Oxfordshire Safeguarding Children Board

"Untouchable Worlds": Protecting Children who are criminally exploited and harmed

Child Safeguarding Practice Review: Jacob

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Executive Summary

Introduction

This Review was commissioned by Oxfordshire's Safeguarding Children Board (OSCB) following a serious incident notification and rapid review of Jacob, a 16-year-old boy who was found dead in his bedroom. The Coroner's Report recorded Jacob was intoxicated and distressed, with insufficient evidence that he had intended to end his life. From July 2017 to April 2019 the Review analyses how Jacob was groomed into a world where he was criminally exploited and exposed to serious levels of youth violence.

The Review considered three key questions:

- How children are responded to when they are at risk of being criminally exploited?
- How the education system responds to children who may present a challenge to schools due to their range of behaviours?
- When supporting and protecting adolescents how well does the partnership work together?

The Review was undertaken and written in a way that is mindful of Jacob's untimely death and the impact this had and continues to have upon his family and those many professionals who tried their best to help and protect him.

Analysis & Findings

The analysis and findings are set out under three main key lines of enquiry:

Criminal Exploitation

The Review clearly finds that Jacob was criminally exploited and significantly harmed in the months prior to his death. It concludes that it was difficult to determine with any certainty that Jacob's death was intended and could have been predicted, given that concerns did not highlight suicidal ideation. The Review shows how the local authority did not have the systems or protocols in place to support children, their families or professionals tasked with this work and to effectively respond to the known vulnerabilities and risks, despite practitioners trying their best with Jacob. This Review comments on the impact of placement sufficiency both locally and nationally. The connection is also made to the wider community responses to ensuring safer areas and the disruption strategies needed when tackling criminal exploitation. This Review finds this was dislocated and not the joined up in approach it needed to be in Jacob's community. As a result of a combination of these factors there were many missed opportunities across the safeguarding system and community approaches to keep Jacob safe from harm.

This Review highlights the need for a national Government Strategy to tackle criminal exploitation and without it, local partnerships are likely to continue to struggle to develop properly resourced and effective multi-agency solutions to this type of crime and its impact on families and communities.

The Education System

The Review unequivocally finds that the education system in Oxfordshire did not systemically respond at all well to children who may have presented with certain behaviours and needs. Jacob was failed by the education system in Oxfordshire as he remained off roll and missing from any type of education provision for over 22 months.

Working Together
The Review finds that at the time children at risk of criminal exploitation in Oxfordshire were likely to be responded to in a fragmented way, with agencies missing from discussions and meetings within the partnership. It shows the push and pull factors which can occur in partnerships and between agencies where there is a difference of opinion and no collective ownership and responsibility is then held at all levels from practitioner to strategic lead. The Review comments on Jacob's situation where discussions went around in circles with his needs being pushed from pillar to post and with no change to his day-to-day life or risk levels within it.

KEY LEARNING

The key learning is detailed under 3 themed headings in the Report and relates to the national and local recommendations for system and practice change.

In summary the key learning highlights the need for:

A System designed to support those working with **criminal exploitation** to:

1. Ensure safer communities which keep a relentless focus on disrupting perpetrators and networks
2. Consider the child's home in the local community and assess what other places might be needed to ensure their physical and psychological safety
3. Support professionals to build relationships with children and understand their world
4. Act upon critical and reachable moments in a child's life
5. Consider the significance of gender in working with exploited children
6. Know the risk factors and predictability
7. Understand the significance of a child's identity within their community networks when assessing levels of risk
8. Manage risk via multi-agency assessments, plans and contingency
9. Ensure the right support to help families and manage the risks together
10. Review the role and function of the National Referral Mechanism
11. Have a national drive and agenda for children at risk of exploitation

An **education system** that ensures:

1. The paramount importance of the role of schools in keeping children safe
2. An education package is put in place in a timely manner for those children who may show challenging behaviours
3. Those children missing education are known and action is swift

Working Together must:

1. Involve all the local safeguarding system to understand extra-familial risk and harm in a timely manner
2. Ensure effective discussion at all levels of seniority result in collective responsibility and ownership which the family understands
3. Put robust systems in place which support all levels when there is a difference of opinion
4. Have a shared language across the partnership

CONCLUSIONS & RECOMMENDATIONS

The Review concludes by asking for national and local change for children at risk of extra familial harms when criminal exploitation is identified. The drive for system change must be led by senior leaders at national and local levels so that multi-agency professionals are better equipped to know what works and have systems and procedures in place to support their day to day practice.

National Recommendations:

Recommendation 1: This Review asks the National Panel to acknowledge and share the key learning and findings from Jacob's Review (along with other recent Reviews[1]) with partner bodies and agencies such as the National Practice Framework, Youth Justice Board Serious Youth Crime and National Referral Mechanism Review so as to inform national policy and practice.

This Review asks for particular attention to be paid to the effectiveness of the National Referral Mechanism in making a difference to children's lives.

Recommendation 2: This Review asks the Department for Education to acknowledge the education key learning and findings from Jacob's Review and provide feedback as to the effectiveness of the Education and Skills Funding Agency process in resolving issues in a timely manner.

The Review asks the Department of Education to provide statute and guidance to local areas and their communities on how to manage the Governance arrangements with academy run schools and local education departments who currently cannot be mandated to accept children on roll.

Recommendation 3: This Review asks the Department for Education to undertake a review of national placement sufficiency for children who need to be in care or placed under secure arrangements. This national review will analyse residential home provision; secure home provision and should include the views and experiences of children and their families who have and continue to use such provisions. This will inform changes to policy, sufficiency levels and contractual arrangements with independent providers.

Local Recommendation:

There is one local recommendation with three actions plans outlined below.

Jacob's Review has shown the serious and significant consequences to children at risk of exploitation. It asks the Multi Agency Safeguarding Arrangements (MASA) and the OSCB to drive county-wide multi-agency system change at a strategic and operational level and address the three key learning areas identified in this Report. This will support and strengthen single and multi-agency practice across the County and reduce the risks of this happening again to other children in Oxfordshire.

MASA will drive and resource the completion of 3 written action plans within 3 months of Jacob's Review being published. The plans will be approved by MASA and monitored by the OSCB Business Group. These themed Action Plans must consider all the key learning identified in this Report, provide names of nominated leads and detail the work needed under each area to achieve change in the system and practice so that a difference is made for children in Oxfordshire.

Action Plan 1: Criminal Exploitation

The key learning set out below is fully addressed in this action plan for children at risk of exploitation in Oxfordshire, overseen by the Chair of the OSCB Child Exploitation Sub-Group.

Key Learning: A System designed to support those working with **criminal exploitation** to:

1. Ensure safer communities which keep a relentless focus on disrupting perpetrators and networks
2. Consider the child's home in the local community and assess what other places might be needed to ensure their physical and psychological safety
3. Support professionals to build relationships with children and understand their world
4. Act upon critical and reachable moments in a child's life
5. Consider the significance of gender in working with exploited children
6. Know the risk factors and predictability
7. Understand the significance of a child's identity within their community networks when assessing levels of risk
8. Manage risk via multi-agency assessments, plans and contingency
9. Ensure the right support to help families and manage the risks together
10. Review the role and function of the National Referral Mechanism
11. Have a national drive and agenda for children at risk of exploitation

There needs to be particular focus upon:

- The delivery arm of the newly designed Youth Justice & Exploitation Service being fully involved in this action plan to ensure system wide change and embed practices across agencies (including the Voluntary Sector and District Housing)
- A joined-up community approach to keeping children safe in their areas by focusing upon crime prevention and reduction - this is led by the county-wide Community Safety Partnerships and Violence Reduction Unit with key statutory agencies (Children's Social Care and Police)
- Continued focused regional work by Children's Social Care to highlight and address placement sufficiency issues at a local and national level
- Local knowledge, understanding and use of the National Referral Mechanism

Action Plan 2: The Education System

The key learning set out below is fully addressed in this action plan for children in the education system in Oxfordshire, overseen by the Chair of the OSCB Safeguarding in Education Sub-Group

Key Learning: An **education system** that ensures:

1. The paramount importance of the role of schools in keeping children safe
2. An education package is put in place in a timely manner for those children who may show challenging behaviours
3. Those children missing education are known and action is swift

This Action Plan should pay particular attention to ensuring:

- Restorative work to resolve the fragmented arrangements between academy schools, alternative provisions and the local authority to ensure collective ownership
- Policy and procedures to track when children are not on roll
- The function of Education Panels in Oxfordshire (In Year Fair Access and Children Missing Education)
- The local application of the Education Skills Funding Agency intervention
- Education packages for children who may be at risk of exploitation and also present a risk to others

Action Plan 3: Working Together

The key learning set out below is addressed in this action plan when working together in Oxfordshire to keep children safe, overseen by the Chair of the OSCB Business Group

Key Learning: **Working Together** must:

1. Involve all the local safeguarding system to understand extra-familial risk and harm in a timely manner
2. Ensure effective discussion at all levels of seniority result in collective responsibility and ownership which the family understands
3. Put robust systems in place which support all levels when there is a difference of opinion
4. Have a shared language across the partnership

This Action Plan must pay particular attention to:

- The child exploitation system re-design in Oxfordshire involves ALL agencies to map and plan services across thresholds of need and risk – the involvement of District Councils and Housing is imperative
- Ensure the escalation policy and Complex Case Panel purpose and function are known and used to share and resolve difference of opinion at all levels of the partnership

Within 1 year of this Review being published a combined Report should be approved by MASA and presented to the Full Board to evidence the system change and progress made. Clear evidence of impact should be shown in the Report to assure MASA and the Board of the system and practice difference to children's day to day lives in Oxfordshire as a result of the work undertaken following the learning identified in Jacob's Review.

Foreword

Jacob was one of the estimated 50,000 children in the UK thought to be exploited[1] and his story tells of an organised criminal world which skilfully coerced, controlled and harmed him with devastating consequences.

The intention of this report is not to go into specific detail of Jacob's life. It focuses on themes within the safeguarding system, practice and the service responses to the risk and harm faced by Jacob and his family in his local community. It considers the interplay between the two worlds where Jacob was highly touchable to those who exploited him and largely untouchable to a child protection system supposed to keep him safe from harm.

This Review saw a family torn apart and left heartbroken by what happened to a much loved son, brother, grandson and uncle. Jacob's family wanted to tell his story along with influencing and affecting change across the safeguarding system in the UK.

This Review found professionals who tried their best to understand Jacob's world, the risks he faced and to think of ways to work with often daily changes to his world. It found a local system which was not able to respond quickly enough and which did not provide practitioners with the structures and services they needed to work effectively with children at risk. It highlights the community safety partnership role to ensure a coordinated response to criminal exploitation.

This Review acknowledges a national picture of children in rural and urban areas being criminally exploited and a need for a UK wide agenda and action plan which prioritises resources in order to enable professionals to work within effective systems with those children at risk of extra-familial harm.

This Review shows the challenging and complex world when children are criminally exploited. It offers findings and recommendations for local and national thinking and includes pockets of good practice which it is hoped will be built upon further along with the local and national forums and current research.

The Review Team would like to thank all those who have been involved in this process across the Oxfordshire Safeguarding Children's Board partnership. Their honesty and reflections have been invaluable. The CSPR process was mindful and the Report written in a style which acknowledges the relationships built with Jacob alongside the impact of what happened to him on his family, his local community and the many professionals who knew him.

Our final thoughts are with Jacob and his family whose lives were forever changed by those who chose to exploit him.

[1] Keeping kids safe: Improving safeguarding responses to gang violence and criminal exploitation, Children's Commissioner February 2019

Introduction

1. Reason for doing the Review

This Child Safeguarding Practice Review (the Review) was commissioned by Oxfordshire's Safeguarding Children Board (OSCB) following a serious incident notification and rapid review of Jacob, a 16 year old boy who was found dead in his bedroom. The Coroner's Report recorded Jacob was intoxicated and distressed, with insufficient evidence that he had intended to end his life. From July 2017 to April 2019 the Review analyses how Jacob was groomed into a world where he was criminally exploited and exposed to serious levels of youth violence.

The purpose of the Review was to consider:

- How children are responded to when they are at risk of being criminally exploited
- How the education system responds to children who may present a challenge to schools due to their range of behaviours
- When supporting and protecting adolescents how well does the partnership work together

2. What the Review found

Through multi-agency examination of events in Jacob's life the Review found the following practice and system themes:

Criminal Exploitation:

- Jacob was known well by key professionals and they tried their best to help him but often they did not know how to do this.
- The knowledge, skill and safeguarding systems to identify and respond to criminal exploitation was at times limited and not consistently applied across agencies or when working together
- The network focused on Jacob's range of behaviours, with a significant gap in disrupting and stopping the criminal exploitation of Jacob while in the community. This meant the risks from organised crime groups / perpetrators remained high
- There was a dislocation between the community safety partnership and the multi-agency safeguarding network as information did not flow as it needed too. The opportunities to keep Jacob safe from harm were therefore missed.

Education

- Jacob was let down by an education system as it did not result in him being placed in a provision that could meet his educational, social and emotional needs.

Working Together:

- The safeguarding system was not able to respond to the risks quickly enough to keep Jacob safe and the provisions of local and national services were limited
- There was a difference of opinion about how to respond to risks and this did not lead to change for Jacob
- The system was fragmented with some key agencies working together and other partners noticeably missing

This Review concludes Jacob was criminally exploited[2] and significantly harmed in the months prior to his death. Jacob had been coerced and controlled for many months by adults operating County Lines[3] and he was trapped in a world he felt he could not escape. Jacob lived in an untouchable world to many who tried to help and protect him. This world was paradoxically highly touchable to those who chose to exploit him; where those adults remained hidden and showed they could quickly adapt to evade being seen or touched by the safeguarding system.

It is evident that despite professional efforts and individuals consistently raising their concerns about levels of risk to and from Jacob life was not changing for him. Indeed, towards the end of his life Jacob's behaviours and known incidents suggested that in fact risk was increasing. There were some professionals who highlighted Jacob was at risk of serious and significant harm which could only be managed safely by moving him out of county and others who held the view the risk could be managed through a trauma informed approach in the community. From what was known at the time it is difficult to determine with any reasonable certainty that Jacob's death was intended and could have been predicted. His mental health was not highlighted as a concern by professionals and the network and his family held the view that the risk to Jacob came from the adults who were exploiting him and not from Jacob himself.

What Happened

3. Jacob's Story

Jacob was born in Oxfordshire on Valentine's Day in 2003. He identified as a white British boy and is described by those professionals who knew him well as a "*joker*"; a cheeky, determined and friendly child, who took pride in his appearance. Professionals shared many fond memories of Jacob including the aspirations he had for his life. His family remember his kindness and sense of humour.

Jacob's 1st two years of life were spent with both parents and his elder Half-Sister (known throughout this report as Sister given the nature of their relationship). There were numerous adverse childhood experiences in these early years and a complexity of factors within the family which influenced the work and approach in supporting Jacob. Jacob and his Mum relocated to the North East of England during Jacob's primary school years and Jacob often spoke of having many positive memories of this time in his childhood. Jacob was described by his family and professionals as being a "*strong-willed child*" and having started well in his Primary School in Oxfordshire and then the North East he was moved in Year 6 to an alternative education provision. This was due to an inability to manage a range of his presenting behaviours described by Mental Health Professionals as "*defiant and oppositional*". Aged 14 years Jacob

[2] The Government definition of criminal exploitation of children is "*where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child under the age of 18. The victim may have been criminally exploited even if the activity appears consensual*" Home Office Guidance 7 February 2020 HMO: London

[3] The UK Government defines county lines as "*a geographically widespread form of harm that is a typical feature of county lines activity*" Home Office Guidance: Criminal exploitation of children and vulnerable adults: county lines 7 February 2020 HMO: London

was assessed by Child and Adolescent Mental Health Services (CAMHS) in Northumbria as having symptoms of Attention Deficit Hyperactivity Disorder (ADHD).

Jacob and his Mum returned to live in a shared private tenancy in Oxfordshire in July 2017 and from this time until his death in April 2019 a story of increasing risk and harm to his safety, health and well-being can be seen through a range of presenting behaviours and needs. The agency and service responses to this are summarised in Section 5.

4. Jacob's Family & Community Perspective: *"Nothing changed to keep Jacob safe"*

Jacob's family are completely devastated by the loss of their much loved son, brother, grandson and uncle. Their participation in the Review has shone a light on a family's experiences and perspective when the risks lie outside of the family and are contextual in nature[4]. The family have shared their thoughts of feeling incredibly powerless in a system which is not designed to respond to keeping children safe when they are being criminally exploited and their hope is that by telling Jacob's story things will change for other children at similar risk of harm. Jacob's parents acknowledge professionals tried their best and yet despite this nothing changed for their son. His parents talk of how he was "*duped into a lifestyle*" of exploitation and how they had not understood the severity of this in the early months. Jacob's family think the most significant learning in his short life is for professionals to act swiftly on the opportunities to ensure children are safe and for children to be engaged in an educational setting each day so that their time is filled.

Members of the local community were involved in this Review such was the strength of feeling for Jacob and their wish to share a local perspective. The community and town in which Jacob lived is characterised in the Office for National Statistics 2019 as having significant inequalities, deprivation and poverty (scoring 6 areas in the locality within the 20% most deprived areas nationally in the UK[5]). The understanding by the community of the emerging presence of County Lines and organised gangs during the Review period was shared. The increasing rates of child poverty and inequalities in the local area have been felt and seen with the closure of local services, including those targeted at adolescence. The community has felt the loss of safe spaces for adolescents, alongside a lack of sufficient funding or partnership effort to work with the community in filling the service gaps for young people. Arguably such a community environment can be drivers for increasing vulnerabilities within youth populations to criminal exploitation where those who are marginalised may feel frustrated and alienated and may look for a false sense of belonging.

5. Thematic Overview

Jacob experienced a range of statutory and voluntary services across agencies and there were a significant number of professionals involved in his life during the 22 months under Review. His assessed levels of need and intervention spanned across all categories as detailed in Oxfordshire's Level of Need Document[6] and he was cared for at home by his family under early help pathways, as a child in need of support[7] and in need of protection[8]. Jacob was in the care system under Section 20[9] and an Interim Care Order[10] with

[4] Contextual Safeguarding is a term developed by Carlene Firmin, University of Bedfordshire which describes an approach to understanding and responding to young people's experiences of significant harm beyond their families. It recognises the different relationships young people form in their neighbourhoods. Parents and carers often have little influence over these contexts.
[5] Vital Statistics in the UK: Population & Health Reference Tables November 2019. Office for National Statistics. HM Government: London
[6] Oxfordshire's Level of Need Link – Oxfordshire Threshold of Needs-2019.pdf
[7] Section 17 of the Children Act 1989 imposes a general duty on local authorities to safeguard and promote the welfare of children "*in need*" in their area.
[8] A section 47 enquiry as defined in the Children Act 1989 means children social care must carry out an investigation when they have "*reasonable cause to suspect that a child who lives in their area is suffering or is likely to suffer significant harm*".
[9] Section 20 of the Children Act 1989 refers to a local authority providing accommodation for children who do not have a place to live. It is often called "*voluntary accommodation*" as parents must agree to their child being looked after by the local authority.
[10] At the start of court proceedings, a local authority may apply for an interim court order which means parental responsibility is shared between parents and the local authority and they can determine where the child will live

his situation before the Courts for consideration. At the end of his life Jacob was subject to a Supervision Order[11] and he was seen as a child in need of support as defined in the Children Act 1989.

In summary Jacob's story and agency responses show that :-

5.1 He was not on roll at any education provision and was a child missing education[12] for 22 months
Jacob's mandatory need for education was not provided by Oxfordshire County Council when he lived at home and when he was in the care of the local authority both in and when out of county for 5 months. Four educational settings were asked to take Jacob on roll, however largely due to his perceived behaviours and risks to other students he remained off roll for almost 2 years. Jacob's family were offered the right of appeal when places were refused. His situation was considered by education panels such as the In Year Fair Access Panel and Children Missing Education to little effect and his needs were overseen and monitored by various professionals, including the Virtual School[13] and the Independent Reviewing Officer Service whilst in local authority care. There were no formal dispute resolutions raised[14] by Children's Social Care and his situation was not escalated to the Education Skills and Funding Agency (ESFA)[15] as it should have been.

5.2 He was not placed before the courts or subject to any criminal orders for alleged offending behaviours which spanned over 22 months.
The police records are extensive. There are 26 police reports when Jacob was recorded as a suspect or offender for mainly violent crimes (towards his Mum and when in care). 21 offences are recorded between 2018 and 2019 with no court convictions. There were 35 intelligence reports submitted which include information about associates; possession of weapons; drug supply and involvement in violent activities towards others. Jacob was known to other local Police areas including London, Derbyshire, Northampton, Northumbria and British Transport. Jacob was suspected of theft; criminal damage; anti-social behaviour; stabbing; physical and verbal threats to others; violence and assaults to others; supply of class A & B drugs; carrying weapons and threats to kill. Often due to a lack of evidence and victims not wishing to press charges the investigations did not proceed. Jacob was known to the Local Police Area (LPA) as part of a group of children linked to anti-social behaviour in the community.

There were also substantial concerns of criminal exploitation: Jacob owned at least 3 mobiles phones, was seen with large amounts of cash; was selling designer clothes to peers at a considerably lower value than their worth; was observed selling drugs in the community and from October 2018 onwards it was suspected he was accruing mounting drug debts.

Jacob was not open to the youth justice service in Oxfordshire and a referral to the National Referral Mechanism was made too late in the day in March 2019, just a month before Jacob's death.

5.3 He attended Hospital for significant physical injuries
Jacob attended the Emergency Department on 3 occasions. In February 2018 he attended for cuts to both hands and a bruise to his eye. In October 2018 Jacob returned home with a deep cut to his cheek and his Mum and professionals held the view he had been slashed across his face. He did not seek treatment for this. In November 2018 Jacob had a lacerated thumb and deep wound to the bone, again suggesting a

[11] A Supervision Order gives the local authority the legal power to monitor the child's needs and progress while living at home.
[12] Children missing education DfE September 2016 HMO: London
[13] The establishment of Virtual School Heads and Virtual Schools places a duty on local authorities to promote and support the education of looked after children
[14] IRO Dispute Resolution Process as detailed in the Independent Reviewing Officers Handbook 2010
[15] The Education Skills Funding Agency (ESFA) is a Government agency accountable for funding education and skills for children, young people and adults. It regulates academies and intervenes where there is a risk of failure or where there is evidence of mismanagement of public funds

knife injury. He needed an operation (plastic surgery) for this and attended two out of the three appointments for follow up physiotherapy. The last attendance at the Emergency Department was in April 2019 with a laceration to his face. All Hospital information was shared appropriately.

Jacob was registered with a local GP Surgery when he returned to Oxfordshire in July 2017 and records show he left the practice in June 2018 (linked to his time in care of the local authority and moving out of county). Jacob was not re-registered with any GP Practice at this time of his death, having had 8 GP changes in his young life. Records show he never attended for any consultations.

5.4 He repeatedly went missing from home and care

Jacob was reported missing over 20 times during the review period and these times escalated when he was in the care of the local authority as he clearly said he wanted to be with his family or friends in his community. Return interviews[16] were mostly undertaken with Jacob (4 not completed and 2 recorded as "refused" by Jacob). The information was not always routinely shared with children's social care and plans tended not to be reviewed or adapted following missing periods. As a child who regularly went missing, Jacob was discussed seven times at the multi-agency Missing Children's Panel. Records show the outcome of Panel oversight was typically to review matters in a month's time. Written information seen does not consider what lay beneath Jacob's need and behaviours to abscond from home and care, what risks he was exposed to while absconding or what co-ordinated community tactics were being planned to disrupt exploitation risks to him.

5.5 His needs were assessed, planned and reviewed via statutory interventions and services

Jacob was subject to nine Strategy Discussions as defined under Working Together 2018[17] as he continued to be at risk of significant harm. The majority of these discussions are recorded and the records show a plan of action to reduce risk being put in place which mainly suggest a further period of monitoring Jacob's on-going situation. Jacob was subject to a period of child protection planning under the category of neglect from March 2018 and until he was accommodated in April 2018. This Review notes the limitations of child protection planning as an effective mechanism for reducing extra familiar risk and harms to children and meaningfully engaging with their families.

5.6 He was a child in care

Jacob's situation escalated in early April 2018 with 5 missing episodes. There were concerns of Jacob being criminally exploited to sell drugs; assaulting others and being arrested on suspicion of serious violence to another. Jacob's Mum was fearful for her own and Jacob's safety and also experienced verbal and physical assaults from her son. Agreement for secure accommodation was initially not given by Children's Services and Jacob's was accommodated under Section 20 of the Children Act 1989 in April 2018. He was placed for 12 days in a series of unregulated provisions, namely hotels with a support package including his Granddad and two staff staying with him.

Later in April 2018 agreement was given for secure accommodation and a search identified a place in Scotland. Jacob and his family view at this time was this was too far from home for Jacob to be placed. In hindsight this is a decision Jacob's family now deeply regret and reflect upon. Jacob was then placed in an in-house residential assessment centre in Oxfordshire at the end of April 2018 and remained there until he moved to an out of county commissioned residential home at the end of May 2018. Jacob remained in the care of the local authority at the out of county residential home until he returned home to his Sister and then his Mum's care in October 2018 under a Supervision Order.

[16] Return Interviews are undertaken to identify children at risk of significant harm and to help reduce and prevent further episodes of running away: *DfE (2014) Statutory Guidance on children who run away and go missing from home or care: London*

[17] Working Together to Safeguard Children 2018 DfE HMO: London

5.7 His needs for permanence were considered & determined by the Courts

In April 2018 the local authority made the decision to place Jacob's situation before the courts as he was experiencing emotional and physical harm due to criminal exploitation. An interim care order was obtained with a Guardian appointed to represent his views, wishes and feelings. This was an appropriate action to take as Jacob ceased to be accommodated under Section 20 of the Children Act 1989 and resulted in a Judge considering his long-term physical, psychological and legal needs as a child. This plan to place Jacob in residential care, rather than secure accommodation was sanctioned by the Judge.

After a period of assessment, the Judge concluded legal matters in October 2018 and made a Supervision Order for Jacob to return home under child in need arrangements. Various family options were considered before deciding Jacob return permanently to his Mum's care. The rehabilitation plan was limited and focused upon Jacob's behaviours, relationship with Mum and did not include a detailed plan to disrupt the risks presenting to Jacob through criminal exploitation whilst in the community. This family-based plan was set within a context of many unsuccessful searches by the Commissioning Service for alternative care options for Jacob.

5.8 His mental health was assessed during the review period. Jacob was not accessing services for his needs and drug use and alcohol levels were not fully known

Jacob was diagnosed with ADHD whilst living in the North East, he did not agree with this and his Psychiatrist in Oxfordshire queried the diagnosis also. Jacob refused medication as it made him feel unwell.

Records show Jacob was well known to FCAMHS and there were extensive efforts at all levels of the service to raise concerns with lead statutory agencies about the risk Jacob posed to himself and others. FCAMHS held the clinical view that Jacob was high risk due to his vulnerabilities and were clear Jacob was not safe with a community plan.

The Psychiatrist assessed Jacob as not requiring specific mental health interventions such as medication or specialist psychological interventions. It was recorded that he had no history of self-harming or suicidal behaviours. It was concluded that he had a range of complex emotional and behavioural needs which are "*subsumed under the broad diagnosis of conduct disorder*"[18]. Multiple attempts were made by FCAMHS throughout the Review period to engage Jacob in therapeutic work; he consistently refused this.

Records show Jacob was using drugs and alcohol and his mood was variable. There was a planned home visit from a specialist team in Children's Services with the aim of reducing his drug use. Jacob was not at home for this 1st meeting and this was not pursued or followed up by the Service as a referral had not been submitted and his consent not obtained. Jacob's family have shared memories of times when Jacob was tearful, bored and low in mood and especially towards the end of 2018 and into 2019. He was frustrated that he had nothing to do in the day and wanted to be in school. Jacob talked to his friend of his idea of buying a school uniform and walking into a school "*to just feel like others*" of his age. He found aspects of home life difficult and in November 2018 he wrote a note about who he would want at his funeral, having taken excessive Hay Fever medication.

[18] Conduct Disorders is a mental health condition in children and young people which causes defiant behaviours and sometimes severe aggressive and/or antisocial behaviour NHS Direct 2013; London: UK

Analysis & Findings, with Key Learning

The Review has found three system and practice areas that are significant in Jacob's story and these are analysed with key learning in this next section. This Review finds similar themes to the Serious Case Reviews concerning "Chris"[19] and Jaden Moodey[20] and the National Panel's Report [21].

6. CRIMINAL EXPLOITATION

The national debate of criminal exploitation of children has been described by some[22] as the "*next big grooming scandal*" as services and organisations struggle to know the extent of the problem, how best to respond to it and continue to see children as the perpetrators rather than victims.

This section considers how the criminal exploitation of Jacob was seen and responded to across the partnership. It is analysed knowing that there was and arguably still is limited research available to organisations who work with children at risk of being criminally exploited; that Government Guidance was only just beginning to be available to support partnerships in their work and that most local authorities including Oxfordshire did not have developed protocols or systems in place for criminal exploitation during the period under Review.

6.1 Key Learning: Ensuring safer communities – a relentless focus on disrupting perpetrators and networks

Since 2016 local data shows a year-on-year picture of increases in drug offences and trafficking in Oxfordshire. Given the geographical location and links to motorways/rail networks, the district in which Jacob lived shows a high number of complex situations involving county lines activity and as outlined in Section 4 this is set within a context of community inequalities, deprivation and poverty. Some described the situation at the time as the local Police area experiencing a huge volume of problem-solving work concerning criminal exploitation with the high-level demand exceeding their capacity. Arguably the situation remains nationally with the numbers of children at risk of criminal exploitation, where demand outstrips the police resources available to respond to concerns in a longer-term problem-solving context.

This Review finds a disconnect between the different local Police Teams during the period analysed. The evidence shows a significant volume of disruption activity in the area by the Neighbourhood Problem Solving Team with a focus on identifying drug lines and associated individuals. This work included arrests being made and the prosecution of a number of adults and young people. Several police operations were set up to target specific activities and tactics deployed to actively develop intelligence and disrupt the groups. Those involved in this work at the time gave the view that the efforts were largely successful in making the local area a "*hostile environment*" for organised crime groups and individuals to operate within.

Records also show the Neighbourhood Problem Solving Team created a document to disrupt anti-social behaviours in the local area, but this document was not kept updated or reviewed; with no supervisory oversight; with a lack of understanding or analysing the make-up of the group of children and with the children involved being referred to as offenders as opposed to through a lens of safeguarding.

Despite this wider disruption activity and intelligence development work in connection with county drug lines in the area, Jacob was never identified as being linked to the networks by the safeguarding partnership. The Police work did not focus as it could have done on the vulnerabilities to Jacob whilst in his local community as the level of risk he was perceived to be at by partner agencies was not fully recognised by those whose job it was to target and disrupt the networks or individuals. There was a silo-

[19] Serious Case Review "Chris" Newham Local Safeguarding Children Board August 2018
[20] Jaden Moodie Serious Case Review Waltham Forest Local Safeguarding Children Board May 2020
[21] *"It was Hard to Escape":* The Child Safeguarding Practice Review Panel Report 2020 DfE: HMO: London
[22] Keeping kids safe: Improving safeguarding responses to gang violence and criminal exploitation, Children's Commissioner February 2019

ed approach to the Police response. On the one hand there was a wider focus upon disrupting and stopping the activities of perpetrators/ organised crime groups in the local area, whilst at the same time a lack of co-ordination and mapping of the individual risks to Jacob when in his community as information and intelligence was not appropriately shared between Police Teams.

The impact of this to Jacob was that the risk whilst in his local community remained at high levels. Those who exploited him were "*untouchable*" to the Police as their details remained unknown to all agencies. The information held and shared by others such as Children's Social Care at various multi-agency meetings concerning risks to Jacob did not translate to effective Police activities or strategies to identify those adults/organised crime groups who were specifically exploiting him.

The management of Jacob's criminal activity was slow and largely ineffective during the period under review. Jacob's offending escalated rapidly within the space of a few months and as a result he bypassed the Youth Restorative Disposal[23] process straight to a Youth Caution (YC)[24]. The Youth Justice Unit (YJU) noted the YOT1[25] submissions for Jacob and tried to collate all outstanding offences so that a disposal decision could be made on all of them at once. This took time due to delays in submitting files to the YJU. The Youth Caution was not administered until 4 months later. Analysis of the police information shows reports were too readily filed by or against Jacob. There were many missed opportunities and a lack of co-ordination to better engage Jacob. A more concerted effort was also needed to support his victims and keep them engaged. The impact of this can be seen by Jacob repeatedly sharing to others how he felt "*untouchable*" to the police and youth justice services.

The ineffective response by the Local Police Area is likely due to a limited capacity and an over reliance on a key individual holding all the information on safeguarding matters in the Neighbourhood Team for individual children. At the time this resulted in poor sharing and dissemination of information within the wider Police Teams and systems. Despite best intentions, the reliance on one individual as opposed to having a system in place meant that when not on duty the processes stopped or fell to an officer who was not trained to perform the role. The flow of information from various multi-agency meetings concerning Jacob was not shared as it should have been with those in the Neighbourhood Problem Solving Team whose task it was to disrupt the activities. The over reliance on an individual was a result of trying to tackle a new phenomenon within existing structures and when the post holder became overwhelmed with information the need for a systems approach was appropriately highlighted and has since been responded to.

[23] YRD = Youth Restorative Disposal – Community Restorative Disposals is the collective National term for both Youth Restorative Disposal and Adult Restorative Disposal. Restorative Disposals are a tool to enable the police to use their professional judgement to make decisions about how to deal more proportionately with lower-level crime and anti-social behaviours. They are primarily aimed at first time offenders where genuine remorse has been expressed, and where the victim has agreed that they do not want the police to take more formal action. It also allows the use of restorative justice techniques, where appropriate, as part of the process. This increases victim inclusivity in the outcome of the offence, and also reduces the likelihood of reoffending by encouraging offenders to face up to the impact of their behaviours and to take responsibility for making good the harm caused.

[24] A Youth Caution may be given for any Summary or Either Way offence where the young offender makes clear and reliable admissions to the offence, there is sufficient evidence for a realistic prospect of conviction (RPoC), but it is not in the public interest to prosecute. Must be referred to the YJU. Unlike adults, a Young person does not have to consent to receiving a Youth Caution, under legislation it is a matter for the police to decide on the appropriate disposal and therefore the young person can receive a YC even if they don't want to accept it, but this should be in rare cases. Voluntary conditions can be imposed, but there is no sanction for failure to complete.

[25] A YOT 1 **must** be submitted for anyone under the age of 18 and within 24 hours when either of the following occur; 1. When a positive disposal is given to a young person – This is usually a YRD on the street, YCW, a first YC (authorized by YJU) or a straight charge from custody 2. When an investigation has concluded and the OIC is seeking a disposal decision from ERO / YJU

Along with this when Jacob came to police attention there were no proven tactics for tackling criminal exploitation, it was described as a "*new phenomenon*" with no advice/guidance available to officers. There was also a difference of opinion between key individuals in the Neighbourhood Team as to what was or was not a priority, which went unresolved and a lack of standard prioritisation hindered disruption activities. At the time this Review finds the Police operated an inconsistent approach in their responses to criminal exploitation in Oxfordshire. If Jacob were a child in Oxford City, he could have been afforded a different response as there were different focuses on activity across the three areas of Cherwell & West: Oxford City and South and Vale. The current framework and written Guidance offered by the Oxford City area may provide a useful county-wide approach in tackling Child Criminal Exploitation.

With the benefit of hindsight, it has been acknowledged that a more cohesive and joined up Police approach was required with a focus on building a relationship with Jacob, so as to stand a better chance of disrupting those who were exploiting him. The Review finds that changes have since been made by the Police and work is progressing in the Neighbourhood Policing Teams when responding to criminal exploitation. The Police and National Crime Agency's[26] response to vulnerable people involved in "county lines" drug offending comments on the police seeing "*both sides of the coin*". This means striking the balance between safeguarding victims, disrupting criminal operations and prosecuting offenders whilst also recognising children involved in county lines activities can be victims as well as offenders. It is suggested that such an approach would reduce the county lines networks ability to exploit children and vulnerable people and the harm those criminals cause in communities.

As well as a policing role the Police and Crime Commissioner (PCC) is also responsible for tackling crime and the causes of it to ensure safer communities. Effective partnership working at a strategic level is essential and one of the ways this is undertaken is through district Community Safety Partnerships (CSP's). CSP's consist of five "responsible authorities" (police, local authority, fire and rescue authority, probation and clinical commissioning groups) and by working together they have a duty to assess local community safety issues and draw up a partnership plan setting out strategic priorities.

The Safer Oxfordshire Partnership is a county-wide partnership that provides strategic oversight and direction for preventing crime and anti-social behaviour across the county. The district Community Safety Partnerships develop strategic plans for their respective areas. The District in which Jacob lived had a Safer Communities Partnership Plan with the overarching duty (as specified in the Crime and Disorder Act 1998) to ensure "*local authorities must do all that they reasonably can in the prevention or crime and disorder*". In addition to this, the plan states it must have cognisance of the Safer Oxfordshire's partnership (SOP) priorities, the Oxfordshire Children's Board and the Safeguarding Adults Board. The priorities of these boards (as detailed in the strategic plans) should complement those of the police, especially those surrounding vulnerability and safeguarding.

The CSP Plan 2017-2021 shows specific priorities on child sexual exploitation, anti-social behaviours, youth provisions and tackling serious and organised crime. The Plan sets out strategic responses with actions to protect vulnerable people through reducing the risk of abuse and exploitation. The activities recorded in CSP minutes show groups working in the local area with young people in schools around substance abuse and child sexual exploitation; early help mentoring schemes and school-based work aimed at reducing the risk of involvement in the criminal justice system.

[26] *Both Sides of the Coin*: the police and National Crime Agency's response to vulnerable people in "county lines" drug offending January 2020 HMICFRS

The Review finds that the CSP's held regular meetings where discussions, data and updates were given predominately by the police on the impact of crime on the local community. It is recorded in a 2018 meeting that "*drugs and crime are still on the up and a big issue*". Records show that no specific actions were raised at these meetings following discussions to ensure the priorities outlined in the 2017-2021 Plan then had the traction needed to ensure a joined up strategic and operational partnership approach. The CSP seem to have been acutely aware of the dangers in the local community along with the risks of serious harm known. However, at that time the co-ordinated strategic approaches of community safety and keeping children safe in their localities were not effective or as developed as they needed to be. This resulted in a fragmented approach in delivering operational services and interventions to individual children such as Jacob and in doing so reduce risk to him in the community. In discussions with District Leaders, it would appear that the community partnership landscape requires further promotion and development. This would then ensure operational information, knowledge and data held by those agencies working with children and their families is regularly shared with the district CSP's to inform their strategic action plans.

6.2 Key Learning: A child's home / The places available to ensure safety

Much has been written about the need for children to have a sense of belonging, a home to call their own and an identity within a family setting and community. Jacob's story of permanence shows a complicated chronology of how he moved between different homes within his own family and the care system, both in and out of county with the Courts involvement in an attempt to keep him safe. This included shared care arrangements between his Mum and grandparents; living with his sister; living in an unregulated home (hotel); living in two residential homes in and out of Oxfordshire and trying to identify secure provisions.

A significant area of discussion across all agencies involved in this Review has focused upon the lack of residential places being available for children who present with behaviours that might be described as "high risk" to themselves or others. This is a well-documented national issue with the Child's Commissioner describing the residential care home system as being "*broken*"[27]. The Commissioner comments on a series of reports that have highlighted the insufficient number of high-quality places, with much professional frustration in knowing what to do with thousands of children and a repeated Government "*failure*" to address the crisis. This Review concurs with that view and highlights a significant lack of placement sufficiency with serious consequences from the evidence seen in Jacob's situation. In a response to this issue of placement sufficiency, Oxfordshire have led the way in the South East region in identifying and addressing the issue of placement sufficiency for children with a complexity of needs – <u>this is seen as an example of good leadership and practice</u> in working with the Independent Children's Homes Association and trying to generate an improved market whilst also looking at the gaps in provisions and highlighting this at a Government level.

<u>Children remaining at home</u>

The principles of the Children Act 1989 outline how children often do best if they remain within their families in their local communities, unless it is unsafe to do so. Jacob's views, wishes and feelings were clear to all those who knew him well in that he wanted to stay in his local area and living with his family. His escalating and extreme behaviours showed his level of distress when placed outside of his family. Jacob's family also wanted for him to remain in his local area, until risk levels became too high and they requested other provisions to keep him safe. It was an on-going debate between children's social care, FCAMHS and with Jacob's family as to what home would provide him with physical and psychological safety, security and stability. This Review highlights the complexity of such decision-making and how it needs to be set within a wider context of disrupting the risks to Jacob whilst in the community if the extra-familial harms are to be reduced, as previously outlined in 6.1.

[27] "*Government accused of "deep ambivalence" to plight of England's children in care*, Guardian article 11/11/2020

Relocating Children at Risk

As we know from Jacob's story and as cited in the research "*during adolescence young people navigate a range of risks that percolate in public spaces*"[28]. In Jacob's situation this involved criminal exploitation, serious youth violence and likely gang-affiliation. One of the responses to managing and reducing extra-familial risks such as these is the strategy of relocating children out of their local area. As Firmin 2019[29] notes this is usually for the primary motivation of professionals to achieve physical safety for the child.

This Review found differing professionals views across the partnership of moving children to ensure their physical safety. Those who were reluctant were sceptical of its long-term benefits although acknowledged how it does often address the immediate risks to physical safety. They were also mindful and gave weight to Jacob's views, wishes and feelings as he was adamant, he wanted to remain at home living in his local community. He had found being in the care of the local authority and especially living out of the county a particularly difficult time where missing episodes escalated, and professionals were cognisant of his psychological well-being if moved out of area. Jacob's parents at the time were also wary of their son moving far away from them as different locations were explored.

There were also those professionals who advocated and at all levels of the partnership for Jacob to be relocated out of area to a therapeutic provision and possibly secure accommodation[30] and then work could commence and keep him safe. This group of professionals did not reach this decision lightly. It was founded upon their assessed risks to his own and others safety in the community and it was made in the knowledge of known national shortages of beds for such provisions. These are highlighted in national Court Judgements concerning the shortages of secure accommodation spaces for children, which have fallen by about a quarter in the last 10 years[31].

The use of secure accommodation

Agreement for secure accommodation was given by a Senior Multi-Agency Panel[32] following an escalation on two occasions however this was not achieved despite many repeated attempts by the Commissioning Team due to a lack of secure provision nationally. There were relatively few "other options" available and identified to Jacob after both attempts at findings a secure bed did not succeed, with a high number of referrals being held on a national waiting list. The professional network described feeling at a loss as to what else they could do given that a contextual framework with interventions to disrupt the risks to Jacob were not established in the County. This highlights further the dislocation between the multi-agency partnership and the wider strategic responsibilities of community safety. A more joined up approach with the Police Problem Solving Team/Community Safety Partnership when strategically working with Children's Social Care, Education and FCAMHS might have yielded a different response to disrupting and tackling the serious organised groups and perpetrators who were exploiting Jacob in his local community.

Placement Sufficiency

Children's Social Care Placement Commissioning Service commented on the lack of local and national accommodation for adolescents who present with a variety of behaviours such as Jacob. Records show some good practice in that the numerous attempts were made, and meetings held to try to secure an appropriate home which would keep him safe and offer therapeutic interventions to help address trauma.

[28] Firmin, C March 2019 *Relocation, relocation, relocation: home and school-moves for children affected extra—familial risks during adolescence* Available via the Contextual Safeguarding Network, University of Bedfordshire

[29] Firmin, C March 2019 *Relocation, relocation, relocation: home and school-moves for children affected extra—familial risks during adolescence* Available via the Contextual Safeguarding Network, University of Bedfordshire

[30] Section 25 of the Children Act 1989 gives legal provision to place a child in secure accommodation for welfare reasons if this child is likely to abscond and will be at risk of significant physical harm if they do or are likely to injure themselves or others

[31] The Guardian 10 October 2018 "*Judge condemns unacceptable lack of secure accommodation for children*" Owen Bowcott

[32] Complex Needs Panel Terms of Reference : complex_case_panel.html

The service was specifically trying to find a foster home or residential home with criminal exploitation and gang specialisms whilst Jacob remained in care. When these were not available and with secure beds being extremely scarce in supply Jacob's family think the focus was lost on continuing to look for other options outside of his family home.

This was a highly complex situation and children's social care decision-making therefore had many factors to consider. There was very limited availability of residential homes for Jacob that could meet his needs, possibly at a distance to his local community. As previously explained, this was also within a context of Jacob's views, wishes and feelings which were listened too as he repeatedly said he did not want to live anywhere other than his family. Children's Social Care were attempting to balance community risk, with limited placement availability and psychological risk to Jacob if placed in a residential home which if not a secure provision would have likely seen an escalation of missing times. The complexity faced and options considered by Children's Social Care also included if secure accommodation was granted by the Courts and a bed found this would-be time limited, likely 3-6 months. Without the wider disruption work being undertaken by the Police and strategically led by the Community Safety Partnership to ensure a safer local area, this temporary fix to ensure physical safety for Jacob would have undoubtedly placed him back in his local community where risk levels from his exploiters would have remained unchanged.

6.3 Support Professionals to build relationships with children and understand their world

This Review shows that there were professionals who knew Jacob well, who saw him often and had built a relationship with him in that he would seek them out to ask for support on certain matters. There was creativity seen in commissioning an ex-gang member to sit alongside Jacob offering mentoring to show him alternative options. Towards the end of the review period in particular trusted relationships with Jacob were maintained by (various practitioners/teams) in Children's Services and the Voluntary Sector and he was beginning to share some of his worries about the world he had been pulled into and how trapped he felt. Such key relationship building took considerable time and a flexible approach; skill and a persistence; and illustrated how professionals showed care to Jacob. These efforts are commendable and highlight *good practice* in relationship building skills.

However, the professional relationship in isolation and with a lack of evidence, trauma informed practice, system thinking and procedures was not enough to keep Jacob safe. Practitioners and Managers were clearly worried for Jacob's well-being and thought he would be seriously injured by a dangerous adult exploiting him or through serious youth violence. Workers talked of feeling at a loss to know what to do for the best and without a policing approach, safeguarding system and procedures which tackled criminal exploitation effectively they often felt "*as if they were making it up as we went along*". Some professionals shared openly about not feeling experienced or sufficiently confident to work with such complexity, even when adequate supervision arrangements and support were in place by Managers.

Jacob had a range of children's social care professionals allocated to him during the period under Review and the mix of change in worker, change in teams (due to organisational structures) also sat alongside varying levels of experience. Experience levels can impact on professional confidence when working with children and their families and these organisational factors remind of the need for on-going staff development with regular training opportunities for complex and emerging areas of practice.

There were missed opportunities to build relationships with Jacob from some parts of the safeguarding network. Jacob told his Mum and other professionals in Children's Social Care that he felt "*untouchable*" to the Police and the Court System. He thought until he reached 18 years old he would be safe to do largely as he wished and he often told his Mum not to worry about his criminal activities. Jacob was largely untouched by the criminal youth justice system which arguably left him highly vulnerable as he remained a "*clean skin*" where those who exploited him knew he was not being monitored closely by professionals within this service. Jacob's family view is that this was not a helpful approach as a level of youth justice

interventions might have resulted in preventative work and in Jacob becoming "*too hot to handle*". His family think his exploiters may have seen youth justice interventions as a deterrent and then not used him as much as part of the drug runs.

When working with children who engage and are coerced into criminal type behaviours it is important to ensure they do not get labelled with a criminal identity and other alternative programmes are offered to support them. In Jacob's situation the evidence suggests that neither were able to happen via the youth justice service. He had a long list of criminal matters that never progressed to any further restorative work with him and this was primarily due to a lack of evidence and matters being dropped. Jacob did not receive any statutory disposal which would have triggered youth justice involvement. This meant that Jacob was not known to or supported by this Service and they were not involved in any discussions or decisions or included in any assessments or planning to reduce risk to him. This was a significant missing piece of the safeguarding jigsaw with Jacob and had this service entered his world and worked with him a clearer picture of his life may have been known.

This Review finds that the system has since changed and there is an established Joint Decision-Making Panel held by the Police and Youth Justice Service to assess suitability for out-of-court disposals and screening for safeguarding concerns. This Panel is recognised as good practice as it enables healthy discussion, challenge and consistent decision-making from a multi-agency group of professionals seeking proportionate outcomes for the young person, and opportunities for involvement in restorative justice for their victim/s. Following the HMIP inspection of Oxfordshire YJS in January 2020, the domain of the Panel was rated as 'outstanding' by inspectors. The report states the following: *In all cases, the YJS made well-informed recommendations to the police and decision-making panel. These recommendations were based on relevant information and assessments, which included the child's understanding and acknowledgement of responsibility. Work was undertaken to reduce the criminalisation of looked-after children. Consideration is given during meetings to children's safety and wellbeing.*

6.4 Key Learning: Act upon critical and reachable moments in a child's life

The National Panel Review[i] explored the systems theory concept of how critical times in a child's life are responded to so as to make a difference to their lived experiences. The National Panel explain how by adopting a flexible and responsive approach in the critical moment in a child's life can have a powerful influence on the direction taken after the event and after conversations have happened. By leaving things, even by a day or two later may be too late to effect change. Such times can include when a child is excluded from school, when they are injured or arrested. The Review into Jaden Moodie's[33] life similarly talks of how "*reachable moments*" are seen and acted upon.

There were numerous critical and reachable moments throughout Jacob's story which could have been acted upon in a different way and possibly with a different outcome for him. To provide one example there were three separate critical, reachable moments identified where physical and psychological risk were increasing to Jacob suggesting things were spiralling out of control. In November 2018 he experienced a deep laceration to his thumb, digital arteries and nerves and in April 2019 he had a 2.5 cm laceration on this face; both were thought to be knife injuries. Another time was seen in April 2019 when Jacob was filmed inflicting serious violence on another young person who had been held against his will. Jacob's emotional presentation during this attack was described as completely out of character.

Towards the end of Jacob's life there is evidence to show how scared he was of the world he had been coerced into, how trapped he felt and it was impacting on his thoughts and feelings. Jacobs' family and the professionals involved have reflected upon this as he was asking for help and support from those he knew best. Particularly towards the end, professionals noticed how often Jacob would visit them in the

[33] Jaden Moodie Serious Case Review Waltham Forest Local Safeguarding Children Board May 2020

locality office and shared how they felt powerless and unsure as to how to best keep him safe in his community. Understandably Jacob would only "*say so much*" and this was possibly due to fear of repercussions to him or his family. Jacob would not have wanted to be seen as a "*grass*" or "*snitch*" and would have been fearful of others suspecting him of this and especially given his status in the community (Hudek 2018[34]).

These significant and reachable moments show there was an escalation of physical and emotional risk for Jacob and this was not re-evaluated and joined up in a multi-agency swift response. Although Emergency Department information was shared concerning the likely knife injuries, this was not responded to in a context of escalating criminal exploitation and gang influence. His mental health was also not re-assessed and support from Children's Services remained under Child in Need arrangements in 2019 when he was filmed acting out violence behaviours towards another. In hindsight this was an oversight with serious consequences by the partnership in not effectively re-assessing the risk and reviewing plans with Jacob and his family. In response to this critical moment, a strategy discussion was urgently required which might have led to a return to Court to consider what other remedies and orders were needed to keep Jacob and others safe.

6.5 Key Learning: The significance of gender in working with exploited children

The National Review into Criminal Exploitation [35] found that ethnicity and gender appeared to be factors when considering vulnerability to harm from criminal exploitation. It was of note to the Reviewer to consider how a child's gender is seen by professionals across the partnership when working with exploitation as the research shows some evidence of a gendered approach to exploitation with males tending to be perceived as perpetrators while females are perceived as victims[36].

Jacob was an adolescent male who identified as white British. In the County in which he lived there had been much systemic work in identifying and responding to child sexual exploitation following the Bullfinch Inquiry in 2012 and the subsequent Serious Case Review[37] . A dedicated multi-agency team, the Kingfisher Service, was established in 2015 to tackle this area of extra-familial sexual abuse of predominately young females (children open to the Service March 2019 show 60 were girls and 7 boys). Their remit was not to consider criminal exploitation. Oxfordshire is aiming to improve the way it works with children who are being exploited and/or are offending and /or are victims of crime by bringing together the Youth Justice Service and Specialist Child Sexual Exploitation Service. The integrated multi-agency approach will work alongside the Violence and Vulnerability Unit across three areas of the county and hopes to embed contextual safeguarding approaches across the county, seeing those children who are groomed, coerced and controlled into committing crime as victims of exploitation.

A spotlight on improving practice and systems in a certain area such as child sexual exploitation can result in emerging areas not being given the space and attention they need, and the partnership have commented on this playing a part in Jacob's story as a young male. This may also be in part alongside a professional tendency to default to an unconscious gender bias[38] which needs a reflective curiosity if girls are seen as needing more protection than boys and as victims, and especially older boys who may be seen as more able to protect themselves and viewed more as perpetrators. There were some anecdotal examples of this provided in the review process which require careful attention by the Partnership. This will further enhance the on-going focused and educational work by the Board in ensuring boys needs are not over-

[34] Hudek, J 2018 Evaluation of the County Lines Project (available online)

[35] "*It was Hard to Escape":* The Child Safeguarding Practice Review Panel Report 2020 DfE: HMO: London

[36] Violence and Vulnerability Unit May 2018 *County Lines – a national summary and emerging best practice* (available online)

[37] Children-A-F-SCR-Learning-Summary-FINAL.pdf

[38] Gender bias is described as an inclination or prejudice against one gender over the other and can be conscious or unconscious: Oxford English Dictionary

looked in Oxfordshire and provide practitioners will the tools to remain professionally curious when identifying and responding to criminal exploitation irrespective of gender.

6.6 Key Learning: Know the risk factors & predictability

The research[39] suggests there are a wide range of risk factors that can increase potential vulnerability to child criminal exploitation. These include poverty, abuse, neglect, behavioural difficulties, school exclusions, additional educational needs, children in care, those who go missing, those who use drugs and those with mental health issues. This research tells us that individual factors can increase potential vulnerability and the presence of more than one can heighten the risk.

Jacob's childhood multi-agency chronology evidences that he had numerous experiences which are likely to have increased risk and these along with a combination of factors in his adolescence years would have meant Jacob was highly attractable to drug networks operating in his local area. These vulnerabilities were considered through an early help assessment completed in December 2017 and single assessment (March 2018). From 2019 Children's Services held the view that a trauma informed approach was needed to understand the current behaviours and how they linked to previous early life experiences and current levels of anxiety and distress. This was an admirable approach which may have yielded more positive results if undertaken earlier in Jacob's story and not when risk was high and on-going various harms to him likely.

A further example of vulnerability and risk was Jacob's mental health which deteriorated over the review period. He was assessed by the Forensic Child and Adolescent Mental Health Team as being a high risk to himself and others at various points but not as having specific mental health needs. The Children's Commissioner (2019) found that gang associated children are over 75% more likely to have an identified mental health need that other young people assessed by children's services and also twice as likely to have a history of self-harm. Jacob's mental health was not seen or understood through a lens of gang affiliation and risk even when he showed his frustrations and upset much more towards the end of his life through his behaviours which became more extreme and violent. He had written a note about his funeral and his feelings of worth in November 2018. These were all warning signs in hindsight that all was not well in his world and this was not acted upon swiftly enough within the partnership. The frustrations felt by Children's Social Care were acknowledged in this Review with discussions centering on the current thresholds for mental health support and interventions via Child & Adolescent Mental Health Services for children who show such behaviours. FCAMHS offered clinical support to Jacob to help him though he said he did not want such input.

When working with children who are under the care of FCAMHs, risk levels are likely to be high and young people are frequently described as 'hard to engage' in assessment or intervention. These considerations are recognised within the FCAMHS service model which allows for ongoing involvement with children recognised as of particularly high risk even if specific mental health interventions are considered unlikely to be feasible. In Jacob's situation FCAMHS continued to try to undertake assessment and provide support and advice to the wider professional network in relation to ongoing emotional issues and specialist evaluation of risk. Jacob's levels of engagement were discussed on a regular basis and was a key factor raised in the escalation to the Complex Case Panel. For FCAMHS to consider closing a child's file when there are ongoing concerns there would need to be a) agreement about this within the wider professional network or b) in very rare instances a decision made that all efforts to escalate the FCAMHS concerns about the young person have been made and that FCAMHS involvement is not proving meaningful within the child's ongoing plan. The latter (b) was decided by FCAMHS in Jacob's situation. The complexity of FCAMHS work means that when closing a child's file, mention is always made to the referring professional that further contact with the team is welcome if required.

[39] Children's Commissioner 2019, National Crime Agency 2017, & Spencer et al 2019

Abusers who operate County Lines rely upon a business model that exploits children and often those children who have some level of vulnerability. They run large-scale operations which are hierarchical in nature with those at the top levels appearing to be "*untouchable*" by agencies. Jacob's Dad talks about the untouchability of those who abused his son and how he was easily groomed into this world by a chance meeting in the town centre saying, "*and it was as simple as that* ". For Jacob with the multiple vulnerabilities as outlined above there would have been a simplicity in which he would have been pulled into this world and as referred to by many in this process Jacob was sadly "*easy pickings*" to being influenced and groomed by his exploiters.

6.7 Key Learning: Understand the significance of a child's identity within their community networks when assessing levels of risk

The building of social connections and relationships with peers is a key part of development during adolescence. The behaviours and actions of groups of young people in their communities has received much public and Government focus with an on-going debate on the definition of what constitutes a "gang". For the purposes of this Review, the 2015 Serious Crime Act definition is used which sets out the features of a gang as a group which consists of at least 3 people; has one or more characteristics that enable its members to be identified by others as a group and which is engaged in violence or involved in the illegal drug market. This is different to an organised crime group or criminal network which the Crown Prosecution Service (2017) describe as planned and co-ordinated criminal behaviour and conduct by people working together on a continual basis. This persistent criminality offers individuals some form of personal gain and/or demonstrative status and causes significant harm, with a corrosive impact to the community.

There is no evidence and therefore it is not with certainty that Jacob defined himself as a street gang member, but it is likely his identity was on the periphery of the above definition of a "gang" membership. His association and involvement in group activity in the community needed to be better understood, assessed and disrupted by the Youth Justice Service, Police and Children's Social Care in sharing intelligence and mapping the risks together. There was a gap in knowing and understanding the risk factors associated with where Jacob spent the majority of his time with his peers in the community and it resulted in pieces of the contextual safeguarding picture of his life being missed. Social connection and spending time with his peers in the local community were clearly important to him and he called them his "*family*". Jacob enjoyed drill music[40] and his family remember how this often "*hyped him up*"; often he would hang around with groups of young people in his community and was seen as an instigator and leader of behaviours.

As research finds[41] children's involvement in child criminal exploitation and gang association is a complex area and needs to be considered in terms of how socially included or excluded a child feels in their community. Jacob was a child who enjoyed financial and material objects such as having the latest tracksuit, bracelets or trainers. Alongside this, county lines and drug dealing may have given him the kudos, respect and recognition that he did not find elsewhere in his life – it became his "*other*" family, life and world when dynamics in his own family were at times strained. This "*other*" world of county lines and drug dealing can make some children more touchable to exploiters if like Jacob and as afore mentioned you live in a community with levels of deprivation, where your aspirations are high and where you experience : "*a denial of reward and a denial of recognition in the conventional world, but find both in the gang and drugs business*" (Andell & Pitts, 2017: 11)

[40] Drill music is a style of rap music and is defined by its dark, violent and nihilistic lyrical content. It has associations with crime.

[41] Robinson et al (2019) *Working County Lines: Child Criminal Exploitation and Illicit drug dealing in Glasgow and Merseyside*. International Journal of Offender Therapy and Comparative Criminology 63(5) , 694-711 , Andell P & Pitts J (2017) Filling the gaps/Joining the dots: the Lambeth gang and youth violence strategy; Lambeth, London

Estimates suggest there are 27,000 children in England who currently identify with being a gang member [42]. Research[43] shows that criminal and organised gangs operate in England by using ruthless and sophisticated means to groom children, with often chilling levels of violence to keep them compliant. While important to remember all children can fall prey to gangs and criminal exploitation, Jacob's known vulnerabilities are likely to have increased the risks factors with emotional health issues, substance use, early adverse childhood experiences and not being in school. Such vulnerabilities as Jacob had are thought to result in being more susceptible to gang inducement or threats. The Children's Commissioner Report (2019) highlights how risk can then be increased or moderated by how services respond to the child's needs and in Jacob's situation not being on-roll at school would have increased susceptibility to serious youth or group violence.

The Review considered risk levels from the shocking serious violence and knife crimes that are likely to have saturated Jacob's life on a regular basis while in the community. It is known Jacob received significant injuries, was found with weapons at home and when arrested by the police and undertook behaviours such as burning clothes in his back garden. At the end of his life it is also known that Jacob inflicted a serious assault on a peer and held him hostage. It is important learning that children who are criminally exploited can also be perpetrators of violence and often they might carry weapons as a warning or so as protect themselves or as part of group affiliation.

6.8 Key Learning: Managing risk via multi-agency assessments, plans and contingency

It was good practice that some of the warning indicators to Jacob's safety and well-being outlined above were regularly shared between the statutory agencies, risk assessed by individual agencies and plans were established within organisations within their own assessment frameworks. However, there is no evidence that his known vulnerabilities or the information shared about him led to effective multi-agency plans which improved life for him. There was a clear lack of Plan B's or contingency for Jacob when things were not changing in his world and the same response was often given to monitor the situation and carrying on with the previous actions agreed. Jacob's family use the term of "*sticking plasters*" and refer to the situation of Jacob being dealt with in a temporary and unsatisfactory way where risk was not reduced. His family feel that "*there were opportunities to make a difference and these were missed*" as different options were not then explored when improvements were not seen and/or services were unavailable.

This Review has found some evidence to suggest that the assessments undertaken and plans put in place focused predominately on Jacob's behaviours, were single agency and silo-ed in approach and did not look beyond this to the contextual risks with sufficient multi-agency coordination despite many meetings and attendance at single and multi-agency Panels. The reason for the lack of a coordinated approach is likely to rest in the county council not having a systems approach to responding to criminal exploitation. There were pockets of emerging good practice and system thinking but this tended to be focused in Oxford City and not County wide and this was a frustration felt deeply by all practitioners and managers involved in this Review as they talked of feeling stuck and not knowing what else to try.

The Community Safety Partnership and those agencies within the children's safeguarding partnership (children's social care, police, health, housing & education) would have benefitted from having a more effective and joined-up approach. This Review highlights the many individual and group meetings that took place at strategic and operational levels in the local area and county wide about safer communities and crime reduction. The flow of information and thinking was not joined up with individual children living in those areas and improving their day to day lives. The community and safeguarding systems needed to map and share all of this information strategically and operationally to plan more effectively together to

[42] Office of National Statistics, British Crime Survey

[43] A systematic map and synthesis review of Child Criminal Exploitation, October 2019 Cardiff University; What Works Centre and Cascade

tackle the criminal exploitation in the local community and for Jacob. This would have enabled critical understanding, analysis and a systemic community response to these wider contextual risk factors. What happened instead was a focus on Jacob's presenting behaviours and responding to immediate risks as they arose and without adjusting plans of intervention. A coordinated and systems wide response to criminal exploitation, backed up by clear policy and procedures would clearly have helped professionals who were struggling with what else to do to keep him safe. Such an approach which could be reviewed and amended in light of new multi-agency contextual information may have allowed a greater focus on the cumulative effects of extra-familial harms and a more comprehensive picture of his day-to-day life when in the community with a plan of interventions based upon the current research of what works for children in these situations. It is hoped that with the new delivery arm of the Child Exploitation Service now being developed, along with the introduction of the Violence Reduction Unit[44] in Oxfordshire along with the recommendations from this Review it will drive strategy and embed cultural change.

Various care plans were being considered as part of the proceedings. It was not always as clear as it needed to be through Children's Services written assessment, plans and review as to what the permanence plan was for Jacob and on what basis the decision had been made. For example, at the second child in care review where a long term plan should be known, a plan for reunification home was proposed without the assessment of his needs being completed and authorised by a Children's Services Manager. The second child in care review was held in two parts, which is not unusual practice but went out of timescale with part 1 being held in mid-July 2018 and part 2 convened early September 2018. The reason for the delay in care planning was explained as not being sure about the best options: whether Jacob should remain in residential care or return home to his family.

Dispute resolution processes could have been instigated on various matters including the use of unregulated placements, lack of education provision and drift and delay in care planning. However, there was regular communication between the social worker, IRO and Guardian and it was known the matter would ultimately be decided by the Courts. Good practice was seen in that both the Guardian and IRO had obtained Jacob's views, wishes and feelings on several occasions by spending 1:1 time with him. He remained adamant he wanted to go home to Mum. Jacob found his time in care difficult and talked of feeling "*embarrassed*" by it and not wanting his family to visit or see him. His Sister describes how "*it didn't work at all for him; he hated it*". Indeed, his behaviours escalated whilst in care and there was a clear impact on his psychological and physical safety as he often went missing. Given his age and level of understanding his views were given considerable weight and some have since reflected on how the balance is made between Jacob's voice and rights alongside his needs to be kept safe from significant harm whilst in the community.

6.9 Key Learning: Ensure the right support to help families and manage risks together "*We knew him best; work with us*"

Jacob's family shared their perspective of involvement with various organisations across the partnership. Individual family members asked for help and support for Jacob on many occasions however the family did not feel they were supported or helped in the right way to effect change for Jacob. This increased tensions within the family too and Jacob was aware of this.

Jacob's Grandfather gave his perspective on the safeguarding system when responding to child criminal exploitation by using a new car analogy. He said "*you buy a new car; you get to know it and you look after it to begin with…after a while it loses its shine and appeal and you do not have the same level of interest in*

[44] In March 2019 the Home Office committed £100 million from the Serious Violence Fund to help tackle serious violence. VRU's are a multi-agency response, formed in local areas to build capacity to tackle the root causes of violence – Home Office Violence Reduction unit Interim Guidance March 2020

it. This is what happened to Jacob, when the system did not know what else to do, the focus was lost on helping him".

Mum in particular reported Jacob missing on many occasions to statutory agencies and shared her worries about managing Jacob's range of behaviours at home and when in the community. She often felt frustrated by a lack of community resources and practical guidance on how best to manage the situation with her son when at home and most importantly when in the community. The serious violence and abuse her son were likely experiencing in the spaces and places he occupied would have been extremely difficult for any parent or family to manage alone.

The usual parenting strategies of setting boundaries and repairing relationships between Jacob and his Mum were provided by Children's Social Care to try to rebuild family connections and mitigate the risky behaviours. Given some of the complexities within the family this was not always straightforward for practitioners to effectively undertake. This was also within an extra familial context of not tackling the wider community risks and disrupting the perpetrators and stopping the exploitation to Jacob. The need for a coordinated strategic approach led by the Community Safety Partnership (District Council and Police) would have rendered this single agency operational work by Children's Social Care largely ineffective and of course unlikely to reduce harms as an intra-familial approach alone would not have kept him safe.

Mum commented on Jacob's life during the review period involving the court processes, children in care provision and statutory interventions which culminated at the end of 2018 with Jacob "*ending up back at square one*" living at home under a supervision order with risk having escalated. In summary the family view highlights there was no effective system in place to respond, help or protect Jacob who was being criminally exploited and no effective support system in place to his family either. The work of SPACE [45] and the National Parents as Partners (NPIES) forums are helpful to consider when developing more effective systems, strategies and solutions when working with families in tackling criminal exploitation.

6.10 Key Learning: The role of the National Referral Mechanism (NRM)

When a child is suspected of being significantly harmed through criminal exploitation there are certain mandatory steps that are required. The Police will consider investigating the offence and Children's Social Care will lead on child protection enquiries and assessments as detailed in Working Together 2018[46]. A referral should also be made to the National Referral Mechanism[47] to determine whether a child is a victim of modern slavery.

If a child is recognised as a potential victim of modern slavery through the NRM referral they can have access to tailored support for a period of at least 45 days while matters are further considered and this can include accommodation and protection, along with independent emotional and practical help including Independent Child Trafficking Guardians (ICTG's)[48].

Although referrals have increased year on year since its introduction in 2009[49] this Review finds that much confusion about its role and purpose continue across the partnership. Despite many missing episodes which should have triggered a referral to the NRM it remains unclear as to why this was not made for Jacob until March 2019, or what the outcome of this referral and what support was offered by the NRM Framework. This delay in referring might lead to a conclusion that Jacob was seen through a lens of

[45] Space (Stop & Prevent Adolescent Criminal Exploitation) is a self-funded organisation helping to raise awareness and campaign to promote more effective working with parents as partners

[46] Working Together to Safeguard Children 2018 DfE; HMO: London

[47] The National Referral Mechanism is a framework for identifying victims of human trafficking and ensuring they receive the appropriate protection and support

[48] National Referral Mechanism Guidance (England and Wales) January 2020 HMO 2020: London

[49] A systematic map and synthesis review of Child Criminal Exploitation, October 2019 Cardiff University; What Works Centre and Cascade

perpetrator and offender and not as a child who was being exploited through modern slavery. Or it might suggest that largely most professionals involved in this process were and remain unsure as to what good it would have achieved if Jacob's needs had been considered under this framework. This suggests that the role and purpose require a national review to ascertain whether it remains fit for the purpose it was intended.

6.11 Key Learning: The Need for a National Drive and Agenda

Jacob's story must not be seen in isolation of the wider national picture of child criminal exploitation. The National Crime Agency (2018) have estimated that there are approximately 1000 branded criminal networks with around 2000 individual lines in the UK. Each individual line is thought to make around £800,000 profit per year, with nationwide profits estimated to be £500 million (Grierson, 2019a[50]). It is also known that serious youth crime across England and Wales has a total economic and social cost of £11 billion[51] – this huge amount of course does not include the devasting individual costs to individuals and their families such as Jacob's. The impact of children being criminally exploited, which includes Jacob's story, is illustrated in the Channel 4 Dispatches Documentary[52] and this Review recommends a national response. Without such a response to criminal exploitation and without a national sufficiency of placements for children who may show high risk behaviours and need specialist homes, it places local authorities in a more difficult position of providing a local response which can then realistically be effective for those children in their local area at risk of criminal exploitation.

7. THE ROLE OF THE EDUCATION SYSTEM

Research[53] has clearly and repeatedly shown that when children fall through the gaps in a system, such as attending an education provision, then they become more vulnerable. This section explores the role of the education system in keeping children safe and considers the fragmented nature of local authorities' education systems, which may well be recognised by other areas nationally with the introduction of Academy Schools.

The Review examined the statutory processes and procedures alongside the local provisions available when children's behaviours are seen as a challenge to those tasked with educating them. It highlights how children can easily fall through the net when the parts of the system do not work well together as in Jacob's situation with harmful consequences to his self-worth and physical and psychological safety.

7.1 Key learning: The role of schools in keeping children safe

Previous Reviews [54] have commented on the importance of a child attending school and how exclusions from school are seen as a trigger point for risk of serious harm. Jacob was not on any admissions roll and did not attend any education provision when he returned to Oxfordshire in July 2017, when he lived in and out of county in care and until his death in April 2019. During this period of almost 2 years the Review finds systemic and enduring drift and delay across the education sector. There is substantial evidence to show that professional practice was impacted by ineffective systems which resulted in much too slow a response to Jacob's need for an education provision. In some areas there was a lack of responsibility and accountability in the education department in progressing matters for Jacob and his situation was described as being "passed from pillar to post".

[50] Grierson, J 2019 County Lines: huge scale £500m drug industry revealed. The Guardian (online) 29/01/2019
[51] Youth Violence Commission Final Report July 2020
[52] britains-child-drug-runners
[53] Children's Commissioner 2019
[54] "*It was Hard to Escape":* The Child Safeguarding Practice Review Panel Report 2020 DfE: HMO: London

The relationship between the County Council's admissions processes and Academy Schools is complicated. Since 2014 Academies are their own admissions authority except where variations have been written into their funding agreement to support fair access[55]. If an Academy School refuses to accept a child the County Council are not in a position to direct them to do so as in Jacob's situation. The matter can be referred to the ESFA and the Secretary of State can make direction. At this time this was not done and was not regularly undertaken as there appeared to be a cultural view that framed it as a slow and cumbersome process with no guarantee of positive outcome. The In-Year Fair Access Panel's functions as detailed in the School Admissions Code 2014 function is to consider and place those children who are deemed "hard to place". There are four county-specific multi-agency Panels across Oxfordshire which include School Leaders, held eight times per year and those who are involved in them commented on the ineffectiveness of Jacob's Panel during the Review period with some provisions being resistant and on-going delays in progressing matters. Dedicated and targeted work by schools and the county council working together is now underway to improve the interplay between the education provisions and education systems in Oxfordshire.

The reasons for the inadequate response to meeting Jacob's education needs are complex and this Review finds many current examples of improvement work. There has been much reflection by education colleagues as to what allowed for a continuing unsatisfactory education situation for Jacob. Much educational debate centred upon the barriers which exist between the County Council and education settings when trying to place children. At the time this resulted in an apparent systemic delay with progressing children's educational needs who remained off roll. This is evidenced further by the Local Government & Social Care Ombudsman[56]. The department lacked capacity during the Review period, with numerous staff changes and insufficient leadership and management oversight. There was at that time a culture of not holding responsibility for progressing the agreed plans to secure an educational place for Jacob. There was evidence seen of passing the responsibility to others without appropriate follow-up; a lack of effective monitoring systems and no locally held data of tracking those children not on roll, along with poorly run Education Panels (the In Year Fair Access Panel; Children Missing Education) which did not affect change for Jacob. The Review finds currently that a plan of work is underway, and changes are being made between schools and the county council to resolve these cultural, practice and system issues in Oxfordshire.

The on-going lack of daily education for Jacob will have played a significant role in not identifying levels of risk and leaving him vulnerable to further episodes or incidents of harm. The possible impact on Jacob is one where he may have felt disheartened as he repeatedly asked for an education provision and was not provided with the opportunity for this as he should have been. Not being on roll or in any education provision left Jacob highly vulnerable to coercion and being criminally exploited as he had nothing to fill the majority of his day or week with and left him with much time on his hands in the community. Not being in a learning environment denied Jacob the many daily experiences, and possibly a relationship with a teacher, which would have given him opportunities and hopes for a different day to day life and for a better future. There would have been a need for creative thinking and some flexibility in supporting Jacob in an education setting but he also wanted this opportunity, often asking to be in a school setting, talking of missing his education and sharing his dreams of what he wanted to become later in life.

7.2 Key Learning : Educating children who may pose a concern due to a range of presenting behaviours

Jacob's educational history of behaviours seen by professionals suggests he would have provided challenges to any education provision in meeting his needs alongside balancing the learning needs of other

[55] Academy Admissions 11th March 2014, updated 19th September 2019 HMO Gov.UK: London
[56] https://www.lgo.org.uk/information-centre/news/2019/jul/oxfordshire-teen-left-out-of-school-for-14-months-because-of-council-delay

children. This Review notes the transfer of information from county to county when Jacob moved homes in July 2017 was not as thorough as it needed to be given his later school experiences and exclusion in the North East. His education, social or emotional needs were not considered for assessment under an Education Health Care Plan (EHCP) [57] and so his needs were all largely speculative and never properly assessed through the required educational processes.

After debate and information being shared via Education & Multi-Agency Panels (the In Year Fair Access Panel and the Multi-Agency Risk Assessment Panel), the alternative education provision in Oxfordshire was recommended as the most appropriate option for Jacob's education. There were multi-agency discussions with the alternative provision and evidence shows a hesitancy to accept Jacob due to the risk he may pose to himself and others attending the provision. It was agreed following advice from FCAMHS (due to his behaviours) a risk assessment was required to understand better how to meet his range of needs and also to ensure the safety of children. This assessment was not forthcoming from Children's Social Care and the provision were informed the place was no longer required.

Jacob not being accepted on roll at any setting meant that the Local Authority remained unable to provide him with access to a suitable programme of education. As a result of a lack of joined up working across the education system, Jacob's situation remained in limbo. This Review has considered the strengths when education departments, schools and alternative providers work effectively together and the safeguarding system in sharing information in a timely manner, mapping out individual and community risks with specialist packages of education and psychological support in meeting the needs of those children who show a range of challenging behaviours.

Research suggests [58] that dangerous drug networks regard Pupil Referral Units and alternative provisions as places to recruit some young people with vulnerabilities and also children in gangs are more likely to be in alternative provisions. This Review finds that some professionals had real concerns about the risks of placing Jacob with other young people in a provision where there was increased risk of being exposed to criminal activities, including drug crimes. The clustering together of groups of children who often have multi vulnerabilities is a highlighted national practice issue which requires further consideration, although the fact remained that Jacob was not on roll at any provision in the area in which he lived.

7.3 Key Learning: Children Missing Education

There is statutory guidance for children missing education[59] which sets out what parents, education authorities and education providers must do so as to ensure children receive suitable full-time education. Oxfordshire now has a local Children Missing Education Policy[60] which spells out clearly its commitments to children and the County acknowledge in this Review that they did not meet their duty to Jacob in providing him with full-time education as a child.

Jacob was a child who moved in and out of the county and in out of the care system which should have afforded him an additional level of scrutiny from an Independent Reviewing Officer and Virtual School, with a Personal Education Plan[61]. Unfortunately, and as previously noted, for Jacob during this 5-month period in care neither provided him the oversight that was needed to resolve the educational issues and secure him an education provision.

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[57] An Education Health Care Plan outlines any special educational needs a child has, and the provision a local authority must put in place to help them

[58] Clarke, T (2019) *The characteristics of gang-associated children and young people*: February 2019 Children's Commissioner

[59] Children Missing Education September 2016 DfE HMO; London

[60] Oxfordshire County Council Child Missing Education Policy 2019 – CE Oxon-Partnership-Brochure

[61] A Personal Education Plan forms an essential part of a child's care plan when they are looked after by a local authority. The PEP will follow the child through their education and records progress.

8. WORKING TOGETHER

Ofsted[62] identify the need for the development of a whole system approach that includes policy, prevention, disruption, protection and support across multiple agencies when working with children at risk of criminal exploitation. This section reflects on the safeguarding systems in place in the particular local area to Jacob whose statutory function was to protect him and keep him safe from harm and this will likely be relatable to other local authority areas across the UK.

8.1. Key learning: Involve all the local safeguarding system to understand extra-familial risk & harm in a timely manner.

There is no specific legislation or policies for child criminal exploitation and is therefore mainly supported under legislation including the Children Act 1989 and the Modern Slavery Act 2015. The statutory guidance for agencies was revised in 2018[63] to include extra-familial risks as child protection issues. However local authorities have received very little guidance and the research is still somewhat limited to support and inform agencies as to the most effective ways of responding to such extra-familial risks. The impact of this means that most professionals working with children at risk of criminal exploitation did not and arguably still do not know how best to support children or reduce risk effectively in this complex area of practice. A professional involved with Jacob describes the current situation as "*trying to fit a square peg in a round hole*" in that they often found themselves in situations with Jacob where what they could offer would not meet his needs or they knew would not work. This context sits alongside cuts to Children's Services which are estimated to have reduced by 50 per cent since 2010[64] and specifically the national funding for new services for exploitation or serious youth crime prevention.

This Review has found some good practice examples of the key statutory partners (Police, Health and Children's Services) working together at a local level, where information was shared and considered together with differences of opinion known. However, the Review has also noted the benefit of having all partner agencies around the table when considering levels of risk – those that held important information and/ or should have been involved include housing providers and district councils, youth services and the voluntary sector.

As previously detailed the Youth Justice System were not involved with Jacob as he did not have a criminal record having not been placed before the Courts. This was arguably a large piece of the safeguarding jigsaw missing from the work with Jacob and his family. The Youth Justice Service, Police and Children's Social Care needed to be interrelated to ensure their practice approaches targeted Jacob who was clearly at risk of criminal exploitation and offered support to him as a victim and not a perpetrator or offender. Youth Justice Services were not part of the wider systemic picture and mapping with Jacob and this meant their local intelligence about Jacob or other children in the community was missed. Care must be taken to not criminalise children or focus solely on offending behaviours but more so to map out which education provisions or which accommodation children live in so as to reduce risks of exploitation and possible networking so as to better understand what support might work for those children groomed into exploitation.

Previous serious case reviews in Oxfordshire have commented on the important and often missing role of housing in the safeguarding network[65]. Housing providers and the district council were key missing parts from the multi-agency table as they held information about the local community and Jacob's family's

[62] Ofsted 2018 in A systematic map and synthesis review of Child Criminal Exploitation, October 2019 Cardiff University; What Works Centre and Cascade
[63] Working Together to Safeguard Children 2018 DfE; HMO: London
[64] ADCS 2018 Safeguarding Pressures Phase 6 to be found here: https://adcs.org.uk
[65] Child-Q-SCR-Summary-sheet

needs. The Review finds the housing provider was not involved or engaged in multi-agency discussions about how to respond to the criminal exploitation of Jacob in a coordinated way. The Housing Provider and District Council held critical information, were part of some local multi-agency discussions in forums concerned with community risks but this did not tie up effectively with meetings about protecting Jacob. As helpfully explained by a professional "*it is so important to make sure the right people are around the table for children at risk of exploitation so that a bigger picture is known*".

The Voluntary Sector provided a specialist community based service to Jacob and his Mum and the remit was to work with children at risk of exploitation and modern slavery. Effective relationships were built and regular 1:1 work was undertaken from November 2018 until April 2019. This was an example of good practice and such provisions can offer children at an early help time an alternative path. Such outreach measures provided at an earlier time of need might offer proactive and preventative solutions when on the edges or just entering worlds of criminal exploitation. A befriending & mentoring service such as this offered a street based and a community focus to Jacob in a safe-space and with leisure activities alongside a much needed listening ear to his family. Jacob began to confide in professionals at this service in 2019 and talked of feeling there was "*no way out"* for him.

Timely and swift action

This Review has shown that the partnership did not consistently offer Jacob a well-coordinated multi-agency approach where risk was quickly identified and responded to, with the numerous critical and reachable moments not being considered and risk strategies and plans remaining single agency in approach. The chances to protect him were not acted upon swiftly enough as professionals felt at a loss as to what else to do and the focus remained on his behaviours predominately as opposed to including systematic county wide and national strategies to effectively reduce risk in the community.

Often where there is a risk of criminal exploitation a child's behaviours seem to need to escalate before services become involved. Spencer et al (2019) describes how the "*multi-agency response is reactive and could be described as crisis management. As the risks and vulnerability grew, behaviours were more serious, more violent and more frequent; agencies struggled to meet their needs*"[66]. The community, the professional network and Jacob's family all share this view and reflect upon the important role of prevention and early help to children and their families and not waiting until crisis points when children are so enmeshed in worlds and are largely untouchable to those trying their hardest to support and protect them.

Much of the crisis work with Jacob happened overnight and was managed by the emergency duty team (EDT). Records of this are detailed and notifications should have been sent via email to the locality day team social worker. However, the system at the time for recording out of hours activity was described as "clunky" with a potential for information to go a drift. A Children's Services EDT re-design in February 2019 evidences a much improved one service approach with practitioners being co-located with the Police which strengthens working together practices; staff in substantiative posts; recording direct into the child's electronic file and daily Skype handover meetings with the Multi-Agency Safeguarding Hub.

In hindsight and on reflection the professional network is able to identify what could have been offered at early points via the Early Help Pathway to Jacob and his family when worries were first emerging, and this could be built upon in further work when developing the new contextual framework in Oxfordshire. The rationale for these reflections is based upon a development of skills and knowledge across the partnership since Jacob's death and when working with criminal exploitation with a clear recognition and need for early intervention with relationship based, evidence informed practice at its heart. This was offered towards the end of Jacob's life by Children's Social Care but by then the extra-familial risks were too high to Jacob.

[66] Spencer, C et al (2019) Vulnerable Adolescents Thematic Review: Croydon Safeguarding Board

8.2 **Key Learning: Effective Discussion to ensure a collective responsibility and ownership which the family should understand**

In 6.4 the Report considers how the reachable and critical moments in Jacob's life were not responded to effectively at a practitioner and manager level when risk was escalating. This Review shines a light on the challenges of how individual agencies and partnerships work together at all levels when a child's situation changes often on a daily basis and how this information is held collectively and understood to inform decision-making. The push and pull factors of multi-agency working when there are many professionals involved with a child, with different roles and responsibilities and likely professional time constraints means that children can be pushed from agency pillar to post with results in a limited collective multi-agency responsibility and ownership. Jacob's family share examples of often being unsure of who was doing what which suggests the multi-agency approach lacked a clarity and shared purpose with clearly defined outcomes to reduce risk and make a different to his day to day life. Families need to know, understand and participate in the decision-making and planning when risk is extra familial. The lack of collective responsibility and ownership is clearly evidenced with Jacob falling through the gap as a child needing education in Oxfordshire and can be also seen at higher levels of seniority via the Complex Case Panel and this is explored further in the next section.

8.3 **Key Learning : The systems which support when there is a difference of opinion**

There was a lack of consensus within the partnership from practitioner to senior leadership level regarding both the level of risk to Jacob and how he should be kept safe from harm both in the immediate and long term between Children's Services and FCAMHS. Jacob was assessed by FCAMHS as needing a secure provision or a therapeutic residential home given the high level of risk and harm to Jacob and others. There is an argument and with hindsight this is made easier to note that a higher level option such as secure accommodation would have provided Jacob with an immediate contained level of care where he would be safe for a limited period while therapeutic work was undertaken and a level of education provided. However, others debated how he would have returned to the local community after this period away and risk would remain as the wider community work was not effective in disrupting the perpetrators. Research[67] at that time was not readily available to help and support the partnership in which approach would offer the most effective outcome for Jacob and this Review debated whose voice is heard and acted upon when there is a professional difference on the most appropriate actions to reduce risk. FCAMHS felt they were not heard on these occasions and said this was not typical of usual working together practices in the County.

Having a difference of professional thinking and/or hypothesis is important when working together to safeguard children. The risk to Jacob was not reduced despite two multi-agency risk assessments and plans being undertaken in April and December 2018. Jacob's needs and level of risk was considered at numerous single and multi-agency Panels across all levels of seniority. The Complex Case Panel is a multi-agency panel at Senior level that was specifically set up following a recommendation in a Serious Case Review[68] to provide a "*fresh pair of eyes*" on complex situations, to provide senior manager support to frontline professionals so as to hold the risk together and enable a working culture which enables professionals to say, "*I'm stuck and I'm not sure what else to do*". The Panel also has a remit to help unstick the variance in opinion about the best options and plans if practitioners cannot agree locally.

[67] Carlene Firmin *Relocation, Relocation, Relocation: Home and school moves for children affected by extra familial risks during adolescence* March 2019

[68] Claire/ Kay Reference OSCB SCR or link re: Complex Case Panel recommendation (Kay to check with Hannah)

This Panel considered Jacob on two occasions during the Review period where the need for secure accommodation was discussed. However, given national shortages for secure beds and a lack of persistence to drive this plan, secure accommodation was never achieved and the high level of risk remained. This difference in professional thinking and responses to how to meet the thresholds of risk in the partnership did not find a workable compromise at this strategic level and this meant plans continued at a family and community-based approach, with Jacob's views, wishes and feelings remaining of paramount importance to stay in his community. Professionals have commented on the number of Panels in operation, their effectiveness in terms of making a difference to children's day to day lives and the need to ensure the right professionals are "*around the table*".

It is clear from hearing from those who are part of the Complex Case Panel there have been benefits of the forum but on this occasion for Jacob the escalation and senior oversight effected no change in risk levels or a positive change to Jacob's lived experience. The reason for this is linked to the dislocated community approach and lack of work to stop or disrupt the activities of the perpetrators exploiting Jacob as afore mentioned. Without disrupting that part of the picture for Jacob, and unless he was removed from his community for a considerable amount of time and under secure arrangements given the risk of continued missing episodes if placed in residential care, extra familial harm in the community would have remained.

A further frustration and tension in the Partnership centred upon the need for specialist psychological work with Jacob to respond to his needs whilst he lived in the community. Jacob did not wish to engage in this work despite repeated efforts by FCAMHS to offer 1:1 sessions. The service kept Jacob's file open due to the high risk identified until January 2019 when it was then closed. The FCAMHS Team concluded they had repeatedly escalated their concerns and did not feel their input was regarded as helpful within the core group of professionals and senior managers. Some parts of the safeguarding system identified this as a gap in support to manage his day to day mental health, however this requires more nuanced analysis to understand reluctance or resistance to services and support. The national and local reputation of mental health services as not being able to meet need until a child is settled and safe resulted in many discussions with Children's Services. Although there is no formal trauma-based service for young people in Oxfordshire, the FCAMHS service works within a trauma-based model and delivers multi-agency trauma-based training to the Partnership.

8.4 **Key Learning: The importance of a shared language**

The language we use can impact on how we view children and their families and how we form our professional judgements and this may result in how risk is seen and support is given. It is important as it can also alter how realistic the picture is of a child. In the Review the use of emotive language has been considered in terms of how it influenced how Jacob was seen by key professionals to analyse whether at times it resulted in an outcome whereby the "*tail wagged the dog*". This means that in certain settings at certain times the behaviour that Jacob was showing or was alleged to have shown took precedent over his other needs and were based on single pieces of evidence or assumption. Jacob's behaviours at times were seen as being too dangerous to include him and this resulted in him being excluded from sources of help. Conversely at other times the levels of risk to Jacob and his vulnerability to being seriously harmed was not seen in the significant way that they should have been despite have various evidential information, professional opinion and incidences of harm.

Risks and strengths need to be recorded accurately, changed in light of new information and present a balanced picture, using the child's own words wherever possible. Jacob's behaviours were at times referred to in highly emotive ways by professionals who had more often than not simply read about Jacob in reports, had never met him and the risk was then escalated to a point where professionals felt he was too unmanageable to be in their provision and posed a risk to others. This is often described as being risk adverse. Alternatively, when Jacob was assessed with evidence by a senior clinical Psychiatrist who had met him on several occasions in the partnership as being a significant risk to himself and others this was

heard and listened too but given the context of placement sufficiency for secure or specialist provisions and a different agency view, was not acted upon in terms of reducing risk to Jacob via effective risk planning to change his immediate situation.

When working to understand a child's world it is important to be aware of unconscious bias and the use of overly emotive language as this can affect how risk is seen by the partnership and to look beyond behaviours to understand needs. The key is in accurate, timely information sharing with all aspects of the child's life evidenced. There is much current thinking and work around changing the narrative for child both locally and on a national level.

Recommendations for System Change which will support and strengthen practice
Jacob's Review makes 3 National Recommendations and 1 Local Recommendation (with 3 Action Plans which relate to the 3 key themes).

9. **National Recommendations:**

Recommendation 1: This Review asks the National Panel to acknowledge and share the key learning and findings from Jacob's Review (along with other recent Reviews[1]) with partner bodies and agencies such as the National Practice Framework, Youth Justice Board Serious Youth Crime and National Referral Mechanism Review so as to inform national policy and practice.

This Review asks for particular attention to be paid to the effectiveness of the National Referral Mechanism in making a difference to children's lives.

Recommendation 2: This Review asks the Department for Education to acknowledge the education key learning and findings from Jacob's Review and provide feedback as to the effectiveness of the Education and Skills Funding Agency process in resolving issues in a timely manner.

The Review asks the Department of Education to provide statute and guidance to local areas and their communities on how to manage the Governance arrangements with academy run schools and local education departments who currently cannot be mandated to accept children on roll.

Recommendation 3: This Review asks the Department for Education to undertake a review of national placement sufficiency for children who need to be in care or placed under secure arrangements. This national review will analyse residential home provision; secure home provision and should include the views and experiences of children and their families who have and continue to use such provisions. This will inform changes to policy, sufficiency levels and contractual arrangements with independent providers.

10. **Local Recommendation**:
There is one local recommendation with three actions plans outlined below.

Jacob's Review has shown the serious and significant consequences to children at risk of exploitation. It asks the Multi Agency Safeguarding Arrangements (MASA) and the OSCB to drive county-wide multi-agency system change at a strategic and operational level and address the three key learning areas identified in

this Report. This will support and strengthen single and multi-agency practice across the County and reduce the risks of this happening again to other children in Oxfordshire.

MASA will drive and resource the completion of 3 written action plans within 3 months of Jacob's Review being published. The plans will be approved by MASA and monitored by the OSCB Business Group. These themed Action Plans must consider all the key learning identified in this Report, provide names of nominated leads and detail the work needed under each area to achieve change in the system and practice so that a difference is made for children in Oxfordshire.

Local Recommendation Action Plan 1: Criminal Exploitation

The key learning set out below is fully addressed in this action plan for children at risk of exploitation in Oxfordshire, overseen by the Chair of the OSCB Child Exploitation Sub-Group.

Key Learning: A System designed to support those working with **criminal exploitation** to:

1. Ensure safer communities which keep a relentless focus on disrupting perpetrators and networks
2. Consider the child's home in the local community and assess what other places might be needed to ensure their physical and psychological safety
3. Support professionals to build relationships with children and understand their world
4. Act upon critical and reachable moments in a child's life
5. Consider the significance of gender in working with exploited children
6. Know the risk factors and predictability
7. Understand the significance of a child's identity within their community networks when assessing levels of risk
8. Manage risk via multi-agency assessments, plans and contingency
9. Ensure the right support to help families and manage the risks together
10. Review the role and function of the National Referral Mechanism
11. Have a national drive and agenda for children at risk of exploitation

There needs to be particular focus upon:

- The delivery arm of the newly designed Youth Justice & Exploitation Service being fully involved in this action plan to ensure system wide change and embed practices across agencies (including the Voluntary Sector and District Housing)
- A joined-up community approach to keeping children safe in their areas by focusing upon crime prevention and reduction - this is led by the county-wide Community Safety Partnerships and Violence Reduction Unit with key statutory agencies (Children's Social Care and Police)
- Continued focused regional work by Children's Social Care to highlight and address placement sufficiency issues at a local and national level
- Local knowledge, understanding and use of the National Referral Mechanism

Local Recommendation Action Plan 2: The Education System

The key learning set out below is fully addressed in this action plan for children in the education system in Oxfordshire, overseen by the Chair of the OSCB Safeguarding in Education Sub-Group

Key Learning: An **education system** that ensures:

1. The paramount importance of the role of schools in keeping children safe
2. An education package is put in place in a timely manner for those children who may show challenging behaviours
3. Those children missing education are known and action is swift

This Action should pay particular attention to ensuring:

- Restorative work to resolve the fragmented arrangements between academy schools, alternative provisions and the local authority to ensure collective ownership
- Policy and procedures to track when children are not on roll
- The function of Education Panels in Oxfordshire (In Year Fair Access and Children Missing Education)
- The local application of the Education Skills Funding Agency intervention
- Education packages for children who may be at risk of exploitation and also present a risk to others

Local Recommendation Action Plan 3: Working Together

The key learning set out below is addressed in this action plan when working together in Oxfordshire to keep children safe, overseen by the Chair of the OSCB Business Group

Key Learning: **Working Together** must:

1. Involve all the local safeguarding system to understand extra-familial risk and harm in a timely manner
2. Ensure effective discussion at all levels of seniority result in collective responsibility and ownership which the family understands
3. Put robust systems in place which support all levels when there is a difference of opinion
4. Have a shared language across the partnership

This Action Plan must pay particular attention to:

- The child exploitation system re-design in Oxfordshire involves ALL agencies to map and plan services across thresholds of need and risk – the involvement of District Councils and Housing is imperative
  Ensure the escalation policy and Complex Case Panel purpose and function are known and used to share and resolve difference of opinion at all levels of the partnership

Within 1 year of this Review being published a combined Report should be approved by MASA and presented to the Full Board to evidence the system change and progress made. Clear evidence of impact should be shown in the Report to assure MASA and the Board of the system and practice difference to

children's day to day lives in Oxfordshire as a result of the work undertaken following the learning identified in Jacob's Review.

11. Reflections & Conclusions

The current English child protection system which is intended to protect those children at risk of harm failed to do so for Jacob. Those involved with Jacob and his family were acutely aware of the dangers and the risk of serious harm he faced from the organised crime groups and perpetrators who exploited him. This Review shows Jacob experienced serious and significant harm in the months prior to his sad and untimely death having been groomed into drug trafficking and experiencing physical and psychological injury as a result of this. Jacob's early life experiences and vulnerabilities predicted he was at risk of being pulled into this world and the system did not respond quickly enough and offer a well-coordinated response to keep him safe. Not being in school only increased risk and is likely to have damaged his self-esteem and identity by closing off avenues for another way. An education provision could have provided him with a space of safety and care. This Review calls for a national educational rethink on the current issues including the role of the ESFA, academy led schools and how children with additional needs are secured their education in a timely manner. Jacob experienced many traumas during his life and this Review highlights a need to look beyond a narrow focus of resilience work or relationship building with the child and to have a greater emphasis on locating and disrupting the environments and spaces that are causing the harm in the first place.

Jacob's Review concurs with the National Panel Report[69] in that the criminal exploitation of children "*is a complex social problem and therefore it requires interventions at national, community, family and child level*'. This Review has shown the need for safer communities for us all to live in and the urgent need for proper resourcing of secure and specialist residential provision when required. Although of course there is no guarantee for Jacob this would have seen a different outcome, it is not enough to simply make local and community recommendations as Jacob's situation will be known by most other local authorities across the UK who are all grappling with the complexities and daily challenges outlined in this review.

It is also simply not good enough to expect families to keep their children safe on their own when the current safeguarding systems are not designed to help and protect children at risk of extra-familial harm where the adults who exploit children criminally move at an alarming pace, with sophistication and often with high levels of violence.

The solution surely lies in a well-resourced, research based National Government Strategy which can be implemented and adequately funded in local areas and delivered by a team of highly skilled and dedicated professionals who are well supported to work with their communities and families. Such a national strategy with local community responses that keep a relentless focus on the child who is being exploited along with implementing multi-agency tactics to disrupt the adult networks and operations in and across communities would hopefully ensure the untouchable worlds where children are trapped become more reachable to the safeguarding system. We should expect, ask and indeed demand no less for Jacob and the many thousands of children in our society who are currently at risk of being criminally exploited.

[69] "*It was Hard to Escape":* The Child Safeguarding Practice Review Panel Report 2020 DfE: HMO: London