subject of neglect through his mother's inability to offer the authoritative parenting that he needed.

7.10 The school did make continued efforts to support and educate Child M. Very quickly pastoral staff became aware that Child M needed an increased amount of support around social skills and behaviour which was provided by the Year Manager and pastoral team. The Year Manager attempted to enlist parental support with a view to building a partnership with the family. However, whilst MM attended some meetings, accompanied by family members, they too struggled to engage MM in a working partnership**.** A managed move was attempted for two months in 2015 but was unsuccessful. Over a 2 ½ year period, the school utilised all resources available to them in an endeavour to maximise Child M's educational attainment and act on his safeguarding needs. Following return from the managed move, Child M was educated at the school outreach centre where attempts were made to integrate him to the mainstream school site. On each occasion, the plans were stalled by a deterioration in Child M's behaviour. In order to promote his educational opportunities, decision was made to commence Year 9 in a Foundation Support Group. Within two months however, he was moved to a supported learning centre where he remained until returning to offsite provision. In both the offsite and Supported Learning Centre, Child M showed he was capable of learning and conforming with very intensive support. It was noted that he responded particularly well to positive male role models, but ultimately, his lack of social skills continually led him to breach behavioural norms and breach of acceptable standards of behaviour in a school community. A behaviour contract was introduced as an attempt to engage Child M directly in the management of his own behaviour. Over this period, Child M was given 7 periods of internal exclusion and 2 occasions of fixed term exclusion.

7.11 In November 2015 the school introduced a flexible timetable which was considered to be the most appropriate provision to manage his needs and behaviour, this was reviewed regularly and his time either increased or decreased until he was taken into custody. This strategy was deployed in order to prevent Child M being permanently excluded. The school had access to flexible options not available to many schools and without this level of resources further exclusions would have been likely. It is apparent however that much of the time the school had to work in isolation to build support for Child M and his family when they would have benefitted from a multi-agency response.

7.12 The school faced two major barriers to effecting change. Firstly, MM could not accept that the problems emanated from outside of the school environment and secondly, for the most part, the school were managing complex problems alone that required a multi-agency effort. Within the 2 ½ year period, Child M was subject to a multi-agency plan for the period of child protection planning only. Although the step-down arrangements discussed at RCPC 2 included a period of child in need planning, this did not happen, and the matter was closed to Children's Social Care without any formalised step-down arrangements. There was no challenge to this outcome by the school, health or support services. The school made continued referrals to multi-agency partners which included Youth Justice Preventative services and back to Children's Social Care following the incident which led to a stabbing. The school experience on both occasions was unsatisfactory as neither continued to be involved due to the unwillingness of Child M to engage or a view that a threshold criterion was not met. The school did challenge the decision of Children's Social Care to take no further actions after the incident which led to a stabbing with the social worker, but when no outcome was received did not move to a formal escalation, which suggests a tendency to see Children's Social Care as experts who must be right or that pursuing challenge is inconsequential. In the practitioners meeting, the LSCB formal escalation procedure was not well known.

7.13 It is clear from the practitioners' meeting that professionals had grave concerns for the risks that Child M was facing and believed that he, in all likelihood was a victim of child sexual exploitation and possibly of criminal exploitation. On two occasions

information was received by the police which alleged that Child M was spending time at the home of an adult male who was known to be a risk to children and who was providing him with cigarettes and money. The signs of CSE were recognised by the professionals. However, the response was over influenced by Child M's denial that he had experienced sexual interactions with the adult male. The Children's Commissioner publication *Protecting Children from Harm: A Critical Assessment of Child Sexual Abuse in the Family Network in England and Priorities for Action* (November 2015), notes that there is an over-reliance on children disclosing abuse to statutory services and that refocusing is required so that professionals are attuned to changes in the behaviour of children and their emotional responses, ultimately enabling them to talk about their experiences. Although placed in the context of familial abuse, the same is true for children experiencing abuse in any setting. The meeting with Child M for the purpose of this review touched on the issue of child exploitation, and whilst Child M withdrew from this discussion, he did confirm that he was subject to this risk and that it contributed to his levels of anger.

7.14 Barnardo's research on the sexual exploitation of boys and young men (2014) noted a number of findings that would have supported professionals in their thinking about Child M and the risks he was facing. For male victims, the societal expectations of masculinity can be a barrier to talking about sexual abuse, and this can be further compounded by ethnicity in respect of communities where a male may feel additionally shamed by disclosing sexual victimisation. Many young males will also fear being labelled gay due to homophobic social attitudes. The potential for the presence of bias with regards to gender, patterns of youth offending and risk of CSE can mean that young males involved with criminal activity are viewed, predominantly, as a risk to others rather than, as would be the case with females, that their criminal behaviour is seen as an indicator of other vulnerabilities. The report concluded that little is known about the sexual exploitation of young males, but that without doubt, the combination of serious social issues, offending and missing behaviour requires multi-agency working to tackle the complexity. The chronology demonstrates a growing need for a multi-agency approach to supporting Child M and to the protection

of the community. A series of three Strategy meetings, the first two within four months of each other, each provided an opportunity to initiate a multi-agency plan.

7.15 The first strategy meeting was held as a consequence of the testimony of an alleged victim of CSE. Child M was 13 years and 10 months. This meeting did not result in a Section 47 investigation. A child and family assessment was completed which led to no further action by Children's Social Care. The assessment noted that Child M had received cigarettes from the male in question and that MM did not understand the safeguarding concerns, so it is a cause for concern in light of this that no ongoing safeguarding needs were identified. The case closure to Children's Social Care was based on one aspect of assessment, that being that Child M had denied he had been harmed. This assessment was one dimensional did not take account of the wider safeguarding factors both in respect of the indicators associated with CSE, but also in relation to Child M's emerging criminality and daily struggle to maintain school life. During the period of completing this assessment, Child M's behaviour was spiralling out of control, but this was interpreted solely as a criminal issue that required a response as an offender rather than a welfare issue that demonstrated that he was a child in need. When considering the potential for a child to be harmed though CSE, non-verbal communications should be viewed as significant as verbal communications. There was good evidence that Child M needed firm guidance and support and this this would not be available to him without statutory intervention.

7.16 A second strategy meeting took place just 3 months later in response to Child M having been arrested on suspicion of a S.18 wounding, namely that he had stabbed a peer with a knife. A section 47 investigation commenced. At this meeting it was noted that Child M was receiving a reduced school timetable of two hours per day and that MM would not support the school to address Child M's behaviour because she always denied he had any responsibility. A further child and family assessment was completed four months later. Again, the behaviour exhibited by Child M was noted as was the fact that MM had declined support with parenting. The social worker noted that the mother struggled to make changes yet still the conclusion was that there was no role for Children's Social Care and that the school should refer Child M to the Youth Justice Service to help him make better choices. This is a second example of superficial

assessment, with an outcome that indicated that the service was looking to support a reason to close rather than assess from a neutral position what was needed. The recording on the incident by the MASH stated 'Child M stabbed his friend during a row. Not seriously injured'. This recording in itself suggests that the incident may have been downgraded by the seriousness of the injury rather than upgraded by the seriousness of the act. Knife crime is an issue that is causing national alarm, and key challenges to the safeguarding of young people and members of the community. The research conducted with young people indicates that the reasons for carrying a knife may be for protection or status acquisition, and furthermore that knife crime can be glamorised through gang association. All of the crimes that Child M committed with a peer group, within which Child M was described by the practitioners as tiny in physical structure but definitely 'in charge'.

7.17 This was a key point at which risk assessment in relation to Child M escalated. He was charged with a Section 18 wounding offence and without a doubt a multi- agency team around the child should have been initiated. A referral was made to the Youth justice service from this point and the service remained involved with Child M and worked to a comprehensive plan. The YOS ASSET assessment noted particular concern about the traumatic experience for Child M of discovering his father's death whilst waking up in bed with him and noted his inability to speak of this issue. Over the following months an allocated mentor and the detached youth service were unable to engage Child M. He had also declined counselling support in respect of the death of his father. Through Positive Steps though Child M did receive a range of support as detailed in the paragraph below.

7.18 It was during this period that the hospital saw Child M, accompanied by an older sibling and recorded that Child M did not want his parent to know he had attended. Child M was 14 years old and stated he had been the victim of an assault by a group of young males. The hospital sent a notification of the incident to the school nurse but requested the notification was 'not sent to the MASH'. This incident does however remind us that as well as the information known to agencies, there was a great deal more information not known to agencies in relation to Child M's day to day life experiences.

7.19 The third strategy meeting was ten months after the previous and four months before Child M committed the crime for which he was convicted with Section 18 assault. Child M was fifteen years old at this point. The meeting was convened following a referral to the MASH from the school of a sibling to inform that the Police Service had executed a warrant at the family home, and searched the property for guns, knives and drugs. The meeting did not initiate a Section 47 investigation. The meeting noted that in the intervening ten months, Child M had:

- been charged with Section 18 wounding
- completed one to one sessions with Drugs Service in respect of drugs and alcohol
- completed one to one sessions with a therapeutic worker, and been taught strategies and techniques to manage his emotions better
- completed one to one sessions with his case worker at YJS, and had demonstrated his understanding of the negative consequences of offending behaviour upon him and his family
- completed the SPIN programme, and taught to recognise signs of exploitation, and identify his support network should he find himself in an exploitative situation

It was noted that Child M also continued to associate with negative peers. The police also confirmed that four substantial bags of money were removed from the property.

7.20 Alongside the above activity, the following events also occurred. Child M was

- administered a youth caution for anti-social behaviour
- arrested on suspicion of assault on 3 occasions, but was not charged either because of insufficient evidence or the reluctance of the victim to provide witness testimony
- the subject of 8 contacts to crime stopper which included information that he was being criminally groomed by older boys, carrying guns and drugs
- attending school at 34% of total

7.21 The information in relation to the alleged assaults was not shared beyond the police. Although Child M was 15 years old, the information was responded to from a criminal perspective without considering the implications for his wider safeguarding and welfare needs. The trial date in relation to the Section 18 wounding charge continued beyond a year and was only concluded when Child M was charged with attempted

murder. All things considered, this is an extraordinary length of time, and, along with three further arrests without charge contributed to Child M experiencing a lack of consequence and perhaps a sense of omnipotence. The work that was being done by the Youth Justice Service was somewhat undermined by the continued criminal activity that the service had no awareness of. Child M was on police bail for over a year with no mechanism in place to share information that impacted both on the professional understanding of how he was responding to the work of the YOS and on the assessment of risk to the public. A comprehensive assessment was completed by YOS, which concluded a medium risk of significant harm and a low risk in relation to re-offending. The low risk of re-offending is questionable given that Child M had a part time school timetable, had not been engaged by detached youth work and was using substances, however, the comprehensive action plan reflected a higher interpretation of risk.

7.22 The professionals had a disbelief that the money did belong to MM, in particular given that it was found in Child M's bedroom. Once again, despite professional thinking to the contrary, and unconfirmed police information that Child M was dealing no further action was taken by Children's Social Care because Child M denied using drugs or bringing weapons into the family home. A single assessment was completed by Children's Social Care again noting MM's inability to provide the necessary guidance and boundaries but moved to close the case because MM could not be forced to work with a child in need plan and it was determined that threshold for ICPC was not met. This decision was made on a single agency basis, the contribution of other agencies to Child M's safeguarding continued but without multi-agency co-ordination. All of the indicators would suggest that Child M was highly troubled, and that MM could not give him what he needed. It is surprising therefore that no actual attempt to initiate a child in need meeting was made, because the decision not to do so only continued the circumstances whereby Child M continued to be at the same level of risk but without the safety net of a multi-agency plan. It should be considered that the presenting features of Child M's circumstances at this time did result in him being at high risk of further offending, and moreover that the nature of that offending was high risk.

7.23 Before the matter was formally closed to Children's Social Care, Child M committed a further assault. Child M was not identified as the assailant until after he was charged with the Attempted Murder. In the following four weeks, Child M committed the following crimes, all in the early hours of the morning:

- a public order offence x 2 towards a police officer
- affray (identified after attempted murder charge)
- Assault and robbery of a 27-year old male (identified after attempted murder charge)
- Assault of 49- year old male which resulted in attempted murder charge.

7.24 The events followed on from the final strategy meeting and played out all of the known risk factors. There was no opportunity to share this information by the police because Child M was not identified immediately for these offences and was linked only after his arrest for the attempted murder. It is difficult to conceive how and why after two strategy meetings in a nine-month period in relation to Child M's criminology there was no system across the partnership to share information and reassess risk in order to safeguard Child M and protect the public. This occurred as a consequence of separating Child M's needs as a child in need with Child M as an offender. Moreover, successive assessments by Children's Social Care had recognised that his future welfare was in jeopardy but, despite recognising that MM had not done so, also failed to invoke any assertive response to this. When this was challenged by the school, no formal response was made, and no escalation was invoked.

7.25 The issue of threshold application by Children's Social Care relies on the judgement of the assessing social worker supported by management oversight. Different social workers are allocated at each point of decision making and given that there was scope for further intervention on four occasions, this represents a concern that there may be a lower application than is intended by the Local Authority threshold document. This could be informed by a drive to gate keep resources or as is more likely by insufficient thinking about the risk that Child M faced, the possible consequences and what needed to happen to mitigate and reduce risk. Skills of critical thinking are pertinent to the ability to act with professional curiosity, and not be swayed by the

presence of the biases that can affect professional thinking. At no point in ceasing the work or referrals with Child M did professionals believe that risk was reduced through an evidential basis. To the contrary, on each occasion, the evidence suggested that Child M continued to be in need and that without further intervention, this would escalate.

7.26 The determination with regard to Section 47 also suggest a variation in the threshold application. During this period, Child M was subject to two Section 47 investigations, one of which led to the period of child protection plan and the second when a search warrant was expected at his home. Section 47 of the Children Act is the duty to investigate significant harm and Working Together places a statutory duty of safeguarding agencies to work together to achieve this. It is therefore difficult to understand why the Strategy meeting 1 in relation to concern for CSE did not result in a Section 47, nor when Child M stabbed another child which indicated a child who needed urgent help.

## 8. Learning

### 8.1 Assessments of children's needs rely on robust understanding of the child/parent relationship, the parental capacity for change and the child's lived experience.

Child M was subject to continued assessments over a 2 ½ year period, four completed by Children's Social Care and two by YOS with particular focus on the risk or re-offending and risk to others. On each occasion, the assessments concluded that Child M's welfare was compromised by an absence of authoritative parenting yet did not progress to a fuller understanding of Child M's day to day lived experience. A range of simple but structured questions would have led to an analysis of how to help Child M: what happened during an average day, what caused concern, what needed to change to prevent ongoing harm, what was expected of a parent to do differently, how will professionals work with the child and family and how to know if the intervention has been effective.

The parent/child dynamic became a rationale from which to accept that change would not happen, rather than the basis from which to understand what was needed to

enable this. This perspective became collusive with the compromised parenting of Child M and formed a basis throughout all assessment activity.

The medium risk of serious harm by YOS when the case was closed by Children's Social Care indicated there was need for further collaboration and consideration about how Child M's needs could be holistically met, in particular taking into account the impact of his part time school attendance. Through the Safeguarding and Wellbeing in Education subgroup, the local partnership is currently developing an Education Neglect Policy which will bring into focus the need to factor education and timetabling into assessments of risk and vulnerability.

8.2 **A parent cannot participate in a partnership with statutory agencies unless a mutual process for communication is achieved. Achieving this requires a sensitivity to many factors of the parent's unique characteristics such as language, cognitive functioning and preconceptions.**

Throughout the interventions, there were only very limited points at which any sense of partnership was achieved with MM. The review does not have the benefit of MM's reflections on how agencies worked with her, but her resistance to doing so is evident across the whole timescale. MM's indulgent attitude to Child M was a barrier, but what is less clear is what attempts were made by professionals to work with MM to understand the strength of her resistance to agencies and what she feared. Where work did take place, this is seen to be instructive rather than reflective, so did not attempt to redress her natural patterns of thinking. The professionals were mindful of the language barrier. However, on occasions they accepted family members and friends as interpreters. For substantive periods, a language worker based within Children's Social Care was used to support work with MM, in particular during the period of child protection planning and period of work related to Strategy Meeting 1. It is possible that MM could have been supported to work with the agencies if more time had been made available getting to know her and forming a relationship over time. The task driven nature of the family support worker and ASU worker work prevented this approach with the consequence that MM always appeared to be a bystander to the interventions in relation to her son. Without engaging MM as a safeguarding partner to Child M, he could only continue to be at risk of harm and a

risk to others. Both YOS and CSC assessment note that 'MM needs to continue notifying the police if he comes home late, giving him clear boundaries' yet MM never once followed advice on this issue.

Although family members were often part of meetings with MM, there were no attempts to build the family into a formalised plan for Child M in order to build resilience and create a greater network of safety in conjunction with statutory services. This was a missed opportunity to enhance a plan for safety.

**8.3 Working with children with complex safeguarding needs requires organisations to adhere to the principles of trauma-informed practice**

This requires professionals to commit to relationship-based practice which listens carefully to young people and help them to recognise how past experiences influence their way or relating to the world around them. It is important to offer young people, through the development of trusting relationships, a way of learning to live with the legacy that trauma leave and the pathway to build a safer life for themselves. This cannot be achieved by a crude signposting to specialist services, but starts from the case manager demonstrating empowerment, choice and control.

**8.4 Working with children at risk of or exposed to CSE is time and resource intensive. Professionals need to form meaningful, safe and trusting relationships with young people over time, to enable young people to confide in the adults who are working with them.**

Professionals remain of the view that Child M was subject to sexual exploitation and possibly criminal exploitation. The grooming process for both has many similarities. The determination that the level of need did not meet the threshold for Children's Social Care in relation to Strategy meeting 1 and 3 in relation to CSE and criminal exploitation were both based on the testimony of Child M not what professional thinking was telling the partnership. The words 'no evidence' appear as justification to rationale to close as though dealing with a test of beyond reasonable doubt rather than considering the balance of probability. Taking into account what is known about children's ability to tell what is happening to them, and the inhibitors that are not known to others, it is simply unrealistic to expect a child to respond to a question posed by an unknown professional when in reality it is very hard to tell a trusted

person. Testimony from the experience of young people able to share experience of exploitation consistently reminds us that the child's own testimony when they may feel in a trapped situation should not be considered as a defining criterion for ongoing assessment and services in relation to exploitation. On both of these occasions, Child M would have been helped by a longer-term plan to achieve a trusted relationship. There is evidence that Child M did respond to the ASU worker and did enjoy the contacts with positive male role models in school.

8.5 **Children who display criminal behaviour should be viewed within the multi-agency partnership as children at risk of harm as well as children who pose risk of harm.**

Child M committed some very serious crimes, fuelled by a level of anger and aggression uncommon to his age and development. The acts did not happen in isolation however. The trajectory towards this point is evident through this review. It is stated that a multi-agency plan around the child should have been initiated at more than one point throughout the timeline of interventions, but it must be accepted that the level of Child M's known offending spiralled after the third strategy meeting, yet there was no mechanism for sharing this across the partnership. Whilst accepting that Child M was only identified as an offender for the ongoing offences after the arrest for Attempted Murder, at the practitioners' meeting, YOS practitioners advised that it is not unusual for further offences to occur when they are working with children that they do not know about charging decisions are made. If YOS are unaware of a young person's ongoing offending, this will impact on the quality of assessment and cause delay in the provision of targeted help to children and families. Similarly, the length of time from initial investigation to court disposal meant that the consequences were not experienced by Child M in a timely manner.

8.6 **Investing time in the development of critical thinking skills across the multi-agency partnership will support professionals to reach the best standards of analysis and decision making for children.**

Whilst great emphasis is placed on the need for quality and reflective thinking, the practitioners reported that less emphasis is placed on helping practitioners to learn and practice the skills involved in critical thinking**.** Because professionals in

safeguarding are called upon to make highly complex decisions on a daily basis, their standards of thinking and awareness of what influences their thinking is one of the most important tools to support judgements and decision making. The examination of this review reveals occasions whereby the decision making is not supported by the analysis of the information to hand. Although there are many definitions of critical thinking, for safeguarding practitioners, a helpful definition is provided by Richard Paul, 'critical thinking is about thinking what you're thinking while you're thinking in order to make your thinking better'. This definition provides a constant reminder to use the skills often more accessible with hindsight than foresight, to maintain a questioning attitude and not be satisfied unless all information sources lead to the same conclusion. Robust thinking skills across the partnership will support a culture of professional challenge.

8.7 **A culture of inter and intra agency challenge is necessary in order to support safe decisions and organisations**

It is evident that agencies were frustrated by the absence of Children's Social Care when trying to improve Child M's circumstances. There is however an absence of challenge and when this did occur it was low level and received without the significance that should have been invoked. Whilst not advocating that all challenge should be escalated through a formal escalation process, this review does raise questions about professionals' understanding and experience of challenge, and it may be prudent for the Board to consider a wider report about the use of challenge across the partnership and what strategies agencies employ to encourage both the making and receiving of challenge in a pro-active way as a means of creating safer working practices.

**Recommendations:**

1. The Safeguarding Partnership to seek assurance from all partners that assessments are inclusive of child/parent relationship, parental capacity for change and the child's lived experience

2. The Safeguarding Partnership to seek assurance from all agencies that they have principles in place to support communications with parents that include the appropriate use of interpreters

3. The Safeguarding Partnership to develop an engagement strategy which guides practitioners to establish the parents' understanding of concerns, taking into account their unique characteristics such as language and cognitive functioning, and how this helps or detracts from their ability to safeguard and protect their children

4. The Safeguarding Partnership to ensure that the development of trusting relationships with young people is at the heart of the model of complex safeguarding

5. The Safeguarding Partnership to promote the principles of trauma-informed practice in working with complex young people

6. The Safeguarding Partnership to reinforce across all agencies that children who display criminal behaviour should be viewed as children at risk of harm as well as children who pose risk of harm. Pathways for referral and assessment should be reinforced

7. The Safeguarding Partnership to support all agencies to invest time in the development of critical thinking skills in order to help professionals to reach the best standards of analysis and decision making for children

8. The Safeguarding Partnership to be provided with assurance that challenge and escalation is part of a healthy part of a safeguarding culture through evidence of challenge and escalation that has improved outcomes for children