Child Safeguarding Practice Review concerning a child referred to as Liam

Born 19th March 2002

Died 19th January 2020

Independent Author: Dr Russell Wate QPM

Contents

1. Introduction 3

2. Terms of Reference, Contributions and Methodology 4

3. Summary of the case (What happened here) 6

4. Analysis of significant safeguarding events (Why things happened) 17

5. Conclusion and Learning 32

6. Recommendations (What needs to happen next) 39

Appendix A – Agencies and panel member details. 42

1. Introduction

The subject of this Child Safeguarding Practice Review (CSPR) is a 17-year-old boy who died on the 19th January 2020 having been stabbed. He is referred to in this review as Liam. He is of a British white ethnicity. At the time of the incident which led to his death Liam was living with his mother, who for the purpose of this review is called LM. Little is known of Liam's father as it appears that he stopped having contact when Liam was about 1 year old.

Hampshire Police were called to an area of Southampton at 06:15 am on 19th January 2020 after reports of an assault, where on arrival they found Liam with a stab wound to his chest. He was taken to Southampton General Hospital but died later that day from his injuries. A 15-year-old boy was arrested and at the time was missing from his residential care home. After an investigation he was charged with Liam's murder, he stated he was acting in self-defence, which the Jury accepted, and he was found not guilty at the Crown Court trial. He was convicted of being in possession of a bladed weapon for which he received a 12-month referral order.

As Liam was residing in Southampton prior to his death, Southampton Safeguarding Children Partnership (SSCP) commissioned this review on the 16th March 2020.

This Child Safeguarding Practice Review has been completed using the criteria from 'Working Together to Safeguard Children 2018'. Following Liam's death, the partnership rapid review meeting concluded that there was a commitment across the agencies to identify learning from his life and death. This would focus on the ways in which the agencies in the Safeguarding Children Partnership had worked both singly and together to keep him safe.

It was agreed that the timeframe for this review would be the period from 19th January 2017 to 19th January 2020.

The review panel requested relevant background and contextual information regarding key factors and significant events involving Liam and his immediate family, which was known or could have been known by agencies during the period.

Background to the family

Liam had a history of involvement with Children's Social Care, the Police, and other agencies throughout his childhood. He was linked to Child Criminal Exploitation (CCE) from the age of 10 years and indications point towards his involvement with County Lines[1] and drug related offending. Liam was a Looked After Child (LAC) and was subject to several placements in different areas of the country, including periods in secure accommodation, once when he was in custody and also for his own welfare.

[1] County Lines is defined in the Serious Violence Strategy 2018 as a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

In 2016, Liam was the subject of a Critical Learning Review within the Youth Offending Service (YOS) and in May 2018 he was one of eight children whose cases were audited by Southampton as part of a mock Joint Targeted Area Inspection (JTAI)[2] in relation to 'children involved with gangs, criminal exploitation, sexual exploitation and missing episodes.' The purpose of the mock inspection was for Southampton to understand better what actions they needed to implement to keep children safe from CCE.

The review concerns the following family members.

Liam. Referred to only by this name in this review.

Relationship to Liam	**Name**
Mother of Liam	LM
Mother of a Friend/ temporary carer	LFM

2. Terms of Reference, Contributions and Methodology

The purpose of a Child Safeguarding Practice Review (Working Together to Safeguard Children July 2018) is to:

- To identify improvements to be made to safeguard and promote the welfare of children at both a local and national level. Learning is relevant locally, but it may have a wider importance for all practitioners working with children and families and for the government and policymakers.

  Specifically, the terms of reference set for this review will focus on the following learning outcomes:

- To ascertain whether we have effective partnership analysis, data collection, mapping of Child Criminal Exploitation (CCE) networks and areas of risk that consider 'County Lines' and more localised exploitation.

- To gain an understanding of the factors in a child's life that might make them vulnerable to a life-ending event (including being a Looked After Child and Adverse Childhood Experiences).

- To gain an understanding of the strategic direction for tackling offending/the criminal exploitation of children and young people within the city of Southampton and vulnerable adolescents.

[2] The Government in 2016 introduced a new series of multi-agency inspections called Joint Targeted Area Inspections of services for vulnerable children and young people (JTAI). The inspections are undertaken by the following inspectorates: Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP).

- To gain an understanding of what services and support were provided, to inform what might work for others in the future to prevent the same outcome. Also, to understand how effective services were, and any barriers.

- To gain an understanding of how risk was managed and communicated across agencies and the family in relation to, risk to self, risk of serious harm to others, likelihood of reoffending.

- To establish how well family members were engaged in the joint protection and management of risk, given the placement at home.

- To understand the time frames for a child suspect under investigation for criminal offences and if necessary, effect change nationally in relation to this.

- To understand the impact of serious violence upon affected parties and ensure effective responses to support this in practice.

- To understand the impact on a child of missing education, educational neglect, not being in employment or training, and how a child with multiple vulnerabilities can be re-engaged with education/training and employment.

- To ensure the learning from this practice review is disseminated across partner agencies to inform future practice.

This review took a holistic look at Liam's life during the agreed timeframe in order to understand the impact of key events and challenges during his early years, his involvement with child criminal exploitation both as a victim and perpetrator of violent offences, and his experiences as a Looked After Child. The report will also consider the barriers to keeping Liam safe and how these might be better addressed in future similar cases. The review will share learning and improvements with all agencies so that better services and support can be offered to children facing complex adversity in their early years, childhood, and adolescence.

This review aims to bring about improvements to the services offered to young people by sharing the relevant learning with practitioners through workshops and briefings following the publication of the report. The report's recommendations will be monitored by the Serious Incident and Learning Group on behalf of the SSCP, to ensure that they are progressed and embedded into Services.

Contributors to the review

A number of local agencies have contributed to this review and details of them can be seen at Appendix A, as can the details of the panel members who were all of great assistance in the compiling of this Child Safeguarding Practice Review.

Methodology

This review was carried out in line with those principles as set out in Working Together 2018 and is proportionate to the case under review.

Agencies with any relevant information or involvement with Liam were asked to provide a chronology of key events and "pen portraits" which summarised each agency's involvement in Liam's early childhood.

Analysis then took place with a review of relevant multi-agency policies, procedures and processes and a learning event was held with panel members, agency leads and key practitioners.

3. Summary of the case (What happened in Liam's life)

This section aims to provide a picture of the lived experience of Liam and his mother LM, as seen through their interactions with agencies and professionals from the various agencies. The chart below breaks down quite simply significant periods in his life.

Southampton (With Mum LM)	2003 (1yrs)- 2011 (10yrs)
Southampton (With Mum LM)	2012 (10yrs)- 2014 (12yrs)
Southampton (Looked After Child begins)-Foster placements, Secure Unit- Custody	2014 (12yrs) – 2016 (14yrs)
Bristol Custody then Birmingham residential placement	2016 (14yrs)- 2017(15yrs)
Portsmouth Specialist foster placement	2017 (15yrs)
Glasgow Secure Unit	2018 (16yrs)
Lancashire	2018 (16yrs)-2019 (17yrs)
Southampton	2019-2020 (17yrs)

How did those professionals who worked closely with Liam see him?

Several of the professionals who have worked with Liam have described quite strongly to the review author, Liam as a different person to the one seen from the information recorded in the next few pages of this report. The review author feels it is extremely important for those readers, to fully understand, what life was like for Liam, is to share these views in this report.

At the practitioner workshop attendees shared their views of Liam. It was said that "Liam lit up a room", "he had an infectious smile and was witty, charismatic and insightful beyond his years". One worker commented that "it was a real joy to have worked with him, and that will stay with me for the rest of my career". Liam could also be very affectionate and a "compulsive hugger" which could come as a surprise to professionals new to working with him. Liam was also described as "a lot of fun" and

although he seemed to feel that he was invincible, one worker said he was “a lovely young person”.

Professionals did, however, acknowledge that Liam presented a real challenge to work with, but also were keen to convey there was ‘another side’ to him.

Pre timeframe period

2003-2011 (Age 1 to 10 years old)

Children’s Social Care’s (CSC) first record of involvement with Liam and his family is in January 2003. This record was from a referral noting that the family were in acute stress. A Social Work initial assessment was requested, and the case was kept open for seven months. There are no further details recorded. There were then 18 reported contacts with CSC between the initial one through to 2009. The social work assessments during this period all found that LM would not engage with agencies so were unable to progress to positive outcomes.

Liam attended Infant School aged four and upon entry it was apparent from their records that he had a high level of behavioural need. He was found to be disruptive, at times aggressive and frequently swore at pupils and staff. He was referred to a local school based ‘Outreach service’ who supported him throughout his time at the school with bespoke behaviour plans and incentive systems. Liam spent some of his day being supported 1:1 by a member of support staff. He left his infant school at the end of year 2 with continued support.

He attended hospital appointments for treatment and surgery for his Talipes, (more commonly referred to as club foot). This led to some periods of time in a wheelchair. When Liam was 6 years old, he was bitten in the face by a dog and he had a disfiguring scar down his left cheek as a result. Records do not indicate whether it was discussed or considered to be a lack of supervision by family members. Liam was left with an unsightly scar and there were concerns for his mental health and wellbeing. It would appear that he was bullied by his peers, quite badly from this time due not only to his club foot and facial scar, but also the fact that due to an attempt to correct an eye condition he also had to wear for a period an eye patch.

Liam was on the Special Educational Needs (SEN) register for Social Emotional and Mental Health (SEMH) due to his behavioural needs and he required support with fine motor work. He moved to a Junior School and continued to have foot surgery which, as already mentioned left him at times in a wheelchair. At about this time he spent some time living with his grandmother due to domestic abuse at home. His timekeeping was poor and staff at his school raised concerns that he was smoking (aged 7 years).

An initial social work assessment was completed in September 2009 due to the domestic abuse (DA) suffered by LM, who was not engaging with agencies at this time. The Police had a lot of contact with LM due to four reports of domestic abuse perpetrated against her. On one occasion Liam who was aged 7, witnessed his mother being beaten around the head and face by her then partner. The partner also caused significant damage to the flat within which they lived. Neighbours called the police on this occasion, as screaming could be heard from their house. As LM had separated from her abusive partner the case was closed. LM was not allowing the visiting social worker to see Liam. Further social work Initial Assessments and referrals took place for matters

such as Liam smoking, committing crime, going missing from home, and having a verbal dispute with a neighbour.

As an 8-year-old Liam was linked to six incidents of anti-social behaviour and police options were limited at this stage as he was below the age of criminal responsibility. During this period four Children and Young Person's Risk notifications[3] (CYPRs) had been submitted by the Police to Children's Social Care and on one occasion the attending officer recorded on the CYPR that he was in two minds as to whether LM was in a fit state to care for her son as he believed that she was drunk. Liam told the officer that he went out to commit crime after arguing with his mother and wanted to ease his frustration. Liam was linked to several criminal damage incidents within the community and was well known to local people for associating with other children who were involved in anti-social behaviour and crime. He was largely unsupervised. Liam was a small child at the time and the damage he caused was quite significant including smashing windows. LM attributed his behaviour to the number of operations he had had in recent months.

During 2011 there were a further four incidents of crime and anti-social behaviour. Liam was still below the age of criminal responsibility and a CYPR completed. The officer identified concerns regarding LM's parenting capacity and within the CYPR there is a third reference to her drinking or being incapacitated due to a hangover. In the November Liam started to go missing from home and the pattern of him not complying with LM emerged. During this same period Liam was also part of a small group who committed a non-dwelling burglary. The CYPR notification submitted by the police at the time indicated that whilst the home environment did not indicate any neglect in terms of its appearance, LM was unable to set and enforce boundaries for Liam. There were additional concerns that LM was staying out all night drinking and was not supervising Liam. LM was allowing Liam to do what he liked, which she stated to the police officer was for her to have an 'easy life'. An alternative view from professionals at the time was the reason LM acted like this, by giving Liam such freedom was to overcompensate for the domestic abuse and the numerous operations that Liam had experienced. This is now the third CYPR and regardless of why LM was parenting Liam this way, there appears to be no consideration at this stage how this cumulative neglect was impacting on Liam.

2012-2014 (Age 10 to 12yrs old)

In 2012, Liam who had now turned 10, was linked to three incidents of anti-social behaviour. Incidents in this period include him 'waving' a knife at another pupil whilst he was in primary school, threatening to smash windows and threatening to stab people. He also threatened an adult with a screwdriver over a financial debt of £10 and he received a police caution for this.

[3] The CYPR (Child and Young Person Risk notification) was superseded by the PPN1 which is a combined risk assessment incorporating; child at risk, adult at risk and the domestic abuse risk assessment (DASH). This is a national form used by a wide number of police forces.

In 2013 there were 21 incidents of crime and anti-social behaviour, his violence continued including possession of an imitation firearm (a BB gun), assault, theft and criminal damage by arson when he started a fire in the block in which he lived. He was also known to carry a knife. As a result of this continuing behaviour and after a theft allegation the Police identified that intervention was urgently required for him to prevent a further escalation in his behaviour. Liam was referred to the Community Tasking and Co-ordinating Group (CTCG)[4] for discussion. In May 2013, he and his mother signed up to an Acceptable Behaviour Contract (ABC) which is a voluntary agreement to try and engage both him and his mother to make changes in behaviour and this was applicable for 6 months. Although Liam was very young to have an ABC at this age (11 years) it was not that unusual. However, several agencies had started to express their concerns regarding Liam's young age and his propensity to become involved in anti-social behaviour and crime. It was now stated that Liam was beyond parental control and LM was depending on alcohol.

Liam's secondary school records showed a history of poor attendance, almost immediately from attending. As a 12-year-old his attendance was only 37.5%.[5] LM was not proactive or consistent in informing the school regarding the reasons for his absence and Liam would often refuse to attend. He exhibited challenging behaviour with incidents of threatening and abusive language towards staff, his refusal to cooperate, leaving school without permission and causing damage. The school continually tried everything they could to support him, including putting in place a quite detailed behaviour plan. However, Liam was excluded for his extremely disruptive behaviour.

Liam and LM were referred to the Families Matter programme (nationally known at the time as Troubled Families). The family were allocated a family support worker and there were Team around the Family (TAF) meetings to put in place actions to negate the issues they were facing. Some of the concerns raised in one TAF Action Plan was that Liam was also drinking whiskey and had been violent towards LM. His case was regarded as complex and a referral was made to the 'Orchard Centre' the Child and Adolescent Mental Health Services (CAMHS) for assessment. This service was unable to engage with Liam and his mother to fully complete the assessment. In addition, as a part of this plan LM was referred to a parenting group called 'Understanding Behaviour' however it is understood that she did not engage. Liam was also referred by his school to 'Changing Places', however he was permanently excluded shortly after this, so this didn't take place.

2014-2016 (Age 12yrs old to 15yrs old) Foster placement, secure unit, and custody

A week before Liam's 12th birthday he was taken into the Care of the Local Authority and placed in foster care. It is recorded it was for his criminality including drug dealing, arson, criminal damage and assault, his mother had refused to have him return home. He had several placements and many occasions of absconding.

[4] This is a multi-agency Anti-Social Behaviour panel led by the local authority community safety team supported by police and other agencies.

[5] Nationally in 2018/19 secondary school pupil attendance was 94.5%, and unauthorised absence as in Liam's case was in only in 1.8% of secondary school children. (DfE March 2020)

Drug and alcohol abuse continued, and he was spending time when absconding living with adults who were involved in criminality including drug dealing. A Child at Risk notification submitted by the Police outlined concerns that Liam was not appropriately supervised and the adults he was associating with were heavily intoxicated. It soon became apparent that Liam was drug running and was being linked to known drug dealers in Southampton. On one occasion Liam was arrested in the Birmingham area with Class A drugs and cannabis which linked him to an Organised Crime Group (OCG) there. He was linked to 34 incidents of crime and anti-social behaviour that year.

From 12th August 2014 to 24th December 2014 Liam was accommodated in a Secure Unit. He had been convicted of drug dealing offences involving heroin, crack cocaine and cannabis valued at over £3000. Upon his release from the Secure Unit, Liam was placed under Section 20 of the Children's Act 1989[6] and during this time he had 5 Foster Care Placements. He was then moved to a residential Children's home in September 2015 after stabbing another child at school in the arm and the leg. The serious nature of this incident was sufficient grounds for a local case review by the Southampton Youth Justice Management Board. Leading on from this there were numerous absconding episodes and Liam was placed under Police protection after absconding to an address in Bristol. Liam was again committing violent crime, including threatening behaviour with a knife, assaulting a Police Officer, and being found in possession of an offensive weapon.

In November 2015 Liam was again placed into the care of the Local Authority and was placed in Lancashire in a residential home. He remained in this placement for nearly a year. In this period an Interim Care Order[7] and a Full Care Order[8] were granted. This period in Lancashire is seen as probably the most settled period in Liam's life, albeit his offending didn't totally cease

On 18th October 2016 Liam was subject to a secure accommodation Order and placed in a Secure Unit in Bristol for an 8-month Custodial Sentence. He remained in this Secure Unit as a Looked After Child.

Timeframe period for review

Custody and then Birmingham

At the start of the timeframe period for this review Liam was serving an 8-month sentence in the secure unit in Bristol. His behaviour there was extremely challenging and because of this Liam was at serious risk from violence and of being violent to others. He had made threats to kill and posed a real risk to staff and residents. Liam presented

[6] Section 20 of the Children Act 1989 provides the local authority with the power to provide accommodation for children without a court order when they do not have somewhere suitable to live. It is widely known as voluntary accommodation because the parents must agree to the child being accommodated.
[7] At the start of care proceedings, a local authority under Section 38 Children Act (1989) may ask the family court to make a temporary court order, called an 'interim care order'.
[8] The local authority can seek a full care order, under section 31 of the Children Act (1989). This grants the local authority parental responsibility for the child, meaning that it can take decisions for the child and override the wishes of the parents.

at the Looked After Child review as very angry and showed no remorse for a previous attack he had initiated. The Looked After Child care plan created for him summarised some of his history but didn't include some of his relevant adverse childhood experiences, such as experiencing domestic abuse. Liam was described as "beyond his mother's control" and becoming "increasingly embroiled in criminal behaviour".

There were many meetings and discussions by agencies to decide what should happen to Liam upon his release on the 16th February 2017. It is reported that a lack of clarity regarding his resettlement impacted significantly on his release plans and there was a lack of a co-ordinated approach from the partners.

Upon his release he was moved to his next care placement at Solihull Lodge in Birmingham. His time there was equally troublesome with many episodes of violent behaviour. He threatened and assaulted staff, caused damage and often had to be restrained. Liam had to change schools and then for a while had no education placement. Without an education placement Liam was left without a routine during the day. By the end of April, he was regularly assaulting staff and was drinking alcohol and taking drugs again. It is unclear what anger or coping skills work was being undertaken with Liam. This is despite the placement being offered under terms of including therapeutic input. The professionals at the practitioner event were in no doubt that this placement was not the nurturing one they felt Liam needed but a very strict rules-based regime that didn't fit with Liam's needs.

Liam was offered an education placement at Southside Training in May 2017. He passed the interview process and performed well. Liam displayed pride in this and was looking forward to starting. This would have been a particularly good time for immediate intervention to try and make a difference.

A few days later Liam caused substantial damage to his bedroom at Solihull Lodge and the Police were called who gave him a warning. Liam then went missing from his placement and was missing for a substantial period of time. He was eventually located on 22nd June when he was arrested. During this time, he had returned to Southampton as he was assaulted by a gang of youths who had allegedly slashed his back with a knife. He didn't attend hospital.

Liam was constantly going missing and being violent and aggressive. He was arrested for many offences of violence, assaults, drug offences, damage, and breaches of existing Court Orders. He was returning to Southampton on a regular basis and involved in criminal activity believed because of exploitation. On one occasion he had stabbed another youth over a drug supply dispute. When he was arrested, he was found in possession of bags of drugs, a knife and 10 mobile phones. Charges were not made until June 2019.

Specialist Foster Placement Portsmouth

After many more episodes of Liam going missing and getting involved in criminality in Southampton, he moved into specialist foster care in Portsmouth which initially Liam told his social worker he was pleased with as he had always wanted to officially return

to the Southampton area. However, this placement only lasted 11 days as wraps of heroin were found in his bedroom. He had also been breaching his curfew and was clearly involved in drug dealing again.

A Structured Assessment of Violence Risk in Youth (SAVRY) review meeting assessed Liam as being high risk, because he lacked empathy and any remorse for his actions. A new placement out of his local area was being sought. He had made it clear that he planned to keep dealing drugs and had been caught recently with a quantity of drugs and was still involved in violent incidents. A secure placement was now being considered.

Liam was always returned to the placement in Portsmouth, but he went missing on practically a daily basis over the Christmas period, where he was either found by the Police or he returned of his own accord. His activities and the people he was with, provided evidence that he was involved in drug dealing and being exploited. On one occasion he stole cash from the home he was staying at. The Police got to the point where they said they would stop looking for him when he was missing during the daytime as it was the placement home's responsibility, (this was the residential placement's interpretation of the conversation, and is not supported by the Police interpretation, as their guidance states they would look for him whenever he was reported missing. However, they always encourage the reporting agency to conduct their own enquiries.) He went missing several times in early January 2018.

Secure Unit Glasgow

In January 2018 Liam was placed in a Secure Unit in Glasgow where he stayed until June 2018. The level of risk and vulnerability that he now posed within the community was deemed unsustainable for him to be kept safe. The purpose of the placement was to support Liam to better understand and address his offending behaviours, his illegal substance misuse and his regular periods of absconding.

Staff in Glasgow observed that Liam used violence as a means of gaining respect. Following a period of assessment, he was diagnosed with conduct disorder and a programme of interventions focusing on anger management and emotional regulation were identified and delivered by staff at the placement in conjunction with the local Forensic and Adolescent Mental Health Services team.

Whilst in the Secure Unit Liam initiated more than 30 instances of staff assault, peer assault and threats of violence requiring him to be held safely by staff. The precursor to these incidents was often staff challenging Liam's antisocial and pro-criminal attitudes and behaviour.

There were though several positive aspects to Liam's placement. At times, he demonstrated that he could work well with staff and other young people and was appointed as a' Young Persons Champion', which is an advocacy role.

Following a 6-week transition period in which Liam was reintegrated into the community he left the Secure Unit on 1st August 2018 and went to a planned move into a local Stepdown Community Services provision. This was part of the exit strategy from

his secure placement but he chose to go and stay with his friend's mother (LFM) in Lancashire. It is believed he knew this person from his time in his previous placement in Lancashire. He then moved to another placement back in Glasgow and commenced a 5-week labouring programme which Liam said he enjoyed but within 3 weeks of this placement and freedom he went missing again. He caused damage and was threatening again for which he was arrested and charged.

Liam had stopped taking his Attention Deficit Hyperactivity Disorder (ADHD) medication which the professionals that worked with him said impacted on his compulsions, mood and volatility and had reverted to alcohol and substance misuse which increased all the risks for him. The review has been unable to ascertain exactly when Liam's diagnosis of ADHD had taken place or if in fact that Liam had an actual diagnosis, but ADHD is mentioned from an early age in all records held by agencies.

Lancashire

Liam was now regularly going missing and returned often to Lancashire (as already stated earlier in this report, this was a place where it appears, he had been most settled in his life). In October he went missing for several weeks and eventually handed himself in to the police stating he did not want to live in Scotland anymore and preferred Lancashire. The local police allowed Liam to remain with LFM (a friend's mother) in Lancashire after undertaking their own checks, but this was not in agreement with Southampton Children Services who wanted to return him to Glasgow.

A statutory visit to Liam took place by a Social Worker, and Liam appeared happy with his new living arrangements and LFM said she was happy to keep Liam with her until he had found a long-term placement. Liam said that making friends in Scotland had been hard and he had built up a drug debt of £200 by taking small bits of cannabis regularly. He had also been threatened. Liam stated that going to a secure unit had "sorted him right out", and he had really liked the staff in his subsequent placement.

By the end of November, the Sexual Exploitation Risk Assessment Framework (SERAF) updated that Liam's risk level was assessed as "medium" and he was still staying with his mother's friend in Lancashire. The assessment stated that he was not displaying any rude or aggressive behaviour. The accommodation had been seen by his Social Worker and assessed as appropriate in the short term. A longer-term placement was being sought for Liam locally to where he was currently living and he had applied for a painting and decorating apprenticeship, which he had wanted for a long time. Professionals that worked with him said he always told them that he was keen to learn a trade. Liam declined a residential placement due to concerns that this would tempt him back into using and selling drugs.

Southampton Local Authority tried to regulate his current placement with a Friends and Family Fostering assessment, however the carer (LFM) withdrew the application for a connected person's assessment. LFM informed the Friends and Family Fostering service that she could not be considered as a Foster Carer for Liam due to the responsibilities that would be required of her. Liam was not adhering to the household rules of his

current placement and this had undermined the placement and the relationship between Liam and her.

By January 2019 Liam started to go absent again but was working with a 'Stepping Stone' a local support service worker and declared that he wanted his own accommodation. He was returning to Southampton and on one occasion went to his mother's home and attacked her partner with a bladed article. LM reported that Liam was not welcome at her home. A High-Risk Domestic Abuse (HRDA) referral was made by the police.

Liam was provided with alternative accommodation in Lancashire and moved in with support by 'Stepping Stones'. A worker visited and found a blue pill and a small Nokia phone in her car after Liam had been a passenger in it. This was in late February and appeared to evidence that Liam was involved in drug dealing again since moving back to Lancashire.

The Southampton (Missing, Exploitation and Trafficking) MET Hub Operational Group assessed that Liam remained at a moderate risk of exploitation. It doesn't appear that there was information sharing by 'Stepping Stones' with Lancashire Police. Liam was very vulnerable living in independent accommodation, and it was unlikely that anyone would be able to report him missing unless he was missing for a considerable period of time.

On the 15th March a statutory visit was made to Liam at his flat from his allocated Social Worker. Liam spoke about his time in care and spoke negatively about his experiences of being taken into care and shared stories about unhappy times living with foster carers. He spoke about wanting to return to Southampton now that his Criminal Behaviour Order had expired as he had lots of friends and family in that area who he hadn't seen for a long time. He stated that he had lived all over the country but nowhere felt like home. He was encouraged not to return to Southampton due to the negative peer influences that would be there, but Liam did not agree with this.

Liam was provided with a Personal Advisor and in May he declared that he was using cocaine and intimated that he was dealing to fund his habit. He was asked if he was using other young people to distribute his drugs and admitted that he was and uses "youngers" to do this. It was pointed out to him that this was the same exploitation that he had experienced himself and it was morally and criminally wrong. Liam said that he "treated them well" and did not recognise that he was exploited nor was he exploiting others as he "looks after them". He was still talking about returning to Southampton.

Southampton

On 28th May 2019 Liam was returned to the care of his mother LM under a placement with parents' regulations. Although his SW tried hard to convince him not to return, Liam was extremely keen to do so. His love bond with his mother was strong. Throughout this period back living with LM he was regularly missing and absconding. He had outstanding criminal charges and an allocated Social Worker and a Personal

Advisor as part of a plan to build a positive relationship for him as he prepared for adulthood. The local Youth Offending Service (YOS) in Southampton were not proactively informed of his return to Southampton.

Liam was arrested for possession of an imitation firearm with intent to cause fear of violence on the 4th of June. After legal advice he gave a "no comment" interview but explained the incident outside of the interview. He said that he was given a gas BB gun by a friend because he wanted to "defend the house" from an ex-girlfriend's brothers who she had threatened to send round. Some damage was also caused to the door of LM's home with spray paint, it was believed that Liam's ex-girlfriend was responsible. Liam had been in a heightened state at home, and LM's boyfriend shouted at him to calm down and with that Liam responded by pointing the BB gun at him, which prompted him to call the Police. Liam was released with no further action as LM corroborated what he had said. No gun or imitation firearm was located however due to the fact he pointed the gun towards LM's boyfriend causing him to fear violence it was reclassified to Common Assault

Further to this Liam posted a video of a girl naked onto his Snapchat account. The video was 30 seconds long and identified her. This led to the girl receiving communications from several men which caused her stress and anxiety. Liam was circulated as a suspect and arrested a few weeks later for disclosing private sexual photographs/film with the intent to cause distress. No charges were made due to evidential difficulties with accessing the technology and a witness that did not wish to provide an account.

Liam's involvement in violence and gang rivalry heightened alarmingly in Southampton. He was seen in possession of a large red handled kitchen knife outside some shops and was arrested for this. A red handled kitchen knife was later located in the bushes near to where he had been seen. As Liam denied the offence fingerprints were sent off for analysis but lengthy delays meant Liam had died before these results were received.

When Liam attended court in Glasgow at the end of June. Liam declined shared accommodation that was being offered by his SW. He stated that he wanted to continue living with LM, and the accommodation on offer would make him feel alone. Liam was still not taking his prescribed ADHD medication, preferring to use cannabis, and was not registered with a GP. The increased risks associated with living with LM and the lack of boundaries is identified in the reports.

Throughout the summer months there were many instances of Liam being seen out on the streets of Southampton and on social media holding knives. He was also not at home and staying at a girlfriend's flat. He was linked to a robbery and a stabbing both involving gangs.

Some three months after Liam left his placement in Lancashire his personal belongings were collected. Fourteen wraps of a brown substance were found within his clothing which was further evidence of his drug dealing. Liam was arrested and released without

charge pending fingerprint analysis, but Liam had died before the results were received. It needs to be noted that both YOS and his SW requested that the local police come and pick up the drugs, but they were advised to flush them down the toilet. Only when the YOS Manager escalated this to the local Chief Inspector did the police come to collect the drugs and send them off for the fingerprint analysis.

Liam's violence was becoming extreme and he was involved in fights with many young men wearing balaclavas or hoods covering their faces, running through the streets in possession of knives and other weapons. Liam had also allegedly shot another youth with a taser gun. Liam was now considered as one of the main instigators of the rival gang violence but was also drawing the attention of the wider criminal scene putting himself in extreme danger.

The Southampton Police High Harm Team were assigned Liam to assist partner agencies in monitoring him to try to curb his offending. Managing Liam as a MAPPA offender was also considered, although in essence he did fit the criteria, a decision was made by a senior officer with a differing view, that this method of management would not be used. The plan was to deal with any offences robustly and to make sure they were always monitored including ongoing investigations and ensuring that all enquiries were completed. Shortly after this he was arrested and charged regarding vehicle interference, but was also involved in an incident where a female was assaulted and he was seen holding a knife but there is no record that he was spoken to about this incident.

A further Pathway Plan for Liam was started on 4th November the plan was to continue attempts to get him to engage with services to reduce risk and promote the achievement of his aspirations. His criminal activities were now of grave concern regarding his own and other's safety. Liam had not been complying with his Youth Offending order nor engaging with his social worker. He was rarely at home, despite this being his agreed placement, and little was known about his whereabouts. By the end of the month Liam was in court facing charges of attempt robbery, GBH with intent and possession of bladed articles. On the date that the professionals meeting was set by the Youth Offending Service (YOS) no other agency turned up for it and it had to be rearranged. The rearranged meeting did take place, but nothing was decided, and another meeting was arranged some two months later and after Liam had died.

Information was becoming known that Liam had stabbed a rival gang member in 2015 and was in real danger of repercussions for this. He was mainly "sofa surfing" now and avoided going to LM's home as he feared for his safety in that area. However, on Christmas Eve he was at her home as he was involved in a verbal altercation with LM's partner and Liam punched him in the face and cut him with a bladed implement. He was arrested but not charged, although a decision was made after his release to charge him. Although clear many years before this, into 2020 it became clear to professionals that Liam was selling drugs and was involved in 'County Lines'.

Liam was arrested on 14th January 2020 and released again and was supported in attending an interview at a local Housing provider and offered an emergency bed. Liam took up the offer of this accommodation, which was local to Southampton, and could offer him an independence and living skills support package and would have been part of the plan to help and support him as he approached adulthood. Sadly, this never happened. The emergency bed was at a YMCA which was deemed unsuitable by YOS which appears to be the right decision, Liam also declined it, because there were no basic amenities in his room, for example no bedsheets available upon his arrival, so he was homeless again.

On 19th January 2020 Liam was fatally stabbed in the chest and died in hospital the same day.

4. Analysis of significant safeguarding events (why things happened)

The review author fully appreciates that the life story as portrayed in the previous pages of this report may come across to some readers as containing a lot of detail. However, this is the story of Liam's extremely complex and troubled childhood. This complexity must have been very difficult for him and his family to live through, at the same time also extremely difficult for those professionals to engage with him and try and put in place interventions to mitigate all of the risks that were happening for Liam. As already mentioned within this report, professionals who knew Liam at the practitioner event were keen to express a very different side to him. They stated that he was lovely young person who was witty, charismatic, and insightful beyond his years.

This analysis includes where possible the responses to the request for information made to each agency. It also takes account of the specific requirements of the terms of reference. These specific terms of reference learning outcomes for the review are best broken down into two clear analysis themes and these are outlined in the box below.

Analysis Themes

1) Individual to Liam and his life story

a) To gain an understanding of the factors in a child's life that might make them vulnerable to a life-ending event (including being a Looked After Child and Adverse Childhood Experiences).

b) How well were family members engaged in the joint protection and management of risk, given the placement at home.

c) To understand the impact of serious violence upon affected parties and ensure effective responses to support this in practice.

d) To understand the impact on a child of missing education, educational neglect, not being in employment or training, and how a child with multiple vulnerabilities can be re-engaged with education/training and employment.

2) Strategic and systems based specific to the Safeguarding Partnership

a) To ascertain whether we have effective partnership analysis, data collection, mapping of Child Criminal Exploitation (CCE) networks and areas of risk that consider 'County Lines' and more localised exploitation.

b) To gain an understanding of the strategic direction for tackling offending/the criminal exploitation of children and young people within the city of Southampton and vulnerable adolescents.

c) To gain an understanding of what services and support were provided, to inform what might work for others in the future to prevent the same outcome. Also, to understand how effective services were, and any barriers.

d) To understand the time frames for a child suspect under investigation for criminal offences and if necessary, affect change nationally in relation to this.

1) Individual to Liam and his life story

a) To gain an understanding of the **factors in a child's life that might make them vulnerable to a life-ending event** (including being a Looked After Child and **Adverse Childhood Experiences).**

Liam spent almost six years in the care of Southampton Local Authority. During this period numerous different placement strategies were tried to reduce the risks to him and by him to others. He spent time in various foster homes, residential care, home with mother, placed with a friend's mother, welfare secure on two occasions and custody. However not one of these placements were able to prevent these risks taking place and escalating.

There appeared to be no consistent plan recorded of what support and interventions were necessary to reduce the risk for Liam, upon his release from the secure unit was to be provided, or by whom. There is no real detail within the management oversight on 19th July 2018 about how this would be achieved. The transition plan provided by the Step-Down placement on 16th July does not include any details regarding these needs either. His social worker was quite clear that he did need a therapeutic placement to help him move forward.

When the blue pill and mobile phone was found in the workers car after Liam had been given a lift, concerns should have been heightened. This was evidence that Liam may be involved in drug running and dealing again since moving back to Lancashire. There is no information regarding this being shared, and it is unclear if the Lancashire Police were informed of the potential intelligence. The MET Hub inquired into this and found that the information had not been shared so requested that this happened.

The statutory Looked After Child reviews were found to be at times outside of the relevant timescales. This included a lack of the statutory Looked After Child health reviews for Liam. The Pathways policy about visiting young people was not always followed. This could be understood due to the distance away from Southampton of his placements. Another reason for a couple of the delays was that his Independent Reviewing Officer (IRO) was once sick and on another occasion on leave, so it was felt best to delay them until the IRO returned.

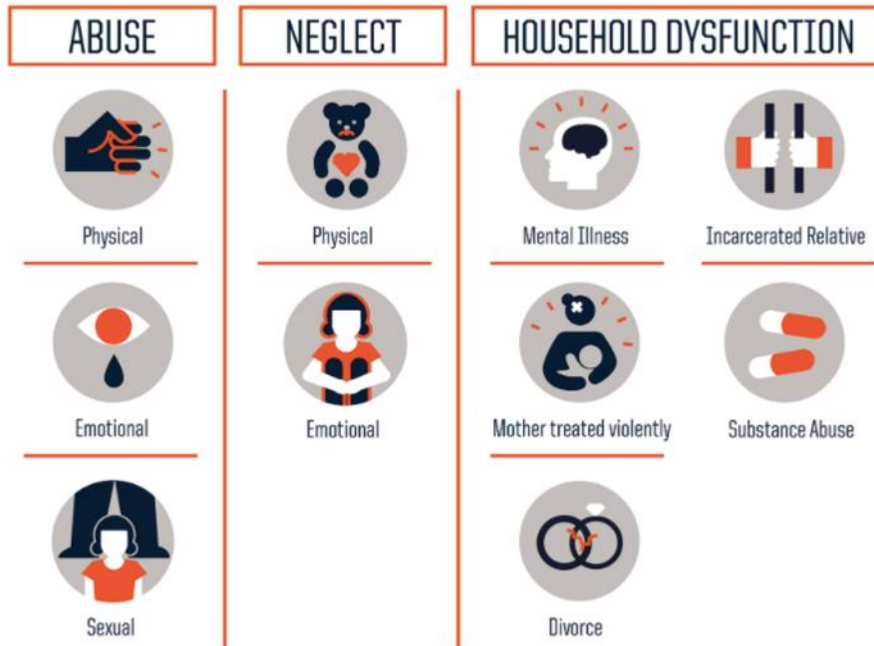
It took three months for Liam's belongings to be collected from his previous placement in Lancashire and discover the hidden drugs and evidence of drug dealing. It could have made a difference to decision making about Liam staying with LM in Southampton if it was known that Liam was dealing and storing drugs at his placement.

After a joint visit by his social worker and YOS worker to Liam in April 2019 there were clear warning signs concerning drug taking, alcohol consumption and a lack of food in the property. It is also concerning how Liam was paying for the drugs and alcohol and who his "friends" were. None of this seems to have been explored by professionals both with him and with other professionals in any great depth or with professional curiosity.

Adverse Childhood Experiences

The term 'Adverse Childhood Experiences[9]' is credited to Dr Vincent Filletti who carried out a study in the United States of over 17,000 people in the 1980's. His study was the first to identify the relationship between experiences in childhood and problems with health and social integration throughout a lifetime. His identified ten ACEs are:

[9] The ACE Score https://www.adversechildhoodexperiences.org.uk/



There is no doubt that Liam experienced multiple ACEs, for example:

- **Sexual Abuse** -There is no information that Liam was ever a victim of sexual abuse, but at a very young age it was recorded by his school that he was displaying sexually explicit behaviour. He also posted on social media the video of a naked girl.
- **Physical Abuse** -Liam witnessed acts of violence on his mother from an early age and personally experienced physical abuse from others. On numerous occasions he was the person carrying out the physical abuse as evidenced by his arrest and conviction record, meaning that he experienced several violent and physical confrontations.
- **Neglect both emotional and physical -**Liam had a troubled childhood and due to his mother's parenting skills experienced high level cumulative neglect at a young age. He became a Looked After Child for almost the rest of his childhood. His periods of being missing from the relative safety of his home saw him faced with neglect too.
- **Mental illness -**The review author has no information in relation to whether Liam's mother or any other relatives had any mental health issues, but Liam was on the SEN register as a child for Social, Emotional and Mental Health (SEMH) due to his behavioural needs. He was also referred to CAMHS for assessment and was later diagnosed with conduct disorder.
- **Divorce** -Liam's father left when Liam was very young, so his parents were clearly separated.
- **Domestic Abuse** -Liam witnessed horrendous domestic abuse on his mother and was also the perpetrator (post 16yrs) of it against her partners.
- **Substance misuse** - There were concerns that LM was staying out all night drinking and due to hangovers was not supervising Liam. Liam himself was misusing controlled

drugs from a very early age and throughout his life. There is also mention in the records that he was misusing alcohol from a very young age as well.

- **Parent Incarceration** -Although not parental Liam himself spent time in both custody and secure environments.

It is clear from the above analysis that Liam experienced several ACEs, from which he was very strongly affected by. Early on in his life he suffered neglect through the limited boundaries he followed, the domestic abuse in the home, and the missing from home periods, appear to have strongly impacted on him and his future behaviour and life choices.

The review author is also unable to quantify from the reports he received, in relation to the treatment and surgery for Liam's Talipes, and the scarring to his face from the dog bite had as an emotional impact on him. These were though, undoubtably, also adverse childhood experiences that he had to cope with. Professionals at the practitioner event were keen to stress that the scar and the club foot had a profound and traumatic effect on him. He was subject to at times an extreme level of bullying by peers. They were also keen to stress about the effects of the trauma he experienced in relation to domestic abuse. Liam had witnessed significant domestic abuse towards his mother at home. It was felt by them that the effect this had on Liam was not fully acknowledged, and that the response to domestic violence at this time should have been timelier and more robust. Liam had explained to a professional that he had felt vulnerable and powerless to protect his mother, and that he'd never allow himself to be in that position again. A professional told the practitioner event that they had asked Liam why he felt he always needed to be "top dog", and he had explained that it was because of what had happened to LM. He also talked about his scar and said this was the first thing people saw of him and he needed to live up to it.

There may have been moments in his life when Liam might have been amenable to make changes to his behaviour and lifestyle. Some people call this moment a 'reachable moment', or in Education a 'teachable moment'. In the National Child Safeguarding practice review panel's report on safeguarding children at risk from criminal exploitation (March 2020) calls this a 'critical moment'.

> *'There is a concept in systemic theory literature described as a critical moment which changes social worlds. Systemic therapists promote the importance of acting wisely to identify when the words used at a particular critical moment can have a powerful influence on the direction taken after the conversation has ended. In a similar vein, the notion of the teachable moment is well established in education, youth offending and health sectors*.[10]'

Liam's first placement in Lancashire was for almost 12 months this was a period when Liam appeared happy and appeared positive about his future. This was a reachable moment. He had a settled team working with him, both from Southampton (YOS, social

[10] The child safeguarding practice review panel (March 2020) It was hard to escape' Safeguarding children at risk from criminal exploitation.

worker and Virtual school) as well as professionals in Lancashire which included those in YOS assisting with caretaking arrangements. The home also had for him, probably for the first time, some positive male role models, who had a nurturing culture.

The review author believes that another of these ‘reachable moments’ for Liam did occur firstly whilst in secure in Glasgow and then following this a placement in Glasgow where he commenced a 5-week labouring programme. This is supported by comments from his social worker, although Liam at first struggled in Glasgow almost two thirds of his time there though was mostly stable and a period of his life where professionals were able to engage with him better. Liam ‘enjoyed’ the programme and the freedom it gave him but after 3 weeks of it he had lapsed back to violent ways again.

The review author is not able to state exactly why professionals were not able to fully capitalise on these two example periods as ‘reachable moments’ in his life, and able to alter the events that came after it. However, the distance for professionals from Southampton to travel to Glasgow and Lancashire would put up barriers for this, as did the time for local professionals to work closely with him. Liam faced a degree of self-isolation within his residential placements and re-engaging with his family are perhaps other reasons that made this difficult to achieve. Possibly the main one though is need for Liam to work through the trauma he suffered as a younger child before he was able to move his life forward. A number of professionals feel that a crucial time to help Liam was these early years of his life, and ask if they could have done a lot more then to support him, through a better understanding of his daily lived experience and the cumulative impact of traumatic events in Liam’s life.

It is also clear that trying to support Liam’s health needs due to his mobility across the country, meant that it was difficult to complete and monitor satisfactorily his health and wellbeing needs.

Although Liam did have some Looked After Child Health reviews, in general, it can be seen from his health records that he regularly missed these statutory health reviews. He would also be referred to have specialist medical reviews, but he would be missing, or moved at the time of the appointments. There was some contact from Liam himself requesting reviews of medical conditions however again; these were often not followed up by the Looked After Child health teams or his social worker or as should have happened challenged by his Independent Reviewing Officer. This was possibly due to him moving around and the complication of needing to re-register at different GP practices.

It was also noted in records difficulties in getting Liam ADHD medication, (as previously stated within this report it is unknown when and if he had a diagnosis for ADHD). This difficulty might be due to lack of knowledge from carers working with Liam. Often, they were going to the GP who would then point them to local CAMHS services; this would have made it difficult for both Liam and his care workers to provide what he needed, and delayed getting medication when he asked, which could have affected Liam wanting to take the medications, bearing in mind his preference to use cannabis as it made him feel more like himself.

b) How well were **family members engaged in the joint protection and management of risk**, in particular involving the placement at home.

Early in Liam's life, professionals became aware that LM was not able to support them in managing the risk that Liam was posing to himself and also by others. They did try various strategies, but LM was not able to set any boundaries for him or to enforce the ones that professionals tried to put in place.

Another strategy they tried was Liam and LM being referred to the Families Matter programme (nationally known at the time as Troubled Families). The family were allocated a family support worker and there were Team around the Family (TAF) meetings to put in place actions to negate the issues they were facing. This also didn't seem to make a difference in supporting LM's parenting or Liam's behaviour.

The review author feels that the taking of Liam into care was the right decision as they quite correctly felt that family members were unable to keep Liam safe. However, a better route for Liam and his mother may have been to go from the voluntary TAF (Early Help) with the in-between support options of Children Services led Child In Need plan and Child Protection plan, and even PLO (Care Proceedings) prior to accommodating him. Using this more traditional route might have put in place a number of interventions one more of which might have been successful.

In early November 2018 when Liam moved in with his friend's mother LFM, this was for a short period of time when Liam appeared happy and was positive about his future. He was seen to be emotional and this was an opportunity for professionals to provide a more robust intervention package with this friend's family, for Liam to endeavour to achieve some change. Another visit saw him happy and opening up about how he felt, but nothing happened to explore what was required to ensure that Liam had access to interventions that would make a difference. No strategy discussion or multi-agency planning meeting occurred either, that could have developed suitable actions.

When Liam came back to live with LM his social worker and others were not at all keen on this happening due to their feeling that she would be unable to manage his risk. There did not appear to be a plan created with LM for her to commit to, to keep Liam safe. It also involved LM giving Liam the other element of his weekly allowance and therefore, if this didn't happen it was probable that Liam would just be expected to live on less income and resort back to illegal ways of earning money to fund his substance use and day-to-day necessities. Given LM's inconsistent engagement and her availability to Liam, was this a reasonable placement to assume that she would consistently manage his risk to both himself and others?

c) To understand the **impact of serious violence upon affected parties** and ensure effective responses to support this in practice.

After the serious assault committed by Liam in September 2015 and in view of his criminal history a Critical Learning Review was requested by the Southampton YOS Management Board and finalised on 1st April 2016.

Recommendations were as follows:

- The YOS Safeguarding Protocol should be amended to include guidance on the joint management of cases where there is a risk to self / public.
- In the future, for similar cases there should be a co-ordinated management plan to minimise the likelihood of further offending or absconding behaviour. This plan should involve the YOS, police, responsible Children's Services team, and the residential provider. There should also be discussion, as appropriate, regarding the remittal of offences to the youth court nearest to placement, to minimise the risks for young people who may abscond whist in Southampton.
- The Principal Officer for Core and Specialist Services should review the care plan for Liam. It will be essential any plan to return Liam to his mother's care involves YOS and the Police as active contributors to manage risk.
- Increasing staff awareness of the impact of domestic abuse is a priority across the Local Authority. For staff in the Youth Offending Service and Families Matter, there is now an opportunity to use the LINX programme to respond to the needs of young people affected. The LINX programme should be promoted by managers across the service and its delivery should be embedded into the 'core offer'.
- Southampton Youth Offending Service has now undertaken two critical learning reviews where anti-social behaviour trends have begun at around age 8, two years before the formal age of criminal responsibility. Both young people became prolific young offenders who used a high degree of violence in their crimes. I recommend that there is discussion about whether local authority and police data be used more effectively to identify the young people at most risk of offending and to allocate resources accordingly.
- A logical progression from tracking would be to ensure that relevant cases are highlighted for intervention within the locality support arrangements (locality teams, community hubs and / or community tasking and co-ordination meetings).
- The YOS management team should ensure that learning from the critical learning review is embedded into staff practice discussion and reflective supervision. YOS managers should ensure that there is a clear, consistent dialogue between YOS case managers and the Police Officer regarding managing risk.
- Police understanding of out of court processes should be strengthened by the YOS Police Officer briefing local Police colleagues
- Youth Offending Service to contribute to the In Year Fair Access Panel. This offers an opportunity for YOS support to be included as part of an overall package of support for young people exhibiting challenging behaviours.
- Southampton Youth Justice Partnership to explore the possibility of a problem-solving court approach to respond to cases where there are non-compliance issues, alongside serious or persistent offending.

The critical learning review proposed some insightful recommendations but it is of concern that after the Critical Learning Review documentation, recommendations and associated chronology were sent to a number of key partnerships leads, the only person who said they were aware of it was the YOS Manager, this awareness though wasn't until after Liam's death, when a colleague highlighted it to him. This does tend to suggest that the recommendations were not reviewed and evaluated on a multi-agency basis for operational effectiveness. Some of the recommendations were actioned, for example Liam's care plan was altered, but not all the recommendations were actioned. The practitioner learning event supported this view that a wider and informed circulation of the learning did not occur. A good initiative to resolve this issue and increase partnership learning is for all relevant Critical Learning Reviews to be shared with the Southampton CSPR sub-group.

When the imitation firearm incident occurred, there is nothing recorded to indicate that the Police Officers attending provided safeguarding advice and following the standard risk assessment to the domestic abuse element of the Public Protection Notice (PPN1) there was no onward referral to a specialist supporting agency. The attending Police Officer had to be prompted by the Multi-Agency Safeguarding Hub (MASH) to complete the child concern section of the PPN1 regarding Liam. Liam was the perpetrator but nonetheless was still a child, and the impact of him carrying out the threat of serious violence was high.

In 2019 the Southampton Police High Harm Team were assigned Liam to assist partner agencies in monitoring him to try to curb his offending including him committing serious violence. Managing Liam as a MAPPA[11] offender was also considered. The review author questions why he was only considered and did not become a MAPPA offender or managed in a similar format. Offenders under 18 are subject to the same procedures as other MAPPA offenders if additional considerations apply. The High Harm team's plan was to *'deal with any offences committed by Liam robustly and to make sure they were monitored at all times including ongoing investigations and ensuring that all enquiries were completed'*. This doesn't appear to have occurred with the serious outstanding matters taking far too long to be expedited. Similarly, there was an incident where a female was assaulted at a party and Liam was present holding a knife, which he pointed and then drew down his leg, but he was never spoken to about this by the Police. This incident was only two weeks after the 'robust' plan was set up.

d) To understand the **impact on a child of missing education**, educational neglect, **not being in employment or training**, and how a child with multiple vulnerabilities can be re-engaged with education/training and employment.

When Liam attended primary school, it is recorded that he had a high level of behavioural need. They found him to be disruptive, at times aggressive and frequently swore at pupils and staff. He is believed but unconfirmed by the examination of his records, that Liam was diagnosed early on in his life with ADHD. The school tried

[11] The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders

incredibly hard to support Liam throughout his time at this school with bespoke behaviour plans and incentive systems. He left at the end of year 6 having had a period of good attendance but needed continued support. LM didn't apply for a secondary school so was allocated a school with difficulties. The virtual school team managed to change this and managed to place him in an OFSTED rated good secondary school.

Following his time in primary school, Liam appeared to have comparatively very little time in Education. When he attended secondary school his school records showed a history of poor attendance. As a 12-year-old his attendance was only 37.5%. He exhibited challenging behaviour with incidents of threatening and abusive language towards staff, his refusal to cooperate, leaving school without permission and causing damage. He was excluded for this extremely disruptive behaviour. Even though the school had to exclude him, they found Liam to be an engaging child, and often asked the virtual school staff how he was doing. Liam then attended the Southampton Pupil Referral Unit; this was a period that he had a bad experience in, due to Liam feeling he was bullied by other pupils, some of whom were exhibiting issues in relation to serious youth violence

Very little is then known about Liam being involved in any periods of meaningful and consistent education. To compound things, he did move around to different placements in various areas of the country including time in custody and secure accommodation which tried to provide him with some education.

Whilst in Birmingham aged 15 years Liam had to change schools and then had no education placement. Without an education placement amongst other concerns it left Liam without a routine during the day.

Liam was offered an education placement at Southside Training in May 2017. He passed the interview process and performed well. Liam displayed pride in this and was looking forward to starting. This would have been a particularly good time for immediate intervention to try and make a difference. This never happened though as due to his behaviour in the residential home he was moved to a placement in Portsmouth.

There were also periods of stability for Liam where interventions may have capitalised on his more reflective frame of mind and renewed interest in engaging in employment and training. The focus of the care planning for Liam was on his accommodation and secondly his education and in particular did not address the underlying issues that drove his use of substances and vulnerability to exploitation.

Educational exclusion may well only have served to have added to Liam's exposure to a criminal gang. Liam's exclusion in secondary school appear to have happened during times where he was not receiving support for his Social, Emotional and Mental Health, like he was registered for and had in Primary School. An educational health care plan (EHCP) application was declined, even though Liam was believed by professionals to be suffering with ADHD and was clearly struggling at school. The declining for an educational health care plan assessment may have been appropriate, as a medical diagnosis in itself does not mean that an EHCP assessment will be agreed, however, this should have been challenged by the professionals working with Liam, such as his social

worker, and the Looked After Child team, including his Look after Child health team, and the virtual school head. The lack of challenge around this suggests little understanding of what an EHCP might have provided for Liam.

It is clear that parental engagement by LM with the schools was not satisfactory with LM often covering up for Liam's non-attendance. When he was excluded were these decisions made subjectively and in the best interest of Liam at the time? Were there alternative considerations made in looking at the risks associated with excluding him from mainstream education? Being in education is seen as a safe place for young people to be, and any efforts to prevent exclusion where possible would be a good preventative move. Although the review author fully understands why some exclusions took place with the overarching need to safeguard other pupils and staff from the behaviour of a child like Liam, educational exclusions are often a bad thing for that individual child.

2) Strategic and systems based specific to the Safeguarding Partnership

The next three sections are probably best answered together as they seem to be linked together to provide an effective answer to them.

a) To ascertain whether we have effective partnership analysis, data collection, mapping **of Child Criminal Exploitation (CCE)** networks and **areas of risk that consider 'County Lines'** and more localised exploitation.
b) To gain an understanding of the **strategic direction for tackling offending/the criminal exploitation of children and young people** within the city of Southampton and vulnerable adolescents.
c) To gain an understanding of what services and support were provided, to **inform what might work for others in the future to prevent the same outcome**. Also, to understand how effective services were, and any barriers.

Southampton Local Safeguarding Children Board (the LSCB was in place at this time before it became the SSCP in 2019) conducted a mock Joint Targeted Area Inspection (JTAI) focussing on; 'children associated with gangs and at risk of criminal exploitation, child sexual exploitation and children missing from home, care or education'. Eight young people aged between 15 to 17 aligned with inspection requirements were selected, this in fact included Liam. Liam completely hit all four of the JTAI themes which were; having missing episodes, being criminally exploited, CSE and being involved with gangs and most of the additional themes were also partially met. At the conclusion of the JTAI the partnership held workshops for professionals. The findings were also fed into the MET Strategic Group and were used to update the MET Action Plan. It was also agreed by the partnership to arrange training for multi-agency staff based on the issues raised in the JTAI. In relation to the individual learning from the JTAI for Liam it is not evident to the review author that this was fed into any actions to intervene and directly support him.

In October 2017 Southampton transformed its Child Sexual Exploitation (CSE) Hub into its current Missing, Exploitation and Trafficking (MET) Hub. The team's role is to undertake missing person return interviews and deliver direct work to young people who are at risk of exploitation. Its policy is that *'every Southampton young person (under 18) who is reported missing will be offered a return interview which is an opportunity to*

meet with a MET Hub worker and talk to them about why they went missing and help them think about what could help them to keep them safe and reduce further missing episodes.' The lack of return interviews is highlighted by a unit case audit in 2018. One reason that Liam had a lack of return interviews might be because Liam was not seen as a 'Southampton young person' as he was living in other areas at the time. A system needs to be put in place by Southampton for the respective hubs to share information so that these opportunities are not missed.

There was a Case Audit undertaken by the MET Hub Team Manager towards the end of 2018 to look at the recordings around Liam's missing episodes. It was not clear from records if any formal strategy discussions ever took place between the Police and Children's Services when Liam was missing for more than 7 days (there were 13 in total). There was no evidence of a multi-agency meeting despite more than "3 in 90 days" missing episodes. Of the 9 missing episodes in a 6-month period, 5 were not recorded as missing episodes within children services records and therefore were not easily identifiable within case recordings. An audit finding is that children's records were not being updated. There is no clear evidence of statutory return interviews being offered by children services on these 5 occasions and there is only evidence of one Return Interview being offered to Liam out of these 9 occasions. The last Looked After Child review in October 2018 clearly refers to missing episodes and Return Interviews procedures needed to be followed by social workers. This audit highlighted the many issues identified within the responses to Liam's repeated missing episodes.

The Department for Education (DfE) 'Statutory guidance on children who run away or go missing from home or care' makes it a requirement that when a missing child is found, they must be offered an independent return interview by the Local Authority. The review author supports the findings of the MET audit and has seen very little evidence that these return home interviews took place on a regular basis and even if they did take place, what positive action took place following them. The review authors' view is that more importance should be placed on the carrying out of the interviews and the value of completing them for the child themselves and any information they can also offer to safeguard themselves and others. The same thoughts equally apply for the carrying out of the police safe and well checks in a consistent manner. Hampshire Police have highlighted that the College of Policing Approved professional Practice (APP) states that: *'The police have a responsibility to ensure that the returning person is safe and well. The purpose of the prevention interview is to identify any ongoing risk or factors which may contribute to the person going missing again. Prevention interviews should therefore be carried out in all high-risk cases but should also be considered for no apparent risk (absent), low and medium cases. The interview provides a valuable opportunity to find out useful information that may indicate harm suffered by the returning person.'* Although safe and well checks were carried out there is no record any information from the safe and well checks being recorded by his social worker or any other local agencies.

There was good practice by the Emergency Department staff who recognised the risk to Liam on the two occasions of assault when he attended hospital and they appropriately raised their concerns. The Police were also involved on these two occasions.

There are examples where information sharing with the MET hub could be improved. The information about Liam now exploiting children should have been passed to the Missing, Exploitation and Trafficking (MET) Hub and local Police as intelligence.

If Children's Services had been made aware that further children were being exploited by Liam and a planning meeting would have been appropriate. The SERAF should also have been updated if it had not been done before as Liam was now exploiting others in the same way he was exploited. Liam had no insight into the impact of this on those children due to his view that he was treating them well. A few days before this Liam was seen by a support worker with some electronic scales, but this information wasn't shared either.

Liam attended Glasgow Sherriff Court in early June 2019 for outstanding assault charges. YOS were not aware of this because the social worker had not advised YOS of the offending behaviour of children outside of the YOS area. Liam also went to Glasgow alone on a train. There are obvious safeguarding risks in allowing this, given concerns that Liam had offended in cities that his train would be passing through and Liam was at risk of reoffending and vulnerable to those exploiting him through County Lines.

Further learning in relation to information sharing is that different agencies have different perceptions of the value and weight of information. This is evidenced in Liam's case through a report from the mock JTAI.
'*Agencies accounts of Liam's experience and behaviour whilst in secure accommodation differ considerably. The MET Hub states that 'it does appear that this period in secure is allowing Liam to begin to engage with the intervention available to him'. These sound quite positive decisions on his part. The Police account says that while in secure accommodation Liam has been wearing expensive Italian designer trainers (starting at £450), says he is in a gang, has been 'barking like a dog and getting into fights' and that 'his working relationship with his social worker has broken down and he is refusing education. He has not spoken to his mum in 3 weeks; he is upset with her due to her agreement with civil secure application'.*

Shortly before Liam's death he was offered emergency accommodation in the YMCA premises. The Personal Advisor stated that the accommodation offered to Liam was sub-standard and this would contribute to the likelihood that Liam would not remain there. The YMCA was also only one of a few accommodation providers available locally but was highlighted as an address of concern and raised by YOS as a previous offending hotspot on multiple occasions. Learning for commissioners of placements for similar young people is not just to find them accommodation for the night, but to ensure it is safe for a child to be placed in.

Southampton City Council have now created the Southampton Violence Reduction Unit (VRU) to tackle the problem of serious violence. The unit have completed a Problem Profile of Most Serious Violence in Southampton (2019) and by way of a response developed the Serious Violence Response Strategy 2020 – 2025. It is too early for the review author to comment on any success yet, but this is clearly a positive way forward to face the challenges of preventing and reducing serious violence in Southampton.

One of the concerns raised in the completion of the problem profile for the unit was that there were gaps in intelligence, which included the recording of school exclusions where a weapon was used, or incidents of a weapon being brought onto a school premises is poorly reported and recorded.

The VRU has been developed using a public health approach and framework, to better understand and prevent violence in the city. The aim of a public health approach is to use evidence to understand the underlying causes of a problem and then to target interventions to address these causes, with a focus on long term as well as short term solutions.

The VRU partnership states (which the review author totally supports) *that 'One of the benefits of adopting a public health approach to tackle the root causes of violence is that interventions, especially those in early childhood can not only prevent individuals developing a propensity for violence, but it can also improve long-term health outcomes, educational outcomes and employment prospects of individuals and communities; as well as having positive impacts for the economy and society*.'[12]

Within the strategy, identifying ACEs is also (as in this report) strongly recognised as a way of improving protective factors and reducing risk.

The year 2020 has also seen the launch of the Hampshire, Isle of Wight, Portsmouth and Southampton areas (HIPS) Child Exploitation Strategy as the Local Safeguarding Children Partnerships have made a strong commitment to collaborate and find common ways of working for shared and complex areas of safeguarding. '*Ensuring that effective and well-established information sharing, and risk assessment mechanisms are in place to understand and identify those at risk of or experiencing any issues of exploitation,*' is the overall objective of the strategy. The review author finds some real strengths involved in this strategy. However, there is no mention of the VRU and how the strategy will work jointly with them.

There is also a HIPS Missing, Exploited and Trafficked Children Information Guide, that all practitioners who work with (or routinely come into contact with) children and families in are expected to be familiar with, that should be referred to.

It was unfortunate that Liam had several changes of social worker later towards the end of his life, and the impact upon his engagement with Children's Services. In one crucial 6-month period in 2019 Liam had 3 different social workers. It is positive, however, that Liam's Personal Advisor remained consistent throughout this period and Liam was at times open about his intentions to the personal advisor.

When young people like Liam are placed a long way away from their home area, soft partnership working is more difficult, and relationship based social care intervention is hard. It was highlighted that Liam wasn't someone you could "do to", practitioners

[12] Public Health England: A whole-system multi-agency approach to serious violence prevention (2019), Online available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/838930/multiagency_approach_to_serious_violence_prevention.pdf

needed to work with him. If he didn't know people in and around his placement, he became very anxious which impacted on his behaviour.

The Independent Reviewing Officer (IRO) stated that given Liam was homeless, that he should be seen with much more frequency. It is unclear if the IRO was aware of the management decision to not visit Liam in the community or at any address and only see him in the office, despite the difficulties that he expressed of coming into the office area. There is a lack of adequate recording of IRO meetings and the contact with Liam.

The review has not found many good examples of Liam's access to counselling before and after he left his time in the placement in Glasgow. Neither any direct work around his offending and exploitation, or the treatment for his early childhood trauma or for his believed ADHD. There was no real plan to provide Liam with a therapeutic intervention or direct work around his substance misuse and exploitation.

This is not to say that individual professionals did not try to make a difference, for example a 'Professional's meeting' was arranged by YOS for 11th November 2019 to discuss the escalating risk concerns and to make a plan going forward. YOS aside, no partner agency attended the meeting which had to be rescheduled at a crucial time in Liam's life. No reason or explanation is given for this. The rearranged meeting went ahead in a limited format but there is no record of the outcome and it was also rearranged again for a date unfortunately after Liam's death. This was the last multi-agency meeting in Liam's life.

d) To understand the **time frames for a child suspect under investigation for criminal offences** and if necessary, affect change nationally in relation to this.

The serious offences committed by Liam on the 16th July 2017 took nearly two years to resolve, this was not in the best interests of managing Liam's risks to himself, to and by others. This meant that Liam never faced a trial or final hearing for them as it was November 2019 before he went to court and the case was sent to the Crown Court due to its severity. At the practitioner event it was highlighted by those professionals that knew him that delays in court cases had a significant effect on Liam and made him very anxious. It also caused issues for his co-defendant whose legal team quite rightly challenged why it took so long to form charges. The delay is attributed to inadequate and sufficiency of resourcing, but the review author asks a question whether there was suitable supervision and assistance with these investigations, to overcome this?

In November 2017 when the drugs were found in Liam's bedroom by his foster carers the police decided to take no further action and the reason for this outcome is not known. This could have sent completely the wrong message to Liam who continued to be involved in drug dealing and already had a supplying drugs conviction. This action also failed to look at Liam as a child victim of exploitation and is a missed opportunity to discover who the perpetrators were, and to carry out any disruption activity.

After the allegations were made about Liam disclosing the video images of a girl, for unknown reasons it was three weeks before Liam was located and arrested. During this time, he was seen by other agencies and failed to attend several important meetings.

There was no communication to the YOS during this time, relating to this now different side to his behaviour.

Some of the police investigations into Liam's offending were not resolved in appropriate timescales for him as a child offender. The knife incident that took place on 27th June 2019 was still not resolved nearly seven months later when Liam died.

The reason for the delays following fingerprint and forensic submissions, were due to several murders in Hampshire during the summer period and was estimated at 20 weeks. However, given Liam's high level of offending and propensity to extreme violence and the risk to himself and others, could this submission have been prioritised or fast tracked? CPS charging advice could also have taken place sooner, as there was other evidence for consideration. There was also very little supervisory input recorded during the investigation until the final outcome which was 29th February 2020.

There is in place a good improvement plan which states that on most crimes there is not a prescribed supervision interval, but 6 weeks without any meaningful supervision is too long in most cases. Frequency should be tailored to the nature of the case, stage, risk, and the experience of the Officer in the Case (OIC). The review author has also been told that the reason for no charges being made for the disclosing of the naked girls video/photos offences was due to '*evidential difficulties with accessing the technology*'. It is hoped that the learning from Liam's case that the issues have now been resolved.

A National Referral Mechanism (NRM)[13] referral was made to the Home Office regarding Liam being exploited as a victim of modern slavery and although Liam wasn't deemed by them a victim of modern slavery, he was allocated a Barnardo's project worker who worked with Liam on keeping safe, to work with him on drug related issues and County Lines. Liam initially resisted but decided that the way forward was to engage and began to address key issues such as risk. He was referred to Forensic CAMHS and discharged by Barnardo's with key recommendations for support.

The Review Panel members were very concerned about the delays with the psychiatric assessment, which they felt for Liam was required, to address support for his exit plan from secure accommodation. There was progress in how Liam had engaged with staff in secure and that he had started taking his ADHD medication which professionals say resulted in significantly fewer outbursts of anger. He also contributed towards conflict management sessions and began to address his own behaviour and to take responsibility for it.

5. Conclusion and learning Themes

The above sections of the review highlight what life was like for Liam and those close to him, and the analysis shows what happened during the period set for the review and at

[13] The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery under section 45, and ensuring they receive the appropriate support. Modern slavery is a complex crime and may involve multiple forms of exploitation.

the previous significant moments in his earlier life. In conclusion there are several key lessons to be learned in relation to safeguarding and promoting the welfare of children in a similar situation.

It is clear to the review author, that the **immediate** events that led to the death of Liam on that Sunday morning could not have been predicted. However, as seen in the information provided by agencies, and following conversations with a number of professionals that knew and worked with Liam, there was always a strong likelihood that either Liam would seriously harm another individual or that he would be seriously harmed or as what tragically happened in January 2020, he would be fatally wounded.

In spite of this view of Liam, the review author must acknowledge the opinions of all of those professionals that really knew Liam, that he was a really lovely and very charismatic young person who was very eloquent and wrote an extremely powerful personal statement that when read out in a practitioners meeting and left the room silent with emotion about his thoughts and feelings and hopes for his future.

The themes for learning that have arisen from this review are:

Learning Themes
• Understanding of the cumulative effect of early childhood trauma, neglect and robust ADHD management. • Liam's adverse childhood experience. Including his 'club foot', dog bite facial scar? Using a trauma informed practice. • Identifying and acting on 'critical moment' opportunities. • Missing from Home, and Return Home Interviews, including police safe and well checks. • School Exclusions. • Placements away from Liam's home. Professional team around the child which must include the IRO and the Looked After Child health support • Length of time criminal investigations took in this case. National Referral Mechanism learning • Work of the MET Hub-Violence reduction unit-HIPS Child Exploitation Strategy

Liam experienced a difficult first few years of life. The conditions in his home life, and LM's needs had a serious cumulative effect of neglect on his development. This was evidenced by Liam's early behaviour which suggested that perhaps more happened in his home life than professionals knew or found out. Professional curiosity in his very early years, in particular the effects on him of the severe domestic abuse his mother suffered may have given professionals opportunities to affect Liam's life course. It would appear appropriate support was not offered, as it maybe should have been and probably would be now. Liam also suffered a life changing injury during his childhood which could have been attributed to a lack of parental supervision, and that a professionally curious approach may have established this and provided support to LM

and also been able to consider what support to provide to Liam in relation to the trauma of the domestic abuse, Talipes and dog bite injury.

Another issue Liam had to deal with throughout his life was management of his ADHD, which had been identified, but possibly not (due to no clear records found by the review panel) diagnosed early in Liam's life. Managing his ADHD by medication was not something that Liam enjoyed or wanted to adhere to. Liam had explained to one worker that he smoked cannabis because his ADHD medication made him feel "unable to be me" (probably reflecting that it effects mood, sleep patterns and appetite). It was noted at the practitioner event that there never appeared to be enough stability achieved for Liam to get the balance right with this medication, and every time he moved to a new placement, the cycle would begin of him beginning to take the medication, experiencing side effects and then stopping it. It was further highlighted at the practitioner event that rather than looking for stability **within** the child, it is our systems that should provide stability **for** the child. The learning is that more should have probably been done earlier in Liam's life in relation to dealing with cumulative effect of Liam's early childhood neglect and trauma to establish a pattern for his life. Professionals who worked with Liam felt that when Liam was on his ADHD medication his periods without causing issues lengthened dramatically.

As detailed in the previous analysis section, Liam had experienced a high number of Adverse Childhood Experiences in his life. It is important for the safeguarding partnership to understand what they were and adopt a trauma informed approach to work through them which would have helped Liam. The partnership has already embarked on work in relation to this area, for example the Police have been proactive with a trauma-informed approach and have been involved with some ACEs training for the LA recently. Hampshire Constabulary are developing a trauma informed approach to policing, embedding the understanding of adverse childhood experiences and resilience factors which is continuing. Some officers and staff have been trained to become Trauma informed Educators, which has been funded through the violence reduction units. Trauma informed training has been embedded within initial training for officers, the 'Neighbourhood Excellence' course and 'Responding with Excellence' course. This will form part of ongoing work which will require cultural change to ensure that officers understand what they should be doing differently when attending incidents and submitting information to partners regarding risk.

There is further governance which the Safeguarding Children Partnership should be fully involved with, this is the Integrated Public Service Board. Their 'Emerging Strategic Plan – A life course approach', has two strategic aims that are relevant to the learning from Liam's life story. *'Strategic Aim 1: To embed trauma–informed and restorative practice that promotes early intervention and prevention across all public services within Hampshire, Isle of Wight, Portsmouth, and Southampton. Strategic Aim 2: To ensure that that there are a range of universal, selective, and targeted interventions in place to prevent or reduce the impact of ACEs & Trauma at a population level.'*

There has been highlighted within this report two main periods of time that a 'critical moment' for Liam may have occurred, once whilst in Lancashire and maybe also whilst

in and on leaving secure accommodation in Glasgow. However, the review author believes that learning for professionals is that much earlier in his childhood those critical moments would have existed, for example when he first started committing crime or at the time of his first conviction. Professionals shouldn't look for the opportunity reactively in adolescent but could think about being proactive in relation to those children that they can foresee their life journey heading the way that Liam's did.

Liam had numerous missing episodes, not just when in out of area placements, but also whilst more locally when in Southampton. A key piece of learning is the value of ensuring return home interviews take place, as well as the police safe and well checks. This will assist not only for that child and their safety planning but also for CCE mapping and disruption activity. In relation to Liam it was expressed at the practitioner event, that the main challenge to carry out these RHI, was the fact that Liam was placed away from the city. Had he been placed locally the MET hub team would have been much more able to respond and the reachable (critical) moments much more likely to have been capitalized upon. At this time the response to do this across the country for a Southampton Looked After Child would have been ad-hoc, sometimes covered by the child's social workers. Liam probably did not get the RHI as consistently as he should have. The Southampton MET Team met him once in Portsmouth and he engaged well. It was highlighted to the review author that a lot has improved since then. A spot-purchase has been made with National Youth Advocacy Service (NYAS) that has helped a lot. Also, during Covid-19 the Southampton MET Team have engaged with young people placed out of area by phone which has worked well and could continue post-Covid where appropriate depending on the young person's needs and profile.

There were at times excellent communication between the multi-agency teams through his social worker, YOS worker and the Virtual School. When Liam was out of education often when a placement had just happened, they ensured there was as little drift and delay in finding him a new school or education provision as possible. Despite these efforts, Liam spent substantial time absent from school or excluded or out of education. The National CSPR panel highlighted in their report 'It was hard to escape,[14]' that keeping young people in mainstream education can be a protective factor for children at risk of criminal exploitation and can safeguard them away from knife crime. *'Exclusion has a major impact on children's lives and if it is unavoidable then there need to be immediate wrap around support to compensate for the lack of structure, sense of belonging and rejection that exclusion from mainstream school can cause.'* The learning from Liam's life is the importance that commissioners at the same time of considering a change in placement to ensure education provision is one of their key considerations.

From the time Liam was first taken into care, which was firstly through a section 20 agreement, and eventually under a full care order, he had numerous placements. These involved time in custody and two periods where he was placed under a secure order for his own welfare. A number of these residential placements were a long distance from

[14] 'The child safeguarding practice review panel (March 2020) It was hard to escape' Safeguarding children at risk from criminal exploitation.

Southampton. The National CSPR panels review of children at risk from criminal exploitation, 'It was hard to escape' comments on the moving children and their families who are at risk of serious harm and violence away from the area they live in. It is seen as 'a very effective short-term measure, providing an immediate reduction in risk and a breathing space.' However, longer term movements as in Liam's case are not seen to be as effective. The child simply goes missing and returns to their familiar home area and/or becomes involved in drug dealing and crime in their new area. Both these are applicable to Liam.

Paradoxically though in Liam's case it was the right thing for him not to be in or near to Southampton as the risk of harm to him was too great. The professionals at the practitioner event agreed with this. The learning is that although the principle of trying not to move children too great a distance from their home area to assist with ensuring a smooth connection with family and professionals, each child must be treated as an individual case. For Liam it was best to be a considerable distance from Southampton, but this is not always the case.

If children are placed a long distance away from their home area, the Looked After Child model of support for them is crucial. This includes the IRO and Looked After Child health nurse. At times this support happened for Liam a team that involved his social worker, YOS worker, his police SPOC and the virtual school combined to offer him support. This was supplemented by caretaking arrangements in the area he was placed best demonstrated by his placement in Lancashire.

There is no mention in Liam's Looked After Child Reviews if they addressed the quality of the Care Plan and if the Care Plan made clear the support and interventions necessary and/or how such intervention/support was to be achieved. Additionally, the Care Plan following exit from his secure unit should have made explicit the exit plan and how this would be achieved.

The IRO has a key role to play in this and should be satisfied that the assessments upon which the care plan is based are comprehensive and adequate, involving the appropriate people and addressing the appropriate issues, that the proposed care plan results logically from the assessments and that it is relevant, viable and achievable.

The statutory Looked After Child health reviews didn't take place on a consistent basis. The Looked After Child health team have an accountability to make these happen, if they don't the SW for the child should be ensuring the child's health needs are met. The IRO should have challenged and where necessary escalated the fact that these were not happening on this consistent basis as part of their advocacy for the child role.

Risk assessments including the SERAF which has now been updated and is a Child Exploitation Risk Assessment Framework (CERAF)[15] should consider contextual safeguarding and how this impact on the young person and any plan to support the

[15] https://hipsprocedures.org.uk/qkyyoy/children-in-specific-circumstances/children-who-are-exploited/

young person. Similarly, the placement plans, and health care plans should be clear about the assessment the plan is based upon and needs identified.

There is no record that the IRO escalated concerns around placements. As already mentioned, the IRO did not escalate that Liam had not engaged in health reviews. The voice of Liam is crucial at such times to understand his views on health matters. In addition to this Looked After Child support around the country a few areas have implemented or are considering implementing a multi- agency vulnerable adolescent service. Children in similar circumstances to Liam would really benefit from the support and interventions a similar service could provide.

The review panel members also wanted to raise the issue of those Looked After Children from other areas placed in Southampton. Some of these children are clearly demonstrating signs of being criminally exploited. This wider issue requires consideration about how Southampton deal with these children from other areas who are placed in the city and have very similar issues to Liam. A more coordinated approach could be taken to understanding these children with similar characteristics to Liam with their placing authority.

The delays that took place in a few of the criminal investigations into Liam's offending did not help him to achieve stability or any closure. This would have enabled professionals to work with him on how to focus on the next stage of his life. In cases of juvenile offenders' speedy resolution should be of paramount consideration.

Further learning is the good practice of the police allocating a Single Point of Contact (SPOC), the involvement of the Southampton Police High Harm Team who were assigned Liam to assist partner agencies in monitoring him to try to curb his offending. Also, good practice was the Police operation that was set up to tackle knife possession and drug activity in an area of Southampton due to its links with CCE and County Lines. The police drew up a plan to 'prepare, prevent, protect and pursue' involving frequent monitoring and foot patrols of this area. The police hoped to identify the associates of Liam to provide early intervention and prevent them from going down the same path as him. Although It is not known whether it was a success or not.

The review author believes that there is merit to be gained from discussions, between the police, the YOS management board and the local criminal Justice board on how best to keep those children that are offending safe from the risks of CCE.

Knowledge of the NRM process should be improved across the partnership in particular that the child is being victimised and investigations should take place into who is carrying out the exploitation and look to pursue them and put in place disruption activity.

There have been two previous reviews carried out that involved Liam. One specifically was the YOS critical learning review and the other which was the mock JTAI. Learning from these and other similar reviews in the future is that they should be shared as widely as possible to the multi-agency partnership, which will help to improve systems and practice for safeguarding children at risk of CCE.

The MET Hub is a good initiative, and there is a link with Violence Reduction Unit. There are discussions ongoing between the two teams about how the offer to vulnerable adolescents can be further enhanced.

There is a HIPS Missing, Exploited and Trafficked Children Information Guide, that all practitioners who work with (or routinely come into contact with) children and families in are expected to be familiar with, that should be referred to.

The Priorities of the HIPS Child Exploitation strategy that are particularly relevant to this case and Liam are: i) Providing a coordinated and effective multi-agency response to all forms of child exploitation across the HIPS areas. ii) Enhancing our understanding of why children go missing and the most effective responses to keep children safe. iii) Strengthening engagement with education settings and working in partnership to understand the specific risks associated with children who are missing from, absent from or not in full time education and whom may be at risk from exploitation. iv)To strengthen our traditional safeguarding responses so they are effective in responding to the experience of children and young people of significant harm beyond their families. v) Strengthening partnership with family members/carers to support engagement in joint protection and management of risk. vi) Understand and consider the use of disruption tactics to keep children safe. vii) Share information and develop an enhanced understanding of perpetrator networks and tactics. viii) Consider and identify our collective 'critical points' in children's lives and circumstances where partnership intervention can be best targeted to have significant impact. ix) Increasing the knowledgebase of professionals involved in working with children who are at risk of or are being exploited to assist in the early identification and onward referral to relevant local services. x)Through LSCP networks, better understanding the lived experience of children who have experienced exploitation to inform our ongoing work at a strategic and local level.

The review author has one concern that the strategy doesn't mention the connection with the work of the VRU. There should be strategic discussions held by the safeguarding children partnership, with in particular the Community safety partnership, but also the YOS management board to ensure there is coordination of activity for children in Southampton who are at risk of CCE to prevent duplication and focus coordinated activity

6. Recommendations

This review has identified learning, and suggest the recommendations as detailed below, the implementation of these will assist the SSCP to deal more effectively with similar circumstances in the future resulting in the improved safety and welfare of children who are experiencing or at risk of CCE.

Recommendation 1 The SSCP should ensure that any learning activity delivered highlights the need for trying to understand the cumulative effect during the early years of a child's life when they are experiencing neglect and living in domestic abuse households. They should seek to develop professionals' knowledge and understanding of the impact of Adverse Childhood Experiences and for professionals to provide a trauma informed response.
Recommendation 2 a) The SSCP should ensure that learning is provided that highlights to professionals the importance of acting on a 'critical moment' for a child at risk of CCE. This should include assurance from the Safeguarding Partners that they have structures in place for them to work as a multi-agency team in place to be able capitalise on this moment. b) Southampton should consider implementing a multi- agency vulnerable adolescent service. Children in similar circumstances to Liam would really benefit from the support and interventions a similar service could provide. (An example is highlighted in the link below[16])
Recommendation 3 a) The SSCP should seek assurance from the MET hub in relation their and partners' activity on the completion of missing from home return interviews. This is particularly important for Looked After Children placed outside of the city. b) The SSCP should enquire on whether Safe and Well checks are being carried out by police in the case of children in care, in particular those placed out of Southampton and what if any information disclosed about the child is being shared with other agencies.
Recommendation 4 a) The SSCP should seek assurance from their partners working in education that the use of permanent exclusion from mainstream education is kept to a minimum (this includes those Looked After Children placed outside of the city), and the information in relation to who these children are, is shared with the MET hub and Violence Reduction Unit (VRU). b) When applications are made for an Education Health Care Plan (EHCP) for Looked After Children, any refusal is reviewed with liaison and discussion taking place with the virtual school and escalation to take place in appropriate cases. The support that an EHCP would have provided may have assisted to keep someone like Liam in education.

[16] https://www.walthamforest.gov.uk/sites/default/files/PDF_SAFEGUARDING%20ADOLESCENTS%20resource.pdf

Recommendation 5

a) The SSCP should seek information on how many Looked After Children are placed more than 20 miles from the city. What does the profile of them look like?

b) The SSCP should also ensure that placement commissioners are aware of this case and ensure that placements are made taking account of the need to find where possible a suitable placement to match the needs of the child (in this case a nurturing placement). The placement also has in place a suitable education proposal. Ensure that the placement can facilitate where possible suitable health involvement including individual health management issues.

c) The SSCP should ask for assurance from the Looked After Child health teams that the children placed out of area, are regularly having their health needs monitored, and the statutory health reviews are taking place in a timely manner.

d) The SSCP should ensure that the IRO at the Looked After Child Reviews have addressed and made clear if there were gaps in the planning and if so, what actions were needed to remedy this. The IRO should record the young person's views gained at the time of the Looked After Child Review and any subsequent contact or attempted contact with the young person.

e) The SSCP should ensure for Looked After Children that those placed outside the city that they still have in place a multi-disciplinary team with the necessary skill set to safeguard the risks to the child from CCE.

Recommendation 6

a) The SSCP should seek assurance that the police improvement plan has led to the outcomes that the police expected in relation to delays to investigations; in particular those that involve children.

b) The SSCP should seek to arrange a meeting with partners in the YOS Management Board, the local Criminal Justice Board to discuss how to keep children safe from CCE.

Recommendation 7

The SSCP have recently (September 2020) agreed that the MET Operational Group is a subgroup of the SSCP.

The SSCP should seek assurance from this subgroup in relation to the delivery of the HIPS CCE action plan. At the same time ensuring the city's VRU take part in the delivery of this action plan.

Recommendation 8

The SSCP should ensure that learning from other reviews taking place into CCE, for example YOS critical learning reviews, and mock exercises such as Joint Agency

Targeted Inspections, are shared as widely as possible, to maximise partnership learning.
Recommendation 9 a) The SSCP should seek to ensure that the HIPS Child Exploitation Strategy is well known and understood by all professionals and agencies that work in Southampton. This strategy should also include the work of the VRU. b) The SSCP should seek to maintain the six weekly meetings which have recently begun with the head of service for the Safe City Partnership. This is to ensure activity tackling CCE within the City takes place in a coordinated manner.

Appendix A

- Solent NHS Trust
- Southampton City Council Children's Social Care
- University Hospital Southampton NHS Trust
- National Probation Service
- Southampton City Council Housing Services
- Southampton Youth Offending Service
- Hampshire Constabulary
- South Central Ambulance Service
- Southampton City Council Education Services
- Southampton City Council Legal Services

Southampton Safeguarding Children Partnership commissioned an independent author to carry out the review. The review is supplied by RJW Associates and the lead reviewer is Dr Russell Wate QPM. He is independent of any agency within Southampton. He is a retired senior Police detective, who is very experienced in the investigation of homicide and in particular child death and neglect issues. He has contributed to several national reviews, inspections, and inquiries, as well as being nationally experienced in all aspects of safeguarding children. He has carried out many Serious Case Reviews (SCR's) and is also an independent chair of two LSCB's. In 2020 Dr Wate was a co-reviewer for the National Panel's review on Vulnerable Adolescents, "it was hard to escape" and it is his work in the area of vulnerable adolescents that led the Partnership to secure Dr Wate as the Independent Reviewer for this Child Safeguarding Practice Review.

The following are members of the panel and are also independent of the case.

Independent Reviewer and Panel Chair
Solent NHS Trust
SCC Youth Offending Service
University Hospital Southampton NHS Trust
SCC Housing Services
Hampshire Constabulary
SCC Education Services
SCC Children's Social Care
Solent NHS Trust (community)
Clinical Commissioning Group