Safeguarding Board publishes Serious Case Review findings

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Wolverhampton Safeguarding Children Board has today (Friday 4 October) published the findings of a Serious Case Review into the death of a 14-year-old last year.

The teenager, who is referred to as Child N in the review, was originally from Lithuania and had lived with her mother and stepfather in the UK for seven years.

Her life was cut tragically short when she was killed in a local park on the night of 11 April 2018. A 16-year-old was subsequently found guilty of her rape and murder and jailed for life on 22 February, 2019.

The Serious Case Review was commissioned by Wolverhampton Safeguarding Children Board to ascertain the involvement of agencies with Child N and to determine if any lessons could be learned about the way in which professionals work together to safeguard children in Wolverhampton.

It considered the 12 months leading up to Child N's death, covering the period in which concerns about her were raised and agencies became involved, and makes a total of eight recommendations for improvement which Wolverhampton Safeguarding Children Board and its partner agencies have either implemented or are in the process of implementing.

Linda Sanders, Independent Chair of Wolverhampton Safeguarding Board, said: "This was a tragic loss of a young, vibrant life, and our thoughts are with the victim's family and friends today.

"What happened to her highlights the risks which vulnerable children and young people can find themselves subject to – and sadly she experienced the dreadful and worst possible consequences which can result.

“What should have been an innocent meeting in a park with a boy that she knew ended with her life being cut cruelly short; what happened to her on that night could never have been foreseen.

"The Serious Case Review was commissioned to see what, if anything, agencies involved could have done differently which could have led to a different outcome.

"The review is very clear in its conclusion that there were no indications that her life was at risk from the person convicted of killing her, nor that her death could have been predicted or prevented.

"She was clearly vulnerable, but despite this, there was no evidence of criminal or sexual exploitation in her life; nor was she involved in gangs. And while she knew her killer, they were not close friends and there was nothing to suggest that, on meeting her, he would embark on such a horrific attack.

"This was a very complex case and the review found a number of areas of good practice by professionals, for instance the good work of her schools in reporting and following up episodes in which she had gone missing, the use of a variety of methods by police including social media to find her when this happened, and the efforts of professionals who built good working relationships with her.

"It also made a number of findings, primarily around the limitations of one of the assessments of her, the way in which agencies respond to missing children reports, misperceptions around what constitutes good attendance at school, and communication and engagement with children, young people and their families – including the need to involve interpreters when English may not be a family's first language.

"Importantly, the review makes eight recommendations for ways in which practice can be improved going forward, and these either have been or are being implemented by the Board and the agencies themselves.

"As a Board, we have also held an internal learning review process in relation to the perpetrator; this has recently been concluded and has also identified a number of actions which are being implemented."

She added: "On behalf of the Board, I would like to thank the family of Child N for their involvement in this review at what of course remains a very difficult time for them."

The purpose of a Serious Case Review is to establish what lessons can be learned about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children, to identify what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result, and, as a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children.

The report, by independent author Amanda Owen, has been published on the Wolverhampton Safeguarding Children Board website, www.wolverhamptonsafeguarding.org.uk.

The agencies involved in the Serious Case Review included Wolverhampton Safeguarding Children Board, the City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Wolverhampton Voluntary

Sector Council, West Midlands Police and Child N's two secondary schools in Wolverhampton.

Wolverhampton Safeguarding Children Board is a partnership of all the main organisations that work in the city to support children, young people and their families.

ENDS

Note to editors:

Amanda Owen, who led this review and wrote the report, is entirely independent of Wolverhampton Safeguarding Children Board and its partner agencies.

The statutory guidance in place at the time of the Child N's death requires Serious Case Reviews to be conducted in such a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed;
- and makes use of relevant research and case evidence to inform the findings.

It is also required that the following principles should be applied by Local Safeguarding Children Boards and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.