

Missing children

This report explores the effectiveness of arrangements to safeguard children and young people, including those who are looked after by the local authority, who are at risk of going missing or running away. Inspectors visited a sample of 10 local authority areas. The report draws on evidence from 105 cases and from the views of children and young people, carers, and professionals from the local authority and from partner agencies.

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Executive summary

Children represented approximately two thirds of the estimated 360,000 missing person incidents in 2009–10. Children in care are three times more likely to go missing from their home than children who are not in care.¹ However, due to the unreliability of available data, it is likely that the true scale of the problem is not fully understood.

A number of recent high-profile court cases concerning child sexual exploitation and high-profile inquiries have highlighted the vulnerability of children who go missing, and the associated risks of sexual exploitation. The government published proposals to tackle child sexual exploitation in November 2011 and announced urgent action to look at the quality of residential care for looked after children in July 2012.²

This report explores the effectiveness of arrangements to safeguard children and young people, including those who are looked after by the local authority, who are at risk of going missing or running away from home. Inspectors visited a sample of 10 local authority areas. The report draws on evidence from 105 cases and from the views of children and young people, carers, and professionals from the local authority and from partner agencies.

The complex and varied reasons identified on a national basis why children go missing were reflected in the nature of the cases seen by inspectors. Children's histories included inadequate parenting, past or current abuse, bullying and domestic violence. Some children who were looked after had experienced several placement moves. Children who went missing were subjected to considerable associated risk, most often from sexual exploitation, drug and alcohol abuse, and becoming the victim or perpetrator of crime.

Inspectors saw evidence of some tenacious partnership working across relevant agencies to safeguard children at risk of going missing. Information was generally shared effectively when children were reported missing and there were some persistent efforts by professionals to engage children.

However, some inconsistency and gaps in practice meant that professionals were not always fully attuned to the needs of children who went missing. For example, it was not often clear whether checks, usually undertaken by police officers, to ensure that children were safe and well after returning home had been undertaken. When they had been, the outcomes of the checks were often not routinely shared with carers and professionals. Similarly, more in-depth return interviews with children by an independent person to explore the reasons why they had run away and to identify

¹ Data from End Child Prostitution and Trafficking (ECPAT); www.ecpat.org.uk.

² *Tackling child sexual exploitation action plan*, Department for Education, 2011; updated 2012; www.education.gov.uk/tackling-child-sexual-exploitation. *Reforms of children's residential care*, Department for Education, 2012; www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/a00213690/childrens-residential-care-reform.

any support needs were rarely evident. Updated risk management plans that identified specific actions to be taken to prevent children from running away and to keep them safe were rarely evident in the cases seen by inspectors.

The lack of routine attention to learning from the experiences of children also contributed to a generally weak understanding at a senior level of the reasons why children go missing. Strategic planning of services to reduce the number of children who go missing was underdeveloped in most local authorities and was hindered further by some poor record management and unreliable data systems. There was, however, an increasing awareness of several related issues, particularly sexual exploitation, which was supported by relevant training.

Nearly all of the cases tracked by inspectors displayed a sensitive and child-centred approach to protecting children who went missing. However, some evidence heard by inspectors about some professionals' attitudes suggests there is no room for complacency.

Key findings

- There is little or no reliable data on missing children, including numbers, characteristics and trends. In most areas and at a national level, the data on incidence reported by local authorities and that reported by the police are very significantly different.
- Common features of cases where the frequency of missing incidents had reduced and children's outcomes had improved were:
 - effective multi-agency cooperation
 - timely and persistent family support
 - continuity of workers
 - listening to and taking account of the views of children.
- Multi-agency working was embedded most strongly at an operational level and inspectors saw evidence of effective and tenacious joint working between professionals to keep children safe.
- A strategic approach to addressing the needs of missing children was less well developed. In nearly all authorities visited there was not a full understanding at a senior level of the reasons why children go missing. Most authorities were unable to evidence the impact of different interventions.
- Poor recording practices meant that local authorities struggled to collate and analyse children's views accurately in order to inform service planning.
- While most procedures and protocols were clear and in place, staff awareness and understanding of those procedures and protocols were variable. Compliance with procedures was generally not effectively tracked by managers.

- Reports to the police of incidents of missing children were shared with relevant agencies promptly.
- Safe and well checks, which should be carried out by police whenever a missing child returns or is found, were not always evident on case file records. In most local authorities visited, the outcomes of those checks that do take place were not routinely shared with all relevant professionals.
- In nearly all local authorities the limited evidence of effective return interviews with children undermined the capacity of professionals to learn more about the reasons and risks attached to children-missing episodes.
- In the cases seen, risk assessments and risk management plans were rarely evident. Those that were in place were often insufficiently specific or up-to-date.
- There was evidence in some local authorities of the effective use of legal action to safeguard children, such as harbouring notices issued to adults who might present a risk.
- Placement instability was a feature of at least a third of the 30 tracked cases where the children were looked after.
- The attention given within procedures to cross-boundary issues, such as looked after children placed out of authority, was variable. Information-sharing between professionals and placement providers based outside the local authority area was of variable quality.
- Reports about missing looked after children were not routinely provided to corporate parenting boards in all local authorities.
- Inspectors saw evidence of some imaginative preventative work, mainly in schools, but the degree of attention paid to prevention was variable.

Recommendations

Government should:

- Take urgent action to establish a single robust, transparent and high quality data system which will provide reliable information on incidences of children going missing.

Local authorities and their partners should:

- conduct an urgent and thorough self-evaluation of the effectiveness of arrangements to meet the needs of children who are at risk of going missing or running away, including the extent of compliance with statutory requirements
- establish, implement and monitor an action plan based on that self-evaluation

- reach a firm and up-to-date understanding of the nature of issues relating to missing children, based on accurate and transparent data and feedback from children and young people, which can facilitate responsive service planning.

Introduction

1. Children represented approximately two thirds of the estimated 360,000 missing person incidents in 2009–10.³ The reasons for running away are varied, complex and unique to individual children. The most frequent reason given is 'problems at home'. Physical abuse from adults, mental health and substance misuse problems, and involvement in criminality are commonly associated with children running away. Missing children are at high risk of physical and sexual abuse, criminality and homelessness. Persistent running away is increasingly understood to be an indicator that a child may be a victim of sexual exploitation.⁴
2. Children in care are three times more likely to go missing from their home than children who are not in care.⁵ However, it is likely that the true extent of the issue is not fully understood. A Community Care investigation in 2011 found that councils are still failing to accurately record the number of children who go missing from care, despite local authorities' statutory duty to record the number of looked after children missing for over 24 hours.⁶
3. The current statutory guidance for children missing from home or care was issued by the Department for Children, Schools and Families in 2009. The guidance defines a missing child or a young runaway as 'children up to the age of 18 who have run away from their home or care placement, have been forced to leave, or whose whereabouts are unknown'.⁷
4. In 2007, the Children's Society report *Stepping up* found that half of the 76 local authorities surveyed had no protocol for managing cases of children missing from home, although nearly 93 per cent had protocols for children

³ *Missing persons: data and analysis 2009/2010*, National Policing Improvement Agency, 2010; www.npia.police.uk/en/17061.htm.

⁴ *Report from the joint inquiry into children who go missing from care*, The All Party Parliamentary Group for Runaway and Missing Children and Adults and the All Party Parliamentary Group for Looked After Children and Care leavers, 2012, p 12; www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/parliamentary-work/appg-inquiry-children-who-go-missing-or-run-away-c.

⁵ Data from End Child Prostitution and Trafficking (ECPAT); www.ecpat.org.uk.

⁶ 'Councils fail to keep figures on missing children in care', *Community care*, 15 November 2011; www.communitycare.co.uk/Articles/15/11/2011/117756/councils-fail-to-keep-figures-on-missing-children-in-care.htm.

⁷ *Statutory guidance on children who run away and go missing from home or care*, Department for Children, Schools and Families, 2009, p 6; www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00670-2009.

missing from care.⁸ A more recent survey of children who go missing undertaken by the same organisation found that, although there was an increased understanding of the risks faced by missing children, there was little evidence of any decrease in the numbers of children who run away.⁹

5. The *Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2010/11* highlighted factors common to outstanding children's homes.¹⁰ These included the systems they put into action as soon as a child goes missing. Underpinned by strong links with the local police, these systems often contributed to a significant reduction in the incidents of children going missing.
6. A national strategy to reduce the number of children and vulnerable adults who go missing from home or care was published by the Home Office in December 2011.¹¹ The action plan sets out how local and central government should respond to the problem, including plans for preventative work, education and early intervention. The strategy followed an All-Party Parliamentary Group (APPG) inquiry into the support for families of missing people in July 2011, which made the overarching recommendation that there should be a cross-government outcomes policy framework for missing persons.
7. A number of recent high-profile court cases of child sexual exploitation have highlighted the vulnerability of children who go missing, especially those who are looked after by the local authority and living in children's homes. A Joint APPG inquiry into children who go missing from care was undertaken in 2012.¹² Key findings from the inquiry included the following.
 - The unreliability of data severely impedes agencies' ability to intervene and respond effectively to missing children.
 - The quality and stability of care placements were variable. Older children, in particular, were often placed considerable distances from home.
 - Some homes had been rated good or outstanding by Ofsted, yet had repeated incidents of children running away. Ofsted did not seek information

⁸ *Stepping up*, The Children's Society, 2008; www.childrenssociety.org.uk/what-we-do/parliamentary-work/policy-areas/children-risk-street/stepping.

⁹ *Still running 3: early findings from our third national survey of runaways*, The Children's Society, 2011; www.childrenssociety.org.uk/news-views/press-release/child-runaways-significant-danger-professionals-fail-step.

¹⁰ *The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills, 2010/11*, Ofsted, 2011, p 125; www.ofsted.gov.uk/resources/annualreport1011.

¹¹ *Missing children and adults: a cross-government strategy*, Home Office, 2011; www.homeoffice.gov.uk/publications/police/missing-persons-strategy?view=Standard&pubID=966333

¹² *Report from the joint inquiry into children who go missing from care*, The All Party Parliamentary Group for Runaway and Missing Children and Adults and the All Party Parliamentary Group for Looked After Children and Care leavers, 2012, p 12; www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/parliamentary-work/appg-inquiry-children-who-go-missing-or-run-away-c.

- from the police prior to their assessments, and findings in relation to individual children's homes were not routinely shared with local authorities.
- Children, and some professionals, reported that signs of abuse or exploitation were not always recognised.
 - Children trafficked from abroad were particularly vulnerable.
8. In May 2012, the Secretary of State for Education asked the Deputy Children's Commissioner to report to him urgently on emerging findings from her ongoing inquiry into child sexual exploitation in gangs and groups. He asked that the report focus particularly on risks facing children living in children's homes. Themes emerging from this accelerated report¹³ included the following.
- Gang- and group-associated child sexual exploitation is taking place across England and is perpetrated by people of varying ages, ethnicities and social backgrounds.
 - Some services are better able to identify gang-associated child sexual exploitation than others; even within one area different services provide different intelligence on both victims and perpetrators.
 - Children are being sexually exploited by gangs and groups made up of people who may be of the same or different age, ethnicity, religion and social backgrounds to them.
 - Children in care and children not in care are being sexually exploited. While the majority of children being sexually exploited are not in care, a disproportionate number are.
9. In response, in July 2012 the government published a progress report on the 'Tackling child sexual exploitation action plan' that it had produced in November 2011. The progress report outlined the significant progress that had been made but stated that there was much more to be done. A step-by-step guide for practitioners on what to do if they suspect a child is being sexually exploited was published at the same time.¹⁴
10. The government also announced action to help protect young people in residential care, to address issues relating to:
- children placed in homes outside their home authority areas

¹³ *Inquiry into child sexual exploitation in gangs and groups, with a special focus on children in care*, Office of the Children's Commissioner, 2012;

www.childrenscommissioner.gov.uk/content/publications/content_580.

¹⁴ *Tackling child sexual exploitation action plan, progress report and step-by-step guide for practitioners*, Department for Education, 2011 and 2012;

www.education.gov.uk/tackling-child-sexual-exploitation.

- the quality and transparency of data relating to looked after children who go missing
- regulations which stop Ofsted telling police and other relevant agencies the location of children's homes.

The government has recently consulted on the proposals.

11. In October 2012, the Children's Rights Director for England published a report giving children's views and experiences of running away from care.¹⁵ Children gave a strong message in the report that adults must listen carefully to, and resolve, problems that they are experiencing where they live and should seek to debrief and listen to children when they return from running away. A further report published in December 2012 showed that some children had resorted to running away if they felt their complaints were not being dealt with effectively, despite the knowledge that they might be putting themselves in danger if they ran away.¹⁶

Methodology of thematic inspection

12. This report summarises the findings from visits by inspectors to 10 local authority areas between August and October 2012. The visits explored the effectiveness of arrangements to safeguard children, including those who are looked after by the local authority, who are at risk of going missing or running away from home. The local authorities varied in size and geographical context and included metropolitan areas, London boroughs and counties of varying size, with a combination of rural and urban features.
13. The local authorities reflected a range of performance in recent relevant inspection outcomes. Of the 10 authorities visited, four had received a judgement of good for the overall effectiveness of safeguarding in their most recent safeguarding and looked after children inspection. Five had been judged as adequate, and one had been judged as inadequate. Three of the local authorities had been judged as good in relation to their services for looked after children, while seven had been judged as adequate.
14. Inspectors sought to identify the key factors that reduced the risk of children going missing and common barriers to good practice by looking at:
 - what had been most successful in reducing incidents of children going missing
 - key partner agencies' understanding of the reasons why children go missing locally and the extent to which this was a shared understanding

¹⁵ *Running away: young people's views on running away from care*, Ofsted 2012; www.ofsted.gov.uk/resources/120022.

¹⁶ *Young people's views on complaints and advocacy*, Ofsted, 2012; www.ofsted.gov.uk/resources/120362.

- how the understanding informed strategy and service planning across relevant agencies
 - how risk to children was assessed and managed
 - the effectiveness of contributions made by other agencies, including the police, education, health and the voluntary sector
 - the extent to which policy and guidance provided an effective framework for good interdisciplinary practice
15. Inspectors undertook visits to the 10 local authority areas between August 2012 and October 2012. On each visit, two inspectors tracked five children's cases which featured children who had gone missing, via meetings with involved professionals and access to case records. Inspectors also examined a randomly selected sample of relevant cases via electronic care records and meetings with practitioners.
16. The five tracked cases in each local authority included three looked after children and two children who were not looked after. Of the three looked after children, at least one was placed in foster care and at least one was placed outside of the local authority area. A total of 50 cases were tracked. A further 55 cases were randomly sampled.
17. The report draws on evidence from discussions with children in each area, some of whom had a long history of going missing. Displayed quotations, unless otherwise stated, are from children spoken to during the thematic inspection visits.
18. Interviews were also held in each local authority area with:
- a senior manager responsible for safeguarding
 - the Local Safeguarding Children Board (LSCB) chair, or an available representative
 - a cross-agency operational group of representatives (for example, from health, education, police and children's social care)
 - a group of social workers
 - a group of children's home staff
 - other relevant agencies or commissioned services.
19. Good practice examples are highlighted in this report to illustrate aspects of good work in a particular area and are not intended to suggest that practice in that area was exemplary in every aspect.

Why children went missing

20. The nature of the cases tracked by inspectors reflected the complexity of reasons why children go missing, as outlined in the introduction to the report. Running away or going missing was often symptomatic of wider problems and, in turn, was likely to exacerbate and add to those difficulties. 'Push' and 'pull' factors were evident; some children sometimes ran *to* a situation that presented risks to them while some ran *away* from something or someone. However, this distinction was not always clear. 'Push' and 'pull' factors were often both apparent in cases.
21. A considerable number of the cases indicated that children's lives were marked by inadequate parenting and past or current abuse. Several children had been disengaged with education for some time. A small number were known to have been subject to bullying. Domestic violence was a feature in several cases. Some children who were looked after had experienced several placement moves while they were in care. Poor emotional well-being, including low self-esteem, was often a feature of the cases seen by inspectors.
22. Children who went missing were subjected to considerable associated risk, most often from sexual exploitation, drug and alcohol abuse, and becoming the victim or perpetrator of crime. Some children in care were running away to be with their friends or their birth families.

Notifications of missing episodes

23. Generally, arrangements for the police to share information with the local authority when a child had been reported missing were robust and were supported by clear procedures. Referrals were sent in a timely manner, usually to an agreed first point of contact within the local authority, such as a contact, referral and assessment service or, outside of normal office hours, to an emergency duty team. This facilitated a prompt assessment of need by the local authority's children's services. Relevant professionals could be informed quickly if the child was looked after.
24. In one authority, the risk assessments incorporated within missing notifications to the local authority were quality assured by a senior officer and followed up by a manager within children's social care to decide what actions were required. In another authority, all notifications that were sent to a secure email address were accompanied by details of visits that the police had made to ensure that the child was safe and well. Although these systems worked well generally, some key professionals were not always informed routinely. For example, independent reviewing officers were not always routinely informed when a looked after child went missing. Similarly, child protection chairs were not consistently informed of children who were subject to a child protection plan going missing.

25. If cases were already known to children's social care, information was passed on appropriately to the professionals involved in the case. One local authority complemented its notification system with 'need to know forms' which were completed by social workers and managers and used to inform senior managers of specific concerns about the welfare of children. This promoted an active oversight by the senior management team of both individual and organisational vulnerabilities.

Generally, inspectors found that missing incidents, however frequent, were reported to the police in line with the local protocol. Inspectors saw several examples of the police responding proactively to each report, despite the considerable demands on their resources and the fact that sometimes the location of the child was known.

Risk management

Safe and well checks

26. Statutory guidance explains that 'safe and well checks' should be carried out by the police as soon as possible after the child has returned,¹⁷ in order to:
- check whether the child has suffered harm
 - find out where and with whom they have been
 - provide an opportunity to disclose any offending by, or against, them.
27. In most cases seen, however, safe and well checks were either not undertaken or were not evident on case file records. In nearly all local authorities visited, the outcomes of those checks that did take place were not routinely shared with all relevant professionals. There was clear evidence of safe and well checks being undertaken (and the content shared with allocated social workers) in only 13 of the cases tracked by inspectors. Sampled cases presented a similar picture of poor information-sharing and non-compliance with statutory guidance.
28. The statutory guidance does state that it may not be practicable for safe and well checks to be undertaken every time a child returns, if that child goes missing frequently. A more flexible approach to repeat runaways was evident in several cases, although it was not always clear why, and by whom, the decision had been made not to undertake checks for each episode. For example, in one case, the social worker felt that repeated missing episodes were seen as 'low risk' by police and that was why, in her view, the checks had not been completed. Similarly, another social worker stated that checks had not been

¹⁷ *Statutory guidance on children who run away and go missing from home or care*, Department for Education, 2009; p 24;
www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00670-2009.

carried out 'because of the frequency of going missing... so the check does get missed'.

29. In another case, a decision had been made that a safe and well check should only be undertaken when the child was found to be at a certain individual's home. However, inspectors found no evidence of checks being completed in those circumstances.
30. There was a mixed view from most agencies of the usefulness of safe and well checks, and their limited worth was sometimes seen as partly due to the lack of sensitivity and awareness of uniformed officers carrying out the visits. In one case, safe and well checks were conducted after each episode for a frequent runaway, but the child was usually verbally abusive to the police officers. A missing persons coordinator from the police took the view that the checks were of little value:

'The visits are often recorded as "officer gave stern words" – the cop tells them off. It's very negative. It's still an issue.'
31. Some of the children spoken to during the visits told inspectors that they felt the checks were like lectures. One child expanded on this:

'Some try to understand and others just tell us to stop going missing and being silly.'
32. Another expressed a common view held by children:

'I don't think young people should be questioned straight away when they come back. It's more important to welcome them and make sure they're safe. They could ask questions a couple of days later – questions about how they could help.'
33. Some areas were working hard to improve the quality of the checks. One police force attempted to take a flexible and sensitive approach over who should carry out the checks and assessed each case accordingly. Another quality assured safe and well checks to ensure they met a required standard. As a result, some checks were not undertaken by uniformed police officers if it was believed that this might be counter-productive.
34. Overall, however, there was a lack of evidence in nearly all the local authorities visited of the safe and well checks being undertaken regularly. There was little evidence that the outcomes and content of those checks that were done were being shared with relevant professionals. This meant that the checks rarely informed case planning. Furthermore, children's views that could be expressed through the visits were rarely taken into full account by the professionals attempting to meet their needs.

Return interviews

'The staff at the children's home tried to talk to me about why I went missing. The more I went missing, the less they tried.'

35. Children's views about their care and the help that they were receiving were evident in most cases seen by inspectors. For example, statutory reviews for looked after children used a variety of methods to support children's participation. Inspectors saw evidence of some persistent efforts by social workers to engage children and to ensure that their voices were heard.
36. Looked after children in several local authorities highlighted the value of having a choice of people to speak to. In one area, a group of looked after children were very positive about seeking information at sexual health clinics:

'They talk to people about running away. We feel more secure there, because they need to have your permission to tell anyone, unless they think you're at risk.'
37. However, the capacity of professionals to learn more about the reasons and risks behind children missing episodes was undermined in nearly all local authorities by a failure to undertake and record interviews with children after they had either been found or had returned home. Inspectors found evidence of return interviews being undertaken in only 11 of the 50 cases that were tracked.
38. Return interviews are described by the statutory guidance as more in-depth than safe and well checks. They should be carried out by an independent person who is suitably skilled to carry out these interviews and can follow up any required actions that may emerge. The interviews should in most cases be completed within 72 hours of a child returning home.
39. Sometimes it became clear that visits had been made to missing children but they had not been recorded as return interviews – one social worker described them as 'buried in the system' – which meant that they were hard to locate on a child's records. Furthermore, if the local authority had wished to collate and analyse the information contained in these interviews, it would have been impossible to do so.
40. The impact of return interviews on care planning and on wider service planning was therefore limited. Although in many cases it was clear that the needs of the child were well understood and discussed on a regular basis at an operational level by a number of agencies, return interviews rarely contributed to a better understanding of the reasons why children went missing, or to an analysis of patterns of behaviour for children who ran away frequently.

41. Inspectors saw some examples of positive outcomes arising from return interviews when they occurred. In one case, the social worker had been able to identify links to a group of males. This information was discussed at a later professionals' meeting and shared with the multi-agency strategic group, informing the management of risk, including the use of a legal order to protect the child. The systematic use of safe and well checks and return interviews was characteristic of persistent and effective collaboration between key agencies and integral involvement of the child's views in the planning process, despite the extremely challenging nature of the case.
42. In another case, the information gleaned by an allocated social worker from a return interview gave her a valuable perspective on the child's family dynamics and the reasons for the child running away. This perspective helped the formulation of a plan that all family members could agree. Underlying issues were addressed through the successful engagement of the parents and missing episodes have reduced.
43. Generally, return interviews were more evident if the frequency of a child's missing episodes was not high. In a number of local authorities, social workers explained that it was not always possible to undertake visits within 72 hours or to visit each time a persistent runaway returned home. This was even more likely when a young person was placed outside of the local authority area. Indeed, despite some evidence of good practice that demonstrated the potential value of the interviews in contributing to effective case planning, the social workers' views were borne out by the overall lack of compliance with the requirements of both the statutory guidance and local authorities' own procedures.
44. Not all children wanted to talk to anyone at a return interview, partly because of the perceived tone of the discussion:

'They should be focused on trying to help, not on interrogating you.'

Another child told inspectors, 'Nothing would make me talk to anyone.'

45. Inspectors identified from the cases reviewed that a regular refusal, especially from frequent runaways, could sometimes lessen the likelihood of the interview being offered. One social worker commented that asking one particular child why they ran away might have prompted a negative response and increased the risk of her running away, so the question was never asked. But, as one social worker stated:

'The [return home] interviews are part of showing the young person that you are worried.'

46. In several local authorities, the tracking and sampling of cases, and conversations with a range of professionals evidenced a lack of understanding of the necessary distinction between safe and well checks and return interviews. Often, the distinction was blurred, leading to a lack of clarity and

purpose in discussions with children, when they occurred. Not all social workers were aware of the reasons for the return interviews and they were often unclear about the procedural requirements. One social worker, when discussing a case where there was no evidence of the interviews being undertaken, described the visits as a 'paper exercise'.

47. Looked after children who lived in children's homes were more likely to receive return interviews than children living in foster care. In several local authorities, however, there was a general understanding that in such circumstances the key worker for the child would carry out the interviews, which raises the question of whether the visits were carried out by someone sufficiently independent.
48. Best practice focused on a careful consideration of who was best to carry out the visits – as in one local authority where, although this was usually a social worker, it could be any professional that the child trusted and knew. Youth service workers in this authority usually visited children who were not looked after and independent advocacy was available.

Worcestershire: Return interviews

Return interviews for children aged 11 years and over who are not known to social care are undertaken by Worcestershire's Support, Guidance and Skills Service. The Early Intervention Family Support Service undertakes return interviews for those under 11 years of age. Both these services work closely with schools to reduce the number of missing incidents.

The Support, Guidance and Skills and Early Intervention Family Support Services have strong and established links with educational settings in the county. Workers from these services are based in some schools, enabling them to access and build rapport quickly with those who go missing. This is essential to making the return interview a meaningful way of exploring the reasons for the missing episode, the child's life at home and their safety while missing. In many cases, the return interview is just the start of the relationship between the child and the worker. Planning ongoing and direct one-to-one support for the child and their family is crucial to future prevention.

The Support, Guidance and Skills and Early Intervention Family Support workers often conduct return interviews in conjunction with staff in the school who already have a good rapport with the pupil. The worker and school staff develop a joint plan for ongoing support and referral to appropriate support agencies and also undertake ongoing work to develop the pupil's understanding of the risks involved in going missing.

The interview is seen as part of a continuous service offered to the child, rather than a one-off interaction, to be undertaken by staff who continue to be accessible to the child.

The interventions from the services have contributed to the 30% reduction in missing children incidents over the last year.

Multi-agency working

49. There were some strong inter-agency relationships at an operational level in all the local authorities visited. Joint working was generally well embedded. Inspectors saw a good deal of evidence of strong operational relationships between the police, especially dedicated officers working with children at risk of going missing or of sexual exploitation, and children's social care. These relationships had often benefited from integrated working arrangements, particularly if agencies were co-located.
50. In one local authority, for example, the co-location of two seconded social workers to the police safeguarding unit had contributed to improved communication, increased capacity and more timely responses to cases where children were at risk of sexual exploitation. Elsewhere, the multi-agency safeguarding hub enabled effective information-sharing across agencies, contributing to well-informed decisions and actions to protect missing children.
51. Most cases seen by inspectors involved good engagement of a wide range of agencies, reflecting the complexity and diversity of many children's needs. In one case, for example, there was active involvement from a wide range of agencies, addressing all areas of the life of a looked after child who was placed outside the local authority. The social worker, acting as lead professional, successfully coordinated activity. Despite the complexity of the case, a clear focus was maintained on managing the serious risks posed by regular missing episodes. Care planning was informed by a robust shared assessment of need and led to an increasingly settled placement and a sharp reduction in the number of times the child ran away.
52. In another local authority, a 'Team around the Family' met every six weeks to evaluate and plan interventions to address the needs of a child who was living at home but was missing regularly and involved in associated risk-taking behaviour. The regular meetings held agencies to account effectively, engaged parents well and provided the child with good opportunities to talk about the underlying reasons for going missing.
53. However, not all multi-agency activity in cases translated into focused activity addressing issues raised by missing children. In one case, for example, a professionals' meeting involving at least six agencies was held at least monthly to discuss the needs of one child, but the work did not focus sufficiently on the frequent missing episodes. The work was not informed by an up-to-date risk management plan, nor was the child regularly seen on her return home.
54. In another local authority, the absence of effective communication had contributed, in the social worker's view, to poorer outcomes for a child. The social worker complained that, in retrospect, the range of agencies involved in

the case had not met frequently enough, which meant that the sometimes conflicting stories given by the child had not been shared and understood fully by the different agencies.

55. Seven authorities had established multi-agency groups that met regularly to discuss cases of concern, including those where running away was a factor. Some groups were designed to address only cases where children going missing was a major cause of concern. The most effective groups were able to harness and share expertise, had timely access to the required resources, and expedited some imaginative solutions to complex cases.
56. For example, one local authority hosted a multi-agency group of operational managers looking at missing episodes. This group exercised considerable influence across the service. It facilitated prompt responses to identified issues and helped to develop expertise across all agencies. Elsewhere, a similar group ensured that senior managers were aware of the children at high risk of going missing, but social workers were not always aware that their cases had been discussed, and this limited the impact of the group on casework. Similarly, a group in another authority was a predominantly case-focused panel of managers, but until recently social workers had not been able to refer cases of concern for discussion.
57. In one case seen by inspectors, a request for a senior manager to approve a placement outside the authority area for a child who was persistently missing had 'hit a brick wall', according to the social worker. Such decisions at the time were taken by a single manager, but were now taken by a panel which shared accountability and made decision-making less reliant on the views of one person.

Staffordshire: Raising the awareness of child sexual exploitation

The MACaRoSE forum¹⁸ was established in January 2010 to comply with the Department for Children, Schools and Families guidance published in 2009 and included members of both Staffordshire and Stoke-on-Trent Safeguarding Boards. The forum has sought to develop links between statutory and third sector agencies, local partnerships, and public protection arrangements and processes for reporting to Local Safeguarding Children Boards (LSCBs). The meetings are now held monthly and a strong focus on child sexual exploitation has been developed.

The work of the MACaRoSE group has been underpinned by Staffordshire Police commissioning regular analyses of local factors. For example, 'Shelter' (2009) looked at the most frequently missing children and the

¹⁸ Multi-Agency Forum for Children at Risk of Sexual Exploitation.

links to Child Sexual Exploitation (CSE). In 2010, 'Topsail' looked at CSE and Organised Crime Group links. These reports were shared with partner agencies and provided the template for current strategy meetings. This approach has extended to Operation Garnet (2012), launched earlier this year and led by the Sexual Exploitation Team.

The group has developed a comprehensive county-wide multi-agency strategy, linked to trafficking and missing children, and has developed a joint policy and protocol. There is a comprehensive menu of training including 'lite-bite' sessions commissioned by the LSCB and theatre productions by the Saltmine Theatre Group that are performed in schools.

The work of MACaRoSE has effectively raised the profile and awareness of child sexual exploitation in the county and this is evidenced by the expansion of the Sexual Exploitation Team in the police from one specialist officer to 12 experienced police officers. Police officers are more alert to the signs of CSE. Information gathered from safe and well checks following missing episodes has been used to secure prosecution and disruption of offenders. There are close partnerships with the local authority to manage the risks presented by looked after children who go missing, especially those living in children's homes.

Hertfordshire: A multi-agency approach to missing children

The operational group MAMCAG (Multi-Agency Missing Children Action Group) was established in 2010. The group receives referrals on specific cases and seeks to manage risk and to reduce further missing episodes.

The group is chaired by the police and includes membership from children's services, education, CAMHS, health, youth services and the voluntary sector. Any child meeting one or more of the following criteria is referred to the group:

- a professional considers the child to be at risk
- the child has been missing for an extended period
- the child has been missing at least three times in the last 90 days.

The group reviews information from all the agencies and puts in place a dynamic Specific, Measurable, Attainable, Timely (SMART) action plan aimed at reducing the missing episodes and associated risk. The action plan is monitored through the group. Any emerging trends or areas of concern are brought to the attention of a strategic group.

The referral process is complemented by an electronic exchange of information between the police and children's services about all missing children and young people on a daily basis at the time of entry on to the police missing persons system. The MAMCAG meetings allow for urgent meetings to be convened should a case require this approach.

Evaluation of the MAMCAG process for the year 2011–12 showed that 43% of the high risk cases reviewed did not repeat missing episodes, a further 12% resulted in only one further missing episode. The terms of reference and name of the group have recently been changed to increase the focus on cases of sexual exploitation not yet presenting as missing episodes.

Use of legal orders

58. Inspectors saw many examples of cases where professionals had been tenacious in their attempts to locate missing children, including visiting the addresses of individuals who were suspected of harbouring missing children and who might have presented a risk. In four cases, the police had used harbouring legislation to tackle cases where children had run away or gone missing and were found with people considered to be inappropriate.¹⁹ Adults who may be harbouring children are formally advised that they must make every attempt to ensure that the child returns home. The implications of a failure to act in the child's interests are explained. In all cases seen by inspectors where this kind of legal recourse was utilised, it was part of a wider package of interventions and was not designed to be the sole solution to the problem. Not all police forces in the areas visited by inspectors used harbouring notices to protect missing children.
59. The issuing of a harbouring notice to family members, along with the threat of media involvement and of further harbouring notices to other relatives, had an almost immediate positive effect on one young runaway who was looked after, and the child's unauthorised returns to his family ceased. Sustained improvement was underpinned by a careful engagement of the child's and the family's views about their contact with each other. Contact is now, after careful assessment, managed flexibly and largely unsupervised.
60. In another case, the use of a harbouring notice, which effectively ceased a young woman's overnight visits to an older man, was allied to some effective direct work with the young woman's parents. The work raised their awareness of grooming techniques, reframed the risk to their daughter and helped them to recognise the safeguarding implications.

Risk assessments

61. Overall, the quality of risk assessments in all local authorities was variable. In most cases seen, suitably specific and timely risk assessments were either not in place or not accessible.

¹⁹ Section 2 of the Child Abduction Act 1984, or section 49 of the Children Act 1989 (if under 18 years and in local authority care).

62. Inspectors did see evidence of some effective risk management in several cases. For example, when concerns arose, strategy meetings involving children’s social care and the police (and sometimes other agencies when necessary) were generally convened in a timely manner, leading to some clear and prompt plans of action. Regular planning meetings and multi-agency panels demonstrated a good understanding of risk and some tenacious attempts to safeguard children. Police notifications in some local authorities incorporated a risk assessment that was reviewed and signed off by a senior officer.
63. Typically, however, in cases tracked by inspectors there was an absence of a coordinated risk assessment that had been developed and followed by all professionals involved. Risk assessments that were in place rarely focused specifically on identified risks associated with going missing and were not always shared effectively with those who needed to be aware of any agreed actions. They were not always updated when circumstances changed or when a child went missing again. Assessments were often difficult to locate, limiting their usefulness. It was not always clear what action was required to be taken, or by whom, in order to manage risk in certain circumstances.
64. Looked after children were more likely to be the subject of risk assessments, especially those in children’s homes, but these were often generic and, again, were not always available to all those, such as emergency duty teams, who might need to put plans into practice. In one local authority, the regional protocol for missing children did not include a risk assessment template for a non-looked after child.
65. Inspectors did see some good practice examples. In one case, an independent service provider had contacted the missing person’s unit to tell them about the placement of a particularly vulnerable child. The existing risk assessment was then translated into a common risk management plan, which was held and updated by the police.
66. In another case, a child had been involved effectively in the development and updating of the risk management plan:
- ‘I’ve learned more about running away. I’ve learned about my safety plan and that the people I was with weren’t true friends.’
67. Elsewhere, a risk assessment was in place for a child living in a children’s home outside of her home authority. The assessment identified specific risks, including sexual exploitation. Details of known contacts were provided. Control measures were in place, with clear accountability for agreed actions. The risk assessment developed as the placement progressed and took appropriate account of the child’s age and understanding.
68. Such positive examples were, unfortunately, exceptional. Although local procedures usually included the requirement to undertake and update risk assessments, they did not always provide clear expectations about what was

required of practitioners, which contributed to inconsistency in application. Managers did not routinely track compliance or provide direction to staff.

Management oversight

69. The general lack of compliance with agreed procedures, including the completion of return interviews, demonstrated that management oversight was not sufficiently robust. It was not always clear how managers would know if actions had not been completed. The variability of recording practice and policies meant that tracking or auditing compliance was difficult: for example, in several authorities the lack of naming protocols for documents such as risk assessments or return interviews, which resulted in difficulties in finding them.
70. Inspectors did see evidence of management oversight in most cases, particularly through supervision or involvement of managers in strategy meetings. There was generally routine consultation with first line managers, although knowledge varied among social workers in most local authorities of when they were required to inform more senior managers of a child going missing.
71. The impact of managers on decision-making was not always evident. For example, in one case, while managers had been alerted to events appropriately and consistently, follow-up work was not monitored. Discussions of cases in supervision were sometimes limited to descriptions of events. They did not always evidence a reflective discussion of the case or result in SMART actions. In some cases, where it was evident that some agreed tasks had not been completed, supervision did not address this sufficiently.

Care planning for looked after children

Placement stability

'Residential homes are the worst places to be, there's lots of staff. Sometimes you don't want many people around.'

72. Placement instability, in areas where there was little placement choice, was a feature in at least a third of the 30 tracked cases where the children were looked after. Going missing contributed to this instability as carers struggled to cope with the regular running away. In turn, placement moves sometimes led to an increase in the frequency of missing incidents.
73. Inspectors saw several examples of cases where effective care planning had led to improved stability for looked after children and an attendant reduction in the frequency of their missing episodes. In several cases, actively seeking the child's views about what he or she wanted from foster carers informed a successful matching process and a subsequent successful placement. Elsewhere, a child responded positively to carers who were able to provide

clear boundaries about rules and expectations while remaining positive about his achievements and progress. This was underpinned by some effective support and direction from the family placement team.

74. The 'chemistry' between a carer and a child was sometimes cited as the central reason for a successful placement. These cases tended to be marked by the ability of carers and professionals to engage the views of children effectively and patiently work through issues such as contact with friends and families. This approach built mutual trust, sought to manage risk proportionately and was important to several groups of children spoken to by inspectors. In one case, support for the child in tracing his birth family had a positive impact upon the child's rate of running away and the stability of his placement, as well as his emotional well-being and sense of identity:

'You need to be encouraged to come home. You need to feel a part of where you're living. Foster families shouldn't say that you're part of the family, then go off on holiday and leave you behind.'

Salford: Reducing missing incidents in a children's home

Young people living at the home occasionally go missing without telling staff where they are and who they are with. This may mean that the young people are putting themselves at risk or experiencing difficulties. Staff work with young people to minimise these risks, making every effort to locate them before reporting procedures are initiated.

The home follows the Pan-Greater Manchester Missing from Home and Care Protocol. Effective, proactive strategies are implemented to reduce missing episodes, and young people are encouraged to talk with someone they can trust.

Examples of good practice include the following.

- Good relationships have been established between the police, staff and young people through regular community police visits to the home.
- Monthly management meetings are held within the home using data collected to identify trends and patterns of behaviour, and to devise strategies that enable staff to manage risks through individual sessions and young people's meetings.
- A bonus system is used to encourage young people to achieve their goals.
- Drug awareness training is provided by a substance misuse worker from the Next Step (leaving care) service who works directly with individual young people, holds training sessions with the staff, and works with mixed groups of staff and young people.

- Young people have the use of a mobile phone to ensure that they can maintain contact. They have a code word to use if they are in danger, and are aware that staff will treat this as serious and urgent.
- The home will accept reversed charge calls made by young people who are missing, and young people have a bus pass so they can return home.
- Staff endeavour to make young people feel comfortable about returning home, without fear of being in trouble. Young people are provided with a warm welcome upon their return, offered a drink or a meal and are given the opportunity to discuss any concerns in a safe environment where they feel valued.

During the period between December 2011 and May 2012 there were 21 reports of young people going missing from the home. During the period between June 2012 and August 2012 there were none.

Independent reviewing officers

75. In nearly all local authorities visited, independent reviewing officers (IROs) were not routinely informed when a looked after child went missing.²⁰ Social workers in several authorities reported that they did not always notify the IRO of each missing episode and they were not always required to do so by the local procedures. However, the emergency duty team in some authorities notified the IRO if a looked after child was reported missing outside of office hours.
76. Inspectors did see evidence in some authorities of good communication between allocated social workers and IROs, and in some cases early reviews were convened as a result of concerns arising from missing episodes. There was also evidence of missing incidents being explored effectively in statutory reviews, placing an emphasis on the underlying causes, and care planning responding accordingly. Elsewhere, however, the significance of missing episodes was not given due attention in the reviews. For example, the minutes of a statutory review in one case mostly provided a description of recent events and addressed the need for containment rather than exploring related issues, preventative strategies or future plans.

Cross-boundary looked after children

77. Cross-boundary issues challenged efforts in most local authorities to reduce the number of incidents of children going missing and to understand the scope of the problem.

²⁰ Local authorities are legally required to appoint an independent reviewing officer for each looked after child. IROs should ensure that the care plans for looked after children are robust and that each child's wishes and feelings are given full and due consideration.

78. Local authorities are required to notify other local authorities if they have placed a looked after child in their area.²¹ However, several authorities visited by inspectors cited the failure of other local authorities to carry out this requirement consistently, which meant that 'host' authorities were unable to know with any degree of certainty how many looked after children were living locally, and how many had gone missing. This affected their capacity to respond fully to the needs of all looked after children in their area, including those children looked after by another authority.
79. Not all local protocols regarding missing children made specific reference to cross-boundary children, who either lived outside the area or had been placed within the local authority's boundaries by another local authority. One authority identified that differing or unclear protocols regarding cross-boundary children sometimes left one area expecting the other to look for a missing child, and vice versa. Occasionally this led to a delay in concerted action to safeguard the child.
80. Inspectors did see evidence of positive efforts to meet the needs of children living locally who were looked after by another authority. For example, one authority is now required by a regional protocol to hold intervention meetings for children who go missing and who are looked after by another authority. These meetings are chaired by the child's allocated social worker and attended by a police representative and other agencies, as appropriate.
81. In several local authorities, stringent efforts had been made to engage independent placement providers in the area, including encouraging a commitment to notify the local authority when a child looked after by another local authority was being placed with them. Elected members in one authority regularly visited independent children's homes as part of their wider corporate parenting role. In another authority, independent providers were required to show evidence that their procedures and protocols were sufficiently robust. Quarterly performance returns were sought, including data on 'missing' episodes. A representative from this local authority said:
- 'Gathering information is difficult, but we now challenge local authorities if we are questioning the viability of a placement.'
82. At least one of the tracked cases in each authority concerned a looked after child who was placed outside his home local authority area. Several of these children had been placed outside the local authority for their own protection, typically to break the cycle of running away that was placing them at risk. A smaller number of children had been placed outside the area due to a lack of placement choice. Some were living quite close to their own local authority.

²¹ The Care Planning, Placement and Case Review (England) Regulations 2010; www.legislation.gov.uk/ukxi/2010/959/contents/made.

83. Local authorities regularly faced a dilemma when considering cross-boundary placements as they sought to strike a balance between removing a child from the risks associated with going missing and moving them far from family and friends. Inspectors saw some evidence of careful assessment of the placement needs before it was decided to commission an independent placement. Outcomes for some children placed outside their home authority had improved, partly as a result of moving away.
84. In a small number of cases, however, it was not clear if longer-term plans were in place to sustain the improvement. In one case, sufficient information had not been passed to the child's new carers to inform their response if the child went missing. In another, the assessment to inform a proposed move to semi-independence had not commenced and plans for the child's next move remained uncertain.

Staffordshire: Independent provider forum

There are more than 60 independent children's homes in Staffordshire.

The independent provider forum was initiated by a police sergeant in the north of the county approximately three years ago. The police were often being asked to respond to minor offences at children's homes such as damage to property or non-serious assaults, but these incidents regularly did not result in charges being pressed. This was a strain on police resources and led to poor outcomes for children.

Correspondingly, children's homes in one particular area (with a large number of independent children's homes) had high rates of missing activity. Procedures for reporting missing episodes were inconsistently applied. There were increasing concerns that children were targeted for sexual exploitation.

A 10-point checklist for offences in children's homes was developed, which children's homes managers were expected to consider before contacting the police. The police sergeant began to visit the homes in the area regularly, providing advice and support to staff and building positive relationships with young people. The police service has since allocated specific police officers to each children's home to act as single points of contact (SPOCs). This approach has been extended to all the other local police areas in Staffordshire.

Quarterly workshops, attended by the police, care providers and the local authority, share good practice and consider responses to various scenarios. Information on missing episodes was originally presented to the group anonymously. However, at the request of care home managers, homes and locations are now included.

The networks developed by the scheme have helped to make strategy meetings more meaningful and to facilitate more effective management of safeguarding concerns. Placing authorities now have better information on which to base placement decisions. The number of missing episodes in the area has halved, the prosecution of adult offenders is more likely, and children's homes are better equipped to tackle missing, and potentially criminal, episodes. The initiative has raised awareness within the police force generally, leading to more meaningful evidence from safe and well checks.

SPOCs report that children feel more comfortable speaking to police officers with whom they have built up a relationship, which improves their relationships with those in authority, including uniformed police.

Trafficked children in care

85. The APPG inquiry into children missing from care identified that the data on trafficked children missing from care was patchy and incomplete, although it was estimated that 60% of suspected child victims of trafficking in local authority care go missing and that trafficked children are often placed in unsuitable accommodation.
86. In the local authorities visited by inspectors variable attention was given to the needs of children who were at risk of being trafficked. The level of attention was partly due to the perceived significance of the issue locally. For example, in one local authority which had a relatively high number of trafficked children as a result of its proximity to key transport routes, a specialist team working with unaccompanied asylum-seeking children had a good understanding of the scope of the problem. They had strengthened their risk assessment processes and worked well with the police, both inside and outside the local authority area, to track and search for children who were believed to have been trafficked and had gone missing.
87. Elsewhere, it was more likely that trafficked children were specifically identified as a concern if that local authority area, at a senior level, had a firm understanding of the groups most likely to go missing, based on an ongoing analysis of data. However, in most authorities, understanding of the issues relating to trafficked children going missing locally was generally based on anecdotal evidence. There was limited evidence of services being shaped by authorities' awareness of the risk of trafficked children going missing, such as the targeted recruitment of specialist family placements.

Service planning: Understanding the issues

88. Generally, there was a growing awareness of the wider agenda relating to missing children across all 10 local authorities visited. This was most commonly evident in the increased level of child sexual exploitation training arranged by LSCBs, and the clear links made in cases that were tracked to issues such as

domestic violence and criminality. The majority of LSCBs stated that reducing the number of incidents of children going missing was a priority for the board, although this priority, and how it would be addressed, was not always explicitly stated. More often, the agenda was addressed in related issues, most commonly in work to combat child sexual exploitation.

89. LSCBs and senior managers in nearly all local authorities received regular information about missing children. Sometimes, this occurred relatively informally – for example, through regular meetings between the police and the head of safeguarding – but in nearly all the authorities visited, more formal reports on missing children were presented to the LSCB, although the quality, frequency and level of analysis within these reports varied. In four authorities, however, the corporate parenting board had not received any information about missing looked after children.
90. All were aware of issues raised by recent court cases, the Joint APPG inquiry and the recent ministerial letter that followed the accelerated report regarding child sexual exploitation.²² However, there was a sluggish response to these issues in a small number of local authorities. Some had not yet formally discussed the ministerial letter at a senior level, although most said that they had plans to do so soon. One authority had delayed the implementation of revised procedures to ensure that the content of the APPG report could be taken fully into account.

Data collection and analysis

91. Eight local authorities visited by inspectors acknowledged that they were experiencing difficulties in ensuring that the data relating to missing children was reliable. Reasons for these problems included the poor inputting of data by practitioners, the lack of connection between different recording systems in separate agencies, and unclear recording protocols for documents which made information difficult to retrieve. In one authority, the reliability of the data was undermined by the duplication of some missing incidents. For example, in a case involving several siblings, one incident was recorded and counted as if all siblings had gone missing, although not all had done so.
92. Two local authorities, however, had been able to establish robust data management systems. One authority's database of missing children had reconciled police and local authority record systems, and included information about missing children living in the area but looked after by another local authority. Another authority's data collection was reliable, consistent and presented in formats that were easy to understand and supported robust

²² *Tackling Child Sexual Exploitation Action Plan, progress report and step-by-step guide for practitioners*, Department for Education, 2011 and 2012; www.education.gov.uk/tackling-child-sexual-exploitation.

analysis. Those authorities which had established reliable databases were not only better placed to reach a well-informed analysis of need and plan services accordingly, the confidence that they had in their management information meant they were more likely to undertake such an analysis regularly.

93. For example, in one local authority, a strategic group that reported to the LSCB and was well supported by an active and influential multi-agency operational group had taken forward several initiatives arising from their developing understanding of need, including a deeper analysis of child sexual exploitation referrals, considering the impact of the distinction made between 'missing' and an 'unauthorised absence', and improving the sharing of information with schools.
94. Few authorities, however, had reached the stage where they were able to express a clear understanding of the scope of the problem locally. Nearly all LSCB representatives spoken to by inspectors reported that the analysis of data remained underdeveloped. The chair of one LSCB admitted that the authority was not in a position to know whether the numbers of children who had gone missing had gone up or down in recent times. Most local authorities were unable to identify clearly which sub-groups of children were most at risk of going missing. Little evidence was seen by inspectors that systematic analysis of data informed the commissioning of specific services to prevent, or respond to, children going missing.
95. Nearly all local authorities' lack of compliance with statutory guidance to undertake and record safe and well checks and return interviews meant that opportunities to analyse and learn from the valuable intelligence that could be gleaned from these interviews were lost. Most importantly, the voices of children were not heard strongly enough when local authorities were exploring the reasons why children go missing and planning services to meet their needs.

Data analysis and service development: Royal Borough of Greenwich

In the Royal Borough of Greenwich, there is a good understanding at a senior level of issues in the local area for children and young people who go missing from home and care. This understanding is informed by effective sharing of data to evaluate the borough's effectiveness in this area of its work. Data systems build in accountabilities for staff and partners at all levels to improve compliance with procedures and protocols.

The Children and Young People's Plan includes targets for reducing incidents of children, including looked after children, going missing from home.

In 2010, Greenwich's Missing Children Needs Assessment led to the establishment of a multi-agency missing children work group to raise

awareness of the issues and to drive the borough's development. Members of the group bring different perspectives and represent a wide range of support agencies. The group meets quarterly and commissions work that is based on its analysis of data and debate. Examples include:

- the identification of increasing missing incidents linked with gang-related criminal activity, which led to the commissioning of the St Giles Trust to deliver specific training to social workers and partners
- work with girls who are vulnerable to sexual exploitation
- commissioning of the Children's Society to work with families of those who go missing from home for short periods of time.

The group has a responsibility to keep senior leaders informed of progress, and senior leaders offer the group a suitable level of challenge.

Training and prevention

96. Only a small number of local authorities had commissioned any specific training that focused on children going missing. Inspectors saw evidence, however, of a growing number of events that sought to raise awareness and expertise across agencies in related areas, such as child sexual exploitation, domestic violence and children missing from education. Similarly, training on attachment issues for foster carers and staff from children's homes addressed relevant issues that contributed to the reduction of missing incidents. In one authority, several information-sharing workshops were being held on missing children and sexual exploitation. Several local authorities had hosted conferences on child sexual exploitation that had been well-attended by professionals from a range of agencies.
97. Social workers in particular told inspectors that they would welcome more specific training that could enhance their capacity to respond to children going missing. Several social workers said that they required more training on procedures and protocols. Some reported that they had received little induction on these matters and had been left to learn 'on the job'. The general lack of clarity among staff in some local authorities about procedural requirements tended to reflect this acknowledged gap in their professional development.
98. Inspectors saw some evidence of imaginative preventative work, mainly in schools, although the degree of attention paid to services that specifically addressed the prevention of children going missing was limited. Policies typically addressed the response to incidents rather than their prevention. Where specific services had been commissioned to support families that might be affected by a child going missing, the capacity of these services to meet demand was sometimes stretched.

99. The wider range of family support services available often tackled the common causes of children going missing, such as domestic violence, drug and alcohol abuse and low self-esteem. Several local authorities, with some justification, pointed to their overall prevention strategy as contributing to a reduction in the risk of children going missing.
100. However, specific training and prevention work was more likely to occur in those local authorities that had a good understanding of the scale and nature of the problem, based on reliable data and strong analysis – but in nearly all authorities visited this understanding was not fully evident.

Salford: The Laureus drama group/DVD project

The drama group was a partnership between the Missing from Home Team, Next Step (Salford Leaving Care Service), Media Academy and Brook Advisory Service.

The 12 young people involved, nine girls and three boys, were identified as missing from home on a number of occasions and as having issues with substance misuse and binge drinking.

A 16-week programme was designed by Next Step. Sessions took place on a Friday evening to serve as a protective factor and offer diversionary activities to the young people, rather than them going missing and becoming involved in under-age binge drinking and multiple drug use and possible sexual exploitation.

A qualified drama tutor and a BBC actress were identified as course tutors. They discussed issues with the young people as to why they were often missing from home, where they went to and what they did. Young people were very open with their views and felt safe within the group. Alcohol was nearly always a factor in children going missing.

The groups were led by the young people and the drama tutor and staff allowed the young people to reflect on their stories and their decision-making in the form of discussions and through art and drama.

Support and advice were offered to the young people if appropriate. As part of the 16-week programme, the Brook Advisory Service delivered targeted workshops on sexual health, contraception and peer pressure. The group reflected upon alcohol usage and harm reduction.

The drama sessions allowed the young people to reflect on why they were running away from home and the possible consequences. Staff allowed the group to come up with their own conclusions through the drama. All the young people were involved in the production of the DVD.

Attendance for the sessions on a Friday night ran at 95% and this contributed significantly to the young people not going missing or misusing substances during the programme.

Many of the young people have since engaged in further projects and increased their skills and social base. They have developed new friendship groups and have achieved accredited qualifications. Eleven of the 12 young people attending the programme stopped going missing from home.

Perceptions and attitudes

101. The APPG inquiry into children missing from care raised concerns about some professionals' attitudes towards children who go missing and the prevailing culture of child protection responses to older children.
102. Cases tracked by inspectors displayed a sensitive and child-centred approach to managing risk. Such an approach was well captured by a manager discussing the efforts taken to address the risks surrounding a child's persistent running away:

'It is our challenge – not her failure.'
103. However, some evidence heard by inspectors suggests that there is no room for complacency.
104. In one case, a social worker commented that 'some behaviours of an older child are seen by agencies as expressing a choice, but this doesn't consider the risks that the young person is placing herself in'. Elsewhere, concern was expressed by the social worker that some police officers and health professionals should have had a better understanding of the vulnerability of a 16-year-old pregnant young woman who was regularly going missing.
105. Discussions with professionals across agencies sometimes raised some similar worries. A youth offending service manager expressed the view that there is still an attitudinal problem among some professionals that may affect safeguarding responses. Children who go missing persistently, he said, are seen as 'delinquent' or 'troublesome'. A police officer was particularly frank when stating that sexual exploitation risks facing a looked after child had not been sufficiently considered in the past. Her persistent running away towards risky situations had been seen as displays of delinquent behaviour, rather than acts of a potential victim of crime and exploitation. Plans to respond to the needs of the child had too often focused on efforts to constrain the behaviour, rather than on the underlying causes.

106. In another local authority, a group of social workers commented that looked after children were often described as 'streetwise' when, in fact, they were among the most vulnerable children in society.

Coventry: 'Say something if you see something' campaign and awareness-raising

The 'Say something if you see something' awareness training for hotel staff in Coventry commenced in May 2012 and is ongoing. The initiative was developed in response to concerns about potential increases in sexual exploitation in Coventry during the Olympics, due to the geographical proximity of the city to London, being a host city and the availability of inexpensive hotel rooms.

A range of partners including Coventry City Council, West Midlands Police, The Children's Society, Stop the Traffik, COMBAT (Combining against Trafficking) and the Terrence Higgins Trust worked together to deliver the campaign and training, targeted at all Coventry hotel staff.

Managers and frontline staff were provided with a free training session delivered by experts in the field. The two-hour interactive training session included:

- talks from experts about child sexual exploitation, adult sex work and trafficking
- a screening of the 'Hidden' DVD from Barnardo's
- an interactive session where participants were given several hotel scenarios and asked to assess whether there was sexual exploitation involved
- guidance on what to look for and what to do.

Managers and staff from two of the major hotel chains in the city took part in the pilot training, which was extremely well received. The training is now being rolled out to other hotels. The overall feedback has been very positive. A recent alerting of the police to a potential sexual exploitation situation by a hotel employee is an example of the training leading to increased awareness and an appropriate response.

Conclusion: What helps children most?

'I think foster carers should try to find you. If the child realised that their foster carer had gone out looking for them, then they'd feel better. That proved to me that they didn't care. If it was their child, they'd go stalking the streets.'

107. It was not always clear whether the intervention from agencies had had a positive impact, although more than half of the tracked cases could demonstrate some improvement for children. When there had been a measurable improvement in outcomes for children who had gone missing and their families, some consistent practice themes could be identified as most helpful to children and their carers.
108. Nearly all cases with good outcomes demonstrated effective multi-agency working, following a sound assessment of need that took full account of historical information. When children were living with their birth families, support to those families was timely and made appropriate use of the common assessment framework. When schools had become concerned, they had made appropriate referrals promptly. Plans were suitably bespoke and incorporated the views of children and their families. Support from agencies continued as long as it was required, leading to fewer repeat referrals.
109. The quality of the child's relationships with professionals in many cases was a key factor in helping children who had been difficult to engage. This was particularly important for looked after children, who had often experienced several changes of social worker:
- 'I get on really well with my social worker; we 'click'... not like my previous social worker who I only saw at meetings. I hardly saw her.'
110. Good matches with well-supported carers were also critical to reducing the number of missing episodes.
111. In several cases, it was apparent that children appreciated the knowledge that the 'safety net' of support was there to help them, even if they sometimes struggled to engage with that support.
112. Most importantly, cases where there had been positive outcomes were nearly all characterised, to varying degrees, by efforts to listen and respond to the views of young people. Inspectors saw several cases where careful and sensitive consultation with children had led to good outcomes.
113. In several cases, social workers telephoned or texted children regularly in the evenings and at weekends to check on their welfare. This kind of persistent availability of staff to listen to children – sometimes initially appearing to be at odds with the child's expressed wishes – led in several cases to eventual

engagement. One child appreciated the sensitive and patient approach taken by an advocate:

'She took the time to talk to me, so I thought I'd take the time to talk to her. She didn't want anything from me.'

This approach led to sustained and helpful support for a child who had previously been extremely resistant to accepting help from professionals.

114. Too often, however, the views, wishes and feelings of children were not effectively or routinely sought by professionals. The harnessing of children's views to inform plans was regularly undermined by a failure to speak to them when they returned or were found. This was particularly true of persistent runaways. Crucially, this meant that agencies were not able to plan services that took full account of the views and experiences of children.

'When a child runs away they're running away from a problem, from a person, or something that's going on in the family. The social worker needs to ask questions, and listen to the answers.'

Further information

Publications by Ofsted

The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills, 2010/11, Ofsted, 2011;
www.ofsted.gov.uk/resources/annualreport1011.

Children's care monitor 2011, Children's Rights Director's report, Ofsted 2012;
www.ofsted.gov.uk/resources/100098.

100 days of care, Ofsted, 2011;
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Running away: young people's views on running away from care, Ofsted, 2012;
www.ofsted.gov.uk/resources/120022.

Young people's views on complaints and advocacy, Ofsted, 2012;
www.ofsted.gov.uk/resources/120362.

Further reading

Good practice guide: safe and well? Looked-after young people who run away, Shelter, 2007;
http://england.shelter.org.uk/professional_resources/policy_and_research/good_practice_downloads.

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Missing children and adults: a cross-government strategy, Home Office, 2011;
www.homeoffice.gov.uk/publications/police/missing-persons-strategy?view=Standard&pubID=966333.

Report from the joint inquiry into children who go missing from care, The All Party Parliamentary Group for Runaway and Missing Children and Adults and the All Party Parliamentary Group for Looked After Children and Care leavers, 2012;
www.childrensociety.org.uk/what-we-do/policy-and-lobbying/parliamentary-work/appg-inquiry-children-who-go-missing-or-run-away-c.

Statutory guidance on children who run away and go missing from home or care, Department for Children, Schools and Families, 2009;
www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00670-2009.

Stepping up: the future of runaways' services, The Children's Society, 2008;
www.childrenssociety.org.uk/what-we-do/parliamentary-work/policy-areas/children-risk-street/stepping.

Still running 3: early findings from our third national survey of runaways, The Children's Society, 2011;
www.childrenssociety.org.uk/news-views/press-release/child-runaways-significant-danger-professionals-fail-step.

Tackling child sexual exploitation action plan, progress report and step-by-step guide for practitioners, Department for Education, 2011 and 2012;
www.education.gov.uk/tackling-child-sexual-exploitation.

Annex A: Providers visited

Local authorities

Coventry City Council

Kirklees Council

Bournemouth Borough Council

Hertfordshire County Council

Salford City Council

Staffordshire County Council

Royal Borough of Greenwich Council

Westminster City Council

Worcestershire County Council

Northamptonshire County Council