CHESHIRE EAST SAFEGUARDING CHILDREN PARTNERSHIP (CESCP) AND

CHESHIRE WEST AND CHESTER SAFEGUARDING CHILDREN PARTNERSHIP (CWAC SCP)

REPORT OF A JOINT THEMATIC REVIEW INTO CONTEXTUAL SAFEGUARDING

OCTOBER 2021

***(updated March - July 2022)**

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'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 because of criminal exploitation, and this is unacceptable. Investment in helping to protect this group is essential and urgent. Doing nothing is not an option'.

Quote from 'It Was Hard to Escape' A Report by the Child Safeguarding Practice Review Panel (2020).[1]

Section 1 Background and Introduction

1.1 Rationale for the Review

This review has been jointly commissioned by CE SCP and CWAC SCP.

The catalyst for this review was an event that took place in October 2020 when police were called to an incident in a public space, where a group of adults and a number of young people were reported to be involved in a disturbance. The incident resulted in three adults being stabbed, one of whom ultimately died of their injuries.

At the outset, the Panel were informed that six young people were involved in the incident, and all had been arrested, bailed and all became 'open' to Children's Social Care (NB some of them were already known or open to CSC as explained below in individual pen pictures). During the course of the investigation, it became clear that one young person was neither present nor involved. As such this review centres on the remaining five young people. NB all references to the sixth young person have been removed from this report (see addendum).

The five young people were from Cheshire East and Cheshire West and Chester. The incident triggered a cross-border meeting at which it was agreed that the criteria for a Local Safeguarding Child Practice Review (LSCPR) was met and that this would be conducted as a joint thematic review.

The two Partnerships saw this as an opportunity to test the local contextual safeguarding system, specifically in relation to Child Criminal Exploitation (CCE).

The young people are referred to throughout this report as S1, S2, S3, S4, and S5. These anonymisations are to protect their identities.

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf

1.2 Purpose of the Review

Whilst this report makes reference to the incident that acted as a catalyst for the review, the purpose of the review is to identify opportunities to strengthen responses to children and young people who may be at risk from child criminal exploitation.

It was agreed that the review should seek to understand the lived experiences of the five young people and to seek the views of professionals working within the CCE and safeguarding systems, with the aim of testing whether the local CCE system was fit for purpose. It was agreed that the review would be tasked with analysing the effectiveness of the current systems across both areas and making recommendations to strengthen the whole system.

The final report was approved by the review panel and by the respective Executive Groups of CE SCP and CWAC SCP.

1.3 Definitions

The following definitions are included to inform the reader:

Definition Contextual Safeguarding

Contextual safeguarding recognises that as young people grow and develop, they are influenced by a whole range of environments and people outside of their family. Children and young people may encounter risk in any of these environments. Sometimes the different contexts are inter-related and can mean that children and young people may encounter multiple risks.

Contextual safeguarding looks at how we can best understand these risks, engage with children and young people, and help to keep them safe. It is an approach that has often been applied to adolescents, though the lessons can equally be applied to younger children and vulnerable adults, especially in today's changing world.

https://learning.nspcc.org.uk/news/2019/october/what-is-contextual-safeguarding

Definition of Child Criminal Exploitation (CCE)

Child Criminal Exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur using technology.

Definition of County Lines

County lines is 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

1.4 The Review Questions

The review set out to answer three key questions:

Question 1: The context: What is known about local conditions that impact contextual safeguarding?

Question 2: The system: Is there a whole system response to contextual safeguarding within each area and across boundaries? Is this joined up? Is it effective? Do agencies understand their roles and expectations?

Question 3: The people: What can we learn from the daily lived experience/perceptions and behaviours of these young people that would help us to respond to known and perceived risks in future?

1.5 Pen pictures of the five young people

The review gathered information about the five young people from a range of sources including agency records (CSC, health, schools) and interviews with their current social workers. (NB The young people themselves and families/carers were not spoken to during the review due to the status of the criminal investigation – see Recommendation 8).

To understand what might have brought these five young people into such a high-risk situation, the review began by looking reviewing available information about their contact with services and building up a brief biography (pen picture) of their lived experiences.

The pen pictures of each young person are set out below. The biographies begin with child S1 and end with the S5 (at the time of the incident their ages ranged from 15-17).

Young Person S1

At the time the incident took place S1 had not been 'flagged' on the CCE/CSE system.

S1 was educated at a local academy and later transferred to another school and was educated off-site. His current social worker[2] identified that S1 'struggled with education' and found it difficult to engage.

Records indicated that S1 had been diagnosed with ADHD[3] but refused to take medication or to comply with any form of treatment.

[2] In every case the term 'current' social worker refers to their worker at the time this report was written (October 2021)

[3] **ADHD** is one of the most common neurodevelopmental disorders of childhood. It is usually first diagnosed in childhood and often lasts into adulthood. Children with **ADHD** may have trouble paying attention, controlling impulsive behaviours (may act without thinking about what the result will be), or be overly active.

S1 had a number of adverse childhood experiences. Records indicate that there was criminality in his family and connections to drug supply.

He had been open to CSC since March 2020 when a Children and Family Assessment was undertaken. He is currently subject to Child in Need (CIN) planning and lives away from his family home with a supportive adult.

S1 was reported to have good relationship with his maternal family.

Since the incident took place S1 has engaged with services and has built a good relationship with his keyworker at a commissioned service, which was seen as being a positive indicator.

Young Person S2

At the time of the incident, S2 had been 'flagged' on the CCE/CSE system and since January 2020 had been graded as medium risk for CCE.

S2 had been 'missing' on several occasions. At the time of the incident a rapid review was pending in relation to S2 as he had recently been found in another part of the country during a missing episode. This had raised concerns that he was a victim of 'County Lines' activity, placing him at high risk of further CCE.

S2 was educated at the same Academy as S1, however he was subject to permanent exclusion (which was subsequently rescinded) however this was not put into place and S2 did not return to school.

S2s mother shared her concerns with Police, Children's Social Care and School that S2 had ADHD. Family Carers and School did not support this. S2 is described as having transitioned well to high school, and although there were some minor issues with behaviour attendance had been good and he had engaged well with support and his studies until October 2019. School noted that as key turning point. They reflected that he had been a "cheeky chap" but following a change in friendship group there was a significant change in his behaviour and a marked deterioration in his engagement with education.

He has had several adverse childhood experiences going back to his early years including substance misuse, domestic abuse between parents, abuse and neglect, and a parent serving a custodial sentence.

He had a long history of involvement with CSC and had been subject to S20 accommodation[4] since October 2020.

S2 was reported to have had poor family relationships which have been an ongoing issue for him.

Intelligence links S2 to Possession with Intent to Supply (PWITS), County Lines, and carrying weapons (knives). S2 is known to use cannabis.

[4] https://childlawadvice.org.uk/information-pages/section-20-accomodation/

His current social worker (see note 2 above) observed that he is at continued risk of being drawn back into CCE as he has strong affiliations and has a reputation amongst his peers as someone who has significant kudos because of his status and associations. It was felt that S2's status in the exploitation network is important to him and his social worker felt that S2 had not been completely open with them about the extent of his involvement.

Since his arrest he had complied with bail conditions and was said to have 'really engaged' with a local commissioned service, which was seen as a positive factor.

Young Person S3

Between February 2020 and April 2020 S3 had been assessed as medium risk and 'flagged' on the CCE system, however this risk rating had been reviewed by the Child Exploitation Operation Group (CEOPs) which resulted in him being re-graded as low risk and therefore closed to the CCE system.

S3 was educated at the same Academy as S1 and S2 and had subsequently enrolled at a college, however he had not attended at the time of writing this report (October 2021)

Records show that S3 has not presented with any significant mental health history and has not been diagnosed with ADHD, but it is noted that he suffers from anxiety and his current social worker (note 2) thinks that, whilst he maintains a good 'front' he probably experiences mental health issues that he does not disclose.

He has a long history of involvement with CSC and has been a Looked After child since 2017. He has been in a long-term placement with a foster carer which has been positive, however the placement ended when the foster carer became unwell and S3 moved to another placement, which was felt to be a major disruption for him.

S3 has been subject to several adverse childhood experiences going back to his early years. He suffered abuse and neglect as a child. There were issues of substance misuse, mental health problems, domestic abuse and criminality in his family.

Following his arrest for the incident, S3 was subject to DoLS[5] which his social worker felt had given him time and space to reflect. He had recently moved to an out of area semi-independent living placement to which he responded positively, although there are concerns about proximity and return to previous risks.

Intelligence links S3 to drugs supply, robbery and carrying a knife. He has a conviction for drugs supply and a prior conviction for stabbing.

Since his arrest S3 has engaged with a local commissioned service, to which he has responded well.

[5] DoLS (Deprivation of Liberty Safeguards) ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and, in the person's, best interests. https://www.scie.org.uk/mca/dols/at-a-glance

Concerns for his future remain in that he is vulnerable to returning to previous associations and does not currently have access to education, training, or employment (NEET)[6].

Young Person S4

S4 had 'missing' episodes and had been flagged on the CCE system and classified as being at 'medium risk'.

He was educated in 'alternative provision' where he experienced a traumatic event (in relation to being restrained).

Health records show that S4 has been diagnosed with ADHD but refuses to take medication or engage in treatment.

S4 had been known to CSC historically and, most recently in January 2020. There are no indications of other adverse childhood experiences.

His parents separated some time ago and his social worker felt that S4 lacked a male role model. It was felt that he strongly relates to associates and refers to them as 'family'. He appears to have responded well to interventions from the Youth Justice Service who were involved with him in relation to a previous offence of S18 wounding.

Intelligence links S4 to the supply of drugs, robbery, and he has a conviction for a previous stabbing for which he served a custodial sentence.

Since his arrest S4 has engaged to some degree with social workers, although initially Covid 19 restrictions had made it difficult to meet with him, and face to face work was something he responded to. Current concerns are that he has an established role in the exploitation hierarchy and has status which he 'enjoys'. This puts him at risk of returning to previous associations and behaviours.

Young Person S5

At the time of the incident, S5 was 'flagged' as medium risk on the CCE system and had historic and recent 'missing' episodes.

He was educated at the same Academy as S1, S2, and S3. He did not achieve at school and at the time of writing this report he is not in education, employment and training (NEET)

Although there is reference in health records to S5 having been put onto the ADHD pathway, he was removed as he did 'not fit the criteria'. The review therefore believes that S5 was not diagnosed with ADHD.

He has been known to CSC for many years and, since 2015 had been a Looked After Child. He lived with a family member for several years prior to entering care, however the family

6 https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/bulletins/youngpeoplenotineducationemploymentortrainingneet/february2016

member was unable to set sufficient boundaries and in 2015 he entered a foster care placement which was said to be extremely positive.

S5 has been subject to several adverse childhood experiences since his early years including bereavement, neglect, familial domestic abuse, criminality and substance misuse.

Previous intelligence has indicated he may have been involved in supply of drugs. His current social worker (see note 2) had concerns about his levels of vulnerability and risk and the possibility that he will return to previous areas of risk in relation to exploitation.

1.5.1. Common Features amongst the five young people

Although each young person's lived experience is unique, the review has identified several important commonalities in their lives as follows:

- All five young people are male
- Four of the five young people are of 'white/British' heritage, one is of dual heritage
- All five young people had experienced one or more adverse childhood experiences as shown in their pen picture profiles and later in this report
- All five young people were known to CSC
- Except for S1 all had been 'flagged' on the CCE system, although their respective 'risk' levels differed.
- Four of the five young people are known to have had 'missing' episodes
- Connections with drugs feature in the lives of all five young people, either as users or sellers
- Two of the five young people had been diagnosed with ADHD (one was removed from the ADHD pathway and in one case the diagnosis is uncertain). Health records show that both young people had refused to take medication and were discharged from the service.
- All five had been involved in incidents (not necessarily crimes) that involved weapons and/or violence
- Four of the young people had at some point in their education, attended the same Academy
- All had been either temporarily or permanently excluded from school at some point during their education. Two of the young people were Not in Education, Employment or Training (NEET).

Further analysis of common features amongst the five is set out **Section 3.3** of this report.

1.6 The Local Context

1.6.1 The CCE System

At the time of this incident CE SCP and CWAC SCP were working within the guidance set out in the Pan-Cheshire Contextual Safeguarding Child Exploitation Pathway 2019, which contains a 'route-map' for identification, risk assessment and referral, to be used by local areas when CCE risks are suspected or known.

The pathway includes a screening and assessment tool to be used where child exploitation, or the risk of it, is suspected and guides frontline practitioners to complete the tool which is then sent to the relevant local authority Children's Service 'front door'. The 'front door' reviews information and instigates appropriate next steps for example children and family single assessment, Section 47, Strategy Meetings as required. All exploitation assessments are shared with a multi-agency panel in the respective areas who make a multi-agency decision on level of risk in relation to child exploitation.

The Pan-Cheshire system was said by practitioners participating in the review to be embedded in the local areas and clearly there is benefit in the approach. However, the review found that aspects of the system require refreshing based on local conditions, particularly the increasing demand (volume); professional (and agency) interpretation of risk; professional interpretation of vulnerability and the availability of local resources to provide interventions at varying levels of risk. The issue of thresholds was also identified as a potential barrier to interventions. These observations are developed later in this report and lead to recommendations regarding possible review of the Pan-Cheshire CCE system.

Section 2 – Conduct of the Review

2.1 Methodology

The event outlined at 1.1 above was the catalyst for the review however detail surrounding the event was not analysed as this is the role of the criminal investigation which is ongoing.

The review's thematic focus in relation to CCE is informed by local policy and practice as well as the individual 'stories' of the young people.

The review used blended methodologies which involved desktop data gathering, interaction with professionals through focus groups and interviews with key professionals and senior management oversight by a review panel that held five meetings during the review. Information gathered from all these sources was used to inform the conclusions and recommendations

As and where appropriate the review refers to national guidance, policy, practice and material from other reviews to inform its conclusions and recommendations

As stated elsewhere in this report, at the time of writing the review has been unable to involve the young people or their families due to ongoing criminal investigations.

2.2 Governance

It was agreed that the review would be a joint review across the two SCPs, with equal focus being given to each area. There are also elements of Pan-Cheshire work that inform the review.

All relevant agencies in each of the local authority areas were included in the review.

Maureen Noble, an independent reviewer was appointed to undertake the review with the review being overseen by the two local Partnership Business Managers and a panel of senior managers from both areas. Terms of reference and an operating schedule were agreed as set out in the 'methodology' section of this report.

A panel (referred to as 'the review panel') was appointed to oversee and direct the review. The panel oversaw the production of this report and agreed the conclusions and recommendations. Panel members were responsible for ensuring their agencies fully participated in the review and for working with the author to produce a final report.

A communications strategy was agreed by the review panel.

Administrative arrangements were agreed by the review panel in conjunction with the respective Partnership Business Managers.

2.3 Scope and Outcomes

The review focused on all five young people involved in the event that triggered the review.

The review considered wider influencing factors e.g. the role of social media in shaping the behaviours and actions of the young people.

School exclusion, pathways for intervention in relation to contextual safeguarding and intended outcomes for young people were considered by the review.

The review considered what, if any, impact there had been on practice as a result of the Covid 19 pandemic

The intended outcomes from the review were that it would clarify:

How might the local system adapt to be more effective in understanding contextual safeguarding, anticipating and reducing risk, managing risk, adopting restorative approaches with young people?

- Can we impact the context? If so, how?
- Can we impact the system? If so, how?
- Can we impact perception and behaviour of young people? If so, how?

2.4 Terms of Reference and Key Lines of Enquiry

Question 1: The context: What is known about local conditions that impact contextual safeguarding:

- the nature and extent of county lines/gang activity,
- specific geographic areas of risk (including transport links)
- specific risk factors (individual and collective)
- effectiveness of local responses (see 'the system') below.

- role played by social media in contextual safeguarding (and how young people perceive this)
- Was there a shared understanding within and across services as to the local context e.g. community safety, safeguarding, criminal justice services?

Question 2: The system: Is there a whole system response to contextual safeguarding within each area and across boundaries? Is this joined up? Is it effective? Do agencies understand their roles and expectations?

- How would the system respond if one of the children had been an adult at the point of the incident? Is there a Whole Life Course response, across transition points, and what does that look like at a service level e.g. criminal justice, safeguarding?
- The use of stop and search as a component of contextual safeguarding and how information is shared across areas and agencies to inform risk assessment and management
- The use and quality of tools, single and multi-agency, to assess and inform risk assessment and the effectiveness of these in informing risk management plans
- The impact of school's current response to risk where there is criminal exploitation and how this can be shaped by best practice – with a focus on behaviour management and school exclusion, and what other services can do to support sustaining young people in education – also to look at alternative provision and risk management
- The extent of inclusion of the assessment of context for all children at the earliest point in early recognition
- What did engagement with Mental Health Services look like, prior to their engagement with Criminal Justice Liaison? How integrated are ADHD services in children's plans?
- Does the system actively engage young people? Is the offer shaped in such a way that children want to engage?
- How is non-engagement communicated at the point of discharge with services?
- The early identification of escalation in MFH episodes, the impact of return home interviews on the safety plan, the role of parental control and the interventions that follow in keeping these children safe.
- Information sharing within local areas and across boundaries, including between Child Exploitation Operational Groups.
- The use of community intelligence including reports of anti-social behaviour, carrying of weapons including knives, drugs and alcohol and community reports of domestic abuse
- Understanding the unintended consequences of disruption in one community to other communities and how this information might be better s hared.

Question 3: The people: What can we learn from the daily lived experience/perceptions and behaviours of these young people that would help us to respond to known and perceived risks in future?

- Known ACEs and responses (including domestic abuse). Is trauma-informed practice embedded in each area?
- ADHD: The impact of children not taking prescribed medication on their behaviour, vulnerability and risk, and how this assessed by health services and informs agency action. Are there any apparent links between ADHD and school exclusion?
- Mental health and well being
    - Impact of school exclusion
    - Impact of pressures to join 'gangs' – exposure to exploitation – personal power and response, identity, status and influence
    - Family factors as features of risk and resilience
    - Bigger picture motivators – culture and community
    - Were needs identified and assessed in a timely way and did the outcomes (EHCP, Health and Social Care Plans etc)
    - Young people's involvement with the Criminal Justice System

NB: As set out earlier, this element of the review was constrained due to the ongoing criminal proceedings. The reviewer was unable to speak with the young people or their families directly, and a recommendation regarding reviewing current CPS guidance[7] is made (see Recommendation 8).

Section 3 Sources of Information to the Review

3.1.1. The subject Young People and their families

From the outset the review intended to involve the five young people and their families. However, due to ongoing criminal proceedings it has not been possible to do so.

NB The panel agreed to monitor the criminal investigation and, if the criminal proceedings conclude within a reasonable timescale, to seek learning from the young people and their families. See Addendum.

3.1.2. Focus Groups

Three multi-agency focus groups were held that involved practitioners and managers from a wide range of agencies across both areas. Some of the practitioners had direct experience of working with the young people.

The focus groups addressed the key lines of enquiry and made recommendations for consideration by the panel, many of which form the basis of the review's recommendations.

Attendees and key messages from focus groups are attached at Appendix 1.

3.1.3. Conversations with Social Workers

The reviewer and relevant business manager held one to one conversation with professionals working with the young person i.e. their current social worker (see note 2 above) or social work manager.

[7] https://www.cps.gov.uk/legal-guidance/safeguarding-children-victims-and-witnesses

Conversation transcripts were shared with professionals to ensure their accuracy. Relevant information from the conversations is included in the pen pictures of each young person.

3.1.4. Local Police Problem Profile

A problem profile is a detailed analysis conducted by local police to identify key risks, threats and opportunities in relation to aspects of crime and criminal behaviour. Much of the information contained in problem profiles is sensitive and protected, however it is made available to local partnerships via the local Serious Organised Crime Boards.

Extracts from Cheshire East and Cheshire West and Chester profiles provided below have direct relevance to this review and are provided to give an overview of the context of CCE within each local area, and to illustrate specific risks as they relate to young people vulnerable to CCE.

Although problem profiles were not shared in advance with participants in this review it is apparent that there are many areas in which the evidence base corresponds with professional experience, understanding and concern.

3.1.5. Local, Regional and National Guidance and Research

The review has used a range of guidance and research to test and triangulate its findings. References are included throughout the body of the report as appropriate.

3.2 Learning Identified by the review

3.2.1. Focus Group Learning

Each focus group was asked to address the terms of reference and key lines of enquiry within a guided discussion. The guided discussion method was used to keep groups focused on the key questions – inevitably the balance between topics was determined to some extent by the participants and by the professional background and focus of participants. This was not deemed to have affected or influenced the content or outcome from the discussions, however, the review panel noted that some topics were not raised by the groups (e.g. the use of stop and search), despite some panel members feeling that these topics were of relevance.

Focus group discussions were fed back to the review panel and form the basis of the key learning, conclusions and recommendations contained in this report.

Learning from all three focus groups is summarised below under thematic headings related to the key lines of enquiry and summarised with bullet points. These themes are consolidated in the conclusions and recommendations in the last chapter of this report.

Learning Themes

3.2.2. The CCE 'system'

All focus groups said that the CCE system works well at the strategic level in both areas, however it was noted by all the groups there are some difficulties in practice (operational

level), which are explored later in this report (e.g. volume of referrals, screening and assessment tools).

It was highlighted that there are similarities in the models in both areas, but that the day-to-day systems operate differently. This was not deemed to be problematic, merely an observation that led to further discussion about differences in implementation (as seen later in this report).

Both areas have a multiagency approach that corresponds with the Pan-Cheshire model. [8]

Cheshire East hold weekly exploitation meetings and two contextual safeguarding meetings, one in Macclesfield and one in Crewe. The groups are focused on actions, they discuss commissioning of services and looking at different ways of engaging to reach vulnerable children and how to engage them proactively.

It was generally felt that there is a joined-up approach to working with families in Cheshire East, and the focus groups highlighted the importance of coming into family lives at the right time and not overwhelming them. A recent development has been that the screening tools are completed in conjunction with families and workers meet with them to get a better picture of what is going on. The lead worker comes to the meeting to present case, so the meeting is not just looking at a piece of paper. This way of working is relatively new but has been helpful in bringing a clearer picture from families.

Cheshire West

Cheshire West holds a weekly Multi-Agency Contextual Safeguarding Hub (CS Hub) meeting which considers all new assessments/referrals and allocates the young person (and when appropriate their peer group or the location) to the most appropriate intervention based on perceived need as opposed to levels of risk. The Hub is attended by the locally commissioned CE service, Pan Cheshire commissioned Missing Service and the local Youth Service all of whom share information and will undertake direct work with the young people as appropriate. Health, Police, Social Care and Education are also present and additional actions are allocated accordingly to ensure there is a co-ordinated response to the child and their family.

Cheshire West also has a monthly Multi-Agency Child Exploitation Operational Group meeting, chaired by Police, which is focused on sharing information to assess the level of risk to a young person, to ensure the plan is progressing and to identify actions pertaining to any perpetrators that are identified. The review heard that the CS Hub has been in place since October 2020 and that a piece of work is underway to review the relationship between CS Hub and CEOPs groups.

Across both areas there are examples of good multi-agency working, however there was some concern expressed in focus groups about how effective the response is when 'things

[8] https://www.proceduresonline.com/LimitedCMS_centrally_managed_content/pancheshire/shared_files/context_sg_strat.pdf

go wrong' for the young person, or when they do not want to engage and/or refuse consent. It was felt that many of the young people who are on the periphery of CCE do not meet the threshold for intervention and can therefore slip below the radar of services. This led to discussions regarding the range of services that are needed to engage at risk young people, and the paucity of some services (e.g. targeted youth support). These aspects are explored under relevant themes below.

Participants felt that the risk management meetings in both areas were long and time consuming (there are different meetings being held and this comment is likely to refer to the CEOPS meetings); a lot of professional's attend, and the number of referrals is increasing. It was suggested that there is a need to look at streamlining and reviewing the local systems, including a review of the quality of completion of the screening/assessment tool, as some of the tools contain very limited information. This may be due to unwillingness to provide information or to the skill and understanding of professionals, however, it was highlighted that there should be training available for all services on how to complete the tools to ensure they are of good quality and can help to shape decision making and interventions (it should be noted that the limited availability of training may be due to the pandemic).

Schools highlighted that more training is needed for schools in the use of CCE tools. There was a view that schools are not 'taken seriously' when making referrals and that existing thresholds should not get in the way of accepting referrals into the CCE system.

3.2.3. Mental Health

All focus groups agreed that there is a strong correlation between mental health and young people known to the CCE system. A recent deep dive exercise undertaken by the Cheshire and Wirral Partnership showed 80% of young people in the CCE system have been referred to/engaged with mental health services.

Mental health was highlighted by all focus groups as an area where more work needs to be done. Concerns were expressed that the five young people and their families/carers did not always recognise or identify their own mental health needs, however it was clear from those who had worked with them that mental health assessment and interventions were critical to addressing current and future risk and vulnerability.

CAMHS and School Nursing were highlighted as services where there may be opportunities to strengthen practice in relation to CCE, and it was suggested that specific packages of care for young people at risk of exploitation might be beneficial.

3.2.4. Prevention, Early Identification and Early Help

All focus groups identified prevention and early help as key elements of a robust, whole-system approach to CCE. Discussions centred around the creation of a 'CCE prevention strategy' and creating opportunities to intervene earlier with those at risk of CCE. Discussions took place about whether the current 'early help offer' was sufficiently focused on CCE indicators. Practitioners who had worked with some of the young people observed

that, when looking at their histories, many of the indicators of future problems were already present.

As well as looking at young people and their families, focus groups also felt that it was important to harness and mobilise neighbourhood and community resources e.g., Police Community Support Officers, Neighbourhood Teams, ASB services and others. Work has begun in both areas to strengthen the links between the Safeguarding Children Partnerships and the Community Safety Partnerships, this is a positive development and should continue.

Preventative work has taken place in both areas in local communities, learning can be developed from this work, and it may serve as a model for preventative work in the future. For example, prior to the incident leading to this review ASB teams in Cheshire West delivered knife crime and exploitation courses to several thousand pupils.

It was reported by focus group participants that community-based staff are doing their best to get in early with young people. Informing parents, using local intelligence, and supporting them has been effective in getting preventative messages out to the community.

School representatives from both areas felt that early identification and intervention could be strengthened. Concerns were again expressed that early indicators of risk and vulnerability do not 'meet the threshold' for intervention and are therefore not addressed. Participants noted that 'there are lots of indicators (*of risk and vulnerability*), but these are often seen in isolation rather than as a whole'.

Referring to other parts of the system e.g. Team Around the Family and the Missing from Home Service it was felt that these interventions do not address the problems and presenting needs, and that a specific CCE early help pathway should be developed.

All focus groups said that there should be increased focus on the prevention of CCE. It was noted that exploiters are sophisticated and know how to target and groom, and that for many young people they are already embroiled in the exploitation network before they realise the danger.

It was highlighted that it is important that professionals (and families/carers) know more about how exploiters work, identifying key factors that make young people vulnerable and spotting the signs early enough to make prevention meaningful.

It was highlighted that the 'prevention panel' model in Cheshire East had been a good one as it enabled referral at an earlier stage. This Panel had been stood down in a restructure, but it was felt that it should be revisited as a useful model.

3.2.5. Definition of Risk and Vulnerability, Use of Language and Communication

There was a strong view in all the focus groups that there does not appear to be a shared definition of risk and vulnerability, or a common language to describe risk and vulnerability across agencies. This impacts on the whole system, from assessment through to interventions, as a shared language and shared understanding is the bedrock of effective multi-agency working.

Some participants expressed the view that CE Ops groups are using a different set of criteria when risk rating, specifically looking for evidence of exploitation which isn't always possible. It was highlighted (on more than one occasion) that there is not enough time for discussion in panels and that they are becoming overloaded, this is the case in both areas.

All focus groups agreed that communication between agencies and across geographic boundaries is critical to successful joint working, it was suggested that developing a communication strategy specific to CCE would be a useful tool.

Focus groups highlighted that crucial to success with at risk young people and families is the ability to identify them early and being agile enough to respond quickly. It was felt that there appear to be different thresholds for vulnerability within contextual safeguarding. As referred to earlier, there is a need to address definitions of what is meant by the term 'vulnerable' and to include these definitions in training and tools to support practice.

The use of language when referring to vulnerability and risk was felt to be crucial to the outcomes for young people in terms of mitigating risk. Shared definitions and clear communication with young people, families and across agencies is needed.

3.2.6. Drugs

There was a strong view in all the groups that young people are becoming increasingly involved in cannabis use and dealing, and that this is seen as 'normal' within some groups of young people. The 'normalisation' of cannabis was expressed as a concern by all three focus groups.

Cannabis as a currency within exploitation appears to be well known locally. This is mirrored in the police problem profiles and is apparent in conversations with young people who are engaged with services.

A discussion took place regarding evidence that cannabis can be a coping mechanism for early trauma and a means of managing symptoms of conditions such as ADHD. Whilst only two of the five young people involved in the incident had been diagnosed with ADHD; there was concern that 'a lot of children are not taking prescribed ADHD medication' reporting that they do not like the effects of medication (saying it makes them feel disconnected and 'like zombies'). It was also reported that some young people feel they only need to take medication whilst they are in attendance at school.

Concerns were raised in practitioner conversations that exploiters may be discouraging young people from taking medication to coerce and control them more easily.

3.2.7. Parents and Carers

The role of parents and carers was highlighted as being key, both in terms of early help and when risk has increased.

It was recognised that it can be challenging to engage parents and carers, however there is already some good practice through direct work, this could be strengthened by targeted packages of work to involve them including training for parents and foster carers (in relation

to CCE); focus on setting rules and boundaries; building and strengthening relationships and working with professionals.

3.2.8. Engaging Young People

Similarly, there is a need to focus on getting young people (at all levels of the risk spectrum) engaged and talking. Noting the lack of trust and trusting relationships experienced by some of the young people in this review, it was also noted that amongst the group of five there were high levels of loyalty to peers (and exploiters), indicating that there are strengths to build on.

Commissioned services that operate in both areas have demonstrated success in maintaining engagement with young people who may have difficulty in forming and maintaining trusting relationships. These models of practice show particular promise for improving outcomes for young people involved in CCE and should be supported and evaluated as part of a whole-system response.

3.2.9. Transition

Focus groups highlighted the importance of recognising that working with highly vulnerable and at-risk young people is a lengthy process, and particularly that it takes time to break down barriers.

There was concern that, when a young person in the CCE system turns 18 there may be a drop-in support and systems and no clear handover or transition to adult services. It was felt that at this time the young person may need more rather than less support because of increased independence.

It was noted that models are being developed in relation to an all-age approach to exploitation and that there is an integrated adult offender management scheme which could be a useful model for CCE.

All focus groups highlighted the need for adults and children's services to work closely together to tackle the broader issues of CCE and to work collaboratively on case management for those young people already identified as being at risk.

3.1.9. Schools/Education

It was highlighted that resources in some schools are stretched, for example one school reported that they no longer have on-site counsellors, which were a useful resource.

An example of good practice is having a link into the Safeguarding Children in Education Teams in both areas. This provides a consistent source of information and provides a single line of communication to the exploitation meetings in both areas which works well for practitioners.

Practitioners in schools are thinking more creatively around school exclusions and work is taking place in both areas to avert school exclusions.

Both Hospital Trusts are part of a scheme aimed at identifying early risk behaviours in the context of self-harm and are sharing information with schools. This has been useful in terms of risk assessment and getting information to the right place. Whilst this was started in relation to work around self-harm there are similar issues around alcohol and substance misuse and the pathway could be applicable to CCE.

3.1.10. Workforce and Services

Focus groups felt that it was important not to lose sight of the good work that has taken place in relation to developing services and skills to address CCE.

However, it was acknowledged that skills in the workforce need to be developed and it was noted that there are opportunities to do this. The message coming through was that 'it is not about creating a whole new workforce, but about using the best person for the job from the staff we already have'. A broad range of professionals need to be involved taking a 'Team around the young person' approach. It is important that there is a lead professional for the young person, but it was felt that this does not need to be a social worker.

All the focus groups noted that services and the system are under pressure and that the pandemic has added to the pressure of services and will continue to do so. Good work is going on in relation to medium and high-risk cases however it was generally felt that those who are deemed as lower risk may not be getting interventions when they need them (early help focus). One practitioner highlighted that with every young person there are 'reachable moments' that offer opportunities for positive interventions at an early stage, the challenge is engaging young people and their families in the right way at the right time.

There are opportunities to tap into the 'community' workforce for example outreach work with Police Community Support Officers. The role of the community in building relationships and trust should not be overlooked.

3.2 Focus Group Learning Summary

Asked to consider 'what could be done differently, what would make a difference' the focus groups made the following observations:

- Develop an Early Help model for CCE that focuses on 'low risk' young people
- Increase staff awareness, confidence, and support via training
- Develop specific definitions of vulnerability and risk across the entire workforce
- Share information about the wider context – understanding of exploitation, local circumstances, levels of risk
- Develop understanding of mental health needs of children and their families as part of the CCE pathway
- Think Family – focus on work with families and carers
- Strengthen focus on prevention both with young people, families, and communities
- Develop stronger links with adult services and create pathways for transition for those already at risk of CEE, recognising that engagement and trust can take a long time to come to fruition

- Develop psychosocial interventions at an earlier stage and adopt models of 'social prescription'
- Empower communities – better use of community and neighbourhood intelligence to inform planning of prevention activity and communications

3.3. Learning from Professional Conversations

The learning set out below is drawn from conversations with the current or most recent social worker for each young person.

As identified earlier in this report, whilst each young person's daily lived experience is unique, there are several elements that are common across all five young people. It is on these areas that the review has focused to derive learning that can inform practice.

3.3.1 Adverse Childhood Experiences

All the young people and/or their families had varying degrees of contact with agencies in relation risk, vulnerability, and adverse childhood experiences. These included exposure to domestic abuse in the family home, exposure to criminality, parental and familial drug and alcohol misuse, familial mental health issues, loss and bereavement, breakdown in family and parental relationships, becoming 'looked after' and abuse and neglect in the family home.

Research indicates that exposure to four or more adverse childhood experiences may result in ongoing trauma, impact brain development, and contribute to conditions such as ADHD. [9] Studies also show that ACE's impact across the life course and contribute to morbidity in adulthood as well as in childhood and adolescence.[10]

3.3.2. Trusted adult relationships and role models

The views of professionals currently involved with the young people indicated that all five were seeking trusted adult relationships and role models. They all appeared to value interventions by commissioned services, and some elements of interventions with Youth Justice and Youth Service workers. There was an equal view that the young people did not relate to 'authority' figures, and, with some exceptions, they viewed social workers as authoritarian.

Professionals experienced some dilemmas regarding enabling and supporting trusted relationships, whilst also discharging their professional duties, this was particularly apparent in terms of sharing information and matters of perceived confidential relationships between workers and young people.

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[9] https://scholar.google.co.uk/scholar?q=Impact+of+ACE%27s+on+child+development&hl=en&as_sdt=0&as_vis=1&oi=scholart

[10] https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30145-8/fulltext#:~:text=Associations%20between%20adverse%20childhood%20experiences%2C%20high%2Drisk,behaviors%2C%20and%20morbidity%20in%20adulthood.&text=Exposure%20to%20ACEs%20is%20also,including%20cancer%20and%20cardiovascular%20disease.

It was suggested that there should be a specific 'team around' approach to young people in the CCE system that would break down barriers with the young person, whilst also ensuring clarity about professional roles and responsibilities.

3.3.3. Being 'Missing' as a Risk Factor in CCE

Four of the five young people had been 'missing' at some point in the period reviewed. The review found that the term 'missing' from home or school can cover a multitude of situations. It is well evidenced that being missing increases exposure and vulnerability to exploitation and can be an indication of involvement in 'County Lines' activity. However, a more specific grading of risk episodes is required to understand the episode and the context.

3.3.4. Health and Mental Health Indicators

Professionals expressed concern that young people who are diagnosed with ADHD may be 'self-medicating' with Cannabis. Anecdotally, there were concerns that exploiters may encourage young people to disengage from treatment to decrease emotional stability and increase impulsive behaviour, thereby making them easier to coerce and control. Whilst there was no specific evidence for this in the young people in this review, it is noted that both young people diagnosed with ADHD had been discharged from services due to non-engagement/compliance with medication.

Although professionals raised significant concerns around mental health issues there is no evidence that these issues have been recognised by the young people or their families or the significance linked to safeguarding concerns by professionals. The review panel felt it important that raising awareness and responding to mental health needs amongst young people and their families is an ongoing priority.

3.3.5. Education

All five young people had experienced disruption to their education. Temporary and permanent school exclusion featured in all young people's profiles as highlighted earlier in this report.

Schools involved in the focus groups highlighted the need to identify and intervene early with young people who were vulnerable to exploitation, whilst recognising that identifying signs and symptoms and developing bespoke responses was challenging.

3.3.6. Behaviour and ASB (Anti-social behaviour)

All five young people had exhibited behavioural problems beginning in early adolescence.

All identified strongly with close friendship groups (although not necessarily between the five individuals involved in the incident). Whilst all the subject young people describe themselves as loyal and see this as a positive trait, they appear to have demonstrated a lack of understanding of the connection between behaviours, actions, and consequences.

All the young people were involved in some form of antisocial behaviour (ASB) which was known in their local community and at school.

All five young people displayed indicators of violent behaviours, and all had either carried or used knives and appeared somewhat desensitised to the use of violence.

It was reported by Social Workers that each of the young people has been severely affected by the criminal proceedings. Some of the young people are 'fatalistic' about their future prospects and feel sure that they will go to prison if charged. Whilst this has resulted in some reflection about their circumstances it was felt that their current fears about the future may not last and that they are all vulnerable to returning to their previous lifestyles.

3.4 Police Problem Profiles

3.4.1 Cheshire East (November 2019)

A detailed problem profile was completed in September 2019 and updated in December 2020. The key areas relating to this review are set out below:

Deprivation figures for 2019 show that Cheshire East ranks 228th out of 317 Local Authority areas in the Indices of Deprivation. Higher levels of deprivation can support the infiltration of OCGs into an area (loan sharks, recruitment of drug dealers, using the homes of the vulnerable for criminality etc) as people can see criminality as a way to a better lifestyle or coping mechanism.

Four neighbourhoods across Cheshire East rank in the 10% most deprived in England. These are Crewe Central, Crewe St Barnabus, Crewe East and Macclesfield South. These areas do show a correlation with the highest numbers of ASB, OCGs and county lines drug dealing teams, discussed later within the document.

> *Cheshire Constabulary has mapped 92 Organised Crime Groups (OCGs) across Cheshire of which 26 are considered active; regional data indicates a further 99 active OCGs also have an impact across the county. (These OCG's are managed by other Forces / Agencies.)*
>
> - *Cheshire East has 17 OCGs linked by residence of OCG members or businesses. The main cluster of residences linked to the 53 OCG nominals are in and around Crewe, Macclesfield and Wilmslow.*
> - *There are 17 companies linked to OCGs in this area of the county. The companies cover a range of services, including restaurants, car washes, haulage firms and property related companies.*
> - *On average, each OCG is linked to approximately 8 crime types.*
> - *Cocaine (Powder) supply is the most prevalent drug criminality linked to OCGs with nominal resident within Cheshire East. This is followed by cannabis supply.*
> - *The OCGs linked to drugs supply are strongly linked to violence against the person type offences and criminal use of firearms.*

- *The majority of OCGs linked to Cheshire East are linked to drug supply, setting up or maintaining drugs markets in the more urbanized areas such as Crewe and Macclesfield. There is also a significant footprint of organized criminality around the Wilmslow area. The impact of the OCGs from Merseyside and Manchester further influences this criminality as they are predominantly linked to drug supply of other Class A substances such as Heroin and Crack Cocaine.*
- *For the period 01/02/2019 to 01/08/2019, the greatest volume of intelligence reports relating to Cheshire East were regarding drugs supply.*
- *There were 12 active 'County Lines' teams (at 02/09/2019) in the Cheshire East area who originate from Merseyside and Greater Manchester; however, this picture changes swiftly. They use local drug users and addresses for their drug activity, which predominantly involves crack cocaine and heroin.*
- *Money laundering is becoming more sophisticated in order to hide criminal finances. This is particularly true within Cheshire East.*
- *Nearly all counts of organised theft relate to Burglary, mainly where the car is targeted by the OCGs, known as Car and Key Burglary.*
- *Cheshire East needs to be considered as vulnerable to theft of firearms. Shotguns are a desired commodity in serious and organised crime. It is important that firearms holders maintain the highest security standards for their weapons.*
- *Cheshire East, along with the other local authority areas within Cheshire, has seen an increase in violence offences. It is likely that the rise in serious violence is linked to the complex relationship between current criminal, social and economic drivers as well as the funding constraints on local public services including Youth Services.*
- *Reports of Anti-Social Behaviour (ASB) have significantly reduced over the last two years in Cheshire East. There is crossover between ASB hotspots and areas of Cheshire East linked to OCGs and SOC. Involvement in ASB can be a pre-cursor to involvement in organised criminality.*
- *The crime rate for 2018 was 80.89 per 1000 population which places Cheshire East as fourth out of the four local authority areas in relation to the crime rate per population within the Cheshire area. The crime rate has risen in Cheshire East from 57.47 per 1,000 people in 2016. This rise is in line with the other Local Authority areas within Cheshire.*
- *The relationship between alcohol and violence is evident, alcohol related crime continues to rise year on year and is currently at a rate of 7.61 per 1,000 population (previously 4.30 per 1,000 population in 2016). Similarly, crime where drugs are an influencing factor continues to increase year on year and currently stands at a rate of 1.84 per 1,000 population (previously 1.10 per 1,000 population in 2016).*
- *Nominals involved in SOC may also be linked to domestic abuse and having adverse effects on their children due to their lifestyle. Reporting of domestic abuse linked to these individuals can be a vital part of a partnership 4P approach to safeguarding and disruption of criminality. A full partnership response ensures safeguarding requirements are met and diversionary measures are taken, as domestic violence is a key element of adverse childhood experience.*

- *The rate of Missing from Home incidents has reduced in 2018 compared to 2017. This is positive as this type of behaviour creates opportunities for OCGs to recruit vulnerable individuals who can enter the offending continuum to become SOC nominals.*
- *Currently, there are no mapped OCGs linked to Child Sexual Exploitation in Cheshire; however, this has been noted as an infrequent feature in some County Lines Teams within Cheshire East.*
- *Vulnerabilities linked to mental health offer SOC networks opportunity to exploit, recruit or coerce their victims in order to further their criminality. This along with substance dependence, high deprivation factors and troubled family life combine to produce favourable circumstances for SOC to take root in local communities and have been recognised as pathways into serious crime.*
- *Victims aged between 50 to 59 years old were the highest level of victims of cyber dependent offences. Currently no OCGs linked to cybercrime are mapped in Cheshire, however, cybercrime, especially cyber-enabled crime, is now considered volume crime especially fraud related offences.*
- *The increasing volume of intelligence reports in Cheshire East relating to Modern Slavery shows an increasing awareness of this crime type across Police and Partners*

The profile highlights that safeguarding of vulnerable children and adults is the highest priority for all public services and partners including charities and local businesses who have the skills and resources to assist those in need.

There is a need for the SOC Local Partnership Board to commit to and create an Asset Audit of all the resources available across the Authority footprint, who will assist in safeguarding, prevention, diversion and reducing the risk to those who are vulnerable to serious and organised crime. Local Safeguarding Boards provide strategic multi-agency leadership to ensure that adults and children in Cheshire are appropriately safeguarded. Boards work with CSPs on cross-cutting issues in such areas as Domestic Abuse, Sexual Exploitation, Human Trafficking, and Mate & Hate Crime. Community Safety Partnerships (CSPs) continue to work closely with the Complex Families team to ensure improved use of police information and joint working with front line police staff

3.4.2. Cheshire West and Chester (September 2019)

A detailed problem profile was completed in September 2019 and updated in December 2020. The key areas relating to this review are set out below:

CWaC ranks 163rd in the national Indices of Deprivation, putting it mid-level for deprivation in the country; the problem profile highlights that higher deprivation can support infiltration of Organised Crime Groups (OCGs)[11]s to an area (loan sharks, recruitment of dealers, using

[11] An OCG is defined (section 45(6)) as a **group** which: has at its purpose, or one of its purposes, the carrying on of criminal activities, and. consists of three or more people who agree to act together to further that purpose.

the homes of the vulnerable for criminality, etc.), as some people see criminality to a better lifestyle or as a coping mechanism.

The profile notes that fourteen neighbourhoods across the Borough rank in the 10% most deprived in England, which is an increase from 12 in 2010, and approximately, 20,600 residents live in these areas. Three neighbourhoods are ranked in the 2% most deprived in England – two in Winsford (Over and Verdin ward and Wharton ward) and one in Chester (Lache ward). Around 4,402 residents live in these areas of CWaC.

Between June 2018 and May 2019 CWaC had the highest number of arrest locations (25 for the Cheshire area) for under 18-year-olds. The subjects ranged from age 14 to 17 years old and were linked mainly to Cannabis offences. The remaining offences were linked to Class A drugs, mainly the supply of Cocaine and Crack.

The profiles note that people involved in serious organised crime may also be linked to domestic abuse and the adverse effects that this can have on children. Reporting of domestic abuse can be a vital part of a partnership 4P[12] approach (set out in the SOC Strategy) to safeguarding and disruption of criminality. A full partnership response ensures safeguarding requirements are met and diversionary measures are taken, as domestic abuse is a key element of adverse childhood experience

The profile notes that the rate of Missing from Home incidents has remained relatively stable, however data for 2019 shows 260 incidents in May, which is the highest recorded per month for CWaC since January 2013. This type of behaviour creates opportunities for OCGs to recruit vulnerable individuals who can enter the offending continuum to become involved in serious organised crime.

The profile highlights that vulnerabilities linked to mental health offer SOC networks opportunities to exploit, recruit or coerce their victims to further their criminality. This along with substance dependence, high deprivation factors and troubled family life combine to produce favourable circumstances for SOC to take root in local communities and have been recognised as pathways into serious crime.

In relation to drug arrests and charges, there were 1533 individuals arrested, of these nominals, 86 were under 18 years old (6%); all were male except for 1 female. The subjects ranged from age 14 to 17 years old and were linked mainly to Class B drug offences (15 offences), mainly Cannabis. The remaining 10 offences were linked to Class A drugs, mainly the supply of Cocaine and Crack. The dominance of cannabis related offences in this data links to 60% (15 counts) of the reason for arrest, however the links to Class A Drug possession and intent to supply demonstrates the links these young people must have had with serious and organised crime.

Anecdotal evidence suggests that some organised criminals use cannabis to get youths addicted to Class A drugs or to create debt bondage, either of which allows for easy exploitation of the individuals. If convicted, these nominals can be given significant

sentences, especially if their role is shown to be a controlling one. Custodial time near likeminded or controlling individuals is shown to increase the risk of remaining involved with SOC and can increase an individual's vulnerabilities such as addiction, debt or threats.

3.4.3 Recommendations linked to this Review (Cheshire East and Cheshire West)

Amongst other recommendations emerging from the 2019 problem profiles in both areas, the following link strongly to the findings of this review:

- *The increase in knife related crime and its links to self-protection, especially amongst young people, needs to be considered and prevented through education as well as diversion.*
- *We need to continue our efforts to prevent and deter young people from becoming linked to drug offending and making themselves vulnerable to serious and organised criminals. The profile indicates that educating our youth about County Lines, potential exploitation and diverting them from criminality needs to start early, between Key Stage 2 and Key Stage 3 within the education curriculum. Home Office resources are available to assist with this delivery.*
- *Closer engagement is required with those that can influence or be good role models (i.e. behavioural teams / young offender organisations / charities / early intervention resources).*
- *Focus on the reduction of ASB could be key to reducing the impact of SOC, reducing acceptance of this and other criminal behaviour.*
- *Links between drug offending and serious organised crime*

3.5. The Impact of Covid 19 Pandemic

Whilst the review is unable to evidence any specific impact on the local conditions in relation to CCE or on the CCE system itself, the following observations are noted:

- All participants in focus groups reported a negative impact on services during the pandemic with some services being unavailable and others unable to see service users leading to a reliance on telephone contact
- Police problem profiles highlight changes in serious organised crime gangs operating models during the pandemic
- Practitioners highlighted difficulties in working with young people (including some of the young people in the review) during periods of lockdown. Face to face work with young people was largely not possible during the most severe restrictions which meant that spending time talking other than by telephone, undertaking activities and visiting young people did not take place.
- Given the importance of forming trusted relationships this had a significant impact on workers' ability to engage during and after periods of lockdown.
- Some of the young people were impacted by the impact of Covid on their families and carers

Section 4 – Findings and Recommendations

4.1 Summary

The review highlighted that there is much good practice to commend in both areas. The review heard many examples of innovative practice, a willingness to challenge and be challenged and a workforce that, at every level is committed to developing a CCE specific 'whole system' approach.

Alongside commitment and willingness, the review identified that workforce development in relation to CCE should be prioritised, all the focus groups recognised that greater confidence and understanding, coupled with access to skills development and management supervision is needed to support practitioners in working effectively in identifying, assessing and providing interventions to children and families at risk of or involved in CCE.

Whilst participants in the review reflected a degree of confidence the existing workforce in both areas has the appropriate skills to respond to CCE, ongoing awareness raising, and training is needed to ensure that the workforce develops at the same pace as the challenge presented by CCE. Concern was expressed at the pace at which exploiters are able to target and recruit young people to their ranks, and the dynamic and insidious nature of their activity cannot be underestimated.

The review highlighted that there is realism and pragmatism in relation to the scale and impact of CCE as a growing issue of concern. It is recognised that the 'offer' to young people from exploiters can be extremely attractive, being both financially lucrative and providing status and 'power' to young people. It is therefore felt to be critically important to inform and educate young people and their families about the risks and dangers associated with CCE, before they become embroiled in the culture of exploitation.

All those who took part in the review agreed that targeted messages and campaigns using 'real life' stories (such as those of the five people in this review) can raise awareness and provide gateways to help and support. Harnessing the power of social media as a tool for communicating and educating should form part of a CCE communication strategy which should be developed in both areas (and possibly at pan-Cheshire level).

The review recognises that each child is unique, and it is therefore important to adopt a flexible, person-centred approach to engagement with children and families.

The Pan-Cheshire model is embedded in both areas and in general is robust, with the principles underpinning the model being sound and well understood by leaders, managers, and practitioners. However, there are aspects of the model that would benefit from review and modification. It is therefore necessary to review processes and tools to ensure that they are fit for purpose and provide a common definition to enable practitioners to accurately identify risks and vulnerabilities.

Finding 1

The review highlighted the need for a strategic multi-agency vision statement in relation to CCE that could be adopted by all agencies across both Partnerships.

The review highlighted that there may be gaps in knowledge and understanding amongst the workforce relating to the wider CCE system. This was reinforced in focus groups and points to the need to ensure that ongoing workforce training and awareness raising, alongside developing the skill set to work effectively with this complex agenda is required.

Recommendation 1

- **Reflect the learning from this review in a strategic multi-agency vision statement regarding contextual safeguarding that informs and directs future practice**

Recommendation 2

- **Use the learning from this review to enhance existing multi-agency universal and targeted training and support to professionals in relation to CCE**

Finding 2

The Pan-Cheshire screening and risk assessment tools have been modified however there is value in conducting a review and possibly refining (the assessment tool was felt by many to be too long and cumbersome to use). There is also a need to widen training across the workforce in the use of screening tools, and the use of the NRM (National Referral Mechanism).

There may be opportunities to develop a Pan-Cheshire CCE-specific early identification/early help model.

The volume of referrals into the CCE system has increased exponentially in both areas. It was felt that risk management meetings are becoming overloaded and there is insufficient time in meetings for detailed case discussions. A review of the pathway from identification through to referral would be of value. There would also be value in reviewing the system for early identification as part of this process.

Recommendation 3

- **The Safeguarding Children Partnerships to share the learning from this review with the Pan Cheshire All-Age Contextual Safeguarding Task Group so that it informs and directs developments in relation to policy and practice e.g. assessment tools, workforce development and referral systems (including managing demand on the system).**

Recommendation 4

- **The Safeguarding Children Partnerships, Community Safety Partnerships and Local Safeguarding Adult Boards should receive assurance that current work to create a Pan-Cheshire all age CCE strategy develops at pace.**

Finding 3

The over-riding message emerging from the review is that early identification and intervention is crucial to diverting children from becoming entrapped by exploiters, which for some young people leads to them entering the hierarchy of exploitation and serious organised crime.

Early identification and intervention present a challenge, as there is no 'blueprint' or hard and fast indicators of vulnerability to CCE, however building a robust evidence base and a suite of early indicators of risk and vulnerability, was seen by everyone involved in the review to be crucial to stemming the increasing number of young people coerced and controlled into exploitation.

The review has highlighted that, for some professionals, the definition of vulnerability is not sufficiently precise and may lead to subjective decision making at all points of contact (early identification, screening and referral). Agencies working together and developing a shared understanding of risk and vulnerability across the whole system is felt to be critical to ensuring that help is available at the right time and in the right place.

The role of health and mental health in increasing vulnerability should not be underestimated. There is a need to strengthen focus and joint working in this area, with opportunities to create a specific CCE/ADHD pathway and to think creatively about how CAMHS can develop their services to respond to CCE.

Recommendation 5

- **The Safeguarding Children Partnerships should be assured that the local early help offer focuses and responds to known vulnerability indicators associated with CCE and that there is a shared and widely understood definition of vulnerability to CCE**

Recommendation 6

- **The Safeguarding Children Partnerships should be assured that the CCE system gives sufficient focus to the physical and mental health needs of young people at risk of or involved in CCE and that pathways, such as the ADHD and CAMHS, are appropriately linked to CCE pathways so that non-engagement is assessed in the context of potential increased vulnerability.**

Finding 4

Many of those who contributed to the review highlighted the need to focus on prevention – both in terms of children and young people's risk factors, as well as tackling exploiters and the conditions within which they can flourish.

Targeted prevention messages at individual, family, community and agency level are needed. As referred to earlier in this report, a CCE communication strategy that

incorporates the use of social media as a powerful communication tool was seen as a positive development.

Support for, and interventions with the families of young people who have become involved in exploitation (it should be noted that there are complex dynamics in relation to young people as victims and as exploiters) is critical, as are interventions to assist young people in exiting exploitation.

It is acknowledged that parents may be fearful of perpetrators as exploiters may intimidate/target individual families. This issue can also be apparent in the wider community.

Linking child and adult safeguarding around CCE will assist in developing a 'life-course' approach to CCE, both in terms of prevention activity and addressing risks and gaps when young people transition to adulthood.

Recommendation 7

- **The Safeguarding Children Partnerships should work alongside the Community Safety Partnerships to communicate prevention messages to local communities and all the services that work to recognise indicators of CCE, including the police power to stop and search.**

Recommendation 8

- **The Safeguarding Children Partnerships should work with the Local Safeguarding Adult Boards to seek assurance that young people transitioning to adult services are offered a transition plan and appropriate ongoing support into adulthood.**

Finding 5

The review was unable to speak to the five young people or their families due to the nature of the offences for which they were being questioned (and one young person ultimately charged and convicted). This resulted in their voices and experiences not being fully captured from their perspective and in their own words (they may or may not have chosen to participate in the review), which could have impinged on useful learning opportunities.

In addition, the review noted that all five young people were continuing to experience significant distress and trauma associated with a lengthy police investigation. The review recognises the primacy of the criminal process due to the serious nature of the potential offences, however the review feels there are opportunities to learn about supporting young people and their families during the criminal process, particularly in relation to their emotional well-being and mental health.

Recommendation 9

The Partnerships should engage with the National Panel in relation to ensuring the voice/lived experience of the child can be gathered during criminal proceedings and that current guidance is not a barrier to doing so.

ADDENDUM UPDATING THE REPORT (JULY 2022)

This addendum provides an update to the original report which was written in October 2021 and submitted to the National Panel on 3rd February 2022.

As set out in the original report, at the time that the review took place the author was unable to speak directly to the young people who are the subjects of this review, or to their families. This was due to the progression of criminal proceedings.

Since completion of the review, the criminal case has concluded, and the original report has been shared with the young people and their families. Both Partnerships have also received feedback from the National Panel.

The review panel held an extraordinary meeting on 7th March 2022 to consider the feedback from the children and families, to reflect on the feedback from the National Panel and to agree how best to present updates and ensure that the young people and their families are sighted on the changes made to the original report prior to publication.

1. Update on Criminal Proceedings

One of the young people was charged with murder, a trial took place in February 2022 and the young person was sentenced to more than eighteen years imprisonment. The mother of this young person contributed her views to the review in June 2022. These views are set out below.

2. Feedback from Young People and their families

The parent of one of the young people originally in scope contacted the review to say that their child should not be referred to in this report as it had been proven that they were not present at the incident leading to the review. All reference to this young person has been removed.

The mother of the young person who was charged with murder and subsequently given a custodial sentence provided the following insights.

Mother said that her son had a very positive experience at primary school and that he was very happy there. He did have some behavioural issues but there was no referral made to CAMHS services which she felt was a failure.

Mother sought support for ADHD when her son was six years of age but there was no formal diagnosis until age eleven. Mother felt that there was insufficient support or understanding of the issues and she was told that he would 'grow out' of the behaviours. She reflected that an earlier diagnosis and interventions would have helped. Contact with an educational psychologist had been helpful but despite ADHD medication being prescribed this did not suit him and he began to 'self-medicate' with cannabis.

She felt that incidents that took place at the 'special provision' school were linked to changes in his behaviour, describing these incidents (related to being restrained) as traumatic. She reflected no counselling or support was offered to assist with his emotional health and wellbeing, which would have assisted his adjustment when moving to another educational establishment.

Mother's reflections were that in general there was little support for the family and that as her son's behaviour became more anti-social there were a range of services offering support but that there was a lack of consistency. Despite reaching out to services mother felt that 'no one really wanted to know'. She said that 'If a parent asks for help then they need it'. She felt she had waited for years for help and that by the time it came it was too late'.

She felt that earlier help and prevention could have changed the outcome for her son.

The review received feedback from two parents and two young people regarding their perception of services in relation to ADHD. One young person advised that they did not recall ever being offered ADHD medication; two young people told health professionals that they stopped taking their medication when not in school. This is potential learning, particularly in the context of extended periods without medication as a result of the pandemic.

Some concerns were also shared that ADHD appointments had 'stopped' during covid, thereby challenging the conclusion in the review that there was a lack of compliance with medication. As a result of this feedback the review meticulously examined records and saw evidence that appointments had been offered, and followed up, before the young person was discharged as a result of non-attendance.

The review nevertheless acknowledges that ADHD engagement pre and post diagnosis with services has a number of complexities. The review reflected that this can be further exacerbated if children are moving between addresses and carers, as happened for some of these young people. As set out in recommendation 5 there is a commitment to continuing to explore how services engage young people and their families.

Feedback from one of the young people suggested that in his view his schooling had some positive aspects that had not been shared with the review, and he felt this should have been reflected.

One young person asked that specific details in relation to members of his family be removed. This has been done.

The report suggested that since his arrest it was reported to the review that S5 had not engaged in any other intervention, however S5 fed back to the review that he had engaged with Youth Justice and had received positive feedback.

3. Feedback from the National Panel

The National Panel suggested that some of the recommendations would be strengthened by including more specific actions. This will be done via a detailed action plan overseen by both partnerships

The feedback from the National Panel included details of the current CPS guidance regarding criminal processes and LCSPRs. The local panel agreed that Recommendation 8 should remain as despite the guidance, complexities continue to exist that impact on the engagement of children and families within reviews of this nature.

4. Future engagement with the young people and their families

Both Partnerships are committed to a continuing dialogue with the young people and their families, as the majority are still engaged with services, however this will not form part of this report.

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