Background

1

This Review followed the tragic death of a 4 year old male child in December 2021. Stanley was born in 2016 and there had been previous service involvement with the family as they lost another child who was 6 months old in 2018. At the time of his death, Stanley was residing with his mother and younger half-brother. He had been staying with his father and paternal grandmother the night prior to his death, and was returned home on the morning of his death due to being very unwell. The cause of Stanley's death is unexplained; however, it was noted that his bowels were impacted. The review period for Stanley falls within the parameters of the Covid 19 pandemic where agencies were working under various pressures; however, statutory obligations in respect of safeguarding remained the same and there was an expectation these continued to be met.

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Gwent Safeguarding

Context

2

At the time of Stanley's death, he and his younger brother were subject to Child Protection Registration. This was primarily due to his mother being in a relationship with a registered sex offender, however there had been other concerns regarding domestic abuse, the mental health of both parents, and a disclosure by Stanley's father that he had sexually abused his niece. This was later retracted but was investigated by Polic with no further action being taken.

During the period of involvement with Children's Services, Stanley was noted to have ongoing health concerns in respect of constipation, he had been prescribed medication by his GP. In the days preceding Stanley's death, there had been no concerns that he was unwell. An ambulance was called upon his return home to his mother's address and Stanley was found to be in cardiac arrest; medical attention was provided at the home before Stanley being conveyed to hospital where he sadly died.

Recommendations

7

Children's Duty to Report Threshold Guidance to be shared with multi agencies. Each agency to consider the implementation of this guidance within their own organisation.

Gwent MAPPA unit to provide training for Gwent IDVA Services to ensure they understand what is expected of them when attending MAPPA meetings.

Gwent MAPPA Unit to provide briefings to all MAPPA chairs regarding the importance of accurate recording of disclosures agreed in MAPPA meetings.

7-minute briefing on Independent Domestic Violence Advisor (IDVA) Services to be formulated (including what the service can provide and the referral process) and shared with organisations.

Theme 1: Quality of Safeguarding Assessments

3

There were concerns that vulnerabilities of Stanley's mother were overlooked when responding to referrals submitted. Stanley's voice was missing from early safeguarding assessments and home visits were not carried out due to the covid pandemic and domestic abuse concerns were overlooked. Similarly, concerns regarding Stanley's father's mental health were not fully acknowledge in respect of his parenting capacity.

Decisions were made without multi-agency strategy meetings taking place despite the threshold being met and there was a lack of information sharing which meant that risk assessment was likely to have been compromised. It is felt that the case should have progressed to S47 enquiries at an earlier stage. There was also a lack of clarity as to the rationale for case closures and concerns that timescales specified within the Wales Safeguarding Procedures were not adhered to.

Recommendations

6

Gwent Safeguarding Board to develop business continuity guidance for agencies to follow in an event or situation whereby service delivery is impacted. Regional guidance will ensure that all agencies are working to an agreed set of standards ensuring that the safeguarding of children, young people and adults is not compromised.

Gwent Safeguarding Board to develop a Quality Assurance framework to ensure the correct process is being followed when closing cases and to ensure Wales Safeguarding Procedures are adhered to.

Local authorities to increase availability and effectiveness of training for frontline practitioners to improve awareness and understanding of engaging meaningfully with fathers.

Strategy Discussion attendance should comply with recommendations set out in the Wales Safeguarding Procedures.

Theme 3: Domestic Abuse being Overlooked

5

Concerns were identified regarding domestic abuse within Stanley's mother relationship and her partner had an extensive history of domestic abuse. However, the focus was on the risk of sexual offending and that the risk of domestic abuse was overlooked. Although it was recorded that disclosures made by Management of Sexual or Violent Offender (MOSOVO) Officers included domestic abuse concerns, it is not clear what extent of information was shared and no disclosures were made under Claire's Law, thus it is unclear if Stanley's mother was fully aware of the risk in this context.

A referral was not made to Independent Domestic Violence Advocates Services (IDVA) in a timely fashion and when it did take place, did not progress due to an administrative error. This was despite IDVA representatives being present at Multi-Agency Public Protection Arrangement (MAPPA) meetings where risk was highlighted.

Theme 2: Missed Opportunities to Submit Safeguarding Referrals

4

Stanley's father shared concerns with the Health Visitor regarding his appearance and general health; He was advised to discuss with Stanley's mother and contact Children's Services if these continued. A visit was then undertaken where the Health Visitor also noted some concerns, however, a Duty to Report was not submitted. It is important that practitioners take ownership for any concerns shared with them and are not reliant upon family members or members of the public to contact Children's Services.

There were also concerns that the National Probation Service were not clear about the capacity of Stanley's mother to supervise contact with her partner, a Registered Sex Offender, however, did not submit a Duty to Report for clarification, despite being aware of a high level of contact.