7 Minute Briefing

Extended Child Practice Review

1 Background

An Extended Child Practice Review was commissioned by Gwent RSB in accordance with the Social Services and Wellbeing (Wales) Act 2014 guidance for Multi Agency Child Practice Reviews This review considers the circumstances of a male Child E who sadly died aged 9 years and 11 months.

Prior to his birth in 2011, concerns were reported to Social Services by the midwife due to parental substance misuse, poor mental health, and domestic abuse. Due to an incident after birth between Child E's parents and to safeguard the Child, it was agreed that he and his mother would reside with maternal grandmother. Whilst living with maternal grandmother, the situation deteriorated quite rapidly with mother leaving the family home. Shortly after this a Residence Order was granted by the Court, affording maternal grandmother equal parental responsibility and the power to decide where the Child resided.

2 Context

For a substantial period (2017-2021) , Child E and his family were supported by Social Services on a Care and Support Plan. During this time numerous safeguarding referrals were submitted to Social Services around Child E's aggressive behaviour, inappropriate language, sexually inappropriate behaviour, allegations of abuse perpetrated by family members and concerns that Child E was beyond parental control.

In 2021, Child E's name was placed on the Child Protection Register due to increased concerns. A legal threshold meeting was held in June 2021 but concluded that as this was the first period of registration, time should be given to allow the Child Protection plan to work.

At a meeting in November 2021, it was agreed that risks were increasing, and the matter should progress to legal threshold meeting. On the 7th of November 2021 Child E was found hanging in the family home. He sadly died in hospital.

3 Learning & Actions

Loss / Grief: Child E's father died in 2019. Support was offered at school; however, he did not engage at this time and did not wish to take up the offer of bereavement counselling. This does not seem to have been revisited. The impact on Child E of his father's death does not appear to have been fully considered. In addition, grandmother had recently suffered bereavement following the death of her sister. This inevitably impacted on her wellbeing and that of Child E.

Mothers Mental Health and Suicide attempts: Three weeks before Child E's death, his mother was hospitalised twice following attempts on her own life. In response to this, contact between Child E and his mother was suspended. Child E was aware of his mother's suicide attempts. This does not appear to have been discussed with him and the impact this would have had on him does not appear to have been fully considered.

4 Learning & Actions

Over optimism in grandmother's ability to manage and effect change: Child E's mother had been known to Social Services as a child, with the concerns regarding Child E mirroring the behaviours that were evident during his mother's childhood. When Child E's mother had another child, grandmother was negatively assessed to provide long term care to the child who was subsequently adopted. In addition to this, grandmother suffered with poor physical health and was in the 'clinically vulnerable' group during the early stages of the covid 19 pandemic.

Missed opportunities to speak to Child E alone: There were several missed opportunities identified to see and speak to Child E alone. Children should be seen on their own so that the child can speak about the impact that the circumstances, which have prompted safeguarding concerns, are having on them.

5 Learning & Actions

Impact of Covid: As a result of the covid 19 pandemic Child E's vulnerability increased. Schools were closed for a significant period during the pandemic, with parents/carers expected to home school their children. Child E was not considered to be eligible for Hub provision which was reserved for those on the child protection register and Children Looked After. During subsequent lock downs, discretion could have been used to provide Child E with a place at the Hub, providing grandmother with respite and ensuring Child E was regularly seen by professionals.

Professional differences: There were concerns about the lack of progress being made on the Care and Support Plan and the emerging child protection concerns. These concerns were communicated between the professionals, however, there is no evidence that concerns were escalated.

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6 Learning & Actions

Systems and Processes: Child E and his family were supported on a Care and Support Plan for four years prior to his name being placed on the Child Protection Register. There were opportunities missed to consider Child E within the child protection arena earlier. There were missed opportunities for initiating PLO at the legal threshold meeting.

Central co-ordination of assessments and plans: Child E and his family were supported on a Care and Support Plan for four years. Despite regular communication between professionals' assessments and plans lacked co-ordination in the time prior to Child E's name being placed on the Child Protection Register. The absence of a comprehensive and co-ordinated plan made it difficult to assess whether any progress was being made.

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7 Recommendations

- The Safeguarding Board should consider developing practice guidance on the lived experience of the child to assist practitioner insight, to ensure that the voice of the child is actively heard.
- Local Authorities should consider enhanced management oversight and review of cases where children and families are supported on a Care and Support Plan for extended periods.
- The Safeguarding Board should consider strengthening and raising awareness across all agencies of the Multi-Agency Practice Guidance: Resolving Professional Differences.
- The Safeguarding Board should consider raising awareness across all agencies of the Multi-Agency Chronology Guidance to ensure chronologies created by different agencies will be presented coherently, giving a clear account of significant events in the lives of the child(ren) and family.