

Multi-Agency Deep Dive Audit into Multi-agency responses when a child has been reported Missing From Home and Care (MFHC)

March 2021

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North Yorkshire Safeguarding Children Partnership (NYSCP) carried out a deep dive multi-agency audit into Multi-agency responses when a child has been reported Missing From Home and Care (MFHC). The audit considered six cases involving children and young people who had been reported as missing from home or care.

When a child or young person goes missing, they are at risk.

The College of Policing (2017) Missing People Authorised Professional Practice (APP) defines a missing episode as:

'Anyone whose whereabouts cannot be established will be considered as missing until located and their well-being or otherwise confirmed. All reports of missing people sit within a continuum of risk from 'no apparent risk (absent)' through to high-risk cases that require immediate, intensive action.'

In North Yorkshire, the [Children who go Missing from Home and Care: Joint Protocol](#) is an agreed multi-agency protocol with the City of York which outlines the multi-agency procedures for when a child or young person goes missing from home or care. This includes children and young people looked after by another Local Authority (LA) and placed in foster care or residential homes or schools within North Yorkshire and the City of York.

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Why may a child or young person go missing and what are the risks?

Children may go missing due to problems such as abuse, neglect, being challenged at home or they may go to somewhere they want to be and/or someone they want to be with.

In some cases, they may have been coerced by someone else and there are clear links between children going missing and child sexual and child criminal exploitation.

The risks faced by young people are the same regardless of how often they go missing. However, younger children and those who go missing often may be more likely to face serious, long-term problems.

The immediate risks associated with going missing, include:

- No means of support or legitimate income – leading to high risk activities;
- Possible involvement in criminal activities;
- Becoming a victim of crime, for example through sexual assault and exploitation;
- Alcohol and substance misuse;
- Deterioration of physical and mental/emotional health;
- Loss of education and training;
- Inappropriate/manipulative/exploitive relationships; and
- Being drawn into County lines/criminal exploitation

Longer-term risks include:

- Substance dependency;
- Involvement in crime;
- Involvement in sexual / criminal exploitation into adulthood;
- Homelessness.

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What did the audit find – areas working well?

The audit initially set out to review four cases; however, after commencement of the audit it was agreed to extend the scope of the audit to include an additional two cases to assess the impact of changes to multi-agency practice.

- **Recognition:**

The quality in recognising MFHC at the point of a notification being made was strong. Partners responded appropriately and as expected in line with their processes. There was good information sharing between all relevant agencies

- **Assessment and Planning:**

There was evidence of good planning and assessment with MFHC Action plans and Risk Assessments being present. There were some good examples of detailed Return To Home Interviews (RTHI) which were carried out with a child and family subsequently to ascertain the circumstances around the missing episode, the risks of going missing, safety plans to reduce further episodes and ascertain if further support is required. There was good evidence to show that detail of missing episodes and RTHI were shared in Multi-Agency Child Exploitation (MACE) Level 2 locality groups enabling information to be considered in regarding the child, locations and associations and improve wider community intelligence.

- **Intervention:**

Partners demonstrated appropriate interventions as would be expected in relation to the risk level attributed to each missing episode. One case showed strong intervention by a Community Safety Hub and coordination of a large-scale community response to locate a particularly vulnerable child.. Another case showed how a School Nurse engaged with a child to provide opportunistic work and support, including support to access sexual health services. Cases also showed evidence of engagement with the Child and Adolescence Mental Health Service (CAMHS) Crisis Team and appropriate responses to allegations against a family member.

- **Joint Working:**

There were some good examples of joint working across agencies. There were some examples of timely and detailed information sharing, in line with the Children who go Missing from Home and Care: Joint Protocol. There was evidence presented at MACE Level 2 Locality Groups that further consideration took place from services in relation to a child's exploitation risk after a missing episode had taken place.

- **Impact and Outcomes:**

Across the cohort of cases the children discussed did not have a further missing episode. There were some examples across the cases that the missing episode provided an opportunity for parents to revisit boundaries and engagement with services increased. Information shared via MACE processes supported locality-based interventions to disrupt child exploitation.

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What did the audit find – areas for development?

- **Recognition:**

There were some inconsistencies in terms of recording specific dates. One case identified a need for clarity around consent issues.

- **Assessment and Planning:**

Some RTHI were limited in exploring the risk of child exploitation where the child had pre-planned to go missing (i.e. had a bag packed). Information shared in MACE meetings needed to be recorded on all relevant agency systems to ensure they inform any future missing episode.

- **Joint Working:**

There were opportunities missed to discuss missing from home notifications with partner agencies such as schools at multi-agency meetings. The sharing of more historical information regarding the family may have been useful to understand missing episodes of a child who has not previously come to the attention of other agencies previously.

- **Impact and Outcomes:**

It was difficult to evidence in some cases if no further MFHC episodes were as a result of interventions and the support of services or whether this was circumstantial.

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What will NYSCP do with these findings?

NYSCP to consider key learning points from this audit:

- Consider the use of an Operation Encompass (Domestic Abuse Notifications to schools) style notification for schools in relation to missing episodes
- Reinforce messages about the notification of missing episodes
- MSPR daily download to be used as the consistent and most accurate date for when missing episodes begin
- Gain clarification regarding the recording of information received from MACE Locality Groups within a child's health records

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Next Steps

- All agencies involved in the audit will feedback specific good practice and areas for development identified for their service during the audit day discussion.
- The findings of the deep dive audit into Multi-agency responses when a child has been reported Missing From Home and Care will be shared with the NYSCP Learning and Improvement Subgroup who will agree and adopt key actions onto the subgroup's overarching action plan. The group will then monitor implementation of the actions to review how learning has been translated into practice.

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Resources:

There is a range of national and local resources and guidance which can support professionals in relation children and young people who go missing:

The North Yorkshire and City of York Children and Young People who go Missing from Home and Care Joint Protocol:

- www.safeguardingchildren.co.uk/professionals/practice-guidance/missing-from-home-and-care

Missing Child/Young Person One Minute Guide:

- www.safeguardingchildren.co.uk/professionals/one-minute-guides/missing-child-young-person-one-minute-guide

NYSCP BeAware Missing from Home and Care:

- www.safeguardingchildren.co.uk/beaware/mfhc