P22

01
Background
P22 was 16 years old. He had been known to agencies since early in his life and had been a looked after child until 2018 when he had been returned to the care of his mother. In the last years of P22's life concerns had been raised about his behaviour which, on reflection, could have been consistent with involvement in criminal exploitation.

02
Safeguarding concerns
Concerns were raised after P22's tragic death about potential child criminal exploitation. P22 had been a cared for child from his early life until his return to his family when he was 12 years old. Alcoholism and domestic abuse in the family home continued to be a concern for P22. During his early teenage years he was involved with criminal activity.

03
The incident
P22 tragically died in a road traffic incident

04
The review
The review considered the following:
- The decision for P22 to be returned to his family without any evidence that changes had been made to issues such as alcoholism and domestic abuse.
- Non- engagement of families
- Child missing from education
- Agencies believing the child to be a criminal rather than being criminally exploited

05
The findings
- Working with the family was seen as difficult. Agencies responded to incidents rather than considering what it was like for P22 to live at home.
- Although P22's involvement in criminal behaviour was known, this did not raise safeguarding concerns about potential child criminal exploitation.
- Evidence of "start again syndrome" as new workers and agencies came involved in P22's life and past information was not always considered in line with current.

06
Recommendations
- A multi-agency task and finish group is to be identified to undertake the following work:
- Ensuring that Tameside Multi agency services are compliant with the recommendations as per national panel review of complex safeguarding In Plain Sight and "It's Hard to Escape"
- Recurrent themes and learning of local rapid reviews and local child safeguarding practice reviews are embedded into multi-agency safeguarding practice
- Agencies need to ensure that their workforce have skills to respectfully challenge families where non –engagement with services is impacting on children and young people receiving support and protection
- Agencies need to ensure that practitioners are aware of policies and procedures in place to escalate concerns about delays to multi-agency planning of care for children such as case conferences, core group meetings and legal gateway planning
- When a young person is identified as being at risk of harm from criminality a safeguarding referral must be raised

07
Implementing Change
- Reflect on the findings and discuss the implications for your service/practice.
- Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations

7 Minute Briefing

Tameside Safeguarding Children Partnership

P22

Name of Organisation .....

Team Manager .....

Name of Section & Team .....

Contact Details .....

Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

1.

2.

3.

Tameside Safeguarding Children Partnership

Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Partnership will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.

What actions have been agreed to improve practice?

What needs to happen?	Who will do it?	By When?	How will you know when it has been done?	How will you know if it has worked?

Tameside Safeguarding Children Partnership

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