Review concerning a teenage child
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7 POINT BRIEFING

1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a review concerning a teenage child following their sudden and tragic death. The child's death was believed to have been caused by a drug overdose.

The areas the review identified included the following:

1. How the risk of a parent posed to a child when imprisoned is managed
2. How engaged the Probation Service are within multi-agency child safeguarding work
3. Unmet needs of a child throughout childhood
4. Effectiveness of communication between services who were supporting the family
5. View and assessment of risk when a child is nearing adulthood
6. Effectiveness of identifying exploitation at an early stage

2 WHO WAS THE CHILD AND THEIR FAMILY?

The child was a teenager, nearing adulthood at the time of their death and resided with their mother, mother's partner, and younger step-sibling. The child's mother and father were separated.

Father had been in and out of prison for a number of years and most recently was released three days prior to the child's death. The child and their family had come into contact with multiple services from 2011 onwards for a variety of issues including the child's behaviour at school, father's influence over them, potential use of and supply of drugs, potential risk to child exploitation.

3 SUMMARY OF THE INCIDENT

It is believed that the child stayed with their father, upon their release from prison and an adult associate, two nights prior to the child's death. On the afternoon, the child was found unresponsive and was sadly pronounced dead by paramedics on the scene.

In the immediacy of the child's death a number of illegal, as well as prescribed drugs were found in the flat where the child died. Both adults including the child's father were arrested on the suspicion of the supply of Class A drugs.

4 KEY POINTS AND ANALYSIS FROM THE REVIEW

1. How the risk of a parent posed to a child when imprisoned is managed

- During the times the child's father had contact with them, their behaviour became more erratic and they faced more risks. The child's father was in and out of prison and spent time outside of the country, which reportedly coincided when there were periods of stability in the child's life
- Though there was some evidence of intervention from services during these periods, this was not always consistent or effective in putting approaches in place to counteract the influence of father. There were traits of typical perpetrator behaviour witnessed within child exploitation, where perpetrators will seek influence and manipulate situations to become the only person a child feels they can trust
- Father's influence was not sufficiently considered within assessment work. Plans did not always capture the impact of the child's relationship father due to the periodic absences from the child's life

2. How engaged the Probation Service are within multi-agency child safeguarding work

- The learning process identified that on reflection there is too much reliance on front line Probation practitioners to share information if the child and family are open to services such as Children's Social Care or making a referral
- There is significant potential to further develop the connectivity with the Probation Service to key children's safeguarding systems such as the Integrated Front Door (IFD) / Multi-Agency Safeguarding Hub (MASH) and Child Exploitation Perpetrator Risk Assessment Meetings (RAM)
- There is a need to create more formal opportunities for information sharing to take place between Probation, Children's Social Care, and other services at an early stage pre-release from prison for individuals who may present indirect risk to children

3. Unmet needs of a child throughout childhood

- The child was known for criminality, risk they posed to others, non-attendance at school, and declining offers of engagement for support. Conversely, there was limited recognition as to how vulnerable they were. For example, the risks they were facing, their learning needs, impact of trauma on their mental health and behaviour, their alcohol and substance use, and the need for trauma informed approaches to help inform how services could establish a relationship with the child and engage with them effectively
- The child attended Emergency Department at hospital historically on two separate occasions, after sustaining injuries whilst under the influence of alcohol and drugs. There was no evidence suggesting there was consideration to refer to substance misuse services. 0-19 service records did not refer to follow ups to Emergency Department attendance notifications
- The child had ADHD and service records indicated that there was a good level of discussion with the GP as to the impact the child's cannabis use would have on being able to take medication. The GP was also directly informed of MASH enquiries and outcomes from health practitioners in the MASH which was actioned by the GP Safeguarding Lead. How GPs are engaged with by children safeguarding systems and processes has been a recent focus of development
- The child's attendance and engagement at school was significantly low. The review reflected the additional vulnerabilities children have when they are not attending, particularly in respect of child exploitation

4. Effectiveness of communication between services who were supporting the family

- Communication between services in particular instances was not always effective. When concerns in respect of the child were becoming more significant from 2019 there seemed to be an absence in how multi-agency work was coordinated and which service took a lead
- When father was released from prison there was confusion amongst services as to his release date. Probation did email services to inform them of the date as part of a wider email which did not register until after father was released. Services reflected that it would have been helpful in these circumstances for a means of out of hours communication between services to have been available

5. View and assessment of risk when a child is nearing adulthood

- Services shared their recognition of father's influence and control over the child but reflected a sense of feeling limited as to what effective measures could be put in place which would prevent or reduce father's contact with the child. The child had been exposed to their father's controlling behaviour from an early age, alongside the additional vulnerabilities they had, services needed to not just consider the child's chronological age but consider where they were in terms of developmental age as to whether they had agency
- Services were limited as to what proactive measures and conditions could be placed upon father to protect the child. It is likely the familial nature of the relationship i.e., father and child, resulted in services considering this issue as contact with a parent in a legal sense. For example, taking into the account the child's wishes and feelings to continue having contact would be paramount as per legal guidance. Where there are concerns of child exploitation within the context of intra-familial harm, the findings from this review suggest there is a need to find balance to mitigate risk of exploitation in cases where a parent may be exploiting their child
- Prior to the child's death they were seen by police at the associate's house the day prior to their death. Police attended to a call at the property which was unrelated to the child. Police noted the child presented as being under the influence of alcohol but did not recognise they were a child at the time and they remained at the property. The child was not reported Missing From Home and Care (MFHC). Whilst, it is only with hindsight, should the child have been reported as missing to the police, when they attended the property, they may have been better placed to recognise the child as a current MISPER (missing person) who needed returning home

6. Effectiveness of identifying exploitation at an early stage

- There were opportunities to identify the child was at risk of child exploitation at an earlier stage. Indicators such as access to drugs, missing from home, selling drugs to other children, concerns in respect of father was referred to in records but it appeared to not lead to considering effectively if the child was at risk of exploitation
- Within the context of child criminal exploitation, there is appropriate focus on extra-familial harm whereby in the majority of incidents a child is at risk from outside of the family home. In this case of the child, although father was not living in the same house as them, they were part of their family network, and it could be considered the child was facing intra-familial harm when viewing their risk to exploitation. Services recognised because it was family members and not adults outside of their family network, this may have clouded judgement in identifying the child's risk to criminal exploitation at an earlier stage

5 WHAT WILL WE DO WITH THESE FINDINGS?

- The full review generated individual, group and system recommendations which are being overseen and implemented by WSCP multi-agency subgroups which are represented by services who work or volunteer with children and families
- WSCP will hold practice review briefings to disseminate the learning and analysis to the children and families workforce

6 NEXT STEPS

- The findings of the review have been approved by WSCP and work is underway in implementing the learning from the incident
- WSCP will consider holding service challenge events for those services involved in the review to report back on how they have implemented recommendations

7 RESOURCES

There are a range of national and local resources, guidance, and training in relation to Child Exploitation on the WSCP Website:

- **Child Exploitation information page**
- **Partnership Intelligence Portal Toolkit**
- **Intelligence Sharing One Minute Guide**
- **Child Exploitation resource page**
- **Contextual Safeguarding resource page**

Wakefield Safeguarding Children Partnership