Wirral Local Safeguarding Children Board

Serious Case Review

CHILD G

Overview Report

January 2013

Agreed by Wirral LSCB on 23rd January 2013 at the Professional Excellence Centre
Contents

1. INTRODUCTION................................................................................................................... 2

2. TERMS OF REFERENCE ........................................................................................................ 4

3. METHODOLOGY.................................................................................................................. 7

4. FAMILY COMPOSITION AS KNOWN TO AGENCIES.......................................................... 7
   Genogram – most recent understanding of family composition............................................. 8

5. NARRATIVE.......................................................................................................................... 9
   From birth until school (October 1994 – September 1999).................................................. 9
   Primary school years (September 1999 – August 2006)..................................................... 9
   Attending mainstream secondary school (September 2006 – August 2008)...................... 11
   Attending secondary special school (September 2008 – end July 2011)............................ 14
   Starting college and living independently (August 2011 – 13 May 2012).......................... 18
   The days leading up to Child G’s death (13 May 2012 – 19 May 2012)............................. 31

6. THE VIEWS OF FAMILY MEMBERS.................................................................................... 38

7. CRITICAL ANALYSIS.......................................................................................................... 39

8. CONSIDERATION OF INDIVIDUAL MANAGEMENT REVIEW REPORTS.......................... 59

9. WHAT CAN THE LSCB LEARN FROM THIS CASE? .......................................................... 63

10. RECOMMENDATIONS.......................................................................................................... 68
    Summary of recommendations.......................................................................................... 74

BIBLIOGRAPHY ....................................................................................................................... 83
1. Introduction

1.1 Child G was a white child, born locally, to English-speaking parents. At the time of her birth, Child G lived with her mother (MG), her father (FG) and her two older siblings; a brother (BG) who was aged 5 and her sister (SG) who was aged 8. Some time around 2000, MG and FG separated and MG began living with her current partner (SFG). SFG was originally understood by agencies to be Child G’s step-father, but it was later reported by MG that SFG was Child G’s biological father. This is disputed by FG.

1.2 At a young age, it was recognised that Child G had learning difficulties and she was later diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD). Child G attended mainstream primary and secondary school, before transferring to a specialist school in Year 9. When she left school, she attended a local further education college for a term. At the time of her death, Child G was living in supported accommodation for young people aged 16-25.

1.3 Child G was murdered by her boyfriend (BfG) in May 2012: Child G was 17 years old and BfG was 18 at that time. In view of the circumstances of Child G’s death and the involvement that both young people had had with local agencies and organisations, Wirral Local Safeguarding Children Board (LSCB) undertook to conduct a serious case review in respect of Child G. This decision was made in line with the LSCB’s statutory reviewing and investigative functions as defined in ‘Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children’ (2010). At the same time, it was agreed that a multi-agency case review would also be completed in respect of BfG.

1.4 Serious case reviews (SCRs) bring together all agencies and organisations who have provided services to a child, in order to consider whether there are lessons to be learnt about the way that they worked together both to safeguard children and to promote their welfare. SCRs should also identify how those lessons learnt will be acted on; what is expected to change as a result; and how inter-agency safeguarding practice will improve.

1.5 A serious case review is undertaken by LSCBs in every case where abuse or neglect is known or suspected and either:

- a child dies; or
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

1.6 Additionally, LSCBs may decide to conduct a SCR whenever a child has been seriously harmed in any of the following situations and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children (including inter-agency and inter-disciplinary working):

- A child sustains a potentially life-threatening injury or serious and permanent impairment of physical and mental health and development through abuse or neglect.
- A child has been seriously harmed as a result of being subjected to sexual abuse
- A parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004.
A child has been seriously harmed following a violent assault perpetrated by another child or an adult.

1.7 The effectiveness of serious case reviews are judged on:

- the extent to which learning and areas for improvement have been effectively identified and translated into a robust action plan which will improve organisational and professional practice to safeguard and promote the welfare of children;
- the extent to which there is evidence that the action plan has already been implemented by all relevant partners and that learning is being embedded in practice;
- the extent to which organisational and professional practice have been reviewed in respect of the child or young person who has died or been injured and the quality of analysis that has been undertaken to understand how and why events occurred, decisions were made and actions were taken or not taken;
- the extent to which the review has appropriately challenged the performance and practice of all agencies, reflecting evidence of the effectiveness of the LSCB in its leadership, performance review and challenge role;
- the extent to which there is evidence in the review of the involvement of the child and the family in the review process and the impact of their contribution; and,
- the involvement of all relevant partners in identifying and planning for necessary organisational and practice change and improvement.

1.8 The effectiveness of serious case reviews is underpinned by the quality of analysis and recommendations in Individual Management Reviews (IMRs) and by the timeliness with which these IMRs are provided. The conduct of this serious case review was hampered by delay. The original date for completion could not be met and a revised timetable was agreed by the SCRP. Not all IMRs were completed in accordance with revised dates for submission. Issues relating to delay are considered in Sections 8 and 9 of this overview report and are addressed by recommendations in Section 10.
2. Terms of Reference

2.1 The decision to undertake a SCR was made by Dennis Charlton, Independent Chair of Wirral LSCB, on 24 May 2012, following the recommendation of the Serious Case Review Committee earlier that day.

2.2 Members of the Serious Case Review Panel (SCRP) constituted to coordinate and oversee the conduct of this SCR are:

- Strategic Service Manager, Safeguarding: Chair
- Designated Nurse Child Protection
- Senior Serious Crime Investigator, Merseyside Police
- Designated Doctor, Safeguarding
- Strategic Service Manager, Social Care Branch, CYPD
- Strategic Service Manager (SEN & Inclusion) CYPD
- Head of Integrated Youth Support Service
- Lead Operational Manager, Connexions
- Additional Learning Support Manager, Wirral Met College
- Assistant Director (Children’s Services), Barnardo’s
- Head of Service Forum Housing Association (FHA)

2.3 The SCRP agreed that an Individual Management Review (IMR) would be required from the following agencies and organisations:

- Children’s Social Care, Wirral Council
- Education Services (Learning and Achievement), Wirral Council
- Merseyside Police
- Forum Housing Association
- Connexions, Greater Merseyside
- Barnardo’s North West (Missing from Home and Domestic Abuse Services)
- Further education provider (Wirral Metropolitan College)
- Integrated Youth Support Services, Wirral Council (IYSS)
- Wirral Community NHS Trust (incorporating: Health Visiting and Speech and Language Services, Safeguarding Supervision and Wirral Walk-in Centre)
- GP services, NHS Wirral
- Cheshire and Wirral Partnership NHS Foundation Trust (Child and Adolescent Mental Health Services (CAMHS) and 16-19 Adolescent Mental Health Services)
- Wirral University Teaching Hospital NHS Foundation Trust:
- School Nursing Service
- Acute Paediatric; Community Paediatric; and, Accident and Emergency Department Care

2.4 In addition, the NHS Wirral Primary Care Trust (PCT)/Clinical Commissioning Group (CCG) would provide a Commissioning Overview Report to add value to the learning from health services and to review the practice of all health care professionals and providers commissioned by the CCG.
2.5 The specific lines of enquiry agreed by the SCRP were to consider:

a. Whether the decisions and actions taken in the case were in line with the policies and procedures of Wirral LSCB and own agency;
b. Were any concerns for the young person’s welfare identified? Consider whether subsequent actions accorded with procedures?
c. The nature of the relationship between Child G and the perpetrator and the extent to which this was mutual and consenting;
d. The recognition of Child G’s needs, particularly with respect to learning difficulties. How were they identified through inter-agency and single-agency assessments?
e. The effectiveness of single and multi-agency plans and whether they met the outcomes, stated or expected;
f. Child G’s transition journey from school to services, post-16;
g. Whether agencies established and took into account the family’s specific cultural, racial, linguistic and religious needs, when delivering services;
h. The extent to which agencies shared information on needs and risks; and
i. Whether Child G’s wishes and feelings were ascertained, properly recorded and taken into account when decisions were made by agencies.

2.6 The overview report should include a clear LSCB action plan which evidences organisational learning and practice change.

2.7 The time period for the review was determined to be from the point of each agency’s knowledge of Child G until her death. Each agency should examine their records for chronology and IMR from this point. The review end date should be the latest possible date of Child G’s death; that is, 19 May 2012. At the time of writing, the date of Child G’s death is undetermined, but is considered to be between 16 and 19 May 2012.

2.8 The LSCB commissioned Isobel Colquhoun, to act as independent overview report writer on 18 June 2012. The overview report writer was not a member of the SCRP but attended as an observer; specifically on 18 June 2012; 23 July 2012; 6 September 2012; 15 October 2012; 26 November 2012; 17 December 2012; and, 9 January 2013. The overview author is a social worker with over 30 years’ experience as a practitioner and manager. The author has previously undertaken serious case overview reports and has completed SCIE training in systems reviews. The author has not been directly employed by Wirral LSCB or by any member agencies and had no prior knowledge of, or operational responsibility for, this case.

2.9 The Chair of the SCRP and the overview author visited Child G’s mother and step-father were visited, with their agreement, on 15 November 2012 to discuss the serious case review and to consider, with them, the extent to which they wished to contribute to the review report. At that point, the criminal case against the young person who had been charged with murdering Child G had not yet been heard. Child G’s mother and step-father determined that they did not want to be involved in the review process, other than to be informed of its findings. However, they were encouraged to consider their position again when the trial was behind them. To that end, further contact was made with them by letter, and then, by telephone, on 20 December 2012. However, neither Child G’s mother nor stepfather wished to participate in the review. No direct contact was made with Child G’s siblings, although the SCRP Chair and overview author offered, through Child G’s mother, to meet with them.
2.10 The chair of the SCRP and the independent author met with Child G’s father on 20 December at a local community centre. Further detail of this discussion is given in Section 6.

2.11 The criminal trial of Child G’s former boyfriend took place in November 2012. He admitted murdering Child G, in addition to committing a number of other serious offences against her. He was given a life sentence, with a minimum period in custody of 22 years. As noted earlier, Wirral LSCB is conducting a critical case review in respect of this young person, who was just 18 years old when he killed Child G and who had, prior to his 18th birthday, been looked after by the local authority.

2.12 The terms of reference for this review indicate that all media enquiries which relate to it shall be managed through Wirral Council’s Public Relations Department on behalf of Wirral LSCB. Media statements shall be agreed with the independent Chair of the LSCB before being issued. A media strategy is being drawn together by the LSCB and by Wirral Council. The local authority will take the lead and co-ordinate all media statements from organisations. The LSCB Chair will ensure that LSCB members are consulted on media statements in so far as is possible in urgent situations and will issue a statement of behalf of the Board.

2.13 This final draft report will be presented to the LSCB on 23 January 2013, with submission to DfE, including action plan, by 31 January 2013.
3. Methodology

3.1 This report is informed by:

- a combined chronology of agency involvement;
- an analysis of all IMRs, including individual health reports;
- minutes of child protection conference and reviews;
- meetings with family members;
- meeting at School2;
- attendance at SCRP; and,
- responses to questions by, and, in some cases, discussion with, IMR authors.

4. Family composition as known to agencies

<table>
<thead>
<tr>
<th>Individual identifier</th>
<th>Relationship to Child G</th>
<th>Date of birth</th>
<th>Date of death</th>
<th>Address</th>
<th>Ethnicity or diversity needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child G</td>
<td>Subject of report</td>
<td>15.10.94</td>
<td>Between 16.05.12 and 19.05.12</td>
<td>Address 2</td>
<td>W/B, with learning difficulties. Given religious denomination: CoE</td>
</tr>
<tr>
<td>MG</td>
<td>Mother of Child G</td>
<td></td>
<td></td>
<td>Address 15</td>
<td>White British</td>
</tr>
<tr>
<td>SFG</td>
<td>Step-father of Child G</td>
<td></td>
<td></td>
<td>Address 15</td>
<td>White British</td>
</tr>
<tr>
<td>FG</td>
<td>Legal father of Child G</td>
<td></td>
<td></td>
<td>Address 14</td>
<td>White British</td>
</tr>
<tr>
<td>SG</td>
<td>Sister of Child G</td>
<td></td>
<td></td>
<td>Address 17</td>
<td>White British</td>
</tr>
<tr>
<td>DSG</td>
<td>Niece of Child G and daughter of SG</td>
<td></td>
<td></td>
<td>Address 17</td>
<td></td>
</tr>
<tr>
<td>BG</td>
<td>Brother of Child G</td>
<td></td>
<td></td>
<td>Address 18</td>
<td>White British</td>
</tr>
</tbody>
</table>
Genogram – most recent understanding of family composition
5. Narrative

From birth until school (October 1994 – September 1999)

5.1 Until Child G went to nursery school, she had little contact with professionals: health visitors made 13 home visits during this time, but succeeded in seeing Child G only 4 times. The effects of this pattern of non-engagement were that gaps developed in Child G’s immunisation programme and her developmental progress was not assessed at 3 years old.

5.2 Two significant episodes offered particular opportunity for health visitors to intervene positively with Child G and her parents, but neither was taken.

5.3 The first of these was in June 1995, when she was seen by HV2 for her eight-month assessment. On this visit, MG reported that she was ‘force-feeding’ Child G, as otherwise she would not eat. HV2 made a referral for counselling for MG, but there is no evidence that MG was offered or attended counselling. There appears to have been no further discussion between health visitors and MG about this. It is likely, therefore, that MG’s emotional state and past life continued, at least in the short-term, to have an impact on the care that she was able to provide for Child G.

5.4 The second occasion was In September 1997, when Child G was almost 3 years old and about to start at nursery school, she attended the Accident and Emergency Department (AED), with suspected ingestion of turpentine. There is no record of follow-up of this incident by the health visitor.

5.5 In addition, although HV2 informed the GP about the pattern of no access visits, there is no indication that health professionals considered this to be a potential safeguarding concern.

5.6 Nursery school staff were quick to identify Child G’s delayed development and they took appropriate action, including, it appears, making a referral to Speech and Language Therapy for her. However, MG was not persuaded that Child G’s difficulties required a plan of action and there is no evidence that the therapist offered a challenge to that view.

5.7 During this period, in addition to a referral for investigation of infantile constipation, Child G was seen by her GP on several occasions for normal childhood illnesses.

5.8 Information provided by the police as part of this review, suggests that family problems, such as parents’ misuse of alcohol and marital difficulties, were likely to have been affecting Child G’s home life during these early years. However, there is no evidence that professionals working with Child G were aware of these issues at the time.

Primary school years (September 1999 – August 2006)

5.9 In January 2001, the local authority agreed to a statutory assessment of Child G’s special educational needs. The school (School3) had had concerns about Child G’s slow progress. She was also easily distracted and needed close supervision to prevent her ‘wandering around aimlessly’. School3 was also concerned about Child G’s aggressive behaviour with
other children, which staff understood to be a consequence of her communication difficulties rather than a deliberate wish to hurt.

5.10 Reports from school, community paediatrics and educational psychology formed the basis of the report to the local authority’s SEN moderating panel which met in September 2001. The panel came to the conclusion that Child G’s needs could be met from within the school’s delegated budget and a statement of SEN was not issued.

5.11 During the rest of Child G’s primary school education, she continued on School Action Plus of the SEN process. Her progress remained slower than would be expected for a child of her years and, in addition, her relationships and behaviours were considered to be immature.

5.12

5.13 Child G’s records occasionally hint at social issues, but it is not until March 2006 that there was an explicit allegation. It was reported that Child G (aged 8) was ‘made to go to bed at 6pm’. The referrer did not believe that Child G had ever been hurt but that she was ‘a frightened little girl’. SSW1 spoke to Child G, a week later. Child G ‘raised no concerns’.

5.14 A very brief (and in parts inaccurate) initial assessment concluded that the referral was malicious: it was, therefore, closed with no further action. There is no evidence that family history of involvement with services informed this outcome. This was a missed opportunity to have understood what family life was like for Child G and to have intervened positively on her behalf.

5.15 When Child G’s primary schooling was coming to an end, MG and SFG were living together (possibly married) and it is not known what contact Child G was having with FG.

5.16 Although Child G’s records do not refer to significant family problems, information provided by agencies indicates that family life could be troubled.

5.17

5.18 There is no evidence, however, that the extent of family difficulties was known to, or was appreciated by, professionals working with Child G during this time.
Attending mainstream secondary school (September 2006 – August 2008)

5.19 The transition from primary school to mainstream secondary school (School1) exposed many of Child G’s vulnerabilities; she struggled to concentrate in class and her behaviour ‘off-task’ was considered to be ‘emotionally driven by a need to secure attention’.

5.20 On October 2006, Child G was found to have a strip of morphine tablets in her bag from a school trip. MG explained that they were her tablets, which had been left in that washbag, after she herself had been in hospital. This explanation was accepted. However, it was later stated that the morphine belonged to SFG who was ‘terminally ill’ at home.

5.21 In November 2006, School1 made a referral to CAMHS citing as reasons for concern: ‘the possible impact of maternal alcohol misuse; conflict at home; and, care often being left to SG’. This request from school was formalised by a GP referral, highlighting MG’s concerns about Child G’s behaviours at home. The first reference to the possibility that Child G might have Attention Deficit and Hyperactivity Disorder (ADHD) is contained in these documents.

5.22 Also, in November 2006, Child G attended school ‘off task’ – unable to get an answer at the home address, the social worker spoke to Child G the following week, in the presence of deputy head. It appears that Child G did not repeat the concerns that she had raised and ‘had difficulty recalling what she had said previously and why’. No further action was taken. There is no record that the details of the referral of 28 November 2006 were discussed with MG.

5.23 School1 initiated ‘Child Concern’ meetings but, in the meantime, Child G’s behaviour continued to deteriorate and she was excluded from school for a period. The effectiveness of the child concern process is considered in Section 7.5.

5.24 In February 2007, MG attended for initial assessment with CAMHS: Child G was not present, as was standard practice at that time. It was noted that Child G had moderate learning difficulties and that the school had initiated screening for ADHD. MG declined offers of parenting support and assistance with managing Child G’s behaviour as well as individual assessment work with Child G: MG felt that they were managing Child G’s behaviours at home and that Child G’s problems predominately related to her special educational needs. However, MG accepted a referral to Junior Youth Inclusion Programme (JYIP). Child G was then discharged from CAMHS.

5.25 At the time of Child G’s referral to JYIP, according to the IYSS IMR, considerable information was held by YOS in relation to BG: [redacted] The service’s last involvement with BG was on 26 February 2007: this was only just over two months prior to the referral to the service of his sister, Child G. There is however no evidence that those working with Child G accessed information about BG. This information did not, therefore, alert others to the risks to Child G or other family members. It was not until 22 June 2007, that JYIP2 became aware of long-standing concerns around her neglect, following a discussion with SWS. This information was not provided by IYSS until the draft overview report had been completed. The implications of this for the
serious case review are discussed in Consideration of Individual Management Reports. (8.34-8.35).

5.26 Further efforts to engage CAMHS therapeutically with the family were unsuccessful, due to the ‘instability of Child G’s home life’.

5.27 On 30 April 2007, School1 informed children’s social care (CSC) that MG was going into hospital for up to 6 weeks and that Child G could not stay with SG, as ‘Child G had broken a bone in SG’s daughter’s foot by deliberately putting a table on it’. This allegation was not investigated.

5.28 On 2 May 2007, SW13 spoke to MG who was in hospital: MG confirmed that Child G was being cared for by SFG and SG. The social work team manager decided that ‘there was no role for social care’ and that the school should be advised ‘to monitor the situation through child concern meetings’. The deputy head challenged this as being unworkable. However, this was not accepted. The following day, SW13 spoke to SG by telephone, confirming that social care would not be providing respite care: SG was dissatisfied with this decision and referred to Child G having broken a window with a roller-skate, ‘in anger’.

5.29 On 14 May 2007, School1 reported that Child G now had nowhere to stay while her mother was in hospital. Child G had alleged that she had been ‘thrown out’ and that she was staying with neighbours. Child G reported ‘feeling scared’ since MG had been in hospital and she alleged that SFG shouted at her and hit her across the face and head. No investigation was made by children’s social care of the allegation that Child G had made. Efforts were made to secure support to enable Child G to remain with SFG.

5.30 It was not established whether FG had parental responsibility and would be able to provide accommodation and care for Child G.

5.31 On 16 May 2007, discussions took place in children’s social care about what should happen next and it was recorded that ‘higher management would not allow Child G to be accommodated’.

5.32 In the face of SFG’s and SG’s expressed hostility towards Child G, children’s social care attempted to provide support to enable her to remain in her family. However, this proved to be unachievable as no family member was prepared to care for Child G [REDACTED]. The social work team manager then informed MG that if no-one else could be found to care for Child G; then, she should be treated as an outpatient, so that she could look after her. [REDACTED]

5.33 MG then made further attempts to persuade SG to look after Child G, but SG re-stated that she would not be able to care for Child G as she could not manage her behaviour. She repeated her allegation that Child G had hurt her daughter. Despite this, children’s social care negotiated that Child G would stay with SG, with the offer of family support over the weekend. It appears that MG may also have opted to an inpatient during the week, with clinic visits at weekend.

5.34 On 1 June 2007, a third ‘child concern meeting’ was held, although it was, in reality, a more of a multi-agency professionals meeting organised by children’s social care. No representative of the school was present as it was held during a school holiday. No family member attended.
5.35 Professional concerns were expressed for Child G’s welfare. These included concerns that she was being neglected; that she had unmet educational needs; and, that her behaviours might make her vulnerable in the community. Discussion took place about the possibility of Child G becoming looked after or becoming the subject of a child protection plan. SW5 commented that a child protection plan ‘would not in itself meet her needs and that the family’s negative feelings towards the department would make this unlikely to work’. The view of the CAMHS worker was, at that point, that ‘foster care seemed the only solution for Child G’. It appears that the meeting favoured accommodating Child G and that a request should be made to the local authority ‘Resource Panel’ for consideration. There is no single jointly-agreed record of this meeting.

5.36 However, the local authority has been unable to find a formal request to accommodate Child G, as it is reported that minutes of these meetings were not systematically taken at that time. The absence of this information is significant because it has not been possible to determine why Child G should not have been looked after at this point, other than the perceived views of higher management. The local authority opted instead to initiate child protection processes; although there is no evidence that a strategy discussion took place or that S47 enquiries were completed.

5.37 Family members were angry that the local authority would not look after Child G and complained about the unreliability of the support services which had been provided. They rejected the suggestion that Child G had been neglected in MG’s and SFG’s care and specifically denied that alcohol misuse was a feature of family life. They gave no indication that they recognised that Child G’s problematic behaviours might be more than innate to Child G or wilful on her part.

5.38 Despite these negative indicators, Child G was made the subject of a child protection plan from June 2007. The category of Child G’s plan was neglect. The effectiveness of the child protection process is considered in Section 7.

5.39 In September 2007, the statutory assessment of Child G’s special educational needs was concluded. She was described as having moderate learning difficulties and was operating academically below the 2nd centile. The educational psychologist’s report provided a clear account of Child G’s needs, characteristics and behaviours, but there is no evidence that this informed the multi-agency safeguarding work with Child G.

5.40 In October 2007, Deputy Head of School faxed CSC expressing concerns about SG’s capacity to act as a parent for Child G, referring to her being seen in school ‘hitting Child G on the head when she has done something wrong’ and using ‘inappropriate language’. This was not pursued.

5.41 Also in October 2007, probation services sent a notification to CSC, prior to BG’s release from custody on licence. This warned that that BG had previously ‘tried to snatch Child G’. In December 2007, probation services spoke to a duty social worker (SW8) about the same matter, querying whether an injunction was in place. The probation officer concerned indicated that a condition would be put on BG’s licence, prohibiting him from contacting family members. However, this question was not answered. Further notifications about BG’s release from prison and requests for information/assessments continued to be sent by probation (21.12.07; 03.01.08 and 09.01.08) but the CSC notes that ‘there was little of substance sent in return’. It was not until 22 January 2008, when MG requested transport for Child G because BG had been following her that CSC discovered that there
was no injunction in existence. It was reported, then, that BG was to be recalled to custody.

5.42 From December 2007, additional support was provided in school, until a place in specialist provision became available. This had the effect of allowing Child G to remain in full-time education and helped her make progress with her school work, pending her move to School2.

5.43 In April 2008, FSW1 visited SG’s home as part of the assessment required by the child protection plan. FSW1 found that Child G was sleeping on the floor on a mattress; the fire in the living room was also on full but with no fire guard; there was ‘an issue’ with the cooker; and, there was evidence of mice. SG’s daughter reported the neighbour ‘dragged Child G around’ and SG did not dispute this. FSW1 recorded that SG needed some advice/support in her own parenting: there is no evidence that this latter was followed up.

5.44 On 2 July 2008, Child G’s plan was ended. The review conference had representatives only from social care and schools and was, therefore, technically not quorate although there is no reference to this in the minutes. The social worker’s report to conference presented an improving picture since the previous review. However, the basis for this judgement was weak. The true level of safeguarding activity is not accurately represented in the minutes.

5.45 The decision of the conference to end the plan was contrary both to the social worker’s written recommendation and to the Deputy Head’s expressed view. The minutes indicate, however, that ‘the majority of agencies present were in agreement that Child G no longer required a plan’. It is not clear how IRO calculated the contribution of agencies, since only two were represented.

5.46 It was recommended that Child G become the subject of a Child in Need Plan. However, by the time that Child G left School1 in August 2008, no such plan had been developed.

5.47 From July 2007, Child G regularly attended activities with JYIP during this time. She appears to have enjoyed these and to have benefited from them. She also enjoyed activities organised through the family centre and contact at weekends with family support workers.

5.48 At no point was the legal relationship between Child G and FG clarified.

Attending secondary special school (September 2008 – end July 2011)

5.49 On 3 September 2008, Child G started specialist secondary school (School2). School2 provides places for up to 200 boys and girls, between the ages of 11 and 19 years old. Pupils at the school have moderate learning difficulties, autistic spectrum conditions and severe learning difficulties. A significant minority have additional barriers to learning such as behavioural difficulties and all have a statement of special educational needs.

5.50 Later that month, just before her fourteenth birthday, Child G returned to the surgery on 11 and 25 November 2008. GP2 did not check Child G’s ‘Fraser competency’ However, at the same time, there were concerns in school about Child G mixing with older boys, and about her
relationship with a particular boy who was 15 years old. SW11 agreed to refer to the CAMHS child in need team and to discuss with MG.

5.51 January, MG informed School2 that Child G’s relationship with this boy was, as she understood it, sexual, which was contrary to what she told SW11.

5.52 Two days later, on 8 January 2009, a Child in Need meeting was held: neither MG nor Child G was present. Discussion took place about Child G and the 15 year old boy. There was a suggestion that Child G might benefit from ‘Keep Safe Work’ through Barnardo’s, but SW11 felt it better to wait for referral to CAMHS child in need team. No actions were given to school nurses, A further Child in Need meeting was arranged to take place on 5 February 2009. However, this was cancelled without explanation on the day and no new meeting date was arranged.

5.53 On 9 February 2009, a telephone call took place between CAMHS4 and SW11, to clarify the referral information. This call was followed by a consultation meeting on 24 February 2009. CAMHS4 recommended that SW11 seek a referral to a social skills group for Child G through school. She felt that the other issues discussed were predominately school based and could be addressed by the educational psychologist. The CAMHS consultation was closed at this point, with no further action to be taken by the CAMHS child in need team. It is not known whether these recommendations were implemented.

5.54 On 5 May 2009, children’s social care ended its involvement with Child G. There is no evidence that notice of, and reasons for, case closure were conveyed in a timely manner to other professionals, to Child G or to other family members. The effectiveness of the Child in Need plan is considered in Section 7.

5.55 On 11 June 2009, Child G was seen in school by the community paediatrician (Paed1) with a view to beginning an assessment for ADHD, and further reviewed on 8 October 2009 when a diagnosis of ADHD was confirmed. Medication was commenced as a trial and reviewed, in her absence, on 12 November 2009. Child G was now in Year 10.

5.56 On 15 June 2010, Child G attended walk-in centre with SFG with an injury to her arm ‘after punching a wall in temper the previous evening’: her arm was X-rayed but it was not broken. Given the description of how her injury occurred, further exploration of the circumstances, with Child G on her own, would have been merited. Information about this visit was provided to GP practice, but there is no evidence of follow-up.

5.57 Child G’s medication had been changed in March 2010, but Child G had started to develop tics, was experiencing nausea and her behaviour had deteriorated at home. Her medication was changed to a non-stimulant once daily medication which continued to be prescribed by primary care until October 2011. The WUTH IMR notes that parents did not attend follow-up appointments with Paed1 at the School2 clinic arranged for September, October and December 2010.

5.58 In September 2010, Child G entered her final year (Year11) at School2. She is reported to have been quite settled at school by this time.
However, on 29 September 2010, the mother of Child G’s friend contacted the police to say that Child G would not go home was her mother had been verbally abusive to her. A patrol car was dispatched to take Child G home. MG reported that she and Child G had had an argument about some missing money.

Then, on 1 January 2011, Child G contacted police from a friend’s house, stating that she had had an argument with her mother and that MG was now threatening her. The police attended and found MG was drunk and causing a disturbance outside Child G’s friend’s house. She was arrested to avoid a Breach of the Peace and released four hours later. The following day, Child G contacted the police again to say that MG ‘had thrown her out’ and was refusing to hand over her ‘personal documents’. Child G was at her friend’s house.

On 4 January 2011, SW4 was allocated the case, as the team manager was concerned that this arrangement might constitute private fostering. In telephone discussion, MG refused to have Child G back ‘as she was worried they might argue’. SW4 talked about private fostering and its implications. MG agreed to an office appointment and gave permission for SW4 to speak to Child G.

On 7 January 2011, MG contacted to rearrange office appointment, due to ill-health. She advised that Child G would be returning home that day, after school today due to various ‘difficult phone conversations’ with friend’s mother the previous evening. SW4 discussed coping strategies with MG; suggested making referrals to relevant services; and, arranged to visit at home on 12 January 2011.

SW4 subsequently completed an initial assessment which identified Child G as being immature with special educational needs, and noted that she could be easily influenced and manipulated by others. Child G seemed ‘eager to please her parents’, although their expectations of her were ‘too high’. Reference was made to both parents’ ill-health however, the issue of MG’s alcohol use was not raised. The assessment recognised that, although the situation had calmed down, things could ‘quickly deteriorate again’ and, in this case Child G would be very vulnerable as no extended family was prepared to look after her.

SW4 concluded that an application should be made to the children with disabilities team to provide direct payments to support respite arrangements for MG and SFG. It was also recommended that a child in need plan be set, ‘to safeguarding Child G’s welfare, to prevent family breakdown and the need for Child G to be accommodated’. In addition, the practice manager who agreed the outcome of the initial assessment suggested that ‘a family group meeting be explored as a means to resolve the family’s relationship issues’. However, no action was taken in respect of any of the proposed recommendations. No reasons for this lack of follow-through have been given, but it clearly represents a missed opportunity to capitalise on her parents’ relative openness, at a time of crisis, to intervention.

On 1 February 2011, Child G’s annual statutory educational review was held at school; this was attended by MG. Discussion took place about Child G’s post-16 options. It was agreed by all concerned that Child G would be ready to leave school and would benefit from going to college. School2 provided a reference for college, recommending Child G as a suitable candidate for a childcare course. On 5 April 2011, Child G attended for interview and was accepted onto the course.
5.66 On 8 May 2011, Child G came to the attention of the police and youth offending team, following an incident of ‘stop-and-search’ when she was found to have secreted her boyfriend’s cannabis in her pocket.

5.67 Then, on 16 May 2011, School2 contacted CADT following Child G’s claim that ‘she had left home after being battered by SFG’. CADT advised school to contact social worker: however, she was off sick. CADT were advised of this, but there was no further contact. There is no reference to this incident in the children’s social care chronology or IMR. This is clearly a gap, as this was another allegation of physical abuse against SFG which was not followed up. It is not known why the school did not escalate this matter when there was no further contact from children’s social care.

5.68 On 25 May 2011, Child G, among others, was discussed at the Respect Panel, following a referral in relation to offence of 8 May 2011. Child G was allocated a worker (YOT1) through the Challenge and Support Programme.

5.69 On 26 July 2011, during her first session with YOT1, Child G reported that she was in a relationship with BfG. YOT1 established that BfG was known to YOS. It is noted that there were concerns that BfG had previously committed [redacted] offence against a [redacted] but that further enquiries had revealed there was no such conviction. However, the IYSS IMR raises the issue of whether professionals continued to have reason to believe that BfG had [redacted] harmed a child, even if a conviction could not be secured. The IMR explores the implications of this omission.

5.70 On 27 July 2011, YOT1 spoke to allocated social worker, SW1 and shared her concerns about Child G’s ‘peers and vulnerability’: it is not specifically stated that this included concerns about BfG. The workers agreed to make a joint visit to Child G on 22 August 2011; delayed to this date due to annual leave arrangements.

5.71 It was around this time, August 2011, that Child G successfully completed her school career, although her last day of attendance is not known. In discussion with staff from School2, it is clear that she was a well-liked pupil who was happy in school. Child G’s attendance was more than 98% over the three years.

5.72 Discussion with staff from School2 for the purposes of this serious case review revealed that when she first came from School1, Child G hit them ‘like a railway train’. Child G was noisy, boisterous, and difficult to manage. Staff wondered whether she would last a week in her new environment.

5.73 At this time, Child G’s family were also difficult to engage: they were ‘not happy’ with School2. However, over time School2 were able to establish a workable relationship with MG and SFG, partly by making home visits and arranging taxis for school visits.

5.74 In the school’s view, it took Child G about a year to settle in but that she blossomed from then on. In addition to her everyday school worker, Child G took part in outdoor activities with the Calvert Trust; she gained a silver Duke of Edinburgh Award; she enjoyed drama and took part in the Liverpool Shakespeare Festival in 2011. Child G achieved entry level 2 in English; ICT and PE; entry level 3 in History and French and GCSE grade G in Maths and Drama.

5.75 Child G was said to be ‘a very smiley girl, with a ‘genuineness and sincerity about her’ who had ‘a really good group of friends’ in school’. Child G’s form tutor described her as very
methodical and liking order; attributes that made her ‘the greatest tidier up ever’. However, Child G ‘talked a good game’ and could appear more able than she actually was. She was said to have ‘a great relationship’ with her Head of Year.

5.76 Child G did not talk much about problems in her home life: they felt that she loved MG and that she worried about her. They were not aware of her spending weekends with SG, although she sometimes stayed at a friend’s house. Child G’s form tutor was aware that Child G liked BFG as she had once asked for her photograph to be placed next to his on a wall display: but she had no inkling that they were boyfriend and girlfriend and absolutely no thought that they had a sexual relationship.

5.77 The school confirmed their view that it was the right decision for Child G to move onto further education (FE) college. She was an independent traveller and was more able in terms of her qualifications to progress than other pupils who were also moving on. Child G also felt that it was a sign of success to go on to college. She very much enjoyed her Leavers’ Meal which was a marker of her transition from school to further education.

5.78 Unfortunately, one of the unintended consequences of Child G moving from school to college was that Child G was lost to paediatric follow up in relation to her ADHD. This has been acknowledged in the health overview report and is addressed by a recommendation in the School Nursing IMR.

Starting college and living independently (August 2011 – 13 May 2012)

5.79 During the summer holiday, between 15-21 August 2011, Child G was missing from home. On 16 August, SFG made a report to the police as Child G had not returned from visiting MG in hospital the previous day. A missing from home enquiry was begun by police that day, but it was not until two days later that Barnardo’s and social services were informed.

5.80 Child G was found on 21 August 2011 at her friend GF’s house in the care of GF’s mother. Child G informed officers that she had been staying with friends and at her father (FG)’s flat since she had been missing from home. EDT was informed. Child G alleged that SFG had assaulted her, but police noted that ‘she refused to make a complaint’. When contacted, MG and SFG refused to allow Child G to return, due to the allegations that she had made against SFG. They denied Child G’s allegation. EDT and police concluded that Child G should remain at her friend’s house overnight, and that the issue could be dealt with more thoroughly the following day.

5.81 On 22 August 2011, Child G was taken to the police station and interviewed by officers ‘to confirm her welfare status’. Barnardo’s project worker, BPW1 attempted to engage MG and SFG by letter and telephone, but no direct contact was made with Child G.

5.82 Also on 22 August, SW1 and YOT1 visited Child G, but now, at her friend’s home. This was the joint meeting that had been agreed on 27 July 2011. Child G gave a description of how SFG had slapped her on the face and of events while she had been missing. Child G said that she was now further afraid to return home, as MG had told her by telephone that she would ‘batter her’ because of what she had said. Child G stated that neither parent had hit her before, although, in fact, she had made very similar allegations in the past. According to the social care chronology, SW1 noted that Child G did not appear to acknowledge the concerns that MG and SFG would have had for her safety and described Child G as ‘smirking’ while discussing what had happened.
5.83 It was noted that BG was to be discharged from prison to this address the following day. SW1 was not aware of the communications between probation/prison and CSC about the possibility that BG might pose a risk of harm to Child G. However, checks made in respect of other members of the household were not entirely reassuring. It was concluded that as was willing to continue to look after Child G, the possibility of a private fostering assessment should be pursued.

5.84 At the beginning of September 2011, Child G started college and it is clear that Child G viewed this positively. Her attendance was always very good and, with support, she was able to apply herself to her work. However, the nature of Child G’s learning difficulties meant that the adjustment to college was always going to be challenging for her. That she was without the benefit of a stable home life and supportive parents or carers must have greatly reduced the likelihood of her succeeding in this task. It is noted, however, that Child G was to receive support in class, from the outset of her course, provided by the college’s additional learning support department (ALS).

5.85 The proposed private fostering assessment had not begun when Child G declared herself homeless in the early hours of 13 October 2011. Unaware of this, BG and GF reported that she was missing. When the police located Child G, she was returned to their household. This incident is discussed in more detail at 7.1.20.

5.86 On 17 October 2011, Child G reported to children’s social care, and to college staff, that she no longer wanted to live with that she did not feel safe. However, there appears to have been no further evaluation of this information by children’s social care, and, as before, their focus was on finding somewhere that Child G could live. No consideration appears to have been given, on this occasion either, to accommodating Child G under S20 Children Act 1989.

5.87 While out with the social worker trying to locate the home of a ‘brother’ who might be able to look after her, Child G retracted her allegation that SFG had hit her. Then, at the social worker’s suggestion and with her active support, Child G was reunited with MG and SFG, despite their initial refusal to consider it.

5.88 This suggests that Child G’s retraction was considered by children’s social care to have more validity than the allegations she had made previously. A proposed professionals’ meeting was also cancelled by children’s social care on the basis that Child G had gone home, despite the fact that other professionals involved with Child G considered that home was not a stable environment.

5.89 In November 2011, following an internal social care case file audit, a management decision was made that there should be an updated assessment of Child G’s circumstances and that a child in need meeting should be set up. Neither of these decisions was implemented, and this represents a missed opportunity to take remedial action. No satisfactory explanation has been given as to why management oversight of these instructions was absent.

5.90 A professionals’ meeting took place on 2 December 2011, although this was limited in its scope, being essentially a meeting between social worker and two members of college staff. Nevertheless, a number of significant issues were raised and actions agreed. Again it was stated that a child in need plan should be established.
5.91 However, before this was realised, on 4 January 2012, the case was closed to children’s social care following discussion with Response Housing Support Worker. Quoted in support of the decision to close the case was that Child G ‘was happy and settled living with MG’ and that she ‘was able to make choices for herself’. However, neither of these statements would have survived critical challenge. Case closure at this point meant that agreed actions were not carried out and there was no obvious mechanism for work with MG and SFG. Response sent Child G an appointment, but, unsurprisingly, she did not attend. The college agreed, on the advice of children’s social care, ‘to monitor Child G and to move into a Team Around the Child if needed’. The college did not challenge the single agency cancellation of the joint agreement made the month before. The college has recognised that this was a deficit and has made a recommendation to request further LSCB training on developing staff confidence to challenge the decisions of CSC.

5.92 On Thursday 19 January 2012, Child G informed the college that MG was due to go into hospital for 9 weeks and, again, this proved to be a critical time for Child G and things became very unsettled again at home. On Sunday 22 January 2012, EDT became involved when MG telephoned to advise that Child G had ‘gone missing’; although she later returned safe and well.

5.93 The following day, 23 January 2012, college advised CADT that Child G appeared to be living with her brother in Chester, following an argument with MG. It is not clear who this ‘brother’ was and there is no record that attempts were made to confirm the relationship between Child G and the person she reported staying with. The college safeguarding manager agreed to speak with Child G with a view to completing a Common Assessment Framework (CAF) and arrange a Team around the Child meeting (TAC) if required.

5.94 On the same day, MG reported to CADT that she ‘no longer wanted Child G in her care as she could not cope’. She explained her health issues and SFG’s and stated that she did not want Child G adding to her problems. She also reported that Child G had not been taking her medication, which was compounding their problems with her behaviour. CADT advised MG that the case was closed and that a TAC was to be set up. According to the joint chronology, MG stated that she had not had any support when the case was open and that she was not aware of any TAC. She was advised to contact Response if the situation escalated again. MG was reported to be ‘not impressed’ with this outcome.

5.95 On 25 January 2012, the combined chronology indicates that the Youth Offending Service became aware that Child G was associating with XBFG who was a subject of Multi-Agency Public Protection Arrangements (MAPPA): this suggests that XBFG was a registered sex offender; was violent; and/or was an offender who posed a serious risk of harm to the public. It was noted that this information was to be shared with SW2, but there is no record in either IYSS IMR of children’s social care IMR that this happened. It is not known whether Child G was made aware of any risk that XBFG might pose to her safety.

5.96 On 26 January 2012, a ‘Team around the Student’ meeting was held in college, attended by safeguarding manager, personal tutor and learning mentor. It was considered unlikely that Child G would be able to continue on her Childhood Studies course when the current component came to an end the following week. Reference was made to Child G’s uncertainty about her paternity and her fear of remaining with SFG while MG was in hospital. College were uncertain whether a referral had been made to CAMHS, as had been agreed at professionals’ meeting. It was agreed to move into TAC.
5.97 On 31 January 2012, Child G’s personal tutor informed her that she would not be able to progress into the next stage of Childhood Studies, due to problems with her behaviour. Child G became very distressed about this and, out of the meeting, ‘began to run around the campus causing a disturbance’. Staff spent a considerable amount of time with Child G trying to sort things out with her. Child G would only return to MG if the police took her. A police officer is reported to have arrived on campus at about 5.50pm and escorted Child G home. An appointment was made for Child G to attend on 2 February 2012 to look at another course.

5.98 On 1 February 2012, Child G arrived at college and reported that MG had thrown her out the previous night. The college safeguarding manager contacted CADT and provided update of events. Child G was reported to be looking unkempt and was refusing to go to the Response Drop-In centre. By chance, a police community support officer (PCSO) was at college that day: he called a police patrol and Child G was arrested to prevent a breach of the peace.

5.99 Police phoned SW2 who advised that the case was now closed. However, she advised that, from her experience, she thought that once MG had calmed, she would allow Child G to return home. No further action was taken by children’s social care. In the event, Child G remained in custody for two hours and was released without charge. Notification was sent to the local YOT and Child G was returned to a neighbour’s address. A referral was also made to the Anti-Social Behaviour Team.

5.100 On 2 February 2012, Child G attend a meeting with her learning mentor as arranged, but unfortunately it was not possible to enrol Child G on either of the courses under consideration, due to funding restrictions. Child G was, therefore, referred to Connexions, to explore other options. The college IMR indicates that Connexions were asked to ‘drive forward a CAF or TAC’, although this is not confirmed in the Connexions IMR.

5.101 On 6 February 2012, Child G attended an open housing drop-in session at Response and met with housing support worker (HSWR2). MG wanted Response to find accommodation for Child G: the first available, as she, MG, was going into hospital the following week and ‘did not want Child G left in the house on her own’. MG stated that ‘she could no longer cope with Child G’s behaviour and requested that she move out indefinitely’. Response then made a telephone referral to FHA, confirming the information given by speaking to Child G’s mum who was still in attendance at Response.

5.102 Child G is noted to have ADHD, connected with her learning disabilities although there was no real exploration of what that meant. Although MG identified some areas where Child G might need support, such as money management, MG appears to have painted a very positive picture otherwise of Child G’s capabilities and under-represented her vulnerabilities. It was not clearly recorded that Child G had had a statement of educational needs.

5.103 A room was identified through the Housing Solutions Team at Address 2; an FHA facility which comprises three blocks of self-contained single person accommodation for up to 63 young people aged between 16 and 25 years old.

5.104 No communication appears to have taken place with CADT at this point. No consideration was given to whether Child G should be provided with accommodation and care under S20 of the Children Act 1989, due to her need, rather than providing her with accommodation,
due to her homelessness. The absence of an assessment of need meant that FHA relied on the limited information provided by Response and MG’s overly-positive reports about Child G’s needs and behaviours. The result was that FHA began with an unrealistically optimistic image of Child G’s capabilities. Child G was allocated a key worker, FH2.

5.105 FH2 quickly recognised that Child G would probably be better placed in a smaller, more supported environment and referrals were made through Response for more specialist accommodation.

5.106 On 10 February 2012, at 11.40pm, Child G contacted the police by telephone and informed them that she was being followed by XBfG2, who had threatened to kill her and who had a knife. XBfG2 was not present when police arrived five minutes later. However, there is no record that any efforts were made to speak to him, either at the time of the incident or afterwards. The police IMR notes that Child G should have been classed as a child at risk, but was not. As a result of this incident, FH2 made a referral to its health engagement worker, FH1.

5.107 On 14 February 2012, FHA completed the first of 38 Notification of Risk Report (NOR) forms that it would complete in the next three months, when Child G reported that she had been drinking and was now stuck in Liverpool with no money. This notification of risk was an established procedure within FHA: the relevant documents were endorsed by the project manager and information entered on a database for the attention of senior officers and the safeguarding lead. However, the FHA IMR recognises that this system tended to lead to a static rather than a dynamic approach to risk management, with responses being made to individual and pre-existing episodes rather than the broader developing picture. Remedial action has been taken by the organisation on the basis of that review.

5.108 Between 17 and 20 February 2012, there was communication between FHA and college in respect of Child G’s child care course: there appears to have been no reference to any existing or proposed CAF or TAC process. At this point of crisis for Child G, the absence of a single, coordinated, multi-agency plan is striking.

5.109 On 20 February 2012, Child G attended for interview at college for food preparation course and completed a written exercise. In the event, however, Child G’s application was unsuccessful.

5.110 Later that evening, on 20 February 2012, Child G left FHA with all her possessions. During the course of the enquiry, there were a number of sightings of Child G. It is noted by Barnardo’s Missing Service project worker (BPW1) on 21 February 2012. When they reported that Child G had disclosed threatening behaviours from an ex-boyfriend and it was agreed that a referral would also be made to Barnardo’s Domestic Abuse Service. FHA informed CSC that Child G was missing. It was agreed that FHA would undertake a CAF on Child G’s return.

5.111 On 22 February, Child G returned to FHA of her own accord. Child G reported to the patrol officer who interviewed her on her return that she had been staying with XBfG2. No connection was made with Child G’s previous report to police (10 February 2012) that XBfG2 had threatened to kill her. The following day, Child G made a further report to the police that XBfG2 ‘had threatened to kill her using a knife’. BPW1 did not make direct contact with Child G on her return to her accommodation, as would have been
appropriate, to assess the risk and the circumstances that led to her leaving her as she did. This is discussed at 7.1.22.

5.112 Unfortunately, Child G had scabies at this time and the view developed that this would make it impossible for Response and Barnardo’s to progress the referrals which had been made. The Barnardo’s IMR indicates that, from their perspective, the risk that scabies posed was a mistaken interpretation of the advice they had sought. This is addressed by a recommendation. However, the effect was that, for both organisations, their assessments and interventions were delayed in ways that were unhelpful to Child G. The delay in seeking alternative accommodation meant that Child G’s stay at Address2 became a longer term option by default rather than by decision. The delay in meeting the project worker was a missed opportunity to develop a relationship with Child G.

5.113 On 24 February 2012, FH11 went to Child G’s flat to give a wake-up call. She went on to say that she was pregnant. Child G agreed to be accompanied to the Brook Clinic to discuss options. There is no evidence that this happened, although she did have a planned appointment with her GP for 28 February 2012.

5.114 In the early hours of 27 February 2012, Child G was taken to the Adult AED after complaining of stomach pains. Child G was reassured and discharged. No notification of her attendance was sent to the children’s liaison manager who provides the link with AED for young people aged 16-17, when referred. EDT provided a taxi for Child G to get back to her accommodation. Child G reported that she had miscarried to staff at FHA. This was the first of seven attendances at AED over the following six weeks.

5.115 On 6 March 2012, Child G reported that, and others, had stolen her digibox. When staff intervened and another resident threw the box at Child G. A short time later, these two residents attacked Child G as she was returning to her room, kicking and punching her. Staff members stopped the assault and phoned the police. Police arrested and and took a witness statement from Child G. Child G was then taken to hospital. This was Child G’s second attendance at AED.

5.116 However, Child G absconded before she was seen by a doctor. In the early hours of 7 March, the junior doctor who was due to see Child G discussed her vulnerability with Registrar: Registrar was of the view that Child G had ‘capacity’ and that the police would return her if they were concerned. The junior doctor was reassured by this advice and did not escalate concerns. There was no notification to children’s liaison manager. Meanwhile, both and were charged with assault and kept in custody to appear before the next available court.

5.117 On 7 March 2012, Child G went with HSWR2 to a pre-arranged appointment with AW1, for support in relation to alcohol misuse and her lack of understanding of the inherent risks. Child G was assessed as having ‘possible dependence’ on alcohol. Child G did not see that there was a problem with her use of alcohol and cited other people doing the same. However, she agreed to attend counselling on 13 March 2012. Child G failed this appointment, and another that was rearranged for her. This service ended on the basis that Child G did not engage with it.
5.118 Then, on the evening of the same day, 7 March 2012, residents informed staff that Child G was having dizzy spells and had collapsed. Child G attended AED, where reference was made to the assault the previous day. Child G was examined, reassured and discharged. However, on return from hospital, her dizzy spells continued. Staff spoke to AED where it was suggested that ‘she might not be eating properly’. Then, in the early hours of 8 March 2012, Child G re-attended AED where she was seen by a different junior doctor. ...but she had a low blood count. Again, there was no referral to children’s liaison manager. Child G was discharged and EDT provided a taxi to return her to her accommodation.

5.119 On 8 March 2012, CADT also made contact with FH2, in relation to the assault by ...and overnight visits to hospital which had been reported to EDT. Discussion took place about the CAF which had been agreed previously but which had not yet been completed. Social care’s view was that Child G was being adequately supported in the community and so no further action by the local authority was necessary.

5.120 On the same day, ...and ...appeared at court. They were granted bail, with conditions to live at a different address and not to approach Child G. They had been evicted from Address2.

5.121 On 10 March 2011, at 7.15am, Child G was found to be heavily under the influence of alcohol and was being abusive to staff. Child G had had a backdated benefits cheque which she had used to buy alcohol which she shared with other residents. The police were called and as Child G continued to be abusive, she was arrested. Child G was risk assessed in custody, when she reported she had tried to cut herself the previous week. Child G was released without charge just over five hours later; when she had sobered up, and the risk of a breach of the peace had passed. Police notified YOT.

5.122 At 7pm, that evening, FH2 met with Child G and discussed the events of the previous night and the risks she was running. Support was offered to Child G to help her manage her money. Then, at 10pm, FH2 completed a further notification and safeguarding risk assessment when XBF2 came on site, and argument took place with Child G. Child G was reported to have been ‘very animated’ and at one point, it was reported to staff that she had followed XBF2 out of the accommodation with a knife, before returning to her flat. At 11pm, Child G was still fuelling the argument with XBF2, who had returned to the site. Child G was unsettled for the rest of the night.

5.123 The following evening, 11 March 2012, Child G was again reported to be in the reception area of her accommodation, under the influence of alcohol, and being threatening and abusive to staff. A risk assessment was completed requesting ‘management intervention’: FH3 (project manager) noted the risk assessment, asking staff ‘to ensure that all referrals are in place’.

5.124 On 16 March 2012, Barnardo’s project worker (BPW2) and Child G’s key worker discussed concerns about Child G’s vulnerability; her alleged use of MKat; her ‘...her failure to seek medication attention and guidance in respect of ...; and, the likelihood that scabies could spread as a consequence of her actions. FH2 referred to a CAF being undertaken and BPW2 asked for a copy to be sent to her. On a second call, BPW2 spoke to FH1 who advised that Child G was likely to be moving to more suitable accommodation with one-to-one support. BPW2 then spoke to FH3 (project manager), indicating that she thought that there were
safeguarding concerns in respect of Child G and emphasised the importance of notifying CADT without delay. A phone call was made to CADT, but the advice to FHA remained to ensure that agencies came together under the TAC process to put in a package of support, in order to ‘regulate concerns’. If concerns were considered to have increased, then FH2 was to ‘call back for further advice’. FHA accepted this, although in reality concerns had already increased. Work that had been done on the CAF was updated and, that evening, Child G was asked to ‘sign it off’, although it is not clear to what extent she participated in the process.

5.125 Ten minutes later, Child G returned to reception complaining of stomach pains. It was suggested that she ring NHS direct but she was insistent on phoning an ambulance. Child G was taken to AED and was assessed in the Acute Medical Assessment Unit (AMAU). A letter was sent to Child G’s GP requesting that Child G be given iron therapy. No referral was made to the Children’s Liaison Manager. Child G contacted EDT to arrange a taxi back to her accommodation.

5.126 In the early hours of the following morning, that is on her return from AED, Child G was found to be ‘acting irrationally’, taking bags of clothes off site then coming back and taking more. She was witnessed speaking to a man, whom she initially said was her brother but who later appeared to be ‘a random person off the street’. Other concerning behaviours continued the next day.

5.127 On 19 March 2012, Child G agreed and signed referral to another housing project, with fewer residents, where it was felt that Child’s ‘complex needs’ could be more effectively met. A referral was also made to Community Psychiatric Nurse (CPN), Adult Mental Health Services, requesting a mental health assessment of Child G, who was now 17 years old. The referral indicated that Child G had a learning disability, with a diagnosis of ADHD, and that she had not been taking her medication, because of side-effects. The referral also highlighted concerns about Child G struggling to maintain her accommodation, due to her presenting behaviours.

5.128 Later that night, Child G again attended AED. Her reason for presentation and examination were the same as when she presented on 17 March 2012. The junior doctor who saw Child G discussed her with a registrar who suggested giving Child G two weeks’ worth of iron tablets and sending a letter to her GP for follow up. The Children’s Liaison Manager was not contacted.

5.129 On the same day, 20 March 2012, Child G attended GP surgery with her support worker. Concerns were raised about Child G’s non-compliance with anti-scabies medication and recent attendances at AED. Child G was diagnosed as having iron deficiency anaemia and irritable bowel syndrome. Checks were also to be made about the possibility that Child G might have coeliac disease.

5.130 On 21 March 2012, Child G was concerned about her safety as [redacted] and [redacted] were outside of the building ‘in breach of their bail conditions’. Police were informed and advice was given. FH3 spoke to Child G, but she was ‘unwilling to take staff advice about staying away from [redacted]’. Child G later made a formal complaint to the police that she had been threatened by [redacted] and [redacted].
5.131 On 22 March 2012, Child G did not wait on site to see CPN, although she had agreed to. The CPN later suggested that the GP might make a referral to the 16-19 CAMHS service, as CAMHS had already been involved. CPN reported that she would try to make contact again with Child G in April, on her return from annual leave, if no referral had been made to CAMHS in the interim.

5.132 On 25 March 2012, Child G attended a meeting with safeguarding manager and with learning mentor at college. Child G was due to start, the following day at the Shaw Trust which delivers the national ‘Foundation Learning Programme’. However, the next morning, Child G telephoned learning mentor to say that she would not be going to the Shaw Trust that day as planned as she ‘felt unwell’. There is no reference to the Shaw Trust in the FHA IMR: it is unclear, therefore, whether Child G’s proposed start had been communicated to them as they had already organised a wake-up call for Child G so that she could be taken to the GP in the morning, with the TAC meeting in the afternoon. Child G never attended this course.

5.133 On 26 March 2012, Child G attended her TAC meeting. The FHA IMR describes the CAF process as a vehicle which should have ‘not only identified levels of risk and need, but might also have given the impetus to the need for action and provided clarity about, and solutions to, the blockages’. Unfortunately, there appears to have been limited expectation of input by other agencies (or by family members) and no perceived authority to hold organisations to account if they failed to take part. As a consequence, the CAF did not reflect all of information known to agencies and it resulted in ‘a limited action plan focusing on health, personal and placement issues’. There is no evidence that agencies not included in the process expressed concerns about their lack of participation. No review date was set and no further TAC meeting took place, despite expressed intentions to hold one. The effectiveness of this process is further discussed in Section 7.

5.134 On 27 March 2012, HSWR2 contacted [REDACTED], which offers ‘a safe, secure environment that provides 24 hour support services for young women aged 16 to 25 years’. It was agreed that an interview would be set up for Child G when her scabies had cleared.

5.135 In the evening of 28 March 2012, staff discovered that Child G had removed restrictor screws from her window and had allowed barred visitors into her flat: all were said to be in an intoxicated state.

5.136 On 29 March 2012, Child G was ‘drinking early’, after having received her benefit payment and expressed the intention to get ‘completely off her head’. That night, at about 10.20pm, staff phoned the police and reported that Child G was smashing bottles and threatening to kill another resident. A patrol was dispatched to the scene and Child G was arrested to prevent a further breach of the peace. Child G was risk assessed at the custody suite, where she stated that she had been drinking cider and that she had cut herself the previous month. A care plan was set out for her. Child G was released without charge, the following morning at about 6am.

5.137 When she returned to her accommodation, Child G apologised for her behaviour the previous night. However, that night, Child G was again found to be very drunk as were her two visitors. When staff tried became involved in a dispute between Child G and other residents, Child G became very aggressive towards them. Police were called and Child G was arrested again to prevent a further breach of the peace and taken to the local custody
suite. On this occasion, Child G informed the police that she had never harmed herself, but was made the subject of a care plan in any case, as it was recognised that this statement contradicted what she had said the night before. The arresting officer was concerned that Child G had been arrested at the same location for the same offence in a very short time and requested that she appear before the next available court to be bound over. However, this did not happen and Child G was released without charge five hours later.

5.138 On 1 April 2012, Child G visited the GP and told staff that she was clear of scabies. Child G was described as ‘very persistent’ in wanting to hang around his flat. FH2 emailed FH1 to arrange for Child G to see a dermatologist. A further similar incident was reported three days later.

5.139 On 2 April 2012, having been upset in the morning, Child G ‘threatened to overdose on pills’. Child G was seen by CPN and was persuaded to hand over the tablets. Child G shared some of her life story with CPN, highlighting poor family relationships as the reason for her being in her current accommodation. Child G reported that she was feeling lonely and angry. Child G confirmed that she had not been taking her medication and noted that her ability to concentrate and conform had spiralled out of control. Child G stated that she had been using self-harm as a coping mechanism. She also reported that she had been using alcohol to excess and that this had meant that she did not have enough money for food or electricity. Child G agreed to work with the alcohol engagement worker from FHA and to a referral to the 16-19 CAMHS team.

5.140 However, shortly after Child G returned to her room, another resident informed staff that Child G was again threatening to take tablets. Staff attended and retrieved tablets from Child G who then expressed a wish to speak to her mother as ‘that usually cheered her up’. At about 3.30pm, Child G left to visit her mother. However, Child G was returned to the project in the early hours of the following morning by the police who had found her staggering in the street with three pint glasses in her bag. Once back in her accommodation Child G could not be settled until about 4am.

5.141 On 4 April 2012, [redacted] was informed by residents that Child G had written his name on the wall by her bed and was telling people that she loved him. FH10 immediately brought this to the attention of FH3 who advised him, and other staff, to monitor Child G’s behaviour towards them.

5.142 Later that evening, at 10pm, she telephoned the police and reported that she had been receiving threats from XBFG2. Child G stated that XBFG2 had threatened to stab her, although she had not seen a knife. A patrol was dispatched and found Child G safe and well. XBFG2 was said to have left the scene. According to the police IMR, Child G made her own way home. This was the third report that Child G had made about XBFG2 and, in each, she had alleged that he had threatened her and had implied that he could have had a knife. The Police IMR acknowledges that in the circumstances it might have been ‘judicious’ to interview XBFG2, at least to obtain his version of events.

5.143 On 8 April 2012, Child G complained to staff that a resident and his girlfriend had ‘trashed’ her flat and refused to clear up the mess. Child G wanted to contact the police to make a complaint: they attended the next day, but concluded that it was not a police matter.
5.144 On 9 April 2012, Child G told staff at FHA that she was upset. There is no reference to such a visit in the GP IMR.

5.145 That evening, residents alerted staff to Child G who was threatening to take tablets in her room. Staff attended and persuaded her to hand over the tablets and took her to the office to discuss her behaviours. Child G became very rude and aggressive, asking staff to phone the police. This angry behaviour continued until Child G went to bed at about 4.45am, the next day. EDT were informed and they ‘provided advice’.

5.146 On 10 April 2012, HSWR2 contacted FH2 who advised that Child G no longer wished to move from Address2.

5.147 On 11 April 2012, CDT spoke to FH3 by telephone. Children’s social care IMR indicates that FH3 reported that Child G was being ‘monitored via TAC’ and that a meeting was to take place the following week. It was also recorded that Child G had met with a community psychiatric nurse for a mental health assessment and that a referral had been made to the CAMHS 16-19 service. Outstanding issues included: Child G’s medication for ADHD; her estrangement from MG; and the need for Child G to move her to a smaller project. The record of this conversation does not fully represent the concerns that were building for Child G.

5.148 In the early hours of 12 April 2012, Child G again attended AED, by ambulance, with a reported ingestion of 15 tablets prescribed for her stomach (an anti-muscle-spasm agent). However she left before treatment could be given at 2.20am.

5.149 On 13 April 2012, Child G attended surgery with FH1 who reported problems with Child G’s compliance with medication, nausea and issues with her behaviour. GP3 made a referral to CAMHS 16-19 Service; prescribed a reduced dose of ADHD medication until review could be completed; and, made an appointment for Child G to [REDACTED]. Three days later, GP3 faxed referral to CAMHS 16-19 Team, asking them to see Child G. The referral letter contains a history of Child G’s recent visits to AED and to GP. Further communication also took place between CPN and CAMHS to ensure that action was being taken. The GP referral was accepted by the service on 1 May 2012. The first appointment was scheduled for 28 May.

5.150 On 14 April 2012, a referral was made to [REDACTED] This referral explained Child G’s needs and indicated that the referral concurred with Child G’s wishes.

5.151 On the evening of 16 April 2012, Child G requested permission for BfG to stay this night: approval was given by FH3.

5.152 On 18 April 2012, Child G told FH1 that she was upset and that she had been taken into custody: the nature of the allegations is unknown. Child G said that she had ‘nearly taken tablets’ but talking things through with FH1, she appeared much calmer. FHA IMR indicates that Child G was reminded about her appointment with Barnardo’s project worker, BPW2, the following day.

5.153 At some point in the day, BfG was signed into the project by staff at the reception desk. Then, at 10pm, Child G alerted staff to [REDACTED] Staff went to Child G’s flat and found GF and BfG: GF stated that she was
Staff asked GF and BFG to leave, which they eventually did, accompanied by Child G. It was noted that Child G was ‘under the influence, very loud and agitated’.

5.154 On 18 April 2012, a referral was made from AED to the Children’s Liaison Manager. Then, on 20 April 2012, the Children’s Liaison Manager made contact with children’s social care expressing concerns about her frequent presentations at AED and her vulnerability. The contact also stated that there had been a delay in making the referral as it had been the hospital’s intention to speak to the school nurse, after the Easter break, but that they had subsequently learnt that Child G was not in school.

5.155 CADT contacted FHA and spoke to Child G’s GP. CADT concluded that no further action was to be taken by children’s social care, but advised ‘Common Assessment Framework to be completed’, although there was already a TAC in place. The combined chronology indicates that FH6 stated in message left for CADT worker, that Child G has been absent from the project for approximately 24 hours and that he was not sure where she was staying. There is no reference to Child G being absent in the FHA IMR, although the next significant diary entry does not take place until 22 April 2012. This is discussed in Section 7.1.

5.156 On the evening of 22 April 2012, Child G reported to the police that she had been assaulted by [redacted]. They advised her to go to the hospital as she had sore ribs. However, Child G chose not to do so. In the early morning of 23 April 2012, police attended Address2 to take a statement and to photograph her injuries. The reporting officer noted that there were no signs of any visible injuries to Child G. The incident was, however, recorded as a crime and [redacted] was the nominated offender. This led to [redacted] arrest on 24 April 2012. However, the Evidence Review Officer decided that no further action would be taken. [redacted] was refused charge and released from custody on the same day. Child G was informed the following afternoon that [redacted] had been released and that no further action was to be taken against her. Although it was positive that Child G was provided with this information as she had requested, the police IMR acknowledges it was ‘a day late’.

5.157 On 27 April 2012, Child G met with BPW2 in the company of FH1. This was described as an introductory session to discuss support available and to gain Child G’s signed consent to receive service. A further meeting was arranged for 4 May 2012, to undertake assessment. It was agreed that FH3 would arrange another TAC meeting; although there is no record that this happened.

5.158 On 29 April 2012, Child G was found to have what she described as her mother’s medication and was threatening to take it. She also reported that her mother had been admitted to hospital with an overdose because SFG had beaten her up. A check was made with the hospital, but MG had been discharged on 25 April 2012. Staff persuaded Child G to give the tablets to them for safekeeping. It is not known how Child G came to be in possession of medication which was not hers. Child G told staff that she was depressed because SFG did not want her to go home; she stated that she would go to see the GP for anti-depressants. CPN was to be informed.

5.159 Later still that evening, it was reported to staff that certain electricity meters had been ‘bridged’: Child G’s meter was one of them. Child G disclosed the name of the resident who had bridged the meters and he was issued with eviction notice. Child G and others were sent letters highlighting concern and remedial actions which were to follow, including attending a Fire Awareness Programme.
5.160 Since being off roll at college, Child G had made a number of unsuccessful attempts to identify a further course. On 1 May 2012, college received Child G’s written application completed an application for a Level 2 Administration course. Child G’s learning mentor liaised with the relevant curriculum leader to see whether it would be possible for Child G to take part in a summer course in this area. The following day, 2 May 2012, Child G received her certificate for completing two social care courses.

5.161 On 4 May 2012, Child G had a meeting with BPW2 to complete an initial assessment and risk assessment. Child G reported that she had not had contact with her ex-partner for four months and was in a new relationship: she had no concerns about violence in this relationship. The result of this assessment was that Child G’s situation at the time indicated that there was low risk of violence towards her. The assessment tool (CAADA DASH) used by BPW2 is a nationally accepted tool, used in Wirral both for adults and, on the advice of commissioners, also for under 18s. However, it relies on self-reporting, which in Child G’s case was often flawed. Indeed, it is noted that Child G had reported a threat by XBFG2 the previous month (See 5.29). In addition, it is not known whether the format makes any allowance for the ‘capacity’ of the young person to participate effectively, where this might be impaired by learning disability. A further meeting was arranged for 11 May 2012, to set up support and safety plans. Unfortunately, BPW2 was absent from work on that day, due to sickness. Sadly, Child G died before a rearranged appointment could take place.

5.162 On 5 May 2012, FH2 met with Child G to review progress. [Redacted] was to be accommodated in the unit and it was known that there had been previous concerns about their relationship. However, both girls were at this stage reported to be very happy with the proposed arrangement: it was noted that Child G had been ‘very supportive’ to [Redacted].

5.163 On 9 May 2012, Child G was involved in an incident with FH10. It appears that Child G was being disruptive and the suggestion is that she was angry and upset with FH10. She stated that she was going to phone the police about him. Child G agreed to go to her room and asked that the police be sent to her flat when they arrived. FH10 informed the duty manager about what had happened and duty manager asked to be informed when the police arrived. However, they did not arrive and there is no reference in the police IMR to Child G making a complaint. This suggests that Child G did not in fact make a complaint. Documentation relating to the incident was sent to the Head of Human Resources, FHA.

5.164 The following day, 10 May 2012, FH3 spoke to Child G. Child G admitted that she had made ‘false allegations’ and apologised for her actions, saying that ‘she did it for attention’. Although it appears that Child G denied to FH3 that she and [Redacted] had ‘a relationship’, the IMR does not consider whether FHA dealt with this incident with reference to, and in accordance with, policy/ procedures in respect of allegations made in relation to individuals working with children. Child G made a further retraction at around 1am the following morning, when she told FH8 that what she had said about ‘her going [Redacted] for a burger and meeting his parents’ was not true. A notification of risk was completed.

5.165 On 12 May 2012, FH2 made a referral to the ‘Intervention Engagement Service’ in which she identified that Child G was looking forward to starting college in September; that she wanted to get on better with residents; that Child G was concerned about ‘her drinking and experimenting with drugs’; and, that she needed diversionary activities to keep her out of trouble and safe.
5.166 However, that evening, at about 6.15pm, the police received a phone call from SBfG to say that Child G had been at her house, twenty minutes earlier, and that Child G had told her that she had had a call from BfG who had told her that ‘he was on the run as he had done something really bad’.

5.167 This phone call took place about sixteen hours after an incident of arson at the home of SBfG’s ex-boyfriend, for which BfG was the suspected perpetrator. SBfG’s ex-boyfriend was at work at the time of the incident, which had been immediately preceded by a burglary. The flat in question was situated on the ground floor, with a young family above. Patrols had been tasked to locate and arrest BfG. No patrol had been available to take a statement immediately from SBfG as a result of her phone call, but the investigating officer in relation to the arson offence is reported to have made unsuccessful attempts to locate both SBfG and Child G. It is not entirely clear when the first contact between Child G and the police took place in relation to this phone call by SBfG.

5.168 Back at her accommodation, Child G was extremely unsettled; wandering up and down the blocks throughout the night. She eventually went to bed at about 4am, but was up again shortly afterwards. Child G was ‘still wandering around’ at 7am on 13 May 2012. It is not evident, at this point, that Child G had shared information about BfG with staff at FHA.

The days leading up to Child G’s death (13 May 2012 – 19 May 2012)

5.169 On the evening of 13 May 2012 and throughout the night, Child G was very unsettled and told FH2 and FH5 that BfG had been arrested for arson, and that a baby was in hospital as a result. This was clearly not true as police arrived afterwards looking for BfG. Child G’s behaviour was very difficult for FH5 to manage.

5.170 At 5 o’clock on the morning of 14 May 2012, BfG was reported by Child G to have thrown stones at her bedroom window. She spoke with him and he told her that he was in big trouble with the police and arranged to meet her later in the day. This information was not given to professionals at the time. However, at lunchtime that day, Child G met BfG in a local shopping centre. BfG had some items stolen from SBfG’s ex-boyfriend’s flat. It appears that Child G and BfG then went to a store, where BfG bought a sleeping bag: they both then took a bus from the town centre to a suburb of the town where there is a wooded nature reserve and public park. BfG took Child G to a tent he had erected in the woodland there and showed her a handgun. He told her that if the police found out where he was they would try to arrest him, and he would shoot them. Child G then left him in the tent and returned to her accommodation; it appears that BfG had asked Child G to meet him at the tent the following day.

5.171 At 4pm the same day, 14 May 2012, FH1 attended the GP with Child G, at Child G’s request. Child G told FH1 that she had spent the day with BfG and was able to produce a receipt with BfG’s name on it which supported this. Child G said that she had been helping police with their enquiries. She said that BfG had a gun and that he did not want to be arrested. FH1 advised Child G only to meet with BfG in public areas. It is not entirely clear when this conversation took place as it was not until 6.15pm, that Child G first contacted the police from a landline at Address2. She told them that a male called BfG was missing from his mother’s home, because he had burnt his sister’s flat down. Child G reported that she had seen him earlier, at about 3pm, where he was staying in the woods. However, Child G did not mention that BfG had a gun. The operator then rang BfG’s grandfather who stated that BfG had been in touch with him from a local
5.172 That evening, Child G told FH13 about having spent the day with BfG who had a gun. She was encouraged to phone the police about this, which she did at 8.25pm. On this occasion, Child G told police that she was BfG’s girlfriend and that he was on the run from the police for arson. She reported that BfG had been in the woods for the last three days. She also said that BfG had a gun and he would shoot officers if they went near him. Child G did not know what kind of gun this was. In both situations, it would have been advisable for staff to speak to the police directly.

5.173 An incident log was created and Child G’s call was linked to her earlier call, although no entry was made to the record to ensure that Child G’s identity was protected. Police ‘supervision’ were made aware of a call involving firearms. Instructions were given to arrange face-to-face contact with Child G and for intelligence checks to be made on BfG, before any further decisions about deployment were made.

5.174 Shortly after Child G’s second call to the police, therefore, three police officers attended Address2. Child G was then taken to the police station to provide a statement. She reports asking Child G if she felt vulnerable, and Child G stated that she did not. Child G confirmed that she had met BfG by arrangement at the shopping centre that day. BfG took her to his tent because he had something to show her. He showed her a black gun; he did not show her any bullets. BfG told Child G that if the police found out where he was and tried to arrest him, he would shoot them. She stated that his tent was quite close to a large supermarket, near to a bus stop. Child G reported that the gun was inside a pocket of the tent directly opposite the entrance. It was not exactly hidden. BfG believed that the police were looking for him because of the fire he had caused. Child G did not know why he had set this fire.

5.175 Child G again stated that BfG had asked her to meet him again the next day at the tent. However, she did not want to go again on her own. The police IMR describes this as ‘the first indication given to the police that there was possibly some element of fear’ of BfG by Child G. However, Child G went on to describe the tent as lime green and big enough for two people. She drew a sketch of the route that BfG had taken her to his tent and gave a description of where she thought the tent was.

5.176 Checks in respect of BfG included details of his home address, DNA and the fact that he was wanted in relation to a recent offence of arson. Warning signs were also present in respect of ‘mental health’; ‘ailments’; ‘self-harm’; and, ‘offends on bail’.

5.177 When Child G returned to her accommodation, she told FH5 that she had ‘cut’ herself, but when there was no evidence found of this, Child G admitted that this had not been true.

5.178 At just before midnight, following a debrief of Child G’s statement, the force incident manager dispatched a patrol to return and speak again to Child G about BfG’s daily habits and mobile phone details. At around the time that the police arrived to collect Child G, it appears that a member of staff from Address2 telephoned the police and informed them...
that Child G had told them about a male with a gun in the woods outside town. However, he wanted to advise them that Child G had a habit of making things up and could not always be believed. He reported that he would inform the police if BfG attended Address2. No reference is made to this telephone call in the FHA IMR.

5.179 At about twenty minutes past midnight, Child G arrived at the police station to make a second more detailed statement. In this statement, Child G described having been in a relationship with BfG for nine months and that he was a very angry person with a bad attitude. He had extreme mood swings and regularly flew off the handle at the smallest thing. The police IMR acknowledges that this could indicate a possible risk to Child G, but notes that in the same instance, she spoke fondly of BfG and stated that she did not want to get him into trouble. The officer who dealt with Child G described her demeanour as ‘compliant, bubbly, talkative and relatively happy’. From the officer’s perspective, Child G did not appear to show any signs of fear of BfG; on the contrary, she appeared to be concerned about what might happen to him.

5.180 Neither this officer nor the enquiry officer who had interviewed Child G earlier understood the term ‘vulnerable’ in the context of ‘a vulnerable witness’: the police IMR attributes this to a gap in staff knowledge, exacerbated by lack of easy access to the necessary criteria to evaluate whether a witness is vulnerable or not. However, the primary function of this classification is to ensure that such witnesses are provided with special measures when matters come to court. The issue of the vulnerable witnesses and gaps in current policy are considered in detail in the police IMR and are addressed by its recommendations 12 and 13.

5.181 The officer took Child G to where she thought she had entered the fields with BfG earlier that day. Child G was then returned to the project where she provided police with BfG’s mobile phone number. The combined chronology indicates that at about 3.30am, Child G came to staff and said that BfG was throwing stones at her window. Staff investigated but no-one was there. Child G went back to bed.

5.182 At about 10.30am on 15 May 2012, police spoke to Child G who told them that she had arranged to meet BfG in the shopping centre at 1pm. Child G was told not to meet BfG unless she had been authorised by the police. The police arranged to interview Child G at the police station at 12 noon.

5.183 On this occasion, Child G stated that she had bumped into BfG the previous day and that he had instigated the meeting that was due to take place that day. This was a different version of events than Child G had given previously when she had said that the arrangement was for her to go to the tent. Child G stated that she was telling the police ‘as part of her civic duty and that she had asked BfG to hand himself in’. Child G stated that if she met BfG and the police were there, he would ‘kick off on her, screaming at her’. The police record indicates that Child G did not mention any physical violence, although the interviewing officer (MP7) specifically asked if he would be violent towards her. Child G provided other information about how BfG was obtaining foods and about two other people who might know of his whereabouts; FBfG and her brother. Plain clothes officers were then sent to the shopping centre, but BfG did not arrive.

5.184 Child G was then taken back to the project where police searched her flat for any mobile phones. She was then taken in an unmarked car to another part of Wirral where she pointed out the house of FBfG. On the way back, Child G was able to identify the bus
stop she and BfG had arrived at the day before. Child G and officers then drove around the area to see if she recognised any landmarks that would identify where the tent was. Child G indicated a green object in the woods. Child G was taken back to her mother’s address at about 5pm. MG was advised to ring 999 if BfG arrived at her address. The officers told Child G not to make any other arrangement to meet with BfG and to call CID if he tried to make contact with her. She was given a contact telephone number.

5.185 A firearms operation was put into place and a tent and camping equipment were recovered. It had been ascertained by this stage that SBfG’s ex-boyfriend had had a BB gun stolen from the flat at the time of the arson offence. Pellets of that type were also found at the campsite. Despite the fact that BF’s shelter had been recovered and it had been identified that he did not have a real firearm, the police IMR indicates that the search for him lost none of its momentum. Enquiries continued as did the intelligence gathering exercise to locate his phone.

5.186 Back at her accommodation, at about 7pm, according to the combined chronology, Child G told FH16 about the day’s events. It is noted that FH16 expressed concerns about Child G raising attention to herself by letting it be known to other residents that she was helping the police. Child G was advised to ‘keep it quiet and stay safe’. It was recorded that Child G left the building at that point. Child G was described as ‘her usual sprightly self’. Then, according to the FHA IMR, just over half an hour later another resident reported to staff that Child G had told her that she was going to her flat to harm herself. Staff responded to find Child G in flat stating that she had no such intention: Child G was advised about telling lies to other residents.

5.187 At about 11pm, Child G talked to another member of staff about being with the police during the day and having taken them to the area where BfG was camping out. Child G stated that ‘the police had found the gun which had her finger-prints on it’. She also reported that another resident’s girlfriend had stolen her scarf. Child G then went off to spend time with GF, coming back to have a cup of tea with FH7 and FH13 in the early hours of the morning. They noted that she was in a good mood.

5.188 On the morning of 16 May 2012, Child G responded to a wake-up call at 6am. She appears to have left the building just after 9am arriving at MG’s address about 10am, from where they went shopping. At just after 1pm, Child G arrived back at the project with her bags of food. She did not stop long enough to put her shopping away before going back out, this time with GF. The two girls boarded a local train, without tickets.

5.189 At 1.30pm, Child G spoke to the police (MP7) and said that she was at the project, although she clearly was not. Child G had already informed FH9 that she was meeting up with BfG and she confirmed this in conversation with the police. She stated that she had spoken to BF the previous evening at about 10pm and that they had arranged to meet at the sweet stall in the market at 2pm. Child G was told to remain at the project and officers were dispatched quickly to cover the meeting.

5.190 At 1.35pm, MP4 spoke to FH6 asking whether Child G was on the premises. FH6 was unsure but reported that she thought that she was on site and had made a few phone calls. MP4 requested that the staff kept an eye on Child G and did not allow her to leave the building.
5.191 At 1.45pm, FH6 received a call from Merseyrail saying that Child G and GF had been caught riding a train without a ticket. FH6 spoke to Child G and told her to return to the project as the police had advised her to remain in the building. Child G stated that she would return immediately. MP4 was advised of this and FH6 agreed that she would call again if Child G had not returned by 2pm.

5.192 At 2pm, FH6 rang again, letting officers know that Child G had not returned. MP4 was made aware of this, but there is no record that this information was made known to MP7. MP7 finished her tour of duty late that day, but before going on annual leave, she briefed her supervision and informed them of the actions she had taken in this case, which included safeguards for Child G. Her supervision agreed with the actions MP7 had set out. No especial significance was given by the police to the fact that Child G had not returned to her accommodation at 2pm and no arrangement was made to check later.

5.193 This is a gap which, with hindsight, appears especially significant. However, no information has been provided to this review which suggests that the police could reasonably have predicted the danger that BfG posed to Child G, based on their knowledge at that time. In addition, police were unaware that Child G was unlikely to stay away from BfG, whatever advice they had given her. Significant information about their relationship was gathered in the form of witness statements from friends and family members after Child G had died.

5.194 Child G and GF had, in the meantime, met up with BG in the town centre. Child G then left GF and BG and went off towards a discount store. She stated that she was going to MG’s address and that she would see GF later at the project. GF recalled that this was about 1.30pm although a witness reported seeing Child G and GF together in the Job Centre between 2.30 and 3pm.

5.195 At 3.15pm, patrols sent to cover the meeting between Child G and BfG were stood down and resumed other duties. The overall operation to locate and arrest BfG remained active.

5.196 It appears that Child G arrived at her family home at about 4pm, where she had a sandwich. The last confirmed sighting of Child G was around 5-6pm, when she was seen on CCTV walking towards the place where she was murdered. A number of other sightings were reported to the police but these were not able to be corroborated.

5.197 Child G clearly did not return to her accommodation that night or the following day.

5.198 On 18 May 2012, according to the combined chronology, Barnardo’s Young People and Domestic Abuse project worker (BPW2) telephoned the housing project and spoke to FH6 in reception to confirm that she had an appointment with Child G at 2.30pm. FH6 reported that Child G had not returned to the property for the last two days. At this point, it appears that FHA had not made any efforts to establish Child G’s whereabouts or to have considered reporting Child G as missing. This is a significant omission in the circumstances and there is no clear explanation for it. As noted earlier, the many Notifications of Risk that had been completed in respect of Child G had been produced in response to incidents and had not been brought together in a way that developed a
broader picture of Child G’s vulnerabilities. Child G’s absence was apparently not seen either as an ‘incident’ that required a response or as an indicator that Child G might be at risk of harm. Additionally, according to the FHA IMR, staff perceived that the police were leading the investigation and as a ‘leading’ agency, they were ‘in control’. It is possible that this perception of another agency being in control diminished the organisation’s attentiveness to its own safeguarding responsibilities in respect of Child G. This was potentially compounded by the fact, identified by the FHA IMR, that safeguarding related risk was seen as the domain of a single senior manager. However, the outcome was, as its IMR acknowledges, that there was a poor strategic response in FHA to this high risk case as it developed. This has been addressed by five separate but related recommendations in the FHA review.

5.199 At around 1pm, that day, MG spoke to FH5 saying that she had not seen Child G for a few days and that she needed to be reported as missing. FH5 then consulted with FH2 and Safeguarding Lead and it was agreed that the police should be informed.

5.200 At around 2.15pm, FH5 reported that Child G was missing from the project and that she had not been there since lunchtime on 16 May 2012. He described Child G as ‘high profile’ and so it was unusual not to see her. He also confirmed that her boyfriend, BFG, was wanted by the police for alleged arson. It was noted that Child G was vulnerable and visited her mother daily. A patrol was dispatched to search Child G’s room and it was noted that her fresh shopping was still in bags. The officer also spoke to MG by telephone: she confirmed that she had not seen Child G either since 16 May 2012, but that she was ‘not overly concerned’. This is somewhat inconsistent with the reported telephone call by MG to the project earlier that day. Other enquiries and checks were also carried out, and the PNC missing person’s bureau was updated. However, there is no record that social services or Barnardo’s were informed by the police that Child G was missing.

5.201 Later, BPSW2 spoke to FH3 to follow up her earlier call about Child G. FH3 confirmed that he was in the process of completing a missing persons report and that the police were going to see MG.

5.202 In the meantime, BFG was in custody, having been arrested by British Transport Police at 9.20am. MP8 spoke to BFG at the custody suite at about 4pm, and BFG stated that he had not seen Child G for a few days. At 7.25pm, BFG was released from custody and returned to his home address with his grandparents.

5.203 Some 20 minutes after BFG was taken home, a member of the public telephoned the police to report that women’s clothing and a tent had been found in the wooded area. There was also some rope ‘as if someone had been tied up’. The Critical Incident Manager made the connection that this might be linked to Child G’s missing from home enquiry and prioritised actions accordingly.

5.204 At around 8.30pm, the police recovered items, amongst which was a handbag with a key and numbered fob on it.

5.205 At around 9.30pm, rang FH8 to let him know that ‘blood stained female clothing and a key had been found in a tent’ in the woodland. It is not known how acquired this information and she was unable to provide the name of any police officer who could confirm this. FH3 was updated with this information.
5.206 At about 11.20pm, [person] arrived back at the project and, ten minutes later, she phoned the police to see if there was any news about Child G.

5.207 At 11.40pm, police officers arrived at Child G’s accommodation and confirmed that the key fitted Child G’s lock. The police reported that BfG had been arrested and that the search for Child G was continuing. FH3 and Safeguarding Lead were updated and relevant documentation completed.

5.208 At around 1am, on 19 May 2012, police attended BfG’s grandparents’ address and conducted a search for Child G. They spoke with BfG who told them that he had not seen Child G since Monday 15 May 2012. This statement appears to have been accepted by officers.

5.209 At around 3.25pm that day, 19 May 2012, contacted the police and reported that BfG had been missing for a week and he thought he had killed a female. A patrol was dispatched immediately. BfG admitted killing Child G and was arrested. A few hours later, he pinpointed where he had buried Child G and her body was recovered by the police.

5.210 At around 8.45pm that evening, FH3 and a senior officer read on the internet that a body, possibly Child G, had been found. FH3 left a message for the safeguarding lead to contact him. At 9.50pm, having discussed the situation with Safeguarding Lead, FH3 rang EDT and discussed the situation with them. The combined chronology also indicates that FHA received information from family members, [person] At 10.45pm, all projects were informed of developments and the protocol for dealing with any enquiries.

5.211 FHA notes indicate that police notified staff that Child G’s body had been found in the early hours of 20 May 2012. One of the residents later reported that she had heard through family members that MG had identified Child G’s body.

5.212 The delay in recognising the safeguarding implications of Child G’s absence from her accommodation meant that there was no multi-agency framework in place at the time that her murder was discovered. This meant, as its IMR acknowledges, that FHA was being informed of developments by ‘gossip’ from residents and the internet and that it was these sources, rather than direct communication with the police, that mainly governed staff and internal responses.
6 The views of family members

6.18 Child G’s mother and stepfather have chosen not to contribute to this serious case review. A visit by the SCRP Chair and independent author has taken place to let them know about the review and to establish the extent to which they wish to be involved. As noted earlier, at the time of that visit, MG and SFG felt unable to participate due to the pressures of the impending trial. MG and SFG both spoke very positively of the support that they had had from the police since Child G had died, and in particular of the services provided by the family liaison officer. However, since then further opportunities have been provided but these have not been taken. Prior to the publication of the review, contact will be made again with the couple.

6.19 On 20 December 2012, the Chair of the SCRP and the independent author met with FG in the company of a supporter. FG reported that, unsurprisingly, this had been a very difficult time for him, and that it is still difficult for him to believe what has happened. FG was clear that he was Child G’s legal and biological father and he disputes any claim to paternity by SFG.

6.20 FG recalled a happy time when the children were young and the upset when his marriage came to an end. FG had little contact with the children from that point, until he re-established a relationship with BG. It was BG who re-introduced Child G to him when he came out of prison.

6.21 On the occasions that he saw Child G she always looked healthy and well-dressed to him. FG was not able to say whether Child G was happy or troubled, as she did not really let him into her thoughts. FG was aware of tensions in her relationship with SFG, but was not aware that she had made allegations that he had hit her. FG assumed that the longstanding antipathy that BG and Child G expressed about him was a consequence of their anger about the ‘split’ between MG and himself.

6.22 The main thing that FG would like to learn from the review was whether Child G could have been looked after by the local authority when she was younger: ‘put into proper care’. He would also like to know what else might have been provided to stop her ‘being left to her own devices’ as he felt that she had been.

6.23 FG was not informed about the difficulties in Child G’s life. However, he does not suggest that he could have offered to care for her. FG recognises that alcohol has played a large part in his life; he regrets this and is currently working to stay free of it.

6.24 Further contact will be made with FG prior to the publication of this report, when discussion will take place about the questions he has raised.
7 Critical analysis

7.18 Were decisions and actions taken in accordance with the policies and procedures of Wirral LSCB and own agencies?

7.1.1 Wirral LSCB has a full range of policies and procedures relating to safeguarding of children and to child protection. These are available on the internet. Discussed below are the common policies and procedures which are particularly relevant.

7.1.2 Managing Individual Cases Where there are Concerns about a Child’s Safety and Welfare

7.1.3 This covers matters such as contacts, referrals, assessments and child protection processes and plans. These procedures are consistent with Working Together to Safeguard Children 2010.

7.1.4 A significant feature of this review was the tendency on the part of children’s social care to misjudge the level of need presented by Child G, both in relation to criteria for child in need and in respect of strategy discussions/s47 enquiries. This was significant because it meant that Child G was not always being provided with integrated services at the correct level and, on occasions, she was not sufficiently safeguarded.

7.1.5 Concerns have also been raised about the comprehensiveness of assessments of need; including the absence of a core assessment when Child G had a child protection plan.

7.1.6 The effectiveness of Child G’s child protection plan and its procedural correctness are considered specifically in 7.2 and 7.5. The most significant breach of procedures, however, was that the case appeared to be managed on a duty basis, rather than by a single allocated social worker. This had a negative impact on assessments; work with the family; work with other professionals; and, taking effective measures to reduce neglect. Information provided to child protection reviews understated this issue.

7.1.7 The effectiveness of work with Child G as a child in need is also considered in detail in 7.2 and 7.5. However, at no point were child in need procedures followed correctly. Child G was often a ‘child in need’ in name only.

7.1.8 Good Practice Guidance for Working with Children and Families Affected by Substance Misuse

7.1.9 This guidance was issued in 2007, while Child G had a child protection plan. Although the document specifically includes an assessment checklist for assessing the impact of parental substance misuse on an individual child, despite the fact that alcohol abuse was considered to be a contributory factor in neglect.

7.1.10 Joint Protocol for the Management of Domestic Abuse Notification from Merseyside Police and Other Agencies

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1 This review spans a 17 year time period. Some discretion is used, therefore, to identify and analyse those decisions and actions which are significant to current practice.
7.1.11 The protocol defines domestic abuse and provides details of actions to be taken whenever there are concerns about the safety or wellbeing of children, whose parents are involved in relationships that are affected by domestic abuse. The police IMR has considered compliance with this policy in detail from a police perspective and has reasonably concluded that the policy was generally implemented according to the relevant procedures. However, the IMR has identified lessons in respect of the retrievability of documents and the timeliness of risk assessments; both of which have been addressed by recommendations. The police IMR also described occasions when risk assessments were inconsistent. Referrals were internal with notifications to children’s social care.

7.1.12 **Sexual Health Policy for Staff Working with Young People under the age of 19**

7.1.13 This policy is designed to support staff in assessing and responding appropriately to young people’s needs in respect of their sexual health. This policy is intended for use by, among others: Connexions, Learning Mentors, Social Care staff, Schools and Colleges teaching and non-teaching staff, Voluntary Organisations, Police and Criminal Justice, Community Health Workers, School Nursing and Youth Service. The date of issue is not provided. It is not possible to deduce from IMRs whether there was reference to this policy. However, although [redacted] was a source of concern for professionals, there is little evidence of a concerted plan to support and guide her, in an effort to reduce her engagement in objectively negative [redacted] relationships.

7.1.14 **Working with Young People Engaged in Sexual Activity**

7.1.15 These procedures are designed to assist those working with children and young people to identify where these relationships may be abusive so that children and young people may need the provision of protection or additional services. The procedures include specific guidance for children of different ages, to reflect differences in the law.

7.1.16 Child G was prescribed oral contraceptive when she was 13 years old (5.49). It is highly unlikely that the prescribing outcome would have been different [redacted]. However, it is clear that, under those circumstances, Child G’s needs should have been formally assessed under this procedure.

7.1.17 **Children and Families Who Go Missing/ Protocol Relating to Children Young People Who Go Missing or Run Away from Home or Care**

7.1.18 This procedure and protocol are designed to enable a consistent response to the needs of children and young people who go missing. It is expected to be followed for all children and young people under 18 years old who are missing. The protocol was updated in 2009.

7.1.19 There are references to Child G being missing on five occasions during her lifetime. These were: 15-21 August 2011; 12-13 October 2011; 22 January 2012; 20-22 February 2012; and, 18 May 2012.

7.1.20 **15-21 August 2011:** Child G was reported missing to police by SFG on 16 August 2011 as she had not returned from visiting MG in hospital the previous day (5.79-5.82). No assessment of need was undertaken by CSC following this incident, and no S47
enquiries were made to establish whether Child G had suffered, or might be at risk of significant harm, despite the circumstances in which she reported that she had gone missing and the circumstances in which she was located. No consideration was given as to whether Child G should be accommodated. This is also considered in detail in 7.2.

7.1.21 **12-13 October 2011**: Child G did not return to her address from college on 12 October 2011 and, in the early hours of 13 October, she declared herself homeless, with a friend, and they were taken to YMCA. SW2 located Child G at her friend’s address on 13 October and, as Child G was unwilling to meet that day, arranged to meet her the following day. There is no indication that SW2 spoke to Child G’s carers, because on the evening of 13 October 2011, BG and GF attended a police station and reported that Child G was missing. A police patrol found Child G at this same friend’s address that evening and she was returned to BG’s address. An automatic notification of this incident was sent to social services and Barnardo’s. BPW1 made contact with SW2 and sent details of the Missing from Home Service to Child G and MG/SFG. However, she did not make contact with Child G in person. On 17 October 2011, SW2 met with Child G in college. Details of this meeting are discussed in 7.2. Child G returned to MG’s care. The effect of this was that Child G was moved from one household where she reported feeling unsafe to the home she had previously fled. No assessment of need was undertaken.

7.1.22 **22 January 2012**: MG reported to EDT that Child G was missing, but she returned later ‘safe and well’.

7.1.23 **20-22 February 2012**: Child G left FHA with all her possessions (5.110-5.111). Police, CSC and Barnardo’s were made aware. On 22 February, Child G returned to FHA of her own accord. As noted previously, Barnardo’s missing from service did not make direct contact with Child G. Referral to another project and ‘awareness that Child G was supported by her key worker and health engagement worker’, as indicated in Barnardo’s IMR, was an inadequate response. However, the Barnardo’s IMR acknowledges that their missing from home service was not as actively involved as it should have been at this time, due to the number of notifications being received by one person. They describe this leading to an approach of letters and telephone calls as opposed to the Assertive Outreach that may have been more effective. This has been addressed in their action plan.

7.1.24 **18 May 2012**: Child G’s whereabouts had been unknown to FHA from 16 May 2012; when she had been instructed to return to her accommodation on police advice, but had not done so. FHA did not make further contact with the police when she did not return at all that day. Efforts could have been made to establish her whereabouts, and there is no doubt that steps should have been taken earlier to ensure that she was reported missing to the police. However, it appears that the significance of her ‘unusual’ absence was not recognised by staff. Events at this time are considered in detail in 6.2.

7.1.25 Although there is evidence that FHA staff responded appropriately when they realised that Child G was formally ‘missing’; the FHA IMR does not specifically address how the organisation manages ‘absence’ of children from their accommodation. This is potentially a gap as on 20 April 2012, Child G was reported to have been absent from the project for 24 hours (5.155).
7.1.26 **Children Living Away From Home**

7.1.27 This procedure is designed to ensure that children living away from home are protected. It deals specifically with private fostering arrangements. This clearly defines private foster care and describes situations which do not constitute private fostering. On that basis, the children’s social care IMR correctly identifies that, for Child G, her living arrangements may have fallen outside this procedure.

7.1.28 However, the more significant question was whether Child G was at risk of significant harm. This is discussed in 7.2.

7.1.29 **Wirral Guide to Integrated Working**

7.1.30 This is a comprehensive guide which provides information about the Team Around the Child Model within the continuum of need and includes information about how to complete a Common Assessment. This guidance was issued in September 2010. A shorter version is also available. The guidance outlines the mechanics of arrangements between partner agencies and children’s social care, through CADT, when children are the subjects of CAF or TAC.

7.1.31 The effectiveness of Team around the Child in relation to Child G is considered both in 7.2 and in 7.5. However, its implementation did not accord with procedures in terms of preparation, timescales and the involvement of others, including area teams. It is not evident that the threshold descriptors were scrutinised to determine whether CAF/TAC would be a suitable response to the complexity of Child G’s circumstances.

7.1.32 Both college and FHA relied on the advice given by CADT without recourse to arbitration by a social work manager. The social care IMR expresses the view that CADT decisions not to pass contacts forward as referrals were appropriate while Child G was living at FHA. However, these decisions appear to have been made on limited information provided in individual contacts, without enquiring about or taking account of Child G’s wider circumstances/history of involvement. It is not known what happened to the copy of the CAF provided by FHA to children’s services, with it repeated statement that ‘little was known about Child G at the project prior to her admission’.

7.1.33 **Escalation Procedure – Children’s Social Care and Other Agencies**

7.1.34 This procedure has been designed to assist all professionals working with children, young people and families who need to know what to do when they have concerns, or a disagreement about, the referral pathway for a child. It takes into account contacts and referrals to CADT and cases which have been allocated to a Lead Professional; as well as to children who are the subject of safeguarding procedures.

7.1.35 There is no indication that this procedure was used by professionals when they had clear concerns about casework management when Child G was the subject of a child protection plan, although the school nurse had been advised to consider this.

7.1.36 During the period when CAF/TAC was being planned or implemented, it is questionable whether college of FHA would have considered this procedure relevant to them, as they did not explicitly challenge the judgement of children’s services.
7.19 **Were concerns for the young person’s welfare identified? Consider whether subsequent actions accorded with procedures.**

7.2.1 This question will be considered in sections relating to periods of Child G’s life as in the narrative.

7.2.2 **From birth until school (October 1994 – September 1999)**

7.2.3 Until Child G went to nursery school, she had little contact with professionals. Health visitors succeeded in seeing Child G only 4 times, although they made many more visits. As a consequence, Child G’s developmental progress was not assessed at 3 years old.

7.2.4 Two significant episodes offered particular opportunity for health visitors to intervene positively with Child G and her parents, but neither was grasped. In addition, although HV2 informed the GP about the pattern of no access visits, there is no indication that health professionals considered this to be a potential safeguarding concern.

7.2.5 Nursery school staff identified Child G’s delayed development and they took appropriate action, although they were not able to persuade MG that there was any difficulty.

7.2.6 No professional working with Child G appears to have been aware of family problems which, with hindsight, must have existed.

7.2.7 **Primary school years (September 1999 – August 2006)**

7.2.8 In primary school, Child G’s learning difficulties and immaturity were recognised and she supported by School Action Plus. In 2006, there was an explicit allegation that she could be suffering from neglect and that domestic violence was a feature of family life. An ineffective assessment by children’ social care of Child G’s needs at that time, was a missed opportunity to have understood what family life was like for Child G and to have intervened positively on her behalf.

7.2.9 When Child G’s primary schooling was coming to an end, she was living with MG and SFG and, according to FG, was having no contact with him. Again, no professionals understood the extent of family problems that were likely to have been impacting on MG’s and SFG’s care. However, a considerable amount of information was held in agency files in respect of BG, in particular.

7.2.10 **Attending mainstream secondary school (September 2006 – August 2008)**

7.2.11 As noted earlier, the transition from primary school to mainstream secondary school exposed many of Child G’s vulnerabilities; she struggled to concentrate in class and her behaviour ‘off-task’ was considered to be emotionally driven by a need to secure attention. School1 identified a range of problems at home which they believed were contributing to Child G’s problems in school and also suggested the possibility that Child G might have ADHD.

7.2.12 School1 initiated ‘Child Concern’ meetings but Child G’s behaviour continued to deteriorate and she was excluded from school for a period. Efforts to engage CAMHS with the family were unsuccessful, for reasons already given.
7.2.13 A crisis arose at the beginning of May 2007, when MG went into hospital for a 6-week course of treatment (5.27-5.33). Concerns were expressed that Child G was being physically and emotionally neglected at home; there were outstanding allegations by Child G about SFG’s care; and, SG had alleged that Child G had injured her daughter.

7.2.14 This review considers that Child G should have been offered a period of accommodation at this time, to allow a more comprehensive assessment of her family circumstances to have taken place.

7.2.15 Child G was made the subject of a child protection plan from June 2007, although there were clear indications that MG and SFG would be unwilling to work with professionals.

7.2.16 Within children’s social care, Child G’s plan appears to have been managed on a duty basis, with the resulting lack of continuity and drive. Assessments were incomplete, no child protection plan was written and such core group meetings as took place were not recorded by means of a single agreed report. New information was not adequately evaluated and there was insufficient rigour in assessing progress. Such changes as were taking place in relation to Child G’s behaviours at school appear to have been attributable primarily to the additional support that was provided for her while she awaited a placement at School2.

7.2.17 Individual professionals in the core group expressed frustration and dissatisfaction about gaps in the process but there was little effective challenge. Case management in children’s social care was poor and there was insufficient scrutiny and vigour brought to the role of conference chair. The child protection plan ended a month before Child G went to her new school.

7.2.18 In September 2007, the statutory assessment of Child G’s special educational needs was concluded. As noted previously, the educational psychologist’s report which provided a clear account of Child G’s needs, characteristics and behaviours did not inform work in child protection.

7.2.19 Attending secondary special school (September 2008 – end July 2011)

7.2.20 After quite a bumpy start, the years that Child G attended special secondary school were a time of relative calm. She was diagnosed as having ADHD: she was prescribed medication which appears to have contributed to her improved behaviour in school. There were concerns about her being [redacted] However, there appears to have been little specific assistance offered to her in terms of sexual health and relationship counselling. No further concerns were expressed in school about this, although this may have continued to be a feature of Child G’s life outside.

7.2.21 During the early months of her last year at school, the instability of Child G’s home life again became apparent: there was evidence of MG’s alcohol misuse and conflict between Child G and MG. In January 2011, an initial assessment was undertaken by CSC and it was recommended that a child in need plan be established. However, no further action was taken and this was clearly a missed opportunity to work with Child G and family.

7.2.22 Significantly, Child G’s relationship with BfG was also latterly disclosed to the Youth Offending Service, but there was limited exploration of the risk that BfG might pose to Child G.
7.2.23 Starting college and living independently (August 2011 – 13 May 2012)

7.2.24 This nine-month period was a difficult time for Child G. She had just left school and, in the month prior to her starting at college, a number of factors combined to place her in a very vulnerable situation. Child G was living apart from MG and SFG in a friend’s household (TC). Child G had been found at this address, after having been missing for a week. The reason Child G gave for leaving home to both the police and to children’s social care was that SFG had assaulted her.

7.2.25 However, there was no recognition in either agency that there should have been a strategy discussion to determine whether a child protection investigation should be undertaken. The police officers who interviewed Child G concluded that Child G did not want to make a complaint and they did not make a referral to FCIU. The focus for children’s social care appears to have been on consolidating Child G’s living arrangements, possibly by means of a private fostering arrangement, rather than on exploring her allegation against her step-father, or in considering whether she should have been looked after.

7.2.26 Child G started college in September 2011 and, although there were problems from the beginning, it appears that this was a positive experience for Child G. The college provided additional resources to support her, including paying for her lunch when she appeared to have no money.

7.2.27 In October 2011, Child G’s living arrangements with TC broke down and she became homeless. This is discussed in 7.1.21. Child G went back to live with MG and SFG.

7.2.28 Although for a brief period, Child G appeared to be happier to be there, the move back brought little positive change in terms of Child G’s presentation in college or her behaviours towards other students and staff. In November 2011, the need for a new assessment and child in need plan was highlight by case file audit in CSC. However, these actions were not implemented.

7.2.29 At a professionals’ meeting in December 2011, Child G’s [redacted] with boyfriends (including the role that alcohol played in this and her repeated concerns [redacted]) remained a concern for professionals as did her poor diet; her limited capacity to care for herself; and her ‘fluctuating self-esteem’, including reported episodes of self-harm. However, CSC closed the case in January 2012 and the proposed follow-up meeting was cancelled. This was the last time that Child G had an allocated social worker, although her circumstances deteriorated considerably over the following months.

7.2.30 Then, in January 2012, as the possibility of MG going into hospital again emerged, the stresses inherent in the family home were further exposed until relationships broke down completely. At the same time, the college reached the conclusion that Child G would not be able to progress to the next stage of her course. This provoked a catastrophic reaction in Child G whose behaviour on campus became uncontrollable, to the extent that she was eventually arrested by police and removed from site.

7.2.31 Child G was now in a state of crisis and, already vulnerable to dangerous relationships, a significant threat to her safety came in the form of her ‘association with’ XBFG who was...
an offender, being managed through MAPPA. As in her relationship with BfG, however, the extent of the risk posed to Child G by XBFG was not explored.

7.2.32 By February 2012, Child G was both out of college and out of her family home. In this situation, Child G was lacking the cornerstones on which a young person’s transition from childhood to adulthood is built. She is likely to have felt unloved and uncared for, with no sense of the continuity that derives from permanent key relationships, even when physically apart from those important people. Her confidence in her own abilities, which had been growing during her school years, must have been crushed. In addition, Child G’s capacity to deal with difficult feelings and practical problems would have been significantly reduced by her learning difficulties and the parental neglect she had already experienced. However, the extent and complexities of her vulnerability appears not to have been recognised by professionals. This is a significant theme in this review.

7.2.33 Child G moved into specialist accommodation, in a complex of three blocks providing self-contained, semi-independent, single person units for up to sixty-three young people aged 16-25 years old. From the beginning of her stay in this unit, concerns were expressed about whether Child G was correctly placed there and the possibility of placement in a smaller, more supported environment was mooted. However, events and Child G’s own ambivalence delayed progress in this regard, so that such a move never took place.

7.2.34 From February until May 2012, Child G remained in the same flat. Considerable efforts were made by the unit staff to meet Child G’s needs either through the housing association’s own resources or by referral to external agencies and organisations. However, as the combined chronology reveals, Child G’s difficulties were wide-ranging and complex, leading to almost daily challenges to staff resources.

7.2.35 Child G’s relationships with friends and other residents were often fraught and erupted, at times, into physical conflict. Relationships with boys could be particularly problematic, in that they were often short-lived and were additionally characterised by naïve expectation, over-involvement and ‘drama’; including suspected and reported threats either of self-harm by them or of violence towards Child G. During the time that Child G was living in the project, for example, she made two related complaints of assault/breach of bail conditions against former residents; an unsubstantiated complaint of assault against GF; and, three uncorroborated complaints of threat of violence from XBFG2. However, despite her reports about their behaviours, Child G persisted in having contact with some of these individuals and, on one occasion, she was found to be perpetuating conflict with XBFG2, following him out of the project ‘with a knife’.

7.2.36 Alcohol both fuelled conflict with others and increased her vulnerability to exploitation, while at the same time it diverted her energies and funds from more beneficial activities. In March 2012, Child G was arrested three times to avoid further breaches of the peace due to her abusive behaviours when drunk. Child G also appears to have experimented with some illegal drug-taking.

7.2.37 In addition to her learning difficulties, Child G suffered a number of health-related problems during this period. Previously diagnosed as suffering from ADHD and having her symptoms tempered by medication, Child G experienced loss of ability to
concentrate and her behaviours appear to have become more erratic and uncontrolled. An infestation of scabies must have been uncomfortable for Child G as well as creating a barrier to other services being provided for her while it remained untreated. Child G also began to fear for her own health and, from the end of February until the middle of April 2012, she had seven presentations at Adult AED, attending on each occasion in the evening or during the night, often with similar concerns. Child G described herself in April 2012, as ‘lonely and angry’.

7.2.38 Although Child G appears to have placed value on education, she was unable to re-establish a pattern of formal learning or training during this time; despite efforts on her part to enrol on courses.

7.2.39 In the last month of her life, Child G had re-established her relationship with BfG.

7.2.40 Throughout this nine month period, Child G was known to a large number of professionals in a variety of agencies and organisations. These included YOT worker; three allocated social workers, CADT and EDT; a number of police officers and community support officer; support/advocacy through WIRED; project workers from Barnardo’s; members of the Respect Panel; college learning mentor, personal tutor and safeguarding officer; her GP practice; housing support workers from Response; three Connexions advisors; CPN and CAMHS worker; staff in AED; and, a range of FHA workers including key worker, health worker, project manager and alcohol misuse specialist. However, their work was not underpinned by a comprehensive assessment of Child G’s needs; it was not coordinated by means of a multi-agency plan; and, there was a distinct absence of a designated lead professional to help deliver effective, integrated support. This too is a significant theme of this review.

7.2.41 Staff at FHA also identified concerns about Child G’s compliance with medical treatments, including for ADHD; about her absence from education; and, about her misuse of alcohol; all in addition to recording individual incidents where Child G had been exposed to, or had created, a risk for others. The organisation made a significant number of internal and external referrals and requests for advice or support, including to CADT. They also attempted to facilitate contact between Child G and other professionals. However, service response was fragmented, did not generally succeed in engaging Child G, and was mostly ineffective. In addition, they undertook a CAF and set up a TAC. This is discussed in 7.5.

7.2.42 However, by the end of this period in the review, little progress had been made in securing Child G alternative accommodation. In addition, Child G had dropped out of alcohol counselling. She had also been discharged by the Respect Panel, despite the fact that a proposed Anti-Social Behaviour Case Conference had not taken place. ASBT2 and PCSTO attempted to meet with Child G but they had not made direct contact with her to arrange the meeting and consequently Child G was not at FHA when they arrived. Child G was not in education, training or employment, although it appears that a course had been identified for September 2012. Child G had met once with Barnardo’s project worker and she had had one appointment with CPN. A referral had been accepted by 16-19 CAMHS but she was not due to be seen until 28 May 2012, when diagnosis and treatment for ADHD was to be reviewed.
7.2.43 The days leading up to Child G’s death (13 May 2012 – 19 May 2012)

7.2.44 Child G had become aware that BfG had been involved in an offence of arson at the flat belonging to his sister’s ex-boyfriend. Although she stated to the police that she did not know why he had done this, it is likely that Child G was aware of some of the background which led to this attack. Child G had spoken directly to Sbfg and, in addition, both she and BfG were part of a larger friendship group which included BG and GF. BfG’s offence and ‘being on the run from the police’ is almost certain to have been a significant topic of discussion among them. It was clearly on Child G’s mind when she was in her accommodation.

7.2.45 In many ways, Child G’s relationship with BfG From Child G’s perspective, it must have appeared intense and dramatic, while at the same time, to an outsider, she was over-investing in a relationship with someone who did not care for her and who was exploiting her sexually. However, the dramatic attraction that BfG held for Child G would surely have increased considerably as she became more involved with his evasion of the police and her naively ambiguous part in his pursuit. Child G was not insightful about relationships and her vulnerability to damaging relationships is likely to have been increased by her youth, by the nature of her learning difficulties and by the emotional deprivation of her family life. There is no evidence that Child G had an established relationship with a dependable, trusted adult in whom she could confide and who could offer her reliable advice, guidance and unconditional support. Child G was exposed to danger, therefore, as her tendency to follow her impulses was ill-restrained by internal qualms or, at that point, by external controls.

7.2.46 Child G’s vulnerabilities were not immediately obvious, however, and there is evidence that she could give the impression of being more able than she actually was. This could be seen in her dealings with the police. Although they had been warned about her unreliability as a witness, it is doubtful that they appreciated the extent of her tendency to embellish the truth or would have understood her complex motivations for doing so. It appears, therefore, that the disparity between how officers perceived Child G and the reality of her circumstances meant that she was able to slip through the safeguards they put in place for her. It has been recognised that Child G should have been identified as a vulnerable witness. However, this would not, of itself, have afforded her greater protection during this time.

7.2.47 A simple phone call, or a series of phone calls, between FHA and the police would have led to earlier recognition that Child G was missing and to more speedy efforts to find her. This was a significant omission which has only been partly explained. However, it is highly unlikely that earlier recognition that Child G was missing could have prevented her death.

7.2.48 It is not known to what extent BfG’s general dangerousness was understood, or could have been understood, by professionals working with him: as noted earlier, that issue is currently being reviewed by Wirral LSCB and its partner agencies. However, it is evident to this review, that the particular circumstances that led to BfG killing Child G, in the way that he did, could not have reasonably been foreseen by the professionals working with Child G during this period.
7.20 Consider the nature of the relationship between Child G and the perpetrator and the extent to which this was mutual and consenting

7.3.1 The nature of the relationship between Child G and BfG was not understood. Professionals were unaware of the level of danger that BfG posed to Child G.

7.3.2 Concerns had been expressed about Child G’s [redacted] and most professionals working with her during the last year of her life, were aware that she was [redacted] vulnerable.

7.3.3 In terms of her relationship with BfG, specifically, other professionals had information about him; including YOS, children’s social care and Barnardo’s. However, it appears that those working with Child G were generally unaware of the potential significance of this: either because they had no suspicion that BfG would hurt Child G or because they did not know that the young people were in a relationship.

7.3.4 The exception to this was in July 2011 when youth offending workers made the connection between Child G and BfG and the issue was raised as to whether Child G would be at risk from him. Unfortunately, information about the alleged offence was provided from a line manager’s memory. Although there was some discussion with the case manager on his return from leave, it appears that there was no specific corroboration of the information provided by YOT1’s line manager. The IYSS IMR acknowledges that; ‘all records held, supplemented by personal knowledge and professional opinion, should have informed a comprehensive assessment of any risk posed to Child G’. However, this did not happen. No targeted work was undertaken with Child G in respect of her relationship with BfG, possibly as a result of this omission. It is crucial that the missed opportunity to undertake a risk assessment is dealt with in the case review of BfG.

7.3.5 It should be noted, however, that Child G had at least two other relationships that were either volatile or potentially dangerous. The first of these was with XBF2 who was subject to MAPPA. In that case, no exploration of this relationship was made beyond identifying that Child G was associating with him. The second relationship was with XBF2. Child G made three separate reports to the police about XBF2 threatening her with violence and, on another occasion, she was observed fuelling an argument with him.

7.3.6 Concerns about this relationship led to FHA making a referral to their Health Education Team for advice and guidance [redacted], as well as to agreeing to a referral to Barnardo’s. However, it has been noted that despite her own reported fears about XBF2, Child G continued to pursue and, according to XBF2, to ‘harass him’. The police did not interview XBF2 in respect of Child G’s complaints and, although on one occasion, notification was sent to FCIU, no further action was taken.

7.3.7 Although Child G could legally consent to having a sexual relationship with BfG in the last months of her life, it is suggested that, in reality, Child G had limited capacity to make what could be described as a psychologically ‘mutual and consenting’ relationship.
7.21 **Consider the recognition of Child G’s needs, particularly with respect to learning difficulties. How were they identified through inter-agency and single-agency assessments?**

7.4.1 Child G’s needs and the extent to which they were understood are discussed in detail in 7.2. Child G’s formal learning needs were identified while she has at school and she was made the subject of a statement of SEN. As a consequence, Child G was provided with dedicated support in mainstream and was provided with a place in specialist school from September 2008 - July 2011.

7.4.2 However, as noted in 7.2, it is evident that Child G’s presentation could be deceptive and the extent of her learning difficulties was not immediately apparent. Her ‘bubbly’ personality seems to have disguised her developmental impairment, particularly on early acquaintance with her. However, without having an understanding of her learning difficulties, it would be difficult to make sense of some of her behaviours and ‘lie-telling’. This was evident in her encounters with a number of professionals in a variety of settings; including with police officers; social workers; medical/AED staff; and, housing support workers.

7.4.3 Throughout her involvement with children’s social care, only three initial assessments were completed. No core assessment was completed, despite the fact that she was the subject of a child protection plan for a year. The children’s social care IMR reports that of three initial assessments completed, two were superficial and ‘did not really identify that she had a learning difficulty’.

7.4.4 The absence of comprehensiveness of assessment was compounded by the lack of a consistent lead professional who really knew Child G and who could have advocated on her behalf. Many of the referrals that were made for support for Child G showed little understanding of the impact that learning difficulties had on Child G’s functioning.

7.4.5 The Health Overview Report considers in detail how Child G’s additional needs due to her learning disability were taken into account when she accessed health services, from birth until she was 17 years old and identifies a number of gaps; including work that might have been done with parents. However, the report particularly focusses on Child G’s attendance at AED in the last six months of her life. It identifies that Child G should have been recognised as a vulnerable young person and that referrals should have been made to the children’s liaison manager who provides a link to children’s services. This has been addressed by a training recommendation in the WUTH Paediatric IMR. It also underpins a recommendation that WUTH complete its business case for 24 hour opening of the Children’s AED.

7.4.6 The health overview report refers also to a toolkit that has been developed to provide clear guidelines to staff involved in providing services to patients with learning disabilities: a recommendation has been included by the Trust to ensure that this practice is audited.

7.22 **Consider the effectiveness of single and multi-agency plans and whether they met the outcomes, stated or expected**

7.5.1 Child G was the subject of a number of plans during her lifetime, as a result of concerns about her well-being, behaviours or safety. These were:
a) Child Concern Plan (December 2006 – June 2007)


c) Child in Need Plan (July 2008 – May 2009)

d) Child in Need Plan recommended January 2011 (not developed, although case remained open to children’s social care until January 2012)

e) Respect Panel/Anti-social Behaviour Team - Challenge and Support (May 2011 –September 2011)

f) Team Around the Student (January 2012)

g) Respect Panel/Anti-social Behaviour Team - Challenge and Support (February 2012 – May 2012)

h) Team Around the Child (March 2012 - )

i) Plans to support Child G’s learning

7.5.2 Child Concern Plan (December 2006 – June 2007)

Child G became the subject of Child Concern in December 2006, near the end of her first term in School1. This followed a referral to children’s social care in November 2006. In total, there were three child concern meetings in respect of Child G. Although there were issues in respect of Child G’s family life, it appears that Child G’s needs were considered, at this stage, to be school-related. Wirral Council supported these Child Concern Meetings, where necessary, through the services of its Area Social Workers. These social workers were not case-holding, but had a generally advisory role particularly with schools. This is somewhat at odds with what happened in this case, as Child G seems to have been allocated to SW13. It should be noted, however, that, according to the children’s social care IMR, procedures governing this process had been relatively recently published (September 2006) and the model was not consistently understood or implemented.

7.5.3 By the time of the second meeting, in February 2007 concerns about Child G’s welfare had increased rather than diminished. Nevertheless, SW13 ended her involvement in March 2007, ‘as things seemed to have improved at home’ and MG ‘did not think that there was a role for social care’.

7.5.4 At the end of April 2007, it appeared that Child G would not be adequately cared for when MG went into hospital. However, CSC resisted increasing its level of involvement. Then, in the middle of May 2007, a crisis had developed in that Child G had nowhere to live. Child G also reported feeling scared at home when her mother was in hospital and alleged that SFG had ‘shouted at her and hit her across the face and head’. As noted earlier, the case had clearly moved across the continuum of need to Level 4, but this was not recognised by children’s social care.

7.5.5 A third ‘child concern meeting’ was held in June 2007. However, this was essentially a misnomer; given that children’s social care appears to have taken the lead in organising the meeting and no representative from the school was able to attend, as it was half-
term. The meeting also discussed the possibility of Child G becoming either looked after or becoming the subject of a child protection plan.

7.5.7 The child concern model was not effective in this case as Child G’s needs were more complex than could be managed by a single agency, even with support. It appears that the school realised this more quickly than did children’s social care.

7.5.8 Child Protection Plan (June 2007 – July 2008)

7.5.9 Child G became the subject of a child protection plan in June 2007, when she was 12 years old. There is no evidence that the plan brought about any changes in Child G’s family life. No detailed child protection plan was developed during this time and social work contact with Child G and her parents was negligible. In the course of thirteen months, Child G was seen on her own by a social worker on four occasions. There was no attempt by a social worker to form a relationship with Child G. It is not surprising, therefore, that her views, wishes and feelings were consistently unrepresented throughout the child protection process. Medical needs were identified and acted on by professionals, but there was no follow-up with parents when appointments were missed. There is no evidence that Child G visited a dentist during the time that she had a child protection plan, despite the absence of dental care being identified as an issue at the ICPC.

7.5.10 However, throughout the time that Child G had a child protection plan, she was also engaged in activities during evenings and at weekends through the Junior Youth Inclusion Programme (JYIP). The purpose of this programme was to help reduce the likelihood of Child G engaging in offending behaviours. Child G appears to have enjoyed these activities and to have benefitted from them; as she did from her involvement with a local children’s centre. However, there is no evidence of a purposeful link between these activities and the child protection process.

7.5.11 Child in Need Plan (July 2008 – May 2009)

7.5.12 Child G’s child protection plan ended just before she transferred to School2 and it was recommended that a Child in Need Plan be drawn up. At this point, Child G was thirteen years old. This did not happen. Child G did not immediately settle in School2 and there was some limited contact between school and children’s social care. One Child in Need meeting took place in January 2009 at which issues were raised about Child G’s reportedly [redacted]. However, no clear action plan resulted from this meeting.

7.5.13 A further meeting arranged for a month later was cancelled, without explanation, on the day.

7.5.14 There are discrepancies in the records of agencies about whether a further review meeting took place on 2 March 2009: it is recorded only on the children’s social care chronology. Children’s social care ended its involvement formally on 5 May 2009, although this fact was not conveyed adequately to other professionals and family members. There was insufficient management oversight of the case within the agency, both while it was allocated and on closure.
7.5.15 This Child In Need plan essentially existed in name only. It was not developed as a working document; Child G and her family were not engaged in the process; and, there were no effective outputs.

7.5.16 Child in Need Plan recommended January 2011 (case open to children’s social care until January 2012)

7.5.17 The involvement of children’s social care began again following an incident between MG and Child G, which led to Child G being ‘thrown out’ and going to live with at a friend’s house for a few days. An initial assessment was completed and, among other proposals, it was recommended that a child in need plan be set ‘to safeguard Child G’s welfare, to prevent family breakdown and the need for Child G to be accommodated’. However, recommendations of the assessment were not implemented and no explanation has been provided for this.

7.5.18 In May 2011, the Education chronology refers to another allegation by Child G that she had been physically assaulted by SFG and notes that unsuccessful attempts were made by School2 to report this to children’s social care. Failure to investigate Child G’s allegation was a clear omission and School2 should have escalated the matter when it became apparent that no action was being taken.

7.5.19 Also in May 2011, the IYSS IMR refers to an agreement by email that ASBT1 would be invited to ‘the first Child in Need meeting’. However, there is no indication that a Child in Need meeting followed.

7.5.20 According to the children’s social care IMR, PM1 became involved in July 2011 and she asked for checks to be made to ascertain whether Child G was still a child in need, ‘given the drift and there having been no active social care involvement’ for the previous 6 months. The IMR acknowledges the inadequacy of this response.

7.5.21 At around the same time, there was communication between YOS and children’s social care about Child G’s ‘peer relationships and vulnerability’. A joint visit was arranged, although this had to be delayed due to annual leave arrangements.

7.5.22 The week before this visit was due to take place, Child G went missing. She was located at a friend’s home on 21 August 2011. On 22 August, both social worker and YOT1 visited her there. This has been discussed in 7.1. The children’s social care IMR acknowledges that there was no management oversight of the incident; due to lack of clarity about which of two managers (PMSW and PM1) should have been responsible. Child G remained a ‘child in need’ although there was no multi-agency plan or review framework in place.

7.5.23 Casework responsibility was transferred within children’s social care specifically to undertake a private fostering assessment, although Child G’s ‘child in need status’ remained. However, there was confusion about whether such an assessment was required and, in the end, none was completed. Child G’s living arrangements came to an end when she declared herself homeless in October 2011. However, the impetus for children’s social care appears to have been to ‘put a roof over Child G’s head’ rather than considering whether the local authority might have other duties towards Child G, as a child in need of services or safeguarding. As noted earlier, this led to Child G being reunited with MG and SFG when she retracted her allegation of abuse against SFG.
7.5.24 In November 2011, as noted earlier, instructions made by PMSW to increase involvement were not carried out and in January 2012, children’s social care closed the case. This decision was made by PM1 and again highlights the confusion that appeared to exist about which manager was making decisions in this case.

7.5.25 Although Child G was ostensibly a ‘child in need’ throughout this period, she did not receive services commensurate with that status. She did not have a child in need plan; there was no active, purposeful multi-agency working; and, there were missed opportunities to safeguard her. There was insufficient knowledge of Child G’s needs and no significant efforts were made to assess them.

7.5.26 Respect Panel/Anti-social Behaviour Team -Challenge and Support (May 2011 – September 2011)

7.5.27 For a period, during the time that Child G had an allocated social worker, she was also known to the Anti-Social Behaviour Team through its Challenge and Support Project. YOT1 had limited contact with Child G and family members: Child G’s first session took place on 26 July 2011 when an ONSET assessment and intervention plan was drawn up; two further one-to-one sessions took place on 1 and 8 August 2011; a joint visit took place with SW1 on 22 August as noted above; and, a final session took place on 2 September 2011. Child G agreed to a referral to WIRED at that point. From IYSS point of view, this intervention was considered successful as Child G was considered to have a better understanding of anti-social behaviour and its consequences.

7.5.28 In addition to personal contact, YOT1 identified potential concerns about the relationship between Child G and BfG, although the details of the evaluation of the risk that he posed are not clearly laid out. YOT1 also made consistent efforts to work with other professionals on Child G’s behalf.

7.5.29 Team Around the Student (January 2012)

7.5.30 Within three weeks of children’s social care ending its involvement with Child G in January 2012, the college safeguarding manager was informed by CADT that MG had been in touch with EDT to state that she was unable to cope with Child G’s behaviour and that Child G had ‘temporarily gone missing’ over the weekend. Child G reported that she was now living in Chester with a ‘brother’. The college understood that children’s social care would not be re-opening the case.

7.5.31 On 26 January 2012, the college set up a ‘Team Around the Student’, which is an internal structured approach to young people at Level 2 on the continuum of need. However, it was evident that Child G’s needs were more complex than this and it was agreed that the response should be increased to ‘Team Around the Child’. However, when Child G was excluded from campus a few days later, college was no longer in a position to act as lead agency. However, this appears not made explicit to children’s social care as CADT continued to suggest that college should set up a TAC. The college made efforts to resolve the issue of lead agency with Connexions, but this was unsuccessful. The task then effectively lapsed rather than being handed over to another agency to complete.
7.5.32 As indicated, Child G’s needs were now greater than they had been when she had had an allocated social worker at the beginning of the month. She was now of college and, a week later, was being provided with homeless accommodation.

7.5.33 Respect Panel/Anti-social Behaviour Team - Challenge and Support (February 2012 – May 2012)

7.5.34 Child G was again referred into the Challenge and Support project following her arrest on college grounds. However, by this time, Child G was living at FHA. There were a number of failed visits to Child G and a proposal, at one point, that an Anti-social Behaviour Case Conference might be required. However, no intervention was provided. The case was closed to the Anti-social Behaviour Team.

7.5.35 There was no purposeful work with Child G as a result of this plan and the anti-social behaviour plan appears to have had minimal formal links, at the level of the child, with services being provided by other agencies.

7.5.36 Team Around the Child (March 2012 - )

7.5.37 When Child G became a resident in FHA accommodation, her capabilities had been overestimated and the level of support that she required had been underestimated. Within three weeks of Child G arriving at FHA, it had become apparent that FHA could not support Child G solely from its own resources. There concerns were brought to a critical point when Child G went missing, at a time when both MG and SFG were reported to be in hospital. As noted earlier, it is not clear why Barnardo’s missing from home service was not more actively involved at this time.

7.5.38 FHA sought advice from CADT and it was recommended that FHA undertake a CAF and set up a TAC for Child G. FHA agreed to undertake the task of completing a CAF and establishing a TAC, although there were indications that Child G’s needs were at Level 4.

7.5.39 The CAF process was not completed until almost 2 months after Child G had arrived at FHA, when further concerns had developed. It was not effective in assessing Child G’s needs and the resulting TAC was unsatisfactory.

7.5.40 Plans to support Child G’s learning

7.5.41 Throughout her life, Child G had a number of plans to support her learning, including a statement of special educational needs. This meant that, despite her learning difficulties and behavioural problems, Child G was supported successfully to complete her secondary education. Child G also had a learning support plan while she was at college. This was successful in the sense that it allowed her to complete the qualification she had enrolled on.

7.5.42 However, Child G’s behaviour both affected her progress in college and was affected by the decision that she could not continue on the course of her choice. Nevertheless, it is unlikely that alternative strategies in her learning support plan would have had a different outcome.

7.6 Consider Child G’s transition journey from school to services, post-16
7.6.1 As noted earlier, Child G’s transition from school to post-16 services was likely to be hazardous as she adjusted from the closed, nurturing environment of school to the more open conditions of college, where greater demands would be made on capacity to direct her own learning and to control her behaviours. However, it appears that Child G was looking forward to college and professionals supported this educational transition appropriately.

7.6.2 Unfortunately, Child G’s school health records were retained in school and there was no formal procedure for transferring health care, in these circumstances, to the appropriate medical service. This has been addressed by a recommendation in this review. However, for Child G it meant that she came adrift from paediatric oversight of the management of her ADHD. Her compliance with medication then reduced and she herself recognised that her ability to concentrate and to conform was severely affected. A formal review of her treatment had been arranged through CAMHS 16-19 Service, but this was not achieved prior to Child G’s death.

7.6.3 Fundamental to managing change successfully is that not too much change is required at the one time. For young people, leaving school and going on to college; the continuity of home life is often a key stabilising factor in their successful transition. Child G did not have that advantage. This meant that the transition to college was going to be especially difficult for her.

7.6.4 Then, almost simultaneously, there were crises in both college and at home. It was at this point that Child G became homeless and NEET. However, despite her history and the complexities of her needs, no consideration was given to accommodating Child G under S20 of the Children Act 1989. This was an omission, as the Southwark Judgement (2009) is considered to have realigned the housing responsibilities for homeless 16 and 17 year olds. It clarifies that the Children Act 1989 has primacy over the Housing Act in providing for children in need, and that children’s social care cannot circumvent its duties by referring to the housing authority. This judgement appears to anticipate that when any homeless 16 or 17 year old is assessed as requiring accommodation, it is highly likely that they will meet the criteria for S20 accommodation and so should become looked after, with all that that entails. It is likely to have applied to Child G.

7.7 Consider whether agencies established and took into account the family’s specific cultural, racial, linguistic and religious needs, when delivering services

7.7.1 Child G was a white girl, born locally into an English speaking family. Most agencies contributing to this review systematically recorded information relating to gender, ethnicity and language. However, not all agencies collect information relating to religion as a matter of course. A number of agencies have referred to their equality and diversity polices and training. As noted above, the exactness of information relating to Child G’s learning difficulties and their impact on her abilities was generally poor. The police did take note of Child G’s ‘special needs’ and provided evidence of how this was taken into account on some occasions.

7.7.2 Issues relating to class, culture and disadvantage have not generally been reflected in the recordings made by agencies. However, these factors are likely to have had an impact on MG’s and SFG’s willingness to work openly with professionals and on the likelihood that professionals, in turn, would be able to influence their beliefs and behaviours.
7.8 Consider the extent to which agencies shared information on needs and risks

7.8.1 This is considered implicitly throughout this critical analysis, but most particularly in 1.1, 1.2 and 1.5.

7.8.2 The quality of information-sharing between professionals was variable. There were examples both of good information-sharing and of omissions. Most sharing of information in respect of needs and risks took place by telephone or in multi-agency meetings. However, the combined chronology cites a significant number of occasions when telephone messages appear not been passed on or when requests for return calls have not been answered. This is particularly true in relation to contact with children’s social care.

7.8.3 The quality of recording of information which was shared was also extremely variable, so that there were often quite different versions of the same communication or meetings held on individual agency records. The absence of single agreed records of core group meetings, child concern meetings or TAC meetings was particularly conspicuous. This meant that there was often no consistent record of discussion or agreed actions, which must have been problematic for individual practitioners and managers as well as making it difficult to develop an organisational or multi-agency overview of incidents, opinions and decisions.

7.8.4 Accurate recording can feel like an administrative burden when events are fresh in a practitioner’s mind. However, the importance of recording incidents, issues and concerns over time has been identified consistently in serious case reviews. For example, in Ofsted’s Learning Lessons Taking Action (2008), it was noted that poor record keeping was a particular failing in 33 out of 50 serious case reviews analysed.

7.8.5 Although considered elsewhere in this critical analysis, the failure to recognise when strategy discussions were required led to missed opportunities to share information about needs and risks in a way that would have contributed to better safeguarding decisions being made. Better multi-agency assessments and plans, with clearer expectations of ‘the lead professional’ could have provided a sharper focus for practitioners, reduced duplication of effort and contributed to safer practice.

7.8.6 The Health Overview Report specifically considers communication between health professionals. In addition to issues identified elsewhere, the Health Overview Report reflects on communication with GPs. It notes that that communication tended to be to the GP in the form of a letter, with minimal evidence of communication from the GP to other health professionals. This is identified as a threat to establishing and maintaining effective working relationships with other health staff who are working with children and families about whom there are concerns. The report addresses this issue by means of recommendation for the NHS Wirral Commissioning Group.

7.8.7 The Health Overview Report also considers the importance of taking action in respect of information received, particularly in relation to no access visits or failed appointments, as this was a feature of all individual health IMRs. Action required in these circumstances is already set out in local policy and standards. The Health Overview Report makes a recommendation for audit of practice against the standard and evaluation of outcomes.
7.9 Consider whether Child G’s wishes and feelings were ascertained, properly recorded and taken into account when decisions were made by agencies.

7.9.1 Child G’s wishes and feelings were not frequently represented in agency records and no single agency IMR provided a fully rounded picture of Child G as a person. This was partly a consequence of the limited contact that professionals often had with her, but was also due to her effective absence from a number of the processes in which her needs were assessed or decisions were made about her.

7.9.2 When Child G had a child protection plan, she was not seen frequently enough and, as a consequence, no relationship was developed with her which would have assisted her to talk about her family life.

7.9.3 Child G’s reports about events in her life were not explored in sufficient depth or with sufficient sensitivity to her learning difficulties. Child G made a number of allegations that were not investigated and reported a number of threats of violence to the police that led to no further action. Although it is not recorded that professionals disbelieved Child G on these occasions, there are references by a social worker and by police to Child G’s ‘smirking’ demeanour, when these matters were being discussed with her. There is a possibility that not all that Child G reported was true, but this should have been more fully explored. Efforts were made to give Child G this opportunity through Barnardo’s project, but, for reasons already discussed, this had not been realised.

7.9.4 Child G’s feelings about the possibility of being looked after were not sought and Child G was not adequately consulted prior to her moving into FHA.

7.9.5 Despite this, however, there is evidence that individual professionals were able to engage with Child G at different times during her life or to work, with, effort on her behalf. These include members of staff at Schools 1 and 2; school nurses; members of college staff; JYIP2; YOT1; and, members of staff at FHA.

7.9.6 In discussion, School2 was able to provide a very full picture of the child that they knew in school. This was made possible by the persistence of staff in building relationships with Child G over time. They were able to provide an environment where she had structured days; was rewarded for effort; and, offered choices she could manage. Nevertheless, School2 recognises that the picture that they had of Child G was not complete, as there were gaps in their knowledge about what was happening outside school and in her home life.
8 Consideration of Individual Management Review reports

8.18 This overview report has been informed by information provided by agencies and organisations through Individual Management Reviews. The extent to which IMRs have met their specific requirements has been variable. Each non-health IMR and the health overview report are considered below.

8.19 Police IMR

8.20 The draft and final versions of the police IMR were provided in a timely manner. The author had no operational responsibility for decisions and actions relating to Child G. The narrative is clear and comprehensive: it comments specifically on five pertinent policy areas. A full analysis of agency practice is provided under the agreed terms of reference. Lessons learnt are consistent with this analysis. Lessons related to inconsistencies in the conduct and timeliness of risk assessments; timeliness of notifications to other agencies when a child is missing and the robustness of response when that child is found; and, policy/procedural gaps in respect of vulnerable and intimidated witnesses. The police review has resulted in 13 recommendations. These are outlined in Section 10. An action plan has been provided. The police were consistently represented on the SCRP.

8.21 Forum Housing Association

8.22 The draft and final versions of FHA IMR were provided in a timely manner, given the revised timetable. The author is employed by Barnardo's and was commissioned by FHA: he had had, therefore, no prior knowledge or responsibility for Child G. The IMR provides a concise narrative of incidents and events relating to Child G. The analysis is thoughtful and is conducted in accordance with the terms of reference. Lessons for the agency relate to internal case management, including recording; risk management systems; multi-agency working practices; and audit and evaluation processes. This learning is addressed by 4 broad recommendations covering 13 key actions, and a clear plan. A number of actions have been completed. FHA was consistently represented on the SCRP. FHA recommendations are outlined in Section 10. FHA should include revision of ‘absence’ policies and procedures as discussed in this review (7.1.24).

8.23 Connexions

8.24 The draft and final versions of the Connexions IMR were provided in timely manner, in accordance with the revised timetable. The author is a member of Wirral LSCB and he has specific strategic responsibilities for Connexions services provided in Wirral. He was not employed by Wirral Connexions during the period covered by the review. The narrative provides a clear history of the agency’s involvement with Child G. The IMR considers agency practice in accordance with the terms of reference. The lessons learnt for the agency relate to the absence of a CAF to support Child G following her exclusion from college and the importance of sharing information appropriately. The learning is supported by an action plan, which indicates that all actions will be achieved by January 2013. Recommendations are not listed separately in the IMR but are included in Section 10.
8.25 **Education/Learning and Achievement**

8.26 The draft and final version of the Learning and Achievement IMR were produced to accord with the revised timetable for the serious case review. The author is a third tier officer within CYPD with responsibilities for special educational needs. He had no operational involvement with Child G. This review is generally limited. The critical analysis does not reflect the terms of reference, which is a serious omission. As a consequence, the learning is superficial. In particular, the report fails to address the role of schools with respect to integrated working and the effectiveness of the agency’s safeguarding practices. Only one single-agency recommendation is identified. No action plan is provided.

8.27 Discussion with the IMR author indicates that he was inexperienced in participating in serious case reviews and that he had insufficient clarity about the process and what was required of him. In addition, the author expressed concerns about his capacity to manage the task satisfactorily. He recognised, however, that it would have assisted the production of the IMR had he consulted with schools directly. Written feedback to the author in respect of the IMR was given by the overview author and consultation was provided by the SCRP chair, prior to sign off by the agency. Learning and Achievement representative did not consistently attend the SCRP.

8.28 The lack of scrutiny provided by this report has been addressed by a recommendation.

8.29 **Barnardo’s**

8.30 This IMR was produced in a timely manner. The author is national safeguarding adviser for Barnardo’s. She had no operational involvement in relation to services provided for Child G. The organisation’s contact with Child G is limited and this is manifest in the IMR. Lessons include the need to ensure that more assertive outreach is made towards children who have been missing. The IMR indicates that this approach has now been put into practice. Other recommendations relate to revising the current contract for missing from care service and to training for staff in respect, in respect of domestic abuse and risk identification. The action plan identifies that these recommendations should have been completed by December 2012. Barnardo’s was not consistently represented at the SCRP.

8.31 **Children’s Social Care**

8.32 The children’s social care IMR was extremely delayed both in draft and in final version, to the detriment of the completion of the overview report. The author is a service manager within children’s social care, but he had no operational responsibility for the services reviewed. In general, the report would have benefitted from further editing as the level of detail obscures both the key elements of the analysis and the lessons learnt. Issues identified by the IMR include gaps in management oversight; issues relating to child protection and to private fostering; and, the importance of reference to historical and family information when undertaking assessments. Ten recommendations have been made, supported by an action plan. A number of the recommendations concern the responsibilities of the LSCB.
8.33 Integrated Youth Support Services

The draft of this IMR was significantly delayed which affected the delivery of the final version of the report. The final IMR was not obtained until after the draft overview report had been completed. The latter version successfully addressed the gaps identified in the draft report. However, a request to take into account information held by the agency about BG has had two significant unexpected consequences. Firstly, it has raised an issue about the effectiveness of safeguarding processes within Youth Offending Services, as it appears that no further action was taken when BG was identified as an offender. This was a missed opportunity to intervene in respect of BG: but it also had serious repercussions for SG, DSG and Child G as the risk posed to them was not considered. This omission is not addressed by the IMR. Secondly, this new information is also pertinent to understanding what life was like at home for Child G and suggests a motivation for BG ‘snatching’ Child G. The lateness in receiving this information has meant that the implications of this disclosure have not been fully integrated into the overview report.

8.35 The narrative of this IMR is comprehensive. With the exception of the issue mentioned above, the analysis successfully identifies gaps in agency practice. Lessons learnt include the absence in some elements of the service of comprehensive procedures; the importance of professional challenge; and, the need to ensure that the information contained in family and related persons’ records is adequately evaluated for relevance. The review led to seven recommendations supported by an action plan. Recommendations are outlined in Section 10 of this overview report. Representation by IYSS on the SCRP was inconsistent.

8.36 The possibility that there was no follow-up in respect of this allegation by BG has been addressed by a recommendation.

8.37 Wirral Metropolitan College

The college IMR was completed in accordance with the revised timetable. Events at college are clearly outlined in the narrative. It is clear that college put considerable effort into supporting Child G both academically and in terms of her welfare. The critical analysis addresses the terms of reference. A range of lessons learnt has led to 14 recommendations. These include the need to: ensure that, wherever possible, full assessment of support needs is undertaken prior to the young person starting college; develop a system of auditing safeguarding files; and, ensure that when young people at risk of not continuing or progressing have a clear and documented action plan recording their understanding of what they need to improve upon. The IMR also recognises the need to challenge professionals from other disciplines where they have doubts about the validity of judgement or actions. The IMR also calls for specific safeguarding training for professionals working with young people of college age. This is reinforced by the findings of the overview report.

8.39 Health Overview Report

The production of the final version of the health overview report was delayed by IMR report author capacity to complete reports to expected submission dates and to the
required standard of analysis. The health overview authors worked with IMR authors, through the Trust Board safeguarding lead, to ensure that all contributing IMRs met a satisfactory standard. These issues are discussed fully in the health overview report and are addressed by recommendations. The delay did not affect the production of the serious case review overview report under the revised timetable. The authors of the health overview report are the designated doctor for safeguarding children and the designated nurse, safeguarding children. Both belong to NHS Wirral, Clinical Commissioning Group: neither had direct clinical involvement in this case.

8.41 The health overview report is clear and well-structured. It gives a very concise summary of the involvement of various health organisations. The report identifies themes that were pertinent to the health IMRs, specifically: no access visits and missed or cancelled appointments; communication between health professionals; multi-agency working; child centred working; supervision; addressing the needs of young people with learning difficulties; and, culturally sensitive practice. These issues are addressed by seven recommendations, supported by an action plan. Two further recommendations relate to the preparation of health IMRs for serious case reviews. These are reproduced in Section 10. Health was consistently represented on the SCRP.
9 What can the LSCB learn from this case?

9.18 Child G was a young woman who had learning difficulties, a diagnosis of ADHD and who had had a statement of SEN. Her parents separated when she was quite young, and Child G spent most of her life living with MG and her SFG. Neither MG nor SFG appear to have understood the nature of Child G’s learning difficulties. Neither were they able to provide her with consistent, loving care. Alcohol abuse and domestic violence were reported to be features of family life. However, previous allegations had been made of abuse and neglect in respect of BG were unknown to professionals working with Child G.

9.19 Organisations and agencies have examined their own practices through their IMRs and have identified lessons and produced 97 recommendations for change. An overview of IMRs is provided in section 8. In addition to the learning for individual organisations or agencies (including those identified in the health overview report), there are a number of significant lessons which have implications for more than one agency and for the LSCB itself. These are discussed below.

9.20 The extent of Child G’s vulnerabilities was not understood by professionals working with her

9.21 Over the years, Child G had contact with a large number of agencies and organisations representative of health; education; social care; police; youth offending; and, housing services. However, there no multi-agency holistic assessment of her needs, characteristics and behaviours took place. No assessment took account of her developmental progress and the ecological relationship that her development had with MG’s and SFG’s capacity to care for her; in the light of their own limitations and difficulties. Information contained in key records was not adequately appraised. Recourse was made to family members, friends and specialist housing provision, but there was no accurate evaluation either of the capacity of such resources to ensure that safe care was provided for Child G. Warning signs of tension in the systems that surrounded Child G were not always heeded.

9.22 Not recognising the extent of Child G’s vulnerabilities had a number of consequences which were significant.

9.23 Child G’s relationships and behaviours were not always understood in the context of both her learning difficulties and of the adversity she had suffered at home

9.24 When Child G was aged 14, she was described by the educational psychologist as having significant general learning difficulties and as being a very vulnerable and needy child whose physical and emotional needs were not being met. As a result, she was said to be impulsive, inconsequential and had poorly developed interpersonal skills. Her perspectives were found to be at odds with how others saw her. This appears to be a good summary of the impact that both Child G’s learning difficulties and her upbringing had had on her social development.

9.25 However, although this assessment was current when Child G was the subject of a child protection plan, it appears not to have been influential in framing the multi-agency understanding of Child G’s needs at that time. The link between her behaviours and parental neglect was lost. An acceptance appeared to grow that Child G’s behaviours were the problem and that these would be managed in a specialist school setting.
9.26 The potential consequences of parental neglect on adolescents and the implications for practitioners are described in Neglect Matters (Stein, 2010). The majority of the potential consequences identified in their research review were realised for Child G.

9.27 It is not known whether Child G’s learning difficulties or ADHD were connected to her ‘lying behaviours’ which caused consternation and frustration for her parents and professionals alike. However, her tendency persisted to act apparently on impulse without thinking of the consequences. In addition, Child G herself recognised that her concentration and capacity to conform had reduced since she had stopped taking her medication.

9.28 Service provision was diffuse and lacked co-ordination

9.29 This is discussed in detail in 1.5 and was a feature of varying degrees of significance at different times in Child G’s life. Contributory factors were clearly the absence of thorough assessments and inaccurate evaluations of the appropriate level of professional response required.

9.30 However, the consequences were particularly evident when Child G was living in FHA accommodation. When seen from Child G’s perspective, there must have been too many people in her life whom she did not know and whose role she did not understand. It is not surprising that her take up of individual services was low.

9.31 Child G was not sufficiently diverted from harmful activities

9.32 Child G was [REDACTED] and [REDACTED]

Concerns were expressed that she was undiscerning in making relationships and that she was vulnerable to sexual exploitation. It was clear to professionals working with Child G that her [REDACTED] relationships with boys were objectively harmful and risky, although she might not have recognised this herself. Her risk of sexual exploitation, already significant due to a combination of her learning difficulties and parental neglect, was increased by her misuse of alcohol and the relative ‘freedom’ of her accommodation.

9.33 Ages of Concern (Ofsted, 2011) found that young people between the ages of 15 and 17 were not always treated as children. That report stressed that the need to recognise the rights, needs and vulnerabilities of this group as children as well as their rights and responsibilities as young adults.

9.34 For Child G, there was significant disparity between her chronological age and her emotional and intellectual development. She was not as grown up as she could appear or, possibly, as she considered herself to be. Child G was ‘lonely and angry’. However, there was recent evidence, from School2, that Child G could benefit from a child-centred approach which included persistent concern from people she knew; structure; reward; and positive choices. Unfortunately, staff in FHA, although willing, lacked capacity to provide this for Child G, particularly since she was out of college.

9.35 The local authority did not adequately consider its responsibilities under S20 Children Act 1989 to provide accommodation to Child G

9.36 MG stated, on more than one occasion, that she was unable to care for Child G and made it clear that she wanted Child G to be looked after. The first crisis was in May 2007 when MG was about to go into hospital herself. There was no evidence that SFG had parental responsibility for Child G and he stated clearly that he did not want to take care of her.
Family members were also unwilling to care for Child G and gave explicit reasons why they could not do so, citing in particular Child G’s behaviours. No other person with parental responsibility for Child G was identified. Child G was 13 years old, but her intellectual and emotional development was behind her chronological age.

9.37 Although an initial assessment had not been completed, it is apparent that Child G was ‘in need’ at that point. MG had effectively informed the local authority that she was being ‘prevented from caring for Child G’ by virtue of being a hospital in-patient. She was unable to identify another carer for Child G, even with the offer of support that had been given. It is difficult to understand how Child G could not ‘require’ accommodation in these circumstances. The rationale for concluding that she should not be looked after was not recorded.

9.38 As noted earlier, if Child G had been accommodated at this time, a core assessment could have been completed and more thorough understanding of what needed to happen next could have been developed.

9.39 Other examples where local authority accommodation might have been an option were in August 2011 and October 2011. On the first of those occasions, Child G remained in a ‘potential private fostering arrangement’ and, on the second, she returned to MG’s and SFG’s care.

9.40 Finally, in February 2012, Child G was provided with accommodation as a homeless young person. This is discussed in 7.6.3. An assessment should have taken place at this point to consider whether she was ‘in need’ and required local authority accommodation.

9.41 Promotion of Child G’s welfare was generally weak and there was insufficient expectation of excellence in practice.

9.42 This finding relates more to professional attitudes than to process and procedures, and so is more difficult to articulate. It is made evident, however, by the absence, at significant times, of professional and managerial scrutiny and challenge.

9.43 For example, although Child G was found to have been neglected, there was almost no challenge to MG and SFG about the care that they provided for her. The impression given is that the assessment, which should have been about their capacity to provide good enough care for Child G, was a task to be completed: it was not seen as a foundation on which a plan for change could be built. The assessment was not tackled with sufficient timeliness, rigour or engagement with its subjects: its findings were based on observation rather than on reflection and challenge. Yet it was accepted by managers, members of the core group and the conference chair.

9.44 Similarly, the challenge offered by members of the core group to casework ‘drift’ was essentially ineffective, as no child protection plan was ever properly formulated. A child protection plan is the basic requirement of child protection work and each member of the core group had individual, as well as collective, responsibility to Child G to ensure that this requirement was met. However, to have done this, professionals would have needed expectation that change could be achieved through their efforts, resolution and persistence to see it through. Regrettably, core group members appear to have moved towards ‘acceptance’ of this situation and their level of challenge diminished as time went on. The lack of a child protection plan should also have been identified by the chair of
conference. However, it was not. Progress appears to have been judged instead by reference to recommendations of previous child protection conference/reviews rather than a dynamic examination of the extent to which neglect had diminished.

9.45 The decision to manage Child G’s child protection plan on a ‘duty’ basis suggests that positively promoting Child G’s welfare and expecting excellence in practice were not objectives in this case. This is also evident in collective and managerial failures to ensure that Child In Need plans were implemented.

9.46 Unfortunately, this is not the first serious case review conducted by the LSCB that has highlighted the lack of scrutiny and challenge. It also reflects one of the principal findings of Ofsted’s evaluations of serious case reviews in 2009 – 2010 (Ofsted, 2010).

9.47 **Due regard was not always given to Child G’s views and feelings.**

9.48 There is a general inadequacy of recording of Child G’s views and feelings in agency records, as noted above. Despite the fact that a number of individual workers were able to engage with Child G and to advocate on her behalf, this was not the overall picture. This is discussed in 1.9. Not hearing the voice of the child is again a common finding in serious case reviews (Ofsted, 2011).

9.49 **LSCB procedures and good practice guides were not systematically consulted and were not always applied as they were intended.**

9.50 This is not a new finding for the Board. It is evident that LSCB procedures are comprehensive and easy to access. They provide helpful aids to assessment and judgement when working with children and families in different circumstances. Not referring to procedures, contributed to practice that was less thorough and judgements that were less acute that they need have been. However, the reasons why many practitioners and managers do not routinely refer to procedures are not simply deducible from the IMRs. Nevertheless, a number of hypotheses are suggested.

9.51 Firstly, it is possible that practitioners and managers are operating confidently, assuming that they are working in ways that are consistent with procedures without checking back with them. This is more likely to happen where practitioners and managers are experienced and ‘expert’; and, in small specialist teams where cultural norms can develop. Chairs of conference would be examples of ‘experts’. CADT would be an example of a small specialist team, where, in fact, consistency of response and decision-making is a recognised aim and managerial practices support this.

9.52 Secondly, it appears that, in times of uncertainty, practitioners placed greater reliance on the advice given by fellow professionals, whether in their own or partner agencies, rather than referring to a written source. Although there were exceptions to this, it was, nevertheless, a feature of multi-agency work in child protection and was particularly noticeable in the relationship between FHA and CADT.

9.53 Thirdly, it is possible that certain practitioners and managers are not familiar with procedures that are relevant to their area of work and are unaware of the benefits that would derive from employing them. This might include Good Practice Guides, for example.

9.54 Finally, there may be practitioners and managers who, for reasons of their own, choose not to refer to procedures.
9.55 This suggests that ‘non-compliance’ with procedures is multi-faceted and that no single solution is going to be successful in bringing about change in this area.
10  Recommendations

10.18  This review has examined practice in respect of Child G over a seventeen year period. Many changes have taken place during this time, nationally and at a local level which have had an impact on the work undertaken by individuals to safeguard children and to promote their welfare. While it has been acknowledged, therefore, that a significant number of the lessons learnt have been identified previously, the review also recognises that remedial actions have been taken in respect of a number of them. This is confirmed by completion of LSCB action plans and by independent inspection (Ofsted, 2011) (Ofsted, 2012). However, not all action by partner agencies has brought about required change. For example, this review has found that there was insufficient attention to the need for parents to change their behaviours in 2007-2008; and, in 2012, Ofsted noted ‘some child protection plans were not sufficiently clear about what action needed to be taken by parents’.

10.19  The independent author and the SCRP are keen, therefore, to ensure that recommendations are neither redundant (as the problem has been removed or reduced) nor ineffective (in that they duplicate actions that have already been taken, but which have not brought about sustained change). This can be difficult to achieve. However, as was the case in the critical analysis, the recommendations of this serious case review will focus on bringing about change in current practices.

10.20  The findings of this review, as described in Section 8, relate to:

a)  understanding the child’s needs, characteristics and behaviours;
b)  providing services that positively promote the child’s welfare as well as reacting to concerns about harm;
c)  ensuring that services are co-ordinated, targeted and delivered by the fewest number of professionals with any individual family;
d)  ensuring that national and local policies and procedures provide a guide to practice;
e)  taking personal responsibility for professional excellence, including issues relating to challenge; and,
f)  ensuring that the child’s views are understood, recorded, and, where appropriate, influence service provision.

10.21  These elements are, however, are ‘ecologically’ related to one another, in that improvement or deterioration in any single element will have a positive or negative impact on other elements within this system. The task is, therefore, to find the actions which are most likely to strengthen the system overall, making good practice the more likely outcome: while still identifying what specific changes are to be achieved. This can also be difficult to accomplish when in an optimal working environment. It will be particularly challenging to the LSCB now; when key organisations are in a state of flux and are adapting to change with reduced resource.

10.22  Enabling staff to practise with confidence is considered by the SCRP to be an example of an outcome which would have a positive effect in terms of every lesson learnt in this review. How can this be achieved, with particular reference to the gaps that this review has identified in relation to practice with Child G?
10.23 Common knowledge, shared expectations and experiences of good outcomes for children and young people are surely fundamental to promoting confident practice in multi-agency work. How to enable these conditions to flourish will be considered in respect of three separate aspects of practice with Child G. Those aspects of practice are: working in child protection; working between Level 3 and Level 4 under Wirral’s Guide to Integrated Working; and, working with young people with complex needs; and, working with 16 and 17 year olds.

10.24 Promoting confident practice in working in child protection

10.25 This review accepts that there have been improvements in practice in child protection since 2007-2008. However, there problems in relation to all elements of child protection planning and process in this case; with insufficient challenge to parents and between professionals and that evidence of this has been provided by case audit and inspection. However, these methods do not directly test professional perceptions of the process or the experience of children and families.

10.26 It recommended that the LSCB undertake a ‘live’ evaluation of child protection in Wirral, by observing conferences/reviews and undertaking verbal/ written consultations with conference chairs and participants, including family members. Consistent with the concerns identified in this particular case (9.41-9.44), this exercise should focus on the extent to which professionals are able to articulate a shared understanding of the problem and the proposed solution; the extent to which the plan is regarded as an ‘enforceable contract’ which applies to professionals as well as to family members; the perceived role of the chair in the case; and, feedback from children and family members about what difference the process has made to them. The results of this process will contribute to the LSCB’s evaluation of child protection practice in Wirral and should be used to inform future action and/ or training.

10.27 Recommendation 1: The LSCB should undertake a ‘live’ evaluation of child protection conferences/reviews in Wirral

10.28 Promoting confident practice in working with children whose needs are between Level 3 and Level 4 under Wirral’s Guide to Integrated Working

10.29 Although it has been found (Ofsted, 2012), that the local authority has in place clear thresholds ‘which are understood and consistently applied by partner agencies’, this review identified uncertainties, when working with Child G, as to what level of need she had. For example, in November 2011, Child G was an ‘open case’ to CSC, having been found to be a child in need in January 2011: an updated assessment was required (7.2.28). However, as noted earlier, the case was closed without this assessment being done, on the basis that Child G was no longer a child in need, and without reference to college. This is discussed in critical analysis.

10.30 Although there would, generally, have been an expectation that a CAF would have been provided to CSC to justify the ‘step up’ to child in need, no assessment was provided to college which explained why Child G was no longer in need and that suggested how her needs could be met through TAC. College, and later, FHA were left to ‘start again’ without the benefit of information already held. Absence of this information impacted on the quality of assessment in CAF and worked against an accurate assessment of Child G’s level of need being made. It acted, in effect, as barrier to future re-referral into CSC.
This was clearly an unintended consequence of implementing a more robust process at Level 3.

10.31 **Recommendation 2: The LSCB should ensure that the Council and its partners clearly identify what information and support should be provided by CSC when plans ‘step-down’ to TAC from child in need**

10.32 College and FHA were persuaded by CADT/CSC that they should undertake a CAF with a view to working with Child G under TAC, although they were not entirely convinced that this was the correct way forward. It appears that they accepted what they understood to be the greater expertise of the local authority. At the point that these decisions were made, there was little dialogue or discussion about Child G’s level of need in terms of the indicators outlined in the Guide to Integrated Working. This was discussed by the SCRP. It is recommended, therefore, that discussions between referring agencies and CADT make direct reference to the agreed ‘Thresholds of Need’. This would have the advantages of reinforcing procedures (9.49); of developing common understanding; and, consequently, making it more likely that the most appropriate professional response is offered.

10.33 **Recommendation 3: The LSCB should ensure that CADT staff encourage active, joint consideration with referring professionals of the agreed thresholds of need and professional response**

10.34 When professionals are practising with good levels of knowledge and confidence, resolution of disagreements can generally be managed early and at the correct level within organisations. However, there are occasions when this cannot be managed and matters need to be escalated to ensure that children and young people receive the standard of service which they are entitled to expect. There is little evidence in this review that professionals took responsibility for this (7.1.33). The following recommendation relates to confident working both in child protection and at Level 3.

10.35 **Recommendation 4: The LSCB should require agencies to provide evidence that staff are aware of the escalation process and that there are systems in place to support and monitor its use**

10.36 **Promoting confident practice with children with complex needs**

10.37 Child G’s complex needs arose from a combination learning difficulties, ADHD and the fact that she had suffered maltreatment. Similarly, a combination of reasons contributed to the absence of a clear understanding of Child G and her circumstances. However, omissions in practice which suggest gaps in professional knowledge were identified at different points during Child G’s life (9.20-9.27)

10.38 In terms of general safeguarding and child protection, the Department of Education recognises that: “Professionals need up-to-date knowledge on the impact of emotional and physical abuse, neglect and poor parenting on children’s welfare. This must be combined with a good understanding of children’s developmental and attachment timescales. This knowledge will help professionals to confidently challenge unacceptable parental behaviours and support timely and well-founded professional decisions” (Department of Education, 2011).
10.39 Safeguarding Children across Services: Messages from Research brings together a body of government-funded research on safeguarding children from neglect and abuse in England and Wales. It provides an overview of recent research projects and highlights the main implications for all professionals involved in the safeguarding process (Ward, 2012).

10.40 **Recommendation 5:** The LSCB should review its ‘Working Together’ training programme to ensure that it reflects the most recent learning and messages from research

10.41 Three other areas of practice revealed gaps in professional knowledge across agencies. These were: understanding the effects on child development and social presentation of moderate learning difficulties; working with young people who are sexually active from a young age; and, safeguarding young people who are 16 and 17 years old.

10.42 **Understanding the effects on child development and social presentation of moderate learning difficulties**

10.43 This refers to raising awareness generally about moderate learning difficulties; to providing guidance to non-specialist staff about working with children with moderate learning difficulties; and to incorporating issues relating to learning difficulties into assessments of need. Specifically, the question arises about making use of information gathered for educational purposes into a multi-agency safeguarding plan. The LSCB should commission a short-life working group of relevant professionals from the local partnership to consider how these ends can be achieved, within the context of LSCB priorities. This should inform subsequent LSCB actions.

10.44 **Recommendation 6:** The LSCB should commission a short-life working group which will advise on how to improve professional knowledge in respect of safeguarding children and young people with moderate learning difficulties

10.45 **Working with young people who are sexually active from a young age**

10.46 Developing a strategy to counter child sexual exploitation is reported to be a current priority for Wirral LSCB. The Board also has in place policies and procedures relating both to the sexual health of under 19s and to working with children who are sexually active (7.1.12 -7.1.16). No specific recommendation for additional work in this area is made. However, it is recommended that consideration is given, within the child sexual exploitation strategy, to ensuring that professionals understand the significance of early sexual activity and are adequately equipped to deal with the issue.

10.47 **Recommendation 7:** The LSCB child sexual exploitation strategy should address providing professionals with skills to respond appropriately to young people who are engaged in sexual activity at a young age

10.48 **Working with young people who are 16 and 17 years old**

10.49 Members of the SCRP included representatives from a variety of agencies and organisations which provide services for young people who are 16 and 17 years old. They discussed the particular issues that affected them in relation to safeguarding. Many of the issues that they raised were similar to those identified in Safeguarding Young People: Responding to young people aged 11 to 17 who are maltreated (Rees, et al., 2010); particularly in relation to perceptions of risk and responses to referrals by CSC.
10.50 SCRP members were of the view that multi-agency training often focussed on the needs of and professional responses to younger children. They felt that professionals working with 16-17 year olds would benefit from specially-designed training.

10.51 **Recommendation 8:** The LSCB should ensure that bespoke safeguarding training is provided for professionals working with 16 and 17 year olds

10.52 This serious case review has found that service provision was diffuse and lacked co-ordination (9.28). It was found that Child G was not adequately diverted from harmful activities (9.31). The local authority is currently working with partners to develop a more appropriate model for working young people who are 16 years and above. SCRP members expressed considerable interest in this and were able to see how partners could contribute productively to it; bringing potential resource and expertise; reducing the possibility of duplication; and ensuring that safeguarding considerations are fully addressed.

10.53 **Recommendation 9:** The LSCB should request that the Director of Children’s Services provide early consultation in respect of proposals for a 16+ service for young people, in order to maximise the opportunity for the LSCB participation in planning such services

10.54 More specifically, this case review found that, at the time of her death, Child G was living in accommodation that was not suitable for her needs. This is discussed in Sections 7 and 9, in particular. Consideration should have been given to accommodating Child G under S20 of the Children Act 1989, rather than by securing accommodation for her under the Housing Act 1996. The local authority has addressed in the last 12 months, and it reported that a new ‘gateway’ process is more robust in that regard.

10.55 **Recommendation 10:** The LSCB should require the local authority to provide evidence that its working practices are consistent with the guidance: ‘Provision of Accommodation for 16 and 17 year old young people who may be homeless and/or require accommodation (DCSF, 2010)’

10.56 This review has revealed that there was no evidence of active reference to policies and procedures and has suggested a number of hypotheses for this. This is not a new finding for the LSCB. Previous recommendations and action plans have addressed this issue. The degree to which those actions have brought about change is not clear. It is recommended, therefore, that the LSCB consider this matter in more detail, with a view to developing a range of strategies to improve uptake. This could include more explicit reference to introduction to procedures in induction processes, work-shop sessions or questionnaires.

10.57 **Recommendation 11:** The LSCB should consider appointing a short-term working group to advise on strategies to increase reference to procedures and good practice guidance

10.58 **Recommendation 12:** The LSCB should require individual agencies to provide evidence that recommendations detailed in agency IMR’s and in the overview report have been enacted
Recommendations arising from shortcomings in IMRs

10.60 **Recommendation 13:** The LSCB should require the Director of Children’s Services to provide evidence that the shortcomings inherent in the Learning and Achievement IMR are addressed.

10.61 **Recommendation 14:** The LSCB should require the Director of Children’s Services to provide evidence both that the specific issue of investigation of allegations made by BG in 2005 has been dealt with and that any practice gaps in respect of referring allegations of abuse to CSC have been addressed.

10.62 **Recommendation 15:** The LSCB, building on the Health Overview IMR recommendations, should engage with partner agencies to establish current capacity and identify and address gaps in capacity to ensure agencies are able to effectively contribute to the Serious case Review process.
Summary of Recommendations

1. The LSCB should undertake a ‘live’ evaluation of child protection conferences/reviews in Wirral

2. The LSCB should ensure that the Council and its partners clearly identify what information and support should be provided by CSC when plans ‘step-down’ to TAC from child in need

3. The LSCB should ensure that CADT staff encourage active, joint consideration with referring professionals of the agreed thresholds of need and professional response

4. The LSCB should require agencies to provide evidence that staff are aware of the escalation process and that there are systems in place to support and monitor its use

5. The LSCB should review its ‘Working Together’ training programme to ensure that it reflects the most recent learning and messages from research

6. The LSCB should commission a short-life working group which will advise on how to improve professional knowledge in respect of safeguarding children and young people with moderate learning difficulties

7. The LSCB child sexual exploitation strategy should address providing professionals with skills to respond appropriately to young people who are engaged in sexual activity at a young age

8. The LSCB should ensure that bespoke safeguarding training is provided for professionals working with 16 and 17 year olds

9. The LSCB should request that the Director of Children’s Services provide early consultation in respect of proposals for a 16+ service for young people, in order to maximise the opportunity for the LSCB participation in planning such services

10. The LSCB should require the local authority to provide evidence that its working practices are consistent with the guidance: ‘Provision of Accommodation for 16 and 17 year old young people who may be homeless and/or require accommodation (DCSF, 2010)’

11. The LSCB should consider appointing a short-term working group to advise on strategies to increase reference to procedures and good practice guidance

12. The LSCB should require individual agencies to provide evidence that recommendations detailed in agency IMR’s and in the overview report have been enacted

13. The LSCB should require the Director of Children’s Services to provide evidence that the shortcomings inherent in the Learning and Achievement IMR are addressed

14. The LSCB should require the Director of Children’s Services to provide evidence both that the specific issue of investigation of allegations made by BG in 2005 has been dealt with and that any practice gaps in respect of referring allegations of abuse to CSC have been addressed

15. The LSCB, building on the Health Overview IMR recommendations, should engage with partner agencies to establish current capacity and identify and address gaps in capacity to ensure agencies are able to effectively contribute to the Serious case Review process
Barnardo’s IMR Recommendations

1. To revise the process following notification re. young people missing from home.
2. To revise the current contract for the missing from home service.
3. To deliver further training for staff re. domestic abuse and risk identification.

Connexions IMR Recommendations

1. CAF processes and procedures will be discussed with all Staff in Wirral as part of supervision discussions with respect to the learning from this case and Adviser practice.
2. Review Caseload management with Advisers to reinforce the importance of direct client work and how this is supported by Agency discussions.
3. Review with Lead PAs Case Work practice and how advisers use previous intelligence to support Young People.
4. Review Company Safeguarding Policy Procedures in respect of the learning from this case.
5. Review Section 139a process with Wirral LA.

Children’s Social Care IMR Recommendations

1. Social Care to undertake a themed audit to consider the impact of changes of social worker in cases, the impact of the transfer of cases from Assessment Teams to Care Managements Teams and also the quality of audits undertaken by managers and how embedded the audits are in practice.
2. In response to the Munro Review of Child Protection, Social Care to review its management structures and how they support best practice.
3. Guidance to be re-issued regarding the types of case appropriate to allocate to students and newly qualified social workers and re-affirming the role of the Practice Educator in supporting students.
4. Guidance to be re-issued regarding the importance of reading historical case files and it being the line managers responsibility to support social workers with this including setting an appropriate amount of time aside for the social worker to be able to do this.
5. An audit of a selection of current Child Protection cases to be undertaken in order to assess the quality and relevance of Conference minutes, the quality of the outline Child Protection Plan, the quality of the subsequent updated Child Protection Plan in the locality social work teams and the recommendations made at Conference.
6. Social Care to undertake an audit of compliance with the newly implemented Child in Need procedure to ensure compliance and understanding from Social Care and other agencies.
7. A plan of work to be discussed and agreed with Wirral Local Safeguarding Children's Board regarding undertaking a Review of Working Together training.

8. The definition of eligibility criteria for Private Fostering to be further clarified in the procedure, to ensure 16-18 year olds with learning difficulties who present themselves as living outside the immediate family are assessed.

9. Social Care to re-issue guidance on the Private Fostering procedure, with a particular focus on situations that preclude an arrangement being Private Fostering and when to undertake an initial assessment.

10. Social Care to provide guidance on and brief out to social work teams, when to undertake checks on adult siblings no longer residing in the household.

Learning and Achievement IMR Recommendations

1. The LSCB offer/insist on auditing a sample of transfer summary record from School 1 and safeguarding records from School 2 to determine how representative of practice Child G’s case is of current practice in recording.

2. A sample of Child Concern Meetings minutes is examined by the LSCB to establish consistency and efficacy of current practice and review them if necessary.

3. That as part of its review into preventative services the Department establishes single gateways for access to services, management and the reporting of decisions to schools.

Forum Housing Association IMR Recommendations

1. Internal Case Management (including Recording Practice) is reviewed and underpinned within policies, procedures & training.

2. Risk Management Systems through all levels of the organisation are reviewed and underpinned within policies, procedures & training.

3. Multi-Agency Working Practices in relation to effective information sharing and working practices are reviewed and underpinned within protocols, policy, procedures and training.

4. Audit & Evaluation processes are enhanced to manage implementation of this action plan and the impact on outcomes for service users.

Health Overview IMR Recommendations

1. All health providers to review processes in place to ensure that the responsibilities of health professionals are clear about what to do when children about who there are safeguarding concerns fail to attend appointments or when they fail to gain access to the child.

2. All health providers to audit the process in place for following up children who do not attend an appointment for specialist care. (Audits should identify the percentage of
missed appointments that was followed up; the percentage of those children followed up who were eventually seen and what action was taken if the child was not seen).

3. NHS Wirral Clinical Commissioning Group will ensure all GP practices complete the Safeguarding Children and Vulnerable Adult Self Assessment Audit Tool and develop an action plan to address gaps in practice (Commissioning Safeguarding Children and Vulnerable Adult Policy Appendix 2, 2012).

4. Arrangements for health visitors and school nurses to inform and update GPs by sending a copy of Team Around the Child meeting minutes to the GP with the consent of carers / young person to be implemented. This recommendation should be audited 6 months after implementation.

5. The capacity and access to appropriate training for school nurses providing services to specialist schools need to be reflected in the school nursing specification currently being developed by commissioners (Public Health).

6. Health organisations to provide supervision audit reports that have taken place within the last 12 months.

7. WUTH to complete business case for 24 hour opening of the Children’s AED.

8. All health provider Safeguarding Board leads must ensure the identified Individual Management Review author has the capacity to undertake and complete reports within the agreed timescales. If this will not be achieved any expected delay must be notified to the Designated professionals at the earliest opportunity.

9. NHS Wirral Clinical Commissioning Group should commission appropriate training for all Individual Management Review report authors to gain the skills to complete comprehensive, analytical reports, including SMART recommendations. Training should take into account the proposed changes to the process that will be included in the review of Working Together, 2010 that is awaited.

Cheshire and Wirral Partnership NHS Foundation Trust - CAMHS IMR Recommendations

1. The lessons learnt from this serious case review to be shared and discussed with practitioners involved as well as CWP services generally.

2. Health Records Audit for CAMHS to focus on:
   - child who is discharged from services
   - Discharge/summary letters are kept on Child file
   - Child who is subject to child protection plans- is there a full set of minutes and core group minutes
• If cases do not have minutes of child protection conferences or core groups they have been requested by the practitioner
• Where appropriate is there evidence of professional challenge?
• Where appropriate is there evidence of escalation?
• Where appropriate educational assessments have been requested

3. There need to be a clear internal written referral process or flowchart for CWP services.

Wirral Community Trust IMR Recommendations

1. Wirral Community Trust to audit their Failure to Gain Access Policy and update policy as required.

2. Wirral Community NHS Trust will report to Children & Young Peoples Department (CYPD) regarding the ongoing delays in practitioners receiving Child Protection Plans following child protection case conference when this occurs. Failure to resolve these issues will continue to be escalated to the Designated Nurse for Safeguarding Children.

3. Wirral Community NHS Trust to evidence use of escalation processes.

4. Unplanned Care Services to be audited with regard to compliance with documentation of consent. The recommendations from the audit should be incorporated into practice.

5. Capacity and consent to be topic for discussion at Action Learning Set.

6. An audit of compliance with learning disabilities toolkit to be undertaken.

NHS Wirral Primary Care Trust / Clinical Commissioning Group GP IMR Recommendations

1. When a child about whom there are safeguarding concerns is discharged for failing to attend medical appointments Primary Care should have a system in place to recall the patient and ensure their health needs are met.

2. NHS Wirral to undertake an audit to ensure that the GP is routinely invited to Child Protection Conference and that if they are unable to attend that a report is sent to be shared at the Conference.

3. NHS Wirral CCG to undertake an audit to look at the quality of reports, to include whether relevant parental information is shared, sent by GPs to Child Protection Conferences.

4. NHS Wirral CCG to ensure that, if a child with learning difficulties is prescribed contraception, her GP ensures that she is Fraser competent.

5. NHS Wirral CCG to ensure that GPs record on medical systems an annual medication review which should include any concerns regarding compliance.
6. NHS Wirral CCG to ensure that all the relevant documents are scanned on the Child’s medical records.

7. NHS Wirral CCG ensure that all GPs complete Equality and Diversity Training and that this should be mandatory.

8. NHS Wirral CCG to undertake an audit to ensure that GP practices are routinely updated on the Child Protection Registration status of children and whether they have a system in place to record the information on the child’s GP records.

9. NHS Wirral CCG undertake an audit to ascertain whether minutes of multi-agency meetings are being routinely circulated to the GP Practice.

10. NHS Wirral CCG to ensure GP practices have a system in place to record death notification on the child’s electronic health records.

11. The importance of speaking to a child, if possible alone, to gain an understanding of their wishes and feelings when safeguarding concerns exist should be re-enforced at GP safeguarding training.

Wirral University Teaching Hospital NHS Foundation Trust – Paediatric IMR Recommendations

1. WUTH to complete update of Failure to Gain Access to a Child or Young Person Policy.

2. That Adult AED staff receive specific training for the safeguarding of young people 16-19 years this should include use of the escalation policy.

3. Computer discharge letters to be generated and completed for all AED attendances.

4. WUTH ensure that the Children’s Liaison Manager receives a daily list for AED attendances for all 16-17 year olds.

5. WUTH to ensure that Community Paediatric appointments for children seen in clinics in special schools are computer generated.

6. WUTH Paediatrics to liaise with the School Nursing Service to develop a formal process for following up children leaving special schools who have on-going medical needs.

7. WUTH ensures that staff are aware of the importance of speaking to the child to ascertain their wishes and feelings particularly when safeguarding concerns exist.

Wirral University Teaching Hospital NHS Foundation Trust – School Nurse IMR Recommendations

1. School Nurse Team Leaders to include in supervision, an audit of the escalation policy.

2. WUTH to put in place a procedure for all children leaving special schools with ongoing health needs to be followed up by the appropriate medical service.

3. School nurse documentation to incorporate the emotional and psychological wellbeing of children and young people as part of all assessments undertaken in order to ensure the child’s wishes and feelings are taken into account and the voice of the child is heard.
Integrated Youth Support Services IMR Recommendations

1. In order to strengthen practice, teams within Targeted Services (IYSS) should adopt written procedures for their areas of work setting out expectations of workers and timescales for action where appropriate. This should include reference to safeguarding procedures and the need to record comprehensive notes particularly when making decisions about a course of action.

2. The comprehensive procedures recently adopted by the Universal Youth Support Service, should be extended to include more detailed procedures relating to the work areas within the Response agency. This should include reference the need to record comprehensive notes particularly when making decisions about a course of action and review current case management processes.

3. Remind staff to raise issues of concern with line managers and use LSCB escalation process.

4. Conclude the investigation into use of electronic system available to YOS to the wider IYSS and/or access to an electronic case management system by Response.

5. Consider access to ICS to identified workers across the IYSS workforce.

Merseyside Police IMR Recommendations

1. Review procedures Force wide for the storage of completed VPRF/1 forms, which should be retrievable for evidential or audit purposes. The feasibility of scanning such forms onto the ‘PROtect’ system should be explored, as this would provide the ideal audit trail. There is an ongoing review of PROtect and consideration is currently being given to the transfer of the management of Domestic Abuse, Child Protection and Vulnerable Adults onto the ‘niche’ system. This would afford the necessary scanning opportunities.

2. Introduce time parameters for the creation of a full and meaningful entry on ‘PROtect’ for all victims, with risk assessment and appropriate referrals. To meet such deadlines, each FCIU would require a dedicated risk assessor.

3. The ‘Compact’ system should be modified to allow MPC’s to send notification e mails to other agencies from within the ‘Compact’ system, thereby providing a less unwieldy procedure that would capture the action within the system and provide an audit trail of that activity.

4. In cases that are deemed serious and where reporting should not be delayed, reporting officers should contact Social Services directly via telephone, and a follow up by fax if requested, to ensure timely sharing of the information with social services. The reporting officer must then update Compact to say the referral to Social Services has been made

5. Until the ‘Compact’ system has been modified, MPC’s throughout the Force should obtain and use a separate MPC role notes account to send and retain copies of missing person notifications. Alternatively such e mails should be stored using the e mail archive system.
6. All Missing Person Coordinators should ensure that timescales for notification of other agencies are met and adhered to as per Force policy.

7. When a ‘Missing Person’ has been found, supervision must ensure that a meaningful ‘return’ interview is conducted in line with Force policy.

8. When dealing with victims of crime officers should ensure that effective contact details are obtained to enable them to be informed immediately of a suspect’s release from custody and any bail conditions.

9. When a written statement is required during the course of a serious incident, that is anything other than routine, then this should be taken by a police officer or investigator involved in the enquiry.

10. When concerns are raised about missing persons, supervision must ensure all enquiries, particularly interviews of key individuals, are conducted in a positive and robust manner, in an effort to ensure the safety of the missing person. Where necessary investigators should be involved in such interviews.

11. The ‘further information’ filed on the youth notification form to be fully updated with aggravating/influencing factors, such as drug or alcohol use, to ensure the YOT are aware of any such aggravating factors from the outset.

12. The Force should commission a stand alone policy in relation to ‘Vulnerable and Intimidated Witnesses’. This should include definitions, the manner in which such witnesses can be identified and also a section in relation to identifying any risk posed to such witnesses in the period between them making a statement and the suspect being arrested.

13. The Force should review the manner in which a persons warning signs are identified and recorded on the various systems available to the police.

Wirral Metropolitan College IMR Recommendations

1. Continue to train all college staff in the application of the college Safeguarding Policy.

2. Continue to ensure that the new guidance regarding completion of Learning Support Assistant logs, is followed by all relevant staff.

3. Ensure the date is included on all concern forms.

4. Ensure that where consent/authorisation from parents is required, procedures are clear as to who can grant this and what to do if the learner is estranged from their parent/guardian.

5. Ensure Learning Mentors and Safeguarding Manager cease providing direct input to learners once they have left the college.

6. Request training from the LSCB in how and when to challenge social workers’ decisions, particularly in relation to older children.

7. Continue to maximise staff awareness of how to identify and respond to learner welfare issues.
8. Improve the consistency in the use of formal behaviour contracts for learners whose behaviour is putting their place in college at jeopardy.

9. Wherever possible, carry out support assessments and produce support plans prior to learners enrolling at college.

10. Ensure that where a decision is taken to delay carrying out a plan for a learner, such as a plan to escalate them to Team Around the Child, this decision is clearly documented.

11. Request further information about every learner/applicant who is known to the Respect panel as to the reasons for this, and use this information to inform our approach to supporting the learner.

12. Consider, in consultation with learners, whether it would be appropriate to start asking learners about their religious beliefs.

13. Develop an internal system for auditing of Safeguarding case files, to confirm that good practice is applied consistently.

14. Ensure that learners at risk of not continuing/progressing have clear and documented action plans recording their understanding of what they need to improve upon.
Bibliography


