A Thematic Review concerning Adrian, Henry and Sam

February 2025

OVERVIEW REPORT

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1. Introduction

This Child Safeguarding Practice Review (CSPR) was commissioned by Bradford District Safeguarding Children Partnership (BDSCP), following a tragic incident involving three children/young people. The details of the incident are not being included to protect the anonymity of those involved.

The review has utilised the details of the lives and experiences of children/young people involved, all of whom had contact with universal, targeted, and statutory services within Bradford prior to the incident, to consider a range of questions within the terms of reference, which are being approached thematically to draw out learning from other reviews, research and promising practice elsewhere.

2. Review Process and Timescales

To support the completion of the Rapid Review Reports each agency was asked to use an information gathering tool template to summarise agency involvement for all children/young people. Each agency was then required to complete a more detailed and analytical information gathering tool to support the CSPR process.

Rapid Review Reports were completed for each child/young person and the decision made to progress to a Local Child Safeguarding Practice Review. All three children/young people had involvement from Children's Social Care prior to the incident, with clear themes emerging from the Rapid Review Process including:

- Low levels of engagement in education
- Familial domestic violence and abuse
- Intergenerational offending within families
- Adverse childhood experiences and trauma
- Incidents of case closure or no further action from Children's Social Care
- References to child criminal exploitation and complex links to offending
- Indicators of extra-familial harm within community settings

These themes informed the development of the Terms of Reference for the CSPR.

The agencies that contributed to the CSPR process are:

- Children's Social Care (CSC) now known as Bradford Children and Families Trust
- Youth Justice Service (YJS)
- Housing
- Education
- Bradford Children and Families Trust - Breaking the Cycle Project
- Yorkshire Ambulance Service NHS Trust (YAS)

- West Yorkshire Police (WYP)
- Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)
- Bradford District Care NHS Foundation Trust (BDCFT)
- Bradford General Practice

Family Engagement:

Whilst the authors of this review were not involved in the attempted contact with the families involved, actions were taken to offer space for the families to engage. The families of the children all declined to take part, and whilst of course that decision is given the utmost respect, it is disappointing that their voices, their experiences and the individual personalities of both the families and the children do not form part of this review. It is therefore noted that all information included in this report is from the perspective of professionals and does not include any input from family members.

Young People's Engagement:

The engagement of those directly involved in the incident who may have been able to contribute, was carefully considered but the traumatic nature of the incident, the loss of their friend and their current circumstances made this inappropriate.

Practitioner Engagement:

A Learning Event was facilitated by the Report Authors on 10th March 2023, with representatives of all agencies invited. There was a requested focus on attendance by those that knew the children/young people. As described elsewhere, changes in staffing meant that very few professionals who had direct contact attended the event.

Thanks is given to the Bradford District Safeguarding Children Partnership for their support with the technical challenges and the thorough minute taking at the Learning Event.

Additional Information Requests and Professional Engagement:

- Despite the various information-gathering exercises described above, the Report Author remained unclear on specific areas of the children/young people's lives and communities. As this information is essential in developing an accurate CSPR report, the following additional meetings were convened: West Yorkshire Police - Safer Neighbourhood Team
- West Yorkshire Police - Chief Inspector, Bradford Safeguarding Partnerships
- Education Designated Safeguarding Leads (DSLs)

CSPR Panel Oversight

A CSPR Panel was in place to oversee the Review process including agreeing the Terms of Reference (see the following section for details), oversight of the information gathering processes, ensuring appropriate professional engagement and information and the review and sign off of this CSPR report.

The CSPR Panel met on the following dates:

- 4th November 2022
- 19th May 2023
- 8th December 2023 (discussion with BDSCP and key professionals)
- 4th January 2024
- 21st June 2024
- 11th July 2024
- 19th September 2024

The Panel included representatives from the following agencies:

- Bradford District Safeguarding Children Partnership
- Children’s Social Care
- West Yorkshire Police
- Yorkshire Ambulance Service
- Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)
- Bradford District Care NHS Foundation Trust (BDCFT)
- Youth Justice Services
- Education
- Bradford District and Craven Health and Care Partnership (ICB)
- Bradford Children and Families Trust - Breaking the Cycle

3.

3. The Scope of the Review

The Bradford District Safeguarding Children Partnership (BDSCP) had developed Terms of Reference (ToR) for the Child Safeguarding Practice Review to guide the commissioning of the Review Author and the focus of the review.

These were then reviewed collaboratively with the BDSCP, the authors and the Review Panel.

The agreed Terms of Reference and questions to be addressed within this report are:

1. Assess how the "adultification" of children involved in criminal activity impacts on agency responses to them. When does safeguarding become vulnerability to criminality?

2. A lack of engagement in education increases a child's vulnerability to Criminal Exploitation. How well was that understood by agencies in Bradford and how effectively did they work to address this for these children? How well was information about children's educational status shared with other agencies?

3. How well did agencies understand the impact of long-standing childhood neglect on the children in this case and how did this factor into risk assessments and safety planning?

4. How well did agencies understand the impact of longstanding exposure to familial domestic abuse on the children in this case and how did this factor into risk assessments and safety planning?

5. How well do agencies identify and respond to the voice and lived experience of older children with additional emphasis on how well agencies are able to work with children suffering from significant brain injuries and/or developmental delay, impairment or other additional needs? How did exposure to childhood trauma in an early age impact on their development in line with their chronological age.

6. How well do agencies understand and respond, engage and effectively risk assess CE concerns in families where older family members have extensive criminal history and how does this impact on assessments? Is there an understanding of how childhood neglect transitions into criminal "grooming".

7. What barriers exist to impede information sharing both inter-agency and intra-agency including how information is shared between adult and children's services at points of transition and what can be done to overcome these?

8. How effective was protective planning undertaken by agencies in keeping children safe? How well did supervision support planning and consider the appropriateness of practice/interventions?

9. How well do agencies support staff in remaining effectively engaged with children who have complex situations and where familial consent for interventions is not given?

10. To explore the issue of “professional hierarchy” impacting on the way that staff manage cases? Do the views of certain professionals, or indeed the court, adversely impact on a professional's ability to respond and react to changes in circumstances in cases?

4. A Few Notes on Language

The Review Author is of the view that language has functions beyond simply communicating information. Language has the power and potential to convey values, shape understanding, frame context, evoke emotions and influence professional responses. As such, it is important to clarify the intended meaning of language used by the Review Author and to flag how professional language throughout the Review may have had unintended consequences.

Children and/or Young People

There is an ongoing challenge in practice and policy, as well as Review processes, about how to refer to those being supported or explored. This is rooted in the need for all professionals to be consistent in their understanding that those under 18 years old are legally defined as children and consequently have a range of legislative frameworks applied to them including the Children Act (1989) and Youth Justice frameworks. This sits alongside the need to recognise the agency of children in their teenage years and to frame them as young people that acknowledges this transitional phase of their development, where their experiences and rights as young adults should also be considered.

In this report the format of ‘children/young people’ is used to recognise this as well as the factual acknowledgement that those at the centre of the report span the legal definitions of children as well as that of adults by virtue of being over 18 years old. ‘Young person’ is intentionally worded as an alternative to ‘adult’ for those who are over 18, as it is clear through research, as well as common sense, that children do not automatically assume the role, skills, knowledge, power or enter the developmental phase of adulthood at their 18th birthday.

Boys/Young Men

At points in the CSPR Report, the wording of ‘boys/young men’ is also used. It is noted that a gendered lens to violence was not a requirement of this CSPR but that there is a reality that this report is centred on three individuals who are male. Whilst not a focus, it is relevant and important to acknowledge this aspect of identity and to consider it in the context of the Terms of Reference, particularly as it relates to experiences of childhood domestic violence and abuse.

Offender and Criminal

Throughout the children/young people's records the phrases of offender (offending)/criminal (criminality) are frequently used.

Whilst it is not the intention of the Review Authors to assert that the boys/young men were not, individually or collectively, involved in criminal acts, it is relevant to note the children and young people's records that relate to convictions. Given the family and community contexts for all three children/young people, these are low in number. Nonetheless, there is a risk, albeit one not evidenced in the review, that despite some references to 'engaging in criminality', that the repeated reference to offending and criminality across the children/young people's records could have distorted professional perceptions of the children/young people as perpetrators. Such distortions may have obscured the reality of them as highly vulnerable children who were being exploited and harmed by those who were proven to be prolific offenders within their families.

5. The Impact of COVID 19

The impact of COVID 19 was not explicitly named as a key line of exploration within the Terms of Reference for this review. However, it is to be noted that the period considered within this review overlaps with the unprecedented impact of COVID 19 individually, organisationally, systemically, politically and societally.

There is a wealth of research and analysis available that explores these impacts, with focus on children, young people and the services that support them and so this is not explored in depth here.

However, it is important to acknowledge that there were unique circumstances during the period under review that include multiple national and local lockdowns, periods of widespread remote education and service delivery, reallocation and refocusing of resources within services and systems and the direct impact on those both receiving and delivering support.

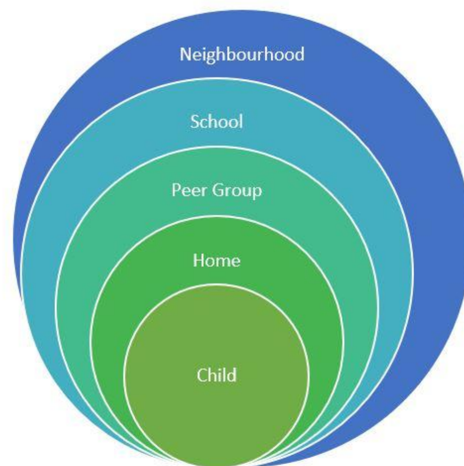
6. Consideration of Themes within the Terms of Reference

This report explores the themes observed across their lives, families, communities, and professional responses. They were also children/young people who had experiences as peers within communities and were the focus of multiple professionals and services.

This CSPR report does not adopt a Contextual Safeguarding approach that has fidelity to the model but draws on the concept to present some contextual understanding. Professor Carlene Firmin developed the concept of Contextual Safeguarding in 2015. Contextual Safeguarding describes child protection and broader safeguarding responses that consider the contexts beyond families and family homes in which abuse, and exploitation occur.

As Professor Firmin explains in a blog[1], the Contextual Safeguarding team at the University of Bedfordshire has worked to convert that idea into a four part framework, and implementation toolkit, which continues to be tested and developed around the UK. In 2018 Contextual Safeguarding was included in statutory guidance, Working Together to Safeguard Children[2].

Contextual Safeguarding is often presented as four concentric circles (Figure 1) to explain and visualise the contextual nature of extra-familial harm.



[1] https://www.contextualsafeguarding.org.uk/blog/using-the-term-contextual-safeguarding-a-view-from-national-policy/
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

Figure 1- The contextual nature of extra-familial harm - adapted from Contextual Safeguarding[3]

6.1 Thematic and contextual overview

The information presented in the table below was obtained by the author retrospectively examining secondary information. However, it is important to note that retrospective analysis has a potential drawback of creating 'hindsight bias'. This type of bias can lead to an oversimplified understanding of the situations experienced by managers and practitioners, resulting in an incomplete understanding of the complexities that influenced decisions and behaviours at that moment in time[4]. To address the potential for hindsight bias, the author provided opportunities for the relevant safeguarding professionals in Bradford to review and provide feedback on the content and factual elements of the review.

Children/Young People	Safeguarding services became aware of all three children/young people from a young age (between 0 and 10 years old, respectively). From the information shared as part of the review, all three children/young people shared similar experiences in terms of concerns about parenting capacity, disruption in education, concerns about 'criminality' (potential child criminal exploitation) and harm connected to their families and home environments. The information provided shows limited evidence that the voices, wishes, and feelings of the children/young people were captured or enacted upon across agencies. Additionally, it is unclear whether professionals *fully* understood the lives and identities of the three boys/young men. There is noted understanding of some dimensions of their lives and interests with attempts to utilise this to provide support that was aligned to their needs and interests but with awareness that there may have been more to explore and consider. The review recognises that the parents of the children/young people engaged with professionals in an inconsistent and limited manner. However, whilst cooperation and collaborative working relationships between parents and practitioners are important, this cannot supersede acting in the children's/young people's best interests[5]. As this review is based solely on the information provided by professionals or recorded on professional electronic systems, without the views of parents or the children/young people, it is difficult to determine whether the efforts

[3] Firmin, C. 2013. Something Old or Something New: Do Pre-Existing Conceptualisations of Abuse Enable a Sufficient Response to Abuse in Young People's Relationships and Peer Groups? In M. Melrose, & J. Pearce, Critical Perspectives on Child Sexual Exploitation and Related Trafficking (pp. 38-51). Hampshire: Palgrave Macmillan.

[4] Woods, D., Dekker, S., Cook, R., Johannesen, L. and Sarter, N. (2010) *Behind Human Error* (2nd ed.). London: CRC Press.

[5] https://assets.publishing.service.gov.uk/media/657b183d0467eb001355f870/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

	and interventions of professionals were those most likely to secure the best outcomes for the children/young people.
Home	All three boys/young men's lives featured domestic violence and abuse between their parents, possible child criminal exploitation, and criminality within the family/extended family context. It also appears that all three families faced financial hardships. The combination of the above factors indicates that home life for the boys/young men may have been turbulent or unpredictable, which may have impacted their feelings of safety, both physically and psychologically. From the information received as part of the review, although professionals were aware of the socio-economic disadvantage the families experienced, the impact of poverty on the children/young people's daily lives appeared normalised. This is indicated by the lack of attention on the families' finances as part of professional assessments or interventions provided.
Peers	During adolescence, as young people try out different aspects of their identity, which may be fluid and contradictory, the primary source of influence and interaction shifts from their parents and family to their peers and peer networks[6]. Consequently, as children enter adolescence, having access to positive and safer peer networks becomes increasingly important. A common theme observed across all three children's/young people's information is the lack of opportunities all three boys/young men experienced in establishing and maintaining relatively healthy peer relationships. This includes significant and frequent disruption to their education and periods of being educated in alternative settings, such as being electively home-educated or being tutored on a 1-2-1 basis. Furthermore, although there was some reference to the boys/young men being able to establish friendships with their peers, sustaining peer relationships appeared more difficult. A combination of aggressive outbursts, unpredictable behaviour, and potential unmet mental and emotional health needs may have influenced these challenges. Professionals recorded these issues as a common concern in boys'/ young men's lives. Other themes relating to peer relationships included cannabis use and group antisocial behaviour.
School/Education	All the children/young people had missed significant periods of education and there were some indicators that at various points they struggled within mainstream settings without additional support. Where needed,

[6] Tomova, L., Andrews, J. and Blakemore, S. (2021) 'The importance of belonging and the avoidance of social risk taking in adolescence', Developmental Review, 61, article number 100981.

	professionals also raised concerns about speech and language and difficulties focusing in lessons. Additionally, there were challenges relating to gaining meaningful engagement from the parents. A significant feature of the boys/young men's education included high levels of absence, challenging behaviour, and difficult relationships with peers and, at times, teachers. This resulted in notable disruption to the boy's/young men's education, including periods of elective home education for two young people, 1-2-1 tuition and attendance at other alternative educational settings. Acknowledging the complex and potentially destabilising experiences all three boys appeared to have in education is an essential aspect of the review, as there is a growing recognition of a relationship between child exploitation and young people missing from education or attending alternative provision[7]. The support each child received from their respective schools varied in terms of the level of professional insight into their well-being often with examples of limited awareness of the complexity of needs these children and young people had, which was directly impacted by the levels of engagement each child and their families had with professionals. Where there was good awareness, the ability to effective support was also impacted by varying levels or engagement by the children and their families. There is evidence that education professionals involved had concerns about their welfare at various times and proactively tried to engage with wider professional networks and safeguarding processes, acting as strong advocates. Whilst it is not clear that this directly contributed to positive impact or outcomes, it is noted as a positive example of relational practice and wider system engagement. There was a theme of elective home education for one child but no evidence that he was in receipt of a suitable home education. The support each child received from their respective schools varied immensely but with indications of positive relationships and a commitment to engaging with wider professional networks to address the boys' needs.
Neighbourhood	The area where the three families live has been discussed numerous times during meetings and panels relating to this review. The area has been described to the Review Author as a crime hot spot and an area in which its residents experience many challenges involving multiple indices of deprivation, high crime rates and organised criminal groups. Therefore, such contexts may impact social attitudes, learning and exposure towards crime. Living in an area with high crime rates and where organised crime groups operate also conceivably increases the probability of exposure to exploitative peers and adults. Furthermore, there are also recognised links

[7] Graham, J. (2021) Excluded or missing from education and child exploitation: literature review and stakeholder views on safeguarding practice — report. Tackling Child Exploitation.

	between poverty, children missing education, child exploitation and serious youth violence [8][9]. The area is characterised as a tight-knit community, with themes of professional mistrust and tolerance of crime, limiting professional engagement and inter/intra-family problem-solving. The reputation projected onto an area may have influenced professional perceptions and assessments of those who frequent or reside there, such as the children/young people discussed in this review.
Youth Justice Services	Each child had unique contact with the youth justice system and so there were varied levels of involvement with Youth Justice Services and so thematic analysis is not possible here. It is noted that there were examples of strong relational practice between professionals within Youth Justice Services and individual children.
Police	There is a significant history of police contact with all three families. There were themes of intergenerational and extended family offending that exposed the children to crime and policing responses within their families. There was an additional policing focus on the area in which the families live given localised issues of crime.
Social Care	Children's Social Care was involved, at various times, in all three children's/young people's lives. Children's Social Care's involvement related to the needs of the three boys/young men, their siblings, and issues relating to parenting challenges and abuse within the home. To varying degrees, domestic abuse was also a focus of professional concern. Before the incident that preceded the review, all children had previous contact with Children's Social Care, which often included child protection concerns. From the case chronologies, there was a cycle of referral, intervention, parental disengagement, and closure for two of the children/young people. There is limited evidence of the benefit Children's Social Care's support had for the families and children/young people or whether they fully recognised all of the intergenerational and contextual risks for each child.
Health	All three children had involvement with primary health services. All three children/young people were registered with a GP. Before the incident, aside from the unrelated traumatic and significant injuries experienced by

[8] Association of Directors of Children's Services (2019) ADCS Discussion Paper: Serious youth violence and knife crime
[9] National Crime Agency (2019) National Strategic Assessment of Serious and Organised Crime

	one of the young people a year earlier, all boys/young men were physically fit and well. As such, contact with primary care services were accessed as and when required to address acute and urgent health needs or for immunisations. The boys/young men had varying degrees of experience with secondary health and support services (including elective health services). The records indicate that health services, including the families' GPs, were responsive and persistent when called upon. Indeed, this appears valid for all health and well-being services, including Children and Adolescent Mental Health Services and school-based counselling services. However, irregular education placements and attendance would likely have affected the offers of school-based support. While support from the GP appeared responsive to the children's/young people's needs, the GP had a limited understanding of their lived experiences (multiple ACEs) as safeguarding information was not consistently shared. The lack of appropriate information sharing is likely to have hindered the GP's knowledge of the broader needs of the children/ young people. There was a pattern of missed health appointments for two children/young people. The frequency of this pattern suggests that the boy's/young men's physical, emotional, and psychological health and well-being were not a consistent priority for the parents.
Society	The families and children/young people subject to this review, as with all those in families and communities, exist within a wider and localised society where societal norms, biases and systems can present harm as well as support. While societal and community-based biases, support and harm are not the primary focus of this CSPR, nonetheless, they remain an important consideration. The Review Author noted that there was an awareness by the professionals involved in the Review process that there were challenges that made continued focus difficult. This was possibly due to assumptions about the prospects of securing engagement or actuating change. Understanding professional responses requires recognition of local contexts. Representatives from Children's Social Care have informed the Author that during the timeframe the review is concerned with, there was increased staff turnover due to strain on services and high demands placed on workers. In addition to the above, a key consideration for this review must include service responses to boys and young men from underserved and ethnic

	minoritised backgrounds. Research suggests that children and families from ethnic minoritised backgrounds are at heightened risk of having their needs misinterpreted or overlooked. This may be a consequence of the tools and assessments services used (which may be Anglo/ Eurocentric in focus) and/or workers' training and support needs[10].

As referenced above, the overlap and intersection of familial harm and extra-familial harm (EFH) is central to this review and professional understanding and responses to these boys and young men during their lives.

The figure below is taken from policy guidance *'Safeguarding children and young people who may be affected by gang activity'*[11] published in 2010. It is important to reiterate that the author is in no way suggesting that these boys were a 'gang' and it is acknowledged that this document is now outdated. However, this version of the Assessment of Children in Need framework is potentially helpful in visually highlighting the risk factors that exist within families and which were intended to support understanding the bridge between familial risk of significant harm within existing child protection frameworks and emerging understanding of extra-familial harm.

[10] Davis, J. and Marsh, N. (2022) 'The Myth of the Universal Child', in D. Holmes (ed) Safeguarding Young People Risk, Rights, Resilience and Relationships. London: Jessica King Publishers, pp. 111–128.

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/189392/DCSF-00064-2010.pdf.pdf

HIGH RISK FACTORS

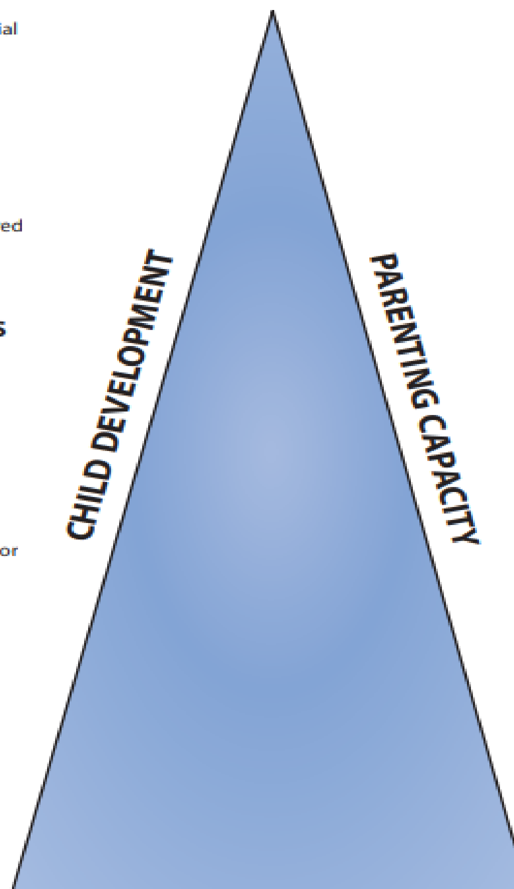
- Early problems with antisocial and criminal behaviour
- Persistent offending
- Unable to regulate own emotions and behaviour
- Physical violence and aggression
- Permanent exclusion from school
- Friends condoning or involved in antisocial and aggressive behaviour
- Alcohol and drug misuse

MEDIUM RISK FACTORS

- Mental health problems
- Aggression, behavioural problems
- Depression
- Truancy and unauthorised absence from school
- Bullied or bullying others
- Medical history of repeated injuries or accidents
- Child in local authority care or leaving care

LOW RISK FACTORS

- Aggressive bullying by siblings
- Lack of ethnic identity
- Peer rejection
- Not involved in positive activities
- Few social ties
- Exposure to violent media



HIGH RISK FACTORS

- Historically involved with or known to social services
- Lax parental supervision
- Lack of parental attachment to child
- Conflict and violence in the home
- Parental abuse
- Parents aggressive towards or unwilling to engage with statutory agencies
- Child is not protected from significant harm or danger, including contact with unsafe adults

MEDIUM RISK FACTORS

- Lack of emotional care
- Allowing child to associate with known troublemakers
- Violent discipline
- Lack of parental discipline
- Inconsistent or minimal boundaries

LOW RISK FACTORS

- Parents don't model positive and responsible behaviour
- Absent parent
- Unstable family environment
- Child left with multiple or unsuitable carers
- Parents unable to communicate effectively with children
- Parent-child separation

FAMILY AND ENVIRONMENT

All aspects of this framework are relevant to this CSPR, but the 'Family and Environment' dimension is particularly pertinent given the key events in chronologies and contextual/thematic analysis. Readers are invited to replace the word 'gang' with that of offending or organised crime. This is not to contest the reality of the existence of gangs but to avoid using this label, which we know to be problematic in its perceived proximity to racism and classism.

FAMILY AND ENVIRONMENT

HIGH RISK FACTORS

- Family members involved with or associated with gangs
- Wider family involved with gangs
- Community norms that tolerate crime
- Local tensions between ethnic/cultural/religious gangs
- Known gang recruitment at school
- Presence of gangs in community
- High level of local crime including drugs market

MEDIUM RISK FACTORS

- Availability and use of drugs
- Criminal conviction of parents or siblings
- Witness or victim of domestic violence

LOW RISK FACTORS

- Lack of positive role models in the community
- Transient families
- Lack of age-appropriate, safe play facilities or diversionary activities for young people in the area
- Financial difficulties affecting child Little interaction with neighbours and community
- High unemployment
- Sustained poverty
- Lack of reliable support from wider family
- Limited access to conventional careers

7. Analysis, Learning and Recommendations

The section below answers the questions highlighted in the Terms of Reference in the opening paragraphs of the review. Where relevant, this section also explores promising local practices and makes recommendations that may have local, regional, or national significance.

Before commencing the final section, it is important to provide context for the review's findings. The review recognises that Bradford Children's Social Care experienced high levels of staff turnover, low staff morale, and challenging service delivery during the timeframe relevant to the report. However, it is also evident that during the past year, the organisation has undergone significant improvements, particularly in terms of leadership, staff retention, and morale. These changes have reflected positively in the increasing understanding and acknowledgement of the issues raised in this review at a strategic, operational, and practice level.

The proactive, open, reflective, non-defensive, and learning-focused engagement in the CSPR process across agencies has further emphasised the progress made in Children's Social Care and multi-agency partners. However, despite these positive changes, the organisation still faces complex challenges concerning engagement and system levels, requiring a concerted and continued effort.

To note is the thematic approach to analysis and the response to the questions asked. Throughout there is reference to 'professionals' as a collective term, this does not mean that what is being described is attributed to all individuals or agencies but that it emerged as a theme.

Additionally, it is noted that within local recommendations there are recurring themes of learning and development as well as focus within supervision.

These recommendations are made individually and specifically to enable focus but with understanding and recognition that they may not all form individual activities within the action plan that follows this review. The overarching recommendation is that the themes referenced can and should factor in a range of development, oversight and supervision activities including management supervision, reflective supervision, self-directed learning and development including access to resources such as those from Research in Practice, team meetings, service development days and other activities to promote and embed reflection of these crucial issues for children and young people.

A Note on Local Recommendations

Since this incident, much work has been underway locally in Bradford including thematic analysis across multiple CSPRs with combined action planning. As such, some of the recommendations below are included as they are pertinent to the learning but are already included in this wider thematic review and actions. Bradford District Local Safeguarding Children Partnership are encouraged to merge recommendations into existing work where appropriate.

1. Assess how the "adultification" of children involved in criminal activity impacts on agency responses to them.

Adultification bias refers to the attributing of adult-like qualities to children and adolescents. This may involve exposing children and young people to adult-like emotions, experiences, responsibilities, and themes, which can lead to the acceleration of their perceived levels of maturity, accountability, and culpability. As a result, the child's rights may be diminished (Davis and Marsh, 2022).

Research on adultification in a UK context is not extensive, but the evidence points to two primary ways adultification manifests. The first is through the social and environmental circumstances in which a child lives. The second is through the perpetuation of stereotypes, prejudices, and racism[12]

In this review, the concept of adultification relates to professionals, consciously or unconsciously, viewing and interacting with the three children/young people as being older and more mature than their chronological age and stage of development suggests. Considering the impact of adultification is important as it can influence professional judgements that relate to assumed emotional capacity and resilience to manage stressful, harmful, and abusive relationships and situations. When children and young people are adultified, it can impact safeguarding responses, resulting in criminal justice responses being prioritised over welfare and safeguarding[13]

The review identified adultification as a critical theme. However, this theme could not be thoroughly tested as, by and large, the professionals directly involved with the children/young people did not contribute to the review process. The absence of input from pertinent professionals resulted from the departure of staff members from the organisation. As a result, the author could not comprehensively examine the influences on decision-making from a practice, management, and legal perspective.

It is important to take into account adultification in the context of youth offending and potential child criminal exploitation. This concept can enhance our comprehension of professional cultural competence, how we conceptualise risk and test hypotheses, and how we perceive children and young people. It is crucial when recording information in children's/young people's case files and when communicating and sharing information in multi-agency settings. When professionals adultify children it can contribute to harm in two ways. First, adultification can contribute to physical harm experienced by children and young people by adults failing to intervene with

[12] Epstein, R., Blake, J. and González, T. (2017). *Girlhood Interrupted: The Erasure of Black Girls' Childhood.* Georgetown Law.
[13] Davis, J. and Marsh, N. (2020), 'Boys to men – The cost of "adultification" in safeguarding Black boys', *Critical and Radical Social Work*, 8(2), pp. 255–259.

appropriate support or neglecting the physical needs and safety of the child/young person. Second, adultification can contribute to emotional and psychological harm experienced by children and young people by adults not responding to the care and support needs of the individual in an age and developmentally appropriate manner.

While it is important to focus on organisational and professional responses and decision-making in the context of this review, it is worth noting that adultification can occur within families and communities and during interactions with professionals and institutions.

From the information presented in this review, the hallmarks of adultification bias are observable across all three boys'/young men's lives. This includes by their parents and during their interactions with professionals and services. Young people who are exposed to domestic abuse and violence are at heightened risk of being adultified as they are forced to navigate complex adult and emotionally and physically abusive environments that are often beyond their comprehension[14].

In relation to interactions with professionals and services, it appears that all three boys/young men were routinely held accountable for their aggressive outbursts and behaviour and that professionals seemed to lack professional curiosity in terms of exploring what other factors may be contributing to how the boys presented. This is illustrated by the framing of the boys/young men as 'offenders' or 'involved in criminality' without acknowledging the family background, the role of the adults around them or the exposure to crime in the communities where they lived.

Examples of Promising Practice

There are indicators that all three children/young were faced with constrained choices with respect to family expectations of criminal behaviour and exposure to violence. It was noted that within policing responses and analysis there was good attention to the complexity and nuance of exploitation within the family and that was considered alongside an enforcement response.

Professionals who cultivate trusting and caring relationships are better equipped to provide support and act as influential adults in the child/young people's lives. This was particularly notable among healthcare professionals and those within Youth Services. For instance, Break the Cycle's referrals are a good example of promising practice. Break the Cycle's approach emphasises fostering positive relationships with young people and providing access to constructive activities that cater to young people's interests.

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[14] Stephens, D. L., (1999). Battered Women's Views of Their Children. *Journal of Interpersonal Violence*, *14*(7), 731-746.

Local Recommendations:

Adultification Bias

1. Bradford District Safeguarding Children Partnership should raise awareness of and seek to understand professional knowledge, understanding and recognition of adultification bias and develop an action plan to address any gaps/learning identified.

Cultural Competency

2. Embedding race, culture, and adolescent development in supervision, case oversight, and reflective learning spaces. It is noted that this is part of wider thematic learning from CSPRs and so is already being considered and implemented.

Adolescent Development

3. Bradford District Safeguarding Children Partnership should seek assurance that age and stage appropriate development is taken into account during assessment processes and that there is professional understanding of adolescent neglect. It is noted that there is already work underway locally to improve the quality of assessments, as part of the Neglect Strategy and subgroups.

Standards of Supervision

4. Case oversight, and reflective learning spaces and supervision should ensure an understanding of the learning identified from this review and how these factors may affect assessment, interventions, support planning and risk analysis.

2. A lack of engagement in education increases a child's vulnerability to Criminal Exploitation. How well was that understood by agencies in Bradford and how effectively did they work to address this for these children? How well was information about children's educational status shared with other agencies?

There is a growing national evidence base that missing education is a key risk/facilitating factor for criminal exploitation. A key report researched and written by Tackling Child Exploitation[15] partners and funded by the Department for Education, *'Excluded or missing from education and child exploitation: literature review and stakeholder views on safeguarding practice — report'* explores in detail the impact of missing from education as a risk factor for exploitation. Whilst this report, and others, focus on the impact of school initiated exclusions, the learning is equally

[15] https://tce.researchinpractice.org.uk/wp-content/uploads/2022/02/2757_TCE_Education__Exploitation_report_v2.pdf

applicable to parent initiated withdrawal from mainstream education as was the case for these children and young people.

When children are not attending education provision there are a range of potential impacts that increase the risk of criminal exploitation as form of familial and extrafamilial harm:

- Children have increased time, without professional oversight, within the community. By virtue of not being at school, they can be seen as prime targets for adults who wish to exploit them as this lack of professional oversight reduces the risk of missing or other reports to law enforcement or child protection agencies. This exploitation can be led by their families as well as Organised Crime Groups (OCGs) who rely on Child Criminal Exploitation to operate criminal enterprises such as County Lines.
- Children have reduced contact with positive adult role models and positive peer influence to counterbalance norms, messaging and expectations that exist within families and communities that are pro-criminal and do not create opportunities for development of hopes and aspirations beyond criminality.
- The reduced contact with professionals means that there is reduced ability to observe and engage children, this reduces the opportunities to identify risk, harm, and abuse and to implement early intervention strategies as well as the sharing of information with other agencies where there are child protection concerns.

It is acknowledged throughout the Review that all had experiences of missing education and that engagement in education was not explicitly analysed or responded to in the context of increased risk of harm and criminal exploitation for these children. In addition, engagement in mainstream or adequate education provision was not sufficiently focused on as a contributing factor to wider risks of significant harm in the context of child protection and parental neglect, despite significant issues over many years.

The term missing from education is used intentionally here, as whilst there are records that show that children were removed from education by parents to be electively home educated (EHE), there is limited evidence that this elective home education was assessed as appropriate to meet the children's/young people's educational needs. The chronologies indicate patterns of parental avoidance of services and limited parental capacity to provide a suitable home education.

The chronologies for all children note the patterns of low levels of educational attendance, engagement, and gaps in adequate educational provision. However, there is limited evidence that these were well explored in a multi-agency context, this is particularly concerning given the considerable involvement in Children's Social Care. During the review process the lack of due diligence was attributed to the high turnover of social work staff and the missed opportunities to invite key educational professionals to strategy and other safeguarding meetings.

The analysis provided by education professionals does not highlight proactive information sharing by other agencies, including Children's Social Care, although there is reference to Child Protection and Child in Need processes and plans.

It is recognised that, with parents avoiding engagement with professionals, assessment informed by observation or information that could be qualified factually was difficult to complete by Children's Social Care or education. However, this barrier and pattern could have been a more significant factor in assessments of child protection risk analysis and attempts to secure School Attendance Orders. It is noted that this was the case for one of the children and this is highlighted as an example of promising practice, as was the return to roll in mainstream education after a period of home education of a second child. However, it is also noted that this did not result in meaningful engagement in mainstream education.

The Review Author acknowledges that the parents avoided engaging with professionals and assessments. This had a significant impact on gaining a comprehensive understanding of the families' needs and what information could be verified and acted upon by Children's Social Care or education services. However, the pattern of disengagement by the parents could have formed a more meaningful aspect of social work assessments, child protection considerations and risk analysis and attempts. The inconsistent engagement with professionals from Children's Social Care, education and health services was a pattern of engagement and possibly control that the parents' exercised, this could have provided evidence in secure School Attendance Orders. It should be noted that the Elective Home Education Team pursued a School Attendance Order for one of the children/young people. The team's persistence in seeking the order is recognised as an example of promising practice. The team also ensured one young person returned to school roll after home education. It should be noted that securing the order did not result in meaningful engagement in mainstream education.

The statutory guidance on Elective Home Education makes it clear that:

Where necessary - because it is evident that a child is simply not receiving suitable education at home and the use of school attendance powers is not achieving a change in that situation - the local authority should be ready to use its safeguarding powers as explained in this guidance. The overriding objective in these cases is to ensure that the child's development is protected from significant harm.

Examples of Promising Practice

- In respect of one of the children, there is clear evidence that the mainstream secondary school proactively engaged with him and his Mother, to explore indicators of Special Educational Needs and Disabilities (SEND), such as dyslexia. Screening was provided, which supported a formal diagnosis and tailored support plans were put in place with regular review.
- Whilst it is not evidenced to have had a positive impact, and a period of one year before a School Attendance Order was secured, the involvement of the Elective Home

Education Team and the securing of this order is positive and is practice that could and should be built on.
- Due to the above, when a second child was removed from school, the school and LA understanding of Elective Home Education (EHE) meant that he was returned to a school roll much sooner.

Local Recommendations

5. Schools and Children's Social Care are encouraged to develop and implement effective information sharing and quality assurance mechanisms for identifying vulnerable children who are missing from school. This includes monitoring patterns of disengagement, high levels of absenteeism, and family disengagement from the education process to identify an effectively respond to education neglect.
6. For Children's Social Care to review child protection and risk escalation processes (particularly where concerns relate to child exploitation and extrafamilial harm), this recommendation refers to cases where education professionals are not actively involved in critical safeguarding meetings, including strategy meetings. Team managers and service leads should pay particular attention to ensuring adequate measures are in place to ensure that the relevant education professionals receive timely invitations to support their participation. This is important to identify educational neglect as part of wider assessment of significant harm.

National Learning

- There is a need for a specific review of the intersection between EHE and Child Criminal Exploitation, to include a review of processes, procedures and powers in this context.

3. How well did agencies understand the impact of long-standing childhood neglect on the children in this case and how did this factor into risk assessments and safety planning?

There were several indications of significant, chronic, and complex neglect in the lives of the children and young people that spanned across various professional agencies' areas of responsibility. These indications included missed medical appointments, inadequate education, lack of parental boundaries and protection against pro-criminal attitudes and behaviours, unsafe and unstable home environments, and exposure to domestic abuse. Nevertheless, the information shared during the review suggests that these indicators were potentially overlooked or obscured due to the absence of more traditional signs of harm, such as appropriate clothing and sufficient nourishment, often apparent in caregiving related to younger children.

The Child in Need Assessment Framework, which pertains to gang involvement or offending (highlighted above), emphasises the various ways that children and young people experience

neglect. The neglect they face is closely tied to the issue of adolescent adultification and the assumption that adolescents are less vulnerable than their younger peers as they can fend for themselves and remove themselves from harmful situations[16]. However, this approach to safeguarding disregarded many of these children's fundamental needs, which their families were not meeting. These include regular exposure to harm such as domestic violence and unaddressed health issues and educational neglect.

Following the analysis of the information provided by agencies as part of the Review process, the findings of the review suggest that there was a lack of adequate risk assessment and safety planning that explored issues specifically relating to adolescent harm and neglect. Where indicators of neglect were noted, there is a theme that professionals responded to concerns in isolated ways that didn't fully capture the long-term indicators of harm using chronologies that built up profiles of significant harm over many years.

As mentioned earlier, the review's findings were limited by the absence of input from various professionals who directly worked with the children/young people and their families. However, the review identified a pattern concerning professional hierarchy, where those with more power, seniority, and perceived expertise to make decisions go unchallenged. This practice, commonly known as 'rubber stamping[17],' often occurs when public sector workers lack the resources, time, or support to arrive at their own conclusions. As a result, they adopt other professionals' decision-making as their own, particularly in specialised areas such as health, family courts, police, education, or social work. One of the consequences of this phenomenon, as observed in the children's and young people's lives subject to this review, is that their lived experiences of ongoing risk and harm were left unexplored and unaddressed by a range of professionals.

Local Recommendations:

7. Provide learning and development which focuses on adolescent development and neglect. It is recommended that this be prioritised by organisations and is incorporated in relevant processes, risk assessment and tools. Where there is not internal expertise or capacity to deliver this, collaboration with other agencies where this may exist should be considered.
8. Consideration should be given to implementing practice tools within Children's Social Care that promote the use of chronologies to aid in decision-making. This is a recommendation that's been highlighted in previous reviews it is acknowledged that work is already underway to explore and address this.
9. The safeguarding partners should explore, through discussion, debate and professional development initiatives, ways of improving professional competence in assessment

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[16] Hanson, E. and Holmes, D. (2014) *That Difficult Age: Developing a More Effective Response to Risks in Adolescence. Evidence Scope*. Totnes: Research in Practice.

[17] Lipsky, M. (2010). *Street-Level Bureaucracy, 30th Ann. Ed.: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

across services that focus on adolescent neglect. It is noted that is underway through the neglect subgroup of the Bradford District Safeguarding Children Partnership.

4. How well did agencies understand the impact of longstanding exposure to familial domestic abuse on the children in this case and how did this factor into risk assessments and safety planning?

Domestic violence and abuse (DVA) was a significant theme in the histories and dynamics of these families. The case chronologies provide examples of where this was well identified, documented, and responded to with appropriate referrals and significant professional interventions. This included the children/young people being subject to child protection plans and social workers obtaining court orders. However, as highlighted by the continuation of violence over many years, these measures did not necessarily deliver the protection needed or achieve the change required to safeguard the children/young people.

The case files often recorded the incidents of DVA but did not fully explore the impact of domestic abuse on the children witnessing it. The effects of domestic violence on children can be devastating and long-lasting. Experiencing violence in the home can lead to a range of emotional and behavioural problems, including anxiety, depression, and aggression (all of which have been identified in the children's behaviour as they progressed into adolescence). Children who grow up in homes where domestic abuse is present are also at increased risk of experiencing abuse themselves, either as children or as adults.

Domestic abuse can significantly disrupt a parent's ability to prioritise their child's welfare, particularly during episodes of abuse. This dynamic can trigger stress responses in children who struggle to reconcile their natural desire for a loving and attentive caregiver with the distress and emotional turmoil caused by their violent behaviour. Children also often have complex feelings about their role in protecting their caregivers, and this can induce feelings of guilt, shame, and feelings of low self-worth that they are unable to provide this protection. The role of protector and carer may also play out in other contexts with misplaced violent and aggressive behaviour.

Male violence against women, particularly by fathers (or father figures) against mothers, can also generate difficult-to-understand emotions and perceptions about the value of their mothers, often the primary caregiver, and women more broadly. Research shows that there are potential links to later issues of harmful sexual behaviour and the perpetration of violence against girls and women.

There are significant gaps in records regarding fathers, stepfathers, and other adult men whose identities are unknown. This is despite multiple references to domestic abuse and violence across the case files and chronologies. This pattern is indicative of professional attitudes and practices that centre around women and mothers taking responsibility for safeguarding children instead of focusing on the source of harm – men and fathers. This form of victim-blaming can

lead to obscuring the analysis of abuse and subsequent plans that ensure the welfare of children and hold abusive parties accountable.

Despite the provision of domestic abuse and violence-focused intervention, there seems to be a lack of broader analysis of the risk of harm, which was often conceptualised as 'family conflict', 'domestic incidents' and 'family breakdown'. This framing potentially obscured the focus on active perpetrators of violence and the harm they posed. This is not to suggest that violence does not have complex drivers and presentations, with both parents exhibiting volatile, abusive, and harmful behaviour. Still, there are clear indicators of significant weapon-enabled violence by fathers against mothers in this Review and patterns of abuse by fathers across various relationships.

The evidence base is growing in terms of the detrimental impact on young men's identity, risk-taking and involvement in criminality (Levell et al.), but this also was not fully acknowledged or responded to in terms of intervention, including in the context of child protection processes and decision making as patterns of domestic abuse and violence started to overlap with patterns of 'criminality' by these children and young people. Professionals must shift the narrative surrounding young men and identify the various societal factors that contribute to their involvement in criminal activity. By doing so, we can implement more effective interventions and support systems that address the root causes of their behaviour and promote positive identity development. This includes providing access to mental health services, mentorship programs, and educational opportunities to help boys and young men channel their energy and potential towards positive outcomes.

Local Recommendations

10. That learning and development focused on domestic abuse and violence should aim to make the link between the harm experienced by children where there is domestic violence and their own offending and risk-taking behaviours. It is noted that this recommendation correlates with thematic learning from CSPRs and is underway.
11. Assurance should be sought that work currently underway ensures that supervision, case review and quality assurance processes are reviewed with a focus on domestic abuse and violence to ensure that there is robust information gathering, analysis and recording. This should consider:
    - That professional curiosity is encouraged.
    - The avoidance of victim blaming language, which is noted as a focus of existing work.
    - The naming of sources of harm, such as perpetrators, where it is legally permitted to do so.

5. How well do agencies identify and respond to the voice and lived experience of older children with additional emphasis on how well agencies are able to work with children suffering from significant brain injuries and/or developmental delay, impairment or other

additional needs? How did exposure to childhood trauma in an early age impact their development in line with their chronological age?

This was a really challenging aspect to analyse during the Review as those that knew these children and young people well were not involved, other than education professionals. However, the lack of focus on the child's voice in records in any significant or meaningful way highlights that there was a gap in practice. It is acknowledged that this links to barriers to engagement, including consent but is noticeably absent and therefore important.

This links to the value and need for relational engagement that was not seen in many aspects of professional involvement. A key exception was that of the Public Health Nurse sitting in Youth Justice Services, whose consistent focus on engagement and child centred work is highlighted as an example of good practice.

In relation to the focus on the child who had an acquired brain injury sustained in 2021, this should have triggered the ALTE (Acute Life Threatening Event) process as outlined in the Child Death Review Statutory and Operational Guidance (England) October 2018. This would have allowed, at the time of his presentation, for a Joint Agency Response (JAR) meeting to be held with all agencies involved with this child to formulate a plan of support, escalation of processes that could have safeguarded him. Due to this process not being followed at the time of presentation this would constitute a missed opportunity as highlighted by agencies in the Review process.

The Centre for Mental Health[18] states that having a head injury "doubles the risk of developing a mental health problem," and that having such an injury "increases the risk of offending by at least 50%." It is understood that impacts of such brain injuries are complex, far reaching, and individualised but can affect physical, cognitive, emotional and behavioural challenges. Some of those impacts of a traumatic brain injury directly relate to offending behaviour, and much literature internationally has been written to explore such links. What we also know is that during adolescence, there are additional risk factors towards impulsivity and offending, that paired with a child having experienced a severe and traumatic brain injury should not be understated or overlooked. All of the above may well have negatively impacted on the child's perception of the world around them, their behaviours, emotional wellbeing and their care and support needs and indeed their relationship with professionals.

It is not clear from the GP entries if the child with a traumatic brain injury was spoken to directly during telephone consultations, most entries state a discussion with the child's mother. Best practice would be to consult directly with the child to provide opportunities to capture his voice and wishes. This was particularly pertinent given that there had been historic concerns about the ability of parents to protect this child from harm, parental coercion, and parental disguised compliance – speaking to the child directly would have enabled the GP to build a more accurate picture of his current lived experience and to further illuminate concerns about parental capacity to centre his welfare and needs.

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[18] https://www.centreformentalhealth.org.uk/publications/traumatic-brain-injury-and-offending

This child has 'left school' aged 12 years and it is documented in the Community Head Rehab Team letter that he had not been able to read or write very well prior to his accident and that since the accident he found reading too difficult to attempt. The GP practice was not aware of this communication barrier and communicated with him via letter. It is possible that this may have impacted on his engagement with primary care and counselling services.

The question about the impact of traumatic early life experiences is hard to assess, as no child or family contributed in any meaningful way to assessments or this Review. There is a wealth of research and evidence that relates to trauma and attachment in early years that is beyond the scope of this Review to present. However, research in Adverse Childhood Experiences (ACEs) seems a useful focus, although must be understood as intending to expand understanding of potentially traumatic events in children's lives and the Review Authors position noted that this framework also has challenges in understanding and application as it was never developed to be individually predictive of experience, impact, or outcomes.

Adverse Childhood Experiences (ACEs) can be described as "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust, or bodily integrity." (Young Minds, 2018[19]).

ACEs are some factors from childhood to think about when considering mental wellbeing and what may be impacting thoughts, feelings, and behaviours. Also, important to think about are the quality of attachment relationships. Whilst there is much data about the correlations between ACEs and outcomes such as perpetrating or being victimised by violence[20], they are not predictive in nature. Many with adversity in childhood go on to live happy, healthy, fulfilled lives and so they must be understood contextually for individuals and families rather than assumptions made about causal links.

Examples of ACEs[21]:

- Physical abuse
- Sexual Abuse
- Emotional Abuse
- Living with someone who abused drugs.
- Living with someone who abused alcohol.
- Exposure to domestic violence.
- Living with someone who has gone to prison.
- Living with someone with serious mental illness.
- Losing a parent through divorce, death, or abandonment.

Some of the other things exposure to ACEs *can* impact, are:

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[19] adversity-and-trauma-informed-practice-guide-for-professionals.pdf (youngminds.org.uk)
[20] https://www.cdc.gov/violenceprevention/aces/index.html
[21] https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

- The ability to recognise and manage different emotions.
- The capacity to make and keep healthy friendships and other relationships.
- The ability to manage behaviour in school settings.
- Difficulties coping with emotions safely without causing harm to self or others.

The lists above are included for clarity and to assist in understanding what are considered ACEs. They are not intended to be a checklist of harm or to be meaningful, predictive, or indicative in their own right. Rather they represent areas we should, as professionals, be curious about and where understanding the experiences that children have in these areas may help us understand how they see the world and how they navigate it including how they communicate through their behaviour.

We know from records that there are several examples of ACEs across the lifespan of the children and young people focused on within this Review but limited analysis of the impact or a commitment to trauma-informed practice.

Trauma-informed practice is well described by Pippa Goodfellow[22], in relation to how it can support young people involved in risky and harmful behaviour and offending. She explains that implementing trauma informed practice involves awareness raising and training, the provision of safe environments, reducing the scope for re-traumatisation and the coordination of provision designed to increase resilience and support. Trauma-informed approaches can be thought of as incorporating three key elements: an understanding of the prevalence of trauma; recognition of the effects of trauma both on those affected and on those who work with them; and the design of services which are informed by this knowledge.

She goes on to explain that by addressing the emotional and psychological needs of young people, services can enable them to better manage their emotions and behaviour as a first step towards making other long-lasting positive changes in their lives. Trauma-informed approaches that seek to build young people's strengths and attachments can help to minimise the impact of their traumatic experiences, reducing the likelihood that they will continue to engage in high-risk and anti-social behaviour. With more insight into how traumatised young people behave, professionals can work more effectively with them, thereby helping them to gain an understanding of their behaviour, take responsibility for themselves and develop negotiated, positive relationships that offer some protection from exploitative and harmful relationships.

Local Recommendations

12. It is noted that this is an emergent theme across CSPRs, and work is ongoing around professional curiosity and voice of the child. It is therefore recommended that this work continues to incorporate a focus on understanding and exploring risky or challenging

[22] http://www.beyondyouthcustody.net/blog/childhood-trauma-offending/

behaviour through the lens of trauma and exploring young people's experiences through a trauma informed lens.

6. How well do agencies understand and respond, engage and effectively risk assessing Criminal Exploitation concerns in families where older family members have an extensive criminal history and how does this impact assessments? Is there an understanding of how childhood neglect transitions into criminal "grooming"?

Evaluating and analysing this area was difficult because the children's/young people's opinions and perspectives and the cooperation of their families were absent from the Review.

There is much written about intergenerational offending, but there is limited applicable research that is specific to the grooming and criminal exploitation of children within families. This is significant and a potential focus of national learning and recommendations.

What is clear from the chronologies compiled by the Review Author is that there is extensive evidence of offending in the families but limited indicators that this was fully identified, explored, or understood by professionals. Consequently, there is a lack of acknowledgement that criminality was a feature of the children's/young people's family life. It is expected practice that the Police should be central to the multi-agency analysis of risk, and it is evident that Police did attend strategy meetings. However, what is unclear is what level of information was shared during these meetings or how this information was assessed. As such, it is challenging to determine this as part of this Review other than to conclude that intergenerational offending was loosely recognised; however, it was not well understood or responded to by professionals; whilst this does not represent a definitive conclusion on practice, it is referenced to ensure that the role, impact and dynamics of intergenerational offending are acknowledged as key to wider understanding of children and young people who commit offences.

Examples of Promising Practice

It is noted that a refreshed approach to local Multi-Agency Child Exploitation meetings (MACE) now ensures that there is strategic, operational, and practice-related focus on children who may be being exploited that draws on information from all safeguarding partners, and so should now surface this type of information for consideration by a range of professionals.

There is now a Multiagency Child Exploitation and Missing Hub that is a co-located multi-agency team. This includes:

- A case management forum coordinating support and interventions to reduce the risk of child exploitation (CE), where risks are considered to be at medium/high risk of being exploited.

- Exploitation social workers co-working alongside allocated social workers, supporting children and young people, those 18 and still vulnerable and for people up to the age of 25 years who have previously been a child in our care.
- An operating model that takes a the ‘think whole family’ approach when supporting young people and relationally based practice.
- Agencies and senior agency professionals working together with parents and children to alert them to the signs of grooming, exploitation, gangs, criminal exploitation, trafficking and county lines.

This process enables broader agencies, outside of the statutory safeguarding sector, to contribute to reducing the risk and impact of child exploitation on individuals, families and impacts for our wider community. This being Bradford’s whole system approach to tackle exploitation. This demonstrates incredibly promising practice.

Local Recommendations

These recommendations acknowledge the local context of the Multiagency Child Exploitation and Missing Hub and the local approach to exploitation which includes both Child Criminal Exploitation (CCE) and Child Sexual Exploitation (CSE). This is acknowledged as having value in reducing silos, simplifying referral pathways and consolidating professional engagement and expertise. However, given the focus on Child Criminal Exploitation (CCE) within this CSPR and the need to consider the dynamics of familial grooming and exploitation related to offending, the following recommendations specify Child Criminal Exploitation for clarity and focus.

13. Bradford District Safeguarding Children Partnership should seek assurance that there is a comprehensive professional development offer on Child Criminal Exploitation (CCE)

13..1 This offer should go beyond one-off training provision and ensure that professionals from across Bradford are supported to understand this issue from a policy perspective and, crucially, to adapt their practice to better meet the needs of criminally exploited children and young people. This could include the work already happening within the Exploitation Hub after review of impact.

13..2 Development offers should aim to improve the early identification of risk and vulnerability, assessment, referral, intervention, and risk management, including using the National Referral Mechanism (NRM) in cases of familial exploitation.

13..3 Supervision, case review and quality assurance processes and frameworks consider, as standard, the role of the National Referral Mechanism where there are any indicators of Criminal Exploitation and where the decision is made not to progress, that this is recorded with defensible decision-making.

13..4 Training for practitioners should be supplemented with advanced practice workshops for managers and team leaders; these should focus on ensuring that those with management oversight of cases can critically evaluate and analyse both presenting risks and professional responses where there are histories of intergenerational offending.

13..5 Bradford District Safeguarding Children Partnership should continue to develop understanding of promising practice related to familial Child Criminal Exploitation and utilise this learning, which is currently underdeveloped nationally, to inform local responses and professional development.

National Recommendations

- As has been referenced in numerous other CSPRs, there is a clear need for a cross-departmental Child Criminal Exploitation strategy that considers both familial and extrafamilial grooming and exploitation.

7. What barriers exist to impede information sharing both inter-agency and intra-agency including how information is shared between adult and children's services at points of transition and what can be done to overcome these?

Transitions have long been acknowledged as significant, but transitional safeguarding is a relatively new concept with promising practice emerging nationally (Holmes et al.). Transitional safeguarding is a term that has gained prominence in recent years due to the growing awareness of the need to protect young people transitioning from childhood to adulthood. This is a crucial phase in the lives of many young people, and they must be supported and protected during this time.

Transitional safeguarding is a way of working that recognises the specific needs and vulnerabilities of young people during this time of transition. The focus is on ensuring that young people are safe and supported as they move from one stage of their life to the next. This can involve various approaches, including working with different agencies and professionals to ensure that all aspects of a young person's life are considered.

Implementing transitional safeguarding requires a coordinated and collaborative approach. Different agencies and professionals, including social workers, education professionals, and health workers, must work with community-based and adult services to identify strengths, risks and vulnerabilities and develop effective strategies and plans to support an effective transition from childhood to adulthood. This may involve sharing information and working closely with young people and their families to ensure that everyone is involved in the process and that the young person's needs are at the centre of all decision-making. According to Holmes et al., effective transitional safeguarding arrangements acknowledge the interconnected nature of safety and well-being needs throughout an individual's life. These arrangements aim to provide integrated support systems that span the transition from Children's Services to Adult Services. Information sharing is a central theme in this review, encompassing missed opportunities to share and co-analyse information. This applies to traditional child protection processes, such as strategy discussions and more contextual safeguarding-focused collaborations and responses.

As outlined previously in the review, agencies must revisit information-sharing pathways after a child or young person experiences traumatic and life-changing injuries. Engaging education professionals proactively and consistently in safeguarding procedures is also essential. While systems issues, including IT, can hinder effective information-sharing, this review did not specifically identify such problems. Nonetheless, having a clear lead to oversee information gathering, analysis, and sharing is essential. The review found that social worker turnover and the stop-and-start approach to social care assessments and interventions can hinder this process. A long-term approach based on chronologies can help address these issues. The first step in effective information-sharing is having the correct information accessible.

Examples of Promising Practice

As noted above, there is a refreshed approach to local Multi Agency Child Exploitation meetings (MACE) now ensures that there is a strategic, operational and practice related focus on children who may be being exploited that draws on information from all safeguarding partners.

Additionally, an 'All Age Exploitation Strategy' has been developed that seeks to ensure that Bradford District Safeguarding Partnership - comprised of Bradford District Safeguarding Children (BDSCP), Bradford Safeguarding Adults Board (BSAB) and the Community Safety Partnership (CSP) - are working together to foster a greater understanding of exploitation, the impact it has on children, young people, adults with care and support needs, and the wider community, and to improve the lives of those who are at risk.

In support of this the group has created a Delivery Plan based on the 4 'P' model (Prepare, Prevent, Protect & Pursue) which allows for a holistic approach to tackle causes and consequences of exploitation by proactively preventing and protecting those who may be at risk of exploitation and pursuing those who are causing the most harm.

This is noted as an example of significant and important promising practice related to transitional safeguarding.

Local Recommendations

14. Building on local work to strengthen transitional safeguarding, the Bradford District Safeguarding Partnership continue to review of the work of Research in Practice on Transitional Safeguarding, with an identified lead, to translate that learning into local practice responses.

8. How effectively did agencies undertake protective planning in keeping children safe? How well did supervision support planning and consider the appropriateness of practice/interventions?

There was a lack of reference to supervision throughout the review process, beyond reference to a separate review process where it was identified that there was learning in regard to management oversight and supervision where this could have been more effective to avoid drift and delay. This includes reflective, clinical and management/case supervision, which is a concern as these are all critical elements of good practice for services, staff, and children.

With proper supervision, social workers can stay focused, leading to improved care for the children they serve. Various types of supervision may have contributed to improved outcomes for the children/young people. For example, reflective supervision allows staff to process their emotions and experiences in a safe and supportive environment, leading to increased job satisfaction and better outcomes for children. Clinical supervision ensures staff members provide evidence-based interventions and stay current on best practices. Management and case supervision help ensure that cases are managed efficiently and effectively and that staff members have the support they need to do their jobs well. These types of supervision, or a combination of supervision types, are necessary for services to be confident in meeting the needs of the children and families they serve.

During the review, it was observed that there needed to be more emphasis or attention on quality supervision. This may have resulted in missed opportunities to provide support, guidance, and direction for social workers. As a result, there may have been reduced levels of scrutiny and prompts for professional curiosity. This could have compromised the analysis of needs that could have assisted in adopting new support or approaches, such as protective planning within a Child Protection and Contextual Safeguarding approach.

As explored, and quoted from, by The Social Care Institute for Excellence (SCIE)[23]:

Time to stop and reflect has been reported as a missing element of day-to-day practice for many members of staff working in social care. Reflection on feelings engendered by the work, including consideration of assumptions or biases that may be driving practice, is an important element of supervision. Alongside this, an evaluation of the strengths and weaknesses of particular courses of action, and how the worker might have acted differently for the greater benefit of the person who uses services, is an essential learning tool facilitating appraisal and continuous improvement. Supervision which encourages reflection and critical thinking will increase the potential for including comments from people who use services within supervisory discussions.

One supervision model that has been used extensively to promote reflection and critical thinking is the supervision cycle[24]. The advantage of the cycle is that it integrates all four functions of

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23 https://www.scie.org.uk/publications/guides/guide50/foundationsofeffectivesupervision/reflectionandcriticalthinking.asp#:~:text=The%20advantage%20of%20the%20cycle,through%20the%20following%20four%20stages.

24 Morrison, T. (2005) 'Staff supervision in social care', Brighton: Pavilion.

supervision – i.e., management, support, development, and mediation. The cycle prompts the supervisor to work collaboratively with the supervisee through the following four stages.

- **Experience** – working with the supervisee to understand what is happening in their current practice. Where this relates directly to work with people who use services it is an opportunity to make sure that their perspective is introduced into the discussion.
- **Reflection** – engaging with the supervisee to explore their feelings, reactions and intuitive responses. This is an opportunity to discuss any anxieties and acknowledge situations where stress may be impacting on their work. Where the discussion relates to specific work with people who use services it is an opportunity to explore any assumptions and biases that might be driving practice. This can be an important element of working with diversity and promoting anti-oppressive practice.
- **Analysis** – helping the supervisee to consider the meaning of the current situation and use their knowledge of similar situations to inform their thinking. At this point alternative explanations may be explored and, where the needs of a service user are being discussed, this is an opportunity to consider the relevance of research and practice knowledge. This in turn may be useful in identifying any learning and development needs for the supervisee.
- **Action planning** – working with the supervisee to identify where they wish to get to and how they are going to get there. Action will automatically result in a need to re-engage with the experience of carrying out identified plans.

Local Recommendations

15. It is understood that Bradford District Safeguarding Children Partnership cannot delegate or designate a particular approach to supervision across partners agencies. As such, rather than prescribing an approach, partner agencies should reassure the partnership that their supervision policies and frameworks are regularly reviewed. These reviews should draw on contemporary research, evidence, and promising practice.

9. How well do agencies support staff in remaining effectively engaged with children who have complex situations and where familial consent for interventions is not given?

Consent is a complex and multifaceted consideration in this review as it spans the children as individuals, as well as their families.

Consent is a concept that often isn't well considered and explored by professionals in the contexts of power differentials, intergenerational and community perceptions of professional harm, the importance of high-quality relationships and the nuanced and personal perceptions of the risk/benefit analysis of professional involvement. It is also impacted and inhibited by direct negative experiences and the transfer of negative perceptions from one agency or professional to another.

Consent as defined by professionals, is best established with individually focused, tailored, culturally competent, consistent, and persistent attempts to engage by those who are seen as credible and safe. The concept of engagement is acknowledged as perpetuating many of the power imbalances and barriers to consent, but creating conducive conditions for relational practice that supports 'consent' requires a systems response as well as positive practice demonstrated by individuals.

This was not an approach that was widely observed through the review and where other partners, including youth services and the voluntary sector, could have been more extensively explored and utilised.

The local system response could be well informed by recently published work[25] on creating conducive conditions for relational practice to flourish in our adolescent safeguarding systems.

The refusal of consent by families for non-statutory (and arguably statutory) support is also a necessary area of focus and where non-engagement could have been better factored into risk assessments and decision making. This needed tighter management oversight and planning in supervision (linked to the previous question), with clear escalation plans if engagement wasn't secured. These plans should have focused on presenting risks that were escalated by non-engagement.

Local Recommendations

16. Previous recommendations consider the role, purpose and effectiveness of supervision. These should be built on to ensure that issues of consent and engagement should be well explored within supervision.
17. Wider consideration should be given by individual agencies to the conducive conditions for relational practice that supports engagement and consent.

10. To explore the issue of "professional hierarchy" impacting on the way that staff manage cases? Do the views of certain professionals, or indeed the court, adversely impact on a professional's ability to respond and react to changes in circumstances in cases?

Professional hierarchy can create significant barriers to effective case management in safeguarding practice. Unfortunately, the views and opinions of certain professionals, as well as the court as was a factor in the decision making around one child, can have a negative impact on a social worker's ability to respond to changes in circumstances in cases. This was evident in all three young people's experiences. Examples of this include decisions made by schools and the courts. There was little evidence that social workers, or indeed other safeguarding

[25] Creating conducive conditions for relational practice to flourish in our adolescent safeguarding systems – LIIA

professionals, provided much in the way of challenge in advocating for the children's/young people's rights.

This issue of professional hierarchy is especially prevalent among those who work in child protection and safeguarding as social workers often find themselves at odds with other professionals involved in a case, such as doctors or lawyers. These professionals may hold differing views on what is in the child's best interests, and social workers may feel that their perspective is not given the weight it deserves[26]

It is important to address this issue to ensure that social workers and partner agencies can effectively manage cases and provide the best possible outcomes for the children and families they serve. Professional hierarchies and tensions can be addressed by promoting open communication and collaboration among professionals and ensuring that all voices are heard and valued[27]. As previously highlighted, due to high staff turnover, it has not been easy to assess the extent to which multi-agency professionals felt that their views had been sought and valued in safeguarding decision-making. It is hoped that the newly established Exploitation Hub and the MACE meetings provide opportunities for colleagues from different agencies to collaborate effectively and ensure all professional perspectives are listened to.

Child protection is a critically important field that requires a collaborative effort from all professionals involved. However, professional hierarchy can often create a barrier to effective communication and decision-making, ultimately affecting the children and families that need support. To overcome this, the following recommendations must be considered to help break down these barriers.

Local Recommendations:

18. For all agencies to continue to develop responses to safeguarding children and young people by fostering a culture of mutual respect and trust among all professionals involved in child protection. This should include commitment to giving input from multi-agency colleagues and from all levels of seniority, equal weight in decision influencing and making.
19. As highlighted above, there is a need to establish clear communication lines and decision-making protocols building on professional challenge pathway.
20. Ensure all safeguarding partners have ongoing access to multi-agency training and professional development, with a commitment from leaders and managers to support

[26] Frost, N., Robinson, M. and Anning, A. (2005) 'Social workers in multidisciplinary teams: Issues and dilemmas for professional practice'. *Child and Family Social Work*, 10(3), pp. 187–196.

[27] Jahans-Baynton, K. and Grealish, A. (2022) 'Safeguarding communications between multiagency professionals when working with children and young people: A qualitative study', *Journal of Child and Adolescent Psychiatric Nursing*, 35(2), pp.171– 178.

access to development and promote a culture of attendance. Sharing such spaces can help break down professional hierarchies by promoting a culture of learning and growth. This can help professionals develop the knowledge and skills to work collaboratively and effectively with others in the field. By investing in training and development, professionals can stay up to date with best practices and approaches and increase their awareness of other agencies' roles and responsibilities.