Serious Case Review

Child N

Agreed by the WSCB 9 September 2019

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1. Introduction

1.1. The Wolverhampton Safeguarding Children Board (WSCB) agreed to undertake a Serious Case Review (SCR) in respect of Child N in April 2018. This decision recognised the potential that lessons could be learned about the way that agencies work together to safeguard children in Wolverhampton[1].

1.2. Following the Report of 14-year-old Child N having gone missing in April 2018, her body was found in a local park the following day. She had been raped and murdered.

A 16-year-old boy, who was known to Child N from school, was subsequently found guilty and sentenced to life imprisonment.

1.3. Child N was originally from Lithuania and had resided in the UK for seven years. She lived with her mother and her stepfather who had been part of the family since Child N was three years old. Prior to her death she was the subject of a Child in Need plan[2] due to concerns about missing episodes and the possible risk of Child Sexual Exploitation (CSE)[3].

2. Process

2.1. An independent lead reviewer, Amanda Owen, was appointed to lead the review and write the report. Ms Owen is an experienced social work manager. She has been involved in case reviews in a number of LSCB areas, and most recently worked as strategic lead for child sexual exploitation and missing children and lead officer for an LSCB. She is entirely independent of WSCB and its partner agencies.

2.2 The process was supported by a review group consisting of representatives from each agency involved in the case, which met regularly. Three practitioner workshops were held to explore what had happened and identify the learning with those practitioners involved at the time. The events were well attended with the exception of the police officers who had direct contact with Child N as rota arrangements can

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[1] It was agreed the SCR would consider the professional involvement with Child N and her family from June 2017.

[2] Child in Need is under Section 17 (10) of the Children Act 1989, a child is a child in need if:

- He/she are unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a disabled child

[3] Child Sexual Exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

mitigate against prioritisation of such meetings for officers directly involved. The primary police priority on this case was that of investigation of the murder, prosecution and the subsequent court case.

2.3 The review considered the 12 months preceding Child N's death as this timeframe encapsulated the period wherein concerns about her were raised and agencies, other than school, became involved. During the review timeframe Child N went to live with her father in Northern Ireland. Written information was received from Belfast Health & Social Care Trust about their involvement with Child N and her family. Contact was made with the school where Child N attended briefly in Northern Ireland.

2.4 The author and a representative from the WSCB met with Child N's mother and stepfather while undertaking the review. Their views are reflected in the report.

2.5 It has not yet been possible to meet with Child N's father. This is being pursued and it hoped that he will be consulted with prior to publication.

2.6 For the purpose of this report, relevant family members are referred to by their relationship to Child N.

3. The Case

3.1. There had been three MASH (Multi-Agency Safeguarding Hub) [4]referrals about Child N in the 10 months prior to her death. The initial referral in June 2017 related to concerns shared by the police about Child N being seen with older males and her association with a child known to be at risk of CSE. There was a Strategy Discussion and a joint visit, to interview Child N in school, was undertaken by a police officer and a social worker. A Child Protection Enquiry[5] was opened but it was jointly agreed there was no reason to be concerned. The case was closed without Child N's parents being seen or informed of the enquiry.

3.2 Later in 2017 the school had increasing concerns about Child N's attendance and they attempted to meet the parents along with an Education Welfare Officer (EWO). Neither Mother nor Stepfather attended.

3.3 Child N was first reported missing in December 2017. Mother shared concerns that Child N may be using drugs and alcohol and she had suspicions of sexual activity.

[4] The MASH is the single point of contact for all safeguarding and early intervention concerns/requests for support regarding children and young people and the single point of contact for triaging and assessing all safeguarding concerns regarding adults in Wolverhampton. It brings together safeguarding professionals from services that have contact with children, young people, adults and families, making the best possible use of their combined knowledge and information to keep people safe from harm.

[5] Child protection enquiries are taken under S47(1) of the Children Act 1989 which states that: 'Where a local authority have reasonable cause to think that a child who lives or is found in the area and is suffering, or is likely to suffer, significant harm the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.' The decision to progress a section 47 enquiry is made at a Strategy discussion and involves the Police, Health and Children Social Care.

Missing return interviews [6]and a CSE toolkit [7]were completed. A social work assessment was then started, but not finished because Child N went to live with her father in Northern Ireland at the end of December 2017.

3.4 Health & Social Care in Belfast became involved following the police reporting concerns about the state of the Father's property. Child N then went to stay with her father's former partner. A social worker from Health & Social Care in Belfast spoke to Child N on the telephone. There was contact between social workers in Belfast and Wolverhampton in January 2018, including information sharing by Wolverhampton about the previous missing episodes and the potential CSE risk. The Wolverhampton social worker was only aware of Child N's move to Belfast as her previous school had informed them. The case was closed in Belfast without any further contact being made with Child N or her family.

3.5 Child N came back to Wolverhampton in February 2018 and started a new Wolverhampton school on 19 March 2018. Following her return Child N was reported missing on several occasions. It is understood that based on information from Child N and her mother's friend, that Child N had been missing from home more frequently; but a number of episodes had not been reported to the police by her mother or stepfather. Two further referrals into the MASH in March 2018 led to a social work assessment, a referral for support from Strengthening Families, and a Child in Need plan which included the completion of the CSE National Working Group (NWG) risk assessment.

3.6 Three days before her death in April 2018, Child N was arrested for the theft of a bank card from the family home. She told the investigating police officer that she stole the card in response to what she considered to be an unfair punishment by her parents. She was subsequently provided with a 'respite bed' in a residential unit overnight under Section 17[8] of the Children Act 1989. She returned home the following day. It was agreed at a strategy discussion that an Initial Child Protection Conference (ICPC)[9] should be held due to a range of concerns. Later the same day Child N went missing from home again. Mother reported her missing the following day and Child N's body was found 24 hours later.

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[6] Missing Return Interview is the terminology used in Wolverhampton for the 'Independent Return Interviews' or 'Return Home Interview' (RHI) undertaken after a child has been missing from home or care. (Statutory guidance on children who run away or go missing from home or care – DfE January 2014)

[7] The CSE Toolkit provides practitioners with guidance and tools to address CSE. There is a CSE screening tool that can be completed by anyone working with a child and a more in-depth assessment tool, known as a National Working Group (NWG) assessment, which is completed by social workers and some specialist practitioners.

[8] In Wolverhampton it is recognised that some families and young people may require additional s.17 support to prevent an admission to Local Authority care. Additional support is made available in specialist residential units which offer respite care which provide both young people and their carers with an opportunity to 'take stock 'whilst the crisis is happening, and the young person returns home swiftly.

[9] A Child Protection Conference is a multi-agency meeting that is held when there is a concern, as the result of a child protection enquiry, that a child or young person may suffering or likely to significant harm.

4. Analysis

4.1 When considering the case, it was agreed that the following areas required analysis, and these areas culminated in the findings from this review. Areas of analysis and findings relate to both systems and practice.

- Assessment and intervention
- Response to missing episodes
- Transfers
- Language

Assessment and intervention

4.2 The first social work assessment took place in June 2017. A police officer who was based with the Strengthening Families Early Help made the referral to the MASH about Child N being seen with older males and her association with a girl known to be at risk of CSE. The referral was rated as 'Amber' (which means that it should be actioned within 24 hours)[10]. There was a strategy meeting held 4 days later, but a joint visit by a police officer and social worker to see Child N didn't subsequently take place until nearly two weeks later.

4.3 Child N told the social worker and the police officer that she was no longer friendly with the girl because the girl's mother had stopped her daughter seeing her. She said that when they had been friends, they just used to go to town, watch films and go to the local park together. The case was closed without the police officer and social worker meeting Child N's mother or stepfather. It was stated that there was some difficulty contacting them because both adults worked long hours. Gaining the parents' perspective may have provided further insight into Child N's life and an opportunity to intervene with the family at an earlier stage. It is also inappropriate to have contact with a child without the parents being made aware in these circumstances. Mother and stepfather have subsequently confirmed that they were unaware of this referral. The social work manager authorised the closure of the case.

4.4 The case was closed as the professionals believed child's presentation at school wasn't consistent with concerns raised in the referral. Checks with the school showed Child N was performing well academically and had good attendance at that point. Both the police officer and the social worker's professional judgement was that there were 'no indications of CSE'. A CSE screening tool was not completed, but

[10] The MASH uses a traffic light rating to inform decision making and timescales: RED - There is a potential child protection issue (e.g. serious injury to the child). To be actioned within 4 hours (or immediately if required). AMBER - There are significant concerns, but immediate action is not required. To be actioned within 24 hours. GREEN - There are concerns regarding a child's wellbeing but, these do not meet statutory requirements (e.g. poor school attendance). To be actioned within 72 hours. For 'Reds' and 'Ambers' the Social Work Unit Manager will decide what agency information is required and then trigger an information request using the MASH information System. This will include the referral information and the RAG rating that has been applied. The Social Work Unit Manager may change the RAG rating as new information comes to light.

the use of the CSE screening tool at this stage wouldn't have flagged significant or serious risk based on what was reported by the school and Child N.

4.5 This practice does not meet expected standards in respect of both timeliness between the strategy meeting and seeing the child, the lack of involvement of other agencies and partners, and because parents were not seen or spoken to as part of the Section 47 enquiry.

Finding One: Closing Section 47 child protection enquiries without involving parents and undertaking checks with all agencies does not allow for a rounded view of risk and need.

Finding Two: All available and relevant assessment tools should be used according to the presenting concerns and should inform final decisions.

4.6 The review considered the issue of undertaking child protection enquiries without speaking to parents and other agencies. Through audit they found that this practice was not widespread.

4.7 Following the June 2017 referral, school were the only agency involved over a 6-month period as attendance was the only concern identified. Appropriately, letters were sent to Child N's Mother and Stepfather, by the school, and a meeting was arranged. The lack of parental response was interpreted as a lack of interest in Child N's education and welfare.

4.8 Mother and Stepfather told the review that everything changed just before Child N's 14th Birthday. Prior to then everything was reportedly fine, and they had no concerns about her behaviour and well-being. They were first alerted by a neighbour in October 2017 to Child N being seen out at 1 am. They said that over the next few months, Child N was spending more and more time away from them and became more like a "lodger." Mother and Stepfather were unhappy about Child N's relationship with her 14-year old boyfriend as they thought her behaviour had changed when she met him. Despite this, they had also talked about the possibility of her living with his family full-time, as Child N liked being there. Mother described Child N's wish to leave home as being "like fire burning under her feet."

4.9 In December 2017 there was a referral to Police and Children's Services by Child N's school. After being informed by the school that Child N had been absent on 6 December 2017, Mother told school staff that Child N had not been home the night before either. The school then reported Child N missing to the police, and two members of staff went looking for her. School staff then made several phone calls to Mother during the evening to find out if Child N had returned home, but there was no reply. They were concerned that Mother and Stepfather were disinterested in Child N's welfare, which was only reinforced in the minds of school staff when they found out that they had both been at work when police officers had called at their home. No further action was taken. The progression of an Early Help Assessment, at this time, would have served to give an overview of Child N's missing episodes, home situation and the professional perception of her parents. In turn, this may have led to

a coordinated multi-agency approach and a better understanding of Child N's home life which may have provided early help [11]interventions to support change.

Good Practice: The school attended by Child N, prior to her move to Belfast, were proactive in the reporting and 'follow up' of Child N's Missing episodes.

4.10 On this occasion Child N returned home after 48 hours. Stepfather challenged her and attempted to ground her, but this was ineffective as Child N left the house again immediately. The difficulties the family had in keeping Child N safe became apparent. Concerns came to light about the extent of the risk when Mother reported that she had searched Child N's room and found a shot glass, a knife, and condoms. At this point, Child N's potential vulnerability to CSE first informed the management of this case.

4.11 At the end of the Autumn term 2017, Mother informed the school that Child N no longer needed a school place as she was going to live with her father in Northern Ireland. The social work assessment ceased as Child N was no longer living in Wolverhampton and the assessment could not be completed or any plans put in place. Police records indicate that they were not made aware of the move to Northern Ireland until approximately a month after. Furthermore, agencies were not informed when Child N returned to Wolverhampton in February 2018.

4.12 In March 2018 a referral was made to the MASH by a friend of Mother's. Another social work assessment was started and completed within 11 working days, which is timely. Other services were appropriately asked to support the family during the assessment, and there is evidence in records of other agencies being part of this assessment. The outcome of the assessment was for Child N to be the subject of a Child in Need plan. The allocation of a social worker in the locality team made a good start on finding the most promising way of engaging with Child N and her family.

4.13 There is no record of a Child in Need meeting being held in March 2018 to bring the family and all relevant professionals together. The social work assessment was completed on 22 March 2018. A Child in Need meeting could have taken place at any time during this process or in the 12 working days before a decision was made to escalate to initial child protection conference. The ICPC was arranged within 15 days of the request, as is expected, but as Child N died prior to this Conference no multiagency meeting took place.

4.14 The assessment includes a completed section on parenting capacity where there is a description of what had happened and what had been said, but exploration of the

[11] **Early Help – single agency response** is the term used to describe where additional needs have been identified that require support; where support can be offered by a single agency co-ordinating a plan where they have control of the resources to fulfil that plan. All agencies and organisations are expected to complete an Early Help Assessment and record this within Eclipse.

Early Help – multi-agency response is the term used to describe where additional needs have been identified that require support; where resources outside of a single agency's control are required to fulfil the plan

parents' own experience and family history required greater focus. A sense of what a day in Child N's life was like, had been captured in the missing return interviews. Mother and Stepfather were asked to be less punitive. Records indicate that they were advised that their parenting styles were abusive, inappropriate and unacceptable. However, they were not offered alternative ways to respond to their daughter. Mother and Stepfather needed to be helped to develop alternative strategies in order to rebuild their relationship with Child N. Mother and Stepfather expressed their frustration at this approach when spoken to as part of the review. They felt their parenting techniques were restricted and this impacted on their ability to control their daughter's behaviour. They said that: "they tied our hands and untied Child N's."

4.15 The assessment could have been further enhanced by the consideration of the family's culture, story and view of the world as by so doing, an improved understanding of the family's dynamics and support networks would have been obtained. This approach may have helped to establish improved relationships and establish increased trust between professionals and the family.

4.16 The use of working agreements by the social worker was a feature of this case. Both parents and the child signed an agreement detailing expectations. The use of working agreements is widespread in social work practice, but the effectiveness of them is questionable; too often, as with Child N, children, young people and their families are not actively engaged in the development of them. A wider debate on their use in the context of restorative practice[12] in Wolverhampton is required.

Finding Three: The use of instructions and restrictions in working agreements for a child, young person and their family are not helpful in enabling them to make changes unless they are actively involved in developing them.

4.17 Language used in professional documentation when considering CSE was, at times, inappropriate[13] with too much onus being placed on the child. Helpful suggested alternatives for inappropriate terms have been widely circulated by the West Midlands Regional Organised Crime Unit (ROCU). It is important that professionals do not repeatedly record inappropriate language verbatim as this can provide a negative and inaccurate view of the child's circumstances[14].

[12] Restorative Practice is a relationship and strength-based approach that embodies a set of core beliefs, principles and a way of being with people that proactively promotes building a sense of community and developing social capital. It is a high support, high challenge model, doing things with people rather than to them or for them that creates a common language and a common approach to engaging families. Practitioners set a clear bottom line with families, which offers a more evidenced-based approach and effective alternative to working agreements.

[13] 'Words matter: Reconceptualising the conceptualisation of child sexual exploitation', in Beckett H and Pearce J (eds) Understanding and Responding to Child Sexual Exploitation. London: Routledge. Coleman, J The Nature of adolescence Routledge 2011

[14] Ofsted, Care Quality Commission, HM Inspectorate of Constabulary and HM Inspectorate of Probation (2016) 'Time to listen': a joined up response to child sexual exploitation' [London]: Ofsted

Finding Four: The appropriate use of language to describe CSE is not fully embedded amongst safeguarding partners.[15]

4.18 After Child N went missing having stolen her Stepfather's bank card, she was arrested and alleged that Mother had hit her the previous day. Given the allegation, it was agreed that Child N would not return home that night and alternative arrangements were made by Children's Services for Child N to spend the night at a local children's services provision under Section 17 Children Act 1989. This was appropriate given the tensions in the family.

4.19 In the short time that Child N was there, she was visited by both a Missing Returns Officer and twice by the social worker. Child N wanted to go home, and the social worker tried to contact Mother throughout the day. When she did eventually manage to speak to her, she arranged to take her home that evening. Mother was unclear about whether Child N was returning home or visiting her family, and the presence of an interpreter could have facilitated better communication about this.

4.20 The practitioner group agreed that there were no grounds to have refused the request for Child N to go home given the focus on working with the family to support her at home. There was no evidence of any injuries resulting from her Mother hitting her and a medical was not pursued due to Child N declining one. There was no obvious, visible evidence to suggest medical attention was required. Consideration could have been given here to engaging a trusted adult to explore Child N's reluctance to have a medical.

4.21 There was intensive activity and support offered after this episode and plans were in place to escalate concerns to both a Multi-Agency Sexual Exploitation (MASE) meeting[16] and an ICPC.

Good Practice: There was a positive start to good relational work with Child N with a swift handover to the Locality Team and a clear focus on a whole family approach.

4.22 Both Mother and Stepfather acknowledged that the second social worker who was involved from late March 2018 had a real desire to help. However, they felt that the "system" was one where, as parents they "were not able to do anything" and that Child N was "unpunishable." They appeared to struggle with managing and reacting to behaviour and events. They swung between inaction (not knowing where she was staying and not reporting her missing) to extreme actions (sending her to live with her father, burning her clothes to stop her going out, either locking her in or out of the house, and fitting a complex alarm system). Mother and Stepfather

[15] WMROCU is made up of officers and staff from Staffordshire, West Midlands, West Mercia and Warwickshire Police. The team's aim is to reduce serious and organised crime in the region.

[16] When young people are vulnerable to, or experiencing CSE, a Multi-Agency Sexual Exploitation (MASE) meeting is held. This is a multiagency meeting, involving the young person and their main carers, and it develops a CSE plan, if required. When a CSE plan is required it focuses on protecting the young person from potential or actual CSE and seeks to identify and reduce risk. In Wolverhampton the chairing of MASE meetings sits with an operational manager who has responsibility for driving forward the support plans and by sharing intelligence with the CSE coordinator who is a specialist CSE advisor, they inform strategic oversight and citywide service delivery.

expressed their frustration at not knowing what they could do and how they could stop her.

4.23 When parents didn't respond to letters or phone calls by school and went to work when Child N was missing, professionals interpreted this as a lack of care for Child N. The review considered the economic drivers[17] of their working long hours in potentially restrictive, inflexible employment which had an impact on their availability. This was not necessarily an indication of lack of care for Child N. The review recognised that Child N's parents were working hard to balance long working hours with seeking to manage the challenges of a teenager, which would have added to any pressures within the household.

4.24 Child N told practitioners that her home life had changed when she was 10 years old; although it wasn't known in what way or whether anything had happened at that time. As part of the police investigation following her death many of Child N's friends were spoken to. They told police that Child N was "unhappy at home" and one friend said that she'd seen bruises on her arms and back. They had witnessed her mother physically assaulting Child N after she had stolen the bank card. One friend said that one or two months before her death, Child N had expressed a wish to die, professionals working with Child N were unaware of this.

4.25 The review considered neglect in this case, applying the six-fold typology of neglect[18] to include medical, nutritional, emotional, educational, physical and lack of supervision. In the course of this review there has been reference to:

- nutritional neglect (when Child N had said she was hungry and had been left locked in her room with no food);
- emotional neglect (Child N considered herself to be the 'problem' within her family)
- educational neglect (Child N was sent to get her own school placement after returning from Northern Ireland)
- physical neglect (lack of clothing after clothes were burned)
- lack of supervision (out early in the morning and late at night, whereabouts not known).

It is possible that these factors magnified Child N's vulnerabilities and pushed her away from her family and towards any perceived kindness and attention. In studies of adolescent neglect, generally[19] the greater the parental input the lower propensity the adolescent had for risk taking behaviours and had higher levels of well-being.

[17] Rowntree, MIS www.jrf.org.uk/report/minimum-income-standard-uk-2018

[18] Horwath, J(a) 2007 Horwath, J (a) 2007 Child Neglect: Identification & Assessment. London: Palgrave MacMillan

[19] The Children's Society 2016 The Children's Society (November 2016) Understanding adolescent neglect: troubled teens: a study of the links between parenting and adolescent neglect: executive summary. [Online report]

Finding Five: As neglect is a complex form of abuse, there needs to be a neglect strategy and guidance for practitioners that has a focus on adolescents[20] and the impact on their development and associated behaviours (drug use, going missing, family breakdown etc).

Response to Missing Episodes

Missing Episodes reported to the Police

4.26 Child N was going missing[21] from home much more frequently than was being reported to the police. Her mother's friend talked about Child N going missing when she referred her to Children's Services in March 2018. Also, Mother told the social worker completing the assessment that Child N had been missing in late 2017, for five days, but she hadn't reported it as she knew she was at her "boyfriend's house." Child N herself told the missing returns officer that she been missing "ten times" but that Mother didn't know about these as she was returning before her mother woke up to go to work.

4.27 There were four missing episodes[22] reported to the police and logged on their systems. Each episode triggered a Missing Return Interview. In this case the response to missing episodes included some delays in entering the details onto the police systems. When Child N was reported missing in April 2018, this was put onto the Police National Computer (PNC) immediately, but her details were not entered onto COMPACT[23] and therefore this missing episode was not subject to a fuller risk assessment by the police. Whilst the officers and call centre staff involved in finding missing persons were not spoken to directly to get their perspective, there was a view from the police shared during the review that delay in getting information on relevant police systems and triggering activity was due to capacity and resource availability at key times.

Finding Six: A lack of timeliness in responding to missing child reports increases the chances that children are exposed to risk for longer periods.

4.28 Prior to the final missing episode, house to house checks of known associates were made by the police and there was success in locating Child N through social media. When concerns about CSE were first raised in December 2017, a 'non-crime child

[20] Holmes, D That Difficult Age: Developing a more effective response to risks in adolescence: Evidence Scope (2015)

[21] An individual is classed as 'Missing' when their whereabouts cannot be established. They remain Missing until located and their wellbeing or otherwise is confirmed. At the time of Child N's missing episodes, the category of 'absent' was also in use in the West Midlands Police force and was used to describe individuals who were ''not at a place where they are expected or required to be and there is no apparent risk''. Absent young people did not receive a Return Interview. The Absent category ceased in May 2019.

[22] College of Policing 2016 https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/

[23] West Midlands Police use two systems to log a missing person the first being the Police National Computer (PNC) and the second, a missing persons case management information system called COMPACT; the latter is also used to enter 'found' notifications.

abuse referral' [24]was raised following her return and checks made for relevant intelligence on known associations. On the same day this intelligence was shared with partners within the MASH and the outcome was for a social work assessment to be undertaken.

Good Practice: The Police used a variety of methods to locate Child N when she was missing**.**

4.29 Child N disclosed in her Missing Return Interview in December 2017 that she had stayed with her former boyfriend for five days (a period of missing not reported to the police). The Missing Return Interview was shared with police. There is no evidence of this being addressed with the former boyfriend or his parents by any professional but, shortly after this disclosure Child N left Wolverhampton to live with her father, so collation of the former boyfriend's details was not done. It was noted by the practitioners' group that Child N was not offered access to sexual health services.

4.30 Child N was known to frequent the local Park when away from home. The Children Missing Operational Group (CMOG)[25] had no intelligence to suggest this park was a known to attract perpetrators of CSE and therefore required no specific police activity. When Child N was reported missing two days later, an assessment of risk should have included looking at her previous history of missing episodes, including locations where she had been recently sighted or found.

4.31 When the police spoke to Mother about the alleged assault following the theft of the bank card, their notes indicated that she looked "tired" and admitted to holding Child N's ponytail but not to hitting her. Whilst we don't have the perspective of the officers involved, it appears from their records that they were sympathetic to Mother's frustration and anger at her daughter's behaviour and decided not to take any further action. Child N was arrested for the theft of the bank card and, having admitted it, was referred by the police to the Youth Offending Team (YOT), who made an appointment to see her in April 2018 but, unfortunately, Child N died prior to this.

Finding Seven: The impact of criminalisation should be considered at the earliest stage as can further damage relationships within the family and be detrimental to the way future actions are understood.

Missing Return Interviews[26]

4.32 There were Missing Return Interviews completed on four occasions when Child N spoke openly and gave a significant amount of detail about what was going on in her

[24] A reporting mechanism used by the police of incidents which are not crimes under the Home Office counting rules

[25] **Children Missing Operations Group (CMOG)** – All Missing children are identified at the multi-agency CMOG; intelligence is shared, and themes are identified to inform Strategic planning and improved practice; this includes information obtained in the Return Interviews.

[26] Wolverhampton Children's Services 'Missing & Return Interviews - 72-hour policy' sets out the way that children who go missing will be interviewed by an independent person on their return and practice is well-established. There is a requirement for the Missing Returns Officer to 'ensure return interview information is sent to the police within 96 hours of the missing return interview. The policy also details that the

life. These are detailed documents with names, locations and description of the push factors (Mother and Stepfather's responses to incidents) and the pull factors (wanting to be with her friends). These interviews provided the richest source of Child N's voice for this review, gave the most insight into the child's lived experience, and informed the narrative that has emerged about what it was like to be Child N at that time. As well as providing an insight into Child N's lived experience, the interviews provided detail and identified potential people of concern. Child N had been missing three times between 7 December and 15 December 2017; the focus was on the duration of the missing episodes and not on their frequency. Whilst the multi-agency procedures[27] make reference to holding a strategy meeting after a child has been missing over 24 hours, it was not routine practice to bring professionals, the child and their family together when a pattern is emerging of shorter missing episodes in succession.

4.33 The picture that emerged was that of a young girl who was not happy at home and who was looking forward to being old enough to leave. Child N told the Missing Returns Officer that "My friends are my family" and described liking "being with friends and listening to music at night." From a contextual safeguarding perspective, it is important to recognise the weight of peer influence on the decisions that young people make, which parents can have little influence over and can undermine parent-child relationships.[28]

4.34 Child N's mother was present at two of the Missing Return Interviews. While this is not best practice as it may inhibit honesty, Child N still provided a very full account of what she'd been doing.

4.35 The completed Missing Return Interview were entered onto the children's information system but were not flagged for anyone's attention. It is understood that changes have subsequently been made to this process. Information is now shared in a timely way, as a telephone conversation takes place between the Missing Returns Officer and the Social Worker.

Good Practice: The Missing Return Interviews are of a good standard and demonstrate good practice with a consistent team undertaking them with close links to the police.

Finding Eight: A policy that focuses on the duration of missing episodes doesn't take into account emerging patterns of frequent shorter episodes.[29]

Children's Services Head of Service should be alerted to a child being missing after 3 days and further escalation activity after 7 days and 14 days.

[27] Children missing from care, home and education – regional child protection procedures 2.20

[28] Firmin, C 2017 Firmin, C Contextual Safeguarding – An Overview of the operational, strategic & conceptual framework – (IASR November 2017)

[29] Ofsted 2016 Child sexual exploitation and children missing from home, care or education A 'deep dive' theme for Ofsted targeted local authority inspections - January 2016

Consideration of CSE

4.36 When Child N returned home following the first missing episode in December 2017, a CSE screening tool was completed appropriately following the Missing Return Interview and identified a number of areas of risk. Overall the information was well recorded.

4.37 A profile emerges of a vulnerable child who had experienced a breakdown in family relationships and had become disconnected from her family. Child N's behaviour towards her parents had changed and she sought to be increasingly independent. She told practitioners that it was "427 days until my 16th birthday" when she believed she could "work, have a flat and live her life."

4.38 The Social Worker thoroughly explored Child N's lifestyle, emotional needs and social networks as Child N talked openly and knowledgably about drugs and had mentioned a bandana which she'd been given, which can in some circumstances signify gang affiliation. An NWG CSE risk assessment tool was completed by a social worker in April 2018 prior to Child N's death. This did not highlight any significant CSE concerns, but as there was a vulnerability to CSE, in line with WSCB guidance the matter was escalated, and Child N was referred for a MASE meeting. This was arranged for early May 2018, but Child N died before this meeting took place.

4.39 The Police investigation undertaken after Child N's death identified there was no indication of gang association nor criminal or sexual exploitation.

Transfers

Belfast Heath & Social Care Trust

4.40 Children's Social Care in Belfast were first alerted to Child N living with her father after the police were called to the house because of a landlord dispute. The police found that Child N was staying there, and the accommodation was deemed unsuitable for a child. Child N was not seen or spoken to.

4.41 The initial focus of Children's Services in Belfast was on the physical conditions and unsuitability of the Father's home. During this time frame, there was a telephone conversation between social workers in Wolverhampton and Belfast, where Child N's vulnerability was shared. This did not lead to any further assessment in Belfast, as the housing issue was resolved by Child N going to stay with Father's former partner and they did not act on the conversation with the Wolverhampton Social Worker. Providing written information about the partially completed Wolverhampton assessment and identified risks in Wolverhampton would have been appropriate in the circumstances as this would have further informed Belfast's decisions in relation to their own policy and practice.[30]

[30] Co-operating to Safeguard Children and Young People in Northern Ireland 29 August 2017 https://www.healthni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland

School Admission

4.42 Child N left her school in Wolverhampton at the end of the Autumn term 2017 and went to stay with her father in Belfast. Her mother informed the school in Wolverhampton and she was therefore taken off the roll. Child N attended a school in Belfast for just three days. After her return to Wolverhampton in February 2018, a request was made for a new school placement. The request for a school place was incorrectly recorded as a "new arrival to the UK". On the basis that Child N was recorded as a new arrival, no checks were made by School Admissions with her previous Wolverhampton school. The admissions form did not include a question about whether a pupil had ever attended a school in Wolverhampton before and therefore, not unreasonably, an assumption was made that she hadn't.

Finding Nine: If processes for responding to a new school admission requests do not include asking the right questions about all previous schools, there can be a delay in sharing the child's information.

4.43 The second Wolverhampton school offered a placement and significant attempts were made to engage with the parents by sending three letters, making two telephone calls and undertaking a home visit over the period of a fortnight. Child N's mother did not initially want her to attend the school. When alerted to the change of school, the first Wolverhampton school sent information about Child N's school history, attendance and attainment to the second Wolverhampton school. Child N attended for an induction and started the following week on 19 March 2018.

Good Practice: The initial Wolverhampton school appropriately provided information to the new school and the new school was tenacious in following up the school admission request.

School Attendance

4.44 In 2016/17 Child N's school attendance was at 93.3% which falls below national guidance on good attendance of 95%.[31] In the social work assessment undertaken in June 2017 her attendance is described as 'good' the threshold for what is considered good attendance was not informed by national standards and therefore gave a false impression of Child N's engagement at school. By the Autumn term, Child N's attendance had deteriorated.

Finding Ten: When school attendance of over 90% is considered 'good' by professionals, the impact on both the child's learning and increased vulnerability can be missed.

[31] **School attendance Guidance for maintained schools, academies, independent schools and local authorities July 2019**. While the Government doesn't set specific attendance targets, schools are expected to set their own. An attendance rate of 95% is generally considered good; this allows for children to miss 9.5 days across the school year. Persistent absence (PA) is defined as an attendance rate of 90% or below.

Language

4.45 The family's first language is Lithuanian. The practitioner group reported that Child N spoke English, Lithuanian and Russian. There wasn't consensus amongst front line practitioners who came into direct contact with the family about how well Mother or Stepfather understood English. It was identified that interpreters were not used by professionals consistently or effectively and there was a belief that the availability of Lithuanian interpreters was limited. There are face-to-face and telephone interpreting services available in Wolverhampton.

4.46 The review has found occasions where there was miscommunication; for example, when Mother was not expecting Child N's return from respite. Working with an interpreter would have enhanced mutual understanding.

4.47 During contact with Mother and Stepfather as part of the review, it was clear that their views would not have been communicated effectively without the use of an interpreter.

Finding Eleven: Working without an interpreter with families for whom English is not their first language can lead to miscommunication about decision making.

5. Summary of Findings

5.1 There are eleven findings from this review. The first five findings that emerged relate to the limitations of an assessment and particularly the need for effective communication and engagement with children, young people and their families.

5.2 Finding One prompted the WSCB to seek reassurance that parents were always seen as part of child protection enquiries. An audit has been undertaken, which demonstrated that parents are routinely seen in all cases apart from where for example they have left the country. The audit findings indicate that what was seen in Child's N's case is not more widespread across Children's Services.

5.3 Language is identified, in Finding Four, as particularly important when working with vulnerable young people as it can impact on professional responses.

5.4 Finding Five demonstrates the need for a Neglect Strategy which is underpinned by an understanding that the transition to adulthood is both a biological and social readjustment and that some risk taking can be positive for young people as that is the way adolescents learn and test the limits of sensible behaviour. [32] Since the start of the review the WSB has reviewed its Neglect Strategy and has been informed by learning from Child N's life experiences and wider research on the significance of focusing on adolescent need. This could be developed further to provide a toolkit for all practitioners working with children and their families to understand the neurological and social development of adolescents.

[32] Understanding **adolescence**: Frontline Briefing (**2014**). Frontline resources. Published: Nov **2014**. Author: John **Coleman**

5.5 Findings Six and Eight relate to risk assessing and locating Child N and bringing together professionals. In May 2019 West Midlands Police adopted the College of Policing Missing guidance in its entirety and children are considered as missing as soon as their whereabouts are unknown.

5.6 Finding Seven relates to the way that children can become criminalised. Child N was arrested because she stole her stepfather's bank card. She said she stole this as she had wanted to buy clothes and that her mother had hit her, however it was Child N who was criminalised, when wider difficulties in relationships in the family were evident.

5.7 Finding Nine relates to children transferring from one school to another and a simple additional question to the admissions form could avoid assumptions being made in situations when children are returning to the city where previously attended a school. The admissions form was amended in January 2019, as soon as this learning emerged, to include an additional question about whether the child had previously attended a school in Wolverhampton.

5.8 Finding Ten relates to perceptions about Child N's school attendance being 'good.' Although 93.3% school attendance may appear, to some professionals to be 'good' the impact on her learning would have been significant.

5.9 Finding Eleven reiterates the need to always involve interpreters when English is not a family's first language. Wolverhampton offer both a face-to-face and telephone interpreting support. Mother and Stepfather did not always have this service made available to them. Face to face interpreting services for languages spoken in the community including Lithuanian are readily available for planned visits (4 days' notice).

Finding One: Closing Section 47 child protection enquiries without involving parents and undertaking checks with all agencies does not allow for a rounded view of risk and need.
Finding Two: All available and relevant assessment tools should be used according to the presenting concerns to inform decision-making.
Finding Three: The use of instructions and restrictions in working agreements for a child, young person and their family are not helpful in enabling them to make changes unless they are actively involved in developing them.
Finding Four: The appropriate use of language to describe child sexual exploitation is not fully embedded amongst safeguarding partners.
Finding Five: As neglect is a complex form of abuse, there needs to be a neglect strategy and guidance for practitioners that has a focus on adolescents and the impact on their development and associated behaviours (drug use, going missing, family breakdown etc)

Finding Six: A lack of timeliness to responding to missing child reports increased the chances that children are missed and exposed to risk for longer periods.
Finding Seven: The impact of criminalisation should be considered at the earliest stage as can further damage relationships within the family and be detrimental to the way future actions are understood.
Finding Eight: A policy that focuses on the duration of missing episodes doesn't take into account emerging patterns of frequent shorter episodes.
Finding Nine: If processes for responding to a new school admission request do not include asking the right questions about all previous schools, there can be a delay in sharing the child's information.
Finding Ten: When school attendance of over 90% is considered 'good' by professionals, the impact on both the child's learning and increased vulnerability can be missed.
Finding Eleven: Working without an interpreter with families for whom English is not their first language can lead to miscommunication about decision making.

6. Conclusion

6.1 Child N's death was a tragic loss of a young, vibrant life. There were no indications that her life was at risk from the person convicted of her killing. Neither evidence from the review nor criminal proceedings shows that Child N's death could have been predicted or prevented. Despite her vulnerabilities, there is no evidence that her murder was a result of either criminal or sexual exploitation; nor is there evidence of criminal or sexual exploitation.

6.2 Child N's parents were frustrated by their daughter's changing needs and struggled to find appropriate ways to manage her. The actions of the parents could be interpreted as punitive or protective, but in either case they required support with alternative parenting strategies.

6.3 For Child N, the pull factors of friends were evident as for many young people. No evidence has been found that any of her friends sought to exploit her, but rather that they were concerned for her.

7. Recommendations

7.1 The findings from this case have been included within the analysis section above as they emerge. Single agency learning has been identified and recommendations have been made that will ensure that the required improvement action is being taken. The case review group for this case, along with the lead reviewer, have considered the learning and have agreed with WSCB that the following recommendations are appropriate:

Recommendation 1 for WSCB

That the WSCB seek reassurance that practitioners make appropriate use of all available and relevant multi-agency assessment tools according to the presenting concerns to inform decision-making.

Recommendation 2 for WSCB

That the WSCB request that guidance on working agreements is developed in the context of Wolverhampton's Restorative Practice approach.

Recommendation 3 for WSCB

That the WSCB consider how to further embed tools that challenge and support professionals in their use of language to describe child sexual abuse.

Recommendation 4 for WSCB

That the WSCB consider further developing its neglect strategy/ practice guidance to have a more distinct focus on adolescents.

Recommendation 5 for WSCB

That the WSCB request that the Missing Returns Interview Policy is reviewed, and escalation includes targeted meetings with focus on frequency of episodes as well as the duration of episodes in order to capture issues at an earlier stage.

Recommendation 6 for WSCB

That the WSCB consider developing a protocol /guidance that when children are arrested that agencies consider together the impact of criminalisation on the child and their family.

Recommendation 7 for WSCB

That the WSCB seek assurance that practitioners are aware of Ofsted guidance on school attendance and understand the significance and impact on learning and development.

Recommendation 8 for WSCB

That the WSCB assure themselves that practitioners are routinely considering the need to access interpreters when needed and that the interpreting offer is sufficient.

8. Appendices

8.1 **Methodology**

The statutory guidance[33] 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;

8.2 **Documents read** Merged Chronology

Missing Return Interview 12 December 2017

Missing Return Interview 20 December 2017

Missing Return Interview 5 April 2018

Missing Return Interview 10 April 2018

Social Work Assessment – dated 12 March 2018

[33] Working Together to Safeguard Children 2015 was the statutory guidance for inter-agency working to safeguard and promote the welfare of children in place at the time of Child N's death. This was superseded by updated statutory guidance 'Working Together to Safeguard Children 2018' (published July 2018)

Multi agency CSE strategy 2016-2018

CSE screening tool dated 12 December 2017 & 4 April 2018

National Working Group (NWG) risk assessment tool dated 7 April 2018

Strategy discussion outcome 6 June 2017

Strategy discussion outcome 9 April 2018

Strategy discussion outcome 10 April 2018 eMarf

from School One dated 8 December17 eMarf

from Police dated 12 December.17

WSCB Multi-Agency CSE Strategy 2016-2018

WSCB Multi-Agency CSE Strategy 2016-2018 updated May 2019

WM CSE Framework v4 July 2015

CSE Pathway- 30 September 2016

Understanding the CSE Pathway- 30 September 2016

'Missing & Return – 72-hour return interviews' Policy - May 2017

MASE Process (Multi-Agency Sexual Exploitation) – undated

Neglect Strategy and Toolkit – dated June 2019

Evidence of Parents involvement in S.47 enquiries- dated 22/08/19

8.3 **Review Team included:**

Role	Agency
Independent Reviewer	Independent
Head of Safeguarding Children/Adults	City of Wolverhampton Council
Designated Nurse for Safeguarding Children	Wolverhampton Clinical Commissioning Group
Deputy Designated Nurse for Safeguarding Children	Wolverhampton Clinical Commissioning Group
Head of Strengthening Families	City of Wolverhampton Council
Service Manager Children's Services	City of Wolverhampton Council
Youth Organisations Wolverhampton Coordinator	Wolverhampton Voluntary Sector Council
Detective Inspector (Public Protection Unit)	West Midlands Police
Safeguarding Board Manager	Wolverhampton Safeguarding Children Board

8.4 **Practitioners' Group**

Role	Agency	Direct contact with child
Designated Safeguarding Lead	First School attended during scope of review	Yes
Missing Returns Officer	City of Wolverhampton Council	Yes
Vice Principal	Second School attended during scope of review	Yes
Social Worker -Children's Services	City of Wolverhampton Council	Yes
Social Worker – Children's Services	City of Wolverhampton Council	Yes
Strengthening Families Delivery Manager	City of Wolverhampton Council	No
Social Work Unit Manager - Children's Services	City of Wolverhampton Council	No
CSE Coordinator – Children's Services	City of Wolverhampton Council	No

8.5 **References**

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Horwath, J (a) 2007 Child Neglect: Identification & Assessment. London: Palgrave MacMillan

NWG https://www.nwgnetwork.org/#

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Child sexual exploitation and children missing from home, care or education A 'deep dive' theme for Ofsted targeted local authority inspections - January 2016

https://www.app.college.police.uk/app-content/major-investigation-and-publicprotection/missing-persons/

Rowntree, MIS www.jrf.org.uk/report/minimum-income-standard-uk-2018

Statutory Guidance on Children who run away or go missing from home or care DfE 2014

Holmes, D That Difficult Age: Developing a more effective response to risks in adolescence: Evidence Scope (2015)

https://west-midlands.police.uk/your-options/missing-people