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**Publication of learning from a Local Child Safeguarding Practice Review**

**Date: 10th October 2023**

**Details:**

This is an incredibly distressing and unusual situation where a young, innocent man, lost his life and his family lost him from their lives forever.

From the Child Safeguarding Practice Review (CSPR) that we are publishing today, it is clear that the fatal incident in October 2020 was neither predictable nor easy to understand. It is equally clear that the child responsible had a traumatic childhood. She pleaded guilty to manslaughter on the grounds of diminished responsibility and is now in the custody of the Secure Estate receiving treatment.

It is rare for a child to commit such a serious crime against an adult; even rarer for a 14-year-old girl. The CSPR explores how and why this happened and identifies key learning which will be used to help improve multi-agency safeguarding policy, practice and management. It is important when reading the report that the reader understands its purpose. This report will help us to learn and improve our practice; it does not seek to apportion blame or examine culpability.

The review is thorough in its analysis of a long and complex history of multi-agency involvement with the child and her family, whilst preserving their anonymity. It identifies five key themes and in total 12 learning points as it examines a life lived mainly in Birmingham, before moving to West Sussex where, a few months later, the fatal stabbing occurred.

Some of the main themes echo those of other CSPR published nationally. There were missed opportunities by services involved with the family, who didn't fully understand her lived experience and the impact of childhood trauma. It also highlights the importance of recognising "family" in the broadest sense, including the role of father figures (present and absent) and harm outside the home as well as within it. The significance of timely information exchange, especially when a child moves to another part of the country, is emphasised. The review provides another case where what has been termed "adultification"[1] occurs, meaning the child is treated as an adult, their offending more than their victimhood is recognised and is the primary focus of agency intervention. The review highlights the need to recognise and seek to understand challenging behaviour in young children. And if a child is considered for exclusion from

[1] Adultification is used to describe how preconceptions of children may lead to them being treated and perceived as being more adult-like (Goff et al 2014).

primary school, especially if this is more than once, this should elicit an effective early multi-agency response.

The Review acknowledges the extensive range of professionals who worked with this child and family; however, despite professionals' efforts, the processes and plans in place did not result in a positive relationship with the family. This meant that professionals did not gain a sound understanding of safeguarding risks and effective mitigations or interventions, which would have resulted in an enduring positive impact for this child and her family.

Even since 2020, services and practice in both Birmingham and West Sussex have evolved and improved, especially in the area of criminal exploitation and contextual safeguarding. All the organisations involved in this review endorse the findings and are committed to embedding the learning.

Tragically, we know that none of this will return this young man to his family, and the thoughts of everyone involved in this case are with his family.

**Penny Thompson CBE**
**Independent Chair**
**Birmingham Safeguarding Children Partnership**

**Chris Robson**
**Independent Chair**
**West Sussex Safeguarding Children Partnership**

**Note to editors**
The purpose of an LCSPR is to establish whether any lessons can be learnt by professional services to help ensure children are better protected in future.

The LCSPR is published on the Partnership's website (https://lscpbirmingham.org.uk). A copy can be downloaded from the table on the webpage (Case Reference BSCB2020-21/02). A copy has been forwarded to the National Case Review Repository hosted by the NSPCC.

If you are concerned about a child living in Birmingham, please ring Birmingham Children's Trust's Children's Advice and Support Service on 0121 303 1888.

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