Diogelu Gwent
Gwent Safeguarding

1 Background

Following the death of a 15 year old child (Child D), an extended Child Practice Review was commissioned. Child D was born in January 2006 at 24 weeks gestation. He spent 19 weeks in a neo-natal unit and was diagnosed with cerebral palsy. Child D was first known to Children's Services Disability Team at the age of 1 years old for Occupational Therapy support due to his complex health needs.

In 2008, Child D was placed with his maternal grandparents as a Child Looked After due to his mother feeling unable to meet his needs; this was followed by a Special Guardianship Order being granted to them some months later. Child D's mother and father had moved to a different area and Child D continued to reside with his maternal grandparents. Concerns regarding home conditions first came to light in 2015.

2 Context

Child's D's mother returned to the family home in 2016 along with her two children from a different relationship. Whilst residing in another area Children's Services had been involved with Child D due to concerns regarding neglect. Home conditions fluctuated from 2015 up until Child D's death. His health continued to be reviewed with no issues being identified. In 2021 concerns were raised regarding medication management for Child D and later that year his named was placed on the Child Protection Register for Neglect. Throughout the time that Children's Services were involved with child D and his family, they remained as part of the Children's Disability Team within the Local Authority Structure.

Prior to Child D's death his Grandparents went on holiday, extra safeguards were put in place due to mother having caring responsibility for Child D. During this time, it was identified that he was suffering from constipation and a prescription was made by his GP; however, this was not collected. Poor home conditions were noted by paramedics and police attending at the time of Child D's death.

3 Theme:

Understanding a child's lived experiences is vital for effective safeguarding. Child D was predominantly non-verbal due to his complex needs. Complexities with speech and language should not be a barrier to developing an understanding of a child's lived experience. The Children's Disability Team within the Local Authority currently falls within the Adult Services Structure. Physical needs relating to child D's disability were met with professional input from services such as Occupational Therapy. However, there is a lack of focus on child D's lived experiences as a child with disabilities living within a home where there was cumulative neglect over a number of years.

Recurrent Poor Home Conditions and Neglect:. The impact of neglect may be more severe for some children, including those with disabilities such as Child D. The cumulative effect of neglect must be considered by professionals, particularly when children have complex needs.

4 Theme:

Risk Assessments for Carers Understanding of Child D's Needs: Child D was residing with his grandparents under the requirements of a Special Guardianship Order, however, there were times when his care was the responsibility of his mother, for example when his grandparents were on holiday. Child D had complex care needs and it is unclear the extent to which mother had the ability to meet these needs whilst also caring for Child D's siblings, and what grandparents understanding of this was. **Specialist equipment**: Child D required a range of specialist equipment due to his health needs; these changed over time as Child D grew and it must also be considered that as Child D grew and his grandparents aged, it may have become more challenging for them to meet his needs. Specialist equipment was provided for Child D however some items were not used due to them causing Child D distress. There were significant delays in obtaining other items, influenced by the Covid 19 pandemic. This highlights the importance of ongoing assessment.

5 Recommendations:

Recommendation 1: The Safeguarding Board should consider developing practice guidance on the lived experience of children with disabilities to assist practitioner insight, to ensure that the voice of the child is actively heard and to support effective action to safeguard children and young people. **Recommendation 2**: Consideration should be given for the Local Authority to review the strategic responsibility for the Children with Disabilities Team within the directorate of the authority. This consideration could include ensuring consistency across the region. **Recommendation 3:** The Safeguarding Board to explore and consider if information from GP's regarding children who are subject to safeguarding procedures, should be shared with Pharmacists to monitor and share information as appropriate. **Recommendation 4:** The Safeguarding Board to consider the addition of a home conditions threshold to the existing regional neglect guidance. Photographs of home environments should be considered to enable professionals and families to identify and enable change, as appropriate.

6 Recommendations:

Recommendation 4 continued: These could also be used to discuss acceptable standards. A multi-agency approach to a cluttered environment should be considered and agencies such as the fire service to be considered for education regarding risk. **Recommendation 5:** When a child is residing with a parent/carer who no longer holds over-riding parental responsibility, Children Services should complete risk assessments for the parent/carer to prove competence related to the care needs of the individual child. **Recommendation 6:** Risk assessments should be completed by the Local Authority in partnership with other relevant agencies to evidence and therefore enable escalation of poor service from outside companies when waiting times for equipment exceed expected timescales. The impact to the child or young person should be considered within this. **Recommendation 7:** Regular assessments of equipment needed for individuals should be undertaken and equipment removed if appropriate by the Local Authority and partnership agencies. Escalation processes should be clear for all staff across all sectors to enhance the care

7 Good Practice

Child D's educational setting recognised when he was in pain and queried the reasons for this with family.

Professionals recognised that Child D's mother may struggle with his care while grandparents were away and ensured measures were put in place including additional support from extended family, additional school playscheme sessions, and Social Worker home visits.

During the Covid 19 pandemic, school maintained regular contact with the family and Child D was offered and attended a hub placement during school closures.

Local Authority provided support at home to enable grandparents to access virtual core groups during the Covid 19 pandemic.