niche
HEALTH & SOCIAL CARE CONSULTING

# Recognising & acting on signs of ‘county lines’ child exploitation

# A case study

November 2018

Author: Jon Wigmore, Lead Investigator
First published: November 2018
Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

This report was commissioned by NHS England and cannot be used or published without their permission.

Niche Health & Social Care Consulting Ltd
1 City Approach
Albert Street
Eccles
MANCHESTER
M30 0BG
Telephone: 0161 785 1001
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

# Contents

1: Introduction ..... 4

2: What is 'county lines'? ..... 5

3: W's story ..... 9

4: Key themes from W's story ..... 21
- Engagement ..... 21
- Safeguarding ..... 23
- Risk assessment and management ..... 24

5: Independent investigation findings & recommendations ..... 25

6: Learning points ..... 30

Appendix: Bibliography and resources ..... 35

# 1 Introduction

1.1 W, a young person, committed a homicide shortly after being discharged from community mental health services. Prior to this, W had no history of seriously violent or criminal behaviour. He had been assessed repeatedly as presenting a low risk of offending. He had no clear mental health diagnosis. W was given a significant prison sentence.

1.2 Unknown to the services working with W over the four years beforehand, as a child, he had been subject to criminal exploitation by a drug gang. This gang was thought to have used W and other young people to supply heroin and cocaine from an urban base to a rural location in England. This criminal model of drug supply, characterised by the trafficking and coercion of children and other vulnerable people, has been termed "county lines". County lines drug dealing was almost certainly the context of the homicide committed by W.

1.3 NHS England initially commissioned us (Niche) to carry out an independent investigation into the care of W.[1][2] During the investigation we interviewed 18 people including W and his family and reviewed over 2,500 pages of evidence from over 20 services.

1.4 Between the commissioning of the investigation and its closing stages, significant new information and guidance about county lines became available through the Home Office, the National Crime Agency, The Children's Society and other agencies. A key action in the Government's April 2018 "Serious Violence Strategy" is to:

"Raise awareness of county lines across key sectors of health, housing, education, social care and youth offending in order that staff working in these frontline settings are able to identify and refer county lines affected individuals and help prevent exploitation."[3]

1.5 NHS England asked us to produce this case study setting out problems, potential solutions and learning in the following areas:

- Recognising signs of gang involvement, including grooming, and the support and safeguarding implications.
- The complexities of accessing professional help for young people and their families, especially when there are several services involved.
- The positive and negative impacts of multiple service assessments and involvement on W and his family.

---

[1] Niche Health & Social Care Consulting Ltd. We (Niche) are a consultancy with national coverage specialising in patient safety investigations and reviews.

[2] The independent investigation followed the NHS England Serious Incident Framework (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. Its aims included the identification of risks and opportunities to improve patient safety. It made recommendations for organisational and system learning for several of the bodies involved in commissioning and providing care and support to W. NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf Department of Health Guidance ECHR Article 2: investigations into mental health incidents https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf

- Key areas for learning and service development for health and social care commissioning communities.

1.6 We would like to express our condolences to the family of G, the man killed by W. G's family chose not to become involved in the investigation. We respect that decision and acknowledge that they and G are the principal victims of the criminal behaviour that we refer to in this case study.

1.7 Threats to the family members of people subject to gang manipulation and coercion are a recognised tool for control. We have changed and omitted identifying facts in this case study and do not describe the homicide. After the homicide W has consistently refused to admit to being under any gang pressure. However, having studied the facts of this case in some detail, we have no doubt that W's experience of being subject to criminal exploitation fully meets the definition of county lines that we set out in the next section.

1.8 It is important that practitioners working with children and vulnerable adults understand what county lines is so that they can identify those at risk or involved in county lines exploitation and know what action to take. County lines is the common denominator in a range of exploitative situations including: drug dealing, violence, gangs, modern slavery and missing persons. The concerted efforts of a range of departments, agencies and organisations are needed to tackle it.

# 2 What is 'county lines'?

2.1 The UK Government definitions of county lines and Child Criminal Exploitation (CCE) are:

"County lines is 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.

Child Criminal Exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology."[4]

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf

2.2 The National Crime Agency (NCA) lists the components of a typical county lines scenario as:

"a. A group (not necessarily affiliated as a gang) establishes a network between an urban hub and county location, into which drugs (primarily heroin and crack cocaine) are supplied.
b. A branded mobile phone line is established in the market, to which orders are placed by introduced customers. [5] The [phone] line will commonly (but not exclusively) be controlled by a third party, remote from the market.
c. The group exploits young or vulnerable persons, to achieve the storage and/or supply of drugs, movement of cash proceeds and to secure the use of dwellings (commonly referred to as cuckooing).[6]
d. The group or individuals exploited by them regularly travel between the urban hub and the county market, to replenish stock and deliver cash.
e. The group is inclined to use intimidation, violence and weapons, including knives, corrosives and firearms."[7]

2.3 The true scale of county lines related crime and abuse remains an evidence gap. In July 2017, the Children's Commissioner for England estimated that 46,000 children were involved in criminal gangs.[8] County lines has become a priority for agencies with safeguarding duties for children and vulnerable adults.

2.4 In July 2017, the Home Office issued "Criminal Exploitation of children and vulnerable adults: County Lines guidance". It identified CCE as integral to county lines. It referred to reports of children as young as 12, usually but not always boys, being exploited by gangs. The age range 15-17 is the most common. The Home Office listed the following factors heightening young people's vulnerability to county lines exploitation:

- "Having prior experience of neglect, physical and/or sexual abuse.
- Lack of a safe/stable home environment, now or in the past (domestic violence or parental substance misuse, mental health issues or criminality, for example).
- Social isolation or social difficulties.
- Economic vulnerability.
- Homelessness or insecure accommodation status.
- Connections with other people involved in gangs.
- Having a physical or learning disability.
- Having mental health or substance misuse issues.
- Being in care (particularly those in residential care and those with interrupted care histories)."

[5] Branded" refers to the marketing of a phone number in an area, for example through social media, business cards and free cigarette lighters. Unlike other criminal activities where telephone numbers are changed on a regular basis, these numbers have value and so are maintained and protected. New legislation was announced by the Government in January 2018 to close these telephone lines down.
[6] Dwellings commonly used to deal from are the homes of vulnerable adults and people (typically drug users) who are indebted to the gang. The NCA reported last November that serviced apartments, holiday lets, budget hotels and caravan parks had also been reported by 10 police forces as being used as dealing locations in rural areas.
[7] http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file
[8] https://www.childrenscommissioner.gov.uk/2017/07/04/shocking-report-by-childrens-commissioner-reveals-millions-of-children-in-england-living-vulnerable-or-high-risk-lives/

2.5 In March 2018, the Children's Society published the second edition of "Criminal exploitation and County Lines: A toolkit for working with children and young people".[9] It summarised the risks as including:

- "Physical injuries: risk of serious violence and death.
- Emotional and psychological trauma.
- Sexual violence: sexual assault, rape, indecent images being taken and shared as part of initiation/revenge/punishment, internally inserting drugs.
- Debt bondage - young person and families being 'in debt' to the exploiters; which is used to control the young person.
- Neglect and basic needs not being met.
- Living in unclean, dangerous and/or unhygienic environments.
- Tiredness and sleep deprivation: child is expected to carry out criminal activities over long periods and through the night.
- Poor attendance and/or attainment at school/college/university".

The NCA reported the prevalence of "plugging" where people are forced to carry drugs internally.[10]

2.6 The Children's Society toolkit quotes Lambeth Safeguarding Children's Board's account of how vulnerable people are exploited:

"Gangs typically recruit and exploit children and vulnerable young people to courier drugs and cash. Typically, users ask for drugs via a mobile phone line used by the gang. Couriers travel between the gang's urban base and the county or coastal locations on a regular basis to collect cash and deliver drugs. Gangs recruit children and young people through deception, intimidation, violence, debt bondage and/or grooming. Gangs also use local property as a base for their activities, and this often involves taking over the home of a vulnerable adult who is unable to challenge them."[11]

2.7 According to the Children's Society, children have been trafficked from London to places as far as Scotland, Devon, Scunthorpe and Liverpool:

"Perpetrators of such exploitation are known to target particularly vulnerable young people, such as those outside of mainstream schooling (i.e. in Pupil Referral Units) and those being looked after by the local authority in a residential care home, or those who have pre-existing mental health conditions." [12]

---

[9] https://www.csepoliceandprevention.org.uk/sites/default/files/Exploitation%20Toolkit.pdf
[10] County Lines Violence, Exploitation & Drug Supply 2017, National Briefing Report, National Crime Agency, November 2017 http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file
[11] https://www.csepoliceandprevention.org.uk/sites/default/files/Exploitation%20Toolkit.pdf
[12] https://www.childrenssociety.org.uk/sites/default/files/county-lines-westminster-hall-debate-jan18.pdf

2.8 The Home Office's 2010 document "Safeguarding children and young people who may be affected by gang activity" sets out the following signs that a young person may be involved in gang activity (while recognising that many are common behaviours for adolescents):

- "Child withdrawn from family.
- Sudden loss of interest in school. Decline in attendance or academic achievement (although it should be noted that some gang members will maintain a good attendance record to avoid coming to notice).
- Being emotionally 'switched off', but also containing frustration / rage.
- Starting to use new or unknown slang words.
- Holding unexplained money or possessions.
- Staying out unusually late without reason, or breaking parental rules consistently.
- Sudden change in appearance – dressing in a particular style or 'uniform' similar to that of other young people they hang around with, including a particular colour.
- Dropping out of positive activities.
- New nickname.
- Unexplained physical injuries, and/or refusal to seek / receive medical treatment for injuries.
- Graffiti style 'tags' on possessions, school books, walls.
- Constantly talking about another young person who seems to have a lot of influence over them.
- Breaking off with old friends and hanging around with one group of people.
- Associating with known or suspected gang members, closeness to siblings or adults in the family who are gang members.
- Starting to adopt certain codes of group behaviour e.g. ways of talking and hand signs.
- Expressing aggressive or intimidating views towards other groups of young people, some of whom may have been friends in the past.
- Being scared when entering certain areas.
- Concerned by the presence of unknown youths in their neighbourhoods.

An important feature of gang involvement is that, the more heavily a child is involved with a gang, the less likely they are to talk about it."[13]

2.9 We return to Government and other best practice guidance for social and health care agencies in part 4 of this report.

[13] https://www.staffsscb.org.uk/Professionals/Resources-Tools/Supplementary-Guidance/DCSF-Safeguarding-children-who-may-be-affected-by-gang-activity-2010.pdf)

# 3 W's story

3.1 W was raised in a rural area of England by his mother and father with two younger siblings. W's family was and remains deeply concerned with his safety and well-being. His family circumstances in no way resembled the situations of deprivation typically associated with young people who are exploited by gangs.

3.2 W experienced a difficult transition to secondary school which he told us he hated. Soon after, he began using alcohol, cannabis and other illicit drugs.

3.3 W's first contact with CAMHS was, aged 12, after a referral for "emotional disorders/problems" from a school nurse.[14] The referral letter mentioned W's mother's concerns about recent superficial self-harming with a blade from a pencil sharpener. There were also "behaviour concerns" at school. W did not attend follow-up appointments and no diagnosis was made.

3.4 Soon after, W was subject to a supported transfer to a different school. There, fixed term exclusions were imposed for verbal abuse, theft, drug-related incidents, bullying, physical assaults and smoking. W was thought by teachers to associate at times with young people who were involved in criminality, in particular the supply of illicit drugs. W experienced increasing episodes of anxiety with thoughts of suicide. He continued to cut himself.

3.5 By the age of 14, W's family had significant concerns about his safety as a result of episodes of agitation, lowered mood and suicidal ideation. When unwell W would smash furniture and damage property at home. W also described feelings of sadness and loneliness as well as self-denigratory thoughts, paranoia, guilt and anger.

3.6 W's antisocial behaviour escalated and just before he turned 15 he was referred by the police to the local Youth Justice Liaison and Diversion Service (Diversion) following a caution for common assault. He had struck another child at school. In a pattern that would repeat over the following three years, W appeared superficially to co-operate and he down-played his mental health symptoms. He expressed remorse and empathy for the child he had struck. Reparation and a referral to the local young person's drug and alcohol service (that we refer to as the drug service) were prescribed.

[14] CAMHS are provided by NHS mental health and community trusts, local authorities as well as by the private and voluntary sectors. In England CAMHS services are mainly commissioned by CCGs and NHS England although local authorities, through local transformation planning, are increasingly involved. CAMHS services are usually characterised as consisting of four tiers:
Tier 1: All children - schools, GPs, health visitors, universal services.
Tier 2: Children vulnerable to mental health problems; targeted services and education, social care and health, for example therapy.
Tier 3: Moderate to severe mental health problems addressed by specialist services, typically in the community.
Tier 4: Severe/highly complex mental health problems addressed by highly specialist services, including inpatient care.

**COMMISSIONING POINTS: INTEGRATION OF MENTAL HEALTH AND YOUTH OFFENDING SERVICES; & DRUG AND ALCOHOL SERVICES**

A theme of W's dealings with mental health and youth offending services would be the positive interventions undertaken by experienced mental health practitioners embedded in the council's youth offending services. They had extensive experience of working in mental health services and could assess, refer and advocate effectively for W. Diversion could be accessed by the police, youth justice professionals and families quickly and without the usual complexities required to activate formal mental health service involvement.

The flexible assertive outreach engagement model employed by the third sector drug team was also highly effective. The worker was responsive to crises, worked closely with W and his parents and attended and contributed to assessments and interventions from other services over a three year period. Continuity of worker and supported engagement strategies like driving W to appointments were highly effective.

3.7 Shortly after seeing Diversion, W's mother cancelled his community reparation appointment with the council's reparations team. W, who was fifteen and a half, had been the victim of an assault the previous weekend. In her call to the service she implied that the assault had been of a sexual nature. The reparation was rescheduled but the inference that the assault had a sexual element was noted but not acted on. At this stage no mental health service was involved.

3.8 The council told us that youth offending services dealing with the report of a potential sexual assault on a young person should encourage the family to report it to the police who would in turn inform social care if there was a safeguarding concern.

**PRACTICE DEVELOPMENT POINT: SAFEGUARDING**

There needs to be a clear pathway when a sexual assault on a child is reported, even if the report is incomplete. If there is a suspicion about a sexual assault it must be followed up i.e. the family must report and if they do not the service must. If in doubt then the service needs to clarify with the family what they know and make a decision based on the probabilities following discussion. If the family is unwilling, the minimum service response would be discussion with service's safeguarding lead who would then decide the best approach with the team. A disclosure of this nature must be acted on. The lack of action from the service in W's case was particularly significant in hindsight as this episode was, quite possibly, child sexual exploitation (CSE) linked to gang manipulation of W.

3.9 W's behaviour at school remained disruptive. He was referred to the reparations team for a second time by the police after hitting another child. He was known to the local police Community Support Officers for antisocial behaviour and would be picked up for two public order offences aged 15-16. A

second opportunity for the reparations team to respond to a report from W's mother of the sexual attack was missed.

3.10 By arrangement with his school, W went on extended leave early in year 11 to concentrate on a work placement. His parents monitored W closely and frequently involved health and youth offending services when they felt he was at risk. There was never sustained social services involvement nor any reported history of violence from W towards family members.

3.11 Soon after he had left school, W was arrested on suspicion of involvement in an attempted robbery of a betting shop. Pressure related to the police investigation and charges would hang over W for the following year until the charges were dropped. In addition, he would disclose that the perpetrators were friends and were applying pressure on him. Incidents where W self-harmed and disclosed suicidal thoughts to his family increased.

3.12 Shortly after the arrest, after an A&E attendance related to thoughts of self-harm, W was assessed by a senior nurse practitioner from the local trust's CAMHS. W was noted to be facing a prison sentence if found guilty. He disclosed recent thoughts of suicide and related behaviour (tying a ligature around his neck which was removed by his mother and sitting on a bridge with thoughts of jumping). As usual, at assessment W appeared insightful. He denied current suicidal ideation or intent. No clear evidence of psychosis would ever be elicited.

3.13 W told the assessing nurse that he had older friends who would order each other to hit random members of the public and smash windows. For the first time, his mother reported the previous year's sexual assault against W in detail to a professional. She told the assessing nurse that a group of older males had performed a sexual act upon W and had posted footage on social media sites. W had refused to cooperate with the police and no arrest had been made.

**PRACTICE DEVELOPMENT POINT: SAFEGUARDING**

This was the first time that mental health services were informed about the sexual abuse incident which had occurred nine months previously. The trust agreed with us that its safeguarding procedures should have been followed. This would have involved a report by the assessing practitioner to their line manager and advice from the Safeguarding Team. Safeguarding considerations should have also informed the risk assessment.

The trust's notes were vague about who the extra-familial abuse was reported to by the family. CAMHS should have cross-checked with the police and social services to make sure it had been dealt with appropriately.

Since the events of this case, more has been found about how young people are groomed and coerced into gang activities. The NCA reported the case of a 17 year old boy who, as a "runner" in a line operating from Liverpool, had been sexually abused by gang members. It also reported a female victim

being filmed while being sexually assaulted by multiple gang members. The footage was used to shame and coerce her boyfriend.[15] In section 2 of this case study we also refer to evidence that indecent images are taken and shared as part of gang initiation/revenge/punishment.

While W was rightly presumed innocent of the betting shop robbery, there were clear signs of his involvement in significant criminality. His account of being pressurised into violent acts by older associates was another potential marker of gang initiation/involvement.

Such disclosures should always raise the index of concern about any external threats that a young person and their family may report or that may become evident through other means (for example injuries to the child).

3.14 As before, W did not attend follow-up CAMHS appointments. He would remain off the mental health trust's radar until another self-injurious incident prompted a new CAMHS referral from A&E. His family told CAMHS that they would seek therapy privately. The youth justice and drug services would be the main sources of support for W and his family from the age of fourteen until the homicide.

**PRACTICE DEVELOPMENT POINT: CONTINUITY OF CARE**

The fact that pressure from others was pushing W towards impulsive self-injurious acts was correctly identified and graded by the mental health professionals who assessed him. Given the risks associated with W's presentation, and the lack of a clear diagnosis, the CAMHS plan to follow W up within 72 hours with a fuller assessment was, we judged, correct.

Here and at other times in this episode we felt that CAMHS could have done much more to support W, his family and the other services involved. The repeated crisis-driven assessments ended in inconclusive plans involving no actions for the service itself. These included suggestions that W might self-refer to therapy and try to avoid his 'friends'. The possibility of ADHD being a factor in W's presentation was never explored and a role for medication for W's anxiety was never considered.

3.15 W, who was now sixteen and a half, increasingly avoided his family and was not contactable by them or the reparations team for days on end. Eventually the reparations team reported him to the out-of-hours social care services and police as missing. However, the outcome of the joint reparations team/social care assessment that followed was inconclusive as was the CAMHS re-assessment after that. In retrospect, W's disappearance for days on end was another potential marker of gang involvement.

[15] http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file

**SAFEGUARDING AWARENESS POINT: RETURN HOME INTERVIEWS**

In England, all children who go missing from home or care are entitled to a return home interview **(**RHI). RHIs are an opportunity for professionals to discuss with the young person why they went missing and what happened to them whilst they were away. They may identify risks of criminal exploitation and offer a way to ensure effective early intervention. RHIs may also serve as a source of intelligence for the police and other safeguarding professionals.

According to the Children's Society:

"RHI provision across England is patchy and evidence demonstrates that not all local authorities offer RHIs to all groups of children and young people who run away or go missing from home or care. The same report found many children reported as 'absent', are not offered a RHI when they return despite evidence from the [All-Party Parliamentary Group] highlighting the risks and vulnerabilities that many of these young people face. Therefore, for a large number of vulnerable children and young people the opportunity to identify county line risk and intervene early may be lost.[16]

3.16 Commendably, youth offending team support was extended to W while he was on police bail relating to the betting shop robbery. Considerable efforts were made to support him in attending an apprenticeship. Meanwhile, W's keyworker in the drug service successfully facilitated his participation in therapeutic work for his substance misuse. The drug service also referred W to an education, training and employment officer to assist him in his aim of establishing himself in employment.

**GOOD PRACTICE POINTS: ENGAGEMENT, TRAINING & EMPLOYMENT**

We commended the youth offending and drug services for their responsive and holistic approach to W's at times avoidant presentation. They liaised effectively with other services and extended additional support to W and his family when he was charged. In particular, the youth offending and drug services seem to have been responsive to the sudden changes in W's behaviour and the risks flagged by his family. In contrast CAMHS repeatedly avoided engaging with W and joint working with the agencies involved.

The centrality of employment and training provision in the prevention of gang activity is emphasised in the guidance.[17] It is clear that, between the ages of 16 and 17, W was walking a tightrope between prosocial activities (in particular employment) and antisocial behaviour and associations. We noted the strenuous efforts of the youth offending and drug services staff to support W's prosocial lifestyle.

[16] Briefing for debate on 'county lines' in London 9.30am-11.00am, Wednesday 17th January, Westminster Hall, https://www.childrenssociety.org.uk/sites/default/files/county-lines-westminster-hall-debate-jan18.pdf
[17] For example Ending Gang Violence and Exploitation, Home Office, 2016, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/491699/Ending_gang_violence_and_Exploitation_FINAL.pdf

3.17 Despite good progress in his work placement, W's unexplained episodes of agitation and sharp dips in mood continued. W was therefore referred again to Diversion which made a new referral to CAMHS, describing:

- "High levels of generalised anxiety, hyper arousal, free-floating anxiety and a sense of impending danger leading to feelings of a paranoid nature towards strangers.
- He reported feeling sad, and lonely with tearful episodes, depressive cognitions (self denigration, guilt, self injury and suicidality).
- [W] is experiencing angry thoughts, feelings and behaviour and has admitted that at times he does want to hurt some people (especially in relation to his paranoid ideas about strangers).
- [W] is also affected by intrusive thoughts and memories and cognitive avoidance of painful feelings with emotional numbing and the pretence that he is actually someone else at times".

**GOOD PRACTICE POINT: ASSESSMENT**

We commended Diversion for the thoroughness of its assessment, 18 months prior to the homicide and for its determination to get the right service in place for W. The assessing nurse correctly realised that W could undergo a relapse quickly and unpredictably, with associated risks to himself and others, however competently he presented during the artificial process of a mental health assessment. Previous assessment formulations had not stood the test of time.

Diversion was the only service prior to the homicide that assessed a potential risk from W of harm to others. In particular, it was understood that there was a fragility to W's grip on the prosocial values and lifestyle that the youth offending team was trying to foster through training and employment-related support.

3.18 W was offered daytime appointments by CAMHS but did not attend due to work commitments. CAMHS resisted efforts by the youth offending team to provide additional support to W in the run-up to the trial. Meanwhile, shortly before W's 17th birthday, his mother told the youth offending team that he had been attacked in relation to alleged drug debts. His phone had been taken and he had been threatened with a knife.

**SAFEGUARDING AWARENESS POINT: DEBT BONDAGE & 'TAXING'**

We contrast W's family's repeated reports of what was happening to W with his own refusal to admit that he was the victim of CCE. It has been reported that the deeper the extent of the CCE, the more reluctant the child is to report it, to a significant extent due to their fears for the impact on their family.

According to the NCA, "Taxing" is a newly-reported term which describes the infliction of violence in order to obtain control i.e. the marking or injuring of a gang member who has done wrong, as a show of strength to others. It is

thought to be used in a similar way to the term 'debt bondage' i.e. the creation of a drugs debt, perhaps through fake robbery, which the victim then has to pay off. Evidence of taxing was reported by 35% of forces (15) with a further 5% of forces (2) noting potential evidence."[18]

3.19 A turning point in W's life occurred shortly after when he was involved in a road traffic collision with a minibus after he had been involved in the theft of a car. Although W was not seriously hurt, he was unable to continue his work placement. The serious charges that had been hanging over him for a year were dropped shortly after the accident, but new charges would follow relating to driving offences. Significantly, the accident left W with no income and a lot of time on his hands.

3.20 W's local CAMHS continued to avoid concerted efforts by the youth offending team and Diversion to accept the referral of W. Meanwhile, in a new CAMHS assessment W disclosed that the people involved in the betting shop robbery were his friends and he would not betray them. The possibility that W had been experiencing post-traumatic stress would be raised inconclusively in successive assessments. Unfortunately this was another thorough assessment with a vague outcome. It was left to W to seek support himself from CAMHS which again declined to get involved.

3.21 W told us that after the accident his drug use and links with criminality became more established as crime had become the only way that he could get money for clothes and drugs. His relationships with family members, from whom he at times demanded money, became more strained. Their anxieties about W's safety in the area where they lived, and about his risk to himself, increased.

**SAFEGUARDING AWARENESS POINT: GROOMING I**

Grooming, which in the county lines context often involves giving a young person money and drugs, is defined as: "… when someone builds an emotional connection with a child to gain their trust for the purposes of exploitation or trafficking. Children and young people can be groomed online or face to face, by a stranger or by someone they know (for example a family member, friend or professional). Groomers may be male or female. They could be any age. Many children and young people don't understand that they have been groomed, or that what has happened is abuse".

The NCA recommends that: "Better education is needed to provide children with an awareness of what grooming is, what it might look like and how they might be at risk. It is important to demystify some of the hype and arm children with the necessary skills to identify what might be happening and how to respond effectively and positively.[19]

3.22 Eight months before the homicide, W's mother approached Diversion with new concerns that her son was becoming suicidal. He had cut himself again

[18] http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file
[19] http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file

and threatened to throw himself down the stairs. W's family was supervising him constantly. Diversion referred W to CAMHS for the third time only to be told that Diversion's own input (provided across a wide patch by a single qualified practitioner) represented "an appropriate community risk management plan avoiding hospital admission". CAMHS decided that W should be referred to adult mental health services given his age and the need for long-term intervention highlighted by Diversion. Confusion would follow over the following two months as the local mental health services assessed and re-assessed W.

**PRACTICE DEVELOPMENT POINT: CAMHS NON-INVOLVEMENT**

It seems unreasonable to us, in the face of the suicide risks, for CAMHS to argue that they would not at least remain involved to help with the risk assessment and management of a child. Even if the referral to adult services was made, CAMHS needed to support the process and the workers whether or not W engaged with them. Again, it seems that the possibility of joint working and a co-ordination role for CAMHS was not fully considered.

3.23 W was found guilty of motoring offences and was given a referral order.[20] He engaged once again with the youth offending team who would oversee the order.

3.24 Suddenly, after an altercation in the street relating to an alleged drug debt, W overdosed on fluoxetine tablets prescribed a month earlier by his GP.[21] He told no one at the time but in an assessment the following week he disclosed that the triggers had been fear and paranoia relating to unnamed people he knew who were involved in drug crime.

3.25 W's mother reported that W had become increasingly isolative and was saying that he was a "weirdo" and that there was someone "in his head". In a joint adult mental health services/CAMHS assessment W again said he felt vulnerable and paranoid outside and he was described as "hypervigilant". He expressed some thoughts of de-realisation and that he was not in control of his actions. W said he had been threatened by "friends" who had been involved in the attempted betting shop robbery. He still felt at risk in relation to assaults and criminal situations he had been involved in and drug debts. It was noted that:

"He reports he feels low in mood, paranoid, hopeless about future, agitated, distressed and feeling that his life is very chaotic. However he feels that he would not like to go into hospital as he feels that this would make him worse and he was visibly very agitated and restless. He became more restless and

[20] A referral order is a community sentence most often used by the courts when dealing with 10 to 17-year-olds who plead guilty to a relatively minor offence. The young offender is referred to a panel of two trained community volunteers and a member of the youth offending team for between three and 12 months. Referral orders can include reparation as well as participation in a programme of interventions and activities to address offending behaviour. A referral order may be revoked by the court for a breach. In this event, a fine or extension of the order may be imposed or the young person may be re-sentenced. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322209/fact-sheet-youth-referral-orders.pdf

[21] Fluoxetine (or Prozac) is a type of antidepressant known as an SSRI (selective serotonin reuptake inhibitor). It usually takes 4 to 6 weeks for fluoxetine to work. Common initial side effects include feeling sick, headaches and trouble sleeping. It has also been linked to agitation and increased suicidal behaviour in the early stages of use.

agitated as the meeting progressed [W] said he feels that there has been very little support and he has felt desperate and alone and that us being involved made him feel very relieved and safe. He and his mum were given all contact numbers and crisis care plan and clear advice regarding what to do if any concerns etc".

3.26 Despite the commendable joined up assessment approach, confusion reigned as to which service should work with W. CAMHS stated that W should be transitioned into adult services but adult services were unsure that he met their criteria.

3.27 Meanwhile, a CAMHS consultant psychiatrist undertook a detailed assessment of W where he referred again to being threatened in relation to a drug debt. An incident where W had been kidnapped and threatened at knifepoint was also mentioned. W's history of reportedly being a victim of physical and sexual abuse in the context of substance misuse was noted as well as his vulnerability, while under the influence, from "peers in the drug ring". A high risk of deterioration was identified. W was assessed as "quite vulnerable" to harm from others. The provisional formulation was of an impulsive suicidal act under the influence of drugs and alcohol related to "adjustment disorder with emotional and behavioural difficulties". The plan included on-going mental health care but clinical responsibility going forward was not identified. Unfortunately the confusion over which mental health team would engage with W continued.

**PRACTICE DEVELOPMENT POINT: MARKERS OF POTENTIAL GANG INVOLVEMENT**

Again, potential markers of W's exploitation including possible debt bondage were recorded by assessing professionals but not recognised as such nor acted upon. W's fears about being out and about in his neighbourhood appear to have been considered largely through the lens of mental health pathology rather than CCE being thought about.

3.28 The day after the CAMHS assessment W said more determinedly than ever that he intended to kill himself. Having left letters saying goodbye to his family, W cut his left forearm longitudinally repeatedly with a razor blade. He was taken to A&E after the police had attended and was referred once again to CAMHS. After further assessments, W who was now expressing determination to kill himself, was admitted voluntarily to a Tier 4 (inpatient) CAMHS facility. The referring staff member noted that "[W] is known to several services but this seems poorly co-ordinated and no lead clinician is identified".

3.29 At this stage a specialist local authority multi-disciplinary team (MDT) for young people became involved in W's care along with CAMHS, the trust's early intervention team, the youth offending team, the drug service, the trust's adult mental health service and the inpatient team in the neighbouring trust's tier 4 facility. Weeks earlier, W had also been assessed by the trust's Transition and Engagement Team (face-to-face) as well as by a different tier 2

CAMHS provider (who did not see him) and staff in the acute trust where he was treated following episodes of self-harm. Diversion and the GP were also involved meaning that a total of 12 services had assessed W over the previous two months, all but one face-to-face. Despite this, no clear pathway for his care had been established.

**PRACTICE DEVELOPMENT POINT: REPEATED ASSESSMENTS**

We commended the individual practitioners for their involvement at this stressful time for W and his family. However, we qualified this with a note of caution about the unintentional but nonetheless real intrusiveness and re-traumatising nature of repeated assessments. These focused on sexual abuse and other features of W's case that, in hindsight, were markers of exploitation.

This was a confusing time for W and his family. Having repeatedly disclosed a complex history of trauma, involvement in drug-related crime and suicidal behaviour over the previous two months, they still did not know which mental health team would pick up W's case or what any mental health service could offer. On several occasions, W's self-injurious behaviour increased immediately after a mental health assessment.

When we met W he told us that he had deliberately refused to co-operate with the pre-sentencing mental health assessment that occurred in prison eight months after the homicide. Having seen that assessment and the judge's comments, our view is that negative inferences were drawn from W's non-cooperation that may have fed directly into the judge's sentencing decision.

The Children's Society noted that a barrier to engagement was that the "Young person may have experienced multiple professionals talking about concerns with them which again could lead a young person feeling frustrated/unable to engage".[22] In our view, this resembled W's experience.

3.30 In hospital, W showed no signs or symptoms of delusions, paranoia or distress and after his second night he asked if he could discharge himself. In the absence of evidence of severe mental health symptoms or suicidal intent he was given home leave over the weekend and discharged the following Monday with a plan of ongoing support from the local authority's MDT service which, it was hoped, might be able to activate CAMHS.

3.31 In its initial assessment based on speaking to W's mother, the MDT noted:

"[W] has been involved in a gang where there has been drug taking and weapons. [18 months previously] he was arrested on suspicion of an attempted betting shop robbery and the house was raided. [W] then disclosed that he had been pressurised to take the blame but the charges against him were dropped.

---

[22] https://www.csepoliceandprevention.org.uk/sites/default/files/Exploitation%20Toolkit.pdf

[W] has said to [his mother] that he has seen things in the gang but he does not want the repercussions from telling the police. However he says that he cannot get some things out of his head. [W] expresses that he would like to move away and have a fresh start."

**PRACTICE DEVELOPMENT POINT: GANG INVOLVEMENT, NATIONAL REFERRAL MECHANISM AND EMERGENCY PROTECTION ORDERS**

With hindsight not available to the services at the time, it is clear that W was the most open about the impact of CCE on his life and its role as a driver of his suicidal behaviour during the admission. It seems to us that he regarded it as his own problem to contain, the disclosure of which would endanger his family as well as amplifying his fears for his own safety and his suicidal tendencies. We emphasise that W was a child during the vast majority of the period where he was subject to exploitation.

It is unclear to us whether W would have met the criteria for the National Referral Mechanism (NRM) which has existed since 2009 to identify human trafficking or modern slavery and ensure that victims receive the appropriate support.[23] Another tool in cases of CCE is the Emergency Protection Order (EPO)[24] derived from Section 46 of the Children Act 1989 which provides for the removal and accommodation of children by police in case of emergency.

Even while disclosing gang intimidation, hindsight tells us that W held back much information. Nor can we say if a real opportunity existed to extricate W from CCE through the NRM or any other mechanism. However, W's case has illustrated the need for practitioners to heighten their awareness of county lines CCE and their knowledge of the available options to inform their dealings with children, their families and partner agencies.

3.32 While awaiting sentencing for manslaughter a year later, W provided this account to the probation officer undertaking the pre-sentencing report which we think related to his activities in the six to nine months preceding the homicide:

"He was introduced to the gang by a friend and older males in the group began to take him on trips to buy drugs, clothes and gadgetry like mobile phones. […] he viewed the males as his friends and his main concern was his confirmed access to free cannabis so he did not question the situation.

W indicated he was aware that the males he chose to associate with were dealing drugs but was unaware of their violent activity. W said he never saw the males being violent towards others and that they were never abusive or threatening towards him. […] in interview W denied ever feeling under pressure from the gang to become involved in criminal activity and stated he did not fear them."

[23] http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism
[24] https://www.legislation.gov.uk/ukpga/1989/41/section/44

**SAFEGUARDING POINT: GROOMING II**

According to the Manchester Safeguarding Children Board: "One of the key factors found in most cases of county lines exploitation is the presence of some form of exchange (e.g. carrying drugs in return for something). Where it is the victim who is offered, promised or given something they need or want, the exchange can include both tangible (such as money, drugs or clothes) and intangible rewards (such as status, protection or perceived friendship or affection).

It is important to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a young person or vulnerable adult does not make them any less of a victim. It is also important to note that the prevention of something negative can also fulfil the requirement for exchange, for example a young person who engages in county lines activity to stop someone carrying out a threat to harm their family."[25]

3.33 W disclosed guilt about drug misuse and gang-related activity and a wish to dissociate himself from it to the trust's early intervention team. He was taken into case management and another psychiatric assessment was arranged. In it, the well-established history was taken including "long-standing issues within personality of negative thinking, low mood and anxiety". As before, there was no evidence of psychosis.

3.34 The day after the assessment W's mother reported that, again, W's mood had dipped with worsening negative thoughts. W's cannabis use had also increased. His family was worried that W would resume self-harming. W meanwhile expressed confusion about the different professionals seeing him. W felt that things were bad around him and he wanted to move away. The people involved in the robbery had recently followed him in their cars and he had run away. He wished they would "just get it over with".

**SAFEGUARDING POINT: EXTERNAL THREATS**

We were concerned that no-one took up the issue of the external threats described by W and his family and the reality or otherwise of these. If there were indeed the external threats described then therapy alone was unlikely to resolve the issues; W would have needed protection. With hindsight, we have no doubt that he needed protection. Here as before we noted the many workers involved. The joint assessment visits represented good practice but formalised multi-agency care planning was needed. In our view W needed someone who could build a relationship with him and help him navigate his way through the process. We highlight the barriers to engagement, and solutions, in the next section.

[25] https://www.manchestersafeguardingboards.co.uk/resource/gangs-and-violence/

3.35 Two months after engaging with the early intervention team, W told the professionals that he had been feeling better and was going away to find seasonal work. Soon after, however, his mood deteriorated markedly and he was verbally aggressive towards his family, smashing bedroom furniture. Fearing that he could harm himself and that a knife had disappeared from his grandmother's home, his family called the police. W denied taking a knife or using cannabis and ascribed the incident to his family "winding him up". W refused to be seen by the early intervention team and was discharged shortly afterwards by all the services involved (apart from the youth offending team with whom he had several months to serve on the referral order).

3.36 Days later W saw an out of hours GP with a facial injury that he said had been caused by rugby tackling a friend and banging his nose on his knee. W refused to accept medical care. He did not attend many of his youth offending team appointments over the following months and was issued with a formal warning about non-compliance with the order. His mother reported him to the police as kidnapped. Days later, a few weeks after his discharge from the early intervention team, W killed G.

**COUNTY LINES AWARENESS: "GOING COUNTRY" OR "OT" and INJURIES TO YOUNG PEOPLE**

Professional concerns should always be activated by implausible accounts of injuries and reports of young people going away to unspecified, unverifiable places where they cannot be seen or easily contacted. With hindsight, it is highly likely that W was "going country" or "out there" (OT) during this period, in other words moving drugs and money between an urban hub and rural "county" locations.

We commend the first-hand accounts of young people of going country to professionals and note the similarities of some to W's experience.[26]

# 4 Key themes from W's story

## Engagement

4.1 The Children's Society lists the following barriers to engagement, all of which we consider relevant to some degree to W's case:

- "Child criminal exploitation not being recognised and responded to as a safeguarding concern.
- Professionals viewing criminal exploitation as a 'lifestyle choice' which can make a young person feel blamed for their exploitation or reinforce a young person's feeling of ownership of an untrue identity of autonomous drug dealer.
- Services not being consistent or persistent in their approach and closing due to 'non engagement'.

[26] For example: https://www.vice.com/en_uk/article/gyjzbw/what-its-really-like-going-country

- Young person fearful of repercussions towards themselves, friends or family if seen to be engaging with professionals.
- Young person may still be being controlled by exploiters and have no ability or power to exit.
- Even if the police are involved, young person still may not feel safe or protected from repercussions.
- Young person may have distrust in services such as police and social care
- Young person may be fearful of getting in trouble with the police or be in breach of court order.
- Children who have experienced previous abuse, fractured attachments and trauma, hold a deep mistrust of adults and services.
- Young person may be made to feel they are in 'debt' to perpetrators and/or reliant on the 'exchange' i.e. money/substances- this is often referred to as 'debt bondage'.
- Young person withdrawn from support network due to grooming process and unable to access services.
- Structural inequalities related to race, gender, ethnicity, class, culture, education.
- Young person may have experienced multiple professionals talking about concerns with them which again could lead a young person feeling frustrated/unable to engage.
- Young person feeling embarrassed/ashamed of their experiences".[27]

4.2 We commend the guidance within the Children's Society toolkit.[28] Key lessons for engagement we have identified from W's case are:

- Better co-ordination of care within and between services to avoid multiple assessments; we consider that CAMHS should take a lead co-ordination role.
- Better awareness of the manifestations of county lines CCE and CSE and of the multi-agency frameworks and resources available to children and their families.
- A more holistic and CCE-aware mode of assessment for mental health professionals where potential links between external threats and superficially mental health-driven behaviours are given more weight.
- An assertive outreach approach to engagement that is responsive, down to earth and experienced as accessible and trustworthy by the child and their family. Continuity of staff involvement was particularly appreciated by W and his family. In our view this approach was demonstrated very effectively in W's case by Diversion and the drug service.

[27] https://www.csepoliceandprevention.org.uk/sites/default/files/Exploitation%20Toolkit.pdf
[28] https://www.csepoliceandprevention.org.uk/sites/default/files/Exploitation%20Toolkit.pdf

## Safeguarding

4.3 With hindsight, we have highlighted the following potential markers of CCE in W's case that were not fully recognised as such at the time:

- Persistent behavioural problems at school and being perceived as a trouble maker
- CSE, bullying and humiliation
- Criminal contact
- Post traumatic elements to his presentation
- Disclosures of external threats related to drug use and distribution
- But also, a refusal to disclose in detail
- Disappearances that were not fully or plausibly explained
- Signs of grooming
- Fear of being out and about; needing money; injuries
- Guilt, despair, self-injury and seemingly impulsive and inexplicable suicidal behaviour.

4.4 The 2010 Home Office guidance "Safeguarding children and young people who may be affected by gang activity" includes the following insights and guides for practice:

- The siblings of young people involved in gangs are at risk of involvement
- Young people who commit crime have significant needs themselves and practitioners have a responsibility to safeguard and promote their welfare: "Victims and offenders are often the same people" with a dual victim and perpetrator status
- "Close partnership working and shared intelligence between local authority children's social care and law enforcement and public protection agencies will be vital to achieve the right balance of support and criminal justice whilst safeguarding the child's welfare."[29]

4.5 We found that the services did not take up safeguarding issues appropriately. We accept that it is always harder when someone is over 16 and refuses to co-operate with investigations. However, there were references to a sexual assault and repeated threats from others. None of the involved services appear to have expressed curiosity about how much of W's presenting symptomatology was connected to external threats despite his repeated references to being threatened. The main approach was advice to W, who was still a child during most of the period under consideration, to avoid his previous "friends".

4.6 We acknowledge that the services involved were faced with a significant, perhaps insurmountable, task, in understanding the CCE that W was exposed to. In this regard we commend the Children's Society advice overleaf (Table 1) about how professionals should develop their understanding of CCE.

[29] https://www.staffsscb.org.uk/Professionals/Resources-Tools/Supplementary-Guidance/DCSF-Safeguarding-children-who-may-be-affected-by-gang-activity-2010.pdf)

**Table 1: Children's Society advice on how professionals should understand CCE** [30]

| Inappropriate terms | Suggested alternatives |
|---|---|
| *Drug running*<br>*He/she is drug running* | Child criminal exploitation (CCE)<br>The child is being trafficked for purpose of criminal exploitation. |
| *Recruit/run/work* | This implies there is a level of choice or control by the child regarding their exploitation and does not take into consideration the grooming, coercion, threats or intimidation. A more appropriate description would be that the child is being criminally exploited. |
| *He/she is choosing this lifestyle* | Again, this implies there is a level of choice or control by the child regarding their exploitation and does not take into consideration the grooming, coercion, threats or intimidation. A more appropriate description would be that the child is being criminally exploited. |
| *Spending time/associating with 'elders'* | The young person says that they are friends with a person and there are concerns about that person's age, the imbalance of power, exploitation, offending. The young person has been groomed, exploited, controlled.<br>If the 'elder' is under the age of 18 years old- this will also need to be considered using child protection processes. |
| *Offering him/her drugs seemingly in return for sex or to run drugs* | Child is being sexually/criminally exploited.<br>Child is being criminally exploited through drug debt.<br>Concerns that the child has been raped.<br>Perpetrators are sexually abusing the child.<br>The child is being sexually abused.<br>The child's vulnerability regarding drug use is being used by others to abuse them.<br>The perpetrators have a hold over the child by the fact that they have a drug dependency. |

## Risk assessment and management

4.7 We found that individual service risk assessments were as thorough and holistic as the information available to each service allowed. We have highlighted how awareness of county lines, CCE and CSE could have enhanced multi-agency risk assessment and management.

[30] https://www.csepoliceandprevention.org.uk/sites/default/files/Exploitation%20Toolkit.pdf

4.8 Our assessment of the interaction between trust services and the youth offending team is that closer joint working would have been of benefit to W and his family. We found scant evidence of attempts on the part of trust staff to collaborate with their youth offending team colleagues even though the youth offending team was the lead agency in managing W's offending risk and had several years' experience of working with him. Better communication was particularly indicated when W was subject to care management through the early intervention team. This might have taken the form of:

- Using information from the youth offending team to assess and manage risk fully (the youth offending team's risk assessments benefited from a far wider evidence base than the trust's, reflecting the views of W's teachers, the police, reparation staff, Diversion and the assigned youth offending team officers as well as the complete forensic history that no trust staff member was ever aware of).
- Jointly assessing the extent and implementation of the multi-agency safeguarding response that should have been applied to W's disclosure of CSE.
- Mutual awareness of, and support for, complementary work undertaken in parallel by each service, for example in helping W to manage his anger and to retain/regain employment.

4.9 We found that if they were not going to do direct work CAMHS should have taken a consultative brief with the other services to help them manage risk, particularly when W's prosocial opportunities were significantly reduced, and his availability in service operating hours increased, after his accident. We also think that CAMHS should have helped everyone to create a longer term management plan for W. Arguably they should have pointed out the need for social services involvement, particularly after the CSE disclosure some years before the homicide. Even if their direct work was limited, CAMHS needed to provide guidance to others who were clearly saying they were out of their depth. This leadership and coordination role was needed more than ever during the confusing multiagency episode preceding the involvement of the early intervention team.

# 5 Summary of findings and recommendations from NHSE's independent investigation into the care of W

5.1 Our overarching conclusion was that all the services that engaged with W provided good quality care and support. We identified missed opportunities by the youth offending services and the trust to invoke safeguarding procedures. We felt that W's and his mother's references to other external threats should also have been explored in more detail. We have expanded on our thinking in that regard in this case study.

5.2 The trust's risk assessments in particular, as we have noted, could have taken in more information. And there could have been much better co-ordination of

the services involved in repeatedly assessing W, few of whom offered him and his family the support they needed.

5.3 We identified a number of options that could have been given more consideration including the use of medication and therapy. We were also critical of the trust for failing to meet the national requirements in its internal investigation and report; and of the local clinical commissioning groups for not referring the investigation back to the trust to complete in line with those requirements.

5.4 Our overarching conclusion was the same as the Trust's - it could not have prevented or predicted the homicide. We reached the same conclusion about the other services involved.

5.5 The most effective service delivery that occurred, we found, was through the involvement of the drug service and Diversion from 2013. In our view both exceeded their remit in their availability to W and his family, particularly during crises. We also commended the extent to which they involved themselves in other services' interventions. Their ready availability to W and his family, and the continuity of practitioner contact that they offered, seems to have engendered a high level of trust. These features of their approach, we found, were the most effective tools for engagement with W. Our view is that they should be given weight in the commissioning and provisioning of services aimed at children being targeted for criminal exploitation.

5.6 We made nine recommendations for the services involved in order to improve learning from this episode of care.

5.7 The recommendations have been grouped into four themes; policy adherence; service delivery, transition and development; staff training and development; and serious incident management.

## Policy adherence

**Recommendation 1**
The Trust must ensure that when safeguarding issues are raised by children, young people and their families, workers follow the safeguarding policy. If there is any question about how the safeguarding policy should be applied, workers should consult the relevant Trust safeguarding advisor.

## Service delivery, transition and development

**Recommendation 2**
The Trust must ensure that a seamless pathway exists between CAMHS and substance misuse and youth offending services provided by other organisations. Substance misuse and youth offending services should not be seen as separate but rather as essential components of a comprehensive service for young people.

**Recommendation 3**
The Trust must review its arrangements for making the expertise of CAMHS psychiatrists available to local GPs and set out concrete steps that will improve their availability to primary care clinicians.

**Recommendation 4**
The Trust must ensure that protocols for service transitions are well-designed and adhered to, the basic principle being that the services follow the patient and artificial boundaries do not hinder the meeting of clinical need.

**Recommendation 5**
The Trust must ensure that when a transfer from one service to another is made, the referring service ensures the patient is reviewed/treated appropriately by them insofar as they are able to do so until the new service takes over. The two services have a responsibility to ensure that they communicate with one another, the receiving service making it clear that they have taken over the patient's management and the referring one not discharging until this has been done.

**Recommendation 9**
The Trust and the council must incorporate key messages from Public Health England's July 2017 document "Better care for people with co-occurring mental health and alcohol/drug use conditions, A guide for commissioners and service providers" into their Local Transformation Plans to ensure that:

- Substance misuse is not seen as a reason for CAMHS to not get involved in the care of a young person.
- Trust services, in particular CAMHS and the early intervention team, collaborate fully with substance misuse services in care planning and risk assessment and management.

### Staff training/development

**Recommendation 6**
The Trust and the council must formally educate staff working with young people about drug and gang culture, with particular reference to:

a. How to pick up clues that service users are involved.
b. The mental health implications.
c. Safeguarding implications.
d. Risk assessment.

### Serious incident management

**Recommendation 7**
The Trust must ensure that its incident investigations fully comply with the requirements of the Serious Incident Framework (SIF).

The Trust must include ensuring that the provisions in section 1.5 of the SIF are followed so that it collaborates with partner organisations whenever possible, when there is an overlap between the Trust's and the partner organisation's investigation.

**Recommendation 8**
The CCGs should ensure that their policies and procedures for reviewing serious incident investigations fully comply with the Serious Incident Framework, in particular section 4.5.2. The policies and procedures should provide clarity about:

(a): The need for all provider incident investigations to receive proportionate scrutiny and challenge, regardless of whether they may later be subject to Level 3 investigation though NHSE;

(b): How internal and partner challenges to the process and/or outcome of an SI investigation should feed into decision-making;

(c): The requirement to highlight concerns or areas requiring further action to the provider at the earliest opportunity to facilitate timely action and resolution of issues raised; and

(d): How requests by the CCG to the provider to undertake additional work are logged, tracked and followed up.

# 6 Learning points

6.1 Home Office guidance identifies the practical and strategic roles for Local Safeguarding Children Boards (LSCBs):

"LSCBs should ensure that local procedures and multi-agency protocols are in place for children at risk of harm through gang activity in their area. Clear protocols can help to create a seamless, collective response to meet the needs of children and young people. The protocols can be part of, and should be consistent with, wider LSCB policies and procedures for safeguarding children and other relevant protocols in the local authority, for example on youth offending. The identification of a child at risk of harm related to gang involvement should trigger the agreed local procedures.

It is important to establish a sound local evidence base, including informal intelligence and anecdotal reports, to use as a starting point for developing local protocols and procedures on gang activity. As noted earlier in the guidance, characteristics and activities of gangs differ widely across the country and local intelligence will be needed to develop a robust evidence base."[31]

6.2 We welcome the interest of the LSCB in W's area in using his case as a learning tool to improve multi-agency initiatives to identify and combat CCE. We highlight the value of a local multi-agency group focusing on gang-related activity to support information-sharing and preventative work across the local authority and maintain an overview of threshold levels across different agencies and the use of specific risk assessment processes.

6.3 The learning points from the case of W are shown below in the categories of practice development safeguarding and good practice, for relevant organisations to use to enhance practice.

[31] https://www.staffsscb.org.uk/Professionals/Resources-Tools/Supplementary-Guidance/DCSF-Safeguarding-children-who-may-be-affected-by-gang-activity-2010.pdf)

**PRACTICE DEVELOPMENT POINT 1 - COUNTY LINES AWARENESS: 'GOING COUNTRY' OR 'OT' and INJURIES TO YOUNG PEOPLE**

Professional concerns should always be activated by implausible accounts of injuries and reports of young people going away to unspecified, unverifiable places where they cannot be seen or easily contacted. With hindsight, it is highly likely that W was 'going country' or 'out there' (OT) during this period, in other words moving drugs and money between the urban hub and semi-rural 'county' locations.

**PRACTICE DEVELOPMENT POINT 2 - CONTINUITY OF CARE**

The fact that pressure from others was pushing W towards impulsive self-injurious acts was correctly identified and graded by the mental health professionals who assessed W. Given the risks associated with W's presentation, and the lack of a clear diagnosis, the CAMHS plan to follow W up within 72 hours with a fuller assessment was, we judged, correct.

Here and at other times in W's story we felt that CAMHS could have done much more to support W, his family and the other services involved. The repeated crisis-driven assessments ended in inconclusive plans involving no actions for the service itself. These included suggestions that W might self-refer to therapy and try to avoid his 'friends'. The possibility of ADHD being a factor in W's presentation was never explored and a role for medication for W's anxiety was never considered.

**PRACTICE DEVELOPMENT POINT 3 - GANG INVOLVEMENT, NATIONAL REFERRAL MECHANISM AND EMERGENCY PROTECTION ORDERS**

With hindsight not available to the services at the time, it is clear that the time of the admission was when W was the most open about the impact of CCE on his life and its role as a driver of his suicidal behaviour. It seems to us that he regarded it as his own problem, the disclosure of which would endanger his family as well as amplifying his fears for his own safety and his suicidal tendencies. We emphasise that W was a child during the vast majority of the period where he was subject to exploitation.

It is unclear to us whether W would have met the criteria for the National Referral Mechanism (NRM) which has existed since 2009 to identify human trafficking or modern slavery and ensure that victims receive the appropriate support. Another tool in cases of CCE is the Emergency Protection Order (EPO) derived from Section 46 of the Children Act 1989 which provides for the removal and accommodation of children by police in case of emergency.

Even while disclosing gang intimidation, hindsight tells us that W held back much information. Nor can we say if a real opportunity existed to extricate W from CCE through the NRM or any other mechanism. However, W's case has illustrated the need for practitioners to heighten their awareness of county lines CCE and their knowledge of the available options to inform their dealings with children and their families.

**SAFEGUARDING POINT 1 - REPORTING ALLEGED SEXUAL ABUSE**

Since the events of this case, more has been found about how young people are groomed and coerced into gang activities. The NCA reported the case of a 17 year old boy who, as a "runner" in a line operating from Liverpool, had been sexually abused by gang members. It also reported a female victim being filmed while being sexually assaulted by multiple gang members. The footage was used to shame and coerce her boyfriend. In section 2 of this case study we also refer to evidence that indecent images are taken and shared as part of gang initiation/revenge/punishment.

While W was rightly presumed innocent of the betting shop robbery, he was potentially associated with significant criminality. His account of being pressurised into violent acts by older associates was another potential marker of gang initiation/involvement.

**SAFEGUARDING POINT 2 - ACTING ON DISCLOSURES OF ABUSE**

There needs to be a clear pathway when a sexual assault on a child is reported, even if the report is incomplete. If there is a suspicion about a sexual assault it must be followed up i.e. the family must report and if they do not the service must. If in doubt then the service needs to clarify with the family what they know and make a decision based on the probabilities following discussion. If the family is unwilling, the minimum service response would be discussions with service's safeguarding lead who would then decide the best approach with the team. A disclosure of this nature must be acted on. The lack of action from the service in W's case was particularly significant in hindsight as this episode was, quite possibly, child sexual exploitation (CSE) linked to gang manipulation of W.

**SAFEGUARDING POINT 3 - DEBT BONDAGE & 'TAXING'**

We contrast W's family's repeated reports of what was happening to W with his own refusal to admit that he was the victim of CCE. It has been reported that the deeper the extent of the CCE, the more reluctant the child is to report it, to a significant extent due to their fears for the impact on their family.

According to the NCA, 'Taxing' is a newly-reported term which describes the infliction of violence in order to obtain control i.e. the marking or injuring of a gang member who has done wrong, as a show of strength to others. It is thought to be used in a similar way to the term 'debt bondage' i.e. the creation of a drugs debt, perhaps through fake robbery, which the victim then has to pay off. Evidence of taxing was reported by 35% of forces (15) with a further 5% of forces (2) noting potential evidence."

**SAFEGUARDING POINT 4 - GROOMING I**

Grooming, which in the county lines context often involves giving a young person money and drugs, is defined as: "… when someone builds an emotional connection with a child to gain their trust for the purposes of exploitation or trafficking. Children and young people can be groomed online or face to face, by a stranger or by someone they know (for example a family member, friend or professional). Groomers may be male or female. They could be any age. Many children and young people don't understand that they have been groomed, or that what has happened is abuse".

The NCA recommends that: "Better education is needed to provide children with an awareness of what grooming is, what it might look like and how they might be at risk. It is important to demystify some of the hype and arm children with the necessary skills to identify what might be happening and how to respond effectively and positively.

**SAFEGUARDING POINT 5 - GROOMING II**

According to the Manchester Safeguarding Children Board: "One of the key factors found in most cases of county lines exploitation is the presence of some form of exchange (e.g. carrying drugs in return for something). Where it is the victim who is offered, promised or given something they need or want, the exchange can include both tangible (such as money, drugs or clothes) and intangible rewards (such as status, protection or perceived friendship or affection).

It is important to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a young person or vulnerable adult does not make them any less of a victim. It is also important to note that the prevention of something negative can also fulfil the requirement for exchange, for example a young person who engages in county lines activity to stop someone carrying out a threat to harm their family.

**SAFEGUARDING POINT 6 - RETURN HOME INTERVIEWS**

In England, all children who go missing from home or care are entitled to a return home interview (RHI). RHIs are an opportunity for professionals to discuss with the young person why they went missing and what happened to them whilst they were away. They may identify risks of criminal exploitation and offer a way to ensure effective early intervention. They may also serve as a source of intelligence for the police and other safeguarding professionals. According to the Children's Society:

"RHI provision across England is patchy and evidence demonstrates that not all local authorities offer RHIs to all groups of children and young people who run away or go missing from home or care. The same report found many children reported as 'absent', are not offered a RHI when they return despite evidence from the [All-Party Parliamentary Group] highlighting the risks and vulnerabilities that many of these young people face. Therefore, for a large number of vulnerable children and young people the opportunity to identify county line risk and intervene early may be lost.

**SAFEGUARDING POINT 7 - EXTERNAL THREATS**

We were concerned that no-one took up the issue of the external threats described by W and his family and the reality or otherwise of these. If there were indeed the external threats described then therapy alone was unlikely to resolve the issues; W would have needed protection. With hindsight, we have no doubt that he needed protection.

Here as before we noted the many workers involved. The joint assessment visits represented good practice but formalised multi-agency care planning was needed. In our view W needed someone who could build a relationship with him and help him navigate his way through the process.

**GOOD PRACTICE POINT 1 - ENGAGEMENT, TRAINING & EMPLOYMENT**

We commended the youth offending and drug services for their responsive and holistic approach to W's at times avoidant presentation. They liaised effectively with other services and extended additional support to W and his family when he was charged. In particular, the youth offending and drug services seem to have been responsive to the sudden changes in W's behaviour and the risks flagged by his family. In contrast CAMHS repeatedly avoided engaging with W and joint working with the agencies involved.

The centrality of employment and training provision in the prevention of gang activity is emphasised in the guidance. It is clear that, between the ages of 16 and 17, W was walking a tightrope between prosocial activities (in particular employment) and antisocial behaviour and associations. Again, we contrasted the strenuous efforts of the youth offending and drug services staff to support W's prosocial lifestyle with CAMHS's repeated refusals to get involved.

**GOOD PRACTICE POINT 2 - ASSESSMENT**

We commended Diversion for the thoroughness of its assessment, 18 months prior to the homicide and for its determination to get the right service in place for W. The assessing nurse correctly realised that W could undergo a relapse quickly and unpredictably, with associated risks to himself and others, however competently he presented during the artificial process of a mental health assessment. Previous assessment formulations had not stood the test of time.

Diversion was the only service prior to the homicide that assessed a potential risk from W of harm to others. In particular, it was understood that there was a fragility to W's grip on the prosocial values and lifestyle that the youth offending team was trying to foster through training and employment-related support.

## Appendix: Bibliography & resources

**Gangs and group offending: guidance for schools**, Department for Children, Schools and Families (DCSF), (2008), https://www.lemosandcrane.co.uk/dev/resources/DCSF%20-%20Guidance%20on%20Gangs%20and%20Group%20Offending%20for%20Schools%5BJune08%5D.doc

**Teenagers at risk, The safeguarding needs of young people in gangs and violent peer groups**, NSPCC, March 2009 https://www.nspcc.org.uk/globalassets/documents/research-reports/teenagers-at-risk-report.pdf

**Safeguarding children and young people who may be affected by gang activity**, Home Office, 2010 (no longer on the Government website but available elsewhere e.g. https://www.staffsscb.org.uk/Professionals/Resources-Tools/Supplementary-Guidance/DCSF-Safeguarding-children-who-may-be-affected-by-gang-activity-2010.pdf)

**Multi Agency Working and Information Sharing Project**, Final report, Home Office, July 2014, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf

**Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children**, HM Government, March 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

**Ending Gang Violence and Exploitation**, Home Office, 2016, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/491699/Ending_gang_violence_and_Exploitation_FINAL.pdf

**County Lines Violence, Exploitation & Drug Supply 2017**, National Briefing Report, National Crime Agency, November 2017 http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file

**What It's Really Like 'Going Country', We spoke to two young men who have been sent miles from home to sell crack and heroin for drug gangs**, 28 November 2017, VICE website, https://www.vice.com/en_uk/article/gyjzbw/what-its-really-like-going-country

**Briefing for debate on ‘county lines’ in London** 9.30am-11.00am, Wednesday 17th January, Westminster Hall, Children’s Society, January 2018, https://www.childrenssociety.org.uk/sites/default/files/county-lines-westminster-hall-debate-jan18.pdf

**Safeguarding Children Affected by Gang Activity and/or Gang-Related Serious Youth Violence**, Multi-agency Protocol and Practice Guidance, Islington Safeguarding Children Board 2018, http://www.islingtonscb.org.uk/SiteCollectionDocuments/Gangs%20Safeguarding%20Protocol%20and%20Appendices.pdf

**Safeguarding children and young people who may be affected by gang activity**, Greater Manchester Safeguarding Partnership, 2018, http://greatermanchesterscb.proceduresonline.com/chapters/p_sg_ch_yp_gang_act.html

**Gang activity & serious youth violence – information for practitioners**
Greater Manchester Safeguarding Partnership, 2018,
https://www.manchestersafeguardingboards.co.uk/resource/gangs-and-violence/

**Resources, Youth Justice Resource Hub**, 2018, https://yjresourcehub.uk/yjb-effective-practice/youth-justice-kits/item/358-county-lines.html

**Children and Young People Trafficked for the Purpose of Criminal Exploitation in Relation to County Lines, A Toolkit for Professionals**, The Children's Society in partnership with Victim Support and the National Police Chiefs' Council (NPCC)
https://www.csepoliceandprevention.org.uk/sites/default/files/Exploitation%20Toolkit.pdf

**Serious Violence Strategy**, The Home Office, April 2018,
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf

**County lines: criminal exploitation of children and vulnerable adults**, Brings together documents and promotional material related to the government's work to end criminal exploitation, April 2018, https://www.gov.uk/government/collections/county-lines-criminal-exploitation-of-children-and-vulnerable-adults

**Keeping children safe in education, statutory guidance for schools and colleges**
(revised guidance commencing on 3 September 2018) 2018
https://www.gov.uk/government/publications/keeping-children-safe-in-education--2

**Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers**, July 2018,
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf