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*“To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities”*

Safeguarding Adult Review – Adult A

Chair and report author: Cherryl Henry-Leach

Date of report: March 2022

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# Introduction

This review concerns Adult A who arrived in the UK from Algeria on 8 November 2018 via Tilbury port. Adult A claimed asylum on arrival in the UK and claimed to be 16 years of age.

* On 28 November 2018, Adult A went to London, he did not return to his placement address and was reported as missing. Although initially identified as a potential victim of trafficking, an assessment by the National Referral Mechanism process concluded that there were no reasonable grounds to suspect that the individual was a victim of modern slavery.
* Adult A presented in Manchester on 22 January 2021 and had regular contact with the Home Office.
* On 2 February 2021, Adult A requested to return home to Algeria.
* Adult A died of suicide on 6 April 2021.

The panel express its sincere condolences to the family of Adult A, and thanks all who participated in this review.

# Legal framework

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

The Thurrock Safeguarding Adults Board (TSAB) SAR Group considered the case referral for Adult A (on 28 May 2021) and concluded that the Board would undertake a discretionary review. This recommendation was approved by the TSAB Independent Chair on 28 May 2021.

# Independent author

An independent author was assigned to lead this review and produce the final overview report. Ms Henry-Leach is an independent consultant who has not been employed by any of the agencies involved in this review and holds experience of leading statutory reviews.

# Scope of review

The SAR considered the events during the following timeframe: 8 November 2018, the date Adult A entered the UK, to 6 April 2021, his date of death. Relevant information from prior to this period was also considered.

# Key lines of inquiry for the review

The overall objective of this SAR was to:

a) Identify learning in relation to the support afforded to Adult A, including how this was offered and if it could have been managed differently; and

b) Through the SAR process, consider the impact of the Covid 19 Pandemic in relation to the services provided to Adult A.

To do this, the SAR addressed the following key lines of inquiry, which were identified by the TSAB SAR Group:

* To explore the effectiveness of how the different agencies involved (or should have been involved) worked together to safeguard the individual including:
  + communications
  + sharing of relevant information
  + accessibility to services
* To make recommendations for improvements, which agencies can use to inform the development of existing policies and practice

# Links to other reviews

During the undertaking of this review, it was confirmed that there were no parallel processes that the panel needed to be cognisant of.

# Methodology

Once the decision to undertake a SAR was made, all agencies were asked to review their records and confirm if they had had any contact with Adult A. This exercise identified that agencies in Manchester had contact with Adult A and a similar approach was made to those agencies. The agencies known to have been involved with Adult A were asked to provide chronologies of agency involvement. These chronologies identified minimal known information and involvement from professionals. The information was shared at a learning event, attended by representatives from the involved agencies and colleagues from the TSAB. This enabled the identification of:

* Good practice
* Learning
* Recommendations to embed the learning

# Agencies involved

This report is based on information provided from the following agencies who contributed to this review:

* Thurrock Council
* British Transport Police
* UK Border Force
* Immigration Enforcement (and acting on behalf of Asylum)
* Manchester City Council
* Essex Police
* Metropolitan Police
* Migrant Help
* Booth Centre

# Publication

In the interest of transparency and disseminating learning, TSAB will publish the SAR report unless this is not possible for reasons of confidentiality. References to individuals have been anonymised within the report. A learning briefing for practitioners will also be published on the TSAB website. The findings from the SAR will also be referred to in the Annual Report. A shared position statement was agreed between all TSAB agencies prior to publishing the SAR report. Media enquiries will be managed through Thurrock Council's press office.

# 10. About this Safeguarding Adult Review

This SAR was commissioned by Thurrock Safeguarding Adults Board (SAB) and managed by a SAR Panel. Terms of Reference for the review were agreed by the SAR panel on 21 November 2021. In summary the agreed process was to consider the information provided by agencies who had had some contact with Adult A while he was in the UK. Due to the minimal involvement with Adult A, chronologies of involvement and summary reports were provided and discussed at a learning workshop on 21 November 2021.

# Involvement of friends and family

The TSAB were advised by the British Transport Police that Adult B was known to have offered Adult A accommodation by Adult A’s father in March 2021. Adult B agreed to be interviewed as part of this review, although Adult B was clear that he did not wish to be named and was still somewhat upset by the events that had occurred as Adult B had been present when Adult A ended his life. Adult B confirmed that Adult A’s father had known Adult B before Adult B settled in the UK, and having children of a similar age, Adult B was willing to help Adult A because “*I wished to support [Adult A] like I wanted others to support my own children if the need arose*.”

When interviewed by the Chair of this review, Adult B advised that he was about to journey to Algeria for a holiday and see family and friends. This included Adult B returning Adult A’s belongings to Adult A’s family. Adult B advised the Chair that the family of Adult A were “*very distressed by the loss of their son. His mother is grieving, and I want to be sure she has son’s belongings, such as they are.”* Adult B clarified that Adult A arrived at Adult B’s family home with a rucksack that contained sunglasses and minimal clothing.

Adult B advised that he felt it would be unlikely that the family of Adult A would agree to speak with the Chair but agreed to speak with the family of Adult A (when Adult B was in Algeria) and hand them correspondence from the Chair, on behalf of the TSAB, by way of extending an opportunity to contribute their views and experiences. The correspondence to Adult A’s family was translated into Arabic, following Adult B confirming that the family do not speak fluent English, and that Adult B also advised that Adult B would read the correspondence to Adult A’s mother if she could not read it. Adult B advised the Chair that he would update the Chair on Adult B’s return to the UK, and this did not occur. The Chair also tried to contact Adult B to obtain an update from the family of Adult A, without success.

As such, that family of Adult A were not able to have the opportunity to view the report prior to publication.

The discussion with Adult B gave some insight in to Adult A’s personality. Adult B described Adult A as *“a very quiet and polite young man. He said very little when he first came to stay with me and my family. But after a few days he seemed to relax in our company and laughed a little with us. He told us he was being followed, but we could not see this was the case – when he told us he could see people watching the house we would look out of our window, and nobody was there. He was very desperate to go home, he had come to this country believing he would have a better life. I do not know what his family life was like [in Algeria] but I do know that he struggled when his parents separated. [Adult A] when staying with us was very clean, but I thought this was due to his being unable to wash whilst he had nowhere to live. He told me he had been sleeping on the streets and begging for food. I would not have wanted this for my son, and that is why I agreed to help my friend [his father], when he called me and asked me to help his son…he told me a few times he was being followed and so we began to go with him when he wanted to leave the house because he was frightened, but we saw no evidence that he was being followed. He did not want to speak to the Police, and he was afraid to do so.”*

Adult B advised the Chair that he supported Adult A with calls to the Home Office. “*He never told me why he left home or why he wanted to go back. His life here is a mystery to me. I tried to encourage him to pray, because he was so desperate to go home, and I also encouraged him to keep in frequent contact with the Home Office because his desperation was such…I didn’t know what else to do. I did wonder if he was ill in his head because he kept saying he was being followed…On the day he died there was no indication that he would…we had an afternoon out, and he was talking to me during that afternoon of him going home. One minute he was at my side and the next he wasn’t…”*

# Equality, diversity and inclusion

Adult A is known to have been a single, 22 year old male who entered the UK illegally. Adult B advised that Adult A’s faith belief was Muslim but was unsure if Adult A practised his faith to any level. Due to minimal information shared with the Panel, it is unknown if Adult A presented with any further protected characteristics, and he is not recorded as having any disabilities or confirmed mental illness. The Panel were cognisant of research[[1]](#footnote-1) that suggests that suicide is considered illegal in Islamic countries but were unable to discuss this in any further detail with Adult B or Adult A’s family. In the absence of family involvement in this review, the panel were unable to consider if any other protected characteristics were applicable to this case or these would have impacted on his access to and engagement with services.

# Summary of Adult A’s life in the UK and contact with Adult A by professionals

In November 2018 he arrived in the UK and was found by Border Force officers in the port of Tilbury shortly after the arrival of a cargo vessel from Belgium. It is understood that Adult A hid himself in the back of a lorry that was carried on a cargo vessel to the UK. An initial interview was undertaken with him at the Port, and Adult A stated that he had left Algeria three months ago. Adult A also mentioned that he had travelled from Algeria to Italy, then onto France and then Belgium, and from Belgium to the UK.

On arrival into the UK, Border Force officers undertook a welfare interview with Adult A. In this interview, Adult A stated his parents were getting divorced and suggested he had left home due to family conflict. Adult A stated he had travelled from Greece but did not confirm when he left Algeria or how long he'd been in Greece before he entered the UK. Adult A also advised the officers undertaking the interview that he was afraid of violence being used against him and that he had no safe place to live or work in the UK. Adult A gave no further details and Border Force officers recorded the information he shared with them in order to support a further interview that would have been undertaken by trained asylum interviewers, at a later date.

In the welfare interview, Adult A gave a date of birth which led Border Force officers to believe he was 16 years old. The officers undertaking the interview did not find any indication that Adult A had been trafficked into the UK. Adult A also told the officers that he made the journey from Belgium to the UK by climbing onto the back of the lorry on his own accord. Adult A also denied making payments to a smuggler, a trafficker or facilitator. Although Adult A remained at the port for a very short period of time, the officers did not observe any obvious signs of trauma or vulnerability at the time of the initial welfare interview. The officers completed their actions, which included a search of Adult A, his property and finger printing. His property is documented as consisting of a rucksack with a limited amount of clothing which was folded pristinely, a small amount of money, headphones and sunglasses. Believing Adult A was 16 years of age, and that he was an unaccompanied asylum seeking child who had no one to care for him in the UK, in line with the agreed protocols of the time, the officers made an immediate referral to Thurrock Children Social Care Emergency Duty team to ensure he was appropriately supported.

The records pertaining to Thurrock Children Social Care confirm that their initial interview took place with Adult A very soon after, within hours of their receipt of the referral from Border Force officers. In their initial contact with Adult A, Adult A told Children’s Social Care workers that he was 16 years of age. A very brief assessment was undertaken, and Adult A was offered accommodation in Ilford. It is understood that another young person also arrived in the UK on the same night and in similar circumstances. Both young people were offered accommodation at the same placement. With support of the Border Force officers, Adult A and the other young person were transported to a placement provided by Thurrock Children Social Care, in Ilford. He also stated that family issues and violence were the reason for him leaving Algeria. Given the late hour and understanding that Adult A would have been exhausted by this point, the panel were assured that any further discussion with him at this time may not have been appropriate.

Adult A met with a social worker from the Looked After Children's team on 14November 2018. It is recorded that he advised the social worker that he had settled well at the placement and the social worker had no health or other concerns. As a result, Thurrock Children Social Care planned for a social worker in the Looked After Children’s team to undertake an age assessment. The panel also understand that Adult A was, at this point, also made aware of the Local Authority’s initial plan to transfer Adult A to another local authority under the Eastern Region Transfer Protocol. This required the undertaking of a needs assessment that is usually completed within the first 14 days of arrival and that leads to a child and family assessment within the first 35 days of arrival.

On 28 November 2018, Adult A was reported as missing to the Metropolitan Police Service (MPS), having failed to return to his placement address that evening with another young person from his placement address with whom he had left with earlier in the day. The Panel confirmed that the placement address for Adult A was beyond the jurisdiction of Essex Police and fell under the geographical jurisdiction of MPS, and the missing person’s report was made to the appropriate Police force, despite the case remaining under the jurisdiction of Thurrock Children’s Social Care. In this report, it was stated that both young people left their belongings at the placement, including their mobile phones. This indicated they were going to return. It was also reported that they had told others at the placement address that they were going to central London as they wanted to see Big Ben. The panel confirmed that Adult A and this young person were both Algerian nationals, who met during their journey to the UK. The panel understand that Adult A absconded just prior to the planned needs and age assessments being undertaken which resulted in the Local Authority being unable to complete these assessments.

After Adult A was reported missing, a strategic meeting was convened by Children’s Social Care. It was noted by colleagues attending the strategic meeting that the name Adult A had given to professionals up to this point had not been verified and that, at this point, there were no realistic lines of enquiry due to Adult A not taking his mobile phone with him when he left the placement address and the Police had not received evidence to support his identification from the Home Office. It was agreed that the case required a full strategy meeting, and this was scheduled for 24 January 2019. In the meantime, it was also agreed that the Police investigation would determine what lines of enquiry could be explored, whilst periodic checks with hospitals, social media sites and on the Police systems would be undertaken.

On 12 December 2018, a photograph was provided by the Home Office and uploaded onto the MPS system.

At the strategy meeting on 24 January 2019, it was established that as Adult A had self-declared to be a juvenile on his arrival into the UK, a missing person report was generated. There was some discussion about the timing of Adult A going missing and the possibility that he may be older than initially stated, but in the absence of any evidence to support this hypothesis, the risk to him was assessed by those attending the strategy meeting as being as Standard due to the lack of any identified aggravating factors aside from his age. This enabled Adult A’s case to be referred to the National Referral Mechanism (NRM) as partners attending the strategy meeting did share a concern that Adult A may have been a victim of trafficking into the country. The referral was received by the NRM on 1 February 2019. The panel also confirmed that at the point of the NRM referral information was appropriately shared with the Police.

By 8 February 2019 a crime report was generated by MPS. This details that Adult A had said he was 16 years of age, and the crime report enabled the formal consideration by MPS of Adult A being subjected to potential exploitation and or modern slavery issues. The panel were assured that this was undertaken in line with existing protocols at the time and was a means to ensure that further enquiries could be undertaken by the Police given the lack of investigative line of enquiries at the point of Adult A being reported as missing. It also ensured that the case of Adult A would be categorised as “long-term missing” and enabled discussion of his case panel meetings on a six-weekly basis.

On 14 February 2019, the case was assessed by the NRM. The outcome of this assessment identified that there were no reasonable grounds to suspect that Adult A was a victim of modern day slavery. This included consideration of Adult A advising UK Border Force officers and social workers that he had not been subjected to any form of coercion, exploitation and that he had made his way into the UK without support.

On 4 March 2019, the MPS crime report was recommended for closure by a supervisor following full consultation with UK Border Force officers and consideration of the NRM risk assessment, which had concluded that there was no evidence of modern slavery concerns upon entry.

On 8 March 2019, a Detective Inspector authorised the closure of the missing person report on the basis that the information provided did not contain any meaningful detail to enable enquiries in addition. The Detective Inspector also noted that the stated age of Adult A could be doubtful given the timing of his absconding.

Toward the end of May 2020 Adult A was transferred to the Local Authority After Care team and continued to be reviewed at the Long Term Missing Panel which occur every six weeks. In August 2019, the Metropolitan Police confirmed with this team that the missing person's episode had been closed by the Police on 8 April 2019. By October 2020, it had been agreed by the Long Term Missing Panel that the case met the criteria for a manager within the After Care team to submit to senior managers within the Local Authority a high risk notification. This intends to ensure an alert to the media, and in this case, was undertaken in that Adult A could be located and offered support. The panel supporting this review could not fully establish why the media alert request was not submitted until October 2020 but understand that resourcing within the After Care team may have impacted on consistent attendance at the six weekly Long Term Missing Panel meetings until October 2020, at which point consistent attendance resumed.

During the winter months of 2020/21, Manchester City Council led local Cold Weather Provision where people without accommodation were accommodated on the same day to prevent them from sleeping outside in very cold temperatures. As part of this provision, the Booth Centre in Manchester ensured indoor support provision for people that were homeless or sleeping rough. The Booth Centre provided a daytime hub, where people could access accommodation in the daytime and then in the evening, the Booth Centre provided an evening or Out Of Hours Hub known as Coffee 4 Craig. On 22 January 2021, Adult A visited the daytime hub, and was referred to the evening hub (Coffee 4 Craig) so that he could receive confirmation as to which accommodation had been allocated to Adult A. Adult A did attend the evening hub and was advised that he had been allocated to a hotel called the Victoria Warehouse. Within this hotel is a team of services that support people to move on, to prevent their return to sleeping rough. The Booth Centre had no further contact with Adult A after ensuring he was referred to the Housing Solution Office. During the time he spent at the Victoria Warehouse, Adult A is recorded as being insular, kept very much to himself and spent most of his days out of the hotel. There were no identified safeguarding concerns or concerns around his mental health that required referral.

The Victoria Warehouse was due to close at the end of March because it was a Cold Weather provision. This required Adult A to be allocated to another hotel and his Cold Weather Coordinators worked with Adult A to identify the right accommodation for him. Adult A presented with no concerns in relation to his welfare or mental health that required referral to Safeguarding or Mental Health Services.

As part of the support to Adult A, Manchester City Council’s Housing Options team also worked with Adult A to determine how they could support him in the longer term as he had no apparent recourse to public funds, which limited his access to accommodation in Manchester. They explored the feasibility of private accommodation for Adult A, who then stated that he wanted to go home back to Algeria. The team then focused their efforts of supporting Adult A to return home and liaised with the Home Office Voluntary Return Service to begin the process of Adult A voluntarily returning home. Manchester City Council also confirmed that Adult A’s case was triaged and confirmed to be an immigration case on their internal systems. Adult A had given Manchester City Council a different date of birth to the date of birth that Adult A had originally given on his arrival into the UK. This resulted in Adult A being on the Manchester City Council systems as an adult aged 22.

On 2 February 2021, the Home Office Voluntary Returns Service (VRS) received a paper based Assisted Voluntary Return (AVR) application from Adult A. The panel understand that, at the time of receipt, this was no longer the method of application, and the form was an electronic form which enables a more expedient response from VRS. Despite the incorrect pro forma being used by Adult A, and although VRS were awaiting a letter of authority from Adult A (which would have enabled them to discuss Adult A’s case with third parties), the AVR application was acted upon by VRS. VRS was contacted by Manchester City Council colleagues on 9 February and very little information could be shared at this stage as VRS had no letter of authority from Adult A to enable this. Adult A was contacted by VRS on 10 February 2021. In the telephone contact, Adult A’s documentation was discussed with him by VRS, and he was advised that VRS were awaiting the outcome of various checks and that if he needed to leave the UK with Home Office support, he would need to have valid documentation in order to travel by plane, namely a valid passport or a valid emergency travel document issued by the Algerian Embassy. Adult A was advised that he needed to contact the Algerian Embassy as his passport had expired and needed a valid emergency travel document. Internal VRS processes at this stage also required the completion of a PNC check, and the panel were advised and assured that although an internal IT glitch resulted in the PNC not being undertaken in a timely manner, had the PNC check been undertaken, it would not have made a difference to the outcome as Adult A was engaging with VRS and was not wanted by the Police for criminal activity.

On 15 February 2021 Adult A advised VRS that he had a valid travel document, but it was in Algeria. Adult A stated that he had contacted his family to see if they could send the valid travel document to him. During this contact Adult A was informed that VRS were waiting on the outcome of some checks and VRS would contact Adult A once the checks had been completed.

Adult A contacted VRS on 17 February 2021 and was advised that VRS were waiting for some information from him, and he had not provided it. Adult A advised that he would send the information by email, and then called later in the day to say he was having trouble sending the email and it was agreed that VRS could send a “test” email whilst on the phone, which he confirmed he received, and enabled Adult A to send the email containing the information required by VRS. Adult A confirmed that his family member was unable to post his passport to him, so again he was advised he needed to apply for an emergency travel document through the embassy. It is understood that the “test” email was received and enabled VRS to engage with Adult A by email.

On 18 February 2021, VRS received a copy of Adult A’s valid travel documentation, namely a passport which was valid until the 1 May 2021. Adult A also advised the VRS that he was “absolutely desperate to go home.”

Thurrock Council unaccompanied asylum seeking children’s review panel contacted the Home Office for an update on Adult A. On 19 February 2021, the Home Office advised that Adult A had made an asylum claim which remained outstanding and that he was in the Voluntary Returns Process. The Home Office also provided the panel with a current address for Adult A confirming he was no longer a missing person.

On 11March 2021 Adult A contacted VRS by email, and advised that he telephoned the Algerian embassy, who had requested a copy of his passport and flight ticket before they would issue him with valid travel documentation. The VRS responded to Adult A by email and confirmed that although they had received a copy of his valid passport, the Algerian borders were closed. The VRS also liaised with Adult A’s Cold Weather Coordinator in Manchester, who was also supporting Adult A to obtain the necessary documentation to enable Adult A to return home. This included a number of forms being sent to Adult A’s Cold Weather Coordinator for completion, and Adult A was also advised by VRS that these forms had been sent to his Cold Weather Coordinator. Adult A advised VRS that people had been following him since 8 March 2021, and asked, if he was being followed by the Home Office. VRS advised Adult A that this was not the case, and he was advised to report his being followed to the Police. Adult A contacted VRS on 12 March 2021 and repeated that people had been following him since 8 March 2021 and he was again advised to report this to the Police. The conversation ended with Adult A being advised by VRS that he needed to ensure the documents sent to his Cold Weather Coordinator needed to be completed and signed by Adult A before being returned to VRS.

On 24 March 2021 Adult A decided to move back to London to stay with a family friend. This accords with the account of Adult B, who advised that Adult A’s father contacted Adult B to request he support his son as Adult A awaited a return flight home to Algeria. Adult A’s Cold Weather Coordinator undertook appropriate enquiries and, having established that there were no safeguarding concerns, supported Adult A to meet with Adult B. It was only after Adult A left that they found out about him being a missing person.

Adult A telephoned VRS on 16 March 2016 and reiterated that he needed a copy of his passport before the Algerian Embassy consulate would issue any travel documentation. The VRS case worker telephoned the Algerian Embassy consulate to confirm Adult A’s account and was advised by the Algerian Embassy consulate that there were no direct flights to Algeria as the borders were closed and these restrictions had resulted in the Algerian Embassy consulate being unable to issue travel documents as they were not currently authorised to do so.

Adult A contacted VRS by telephone on 23, 25 and 26 March 2021. On 25 March 2021, he provided a new address to VRS and was advised again that the Algerian borders were closed and that VRS still could not support his return to Algeria. Adult A contacted VRS on 31March 2021, and during this call he advised VRS that he understood that the Algerian borders would open from 1April 2021. VRS requested clarification on the date of the Algerian Borders reopening from the Home Office Country team but due to annual leave over the Easter period there was a delay in this clarification being responded to.

Adult A telephoned VRS on 6 April 2021 and advised he wanted new accommodation. VRS explained that they were unable to provide accommodation, but signposted Adult A to Migrant Help[[2]](#footnote-2) number, advising Adult A that Migrant Help may be able to support Adult A with the provision of accommodation. (It is understood by the Panel that Migrant Help also hold a contract with the Home Office, and this enables them to provide accommodation to asylum seekers and failed asylum seekers but in VRS process. This is known as section 4 support).

Adult A was also advised that, when he changed his address, he should contact VRS to give an up-to-date address. At the request of Adult A the call handler repeated this advice to the friend Adult A was staying with, confirmed by the panel to be Adult B.

On 7 April 2021 the Home Office Command and Control Unit was contacted by British Transport Police and advised that Adult A was deceased.

# Good practice identified during this review

The panel identified the following areas of good practice.

Although Adult A did not disclose to Border Force officers any information that raised concerns of modern slavery or human trafficking, there was good adherence to Home Office protocols about missing minors. This includes recognition of social work best practice standards of the time that resulted in a NRM referral and assessment.

After Adult A was reported as a missing person, most agencies, although suspecting that Adult A had not provided a correct date of birth and may not be a child, in the absence of any evidence to support this hypothesis, proceeded on the basis that he was a missing child. This occurred despite being unable to undertake an investigation for the reasons catalogued above.

The Panel noted that the Multi Agency approach to share information about missing persons through the Long-Term Missing Panels was innovative and commendable.

When MPS generated a crime report on 8 February 2019, guidance issued by the Continuous Policing Improvement in relation to missing persons indicates that generating a crime report was only required where there was information to suggest risk of exploitation or human trafficking. The panel were assured that the generation of this crime report was above the expected standards, given the information shared by Adult A with Border force officials at the point of his entry into the UK.

Although services were disrupted by the restrictions imposed by central Government in the national response to the Covid 19 pandemic, there were meaningful and extensive attempts to engage with Adult A when he approached services in Manchester for support.

Similarly, although VRS required Adult A to engage with their service of his own volition, when Adult A approached VRS for support to return to his family in Algeria, VRS team continued to engage Adult A and ensured that he received appropriate sign posting advice in relation to his accommodation needs.

When Adult A was identified as an adult, there was good evidence that indicated his wishes were heard, informed support and he was empowered to make decisions.

# Learning identified and recommendations

The panel noted the following learning from this review.

The panel noted that Adult A informed Border Force officers that he entered the UK, having decided to leave Algeria because of family violence. The panel were not able to clarify this with Adult B or Adult A’s family. This would have been explored as part of the needs and family assessments that Children’s Social Care planned to undertake. It also noted that domestic abuse, in the UK, may enable a person access to public funds as an adult, and had Adult A admitted to, or assessed as being an Adult, panel members believed he would have been referred to Adult Safeguarding or Social Care to ensure this was fully explored with him as part of a Human Rights Assessment[[3]](#footnote-3). It was noted that the Thurrock Local Authority does not have an Immigration and Asylum team to lead this assessment or advise colleagues on its undertaking. Although Adult A was reported as missing before any of the assessments could have been undertaken with him by Children’s Social Care, the panel agreed that the TSAB needed to assure itself that the pathway to support victims of domestic abuse without recourse to public funding is well known or established within the Thurrock Local Authority area.

# Learning point 1:

*When migrant or asylum-seeking individuals state they are fleeing domestic violence, we need to undertake a Human Rights Assessment that may identify if they have recourse to public funding to avoid destitution.*

Recommendation 1**: In the absence of learning or evidence from this review to support it making a recommendation to address this potential concern, the panel invites the TSAB to ensure this pathway is embedded within its safeguarding processes.**

Given the geographical boundaries of Essex Police and MPS, the panel were informed that meetings of the Long-Term Missing Panels have regular representation from Essex Police and the missing person’s liaison officer from Essex Police, but a representative from the MPS is invited but the same person is unable to attend every meeting. Some Panel members felt that this was a missed opportunity to ensure robust information sharing between professionals. However, further clarification with MPS gave assurance that this is a proportionate response given the extensive geographical boundaries MPS cover and that MPS will share appropriate information to inform decisions that will impact on case management and progression. In the case of Adult A, the Panel were advised that this information was shared with the Local Authority area covering Adult A’s initial placement and believed this enabled proportionate decisions about Adult A’s case progression involving multi-agency collaboration and agreement. It remained unclear to the Panel if this information was shared between Children’s Social Care colleagues within the two Local Authority Areas (i.e., Thurrock and the Local Authority covering Adult A’s placement).

MPS advised the panel that the original missing person report was closed in line with policy which dictates a case-by-case consideration and makes clear that where risks are clear and apparent Police will deal with a subject as missing. In this case there was no evidence of heightened risk and, on a balance of probabilities it appeared more likely than not that Adult A was an absconder as opposed to a missing migrant child, based on the apparent absconding ahead of the age assessment coupled with the hypothesis that the realistic location of Adult A would occur if Adult A self-presented to authorities providing the same identity details given at point of entry. It also confirmed that the closure of the report was appropriate.

The Panel were assured that MPS actions of March 2019 were in line with current policies of the time, which have not changed significantly since 2018.

Whilst the Panel determined that the MPS actions in March 2019 were appropriate and in line with existing policy. Some members of the panel did not agree with this position, and so further consideration was given to the decision made by MPS on 9 April 2021, when MPS closed the case. MPS documented that Adult A was now classed as an Adult and the decision records the following rationale: *“where an individual enters the UK illegally and sought to avoid the authorities, the Police cannot be expected to investigate these cases as missing and the responsibility lies with UK Border Force when no information is available.”* The Home Office agreed that had Adult A been identified as an Adult at his point of entry into the UK, then his case progression, following him being reported as missing, would have met the criteria for immigration enforcement, however, it would still be expected that the police take primacy in a missing person investigation because:

* The Home Office do not have investigative powers in relation to missing persons, nor do Children’s Social Care. As such, when a person becomes missing, it is a Police matter as they hold such investigative powers. In this context the Police would become the lead agency and other agencies would have looked to their leadership to inform the decisions they made.
* At the point MPS closed the crime report, Adult A had not been formally identified as an adult at the point he was reported as missing, and was, at that point, a missing person who was under the age of 18. He was only identified as an adult in March 2021.

The panel also considered if any investigative opportunities were fully explored to locate Adult A, including the mobile phones belonging to both males which do not appear to have been examined in any way as part of the investigative enquiries and colleagues assumed that this is because the mobile phones were left by the young men at their initial placement. In the absence of any indicators of any criminal activity, including trafficking and exploitation, in relation to Adult A’s disappearance or entry into the UK, the Panel were advised that not interrogating the devices was a proportionate decision by the MPS. MPS also advised that the veracity of the account the young men gave and might have supported Adult A’s advising Border Force officers that he had entered the UK under his own volition and not been trafficked was called into question by the information shared with them in the early stages of their investigation when investigating officers were advised that Adult A had received calls whilst in the placement under a different name. The Panel were further assured that following learning in relation to Missing Persons in another statutory review, the MPS had undertaken significant changes to ensure that cases pertaining to missing persons, including Adult A, were subjected to frequent review by a dedicated team led by a Detective Inspector. In relation to Adult A, on the initial information received by MPS, on the basis that he was a missing child, had generated a crime report which enabled MPS to undertake wider enquiries to rule out the possibility that Adult A was a victim of trafficking or exploitation. MPS closed the crime report *after* those enquiries had been explored, and these did not indicate Adult A was the victim of criminal activity. At the point of considering if the crime report, should remain open, MPS also communicated their decision, and rationale for it, with the Local Authority area providing the placement. On receiving no adverse comments in making its recommendation, the Panel was mindful of proportionality and did not seek to fetter the MPS decision making process, fully accepting that such decisions do indeed need to be made on a case by case basis, but suggests that due to the organisation size and structure of MPS, this review had enabled MPS to recognise a need for the MPS to proactively ensure policing colleagues from neighbouring forces were able to fully represent their input into the Long Term Missing Panel meetings so that information the MPS share with partner agencies could also be fed into these meetings. Although beyond the scoping period of this review, discussions with the MPS during this review, also enabled the Safeguarding Board Officer to agree with MPS the pathways for their involvement in safeguarding and multi-agency reviews.

# Learning point 2:

*To ensure the well-being of vulnerable adults and children, we need to understand the professional roles, processes and constraints within which operate and be confident that these are fully understood by our colleagues.*

Recommendation 2**: That the MPS Lead Officer for Missing Persons ensures officers in neighbouring county Police forces are aware of the MPS contact and can ensure that MPS information is fed into case management discussions at Long Term Missing Panel meetings and discussions to ensure robust information sharing and collaborative multi-agency decisions.**

Recommendation 3**: MPS Officers within the Specialist Crime Review Group to review their external communication to partner agencies and remind officers located within Basic Command Units of their role in leading MPS involvement in statutory reviews.**

This discussion also identified that the roles of Home Office Departments are not clearly understood by partner agencies. It noted that Border Force officials will only assume responsibility for a case at the beginning of a person entering the UK. Once a person is here and linked to this country, without extant leave, then the responsibility lies with Immigration Enforcement, the Panel also noted that Adult A was still within the asylum process when he went missing. This enabled the Home Office to clarify that Border Force colleagues will only assume responsibility for an individual at the beginning of a process – on entry to the UK. Once in the UK, an individual, who does not hold valid leave to be in the UK, will progress to Immigration Enforcement, unless the applicant has claimed asylum and a decision is still pending on their claim. Their case will then be held by UK Immigration and Protection teams.

# Learning point 3:

*We need to be confident that all our partners are referring to the right departments.*

Recommendation 4**: The Home Office ensures that partner agencies are cognisant of the roles of each department and when a case would require the input of specific departments.**

The Panel noted that VRS were not formally notified of Adult A being reported as missing but were told informally and noted this update on their systems on 3 January 2019. It is understood by the Panel that the Home Office did not complete their systems in full at this point and it remains unclear if this was an oversight or if Home Office colleagues were awaiting the formal notification being received. When Adult A contacted VRS, VRS could see he was reported as missing and a HO official notified Thurrock Council that the applicant had come to their notice on 19 February 2021. The Panel agreed with the Home Office’s view that Home Office colleagues could have also undertaken steps at that point to notify the police. This information was not passed to the Long-Term Missing person team and has been reviewed internally within Thurrock Council and internal measures put in place.

# Learning point 4:

*Our internal systems need to appropriately tag and flag key information to ensure responsive case progression and information sharing.*

**The Panel were assured that this has been addressed by Home Office colleagues as an internal learning and make no recommendation in relation to this finding.**

This discussion elicited panel agreement that when a person is missing it is critical that all relevant agencies are aware. This specifically included ensuring that Home Office colleagues were aware of missing individuals falling under the remit of Home Office colleagues, so that they can flag their internal systems. Whilst the willingness to ensure this was undertaken routinely was applauded by the panel, it agreed that such an important arrangement needed to be formalised by senior management within Children’s Social Care to ensure seamless transition of provision should the current post holder change roles in the future. The Panel also agreed that this review has highlighted that a system wide national approach to enable colleagues to undertake routine checks when encountering a new service user for the first time. The Panel noted that, currently, the only system that can enable this would be the Police National Computer. The Panel agreed that enabling system wide access was beyond the scope of the Panel to recommend, despite doing so would robustly ensure that missing persons could be located (and flagged on systems as located) should they surface in another part of the UK and ensure that they are afforded the appropriate support from partner agencies, such as the Home Office. The Panel invites the Board to consider how this could be achieved.

Learning point 5*:*

*We need to strategically ensure informal arrangements that ensure timely sharing of key information are formalised so that that they are not person dependent and inform part of a post holder’s responsibilities.*

Recommendation 5**: Children’s Social Care’s strategic lead care to formalise the process that ensures Home Office colleagues are enabled to appropriately tag their internal systems when a person is reported as missing.**

***Noting the national learning from this discussion, the Panel do not make a recommendation in relation to this finding but does invite the TSAB to consider how this development can be progressed at a national level.***

The panel noted that when Adult A applied to the Home Office Voluntary Return Service (VRS) he submitted a paper application, and the application process at the time required, and now requires, individuals to contact VRS by telephone or begin their application online via an online form available on gov.uk. This enables applicants, through their answers to two questions, which identify how the applicant heard about VRS and the reason for their desire to voluntarily return to their country of origin. In the case of Adult A, it is understood that the paper form that Adult A completed did not include these questions. This meant that Adult A did not advise VRS staff of his being followed until he had been in contact with VRS for a month. The panel agreed with the Home Office finding that had the questions been put to Adult A at the point he applied for voluntary return, he may have had the opportunity to disclose he was being followed sooner. The Panel agreed that questions asked within the triage process could present an opportunity that would enable professionals to enquire about any safety and medical concerns, including concerns about their mental wellbeing. Although there was agreement that this may have presented an opportunity to receive more information from Adult A about his circumstances, this would not have changed the outcome for Adult A, due to the Algerian borders being closed because of the Covid 19 travel restrictions, it may have increased his confidence to disclose this to other services such as the Police.

Learning point 6*:*

*We need to encourage service users to disclose concerns at the earliest opportunity.*

Recommendation 6**: All agencies are to proactively ask about presenting concerns in relation to medical and mental health issues when undertaking new contact with service.**

The panel also considered the urgency and desperation of Adult A to return home. It noted that the Covid 19 restrictions were in place throughout the scope of the review. It considered Home Office information that suggests many applicants that come through VRS contact VRS on an almost a daily basis, because once they have decided to return home, they wish this to take place as soon as possible. It also noted that contact with VRS has increased during the period of Covid 19 restrictions and may be linked to the concern for loved ones impacted by the virus. It agreed that in relation to Adult A, taken in isolation, Adult A’s constant contact with VRS may not have been unusual behaviour. The Panel also considered emerging research that indicates that, in terms of mental health and wellbeing, the most negatively affected age group are 25-39 year olds, of whom six in ten (60%) said the disease and accompanying lockdown had taken its toll on their mental health[[4]](#footnote-4). It also noted that some individuals, during the pandemic, have developed a mental illness for the first time[[5]](#footnote-5), and that this appears to be linked to social isolation and quarantine directly harming people’s mental and emotional wellbeing[[6]](#footnote-6). The panel noted that Adult A was a young man who appeared to be isolated within the UK and considered, and agreed that, the impact of the Pandemic on Adult A, who had recently undergone a journey to reach the UK that most individuals would have found traumatic, was likely to have further traumatised him. It noted that Adult A may have been experiencing trauma induced paranoia if he was not being subjected to criminal activity, and so explored if all agencies who came in contact with him were ensuring trauma informed support. It noted that humane responses did not always equate to professionals being trauma informed in their support of persons with vulnerabilities, including migrant and asylum-seeking individuals, and agreed this was a key learning from this review that should be embedded in practice so that trauma informed responses and support are consistently provided beyond the Pandemic.

Learning point 7*:*

*Responses did not always equate to professionals being trauma informed in their support of persons with vulnerabilities, including migrant and asylum-seeking individuals and we need to support practitioners to be trauma informed in their practice, particularly during the Covid 19 pandemic and beyond.*

Recommendation 7**: The panel invite the TSAB to support its constituent agencies to ensure that migrant and asylum-seeking individuals receive trauma informed contact and support by ensuring access to trauma informed training.**

Whilst the Panel, in the absence of any assessment that confirmed Adult A was experiencing a mental health crisis, could not definitively say this was an issue for Adult A, it could not rule it out, having noted that between 11 March and 6 April 2021, Adult A informed VRS staff that he was being followed. The panel noted that, whilst Adult A was given the correct advice (i.e., to advise anyone being followed to call the Police), there was a potential missed opportunity to explore this further with Adult A as unusual information. It agreed that more sensitive probing of this information by VRS could have been undertaken with Adult A and possibly enabled third party reporting by VRS to the Police, rather than placing the onus on Adult A to approach the Police. The Home Office fully accepted that whilst VRS requires actions to be taken by individuals, further questioning of Adult A could have enabled VRS staff to email appropriate information to the Essex control room where an incident would have been created and triaged. This would have also partially removed the onus on VRS staff to identify potential safeguarding and/or mental health issues, enabled partners to learn the location of Adult A and triage any support needs that could have been afforded to Adult A.

Learning point 8*:*

*We need to support our practitioners to recognise the importance and value of sharing third party information with key partners that may enable safeguarding and provision of appropriate support in addition to placing the onus on the individuals we are supporting to seek help.*

Recommendation 8**: All agencies to ensure that departments having contact with individuals who report unusual occurrences, e.g., they are being followed, understand the need to, and ensure, this information is shared under third party reporting arrangements to enable further support needs to be triaged and offered where appropriate.**

Manchester City Council (MCC) advised the panel that, in an ideal world, PNC checks should automatically take place for all under 25’s or people that have no recourse to public funds. If a person is from Manchester, MCC have access to those systems so checks can be made to determine if an adult is homeless or known to social care and/or policing colleagues. It also enables MCC staff to be aware of any risk issues when supporting vulnerable individuals who may pose a risk to members of the public. However, MCC also advised that if a person is not from Manchester or is not known to MCC, there is not a set process in place, particularly for under 25’s. The Panel agreed with MCC’s finding that this resulted in a delay in establishing if Adult A was known to any key partners and had the PNC check been undertaken promptly, it may have identified that Adult A had been reported as missing, but also noted that Adult A had informed MCC colleagues of his correct date of birth so the panel could not be sure this would have been the case.

Learning point 9***:***

*To protect our colleagues and also to ensure robust safeguarding of young people, we need to ensure our processes enable effective case management and risk mitigation.*

**MCC are progressing this learning and are formalising a process that will enable PNC checks on all persons aged 25 and under, including individuals who do not come from Manchester. The panel make no recommendation in relation to this finding.**

It also meant that MCC did not contact colleagues in Thurrock and identified that local authority systems are not linked together and can result in support being offered or provided to an individual who may be known to another local authority as was the case with Adult A. The Panel noted that, if this gap information sharing could be addressed, then it would make it easier to share information about individuals who are vulnerable or reported as missing.

Learning point 10*:*

*At a national level, we need to be confident that information is shared with partners in other areas, so that we can ensure effective safeguarding.*

**Noting this was national learning, the Panel do not make a recommendation in relation to this finding but does invite the TSAB to consider how this development can be progressed at a national level.**

Summary of Recommendations**:**

**Recommendation 1:** In the absence of learning or evidence from this review to support it making a recommendation to address this potential concern, the panel invites the TSAB to ensure this pathway is embedded within its safeguarding processes.

**Recommendation 2:** That the MPS Lead Officer for Missing Persons ensures officers in neighbouring county Police forces are aware of the MPS contact and can ensure that MPS information is fed into case management discussions at Long Term Missing Panel meetings and discussions to ensure robust information sharing and collaborative multi-agency decisions.

**Recommendation 3:** MPS Officers within the Specialist Crime Review Group to review their external communication to partner agencies and remind officers located within Basic Command Units of their role in leading MPS involvement in statutory reviews.

**Recommendation 4:** The Home Office ensures that partner agencies are cognisant of the roles of each department and when a case would require the input of specific departments.

**Recommendation 5:** Children’s Social Care’s strategic lead care to formalise the process that ensures Home Office colleagues are enabled to appropriately tag their internal systems when a person is reported as missing.

**Recommendation 6:** All agencies are to proactively ask about presenting concerns in relation to medical and mental health issues when undertaking new contact with service.

**Recommendation 7:** The panel invite the TSAB to support its constituent agencies to ensure that migrant and asylum-seeking individuals receive trauma informed contact and support by ensuring access to trauma informed training.

**Recommendation 8:** All agencies to ensure that departments having contact with individuals who report unusual occurrences, e.g., they are being followed, understand the need to, and ensure, this information is shared under third party reporting arrangements to enable further support needs to be triaged and offered where appropriate.

In addition to the above recommendations, the panel identified national learning from this review. This relates to how, at a national level, colleagues would benefit from a national system to:

* Flag missing persons as located
* Ensure the safety of colleagues and mitigate any risk posed to them when undertaking first contact with service users

Noting the complexity of this learning, the Panel do not make a recommendation in relation to it but does invite the TSAB to consider how this development can be progressed at a national level.

# Conclusions

This review highlighted that migrant and asylum-seeking individuals are likely to reach the UK having experienced a level of trauma. This will be undoubtedly compounded by the current Pandemic and the resulting restrictions and requires us to be trauma informed when responding to and supporting their needs.

The review did not identify any safeguarding concerns or concerns about Adult A’s mental wellbeing that cause professionals involved with him to question if Adult A had capacity to make his decisions and assess this.

It did identify some areas where improvements in information sharing could be made.

Sadly, Adult A’s family did not contribute to this review, but the panel and the TSAB extend its deepest condolences to them. It also thanks Adult B for the contributions made by this individual in the undertaking of this review.

1. Khan MM. Suicide and attempted suicide in Pakistan. *Crisis.*1998;19(4):172–176; Lester D. Suicide and Islam. *Arch Suicide Res.*2006;10(1):77–97 (located within [The relationship between suicide and Islam: a cross-national study (nih.gov)](about:blank)) [↑](#footnote-ref-1)
2. Migrant Help is a national charity that independent advice and guidance to asylum seekers and victims of trafficking across the UK [↑](#footnote-ref-2)
3. [Apply for destitution domestic violence (DDV) concession - GOV.UK (www.gov.uk)](about:blank); [NRPF Network | Assessments when the exclusion applies](about:blank#:~:text=The%20primary%20purpose%20of%20the%20human%20rights%20assessment,Facilitates%20an%20open%20conversation%20about%20all%20available%20options) [↑](#footnote-ref-3)
4. [The impact of coronavirus on mental health and relationships | YouGov](about:blank) [↑](#footnote-ref-4)
5. [bma-the-impact-of-covid-19-on-mental-health-in-england.pdf](about:blank) [↑](#footnote-ref-5)
6. Brooks S, Webster R, Smith L et al. (2020) The Psychological Impact of Quarantine and How to Reduce It: Rapid Review of the Evidence. The Lancet 395: 912-20 [↑](#footnote-ref-6)