# Northamptonshire Safeguarding Children Partnership

# Child Safeguarding Practice Review

## Young Person BG – Overview Report

*"Young Person BG was a livewire, I looked forward to seeing [them]. BG was always polite and respectful when [they] came to see me."*

*"Young Person BG was a lovely person…[they] would always shout my name, come over and have a chat in the street, even when I had finished working with [them]. BG didn't want to lose sight of who [they were] – even if [they were] in in the community with friends, [they] would still stop and say hello."*

*"When BG was upset, sometimes I just wanted to give [them] a hug and tell [them] it would be ok."*

**Combined feedback from various practitioners describing Young Person BG at the Practitioner Learning Event, 23 February 2022**

**Lead Reviewer**
**Mick Brims**
**November 2022**

## 1.0 Young Person BG

On 5 August 2021, Young Person BG was present in a local public space with a friend, where they were accosted by Young Person A and an associate, whereby BG was fatally stabbed. BG's friend was also stabbed but managed to escape the area and survived. BG survived for a time, supported and comforted by a 999 Dispatcher over the telephone. BG subsequently sadly passed away, with the Coroner finding that BG's cause of death was due to a 'stab wound to the chest'.

A subsequent police investigation and criminal proceedings indicated A had not sought out BG or BG's friend specifically with the intent to cause injury; it appears that A and A's associate were seeking to commit a robbery. BG and BG's friend were identified for A and A's associate by other persons in the area as potentially having money and/or drugs on their person, leading to A and A's associate approaching them to rob them. This interaction escalated into violence, leading to BG's death.

## 2.0 Child Safeguarding Practice Review

Northamptonshire Safeguarding Children Partnership (NSCP) Strategic Partners took the decision to complete a Child Safeguarding Practice Review (CSPR) in September 2021, following advice from the National Child Safeguarding Practice Review Panel. Terms of Reference were agreed, with a view that the CSPR would explore the following practice themes:

- Extra-Familial Harm & Professional Understanding of Gangs – Identification & Risk Assessment
- Extra-Familial Harm & Professional Understanding of Gangs – Multi-agency Responses
- Cannabis Misuse
- Diagnosing Neurodevelopmental Disorders in Children
- Adolescent Neglect
- Domestic Abuse & Adolescents
- Practice Context – COVID-19

## 3.0 Methodology

In addition to considering the circumstances of Young Person BG, the Independent Reviewer was directed to review these key emerging themes across a further five young people (six including BG) who had been exposed to or suffered youth violence.

Two of these young people sustained non-fatal stab wounds in 2020 (they were unrelated to the circumstances surrounding BG's death). These young people did not reach the CSPR threshold individually; however, they were identified as having some thematic safeguarding issues in common with the other four young people as mentioned above.

This CSPR was then completed through examination of Agency Reports and convening a series of Learning Events examining the Scoping Period from 1 November 2019 to 5 August 2021:

- A **Practitioner Learning Event** attended by professionals who had worked directly with BG was held on 23 February 2022 to further understand BG's circumstances and consider the safeguarding themes outlined above. Whilst two key agencies were not in attendance, the

event provided a sense of BG as a young person alongside helpful reflections to inform safeguarding practice improvement.

- A **Thematic Learning Event** was held 6 May 2022 to consider the safeguarding themes outlined above regarding the six young people (including BG). This was well-attended by multi-agency partner representatives and has helped inform learning and recommendations regarding safeguarding practice.
- A **Neurodevelopmental Learning Event** was held on 7 July 2022 attended by multi-agency partners, to enable specific focus on how Attention Deficit Hyperactivity Disorder is diagnosed, how support was provided to BG and to reflect on systemic learning regarding support for children and young people with neurodevelopmental considerations at risk of Child Criminal Exploitation.

## 4.0 Family Contact

Contact was made with Young Person BG's parents in November 2021 after the CSPR commenced with the assistance of the Police Liaison Officer supporting the family through criminal proceedings involving BG's assailant. BG's parents declined to meet with the Independent Reviewer at that time.

Following conclusion of the criminal trial regarding Young Person A (BG's assailant) in July 2022, who was then sentenced in September 2022, further contact was made with BG's parents in November 2022; however, BG's parents declined to meet with the Independent Reviewer.

After Young Person A was sentenced, the Northamptonshire LSCP Learning Review Subgroup decided that contact should be made with Young Person A and their mother to seek their perspective on safeguarding support offered for A. Contact was made with Young Person A (in detention) and their mother, however both declined to meet with the Independent Reviewer prior to publication of this report.

## 5.0 Pen Picture, Outline Family History & Key Scoping Period Incidents – Young Person BG

### Pen Picture & Outline Family History

Young Person BG was nearly 16-and-a-half years of age when they were killed in August 2021. BG lived with their mother and younger sibling; BG's father left the family home some years earlier, although BG maintained a level of contact. BG's family is of White British background.

BG experienced domestic abuse between their parents as a primary school-aged child, with parental alcohol misuse linked to this domestic abuse. BG was known to be opposed to alcohol consumption due to these experiences. There is evidence that in some of the domestic incidents between BG and their mother (after BG's father left the home), BG's mother was reported to have been drinking. BG was known to have had a fluctuating relationship with their mother; feedback from practitioners noted instances of both conflict and affection between them.

Young Person BG was neurodiverse, having been diagnosed with Attention Deficit Hyperactivity Disorder ('ADHD') in September 2018 and continued to receive support from a Specialist ASD/ADHD Team in Northamptonshire from that point onward. BG was also diagnosed with Oppositional Defiant Disorder at this time.

BG attended an alternative education provision and was waiting to take up a place at a local college in September 2021 when they were fatally assaulted. BG had previously been excluded from mainstream education provision in June 2017, aged 12**,** over two years prior to the Scoping Period**.** BG started to receive support via an Education, Health & Care Plan (EHCP) in May 2019, aged 14yrs and commenced alternative education with Education Provider 2 in September 2019, after a period of time at a different education provider after permanent exclusion.

BG smoked cannabis on a regular basis (at varying levels) from age 11. After receiving an ADHD Diagnosis, BG's use of cannabis oscillated alongside levels of compliance in taking ADHD medication. At times, BG was described as using cannabis to 'self-medicate' regarding ADHD, whilst BG themself grappled with the positive impact of medication at school (enhanced levels of concentration and achievement) with medication side effects (reduced appetite and weight loss).

Concerns that BG was at risk of Child Criminal Exploitation via potential links to the ~ Gang were held from 2016 (aged 11) onward. At one stage, BG experienced a period of adolescent homelessness linked to exploitation, when they went to stay with an adult family friend. Other exploitation concerns included potential involvement in vehicle theft, being found by Police in motor vehicles with other adults and other young people out of county, incidents of going missing and one incident where BG was threatened with a weapon. Concern was also held that BG was associating with young people with potential involvement with gangs. BG was made subject to a Child Protection Plan in 2018-19 and the family were relocated by housing due to anti-social behaviour concerns and exploitation risks. BG received support from the Youth Offending Service in response to anti-social behaviour offences and around substance misuse. The Child Protection Plan concluded in November 2019, after improved attendance at education and reduced concerns around exploitation risks.

BG broke their leg in a bicycle accident in September 2019, leading to serious medical complications that raised concerns about potential amputation in December 2019, due to delays in healing and a subsequent infection that required hospitalisation.BG is described by professionals as having been a vibrant, sociable young person. BG was well-known in their local area, with their willingness to socialise outside of the family home formed part of concerns held for BG, who was often observed in the company of older young people. BG was known to enjoy mathematics and obtained GCSEs, although practitioner feedback suggests BG may have achieved further with fewer absences from education. BG also demonstrated insight into their own world and lived experience, although at times expressed doubt about their own ability to achieve, as they felt their own behaviour might prevent this.

<u>Key Scoping Period Incidents</u>

- In November 2019, the multi-agency network continued to support Young Person BG and their family through a Child In Need Plan, after a previous Child Protection Plan ceased. In early 2020, BG was hospitalised from complications arising from bicycle accident in the previous summer. BG fortunately recovered fully. BG's CIN Plan was closed at the end of January 2020, with Early Help support to continue.
- In February 2020, Young Person BG disclosed to Education Provider 2 he had been found out-of-county the previous evening in a vehicle with adults after being chased by Police.

- Between March & April 2020, BG moved between virtual and on-site education in response to COVID-19 lockdown requirements. Fluctuations were noted between BG taking ADHD medication and using cannabis.
- In May 2020, BG left home to live with a family friend after a domestic incident with BG's mother. BG suffered financial exploitation and was again found in a car with adults by Police.
- In mid-September 2020, Young Person BG showed a staff member at Education Provider 2 a video of BG stealing a moped in the early hours of the morning.
- In early October 2020, MASH notified BG had been given prescription medication by BG's mother that was meant to be taken by her. A Child Protection Conference was held in November 2020, with an outcome that a Child In Need Plan was to commence.
- This CIN Plan continued until February 2021 when Children's Services ceased involvement with BG. It had not been possible to see BG, as BG and their mother did not want Children's Services involvement.
- In April 2021, the first domestic disturbance between BG and their mother in nearly 12 months was reported to Police, with a further domestic incident reported in May 2021.
- In between these domestic incidents, BG went missing on one occasion and returned under the influence of cannabis. The next day, a young person reported to Police they had been threatened by BG and another young person with an implement.
- In May 2021, the Specialist ASD/ADHD Team completed a telephone consultation with BG and their mother; BG was planning to resume ADHD medication in preparation for college.
- In June 2021, BG was seen riding a moped without a license plate whilst not wearing a helmet. In July 2021, BG suffered involved in a serious motorcycle accident. BG suffered serious head injuries, although later recovered and was discharged home.
- Young Person BG was then the victim of a fatal assault in August 2021.

## 6.0 Young Person A (BG's assailant)

On 5 August 2021, Young Person BG was fatally assaulted by A, a 16-year-old young person who had recently been in the care of Children's Services, after A was initially remanded into local authority accommodation and then made subject to a local authority residence requirement within a Youth Rehabilitation Order. There was substantial, ongoing concern that A had been pulled into Child Criminal Exploitation for some years prior to BG's death.

Circumstances around A's recent history and return to Northamptonshire are considered later in this document, alongside other young people selected for thematic review.

## 7.0 Extra-Familial Harm & Understanding of Gangs – Identification & Risk Assessment

Safeguarding agencies came to learn that Young Person BG had at points been associated with young people who had potential gang links as early as 2016-17. Despite this lengthy history of potential links or association with those involved in local gangs, there was no explicit exploration of extra-familial harm risks within the Scoping Period. Despite a number of incidents of concern regarding child exploitation, the picture of who BG may have associated with and what level of extra-familial risk BG may have experienced in different contexts of their life is unclear.

There are numerous instances of limited multi-agency communication preventing recognition of extra-familial harm risks where relevant agencies did not share or were not furnished with key

information. MASH (Multi Agency Safeguarding Hub) risk assessments were often concluded with limited understanding of family history and aggregated CCE (Child Criminal Exploitation) risks for BG that had accumulated over time. Opportunities were missed to share information within the MASH to gather intelligence and understand potential extra-familial harm risks, such as Police not sending in Child Public Protection Notices (PPN's) to MASH, or assumptions made that other agencies were aware of concerns for BG (e.g. an agency assuming that MASH aware of an issue as Police are aware, or vice versa). Northamptonshire Police have changed their processes to ensure that a Child PPN is sent to MASH as a result of all contacts with children under 18 years of age containing a potential safeguarding risk, as a result of previous NSCP case learning.

Work within the Scoping Period evidences limited professional curiosity around exploration of potential gang links and is not supported by multi-agency review or consideration, such as mapping activity, complex strategy meetings or VAP (Vulnerable Adolescent Panel) referrals for BG. There is limited evidence that risk assessments within the Scoping Period were informed by a detailed understanding of local gang activity, outside of potential ~ Gang involvement being noted in passing in some documents. The ~ Gang is an established local Urban Street Gang, well-known to Northamptonshire safeguarding agencies as posing extra-familial harm risks to young people.

Risk assessments for BG were not routinely informed by analysis of major incidents (such as serious injuries from motorcycle accidents, multiple instances of being found in cars with adults and domestic abuse incidents). A Child & Family Assessment occurred when BG left the family home in May 2020 and a Child Protection Conference was held in November 2020, after BG was given a sleeping tablet by their mother. Extra-familial harm risks were acknowledged in these instances, however, did not meaningfully factor into risk assessments to influence planning and support for BG.

Given limited identification of CCE risks for BG, single agency intervention and support around extra-familial harm risks for BG are extremely limited. By extension, limited recognition of CCE risks meant that multi-agency planning to drive co-ordinated responses was not implemented effectively for BG over the course of the Scoping Period, in stark contrast to the more integrated approach undertaken to address extra-familial harm in the Pre-Scoping Period.

**8.0 Multi-Agency Responses to Extra-Familial Harm & Professional Understanding of Gangs**

Limited identification and ineffective analysis of extra-familial harm risks for BG meant that single and multi-agency responses were extremely limited in reducing extra-familial risks. Effective multi-agency planning did not occur in the Scoping Period around extra-familial harm risks, with an intra-familial focus noted in the limited multi-agency planning activity took place, such as at the Child Protection Conference in November 2020.

The multi-agency response to extra-familial risk for BG is not consistent with the wider local extra-familial harm offer and thresholds. Thresholds guidance is clear that a Strategy Meeting threshold is met when there is clear concern about extra-familial harm risks, as per financial exploitation suffered by BG in May 2020. VAP and ARM (Adolescent Risk Management) Plans are other multi-agency responses to assess, consider and co-ordinate responses to extra-familial harm, however these processes were not enacted for BG.

Over the last 19 months of BG's life, there was no formal activity undertaken to understand if BG had links to a local Gang. Complex Strategy Meetings & mapping activity to consider associates and

identify contexts in BG's life where intervention and disruption was required did not occur. Reported extra-familial harm risks either led to Early Help referrals or when a Child & Family Assessment was completed, intra-familial harm remained the primary focus of analysis.

This in turn led to most referrals of concern in the Scoping Period not leading to a longer period of ongoing Children's Services involvement, which may have supported co-ordination of multi-agency input via either Child Protection, Child In Need (CIN) or Adolescent Risk Management planning and support. However, when CIN Plans were in place, these were ended within a couple of months of Child Protection Conferences, with the last CIN Plan in February 2021 concluding without BG having been seen in person or a meaningful multi-agency meeting convened since the Child Protection Conference in November 2020 to consider progress of work to support BG around exploitation risks.

Practitioner feedback indicates a need for enhanced professional understanding of the impact of potential gang involvement to effectively support young people and disrupt child exploitation activity. This includes:

- increased understanding of exploitation risks when potential gang involvement is identified;
- when and how intelligence about potential extra-familial harm risks can be shared with Police and other services,
- ensuring the NSCP Thresholds Guidance document is explicit in noting pathways for referral when gang associations are identified to Children's Services MASH and how to use online education portals, where schools can report information and intelligence to Police,
- knowledge of how to access the VAP Panel for multi-agency advice and understanding and;
- how the Adolescent Risk Management Plan process works to provide ongoing safeguarding support for young people and disruption of perpetrators of child exploitation.

## 9.0 Cannabis Use

There is limited consideration of cannabis use in safeguarding risk thresholds within MASH, Police records, Child & Family Assessments and Child Protection Conference records during the Scoping Period. Professional feedback indicates a level of overall normalisation of cannabis and ensuing limited curiosity around where BG obtained cannabis and any potential ramifications regarding Child Criminal Exploitation risks. Discussion at the Thematic Learning Event on 5 May 2022 highlighted the need to reset the approach for all safeguarding professionals to the risks posed by procuring and ongoing use of cannabis for young people.

It is accepted that BG's use of cannabis was so routine, over such a length of time, that this was not considered meaningfully within risk assessments or challenged of itself, although some agencies expressed concern about CCE risks at times regarding how BG was obtaining (or being given) cannabis. Agencies have also acknowledged opportunities where greater professional curiosity could have been exercised to explore how BG was accessing cannabis as a follow-on step during discussions where BG was being challenged about continued smoking and was offered support to cease using cannabis.

Analysis from a range of partner agencies over the Pre-Scoping Period (when cannabis use began) has identified limited professional curiosity as to how BG commenced cannabis use at such a young age. It is not clear how disclosures that BG was using cannabis were linked to intelligence-gathering for multi-agency co-ordination at the time in exploring contextual links such as BG's network

(reported to be older teenage males), how BG might be sourcing cannabis and broader implications regarding CCE risks (e.g. whether initial provision of cannabis to BG and/or ongoing use could have generated drug debts that would create an exploitation pull factor).

Support was offered to BG and their family to reduce or stop using cannabis during the Pre-Scoping Period. There is no evidence of BG being offered dedicated support from a specialist substance misuse service around cannabis misuse during the Scoping Period.

**10.0 – Cannabis Use & ADHD medication**

The Child Protection Conference in November 2019 locates responsibility for reduced cannabis use within Young Person BG, noting that they had to '*make choices*' to reduce cannabis/cigarette smoking to enable BG's leg to heal after suffering serious injury (that nearly led to amputation). Meeting records do not evidence multi-agency curiosity regarding the source of cannabis, how potential exploitation push factors could be leading to Young Person BG smoking cannabis and how these factors may have influenced intervention or disruption.

Over the course of the Scoping Period, there is substantial information about BG continuing to use cannabis, how this interacted with BG taking ADHD medication and how cannabis was viewed as part of BG's lived experience. From the conclusion of the Child Protection Case Conference in November 2019 to BG's consultation with the Specialist ADHD Team in February 2020, BG was reporting taking their medication. At a medication review in February 2020, BG stated they were taking medication, their cannabis use had decreased, they were enjoying attending school, relationships at home were better and BG was not in trouble with Police – this discussion occurred a month prior to the first national COVID-19 Lockdown commencing. It is noted that BG was first found in a car by Police with other adults (as noted above) a few days later.

In late February 2020, BG's GP noted a strong smell of cannabis when BG and their mother attended an appointment for wound treatment – it was unclear to the GP who had been smoking cannabis. Cannabis scent noted again by GP at a further appointment in mid-March 2020; BG was challenged by GP to cease usage, BG was reluctant. When seen by the Practice Nurse at GP Surgery in early April 2020, cannabis odour noted again for BG, which was further noted at a follow-up appointment a week later. BG was accessing home schooling due to lockdown requirements at this time.

By mid-April 2020, BG's mother reported BG was no longer taking ADHD medication and exhibiting challenging behaviour, however reports were also received by Education Provider 2 that BG was inconsistently taking ADHD medication and cannabis use was increasing as a result; arrangements were made for BG to access some on-site education again by end April 2020.

By May 2020, BG had left the family home to stay with a family friend, and concerns highlighted from welfare visits by Education Provider 2 and feedback from BG's mother that he was gaining weight and likely not taking ADHD medication. The Specialist ADHD team became aware when they contacted BG's mother in June 2020 and found out he was not at home. When benefits payments were then fraudulently transferred to the adult male BG was staying with, concern was held this would fund cannabis use.

At the time of the Strategy Meeting in October 2020 after BG's mother gave BG a prescription sleeping tablet, BG is noted to be continuing to smoke cannabis and not taking ADHD medication. Telephone discussions between the Specialist ASD/ADHD Team and BG's mother indicated BG had

not taken ADHD medication for several months due to side effects and was smoking cannabis frequently.

The subsequent Child Protection Case Conference in November 2020 also notes concern that BG was 'self-medicating' with cannabis, this was felt to be impacting upon their ability to focus at school and concern expressed that how BG obtained cannabis was an unknown. In describing the circumstances in which BG was given half a prescription medication sleeping tablet, BG's mother noted that the next morning BG was ok, noting that they 'smoked 3 bongs' before school and that BG frequently asked their transport to wait whilst BG smoked cannabis. The Conference noted the need for BG's *'…parents to find a way of effectively managing BG's ADHD and cannabis use. It is not just down to the parents; they need appropriate support in place. The primary support and guidance will come from the ADHD Team. There has been a lack of consultation with the ADHD Team prior to this conference…*'[1]

The Child In Need Plan for BG was subsequently closed in mid-February 2021, suggesting Children's Services had not been able to effectively work with the family, who did not want any further involvement.

As noted above, cannabis use is noted in subsequent MASH Referrals in May 2021 regarding a domestic incident at home and in information shared with MASH in July 2021, where BG was noted to be under the influence/smelling of cannabis by hospital medical staff when BG was brought in after suffering serious head injuries in a motorcycle accident.

A dynamic that is acknowledged by professionals working with BG was the idea that BG preferred at times to 'self-medicate' with cannabis rather than take ADHD medication. This in turn has raised the challenge for practitioners to consider whether there was an inordinate focus on working to get BG to take ADHD medication, without considering other 'non-medication' ways of supporting young people with ADHD and addressing cannabis use as potential CCE risk of itself (as considered above).

The Specialist ASD/ADHD Team became involved from diagnosis onward in September 2018 until BG's life ended, incorporating regular six-monthly medication reviews for BG by a Specialist ASD/ADHD Nurse. This team appeared to build a positive relationship with BG and their mother.

It was known that ADHD medication could suppress BG's appetite. Sometimes this created issues where BG would lose weight and perhaps would not wish to take medication any longer and would instead smoke cannabis. Cannabis use remained a constant throughout the Scoping Period, although there were reports from BG that cannabis consumption reduced during periods when BG was taking ADHD medication.

A detailed discussion with practitioners including the Specialist ASD/ADHD Team occurred during the Practitioner Learning Event for BG. BG did share with the Specialist ASD/ADHD Team that they 'self-medicated' with cannabis; feedback from the Specialist Team is that this is not an unusual situation in their experience where children and adults use cannabis due to perceived benefits; some people anecdotally report that cannabis can assist with restlessness, although this does not always help with attention difficulties. The Specialist ASD/ADHD Team noted that when treating ADHD with medication, there are often signs of improvement around core symptoms for a young person (e.g.

[1] Child Protection Conference Minutes – Young Person BG, November 2020

concentration, impulsivity and hyperactivity) and a potential levelling off of extremes in mood (e.g. being quick to anger). However, the impact of improvements in these areas can also have positive knock-on effects in other areas of life, such as improvements in family relationships, achievement at school and socialisation, as noted by above by BG in February 2020. This was felt to outline how the impact of medication could be positive in influencing other areas of BG's life, whilst BG's mother and professionals working with BG seemed to be able to rapidly identify when BG was not taking medication based on their presentation; Education Provider 2 felt it could be immediately identified upon arrival in the morning when BG had not taken medication.

Reflective discussion occurred around taking a realistic approach in managing cannabis use, as directing a young person (or adult) to stop using cannabis entirely – particularly if they feel it is helpful - was unlikely to be successful; substance misuse support is most effective when a person wishes to seek this help out of a wish to stop using cannabis. Efforts were made to support BG to access substance issue support in 2018, however they did not wish to engage with this. It was noted during the Thematic Learning Event on 6 May 2022, the Youth Offending Service have now moved to an automatic referral to substance misuse support for young people identified as smoking cannabis to enable expert assistance for young people in deciding whether to access substance misuse support, moving on from a position of only offering this based on the young person's willingness to work with support services. This suggests potential for agency partners to come together to review and develop their approach to cannabis use support service offers.

Within the Scoping Period, no information is available to suggest that BG was linked in with specific support regarding cannabis misuse as a result of multi-agency working within the Child In Need Plan in 2019-20, or as a result of the Initial Child Protection Conference and subsequent Child in Need Plan from November 2020 to February 2021.

## 11.0 Diagnosing Neurodevelopmental Disorders in Children

### Diagnosing ADHD & Adverse Childhood Experiences (ACE's)

There is limited evidence of ACE's informing recent MASH Decisions, Children's Services assessments or Police decision-making or that ACE's influenced decision-making around information-sharing in some instances. As with cannabis use, ADHD is often referenced as something that BG 'had', however this information was not then considered in analysing potential risks for BG.

A detailed explanation has been provided by the Specialist ASD/ADHD Team around how ACEs are considered as part of ADHD assessment, however diagnosis is guided by the presence of persistent ADHD symptoms within a clear set of clinical guidelines. It is asserted that this process was followed in assigning BG's diagnosis of ADHD. It is not clear that a detailed understanding of ADHD symptoms inspired curiosity or exploration from other agencies with BG or their family about how ADHD symptoms could create vulnerability to Child Criminal Exploitation. As with cannabis use, there is a sense that ADHD once diagnosed was simply seen as a part of BG, without considering the implications of this diagnosis alongside presenting risks.

A detailed Practitioner discussion was held regarding the influence and importance of Adverse Childhood Experiences (ACE's) in assessing for ADHD at the Practitioner Learning Event on 23 February 2022, informed by input from Specialist ASD/ADHD Team staff, indicating that understanding of the interplay between ACEs and ADHD is a complex, developing area of research.

Feedback indicated that it is not unusual for young people who are diagnosed with ADHD to have also experienced ACEs, with some studies suggesting that environmental factors such as ACEs are present for between 12-40% of young people diagnosed with ADHD, however this must be balanced against a range of other factors. Feedback indicated for example that when considering factors contributing to ADHD diagnosis, studies suggest a strong level of genetic heritability (up to 75% across studies) for ADHD. ACE's are an important factor, however are not determinative on their own regarding ADHD diagnosis.

The Specialist ASD/ADHD Team also clarified that substance misuse and learning difficulties were not excluding factors for an ADHD diagnosis, as these are not mutually exclusive issues. It was noted that BG had two prior cognitive assessments before ADHD Diagnosis. Whilst these assessments were clear in identifying elements of executive functioning deficits (e.g. time management, memory, organisational and planning skills issues), the variations in BG's cognitive profile clearly indicated that they did not have an intellectual disability, where a more global indication of deficit across all elements of functioning would be expected. In considering ADHD diagnosis again, feedback from the Specialist ASD/ADHD Team was that BG, as a younger child, reached their developmental milestones (in contrast to persons with a broader learning delay) and was able to undertake a range of adaptive functioning tasks (e.g. using money, taking transport, making decisions). Feedback from Education Provider 2 noted that BG did reasonably well in GCSE's (Level 3) in a number of subjects and was engaged with education at different points, particularly when supported to manage ADHD. There was no doubt of BG's ability to learn; the broader social challenge for BG (and many other adolescent young people) was interpreting relationships and understanding whether other people around BG were real friends, or wished to take advantage of BG.

In was noted that ADHD diagnosis is only made on the basis of observed, persistent symptoms that are pervasive in manifesting across different areas of a young person's life. For BG, symptoms around concentration/inattention, impulsivity and hyperactivity were noted across a range of settings (reports from how BG presented at home, at school and from other professionals working with BG at the time in 2018.). BG was also observed to demonstrate some of these symptoms at the ADHD clinic**.** Furthermore, the impact of medication can also provide a measure of instruction that the diagnosis is helpful, as the nature of ADHD Medication is such that it is effective only for those with ADHD symptoms, which was demonstrated for BG.

<u>Attention Deficit Hyperactivity Disorder & Medication Interruptions</u>

It is clear that ADHD medication had an important role in work to support BG in managing ADHD symptoms, accessing education and enjoying family life. There have been some elements of challenge about whether there was too much focus on administration of medication and not considering other elements of support, as outlined in the Thematic Learning Event discussion on 6 May 2022, which noted the need for complimentary, 'non-medication' approaches when medication is not being taken. There are examples in assessments, reports and decisions where there is a focus on medication compliance at the expense of holistic analysis and response.

Feedback across the professional network at the Practitioner Learning Event identified an important element around how the impact of ADHD Medication in supporting BG was potentially reduced by enforced breaks of administering medication. At least three key periods are noted for BG over the last 18 months of BG's life where taking ADHD Medication may have been externally disrupted; two

occasions due to hospital admission and a third occasion where they were not being cared for by a responsible adult:

- December 2019 – BG spent 11 days as an inpatient to treat a serious infection following suffering a broken leg in September 2019;
- May-June 2020 – BG went to stay with an adult male family friend. Whilst BG's mother did visit them at this address to ensure they had a continued supply of ADHD medication, it is suspected that BG did not take this and instead smoked cannabis;
- July 2021 – BG spent a period of time as an inpatient following serious head injuries as a result of a motorcycle accident.

Feedback at the Practitioner Learning Event from health colleagues across a range of services highlighted a key interface issue between acute and community medical services. Health practitioners noted when a person is admitted to hospital, all existing or ongoing medications are stopped without consultation with community physicians or psychiatric services. For BG, this may have had substantial ramifications; at the time of their admission in December 2019, BG had just been stepped down from a Child Protection Plan due to a range of improvements in their life, including the positive impact of ADHD medication. Learning for acute settings includes liaising with the Specialist ASD/ADHD Team when considering any decision to cease ADHD medication for a young person during a stay in an acute facility, given that in many circumstances, this medication is unlikely to cause contra-indications with other medication being administered.

Health professionals noted that in addition to medication being ceased upon admission, typically upon discharge, patients are not given guidance on restarting previous medications. This leads to an enforced break from ongoing medication alongside limited support in recommencing established medication regimes. After these breaks, BG was noted to have stated that they no longer wanted to take medication; health analysis notes that contact was made with BG and their family by the Specialist ASD/ADHD Team to ensure that risks of discontinuing taking medication were explained to ensure BG made an informed decision around this.

Whilst BG reported to the Specialist ASD/ADHD Team in February 2020 that they were still taking medication, as noted above, within the next few months, BG was presenting regularly to community health professionals having smoked cannabis and by May 2020 their engagement at school had reduced. BG then moved out of the family home, leading to a further period where the opportunity to receive support (from their mother to take medication) was reduced. By August 2020, BG reported that they were not taking ADHD medication, a factor that was reiterated at the Child Protection Conference in November 2020.

In May 2021, BG agreed with Specialist ASD/ADHD Team staff that they would recommence taking ADHD medication, however in early July 2021 after a serious motorcycle accident, BG spent time as an inpatient again, whereby ADHD medication was again ceased.

Health analysis suggests that there were opportunities at different points when BG was in hospital to ascertain what might be influencing their view not to continue with medication at that time and how they were being supported to take it by their family. Health note that School Nursing could have considered an In-Depth Health Assessment (IDHA), which would have provided an opportunity to explore extra-familial harm risks; however, the Specialist ASD/ADHD Team would be lead practitioners, potentially meaning that an IDHA would not have been undertaken given regular

engagement via medication reviews through a specialist service for BG. As noted above, the Specialist ASD/ADHD Team remained in contact with BG and their family, even during periods where BG was not taking ADHD medication.

ADHD & Access to Education

BG was excluded from school in 2017, some two years prior to the Scoping Period Reviewing information provided, Education Provider 2 demonstrated commitment to BG's welfare over lockdown periods and periods where BG did not wish to attend school by routinely completing welfare visits to BG at home and making referrals to MASH when concerns arose. It is not clear from information provided what efforts were made in the Pre-Scoping period to consider re-integration for BG in mainstream school before permanent exclusion occurred.

After BG returned home in July 2020 from staying with the adult family friend, there was a period where BG was educated at home, with feedback to Health that BG could not return to school unless they recommenced taking ADHD medication. The Specialist ASD/ADHD Service queried this, stating that a school should be able to facilitate a child with additional needs to return to school, with medication not being a reason for exclusion. Information provided by Education Provider 2 suggests the decision for BG not to be educated on site at that time due to the risk BG posed to other students at school due to limited mindfulness of COVID-19; BG was seen to spit on occasions.

Regarding BG's overall engagement with education, as noted Education Provider 2 could immediately ascertain when BG had taken ADHD medication on account of their ability to become engaged with school activities. BG was noted to have considerable academic ability and achieved GCSEs based on coursework and predicted grades despite the challenges posed by COVID-19.

ADHD & Risk Assessment Formulation

Within the Scoping Period, it is not clear how a diagnosis of ADHD was factored into risk assessment or support plans for BG (outside of an EHCP Plan), given that only one referral in October 2020 led to creation of a multi-agency plan around BG. Child & Family Assessments, the Child In Need Plan in November 2020 and MASH referral decisions do acknowledge this ADHD diagnosis, but do not actively consider this as part of potential vulnerability to extra-familial risks either. MASH decisions and Children's Services Child & Family Assessments in the Scoping Period would have been enhanced by considering how untreated or unsupported ADHD symptoms could increase risks for Young Person BG being drawn into Child Exploitation. It is also not clear that enhanced vulnerability to Child Criminal Exploitation linked to ADHD diagnosis was factored into Police decisions not to send PPN notifications to MASH around key incidents of potential child exploitation.

## 12.0 Domestic Abuse

Very limited evidence was located to suggest that BG's childhood experience of domestic abuse was considered as part of analysing risk for BG during the Scoping Period. Risk assessments from various agencies during this time do not meaningfully consider a potentially emerging theme around arguments between BG and their mother containing abusive elements that could be considered from a perpetrator perspective for BG as a young person approaching adulthood.

The current Northamptonshire Violence Against Women and Girls (VAWG) Strategy and range of support agencies does not incorporate dedicated services for potentially emerging perpetrators of

domestic abuse between 16-18 years of age. Risk Assessments and Child In Need Plans during the Scoping Period do not identify domestic abuse for BG as a potential perpetrator and do not incorporate exploration of potential support for BG in this context.

In considering domestic abuse and intra-familial conflict for BG, the vast majority of reported incidents between BG and their mother occurred prior to the Scoping Period, with support provided over the course of the previous Child Protection Plan. BG and their mother received extensive support from the Multi-Systemic Therapy (MST) Team during this period.

There were three reported incidents of intra-familial conflict within the Scoping Period; the argument between BG and their mother that led to BG going to stay with a family friend in May 2020, an argument in April 2021 when BG damaged a car and a further argument in May 2021.

The incident in April 2021 was the first domestic disturbance between BG and their mother in nearly 12 months and was reported to Police after BG damaged a car. Northamptonshire Police submitted a Domestic PPN (rather than a Child PPN) on this occasion, meaning this information did not come to attention of partner safeguarding agencies in MASH, whilst MADRA (Multi-Agency Daily Risk Assessment meeting) was not implemented at that time.

Whilst the further domestic incident in May 2021 was considered by the then newly-established MADRA, outcomes are unclear beyond noting that 'appropriate support noted to be in place' - it is not stated what this support consisted of. This referral was considered by MASH and information sought from other agencies, however information provided is very brief, is not representative of the full scope of involvement that key services had had with BG and is recorded in a manner that is not in line with professional recording standards. Children's Services information is limited to referencing the referral that led to the Initial Child Protection Conference in November 2020 (without referencing the Conference itself) and otherwise notes that BG had not been taking their ADHD medication. Police information simply notes that this was the '2nd in 12 months' (understood to be 2nd domestic incident notification). Police MASH information does not reference the lengthy history of concern for BG around Child Criminal Exploitation, alongside other prior intra-familial issues and even recent events around BG threatening another young person with a metal implement just a few weeks earlier. Based on information available, BG had come to attention on at least twenty previous occasions from 2017 – 2020 for a range of concerns from domestic incidents involving their mother through to CCE risks noted above.

As noted in other MASH decisions above, the decision not to progress to a referral for a Child & Family Assessment (or not to refer on to any other partner agency for support) is not located within the NSCP Threshold Guidance document and does not include a balancing risk analysis, taking full account of family history of involvement and information provided by MASH partners. Education Provider 2 also contacted MASH the next day after becoming aware of this domestic incident, however, were not fully aware of incident details. Education Provider 2 notes MASH advice to 'keep a close watch' on BG, however they did not receive any further information about the incident from MASH to clarify what Education Provider 2 should be watching for.

At that time, BG was 16 years old and it is unclear how these incidents were considered within the context of legally-defined domestic abuse and what preventative and psychological support may have been required for BG and their mother to reduce risk of further domestic abuse. Child & Family Assessments and feedback from the MADRA discussion noted above do not explore the impact of

historic domestic abuse or more recent conflict within the Scoping Period between BG and their mother. It is noted that the last Child & Family Assessment completed for BG was for Conference in November 2020, however more domestic incidents in 2021 between BG and their mother (alongside other concerns) did not reach the threshold in MASH for a new Child & Family Assessment. No information has been obtained to suggest that either BG or their mother were referred on for further support around domestic abuse due to conflict between them within the Scoping Period.

In terms of available interventions, Northamptonshire's Domestic Abuse & Sexual Violence Strategy 2019-22 (Draft)[2] outlines current services providing support to those experiencing domestic abuse, including local services such as VOICE, that provide a specific service for children who have experienced domestic abuse aged six years and older. However, this Review has not identified any service available to young people who have experienced domestic abuse in Northamptonshire that specifically seeks to work with potential teenage domestic abuse perpetrators or young people demonstrating signs of aggressive interactions toward women and girls within the family. Health note the ability of a combined approach through Youth Offending Service (YOS), Police and other organisations like CIRV (Community Initiative to Reduce Violence) to provide direct work interventions (potentially linked in with other offending risks) to address healthy relationships and provide perpetrator support for a young person who may be at risk of perpetrating domestic abuse. Children's Services note that the Children & Families Support Service (CFSS)[3] has an offer to support young people who have experienced domestic abuse to keep safe in future relationships. This service can work with young people who may be at risk of perpetrating domestic abuse also.

Finally, it is noted that the MADRA meeting has now been disbanded. Feedback from Northamptonshire Police indicates that the work of the previous MADRA structure is now integrated within day-to-day Police business. Assurance is required that due consideration of risks relating to young people experiencing or potentially perpetrating domestic abuse is at least as effective within Northamptonshire Police as within the multi-agency MADRA.

## 13.0 Adolescent Neglect

In contrast to the Pre-Scoping Period, it is unclear how the impact of childhood concerns or more recent issues around neglect were identified and analysed during the Scoping Period. Although intra-familial risk is identified and at times considered cumulatively, this is not consistent across decision-making and does not regularly inform risk analysis across a number of safeguarding agencies. In situations where adolescent neglect may have been a factor, the focus appeared to be around the relationship between BG and their mother, without analysing experiences or sources of conflict that could be informing these disturbances between family members. As noted above, this appears to be an element in Children's Services response to BG leaving home in 2020.

Thematic issues outlined in other practice areas above around quality of MASH risk analysis, depth of Children's Services Child & Family Assessments and limited co-ordinated, multi-agency planning over the Scoping Period apply to elements of how adolescent neglect was recognised for BG. There has been little evidence of in-depth consideration of the cumulative impact of neglect for BG, from considering the impact of trauma and Adverse Childhood Experiences around domestic abuse and

[3] Support for victims of domestic abuse - Families and carers (nctrust.co.uk)

parental alcohol misuse at a younger age to the potential impact for BG of spending six to eight weeks in the care of an adult male where they were criminally exploited in May 2020, after leaving home after an argument with their mother.

From a Health perspective, it is noted in their analysis that a Graded Care Profile could have been considered to highlight neglect concerns; this is correct, although neglect concerns could potentially have been immediately understood through a detailed Child & Family Assessment. However, in the months prior to their death, BG and their mother consistently declined to be part of assessments and Child In Need Planning, whilst the multi-agency network did not develop a co-ordinated approach to overcome resistance in working with BG and their mother. It is unlikely that a Graded Care Profile could have been completed by some agencies (Children's Services) without multi-agency planning to identify the best way to work with the family to gain access and create change.

Health have also explored the potential issues noted about BG not being consistently brought to appointments, however cannot identify patterns of concern regarding missed sessions across multiple health services. It is clear that BG has missed appointments at different stages, with the most concerning being some missed health appointments as part of recovering from a broken leg in 2019, which eventually became seriously infected and required hospital treatment. However, there is subsequent evidence of BG being taken to GP appointments after the further operation around infection, although conversely BG and/or their mother were not willing to see the physiotherapist supporting BG's rehabilitation from that injury.

Concern was held that there was an element of covering that BG had left the family home in late April/early May 2020 before being located at the home of a family friend. The Child & Family Assessment completed at that time does not provide further insight into this element of BG leaving the family home. As with other elements of this Review, whilst the impact of arguments between BG and their mother are considered on an intra-familial basis, the potential impact of challenging parental relationships are not meaningfully considered as a potential push factor towards extra-familial risk vulnerability for BG.

It is not clear that there is widespread non-attendance at appointments, although there are certainly instances where BG did miss some health appointments, alongside examples where BG and their mother did attend. Contact and attendance at appointments with the Specialist ASD/ADHD Team appears to have been consistent overall, with arrangements made to re-book appointments where they could not be made. There are also periods where BG is taken to the GP fairly consistently in response to physical health concerns (such as when BG acquired a leg injury after the motorcycle accident), despite concern at other times about limited engagement such as the potential delay in BG's mother recognising that BG's leg wound was infected. Whilst challenges in working effectively with BG's family were experienced by some agencies, other agencies did develop working relationships with the family and non-attendance was not consistent across various elements of BG's life.

In considering BG's emotional needs, it is challenging to locate BG's voice around their view at home and potential experiences of neglect due to limited instances where their voice was directly obtained, due to factors such as decisions not to commence Child & Family Assessments and the family not wishing to work with Children's Services over the last several months of BG's life. The reviewer remains mindful of the potential impact of any experienced child exploitation trauma that could have been influencing BG's role in arguments with their mother in April and May 2021,

although no further assessment occurred of these incidents to ascertain how these incidents came about or if neglect was a factor. Finally, as there was limited ongoing multi-planning for BG during the Scoping Period, there is limited evidence of multi-agency consideration of BG's social/emotional communication needs to develop plans to work effectively with BG.

**14.0 COVID-19 context**

Increasingly, literature is becoming available about the impact of the COVID-19 lockdowns for children and young people, including those with Special Educational Needs (SEN). Findings from one study suggests key issues for young people with ADHD related to SEN School places not being as available in the first lockdown (March – June 2020) and many young people with ADHD were not able to undertake normal activities to expend energy. An increase in families of children with SEN going into crisis noted to have occurred during these periods also. [4]

Tracing lockdown periods to chronological events, BG was noted in February 2020 to be happy at school, feeling things at home were improving and was taking their ADHD medication. In March 2020, BG appeared to stop taking medication and some concerns were noted about their behaviour at school before lockdown commenced on 23 March 2020. By 9 April 2020, Education Provider 2 sought to bring BG back to school as welfare visits to BG suggested they were not coping well with home schooling. By the end of April, it was claimed BG had gone to stay at their father's and in May 2020 it became clear BG was staying with a family friend where they suffered financial exploitation.

During the second lockdown period from October to early December 2020, the Strategy Meeting and Child Protection Conference regarding BG being given prescription medication by BG's mother took place. The third national lockdown from early January to late February 2021 covered most of the brief CIN Plan, which was closed before this lockdown lifted without gaining access to BG. It is noted that due to behavioural issues over these periods (which included racist comments, sexualised comments about another student or at times concerns about BG's willingness to adhere to lockdown requirements such as using PPE [Personal Protective Equipment]), BG did have a number of fixed term exclusions that meant they spent time at home, rather than in education.

Children's Services noted that during lockdown periods, home visiting only occurred if a high-risk rating was applied; BG was not open for a sustained period of time and visits that were attempted were unsuccessful. Health noted that staffing levels for community 0-19 years services were heavily reduced during lockdown periods due to redeployment, however BG retained the oversight of the Specialist ASD/ADHD Team as their lead health professional.

Challenges are documented by Education Provider 2 at times in balancing the health needs of all students at their provision (the majority of which have additional needs) against ensuring BG's access to school. BG was noted to spit on some occasions, which created hygiene risks given the nature of COVID-19, whilst at other times BG would not wear PPE. This is an example of the COVID-19 practice context impacting upon BG's education.

[4] *"Impact of the COVID-19 Pandemic on Education, Health & Social Care Provision for Children with Special Educational Needs and Disabilities (SEND): The Ask, Listen, Act Summary."* Ashworth et al, National Institute for Health Research. February 2022. (https://www.ljmu.ac.uk/~/media/files/ljmu/research/centres-and-institutes/rcbb/ask-listen-act-study-summary-final.pdf?la=en)

On balance, COVID-19 circumstances placed strain on BG's relationship with their mother at points, whilst also creating challenges at times for BG to access school. This doubtless broke up the routine and consistency that may have supported BG in different areas of their life.

## 15.0 Summary Learning – Young Person A & Thematic Review

This Review considered key records for Young Person A, alongside reviewing emerging thematic learning across a cohort of six young people (including Young Persons BG & A). Areas of commonality and difference in lived experience and safeguarding risk are explored here for these young people.

### Contact with Agencies, Family History & Thematic Safeguarding Risks

Young people considered in this thematic cohort had contact with Police over time for a range concerns including involvement in robbery, carrying or use of knives, anti-social behaviour, riding or stealing two-wheeled vehicles, being found in or entering cars of unknown older males, assault and (for some young people) suspected possession of Class A drugs (and potential Possession With Intent To Supply). One young person was arrested regarding firearms offences. Levels of police contact with each young person varies considerably, with some young people having a handful of direct contacts with police due to extra-familial harm risks alongside additional police contacts relating to family history of parenting concerns when they were younger children. In contrast, other young people in this cohort have a higher rate of recent contact with Police, including one young person who was known to police in over one hundred contacts during the Scoping Period.

All young people have had previous contact with Children's Services, often over an extended period of time as a result of domestic abuse, parental alcohol abuse or neglect. Three young people have been subject to Child Protection Plans, five young people subject to CIN plans. Care Proceedings were considered for three young people, with only Young Person A coming into care briefly between March and May 2021 via remand into local authority care followed by a Youth Rehabilitation Order accommodation requirement until August 2021.

Despite the levels of contact with Police and, for some young people, previously identified risks of extra-familial harm and gang association, only two young people in this cohort have had contact and support from Youth Offending Services.

All young people were registered with general practitioners and had a range of contacts with health services at various points over time.

### Ethnicity, Representation & Adultification

All young people considered here are aged 15-17yrs at the time of Young Person BG's death in August 2021. Three young people are described as having a 'White' ethnicity category, whilst three are described as having a 'Black' ethnicity category. At a thematic level across a small cohort of young people, it is not possible to provide detailed analysis around how the cultural heritage of each young person was considered and how effectively safeguarding responses for these young people evidenced cultural awareness, curiosity and sensitivity in providing support and intervention.

Requests for wide-ranging data from the Community Safety Partnership around demographic information for young people suffering child exploitation and extra-familial harm risks in Northamptonshire were unsuccessful. Other areas of this CSPR have highlighted the need to

assimilate multi-agency data into a Home Office 'Problem Profile'[5] to fully understand the cohort of young people to provide prevention, intervention and disruption responses that will be informed by the range of young people who are being drawn into exploitation, the offences they are being co-opted into undertaking, their criminal, educational and social outcomes. Furthermore, four young people in this cohort were victims of stabbings, whilst one young person was a perpetrator of a stabbing and another was acquitted of this action. These six young people are not a homogenous cohort in terms of their circumstances and as such, would require a much wider, comprehensive dataset to understand over or under-representation in terms of victims or perpetrators of crime and how this interacts with age, gender and ethnicity demographics in Northamptonshire. This highlights the need for an overarching Child Exploitation Strategy that will include development of a Problem Profile to enable a clear understanding of how young people are demographically represented as victims of child exploitation and serious youth violence, alongside potential perpetrators of serious youth violence.

It is important to acknowledge available feedback around how approaches to support young people at risk of exploitation have considered young people of minority ethnic backgrounds. Children's Services internal review of Young Person A and another young person has highlighted concern about the potential presence of 'adultification', as outlined by Jahnine Davis - *"The concept of adultification is when notions of innocence and vulnerability are not afforded to certain children. This is determined by people and institutions who hold power over them. When adultification occurs outside of the home it is always founded within discrimination and bias. There are various definitions of adultification, all relate to a child's personal characteristics, socio-economic influences and/or lived experiences. Regardless of the context in which adultification take place, the impact results in children's rights being either diminished or not upheld.'*[6]

Children's Services internal review found that elements of adultification were evident when considering A (and another young person in the thematic review cohort). Some file recording language attributed enhanced responsibility and ability to A above and beyond that of a young person of their age regarding their safety and decision-making, noting A 'turning up when they are ready' or 'they are putting themself at risk'. Similar language that attributes responsibility is replicated elsewhere for other young people considered thematically in this CSPR.

Furthermore, whilst there was a strong relational practice focus after A moved to out of county placement, if completing a detailed review process, the Reviewer would explore whether A was afforded innocence and vulnerability over time by agencies supporting them in response to their previous experiences of trauma both overseas in 2018-19 (when A was essentially left to fend for themself as an adult) and due to Child Criminal Exploitation after returning to the UK, where A was involved in violent assaults and drug offences. Finally, review of A's circumstances suggested contrasting views and understanding across agencies about whether A was a victim of modern slavery; this suggests a need to consider what factors shaped these decisions so that young people received timely support as victims of Child Exploitation. As a counterpoint however, it is also noted

[5] *Child Exploitation Disruption Toolkit.* Home Office. Last updated 1 September 2022. (https://www.gov.uk/government/publications/child-exploitation-disruption-toolkit)

[6] *"Adultification Bias within Child Protection & Safeguarding."* J. Davis, HM Inspectorate of Probation Academic Insights. June 2022. (https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/06/Academic-Insights-Adultification-bias-within-child-protection-and-safeguarding.pdf)

that A was the only child in this cohort to be made subject to a VAP Panel referral, suggesting there was recognition that A had and was suffering Child Exploitation.

Adultification is also noted to occur in other contexts, such as domestic abuse, homelessness and other circumstances that create risk for young people where adultification can lead to a diminished safeguarding response.[7] This raises constructive queries about broader themes outlined in this CSPR where responsibility is attributed for behaviour that may be influenced by exploitation or trauma. This is potentially evident in considering the circumstances of another Young Person, who was homeless for a period of ten months from ages 15-16, suggesting limited professional recognition of the impact of this upon the young person, although they are reported to have concealed homelessness for a substantial period of time. Considering the circumstances of Young Person A again, adultification could provide a helpful prism for analysis of why Children's Services did not issue care proceedings for A, given the extensive history of trauma, concerns around exploitation and escalating violence for a child of 15-16 years of age. Ultimately, for A and other young people of Black ethnicity in this thematic review cohort, much deeper exploration would need to occur with practitioners, agencies and young people themselves to understand these factors fully. As part of developing a Child Exploitation & Extra-Familial Harm Strategy, there is an opportunity to meaningfully engage with issues such as over and under-representation of young people based on age, gender and ethnicity bases, whilst identifying potential causes of bias and discrimination that could impact upon an effective Child Exploitation response for young people in Northamptonshire.

## 16.0 Key Practice Findings

The following Key Practice Findings outline where learning can occur for safeguarding practice:

- Extra-familial harm risks were not appropriately identified for BG in the Scoping Period. In contrast to the multi-agency approach in the Pre-Scoping Period, incidents of significant harm including financial Child Criminal Exploitation and serious (non-violence-related) personal injury did not meet threshold for Child & Family Assessment and/or s.47 child protection investigations on a number of occasions. Despite concerns around potential gang association and personal cannabis use since at least 2017, family and extra-familial risk history was not routinely fully considered and analysed within threshold decisions.
- Oversights in multi-agency communication meant that key information about intra and extra-familial harm risks were not always passed on to MASH, Police or key partner organisations to ensure all professionals were aware of safeguarding risks.
- Limited risk analysis and inappropriate threshold application meant that BG was not subject to a period of meaningful multi-agency planning from February 2020 until their death in August 2021. Child & Family Assessments were not comprehensive in considering BG's safeguarding and support needs and key threshold decisions were not located within local threshold guidance. In reviewing the intervention and disruption responses for other young people reviewed thematically, disparate responses have been identified, with one young person subject to a substantial range of interventions and multi-agency oversight, in contrast to that of BG and others reviewed.
- Practitioners identified that BG's entrenched cannabis use was normalised over time, with BG not receiving referral to a specialist service or dedicated input around cannabis reduction or

[7] Ibid (Footnote 15)

cessation over the Scoping Period. Cannabis use was a factor across the six young people reviewed thematically.

- Strengths have been identified in the intelligence-sharing capacity of the Vulnerable Adolescent Panel regarding Young Person A, although intervention and disruption would be enhanced by VAP tracking actions for impact. Panel impact would also be enhanced by lead practitioners and independent reviewers (such as Child Protection Chairpersons and Independent Reviewing Officers) and line managers ensuring that actions from this forum are integrated within concurrent Adolescent Risk Management Plans or Looked After Child Care Plans (when in place).
- Exploration of how safeguarding professionals understand local gang structures and what it means for a young person to be part of or associated with a gang has highlighted the need for safeguarding agencies to have an informed understanding of local gang structures, knowledge of all disruption tools available. A means of regular strategic feedback from Police to partner safeguarding agencies to refresh knowledge around gang activity and ongoing operational and strategic initiatives to disrupt gangs and keep young people safe is required. This will enable senior managers to support practitioners in developing a greater understanding of how gangs work in Northamptonshire and the most effective way to respond to concerns about gang involvement for a young person.
- Thematic Review of intervention and disruption approaches across six young people has highlighted a range of initiatives to address Extra-Familial Harm risks. These include a relational practice focus within Children's Services, alongside ongoing joint integrated data analysis of the cohort of young people identified as being at risk of extra-familial harm by YOS and Police. Northamptonshire Police have also deployed advanced data analysis software to predictively identify young people who may be at risk of exploitation or serious youth violence. Children's Services have implemented an Adolescent Risk Management Plan (ARM), although agency feedback suggests that practitioners are unclear on when this type of plan should be implemented for a young person at risk of extra-familial harm. These initiatives to explore and develop multi-agency data analysis, early intervention and disruption approaches within different segments of the multi-agency network would be further enhanced via integration into an encompassing Child Exploitation Strategy across NSCP and North and West Northamptonshire Community Safety Partnerships to develop a 'Problem Profile' and ensure the ability to dynamically understand changes in data to understand the needs of young people at risk of Child Criminal Exploitation. However, despite these positive developments, NSCP partner agencies have not yet implemented an agreed multi-agency practice framework to specifically address extra-familial risk, or a dedicated Child Exploitation Strategy in Northamptonshire.
- Practitioners and strategic leaders identified a need to refresh and embed working knowledge of all available extra-familial risk pathways, multi-agency oversight forums and safeguarding agencies providing intervention and supporting disruption activity to enhance the safeguarding partnership's ability to identify and appropriately respond to extra-familial risk when and where it is identified for young people.
- Practitioners recognised that there was a substantial focus on ensuring that BG adhered to taking ADHD medication and that a more holistic focus around other non-medication-based interventions to support BG may have assisted during periods where BG was smoking cannabis and not using ADHD medication.

- Although domestic incidents between BG and their mother were not frequent during the Scoping Period, these incidents were not analysed against the considerable Pre-Scoping Period history of these disturbances. Risk analysis would have been enhanced by considering interventions to support BG as a 16-year-old potential perpetrator of domestic abuse. Domestic abuse was also identified as a common factor across the six young people reviewed thematically, with extensive histories of domestic abuse trauma noted in shaping the childhood experiences of some young people reviewed. Thematic learning identified the need to reflect upon service offers or young people who could potentially become perpetrators of domestic abuse, alongside enhancing practitioner knowledge of interventions and support pathways available.
- BG experienced Adolescent Neglect when they left the family home during the first COVID lockdown to stay with a family friend, where he experienced financial exploitation. A s.47 Child Protection Investigation was not completed and there is no evidence that a National Referral Mechanism referral for BG was sent, or the criteria for sending a NRM referral were considered. Thematic Review indicates that a further two young people also reviewed experienced adolescent homelessness, including one young person who was homeless for several months. This has highlighted the impact of trauma and risk of exploitation for young people who are forced to live out of home.
- Positive Practice has been identified around the role of health and education services in remaining connected to BG during the COVID-19 pandemic to meet BG's health and educational needs.
- Action will be implemented to develop a clear understanding of neurodiversity within Northamptonshire, particularly with regard to ADHD, to secure funding for services to meet needs identified by this cohort analysis, alongside extra-familial harm cohort identification noted above.
- Review of Young Person A's circumstances has highlighted that safeguarding agencies need to retain a clear understanding of the legal and practical implications when a young person is Remanded into Local Authority Accommodation and is made subject to a Youth Rehabilitation Order with a local authority residence/ accommodation requirement. Effective parallel planning (including potential use of care proceedings or s.20 accommodation) is required to remain focused on the immediate and longer-term needs of young people when subject to these short-term, court-ordered conditions. For Young Person A, it is not clear that appropriate multi-agency parallel planning took place to consider the need for either issuing care proceedings to share parental responsibility or ensure that appropriate assessments were undertaken to secure s.20 agreement from A in line with 'Southwark Judgement' directives as part of longer-term transition planning for A. Furthermore, A was not referred back to VAP Panel for multi-agency advice to support return planning, despite VAP Panel noting A should be re-referred should they wish to return to Northamptonshire. Limited parallel planning as above meant that when A reached the end of their local authority residence requirement and no longer retained Child In Care status, they returned to Northamptonshire. Within 24 hours of this event, BG had been killed. Review of the NRM (National Referral Mechanism) Referral for Young Person A has highlighted the need to consider the current shared understanding across the partnership around when modern slavery concerns may emerge for a Young Person, alongside reflecting upon and addressing language and perspectives that locate responsibility for behaviour and involvement in crime

within the young person, rather than as a result of suffering child criminal exploitation and potentially resultant trauma. Internal Children's Services review of A has also highlighted the importance of considering 'adultification' of Black young people experiencing exploitation and the need to reflect upon how to effectively identify and address potential sources of bias when identifying extra-familial harm and developing a collaborative strategic response to extra-familial harm.

## 17.0 Conclusions & Needs Analysis

This CSPR Report has commented extensively on a wide range of issues summarised briefly here, based on consideration of Young Person BG's circumstances, information about Young Person A and broader thematic analysis of six young people drawn into exploitation and youth violence.

Whilst it is not possible to say definitively that BG's death would have been avoided through enhanced identification, threshold decision-making, assessment and intervention around extra-familial harm, this CSPR has clearly highlighted the importance of work with young people being fully informed by a professionally curious approach to family history, previous risks and interventions around extra-familial harm, working knowledge of the real-terms impact of ADHD for each individual young person, ongoing professional challenge of cannabis use to identify potential extra-familial risk and effective risk analysis of intra versus extra-familial harm risks.

Consideration of information around Young Person A has highlighted a range of potential learning for safeguarding agencies around co-ordination of multi-agency planning and ensuring embedding of activity from the multi-agency VAP Panel in ongoing safeguarding plans for young people as part of a joined-up approach to addressing extra-familial risk. Over the course of this CSPR, it has become clear through thematic review of six young people that at this time, extra-familial harm pathways are not clear, with many agencies lacking awareness of VAP or ARM Plans or how to effectively respond when a young person is identified as being associated with a gang.

There is evidence of pockets of work to build pathways, however this requires a cohesive, co-ordinated approach to develop an end-to end system that will consider the needs of young people at all stages and provide effective, joined-up responses. Furthermore, consideration of the NRM referral for Young Person A has highlighted the need for the NSCP to constructively challenge partner agencies to reflect upon how young people are viewed within the context of suffering child exploitation and modern slavery. Agencies must avoid ascribing responsibility to young people for the exploitation they are experiencing and instead locate this within exploiters creating extra-familial risks, whilst remaining mindful of potential adultification or other forms of bias that could potentially exist in developing an effective approach to extra-familial harm. A's circumstances have also highlighted the importance of clarification of legal status, a proactive approach to seeking parental responsibility for young people at very high risk of exploitation (when appropriate to their needs) and the need for ongoing curiosity for young people safely placed out of county to explore the impact of exploitation-based trauma when undertaking multi-agency planning or considering when a young person may seek to return to their home area.

Thematic review of the needs of six young people have clarified the need for enhanced practitioner knowledge of the impact of ADHD, challenging and dismantling normalisation of cannabis use amongst young people, the impact of adolescent neglect and prevalent key Adverse Childhood Experiences such as domestic abuse and parental substance misuse. All of these issues are complex

in terms of impact for young people over time and require enhanced practitioner knowledge and curiosity to ensure that assessments and interventions adequately factor in the immediate and accrued impact of these experiences. At a strategic commissioning level, the need for a holistic ADHD Pathway integrating non-medication support options has also been identified.

Finally, over the course of this CSPR, the value of curiosity and engagement with young people to understand their circumstances and insights they can provide around keeping young people safe has been highlighted where this direct contact with young people has been limited, or where further exploration of trauma and previous experiences could provide information around potential future risk of harm. This can include Appreciative Inquiry approaches, so that existing strengths can be built on alongside areas of improvement outlined in this CSPR report.

The primary conclusion of this CSPR process is that there is a need for a nuanced, all-encompassing Child Exploitation & Extra-Familial Harm Strategy that:

- Develops a wide-ranging and ongoing consultation process with young people and former young people who have been at risk of or experienced child exploitation to enable expert input into strategic action to address extra-familial harm and Child Exploitation risks;
- Integrates an agreed practice framework as part of a 'whole systems change' approach to addressing extra-familial harm and child exploitation;
- Develops a comprehensive Home Office 'Problem Profile' knowledge of the cohort of young people at risk of exploitation;
- Develops strategic initiatives to construct a 'very early intervention' approach (identified through thematic review of six young people) based on qualitative and quantitative sources that provides clear early intervention pathways, shaped by feedback from young people and communities around how to effectively reduce risk of extra-familial harm for young people;
- Supports timely, effective multi-agency information-sharing and communication to ensure that Child Exploitation is identified, appropriately analysed via risk thresholds and effective multi-agency responses are developed through sharing of safeguarding concerns to all relevant agencies, whether through the MASH process or via ongoing multi-agency safeguarding activity;
- Enables effective protective intervention for young people at risk of Child Exploitation, including identifying and integrating all services and interventions across the county that support young people at risk of or experiencing exploitation to develop clear, effective intelligence-sharing and intervention pathways;
- Enables enhanced practitioner knowledge of how to effectively support young people at risk of exploitation, including meaningful analysis of potentials risk regarding family history and previous professional involvement, cannabis and substance misuse, the impact of ADHD for individual young people, adolescent homelessness and an understanding of how young people are coerced and compelled into suffering ongoing Child Exploitation;
- Supports multi-agency contextual disruption of gang activity and exploitation of young people, including increasing practitioner knowledge of all disruption options available, when and how these can be accessed and how practitioners can respond to reports of gang involvement to ensure swift, timely intervention for young people and disruption of criminal exploitation;
- Reviews and enhances strategic-level information-sharing of gang activity, exploitation trends, high risk local contexts and planned high-level disruption operations against Urban Street Gangs to ensure strategic leaders retain ongoing knowledge of local gang structures, efforts to disrupt

their activities and can consider young people who may be affected by broader disruption work in advance and;

- Drives cultural change in emphasizing the importance of risk analysis of extra-familial risks alongside intra-familial concern and constructively challenges all safeguarding practitioners to refrain from locating responsibility for extra-familial risks within the young person. This strategy will also promote the importance of identifying and understanding the power of external push-pull factors, enhanced awareness of potential for bias in considering extra-familial risks and the impact of trauma upon young people drawn into Child Exploitation.

## 18.0 Strategic Recommendations

1. NSCP to develop & implement a multi-agency strategy & practice framework to support the identification, risk analysis, intervention & disruption of Child Exploitation.

2. NSCP, North Northamptonshire Commissioning Services, North Northamptonshire Community Safety Partnership and Violence Against Women and Girls Leads to conduct a needs analysis to review domestic abuse services for young people aged 16-18 years who may be at risk of perpetrating domestic abuse.

3. Northamptonshire Healthcare Foundation NHS Trust in collaboration with key partners to review their existing ADHD pathway, which offers choice to young people and their families about treatment. Review of existing ADHD Pathway to consider the importance of ensuring advice is given for non-medication options to young people and their families and to consider multi-agency learning initiatives to enhance safeguarding practitioner understanding of how to support young people with neuro-diverse conditions such as ADHD