Diogelu Gwent
Gwent Safeguarding

7 Minute Briefing

Child Practice Review

1 Background

A Child Practice review was commissioned by the Chair of the South East Wales Safeguarding Children's Board on the recommendation of the Joint Case Review Group. This was in accordance with 'Working Together to Safeguard People: Volume, Child Practice Reviews, Social Services and Well-Being (Wales) Act 2014, following the death by hanging of a 17-year-old female in October 2021. Child L was born in Latvia and resided with her maternal grandmother as her mother had relocated to Bristol. At the age of 8, Child L and her grandmother followed. In 2014 the family were open to Children's Services because of concerns regarding sexualised behaviour, domestic abuse, reports of violence perpetrated towards Child L by her mother and stepfather, as well as self-harm and a possible suicide attempt. In 2015, Child L was removed from the care of her mother and stepfather by police with an Interim Care Order. In March 2016 she returned to the family home.

2 Context

The family relocated to South Wales where there were referrals and contact with multiple agencies due to the relationship between Child L and her family. In 2019 aged 14 years of age, Child L moved out of the family home and went to live with an 18-year-old male and his mother, this arrangement was supported by Child L's mother. Child L's Grandmother and Education services raised concerns about the relationship with the older male. A multi-agency Strategy Discussion should have taken place but there is no record of this being considered. Children's Services concluded that there was no evidence of abuse or exploitation. As a result Child L remained living with the male and his mother. In 2021, at 16 years of age, Child L presented as homeless following the breakdown of her relationship. At the time of her death Child L was residing in temporary supported accommodation provided by the Local Authority. Staff at the temporary accommodation found Child L hanging and deceased in her room in October 2021 during morning wellbeing checks.

3 Learning

Missed opportunities: Within the 2-year period leading up to Child L's death there were missed opportunities to submit Public Protection Notices (PPNs) and Duty to Reports (DTRs). There were several concerns documented on Child L's residents file at her accommodation related to risk factors associated with **Child Sexual Exploitation.** Warning signs of potential exploitation do not seem to have been considered.

Missing safeguarding information and cross border sharing: It is unclear what steps were taken by Children's Services, to obtain information from the previous LA Children's Services team as part of Child L's assessments. As Child L was never assessed as requiring ongoing intervention, it appears that no one requested or followed up on initial requests for information. . If this information was known earlier intervention may have occurred.

4 Learning

Voice of the child: Child L was at times treated as an adult who could make decisions without support, and at other times was viewed as a child who needed her mother to make decisions on her behalf. There is limited evidence of her voice being considered in the assessments that were completed.

Quality of safeguarding assessments: Two assessments were completed in the review period. As a result of the covid 19 pandemic assessments were completed over the telephone. It was felt that the first assessment failed to fully consider the wider risk factors associated with Child L. During the second assessment there was no evidence to indicate that the Southwark Judgement had been applied to the assessment. If the Judgement had been applied, it may have ensured Child L received the wider protections and entitlements of leaving care services. On both occasions Child L's safety was not considered under the Safeguarding Procedures.

5 Recommendations

Recommendation 1: Supported accommodation provider ensures there is a safeguarding training and development plan in place.

Recommendation 2: All agencies to remind staff of the importance of acknowledging the age of the child when considering the presenting concerns, the child's lived experience and the required actions in line with the All Wales Safeguarding Procedures.

Recommendation 3: All agencies to review internal recording tools to ensure the voice of the child is promoted and evidenced.

Recommendation 4/5: Children's Services Practitioners must ensure children are seen (and seen alone if appropriate) as part of an assessment. If parents refuse or challenge the need for a child to be seen (and seen alone if appropriate) this must be escalated and recorded.
Recommendation 6: The Safeguarding Board consider developing practice guidance on the lived experience of the child

6 Recommendations

Recommendation 7: Children's Services and Housing to ensure that relevant staff are aware of the Southwark Judgement. Agencies may need to review their assessment tools to ensure they are child focussed, promote the voice of the child and record that the child has capacity to provide informed consent.

Recommendation 8: Safeguarding Board to request the All Wales Leaving Care Forum consider the development of materials (videos/podcasts) created by care experienced young people that can be used to support 16/17-year-olds in understanding the Southwark Judgement.
Recommendation 9: All agencies to ensure they have procedures in place to gather historical information from other areas and have clear escalation policies in place if this information is not provided in a reasonable timescale.

Recommendation 10: In the event of another pandemic agencies need to have clear contingency plans in place for children and young people to ensure that they are seen face to face.

7 Positive Practice can we put this before learning?

Education settings submitted several referrals to Children's Services and also maintained regular contact with Child L throughout Covid offering Child L support with academic tasks.

Since Child Ls death **Gwent Police** have included ACE and trauma informed training for their workforce.

Since Child Ls death **the Health Board** confirmed that they have now implemented a process for the submission of safeguarding referrals that ensures that safeguarding referrals are being sent on the day the safeguarding concern or issue is raised.

The **supported accommodation** are currently reviewing the safeguarding training plan to ensure that all staff receive ACE training, CSE training and domestic abuse training.