Child Safeguarding Practice Review into the death of Adult A

(BSCP 2020/21-02)

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Publication date:
10th October 2023

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1. Background

1.1 In December 2020 Birmingham Safeguarding Children Partnership (BSCP), working in close collaboration with West Sussex Safeguarding Children Partnership and both areas Community Safety Partnerships, commissioned a Child Safeguarding Practice Review (CSPR) following the fatal stabbing of Adult A, in October 2020 (to be referred to as 'the fatal incident'). A 14-year-old girl pleaded guilty to manslaughter on the grounds of diminished responsibility. The trial Judge imposed reporting restrictions prohibiting the child's name from being made public. In adherence with national guidance the names of all individuals have been anonymised to protect the welfare of the vulnerable adults involved and the girl who will be referred to as 'Child A'.

1.2 The circumstances of this case also met the criteria for a Domestic Homicide Review. It was agreed the learning would be captured in a single independent review, the CSPR. Although Child A was living in West Sussex at the time of the fatal incident, she had spent most of her life in Birmingham, only moving to West Sussex in April 2020. It is for that reason BSCP agreed to lead the review.

1.3 Systems reviews usually assess practice within a relatively short defined period, focusing on key practice episodes that can help identify areas for improvement in partnership practice. However, in the case of this review, in order to maximise the opportunity to learn, it was considered necessary to look broadly from when Child A's mother became pregnant with her, and to examine in detail from Summer 2019, the time Child A suffered significant trauma at the hands of another.

1.4 The review focuses on two key questions, with the analysis considering twelve key lines of enquiry that were agreed by the Safeguarding Children Partnerships and Community Safety Partnerships in both West Sussex and Birmingham and the Review Team at the start of the review process:

Review Questions:

1. ***How effectively do agencies, singularly and together, understand, identify and respond to the needs of those at greatest risk from children exhibiting the most harmful behaviours?***

2. ***How effectively do agencies, singularly and together, understand, identify and respond to the needs of the most vulnerable children, who display the most harmful behaviours, and do current systems meet the needs of the most traumatised children?***

Key Lines of Enquiry:

1. What consideration was given to Child A's mother being a vulnerable child in her own right, a victim of domestic abuse, and a young mother?
2. The impact of childhood trauma on a child A's development, including

exposure to domestic abuse in utero. Professionals' understanding of that and the effectiveness of services to recognise and mitigate the impact of severe trauma.

3. How well did agencies recognise the importance of family history to influence intervention, as well as intersectionality?
4. What assessment was there of the family dynamic and the role of Adult A in Child A's life?
5. How effectively did agencies engage with Child A?
6. Agencies' responses to a young girl being abused and possibly exploited. The effectiveness of the systems in place to protect such children. This line of enquiry will consider extra-familial harm/contextual safeguarding.
7. The effectiveness of partnership intervention offered in relation to Child A, following the high-risk incidents; the quality of the Child in Need Plans, Child Protection Plans and the assessment of parenting capacity. To include interventions to support housing and accommodation provision.
8. The effectiveness of interventions to address Child A's offending behaviour and how well the risk to herself and others, including Adult A, was assessed and managed, including the need for protection for those individuals.
9. The effectiveness of the continuity of care, support and information exchange following Child A and her mother's move from Birmingham to West Sussex.
10. How were Child A, and her mother, and Adult A's ethnicity and culture considered as part of assessments and interventions and did this impact on their identity and self- esteem?
11. To what extent, if any, did the impact of the Covid-19 pandemic affect the delivery of support and services to Child A, her mother and Adult A?
12. Identify any emerging good practice to be incorporated within the overall learning from this case for wider dissemination.

2. Introduction

2.1 One of the challenges of this CSPR is achieving the correct balance between the focus on Adult A and Child A. On the one hand what happened to Adult A is immeasurable because his life was taken, but Child A is more than a perpetrator of a terrible crime. She is also a vulnerable child who has been a victim of significant and horrific trauma and abuse in her short life. The focus of the independent review has to be the learning and that means focusing on Child A's life and lived experience, culminating in Adult A's tragic death. The aim of the independent review is to ensure we maximise the opportunity to learn and try to prevent similar tragedies in the future.

2.2 Although some professionals were aware of Adult A, he did not have a formal role in Child A's life, although at one point he did ask to be included in a family assessment and he did ask for advice on how best to support Child A. Professionals only became aware of his involvement in June 2020, which was four months prior to his death. There may have been systemic reasons as to why agencies did not make more effort to engage with Adult A, or Adult A did not engage more with agencies, which I will address later in the report. Although they were concerned

about him, Adult A told his parents he did not want to leave Child A's mother. Since Adult A's death, Child A has told professionals she saw him as a positive influence in her life.

2.3 Due to the fact that Child A is exactly that, a child, and although her identity is not in the public arena, there will be many individuals who know who Child A is. It would therefore be unethical to include in this report some of the details in relation to the trauma and abuse that Child A suffered. Some details have therefore been omitted to protect Child A. The same applies to certain information about her mother.

2.4 At the time of the initial drafting of this report, the Department for Education's Independent Review of Children's Social Care[1] was published. As the report states 'the system of child protection can and must do better for children'. That applies to Child A as much as it does to every other child. The same is true of the report finding 'a more tailored and coherent response is needed to harms outside of the home, like county lines, criminal or sexual exploitation or abuse between peers.'

The Family

2.5 The Lead Reviewer met with Adult A's parents, who gave a powerful and heartrending pen picture of their son and the situation he was in with Child A and her mother. His kindness and loyalty very much came through in that interview. They described how equally proud he was to call himself both a Londoner and a Jamaican. His cultural heritage was important to him. He was a kind and gentle man, who was a gifted musician. His partner was Child A's mother. Their relationship started after she moved to West Sussex.

2.6 Child A identifies as being a 'black woman', although she is a child and of mixed heritage. Child A was born in Birmingham where she spent most of her childhood before moving to West Sussex. Child A has a development age of half her actual age. Child A has two half-siblings, to be referred to as Half-sibling One and Half-sibling Two in the report. Her parents will be referred to as the mother and the father.

Summary of the case and Child A's life up to the fatal incident

2.7 Agency records show significant family issues and agency involvement during Child A's mother's childhood.

2.8 Child A's mother became pregnant with her when she was 17. Child A was born in 2006. Child A's father had a long history of criminality and violence. There is no evidence he had a relationship of any description with Child A up until the date of the fatal incident; however, the apparent risk he presented was a constant factor throughout her childhood and was likely to have caused her at the very least

[1] https://childrenssocialcare.independent-review.uk/wp-content/uploads/2022/05/The-independent-review-of-childrens-social-care-Final-report.pdf

anxiety, but quite possibly trauma.

2.9 Between 2014 and October 2020 Child A was the subject of a number of different types of multi-agency support plans; education health and care plans, child in need plans and child protection plans.

2.10 Although there was significant professional involvement there is no clear picture as to what Child A's day-to-day life was like. There was limited exploration or understanding of what life was like for this child; what was the impact of intersectionality in her life's experiences? Was there adultification of Child A? Who cared for her? Who protected her? Who was meeting her basic needs? Were her emotional needs met? Did she have any friends? Who was Child A? This will be explored further in the report.

2.11 During her pregnancy with Child A, her mother reported domestic abuse. Child A's parents did not live together when she was born and as far as professionals were aware Child A lived alone with her mother, until her mother met her next partner in 2011 by whom she had two children, Half-sibling One and Half-sibling Two. The relationship came to an end in 2019. Although he was in her life for seven years, little is known about Child A's relationship with the father of her half-siblings. Child A's response to the report author when his name was mentioned made it clear she was unwilling to talk about him.

2.12 Until Child A attended primary school, there was little professional involvement with the family other than support for domestic abuse relating to Child A's father making threats. At nursery she was described as settling in well.

2.13 Child A started displaying behaviours usually associated with significant trauma at school from a young age. There was evidence of a chaotic and neglectful homelife from the time Child A was six and one of the ways this manifested itself was in Child A becoming increasingly aggressive and violent in school. She attended several different primary schools in four years, including a 10-week intervention in alternative provision. Poor attendance and staff struggling to cope with her behaviours were an issue throughout.

2.14 For much of her time at primary school Child A was on a reduced timetable because the schools could not manage her behaviour. She was permanently excluded from her third primary school when she was eight years old. Prior to the permanent exclusion, there were numerous restraints and fixed term exclusions for violent incidents.

2.15 From then until the fatal incident Child A's schooling was sporadic. She spent time in several educational establishments in and around Birmingham and then West Sussex, but there were significant gaps in between each one and her attendance was often poor.

2.16 In 2015 Child A was assessed as having mild learning difficulties.

2.17 Child A's vulnerability increased and the impact of her life's experiences resulted in the adults around her being increasingly challenged by how this was impacting. In 2017 when she was 10 there were a number of incidents, including one incident where she smothered her three-year-old half-sibling. At this time Child A was always exhausted at school and regularly slept for three to four hours a day at school. There were concerns of physical neglect. She was often violent and aggressive, both to people and to property. She was also starting to make racist comments, which continued, and was displaying some extremely concerning sexualised behaviours.

2.18 In 2019 Child A was showing more and more signs of worrying behaviour. She started going missing regularly. She was arrested on a number of occasions, including for being in possession of a bladed article, where she had to be restrained by the police officer, whom she assaulted. On that occasion she was found to be in the possession of a debit card of a 17-year-old male. She told professionals he had sexually assaulted her at his home, after she met him. Child A was given a three-month conditional caution for common assault of a police officer and being in possession of a bladed article in a public place. She was 12 years old. She was also still being aggressive at school.

2.19 It was in June 2019 that Child A first threatened her mother with a knife, having argued with her and allegedly trashed the house. These violent outbursts had focused on the mother until the fatal incident. On that occasion she ran from the home and was later found intoxicated, having smoked cannabis. It later transpired that she had been subjected to a significant assault by a 16-year-old boy.

2.20 From then until the fatal incident, Child A's vulnerability and risk of harm became more and more apparent. She started self-harming and her behaviours escalated. Child A frequently went missing, and she continued to attack and rob others and make further threats of harm. The attacks were sometimes thought to be racially motivated. At one point she was taken into police protection because of threats to stab her mother and grandmother. She was placed in emergency foster care. There were also allegations of attacks on Child A, including by adult males, and continued concerns of child criminal exploitation – the police knew she had links to addresses with known gang and firearm activity, child exploitation and modern-day slavery.

2.21 In August 2019, Child A was admitted to hospital because she had contracted a medical condition that required treatment, which she refused. Her GP was extremely concerned about her. She was seen with cuts on her arms and described daily suicidal thoughts.

2.22 In September 2019, when she was 13, Child A was assessed by a psychologist as functioning as a child of eight to nine years.

2.23 Later that year Child A's half-siblings told professionals that there was abuse in the home, with Child A being both a victim and a perpetrator of physical and verbal abuse. Shortly after this, Child A's mother and the father of her half-siblings

separated and the half-siblings went to live with their father, as directed by the court.

2.24 As time went on the police continued to have concerns that Child A could be being criminally exploited and used to deal drugs or run drugs. Her mobile phone had been monitored by the police and she was travelling considerable distances by public transport. She also had links with known gang members. She was a 13-year-old child.

2.25 In 2020 the situation continued to deteriorate, and Child A's life became more and more turbulent. She was remanded to the secure juvenile estate, following an incident in which she stabbed her mother in the leg and then set fire to her bedroom. On her release she returned to live with her mother.

2.26 In April 2020 Child A's mother moved to London and advised she would be joined by her daughter, Child A. Child A's mother was offered an option of private rented accommodation in Crawley, West Sussex by the London Borough of Hammersmith and Fulham Housing Department. Following the move to West Sussex there was a significant reduction in Child A's offending and antisocial behaviour, violence / aggression and there were few reported incidents of her being missing. There was, however, sporadic violence / aggression by Child A towards her mother and in August 2020 Child A's mother told the police that Child A was making threats towards herself and towards Adult A. There were also incidents of Child A being aggressive with minor assaults of peers at the education centre she started to attend.

2.27 Similarly, there was initially no evidence of exploitation in West Sussex, but it was then acknowledged Child A should be classed as vulnerable to exploitation as concerns started to escalate again, in terms of the clothing she was wearing, her comments and behaviour.

2.28 The last known incident, prior to the fatal incident, was a fight between Child A and another female five weeks earlier.

2.29 The fatal incident followed a number of days of alleged threats by Child A to stab her mother. Child A's mother had had to return to Birmingham to visit a sick relative. She had left Child A in the care of Adult A but Child A had not remained in the home. Adult A informed Child A's mother, who reported Child A missing to the police. Child A was found and was taken to another relative's house. Child A later returned to her home. Adult A returned to the property, which had been damaged by Child A, and an alleged argument between Adult A and Child A ensued which culminated in the tragic and fatal incident when Adult A was stabbed and sadly died.

3. Analysis of Local Practice and Emerging Key Themes

3.1 The analysis of partnership intervention, safeguarding practice and systems has concentrated on the two review questions and key lines of enquiry to identify

systemic learning to inform the continuous improvement of safeguarding partnership practice in Birmingham and West Sussex. The Review Team identified five key themes, which provide the framework for the ten local and two national learning points. Each Learning point is followed by a summary of the action that has been taken to embed the local learning. The five key themes are:

- Identifying, understanding, and responding to the needs of those at greatest risk from children exhibiting the most harmful behaviour
- The effectiveness of systems to protect those most vulnerable, particularly within the context of Intersectionality, Structural Racism, Adultification and Extra-Familial Harm
- Understanding Family Dynamics, Needs and History in its broadest context is vital
- The importance of recognising and understanding the impact of Trauma and Abuse on Children and utilising a trauma-informed approach
- The Importance of the Continuity of Care, Support and Information Exchange when a Child Moves Area

3.2 It is important to state that the review recognised and saw many good examples of the commitment, effort and time spent by frontline professionals working with this vulnerable child and family and what this report goes on to say does not diminish that but identifies a number of significant areas for systemic learning.

Identifying, understanding, and responding to the needs of those at greatest risk from children exhibiting the most harmful behaviour

3.3 It was evident during the review that Child A's mother had expressed concerns to professionals on several occasions about the danger Child A posed. Child A had made a number of threats towards her mother and grandmother. In August 2020 Child A's mother told the police that her daughter had threatened her and Adult A and that she feared further violence. Later in October 2020 whilst Adult A was looking after Child A, she went missing. The Police Missing Report indicated that although Adult A did not express any concerns regarding himself, he did believe that Child A posed a risk to her mother.

3.4 There were a number of incidents which should have been seen as warning signs. One of those was in 2017, when Child A disclosed at school that she had smothered her three-year-old half-sibling, stating she was in a rage and could not stop herself. This was a significant concern, which should have been explored, both from the safeguarding perspective but also the context around this incident and risk management. None of those things happened.

3.5 In May/June 2019 there were several indicators of escalating behaviours of concern. Child A going missing, being the subject of a significant assault, an escalation of violence from others towards others and an increase in threatening her mother with

a knife, all within the space of one month. This should have been another warning sign. The introduction of weapons used in a threatening and proactive manner (as opposed to reactive) and in the context of the other behaviour and her history, should have again prompted a referral to CAMHS, in addition to involvement from other agencies, including the local authority.

3.6 In October 2019, Birmingham Children's Trust (BCT) commissioned a psychological assessment of the family, as part of the Public Law Outline i.e. pre-proceedings, in relation to Child A and her two half-siblings. The assessment was completed in March 2020. This assessment will be referenced throughout this report as 'the psychological assessment'. There is no evidence this assessment was taken into account by professionals. (There were issues with the sharing of the assessment with agencies in West Sussex which will be addressed later in the report).

3.7 Child A continued to make threats to stab her mother later in 2019 however there was also another change in her violent behaviour towards others; there was more evidence of racially aggravated attacks and threatening with a knife and an escalation in behaviours in the space of weeks. This too should have been a red flag for professionals.

3.8 When Child A was the subject of a Referral Order the planned work included engagement in education, managing her thoughts and emotions, understanding the impact and consequences of her actions on victims and the community, substance misuse and 30 hours of reparation to repair the harm caused to the community. As part of the intensive contract Child A was also due to participate in work regarding knife crime and consequences. The contract also acknowledged the need to monitor and respond to safeguarding and child protection concerns in relation to exploitation of Child A, sexual abuse, familial relationships and parenting capacity, emotional wellbeing and mental health, and the safety and suitability of their living arrangements.

3.9 A major barrier to effective interventions to address Child A's involvement in offending behaviours was the fact that the professionals were constantly 'fire-fighting'. The constant incidents, and her going missing, made the work challenging to complete.

3.10 Although there were fewer incidents when Child A moved to West Sussex there was limited progress, for example finding and starting a school placement, engaging Child A in sessions with staff, etc. There were also barriers to meaningful engagement; the volatile relationship between Child A and her mother, her mother's inconsistency in terms of her request for support and then withdrawal of this, the suitability of their accommodation and the instability of it from the end of September and October, when they had periods in temporary B&B; but ultimately the significant and extreme abuse and trauma experienced by Child A, and to a degree her mother, was a barrier to forming a trusting relationship that would facilitate change.

3.11 The focus of the Youth Justice Service (YJS) in West Sussex was on reducing the risk of Child A reoffending and harm to others, as well as keeping her safe. The initial focus of the work is always to build a trusting relationship with the child and their primary carer, as it is well-recognised this is fundamental to facilitating change. In this case this was critical given the extreme abuse / trauma Child A had had been exposed to and the associated lack of trust in any adults but particularly professionals – why trust when professionals / adults had let her down and not kept her safe in the past?

3.12 There is no doubt that the YJS put considerable effort and creativity into how to work most effectively with Child A and were informed by the psychological assessment when they received it however it is the view of the review team that they were not going to be able to affect change with such a complex set of circumstances; a highly traumatised child, living with a mother who was unable to keep her safe, in unsuitable accommodation and the complete lack of trust and therefore engagement with professionals by either Child A or her mother.

3.13 Even if this had been recognised by professionals the only option, within the current legislative framework, was care (see National Learning Point Two) and the only time Child A had been placed in care previously she had run away, and most of the time her mother did not want her to go into care. As well as this, professionals would also have been mindful that placing children at risk of abuse, including exploitation, away from home can actually put the child at further risk of harm.

Learning Point One

If they are to understand a child's world and risks and vulnerabilities, professionals must look beyond the primary carer and also use critical thinking and challenge to reflect on what the child is trying to communicate through their behaviour and interaction with others.

Additional comment

In this case no consideration was given to Child A's biological father, because the mother said he was not in her life. No consideration was given as to the impact on Child A of her half-siblings' father, both when he was in her life and then when he and her mother separated. At no point was he assessed in terms of risks and strengths. The same is true of Adult A.

A sense of professional curiosity, critical thinking, and challenge about significant other people in Child A's life was missing from this case. This is a common finding in reviews nationally.

Local Action to Embed Learning:

Birmingham **-** Birmingham Children's Trust (BCT) has enhanced its relationship-based practice model, which explicitly names the 'golden threads' (core principles) of our approach. These include enabling practitioners and managers to be trauma informed and attachment aware, be developmentally sensitive in terms of understanding the impact of adversity on

child development, recognising needs at different ages and developmental stages and seeking to understand family struggles in the context of wider situations and communities in which families live. All staff within the Trust are being trained in respect of this model '(Connections Count').

Alongside this, BCT has developed new Practice Standards which include promoting good quality assessments. These promote the inclusion of all significant people in the child's world.

The Birmingham Safeguarding Children Partnership (BSCP) undertakes an ongoing programme of Multi-Agency Case File Audits to evaluate the effectiveness and quality of partnership working. The audits examine practitioners' understanding of family dynamics, history, needs and appropriateness of partnership engagement and assessment of risk. The Audit methodology seeks assurance that impact of 'invisible men' has been considered. Action plans are developed following each audit to support practice improvement within and across agencies.

West Sussex – West Sussex County Council (WSCC) now use the Family Safeguarding Model, a strengths-based approach working collaboratively with families to identify the changes needed and to achieve better outcomes for children.

West Sussex Safeguarding Children Partnership (WSSCP) include professional curiosity, critical thinking and challenge within a range of training modules for frontline professionals to enable them to work confidently and effectively with children and families.

3.14 There is no evidence to suggest the function of Child A's violent behaviour was ever formulated or explored appropriately, and therefore it could not be appropriately risk managed.

3.15 There was never a formal risk assessment by the police, CSC or YJS, in relation to risks to Adult A. However, CSC and YJS were unaware Child A's mother had alleged Child A was also making threats against Adult A. The assessments undertaken by the YJS both in Birmingham and West Sussex, did assess the risk the child presented to her mother as there was clear evidence she was a victim of aggression and violence perpetrated by Child A. YJS had assessed that due to her past trauma and abuse, alongside her functioning capacity Child A struggled with emotional regulation and could potentially assault peers, those she was in a close relationship with and those in authority, but no agency specifically identified Adult A as a possible victim. The review considers that there was a significant oversight, which came about because of a lack of information sharing between the police and partner agencies, in relation to what Child A's mother had said to the police about Child A also making threats against Adult A.

3.16 Child A's offence against her mother in 2020 did not meet the threshold for Child A to be considered under the framework for protecting the public against those who commit the most serious violent and sexual offences; Multi-Agency Public Protection Arrangements (MAPPA). The Police, Crime, Sentencing and Courts Act

2022, expands the range of statutory measures to prevent and address violent crime. The new arrangements create an opportunity for earlier partnership intervention at a lower level than MAPPA.

3.17 Research should always inform practice. It is important to be clear that there is very limited research about children who kill. The reason for that is it is rare for children to commit serious crimes and even rarer for a child to kill someone. Equally, when children do kill it is much more likely that they kill another child, and one who is younger than they are. For a child to kill an adult is the rarest phenomenon of all. Only the police knew that Child A was allegedly making threats against Adult A, as well as her mother and grandmother. That information was not shared with other agencies, which it should have been. Having said that there was also little multi-agency focus on the risk to Child A's mother, or grandmother, despite Child A's threats and previous actions.

3.18 The psychological assessment was not asked to address the risk that Child A posed to others, either within the context of the home, or to others. This was a missed opportunity.

3.19 The risk posed to Adult A was never assessed, he was seen very much as on the periphery of partnership intervention. Also, and perhaps more importantly, Adult A had never expressed concerns to professionals regarding Child A being a threat to him, including the day before the fatal incident when he reported her missing to the police. The Police Missing Report indicated that although Adult A did not express any concerns regarding himself, he did believe that Child A posed a risk to her mother. What was equally significant was there was no evidence Child A was making threats of harm against Adult A to anyone else.

Learning Point Two

There needs to be a much greater understanding of the factors which contribute to children committing the most serious of offences.

Local Action to Embed Learning

Birmingham **-** The West Midlands Violence Reduction Partnership produces a strategic assessment of serious violent crime, which informs the coordination of partnership intervention in Birmingham both strategically and operationally through the Contextual Safeguarding Board and the Community Safety Partnership. This work is under pinned by the multi-agency Empower-U Hub's work with children and young people at risk of exploitation. The BSCP Independent Chair is a member of the Birmingham Children's and Young People's Partnership bringing together the City's strategic leaders from the Statutory Partnerships to work on cross cutting themes as part of the wider children's safeguarding agenda. The BSCP and Community Safety Partnership co-hosted a Leaders' event to initiate the development of the Serious Violence Strategy. The draft Birmingham Serious Violence Strategy was presented to the BSCP Executive Board on 25.01.2023.

The enhanced BCT practice model critically promotes an understanding and the early identification of the impact of early childhood trauma on behaviours and the importance of assessing risk factors in the context of wider family environmental issues.

West Sussex **-** The Serious Violence Duty came into force in April 2023 and is now being implemented in West Sussex. This places a statutory duty on relevant services to work together to share information, collaborate and plan to prevent and reduce serious violence within their local communities. The WSSCP are committed to understanding the drivers that influence and impact on serious violence and have commissioned an independent organisation to provide specialist consultancy to achieve this and help shape the partnership response. This includes engagement with children and young people who have experienced serious violence.

In West Sussex the Violence & Exploitation Reduction Partnership (VERP) lead on tackling exploitation and knife crime. WSCC is committed to reducing serious violence and have developed two specific roles within the Community Safety and Wellbeing Team to support this aim. The Serious Violence Lead Officer and the Contextual Safeguarding Co-Ordinator are both aligned to work towards delivery of the Serious Violence Duty and the Violence Reduction Partnership.

3.20 CSC knew about Adult A and undertook the relevant criminal record check, because he was having contact with a child who was vulnerable. Although Adult A had asked to form part of a CSC assessment and it being seen by some professionals that he was a positive role model for Child A, he was viewed very much as being on the periphery by all of the professionals involved.

3.21 There is little evidence of any in-depth or accurate assessment of the family dynamic and the role of Adult A in Child A's life by any of the relevant agencies.

3.22 The National Child Safeguarding Panel published research last year entitled "The Myth of Invisible Men"[2]. Although that was specifically in relation to children under the age of one and birth fathers who are the perpetrators of abuse, as the report states "'Invisible men' is a term that comes up frequently in case reviews yet there has not been an in-depth and sustained exploration of why this is the case and what the consequences for children might be". In this case there seems to be two reasons for Adult A's involvement being overlooked. The first is that he was not Child A's father and the second, he did not actually live in the family home. This meant he was seen very much as Child A's mother's partner, as opposed to a stepfather to Child A. This was a missed opportunity by professionals.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

Learning Point Three

It is equally important that professionals consider all the adults in a child's life, both from a strengths and risks perspective from the adult to the child, but equally from the child to all the adults, if the child is making serious threats of violence.

Additional comments
An adult does not have to live in the family home to be either a risk, or a strength and it is essential that professionals think systemically around the child. The same is true, as tragically happened in this case, when assessing risks to the adults in that child's life.

Practitioners should be mindful and record explicitly the context of relationships and male involvement in a household. Too often consideration is based on a too rigidly defined view of a person's "role" as being involved in the life of the child or not, rather than the fluidity of the person's role in a household and family. Describing involvement in rigid terms is unhelpful.

Local Action to Embed Learning

Birmingham **-** BCTs' enhanced practice model supported by new Practice Standards promotes the need for practitioners and managers to consider the child in the context of their history, family and wider environmental factors, taking into account the impact of adverse childhood experiences. The model promotes both a strengths and risk-based approach to practice.

West Sussex **-** Whilst the Myth of Invisible Men focused on learning from children under the age of one, there are many transferable learning points about including significant others within assessments and reports. WSSCP have committed to renewing 'Dadpad' for a further 4 years from 01/01/2023 and is available to all parents with an emphasis on men and Dads and male carers. A 'Myth of Invisible Men' multi-agency task and finish group has been convened to address the National panel recommendations.

The Family Safeguarding Model is a whole family strengths-based approach used in child protection. The aim is to increase the understanding of the wider family strengths and supports, including significant others, non-resident parent and friends, building in family networks to all child in need and child protection plans.

The WSSCP has an annual programme within the Improvement and Action Group which review cases from a multi-agency perspective with a special focus on the involvement of fathers and significant others.

The effectiveness of systems to protect those most vulnerable, particularly within the context of Intersectionality, Structural Racism, Adultification and Extra-Familial Harm

3.23 The Oxford dictionary defines Intersectionality as 'the interconnected nature of

social categorisations such as race, class and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.'[3] Intersectionality is defined by Crenshaw in 2018 *as* "Intersectionality is a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking."[4]

3.24 There is a growing body of evidence and research that children from Black, Asian, and some other minority ethnic communities are seen as more streetwise, savvy and grown up by professionals, less innocent than White, British children. This is known as 'adultification bias'.

3.25 In the words of the NSPCC "This particularly affects Black children, who might be viewed primarily as a threat rather than as a child who needs support (Davis and Marsh, 2020; Georgetown Law Centre on Poverty and Inequality, 2019). Children who have been adultified might also be perceived as having more understanding of their actions and the consequences of their actions. For example, an analysis of case reviews found that practitioners assumed Black boys who were involved in gangs would be able to protect themselves from harm, even after they had been reported missing from home or care. This resulted in the practitioners not acting to protect the boys from sexual exploitation, youth violence and drug and alcohol misuse (Bernard and Harris, 2019)"[5]

3.26 In September 2021 a report was published entitled Building Safety[6]. Although this research focussed specifically on Black boys and young men in Lambeth, its findings can be extrapolated considerably wider, not just geographically, but also to Black girls and young women in Britain. The report considered why most of the boys/young men included in the research had been in contact with children's social care in early childhood or adolescence and asked the question about why professionals were struggling to provide the appropriate levels of support to keep these young men safe.

3.27 "Building Safety" also references other research and states "there is also an emerging understanding of the role that structural factors such as poverty and racism play in shaping young people's experiences of harm in their communities and the extent to which services offer effective help (or not). This research has highlighted the role of poverty and class in shaping young girls' vulnerability to child sexual exploitation whilst simultaneously stifling the ability of social services (sic) and the police to recognise them as victims. "Building Safety" also highlights the relationship between school exclusion and ethnicity[7] and the fact that Black and

[3] https://www.womankind.org.uk/intersectionality-101-what-is-it-and-why-is-it-important/

[4] What is meant by the concept of 'intersectionality'? - Using intersectionality to understand structural inequality in Scotland: evidence synthesis - gov.scot (www.gov.scot)

[5] https://learning.nspcc.org.uk/safeguarding-child-protection/children-from-black-asian- minoritised-ethnic-communities#heading-top

[6] https://www.contextualsafeguarding.org.uk/media/zcthpoqu/building-safety-final.pdf

[7] https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/absence-and-

White/Afro Caribbean children are more likely to be excluded than their White British peers.

3.28 The report highlights the relationship between structural factors, service responses, and the difficulties experienced by children and families, including:

- The inequalities in children's chances of being able to grow up safely in their families and communities
- Poverty and associated features, such as inadequate and insecure work, housing and health difficulties, are key contributors to family difficulties
- The shame associated with poverty affects psychological health and contributes to parents' lack of self-efficacy and confidence in parenting
- The inter-connection of psychological harms with social conditions
- The importance of social connections to individual and family wellbeing

3.29 One of the recommendations of the report was for agencies to "create safe, courageous, reflective spaces for professionals to think about what racism is, what it does and, what is within their, and their institutions' agency to change".

3.30 What the report highlights is that for less well-informed professionals and agencies the focus is very much on interpersonal racism, if racism is considered at all. Racism can then be dismissed as a factor impacting on individuals and families lives if 'evidence' of interpersonal racism is not explored or proved, rather than accepting that racism is a systemic issue in Britain and the impact that then has on individuals and families.

3.31 It is a concern of the review that adultification bias was a factor in many aspects of this case. In the words of the Child Q report[8] "There is a growing body of evidence and research in this field, including the work of Listen Up and Jahnine Davis"[9].

3.32 Just as with Child Q "in reflecting on how adultification bias might have been evident in practice, this can be seen in the fact that Child A (in this case) received a largely criminal justice response from the adults around her, rather than a child protection response. This firmly echoes the findings of Davis and Marsh, 2020.

3.33 Every aspect of this review, both in relation to Adult A and Child A and her mother, should be read through the prism of intersectionality and structural racism.

3.34 Child A told the review she is 'a black woman'. She is absolutely clear that this is how she identifies, even though her heritage is mixed. Child A is of the view that she

exclusions/permanent-exclusions/latest

[8] https://chscp.org.uk/wp-content/uploads/2022/03/Child-Q-PUBLISHED-14-March-22.pdf

[9] https://listenupresearch.org/staff_member/jahnine-davis/

was treated differently by professionals because of the colour of her skin but was not able to give specific examples.

3.35 At one point Child A had said she wanted a social worker who was black. A black social worker was allocated to her. Interestingly Child A had no recollection of this social worker when speaking to the review.

3.36 Child A was assigned a female youth offending worker in Birmingham, which is what she said she wanted. There were some allegations of racism in relation to Child A but the issues that were discussed were much more Child A herself being racist towards others.

3.37 There is little evidence that Child A's ethnicity and culture formed part of assessments and interventions and no mention of her identifying as a 'Black woman' in reports and assessments seen by the review. Whilst there is little evidence of overt racism directed at Child A, apart from her alleging other children being racist towards her at school, the review has concerns, as previously stated, about adultification bias.

3.38 Adult A's parents told the review Adult A experienced racism and self-identified as black because of this. Adult A identified very strongly with Jamaica. He identified as a Londoner but also British and Jamaican. As Adult A was not considered as part of formal assessments and interventions in any way, his ethnicity and culture would not have been taken into account either.

Learning Point Four

A child's presenting behaviour needs to be recognised and considered as a form of communication, and behaviour that is challenging for professionals should be seen as a reason to work with a child not as a barrier, nor simply a pejorative label.

Additional Comment

Any assessment of a child should be seen through the lens of intersectionality and possible adultification. It is deeply concerning that in this case Child A was being attributed adult like qualities and abilities when as an eight-year-old child her development would not be this sophisticated particularly given the trauma she had experience which would have delayed her brain and cognitive development, not enhanced it. The review will consider systemic issues such as intersectionality and possible adultification bias later in the report.

Child A's presenting behaviours up until the fatal incident were extreme and should have been viewed as a communication of need based on her experience of severe abuse and trauma. Too often services focus on the behaviour and not what the child or parent is trying to communicate to professionals and others.

Local Action to Embed Learning

Birmingham – BCT's enhanced practice model supports practitioners and managers to look

beyond the child or young person's behaviour, promoting multi-layered understanding complex behavioural and family dynamics. The model seeks to enable practitioners to better understand the child's world as we develop more trauma-informed ways of working and seek to create the counter-conditions to address the impact of adverse childhood experiences and more effective strengths-based plans and interventions.

BCT has delivered a number of training opportunities enabling staff to understand the impact of adultification of black children and more specifically black girls. Intersectionality forms part of the supervision model adopted and rolled-out to all managers.

A 'Learning Lessons from Serious Cases' Briefing note has been produced to assist in cascading the learning together with good practice. This will be published alongside the LCSPR Report. The BSCP are hosting a webinar targeted at front-line practitioners and managers from Birmingham and West Sussex to share the learning from the review, this will include an input from one of the leading experts on adultification and intersectionality.

West Sussex - WSSCP has delivered Trauma Informed Practice training to frontline practitioners and senior leads during 2022/23 and is commissioned to continue during 2023/24.

3.39 BCT became involved with the family, for the first time, after Child A had been drugged and subjected to a significant assault in June 2019. She was 13 years old. Whilst it was positive that agencies saw Child A as a vulnerable child at this point there were many missed opportunities to protect her and there is no evidence that systems put in place to protect her had any effect at all.

3.40 At the time of the significant assault on Child A the GP made a referral to Forward Thinking Birmingham (FTB) (Mental Health Services for under 25-year-olds). Child A was assessed by FTB as being routine/low risk. The review strongly disagrees with that assessment as the referral was made due to her history of self-harm, aggressive behaviour and the circumstances around the recent significant assault.

3.41 It was in 2019 that Child A's behaviour deteriorated significantly again. She started going missing regularly. She was being aggressive at school, including punching other pupils. She was arrested on several occasions, including possessing a bladed article, where she had to be restrained by the police officer, whom she assaulted and was subsequently given a three-month conditional caution. On that occasion she was also found to be in the possession of a debit card of a 17-year-old male. She told professionals he had kidnapped her, sexually assaulted her at his home, after she met him. The police wanted to investigate the allegation, but they were unable to gain Child A's cooperation and therefore the incident was filed. She was 12 years old.

3.42 There is Government guidance on dealing with youth offending[10] balancing

[10] metro viewer (yjlc.uk)

protecting the public and innocent victims, but also the increasing recognition that children who offend can be victims, as well as perpetrators. Police forces also have a number of tools available to them when dealing with children as offenders, whilst balancing the needs of the child in terms of understanding vulnerability, safeguarding and diversion however there is not always consistency in practice, which can depend on seniority and knowledge, within and across police forces and/or between different agencies.

3.43 Whilst a referral to the Multi-Agency Safeguarding Hub should always be made when concerns are raised to the police about a child, whether as a victim, a perpetrator, or both, in this case, because of the severity of the offences, Child A was criminalised for her behaviour but professionals failed to recognise how vulnerable she herself was, as a 12-year-old girl and no referral was made to CSC. It is also important to note that National Police Chief Council guidance indicates that where there is sufficient evidence to charge a child under the age of 16 with a knife-related offence for the first time with no aggravating features, then they should be given a Youth Caution or Youth Conditional Caution.[11]

3.44 In June 2019 Child A allegedly threatened her mother with a knife. There is no evidence relevant agencies considered risk to Child A or others following this allegation.

3.45 Although it was recognised, to some degree, that Child A was at risk of exploitation and she was the subject of a number of exploitation meetings and strategy discussions, professionals were not using the evidence when considering the level or types of risk. Generally, she was also not deemed to be at risk of criminal exploitation, or modern-day slavery, even though in November 2019, at a Multi-agency Exploitation meeting the police shared concerns that she could be involved in dealing drugs or running drugs. The police knew through their enquiries that she was travelling by public transport across a large geographical area. It was also discussed that she had links with known gang members, as well as other girls deemed to be at risk of child exploitation. At different points Child A was deemed to be at high, medium or low risk but there is no evidence that partnership intervention including the referral to the National Referral Mechanism, the framework for identifying and referring potential victims of modern slavery to ensure they receive appropriate support, made any difference at all. There was no clear plan following the multi-agency Exploitation meeting and no meaningful criminal investigation recognising Child A as a victim of exploitation.

3.46 From the first moment it was recognised that Child A was at risk of exploitation she was always at high risk. There was no evidence to support the conclusion that the risk level had decreased, at the points those decisions were made, other than when

Youth Out-of-Court Disposals: Guide for Police and Youth Offending Services (publishing.service.gov.uk)
Youth Offenders | The Crown Prosecution Service (cps.gov.uk)

[11] https://www.college.police.uk/app/major-investigation-and-public-protection/knife-crime

she was detained in a secure unit between February and April 2020. She had been drugged and subjected to a significant assault at 12, she was carrying out increasingly violent attacks on others, including police officers. She was threatening to stab her mother and grandmother. She did stab her mother. She was also the victim of other alleged, violent assaults. She was regularly going missing. There was no multi-agency discussion about her online activity and yet she was clearly meeting individuals who were strangers to her.

3.47 It should be said that BCT's processes for identifying and responding to contextual safeguarding risks have been updated and are now more robust than they were at this time, particularly with the introduction of a Contextual Safeguarding Hub and daily Disruption Planning Meetings focusing on addressing needs for children, young people and perpetrators.

3.48 In the months prior to the fatal incident there were more concerns about Child A going missing, and who she was associating with, there were concerns about her being outside with very little clothing on – on one occasion returning home only wearing on her top half her bra and a coat, she no longer had her top on, and also concerns that she had started going back to Birmingham. Child A's mother was also clear, after the incident in June 2019 that she was fearful of Child A and worried that she would be seriously harmed by her. It was this incident that led to the ICPC and Child A becoming the subject of a child protection plan again, with the plan being to support the mother and Child A and work on reducing the risks. There is little evidence any of the work instigated over the following four-month period affected meaningful change.

3.49 There were three legal planning meetings held by BCT between October 2019 and January 2020. Each one concluded that threshold was met for an Interim Care Order and removal. On no occasion did BCT take the advice and seek to remove Child A from her mother's care. Each time she returned or remained at home. The review concurs with the legal advice that Child A's mother was unable to keep her safe and she should have been removed.

3.50 A fourth legal planning meeting was held in April 2020. The legal advice was that the threshold for removal of the child from her family home was met but that issuing an application to the court was not necessary. It was agreed that Child A would return home to her mother and that Child A and her mother should work with BCT. The review disagrees with the rationale for that decision. There was considerable evidence that professionals were not able to effect positive change working with Child A and her mother and those relationships in themselves were difficult, and neither Child A nor her mother were always willing to work with BCT.

3.51 It is the opinion of the review that the systems in place to protect such vulnerable children were ineffectual. This reflects the research referenced in the "Building Safety" report which highlights that "complex contextual factors interplay to create the conditions in which the abuse of adolescents takes place, and those traditional safeguarding partnerships, in which social care work with families and the police

and community safety teams deal with harm in communities, were limited in their ability to keep these young people safe."

3.52 It is easy to be critical of how professionals have acted but what has to be considered is the 'why?' Were there alternatives to what was being done? What one would have wanted to see was all the key professionals recognising how vulnerable Child A was, recognising the existing plans were not working and actually the risks were increasing and increasing from 2019 and therefore professionals considering what needed to change. Key here is BCT not sharing the psychological assessment with West Sussex, as mentioned elsewhere. But even if that vulnerability had been recognised what options were there available? If the threshold for detaining a child, which is a higher threshold than removing a child from their parents' care, against the parent's will, is not met then the options are a child remaining at home on a plan of some description or foster or residential care, but that relies on a child not running away from care, which in this case Child A had done before and as she told the review, she would have done again. As stated elsewhere, that was why the mother refused to allow Child A to go into voluntary care, because she had run away from a foster home previously.

3.53 As stated elsewhere, the psychological assessment held vital information and advice. It described Child A as a 13-year-old girl with a significant intellectual impairment who was suffering from post-traumatic stress disorder and who met the diagnostic criteria for having a conduct disorder. The assessment recommended Child A would benefit from individual therapeutic work to address the emotional consequences of her abuse, as well as coaching safety skills and sexual abuse prevention. It also recommended Child A would benefit from cognitive behavioural therapy specifically to address her conduct problems and educational remediation. The report made it clear that Child A received the interventions before consideration was given to her returning to live with her mother; she was in the secure unit at the time the assessment was completed. None of the recommendations of the assessment were taken up.

3.54 Partnership action focused predominately on Child A's offending behaviour and how to keep her safe. Although, when aged 12 years there were two incidents where she was recognised as a victim of serious assaults. In the words of Dr Carlene Firmin 'the various ways in which young people's victimisation can overlap with their involvement in offending, harmful or exploitative behaviours have been well documented in case reviews, Inquiries and wider research studies. Examples of professionals who struggle to recognise the victimisation of young people who they also characterised as perpetrators have been evidenced across a number of publications. This is a system-wide issue, with a need to refer a young person as a victim or perpetrator in order to determine a service for them; make charging or investigation decisions; assess the risk they face or pose; and prioritise interventions have all been evidenced.'[12]

[12] https://www.uobcsepolicinghub.org.uk/assets/documents/Vic-perp-overlap-briefing-Final.pdf

Learning Point Five

Children involved in offending behaviours must be recognised as vulnerable too and resolving their unmet needs is critical to reducing the risk they present to others. These children have often experienced abuse, exploitation and trauma and their offending behaviour and risk towards others should be seen in this context.

Additional comment

A 12-year-old girl carrying a knife is not common and all agencies should be asking themselves why such a young child feels the need to carry a weapon.

Whilst work is constantly being done to strengthen the collaboration between criminal justice agencies around diversionary activity for children, there is still work to do around raising understanding of the impact of trauma and the vulnerability in children. Offending behaviour in children should be seen as a symptom of their experiences and trauma as opposed to the problem to be tackled in isolation. Criminal justice services must start understanding and responding to children in the system differently. Unless offending behaviour is seen as a symptom of other things it will not be possible to affect positive change. This work should be underpinned by relationship-based practices that are key to healing trauma.

Local Action to Embed Learning

Birmingham – West Midlands Violence Reduction Partnership (VRP) and Contextual Safeguarding Board are overseeing the effective implementation of the Department for Education funded 'Safe (Support, Attend, Fulfil, Exceed) Taskforce' of early intervention of children and young people at risk of exploitation. There will be an evaluation of the impact of intervention to identify and embed good practice. West Midlands VRP provide BSCP with project updates.

Birmingham has an established Empower-U Multi-Agency Hub of trained specialists working with children at risk of criminal exploitation. Disruption Planning meetings focus on the coordination of partnership intervention, victim, offender and location. The Youth Offending Service (YOS) bring partners together to concentrate on children presenting a high or very high risk of serious harm through Local Risk Panels. A new joint working protocol has been developed between children's social care and the YOS to more explicitly outline roles and responsibilities in respect of vulnerable children and young people involved with both services. The BSCP undertakes independent audit and scrutiny of the impact of Disruption Planning. Extensive targeted work is being undertaken with young people in Birmingham who are disaffected and at risk of being drawn into criminal child exploitation and gang affiliation.

The BSCP has published a briefing note to enhance understanding and application of the National Referral Mechanism.

In September 2022 West Midlands Police delivered multi-agency training to raise awareness and improve practitioners' understanding of the threat from County Lines and wider child criminal exploitation.

Extensive targeted work is being undertaken with young people across Birmingham who are disaffected and at risk of being drawn into criminal child exploitation and gang affiliation, coordinated through the 'Safe Taskforce' and Empower-U Hub. The West Midlands VRP provided the BSCP Executive Board with a progress report in September 2022. The BSCP Executive Board will continue to seek further assurance and updates on progress.

West Sussex **-** WSSCP training programme includes exploitation training. The impact of the training will be reviewed.

The Youth Justice Service Disproportionality Project seeks to provide additional support for children who are of the global majority and who are disproportionately represented in the youth justice service caseload. The aims of the programme are to provide them with increased support from a youth work provider and who is also from a similar background and ethnicity and who therefore may provide a different level of support to meet their needs. Capturing their voice and experience of services is critical part of this project to inform service development.

The Knife Intervention Project in West Sussex delivers targeted youth and peer group support and community-based interventions. These are allocated to children and young people who are identified through partnership intelligence and data as posing an enhanced risk of possessing knives and committing serious violence offences. As well as providing the individual children and professionals working with them increased resources, the programme also seeks to work contextually and the need to make the places and spaces where harm occurs safer.

The Violence & Exploitation Reduction Partnership (VERP) implemented contextual safeguarding in West Sussex in 2018 and Community Safety has a lead officer supporting this multi-agency approach.

A weekly MACE triage system has been introduced in West Sussex for partners to bring and discuss their intelligence so that contextual risks and themes can be analysed, and plans formulated with the intention of making places and spaces safer for children. Children are referred using the Child Exploitation Screening Tool. Fortnightly MACE panels are held to discuss and safety plan for children at high risk of exploitation.

Understanding Family Dynamics, Needs and History in its broad context is vital

3.55 All agencies and the frontline professionals said they recognised the importance of family history**.** In this case the family history was known but this knowledge did not inform partnership intervention. There is little evidence of professionals asking the 'why questions'. A lack of professional curiosity is a common finding in case reviews. Services can be too focussed on telling families what they are concerned about,

rather than asking the family questions and making every effort to understand the family's perception and opinions. For any service to be effective it is essential professionals understand the family's history and the family's position.

3.56 One significant omission was any consideration of the impact of Child A's father on her life. Because Child A's mother said he was not involved in Child A's life, that was just accepted, which it should not have been. Just because a parent is not physically in a child's life does not mean there will be no impact. Not only the domestic abuse but there was also no exploration with Child A as to how she felt about her father; whether she had conflicting emotions about him, and whether there was a void in her life. It is an extremely common finding from case reviews that men are overlooked. That happened in this case too, both in relation to Child A's father but also in relation to Adult A. It is essential practitioners are alert to, and articulate, the specific involvement and impact on family dynamics of adult males in and around the household.

3.57 Another significant omission was that there is no evidence any consideration was given to the fact that Child A's mother had been a vulnerable child herself, even though she was a victim of domestic abuse during her pregnancy with Child A and her partner was a known perpetrator of domestic abuse. She was 17 and did not register her pregnancy with the GP until quite late. It is well recognised that vulnerable groups of women (domestic abuse, safeguarding issues, substance misuse, low social class, newly arrived migrants/refugees/asylum seekers) are less likely to attend for antenatal care or book late. MBRRACE (2020)[13] report that women with extreme vulnerabilities may have a compromised ability to access care and comply with treatment.

3.58 When Child A's mother presented at hospital, reporting domestic abuse, child protection processes should have been initiated for both her, and her unborn baby. Police records indicate that the mother 'declined police involvement'. It should not have been a choice; it is child protection.

3.59 It is not clear why this did not trigger intervention by the police and hospital, although intersectionality was a concept little understood at that time. With the passage of time, it is challenging to provide greater clarity. The system now demonstrates a clear awareness of the vulnerability of late bookers. They will be placed under consultant care and risk assessed with a recognition that this includes a safeguarding referral and necessary referrals made in response to identified need. There is also a maternity liaison system between health visitors and midwives where the hospital recognises potential risks including accumulated risk factors such as age, late booking and domestic abuse.

3.60 It is not clear what the relationship was like between Child A and the father of her half siblings, with whom she lived for several years. Her mother described it as a very good relationship but as stated elsewhere, Child A herself was unwilling to talk

[13] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report- 2020/MBRRACE-UK_Maternal_Report_2020_-_Lay_Summary_v10.pdf

about him.

3.61 Whilst Child A and her mother lived in Birmingham there were several references to organising a family group conference. There was a considerable amount of information on record about both Child A's birth father and Child A's maternal grandparents. There was no evidence of extended family members being able to provide Child A with any protective factors. Whilst family group conferences must be considered as part of the Public Law Outline it is the opinion of the review team that once the initial exploration had taken place, a family group conference would have been entirely inappropriate. That was also the view of the family group conference team in Birmingham and that suggests a lack of clear practice planning by BCT and their legal advisors in the continued recommendations for a family group conference to be held.

3.62 Apart from one or two exceptions there was an expectation that both Child A and her mother would engage with services. When this did not happen, they were seen as 'hard to engage'. The focus was on them, rather than services thinking how they could adapt. This is a very common in reviews. Again, it is important to be mindful of the findings of the psychological assessment, in terms of the respective learning disabilities and difficulties of both Child A and her mother.

3.63 As set out in this report Child A's mother told the review that professionals talked about her lack of parental control, her inability to parent and her failings. As stated elsewhere, the psychological assessment should have been used to inform practice, but it was not. Part of the brief was to assess Child A's mother's parental capacity to identify and recognise risk and to keep her children safe from harm. In terms of parenting capacity, the assessment concluded Child A's mother had 'significant intellectual impairment' and that if Child A was to return home, on her release from the secure unit, her mother should access an individualised home-based parenting programme. The assessment concluded, however, that Child A's mother was likely to struggle, because of her cognitive limitations, to acquire the skills necessary to meet Child A's needs and she would be unable to keep Child A safe.

3.64 The psychological assessment concluded that Child A's mother masked her intellectual impairment well and the author states 'I think it is very likely that those supporting her will overestimate her intellectual abilities'. That is clearly what happened because, without having sight of the psychological assessment, there is no view from professionals in West Sussex that this was a concern and therefore their expectations were that they could work with Child A's mother as they worked with other parents/carers who did not have significant intellectual impairment. If West Sussex had been privy to this information when Child A and her mother arrived in West Sussex they could have sought advice as to how to work more effectively with Child A's mother. When they did receive the report a few months later they did adapt the way they worked with her, although there is no evidence of the impact of that.

3.65 Professionals expressed frustrations that the mother would oscillate in her views.

At times wanting her daughter to go into care, wanting her to be prosecuted for offences against her but then always retracting and wanting her home again and unwilling to support prosecution. When Child A would return home, after going missing, her mother would often block the return interviews. Child A's mother told the review that she did not think foster care would work because they would not be able to keep Child A safe and she would just run away, as she had done when she had been placed in emergency foster care at one point. She did also express that view to agencies in the months leading up to the fatal incident. Her view was the only thing that would work was a secure unit that offered therapeutic support. She described to the review not wanting Child A to be prosecuted because that would be a permanent marker on her and would have too significant an impact on her life. She felt just getting the police involved was enough. She said she did sometimes stop professionals seeing Child A because Child A did not want to see them, and she felt she had to protect her child and there were so many different professionals involved.

3.66 Child A's mother was clear with the review as to what she wanted. She wanted CSC involved, but for a specific reason. She did not want any parenting support and felt she knew exactly what to do and no one could teach her anything. She told the review that the parenting course she had to attend taught her nothing and the teacher ended up asking her questions. She wanted CSC involved because she believed they had the power to make other agencies get involved and all that she wanted was support with Child A's behaviour. She did say that she felt all the schools that Child A attended had done their best to try and support Child A. She did not believe any of the plans that were put in place helped Child A in anyway at all. The review would have to concur with this view. It was also very powerful hearing from Child A's mother.

3.67 Child A told the review very similar things. She sees social workers as breaking up families when what they should be doing is listening to and talking to families and helping the family more. She was also clear she did not ever want to go into care. She described running away from the emergency foster placement because she said there was a small boy in the placement and she felt it was wrong that she was there with him. She described not wanting to frighten him or make him feel unsafe by her being there, so she ran away.

3.68 Child A's mother said she felt listened to, being interviewed for the CSPR. Child A's mother's experience of professionals' involvement was that while she was consistently asking for help with Child A's behaviour, year after year, she never received the help and her perception was all the professionals talked about was her lack of parental control, her inability to parent and her failings, rather than offering any support that actually made a difference. Child A's mother felt professionals working with the family did not listen to her and hear what she was saying, and her reasons for her actions/decisions. The review finds that Child A's mother's experience of services is valid and reflective of the wider findings of the review.

3.69 As stated earlier, it is a common finding from reviews that professionals can be very

good at telling families what they are concerned about and not so good at asking families where they are coming from, what their position is. Whilst there is no guarantee that Child A's mother would have spoken to frontline professionals, as she spoke to the review, time should have been taken to try to understand her position; why she sometimes blocked professionals from seeing Child A; why she had the view she did about foster care and why she would retract her support for a prosecution. All of which are actions that would be entirely understandable to any parent.

3.70 The view and experience of some of the frontline professionals was that Child A's mother could be a barrier to them working effectively with the family, including Child A. If they had understood her position, they could have worked from that point and there would have been a greater opportunity for effective partnership working between the family and the services and a greater understanding of the family dynamic.

3.71 There was a high turnover of staff working with Child A and her mother and the impact of the constant repetition of assessments/questions/interactions were not conducive to their engagement.

3.72 Child A's mother told the review that she had told Adult A that he could not live with her 24/7 as her focus had to be on Child A. Whilst the review cannot confirm this, if this was what happened it would have been helpful for frontline professionals to have known that and that Child A's mother did seem to have her focus on Child A. What is known is that Child A's mother did ask Adult A to look after Child A while she went to visit her mother, who was terminally ill, in Birmingham.

3.73 Although it was known that Child A and her mother had a difficult relationship there is no evidence this was explored by the agencies involved. There was evidence that Child A was physically and emotionally abusive towards her mother – making threats to her and attacking her, including with a knife. There was evidence her mother was emotionally abusive towards her – saying it was Child A's own fault she was subjected to a significant assault, for example. There were also allegations Child A's half-siblings made that she was also physically abusive towards Child A and that Child A was physically abusive towards them. Child A was also seen hitting one of her half-siblings so hard he fell to the floor.

3.74 With Child A, the protective factors seemed to be very limited, and this was not factored into the planning and interventions to safeguard and support Child A, the focus being on risk factors and vulnerabilities. If professionals had given this greater focus maybe they would have asked the same question that the review has asked, were there actually any protective factors for Child A in place?

3.75 There were considerable and known concerns about Child A's mother's ability to parent. Child A had no known positive role models in her life and the fact that Adult A clearly wanted to help and offered himself to be part of a CSC assessment but was overlooked was a missed opportunity. It is known that he attended a child

protection conference in West Sussex and that he would ask professionals for advice on what he could do to assist and what to do when Child A's behaviour escalated. It is known he encouraged Child A to go to appointments.

3.76 Child A became the subject of a child in need plan after she was subjected to a significant assault, aged 12. It is the view of the review team that this should have been a child protection plan because of the known risks and vulnerabilities. Later she became the subject of a child protection plan, until the time she was remanded in custody in February 2020. From there she automatically became a child in care and the child protection plan was discontinued. A legal planning meeting took place prior to her release from the secure unit in April 2020. The meeting did not consider the recommendations from the psychological assessment and the plan was made for her to return home given mother's willingness to work with agencies and it was felt it would be draconian to apply for an interim care order. The Independent reviewing officer disagreed with this plan. As stated previously, the review strongly disagrees with the decision made to go against the recommendation of the psychological assessment, and an interim care order should have been sought. There was also considerable evidence, over many years, of unrealistic expectations being placed on the mother and her ability to keep Child A safe. As professionals decided that Child A could return home this, in effect, meant they did not deem her to be at risk of significant harm in the home. This resulted in Child A only being assessed as a child in need, which meant other processes were not triggered. Child A could only have been assessed as a child in need, which is what happened.

3.77 As with all other types of support, when reviewing the child protection and child in need plans in place at different times there is no evidence any of the plans resulted in sustained improvement in Child A's situation.

Learning Point Six

All agencies need to constantly question and challenge themselves on how well they understand a family and how effectively they are working, both with the family, within their own agency and with each other.

Additional comment
Understanding a family's narrative is critical to understanding need and what interventions are most likely to succeed.

Listening to families and understanding families will give professionals the greatest chance of improving the child's life, along with having realistic expectations of both the parents' ability/willingness to change and the child's ability to change.

For any system to be effective professionals must continually examine the effectiveness of the plan/s in place and focus on outcomes. Agencies must continually ask themselves the questions 'Is this plan working? Is this child safer? Are things getting better for this child and if not, what do we need to do differently?' In other words, the 'So what?' question.

It is not unique to this case review that a child is the subject of a range of different plans and the subject of multiple meetings, sometimes over significant periods of time, whilst things continue to deteriorate for the child.

Having a plan of any description in place does not protect a child, nor does having multiple meetings about the child.

Individual agencies may also need their own plan but work should be undertaken to support joint and collaborative planning which reflects each agency's role and perspective. Plans need to be sequenced and it should be clear who is delivering what, when. They should then be reviewed and progress against the plan measured and recorded to demonstrate impact and improved outcomes for the child. There also needs to be contingency / parallel planning.

Services need to be outcome focused and constantly reflect on whether their intervention is effective and if not, what needs to be done differently, rather than simply describing children and their families as 'hard to reach' or 'hard to engage'.

The language professionals use is extremely powerful. Using terms such as 'hard to reach' or 'hard to engage' gives professionals permission to step away from those families. It is we, the professionals, who have the difficulty engaging with such families and the focus needs to be on the services and the professionals and how we can change and adapt to meet the needs of all the children and their families that we are there to support.

All work with families should be strengths/asset/relationship based and collaborative, working with families, not doing to them.

The focus for all work with families should be on building strengths and protective factors. There must be a focus in all plans on identifying the positives within a family and work done to encourage and support the development of these, as they will lead to other positive developments i.e. a strengths-based approach not a deficit model.

Supervision and professional challenge are essential components in effective multi-agency working. This is a common finding from reviews. There is no evidence of the impact of supervision in this case which could have provided oversight, advice and guidance.

The same is true of professional challenge. A lack of professional challenge is a common finding from reviews. There were only two examples of professional challenge in this case, the first being the independent reviewing officer who challenged the decision that Child A should return home after her detention, but nothing came of that challenge. The second was when West Sussex CSC escalated concerns about BCT not sharing information in a timely manner. Even when agencies were referring to other services and were told their thresholds were not met this was just accepted.

Local Action to Embed Learning

Birmingham **-** BCT's enhanced practice model and associated Practice Standards explicitly promotes effective assessment and planning within the Trust and with partners. This work is

supported by a wider coalition of partners who seek to developed trauma-informed practice across all agencies who work with children and families.

BCT has revised and re-launched its Supervision Policy supported by regular practice learning and thematic audits. All managers have been trained in a systemic model of supervision.

The emerging learning from this review has informed the BSCP Quality Assurance and Audit Programme. In 2022 BSCP conducted case file audits. As part of the audit processes consideration is given to the quality of multi-agency engagement with the child and their family. Through the audits areas for further improvement are identified and acted upon, with the BSCP overseeing implementation of learning.

The BSCP 'Right Help Right Time' (RHRT) is currently being refreshed and will be strengthened to include links to the BSCP professional dispute and escalation protocol.

The BSCP Training Programme for 2022/23 included specific training for practitioners about the importance and application of professional curiosity and challenge. The training programme has been supported by the publication of Learning Lessons Briefing Notes again focusing on professional curiosity and sharing good practice with front-line practitioners across the children's workforce. The BSCP Annual report is scheduled for presentation to the Executive Board in November 2023 which will report upon the impact and outcome of the quality assurance activity and Multi-Agency Safeguarding Training Programme for 2020/23.

Since 2022 the BSCP refreshed Case File Audits programme has been able to provide enhanced scrutiny of multi-agency decision making, escalation and the impact of supervision. The new audit methodology focuses on the quality of assessments, intervention and effectiveness of plans in place to support the child and family.

West Sussex - In West Sussex all social workers across Children's Social Care and Early Help are using newly reviewed/updated strengths-based guidance, this together with a comprehensive Neglect strategy and tools focuses practitioners to gather background information about the family, to be curious and ask the "why", analysing the information, looking for patterns and potential systemic patterns of behaviour will enhance the quality of interventions and work will be able to get to the root cause of challenges / barriers of effective parenting. There is a robust quality assurance process to ensure families are provided with the right support at the right time, this includes audits, observations of practice, family feedback and mock inspections.

West Sussex Children Social Care has developed its outcome focused planning through delivery of training. Early Help Team Around the Family meetings are driving forward outcome focussed planning. WSSCP recognises further action is needed across the partnership to ensure plans are shared and contributed to by all partner agencies and organisations.

A 'Day in my Life' tool is used by frontline practitioners to gain an understanding of the child's lived experience. All WSSCP audits include a question about tools used by professionals when working with children and families and a multi-agency neglect audit was undertaken in July 2022.

3.78 There is significant evidence of the different primary schools involved reaching out and referring to other agencies to try to get the right support for Child A and support being provided through a range of plans, but there is little evidence that the intervention made a difference. Child A's attendance at school was poor, however, this didn't result in prosecution. That may be because Child A's mother told one school that they were causing her illness during her pregnancy by repeatedly contacting her regarding Child A's poor attendance. It was known that the mother had been in hospital with pregnancy related issues at that time. There is also evidence that, to varying degrees of success, the schools tried to work with the mother and her partner at that time, the father of Child A's half-siblings. At the school Child A was finally excluded from there was an individual education plan in place. There was also a member of staff allocated to Child A to provide one-to-one support. There is significant evidence that the school tried extremely hard to support Child A. When this did not work in school, they referred to outreach support, they wrote to the GP asking for support requesting an assessment of Child A.

3.79 It is very unusual for an eight-year-old, and particularly an eight-year-old girl, to be permanently excluded from school. In 2021/22 a total of 758 children were permanently excluded from state-funded primary schools[14]. Research shows that boys have nearly three times the number of permanent exclusions, 0.11 compared with 0.04 for girls[15]. This should have been seen, by all agencies, as a significant red flag, which should have been explored further.

Learning Point Seven

A child at risk of being permanently excluded should trigger a multi-agency safeguarding response.

Additional comment

Eight out of ten children who are in custody have been excluded from school.[16] If the child is a primary-aged child this should be seen as an additional concern. When a child is permanently excluded there can be a time lag of a week, or so, before education is provided, and that may only be online. During that time there could be no professional eyes on that child at an extremely vulnerable time in their lives.

Local Action to Embed Learning

Birmingham **-** In Birmingham the Reducing Exclusions Working Group have strengthening relationships between Education settings and their local partnerships building a 'Team

[14] Permanent exclusions and suspensions in England, Summer term 2021/22 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

[15] https://www.socialfinance.org.uk/resources/publications/whos-risk-exclusion-analysis- cheshire-west-and-chester

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/956621/youth-justice-statistics-2019-2020.pdf

Around the School' approach to enable teachers to contact professionals who can help them deliver effective early help to children and families. https://www.localofferbirmingham.co.uk/team-around-the-school-3/

In Birmingham, schools can access locality based Early Help and Support for children at risk of fixed term and permanent exclusion. Ealy Help Coordinators visit school settings to discuss families that schools are concerned about before the risks increases and in October 2022 a multi-agency Inclusion Panel was introduced in Birmingham to try and reduce school exclusions.

Birmingham Safeguarding Children Partnership are overseeing a refresh and update of Multi-Agency Threshold Guidance 'Right Help Right Time' which emphasizes the importance of seeking early partnership intervention for children at risk of exclusion. Birmingham schools are now advised to liaise with the Child Advice and Support Service (CASS) for all children under 11 that are at risk of being permanently excluded.

The Director of Children's Services established a Reducing Exclusions Group which provide regular reports on progress to reduce school exclusions in Birmingham. In September 2022 the BSCP were provided with an analysis of primary school exclusion data which provided greater understanding of the issues and support required. The BSCP continues to seek further assurance of progress.

West Sussex - The West Sussex Schools Inclusion Project provides funding for a range of programmes across schools in WS. This includes an enhanced offer of support in schools to children who are at risk of exclusion. Recently externally evaluated, the programme of work has been highlighted to support outcomes.

West Sussex are in the process of refining processes which best support pupils at risk of exclusion, including a care plan.

WSSCP thresholds have been reviewed and updated to ensure a robust multi agency response to children at risk from exclusion.

3.80 When Child A and her mother moved to West Sussex they lived in accommodation that was well known in the area for housing residents with a range of issues - anti-social behaviours / criminality, mental health issues, domestic abuse, substance misuse, i.e. individuals that were hard to house and may have previously lost council / housing association accommodation. There would be varying levels of vulnerability and risk for all tenants at the property. When Child A and her mother moved to West Sussex there was no further role or necessary duty for involvement from LBH&F Housing Department.

3.81 Child A's mother told the review the block was noisy, with lots of shouting at night and that Child A slept with a knife under her pillow because she was scared. It is important to be clear that Child A's mother wanted to move to London and went to the LBH&F. It was they who identified alternative accommodation for the family in

Crawley in West Sussex. Detailed information about Child A was not made available to LBH&F by BCT, prior to Child A returning to live with her mother. Child A was not considered part of the mother's housing application and when Child A did move to live with her mother, they were no longer in LBH&F and there was no further required statutory involvement with LBH&F.

Learning Point Eight

It is essential that housing authorities consider risk and vulnerability when placing vulnerable individuals and families into accommodation in discharge of its homelessness duties. It is equally essential that housing is routinely included in multi-agency working to support vulnerable families.

Additional comment

The review recognises that housing provision is limited however this learning point is about housing authorities thinking creatively about the use of private rented accommodation to ensure that, wherever possible, vulnerable children and their families are not placed in accommodation with individual residents who are deemed hard to home. It is not uncommon for a CSPR to find that a vulnerable family has been placed in unsuitable housing, in relation to the other residents in that accommodation.

It is therefore essential that all key agencies, including housing, should be routinely working together to consider how best to place the most vulnerable cohorts of individuals.

It is also a common finding from case reviews that housing services are a missing link in child protection cases, and they are disconnected from the multi-agency networks in place to protect children and housing services are frequently not included in multi-agency working to protect children. This is in spite of the Children Act 2004 s.11 duties on a range of organisations, including housing, to "ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children". Working Together to Safeguard Children 2018 also makes it clear that "Housing authorities also have an important role to play in safeguarding vulnerable young people, including young people who are pregnant, leaving care or a secure establishment".

This gap has been highlighted again in a recent report by the Local Government and Social Care Ombudsman entitled "More Home Truths"[17], which noted a failure of housing organisations in sharing information with other services, including social care and the importance of joint working.

In this case the joint working between housing and other agencies was compromised by the housing allocation system; to relieve the family's homelessness the London Borough of Hammersmith & Fulham offered an option of private rented accommodation in West Sussex, which mother accepted. Hammersmith and Fulham informed BCT that Child A's mother had

[17] https://insidecroydon.com/wp-content/uploads/2023/03/Ombudsmans-report-on-homelessness.pdf

moved to the address in West Sussex. There was delay from services in Birmingham as to who they should be liaising with in West Sussex.

Local Action to Embed Learning

Birmingham **-** In Birmingham, the Director, Housing Solutions & Support Service is a member of the BSCP Executive Board. City housing is actively engaged in the Safeguarding arrangements in Birmingham, including the Multi-Agency Safeguarding Hub (MASH)

West Sussex **-** In West Sussex, Districts and Boroughs are represented on WSSCP sub-groups and Steering Group. The WSCC Community Safety and Wellbeing Partnership's Domestic Abuse team recently appointed two Housing Independent Domestic Abuse Advisers who work closely with District and Borough Housing Options teams to support a joint response to victim/survivors seeking housing support and safe accommodation as a result of their experiences of domestic abuse. This includes training housing options staff.

The importance of recognising and understanding the impact of Trauma and Abuse on Children and utilising a trauma-informed approach

3.82 There is no evidence that any of the agencies working with Child A acknowledged, explored or considered the impact of the exposure to domestic abuse in utero.

3.83 When asked about her safe places and who protected her, when she was a little girl, Child A was not able to name anyone or anywhere. She described herself as very independent and said she would look after herself, even when she was a toddler. The concept of safe places or safe people was not one she seemed to understand.

3.84 The psychological assessment undertaken in October 2019, concluded 'it is highly likely that Child A suffered emotional and psychological trauma from the impact of living in a household dominated by tension and fear'.

3.85 Child A's attendance at school was sporadic. The national average attendance for primary age children is around 96%. In Birmingham it is around 95%. Child A's attendance at her different primary schools averaged at 50%. This equates to missing half of the academic year (19.5 weeks). Department for Education data shows that poor attendance impacts a child's academic progress in school and their attainment. In addition, relationships with peers and teachers are difficult to maintain with such frequent absences. Persistent absence is defined as a child with 10% or more absences.

3.86 There is no evidence that any of the primary schools, or partner agencies, were looking behind her behaviour. The actions taken were very much around responding to the violent incidents, of which there were a significant number, rather than asking 'what is causing this behaviour?', which is what should have happened. It is apparent that the school had so much to do, responding to each and

every incident and providing one-to-one support for Child A that they were consumed by that, rather than reflecting on why she was behaving the way that she was. Child A was one child of many. The school had to put Child A on a part-time timetable, before she was permanently excluded, because they simply did not have the staff to supervise her full-time, which is what was required to keep her and other children safe. Between October 2013 and March 2015, when she was permanently excluded, there were at least 18 days where significant incidents took place and on many of those days' multiple incidents. For those of us who do not work in education it is hard to understand how challenging this would be for a school to manage.

3.87 Child A told the review schools need to understand that when a child is "messing around, or misbehaving", they are doing that because the work is too hard, or they are not enjoying it. Child A only remembers one teacher who she said made the effort to take her out of the classroom and talk to her and explain things.

3.88 The Department for Education has recently published a report entitled "Working Together to Improve School Attendance".[18] The guidance sets out what education settings and local authorities should do where there are barriers to attendance for a pupil or family who have complex needs where signposting to services is not sufficient. It makes it clear that schools, local authorities, and other services should work together to provide more intensive whole family support to address any difficulties as soon as it becomes clear that families would benefit from this approach. Schools and local authorities are also specifically expected to have agreed a joint approach for all severely absent pupils. The guidance sets out that multi-disciplinary support should build on the existing early help offer in local authorities rather than requiring additional resource. In line with early help principles, the family should receive a single assessment, plan, and where necessary, a single lead practitioner. This should be from the team or service best placed to support the family and their needs, which may be the school, a local authority team or service or another statutory partner such as a health professional. Therefore, when considering how professionals dealt with Child A's education, and could that be repeated now, one would hope that this new guidance, combined with the fact that eight years further on trauma informed practice should be at the front and centre of every school's practice, means a Child A of today should be managed very differently.

3.89 At one point the school made a referral to CAMHS, which was declined. They were told it did not meet threshold. Whilst the review accept that services need referral criteria, for children such as Child A they essentially fall between the gaps. There will be many other examples of this throughout the report. This referral to CAMHS might have been better directed towards an assessment of Child A by community paediatrics, given her age and behaviour.

[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1099677/Working_together_to_improve_school_attendance.pdf

3.90 There can be a tendency for CAMHS to describe how a child is presenting as 'behaviour' and therefore conclude the child does not meet the threshold for their service but if services are so rigid on 'behaviour' they lose looking at what is driving that behaviour, which should always be a vital component in any assessment.

3.91 This is a significant challenge for CAMHS and is one of the reasons forensic CAMHS was set up, especially where risk factors involve mental health and risk towards others. In this case a referral to forensic CAMHS was not made, as it was identified that Child A required therapeutic support and a referral was made to a trauma specialist centre for trauma therapy. This service also facilitates practitioner case formulations for the YJS, but did not provide any direct work for Child A due to the fatal incident occurring before work commenced.

3.92 There is evidence that Child A's final primary school viewed her with some hostility. They described her as having no compassion or remorse for the person she had hurt or upset and described her as going on a 'revenge mission' if someone retaliated or accidentally did something to her. Even withstanding the challenge for the school of managing a child with such extreme behaviours, Child A was eight years old and whilst the school wanted a special educational needs and disabilities assessment there was no consideration that her behaviour might be as a result of trauma and the impact of intersectionality and her life experiences, which there should have been. This was a failure of the system as a whole. Other agencies were involved and there is no evidence any other agency considered the 'why'.

3.93 Frontline professionals spoke of the need for 'trauma-informed practice' but went on to say that relationship building was difficult due to Child A being chaotic and the need for constant 'firefighting' by practitioners. Sometimes, almost daily, they were responding to crises, there simply was not the time to do the preventative, strengthening, relationship-building work. It would have helped YJS and CSC in West Sussex considerably if they had had access to the psychological assessment, which would have helped inform their practice. West Sussex YJS were the only agency who demonstrated an awareness of trauma-informed practice.

3.94 The child protection plan should have been shaped by the psychological assessment.

Learning Point Nine

It is essential that all services recognise the impact of childhood trauma, including in utero, on a child's development and behaviour and services are sufficiently flexible to create bespoke support packages that meet the needs of each individual child and their family.

Additional comment
Assessments must be as much geared towards provision of support as investigation of risk.

Local Action to Embed Learning

Birmingham **-** The BSCP commissioned the National Working Group (NWG) to develop a module on 'Trauma - Impact on Young People' and delivered nine courses during 2021-22. The training was subject of independent observation and evaluation. The evaluation feedback help inform the continuous development of training in this important area.

The aspiration of the BCT and its partners is to develop trauma-informed based practice across agencies and commissioned services. BCT's practice model, 'Connections Count' provides a strong foundation as we seek to create the counter-conditions for tackling the negative impact of childhood adverse.

West Sussex **-** WSSCP have delivered Trauma Informed Practice training for frontline professionals and senior leads during 2022/23 and have commissioned training for 2023/24.

The Importance of the Continuity of Care, Support and Information Exchange when a Child Moves Area

3.95 Apart from the Youth Offending Service and the police, the transfer of the information that was shared by Birmingham to West Sussex children's services was too slow and insufficient and significantly impacted on West Sussex's ability to support Child A in the best way possible, having so little information about her and her mother, when they first moved to West Sussex. It meant that West Sussex were left working with a highly complex family whilst not having a full understanding of their presentation. The transfer of vital information from BCT only came after the issue was escalated to heads of service by West Sussex CSC. The review team considers this extremely poor practice.

3.96 The psychological assessment commissioned by BCT should have formed the basis of all support offered to Child A and her mother from that point because it was a hugely detailed assessment of both Child A and her mother and made vital recommendations as to how to work as effectively as possible with them both, taking into particular consideration their different learning difficulties/disabilities. The report was never used to inform practice. Part of the reason for that was because when BCT received the report Child A had yet to be discharged from the secure unit she was in and her mother had moved to London but it was not certain where Child A and her mother were likely to be living when Child A was released. Initially the mother stayed with a relation in Hammersmith and the plan was for them to live there when Child A was released. BCT notified Hammersmith and Fulham CSC. The mother then applied for accommodation and was offered a property within the London Borough of Ealing. BCT then notified Ealing CSC. This property was unsuitable and she was subsequently offered the property in West Sussex, which she accepted. On Child A's release from custody and discharge from care she and her mother went directly to West Sussex, to a property identified by LBH&F Housing Department. Another reason why the psychological assessment was

delayed in reaching West Sussex was that it also contained information about the half siblings which needed to be redacted.

3.97 If the services supporting Child A in West Sussex had had access to the psychological assessment it would have been extremely helpful to them in understanding how best to support Child A and her mother. (The YJS did receive it two months after Child A arrived in West Sussex but CSC never did). For example, the assessment concluded that Child A was functioning intellectually within the mild learning disability range, with a full-scale IQ of between 50 and 70, as well as meeting the diagnostic criteria for having a conduct disorder and post-traumatic stress disorder.

3.98 Prior to her being remanded, agencies in Birmingham had assessed Child A as being at high risk of exploitation and also at risk of criminal exploitation. She had been the subject of a child protection plan at the time, but this was automatically discontinued when she was remanded and therefore became a child in care. At the point of discharge from the secure unit BCT looked to hold an initial child protection conference but this was not possible because the family moved to West Sussex. At the point Child A went to live in West Sussex she was only deemed to be a child in need by BCT.

3.99 Child A's EHCP was not transferred to West Sussex until June 2020, which made it difficult to find the best placement without knowledge of her background and history, which were not known until Child A herself disclosed details of a previous serious assault.

3.100 There was also a delay in the transfer of school records to West Sussex. That may have been partly because her last school in the Birmingham area did not know where she was transferring to in West Sussex, because she had gone to a secure unit before moving to West Sussex.

3.101 The school nurses would have been able to communicate information between schools but were not aware Child A had moved until July 2020.

3.102 As the information trickled in from Birmingham and West Sussex gained a greater level of understanding of the risks and vulnerabilities, Child A went from child in need to child protection immediately. West Sussex recognised her vulnerability but the delay in the information being shared by agencies in Birmingham meant they were less equipped to meet Child A and her mother's needs because they simply did not have the information they needed.

Learning Point Ten

If agencies are to work effectively to protect the most vulnerable children, it is essential there is a clear framework and processes for both information and support for children and families transferring between local authorities.

Additional comment
In this case it was further complicated because initially the mother moved to the London Borough of Hammersmith and Fulham and it was they who offered her accommodation in West Sussex. For Birmingham it was not clear for a while where the mother was going to settle permanently and that did not help with the process of sharing information.

Whilst there may be challenges in sharing some information, for example a report that is court ordered, the law is very clear that professionals must act in the best interests of the child. Sharing key information with relevant agencies is acting in the best interest of the child.

Local Action to Embed Learning

Birmingham **-** BCT in conjunction with Solihull Children's Services developed a protocol to improve the continuity of care and sharing of information for children moving between the two authorities. This guidance has been developed into a West Midlands Regional Guidance complementing National Guidance on the transfer of cases.

Information-sharing is a routine element of BCT's practice evaluation and audit activity, which provides an opportunity for managers to test out with practitioners their understanding of information-sharing including where this involves children moving between local authorities. Additional scrutiny is offered by Independent Reviewing Officers and Principal Officers when children who are subject to child in care or child protection planning move to another LA.

West Sussex **-** In West Sussex, guidance for professionals for sharing of information about families transferring between authorities is set out in the Pan Sussex Policies and Procedures. The subgroup meets quarterly to ensure procedures are reviewed and updated and practitioners are informed of any changes in process.

4. National Learning

4.1 As well as the local learning the review has also identified two potential areas for national learning that provide an opportunity to further enhance how we work together to safeguarding children nationally. The review respectfully requests that the Child Safeguarding Review Panel and Department for Education consider each of these issues as national learning points:

National Learning Point One

There needs to be a much greater understanding of the factors which contribute to children committing the most serious of offences, including adultification bias and intersectionality, and children involved in offending behaviours must be better recognised as vulnerable too.

Additional Comments
Resolving the unmet needs of this cohort of children is critical to reducing the risk they present to others. These children have often experienced abuse, exploitation and trauma

and their offending behaviour and risk towards others should be seen in this context.

The Child Safeguarding National Review Panel is to undertake a thematic project about child protection, ethnicity and racial bias as part of its 2023-2024 work plan. The review respectfully requests the project considers the learning from this CSPR as part of its review.

National Learning Point Two

Vulnerable children would be better protected if statutory procedures were strengthened in relation to the following:

- ***children on the verge of being permanently excluded from school***
- ***there being a greater requirement for housing to be involved routinely in multi-agency working and housing providers having to consider risk and vulnerability when placing vulnerable children and their families***
- ***the protection of deeply traumatised older children and children who are dangerous and potentially pose of risk of serious harm to others***
- ***vulnerable children and families transferring between local authorities***

Children on the Verge of Being Excluded

It is a finding of this review that when a child is at risk of being permanently excluded this should trigger a multi-agency safeguarding response. The revision of Working Together to Safeguard Children 2023, could include guidance on action to be taken when a child is at risk of being permanently excluded. Built around a requirement for schools to notify their local education authority, triggering a multi-agency meeting to discuss the child and agree what action and support is required to avoid the need for exclusion.

Effective Engagement of Housing in Safeguarding Arrangements

As stated in the Local Learning Point Eight: the review recognises that housing provision is limited however this learning point is about housing providers thinking creatively about the use of their housing stock to ensure that, wherever possible, vulnerable children and their families are not placed in accommodation with individual residents who are deemed hard to home. It is not uncommon for a CSPR to find that a vulnerable family has been placed in unsuitable housing, in relation to the other residents in that accommodation.

It is essential that housing is routinely included in multi-agency working to support vulnerable families. It is a common finding from case reviews that housing is a missing link in child protection cases and are disconnected from the multi-agency networks in place to protect children and housing services are frequently not included in multi-agency working to protect children. This is despite Working Together to Safeguard Children 2018 making it clear that "Housing authorities also have an important role to play in safeguarding vulnerable young people, including young people who are pregnant, leaving care or a secure establishment".

This gap has been highlighted again in a recent report by the Local Government and Social Care Ombudsman entitled "More Home Truths". The reports notes the importance of joint working.

The review respectfully requests that Working Together to Safeguard Children, 2023 strengthens the importance of housing being involved routinely in multi-agency arrangements to safeguard children.

The review also respectfully recommends the Secretary of State for Education shares this learning across relevant Government departments, most importantly with his/her colleague, the Secretary of State for Levelling Up, Housing and Communities.

Protecting Deeply Traumatised Older Children and Children who are Dangerous and Potentially Pose a Risk to Others

In the Independent Review of Children's Social Care[19] Josh MacAlister highlights the fact that 'Teenagers are the largest growing cohort in both child protection and care'. He also highlights the fact that from the age of 12 'there is a sharp increase in child alcohol and drug misuse, child sexual exploitation, trafficking, gangs, missing children, socially unacceptable behaviour and self-harm (Fitzsimons et al., 2022) and that 'Historically children's social care has been geared towards younger children and harms coming from family or inside the home. As a result, responses to teenagers" needs by children's social care are often weak. A study of 841 cases in one local authority found that all cases referred due to serious youth violence or gang-related behaviour were closed without assessment (Lloyd & Firmin, 2020)'.

In their response to the report[20] the Department for Education states that teenagers 'often have more complex needs and are at particular risk from a range of harms outside the home, including criminal and sexual exploitation. These are issues that children's social care was not originally designed to deal with and they require strong family and community engagement alongside effective multi-agency working'.

What neither of these reports take into account are the challenges of working with children who are of an age to vote with their feet. The current legislative framework is effective for protecting younger children, for whom the State can decide with whom they will live and spend time with, and whether that time is supervised, or not. The updating of Working Together to Safeguard Children 2023 creates an opportunity for experts in this field to revisit how best older children can be protected from harm, and how the public can be protected from older children at risk of harming others.

As stated previously in the report this learning point has also been highlighted in the recent research "Building Safety".

Many would agree that it is right we have such a high threshold for detaining children in England. At the same time there is constant criticism of the current system where children are identified as being at risk of exploitation, or who are even known to be being exploited, being 'allowed' to go to the places where the abuse continues.

[19] https://webarchive.nationalarchives.gov.uk/ukgwa/20230308122535mp_/https://childrenssocialcare.independent-review.uk/wp-content/uploads/2022/05/The-independent-review-of-childrens-social-care-Final-report.pdf

[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1147317/Children_s_social_care_stable_homes_consultation_February_2023.pdf

Vulnerable children and families transferring between local authorities
There is an opportunity to further enhance national guidance and introduce timescales for the effective transfer of information between organisations when a child moves to a new area, in the revision of Working Together to Safeguard Children 2023.

5 Summary and Conclusions

5.1 As set out at the start of this report this review sets out to answer two key questions:

1. How effectively do agencies, singularly and together, understand, identify and respond to the needs of those at greatest risk from children exhibiting the most harmful behaviours?

2. How effectively do agencies, singularly and together, understand, identify and respond to the needs of the most vulnerable children, who display the most harmful behaviours, and do current systems meet the needs of the most traumatised children?

5.2 When undertaking CSPRs there is always a question about whether the issue lay with the systems in place not being fit for purpose or was it the professionals not adhering to the systems in place and, if not, why that might be. As is usually the case this review has found examples of both. This CSPR has identified invaluable local and national learning, in terms of current systems in place, particularly around children being excluded from school, children moving areas, the systems in place to protect older children, the importance of involving housing in systems to protect children, recognising child perpetrators of crime as victims and adultification bias and intersectionality.

5.3 The review has identified five key themes and 10 local key learning points and 2 national learning points.

5.4 There is no doubt this is an extremely complex case where professionals faced significant challenges in providing an effective multi-agency response to the fluctuations in risk and the changing needs of Child A and her family, but significant learning has come from this review.

5.5 First and foremost a child must be recognised as exactly that, with the vulnerabilities that brings, and it is crucial that professionals look to understand behaviours, of both children and their families, and that 'the family' is seen in its broadest context, and both strengths and risks are considered. All work with families should be strengths/asset/relationship based and collaborative and the best chance of achieving this is understanding the family's position and why the child and their family are presenting and behaving the way that they are, and labelling children and their families is unhelpful.

5.6 Each service must have referral criteria but the challenge for professionals is what is the right intervention pathway? There is also still bias about females committing violent offences and their risk of harm towards others. Whilst there is clear evidence that males commit more violent acts (Youth Justice Board 2019/2020), research regarding violence and who the likely perpetrators and victims are, has found that there remains a stereotypical view with the labelling of these behaviours as typical male or female (Johannes Lunneblad & Johansson, 2018). In complex cases such as this all professionals need to remain mindful of any potential bias, when balancing vulnerability in addition to assessing potential risk of harm to others, and ensure gender is not an issue in their management plans.

5.7 In this case Child A was bounced between services, having not met the threshold for CAMHS, despite a number of referrals being made. On each occasion alternative services were approached but sometimes Child A did not meet their service specification either and these processes sometimes took weeks or months. There was a lack of continuity and access to therapeutic services. This happens too often, and agencies didn't utilise local escalation protocols to raise concerns and challenge decision making with regard to accessing CAMHS. This resulted in a lack of targeted care and support for Child A and at best fragmented service provision.

5.8 More joined-up working in the form of complex case discussions with the key agencies involved, to identify the appropriate approach, would be much more effective rather than layering on service after service after service. It is worth noting that in 2019, after the significant assault, Child A was known to be overwhelmed by the number of services and professionals involved.

5.9 There is little evidence that, despite significant input and undoubted time and effort, partnership intervention had any positive effect over Child A's lifetime. Significant numbers of assessments and different types of plans and assessments via multi agency panels for children at risk of exploitation seemed to have little effect in delivering sustained change in Child A's life. When considering the 'why?' there were many factors at play; the dysfunction within the family, the levels of learning needs and extreme trauma, professionals constantly firefighting at times. There were also poor relationships between professionals and Child A, and professionals and the mother, frequent moves between educational settings, changing services and professionals, the family moving, service thresholds for support not being met, resulting in Child A being bounced around between services. There was a lack of understanding of both the mother and Child A's additional needs and how this adversely affected how they responded and could be engaged with by services and professionals. At times the mother was seen as being obstructive and difficult to work with effectively. There were also the issues of possible adultification bias and the impact of intersectionality and how this played a part in professionals' networks not fully recognising and responding to risk all had their impact.

5.10 There is some evidence the pandemic impacted on the ability of professionals to best support Child A: Child A had a school place allocated in June 2020 but would not attend until the September, because of the pandemic. The YJS recognised the

complexity of the case and the importance of building a relationship with Child A and her mother and some professionals ensured face-to-face meetings happened, even during lockdowns, as did CSC. Additional contact was provided virtually.

5.11 It is easy to be wise with hindsight. The review has made considerable efforts to be mindful of that point.

5.12 Finally, for reasons stated in the introduction there is greater emphasis in the report on Child A rather than Adult A. That is in no way a reflection on importance. All those involved in this review recognise and acknowledge that ultimately a young man lost his life and that has to be the greatest tragedy.

6 Appendices

Appendix One - Acronyms Used

CSC	Children's Social Care
BCT	Birmingham Children's Trust (Children's Social Care in Birmingham)
FTB	Forward Thinking Birmingham (Mental Health Service for 0–25-year-olds)
MST	Multisystemic Therapy
ICPC	Initial Child Protection Conference
RCPC	Review Child Protection Conference
CP	Child Protection
SENAR	Special Education Needs Assessment and Review Service, Birmingham
MASE	Multi-Agency Sexual Exploitation Panel
EHCT	Education Health and Care Plan
YJS	Youth Justice Service (West Sussex)
YOS	Youth Offending Service (Birmingham)
LBH&F	London Borough of Hammersmith & Fulham
BSCP	Birmingham Safeguarding Children Partnership
WSSCP	West Sussex Safeguarding Children Partnership
WSCC	West Sussex Children's Services
MAPPA	Multi-Agency Public Protection Arrangements
CIN	Children in Need
CAMHS	Child and Adolescence Mental Health Service
fCAMHS	Forensic Child and Adolescence Mental Health Service
VRP	Violence Reduction Partnership

Appendix Two - The Working of the CSPR

Methodology and Limitations

Working Together to Safeguard Children, 2018 clearly sets out what is required in CSPRs and the National Child Safeguarding Panel offers helpful guidance.

This is a systems review. I, as the lead reviewer, have worked closely with a review team – a team made up of senior managers from each of the agencies involved, across Birmingham and West Sussex. Although the report is published in my name it is the work of the review team as a whole. There has also been input from frontline professionals who supported Child A and her family. There were no professionals supporting Adult A.

It is essential that agencies, wherever possible, learn from families and their experiences of services, and therefore involving family members in a child safeguarding practice review is an essential component. Adult A's parents have contributed to the review, as have Child A and her mother.

The smooth running of the review was enabled by the support of BSCP.

Review Team

Agency	Member
Independent Lead Reviewer	Joanna Nicolas
Birmingham Children's Trust	Head of Service, Independent Review Service
Birmingham Community Healthcare	Head of Service for Safeguarding Children
Birmingham & Solihull Clinical Commissioning Group	Deputy Designated Nurse Safeguarding Children & Adults
Education, BCC	Independent Education Advisor
Education, West Sussex County Council	Safeguarding in Education Manager
Education Psychologist Service, Birmingham City Council	Specialist Senior Educational Psychologist
Forward Thinking Birmingham, Birmingham Women's & Children's NHS Foundation Trust	Named Nurse Safeguarding
Sussex Police	Detective Sergeant, Strategic Safeguarding Team
West Midlands Police	Detective Sergeant, Force Review Team. Public Protection Unit
West Sussex Children's Services	Head of Safeguarding
West Sussex County Council	Violence Reduction Partnership Lead, Community Safety & Wellbeing
Sussex Clinical Commissioning Group	Designated Nurse for Safeguarding Children
University Hospitals Birmingham Foundation Trust	Interim Head of Safeguarding
Youth Justice Service, West Sussex	Youth Justice Service Manager
Youth Offending Service, Birmingham	Head of Service
Co-opted Member	Forensic Psychologist

Timeframe

It was agreed analysis of the key events would be conducted from the time when professionals became aware of mother's pregnancy on or around October 2005, up until 27th October 2020, the date of the homicide. However, the review would specifically engage front-line practitioners who worked with and supported the family from the 17th June 2019, when Child A was subject to a violent sexual assault, up until the fatal incident. This is to include the period when the family moved from Birmingham to West Sussex and the work undertaken to support the family.

Appendix Three - About the Author

I have worked in child protection/safeguarding for 29 years, the last fourteen of those as an independent safeguarding consultant, case review author and trainer.

I am an accredited systems lead reviewer having undertaken the Social Care Institute of Excellence's Learning Together systems methodology training in 2011. I have been leading systems reviews since then.

For more information please see my website https://joannanicolas.co.uk