# Safeguarding Case Review Learning Brief



## Child G and Child H

### How to use this learning brief

This learning brief is one of the ways in which the Safeguarding Board aims to share learning as widely as possible to support practice. The briefing pulls together key messages from the review and the lessons learnt to enable you and your team to reflect and challenge your thinking.

Please take the time to read it and consider the following questions:

- Does this case identify any learning for my individual practice?
- Does it help identify any training or development needs?
- Does anything need to change within my team or service to implement this learning and support best practice?

## Background to the learning review of Child G and Child H

A learning review was commissioned into two children who were known to have been associated with the supply of illicit drugs to provide important insight and understanding of the circumstances surrounding their involvement.

CHILD G was known to children's services and thought to be at risk for owing money to a known drug dealer and acting as a runner for his 'county line'. CHILD H is known to have associated with CHILD G and both were arrested for intent to supply class A drugs. It was suggested that CHILD H's father may also have been involved in the supply of drugs.

# Further learning also identified in:

- <u>Learning from the murder of 'Child C'</u>
  Waltham Forest Safeguarding Children Board (2020)
- It was hard to escape
  The Child Safeguarding Practice Review Panel (2020)
- National Case Review Repository

# Learning and Key Messages

#### Establishing relationships with children

Despite the challenges of engagement, safety plans should be flexible to allow the adult with an established relationship (or the best chance of establishing a trusted relationship) to be the "lead professional". Relationships are essential for maximising 'reachable moments' to ensure children remain involved in their own safety planning.

#### **Ensure robust safety plans**

Consideration should be given as to whether robust safety plans could be incorporated into CIN plans to maintain CSC ownership/oversight while allowing scope for flexibility. While it appears there is a need for an alternative multiagency framework to share information /intelligence and proactively address needs of children involved in criminal exploitation, such developments should operate within a statutory framework and should only be developed with the endorsement of safeguarding partners.

Impact of children not being in school

Professionals should work together to minimise the impact of schools' decisions to exclude/undertake 'managed moves' and recognise the risk of such children being drawn into criminal exploitation.

#### Reflect on the perception of children

Professionals should reflect on their perception of children involved in criminal exploitation, the language they use to describe them and the context in which any criminal activity is being undertaken.

#### Analysis of emerging risks

Routine analysis of data (including use of NRM related intelligence and profiling of adults within the criminal justice system) should inform strategic planning and identification of gaps in our understanding of emerging risks. Operational safety planning (contextual safeguarding) should ensure the identification of vulnerable locations and target sources of harm for disruption.

## **Support for professionals**

It is essential that professionals involved in this challenging area of work have regular access to support and supervision that addresses unconscious bias and ensures contextual (child centred) practice.