Child Practice Review Report

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South East Wales Safeguarding Board
Concise Child Practice Review

Re: SEWSCB 2/2022

Brief outline of circumstances resulting in the Review

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 suicide of a 17 year old female in October 2021.

At the time of her death Child L was residing in temporary supported accommodation. This accommodation was provided to her by the Local Authority following a homelessness assessment in May 2021**.**

Staff at the temporary accommodation found Child L deceased in her room in October 2021 during morning wellbeing checks. Child L had died by hanging.

Attempts were made to involve Child L's family in the review, however following a discussion with the Family Liaison Officer they did not feel able to engage in the process. They did not feel able to share a name they wished for her to be referred to in this report. Consequently, she will be referred to as Child L.

Background

Child L was born in Latvia and spent her early life there, residing with her maternal grandmother. Child L's father committed suicide when she was 3 years old. Child L's mother was living in the UK, and at the age of 8 Child L and her grandmother both moved to England to reside with her.

Child L's mother remarried and had 2 children, Child L's step siblings, who were age 2 and 3 at the time of Child L's death. One of Child L's step siblings has a terminal illness.

Child L had come to the attention of services from as early as 2014, when she was 10 years of age. Her case was open to the local Children's Services because of concerns regarding sexualised behaviour. There were allegations of domestic abuse within the family home and reports of violence perpetrated towards Child L by her mother and stepfather.

Over the 2 year period Child L was known to the English Local Authority, Children's Services there were continued concerns regarding sexualised behaviour, neglect issues within the home and ongoing physical violence.

There were also issues reported regarding Child L's mental health. Her mother reported that Child L had attempted to cut her wrists in 2014 when she was aged 10 years. In 2015, when she was aged 11, Child L advised it was her intention to attempt suicide by hanging. She was located in the school toilets with a chain around her neck.

Child L's development was noted to have been impacted by adverse childhood experiences and she was reported to be fearful of both her mother and stepfather.

As a result of these concerns Child L was removed from the care of her mother and stepfather by police and an Interim Care Order was made in November 2015.

In March 2016 a Child Looked After (CLA) review noted:

- Child L's overall needs and mother's parenting capacity were assessed through the court proceedings
- Child L had a CLA medical assessment, a Child Adolescent Mental Health Service (CAMHS) consultation and was assessed by an expert child psychologist through the court proceedings
- Child L was found to have an IQ of 68 which meant she had a level of additional learning needs (the average IQ level for a child of 12 is 77)
- Child L was subject to a Personal Education Plan (PEP) and had not been doing well at school since before coming into care
- Child L was saying she wanted to return home to live with her family and was not afraid
- Child L was noted to be 'a complex child who would likely need lots of support to thrive'
- Child L had been assessed via the proceedings

Child L remained in a foster placement until March 2016 when she was returned to the family home.

Following her return to the family home, Child L continued to be open to services for issues including child sexual exploitation (CSE), missing episodes and mental health concerns.

The family relocated to Wales and resided in the Newport area. At the time of relocation Child L was no longer open to Children services in England, therefore a handover was not completed or requested by the Local Authority.

Once Child L moved into Wales and was attending a mainstream education setting in the area, there were referrals and contact with multiple agencies due to the relationship between Child L and her family, which continued to be challenging.

In 2019 aged 14 years of age, Child L moved out of the family home and went to live with her 18 year old male partner and his mother. This arrangement was supported by Child L's mother. Child L was also no longer in mainstream education due to attendance and behavioural issues and was attending an Education Centre in the Local Authority area.

Child L's maternal Grandmother and the Education Centre both raised concerns about the relationship with the older male, however, Children's Services concluded that there was no evidence of abuse or exploitation. As a result, Child L remained living with her partner and his mother.

In 2021, at 16 years of age, Child L presented as homeless following the breakdown of her relationship with both her mother and her older partner she had been residing with.

Following a homelessness assessment undertaken by the Local Authority Child L was placed at temporary supported accommodation managed by a supported housing provider. She was placed there in May 2021. She had been in the setting for 5 months when she died in October 2021.

Time Period Reviewed

The time period for the review was agreed from 1st October 2019 to 1st October 2021.

Practice and organisational learning

In undertaking this review, we are grateful for the agency chronologies submitted and to the professionals who attended the learning event.

Themes and Learning Points

There were 5 overarching themes identified which have informed the learning points from this review.

- Missed opportunities to submit safeguarding referrals
- Lack of child centred safeguarding assessments
- Quality of safeguarding assessments
- Missing safeguarding information and cross border sharing
- Covid-19 arrangements

Theme 1: Missed opportunities to submit safeguarding referrals

Within the 2 year period leading up to Child L's death there were missed opportunities to submit safeguarding referrals. These included failures to submit Public Protection Notices (PPNs) and Duty to Reports (DTRs).

Police missed opportunities:
In October 2019 there was a report of an assault made to Gwent Police. It was alleged that Child L had assaulted a neighbour in the street over an ongoing 'feud'. No further action was taken by the Police despite Child L being only 15 years old and the others involved in the assault were adults.

In June 2021 Child L was reported missing by supported accommodation staff where she was residing, as she was 16 years old and had not returned to the accommodation. As part of the enquiries the police officers looked in Child L's room where they found an empty bottle of vodka and condoms. No PPN was submitted by Gwent Police for this incident.

Housing missed opportunities:
Between May and October 2021 whilst in supported accommodation staff documented the following concerns on Child L's case file:

- Relationships with different adult males
- Regularly attending an area of Newport - reported known concerns about this area and Child L having no known connections to be there
- Associating with another young female who was known to agencies as a complex young adult and a victim of child sexual exploitation (CSE)
- Domestic Abuse concerns whereby Child L and another resident reported incidents of physical abuse and controlling behaviour from Child L's partner
- Adult males collecting and dropping Child L off at the accommodation
- Missing episodes, staying out all night, and regularly returning late
- Empty vodka bottle and condoms found in her room
- Adult Males staying in her room
- Refusing wellbeing checks
- Reporting to staff she was pregnant
- Self-disclosure that she was consuming alcohol
- Reporting an inability to cope and feeling that her mental health was deteriorating

The concerns were documented on Child L's residents file but a DTR was not submitted to Children' Services. Attempts were made to engage a social worker via emails but these were not successful or the right mechanism to prompt a new assessment, as the case was not open to them.

Health Board missed opportunities:
The Emergency Department with Aneurin Bevan University Health Board submitted a DTR for Child L a week prior to death. Unfortunately, the referral from ED Staff was completed on the 29th September 2021 but was not received by Children's

Services prior to Child L's death in October 2021. This was due to Health system issues pertaining to completing documentation, scanning, uploading and submitting them to the correct Children's Services.

Good Practice

It has been identified throughout this review that Child L's education settings responded promptly to safeguarding issues and submitted several referrals to Children's Services.

Also, one week prior to her death Child L reported to the ED with Aneurin Bevan University Health Board due to chest pains.

Whilst talking to hospital staff she self-reported that she was using a significant amount of cannabis amounting to a cost of £70 each day. It was also noted within the medical records that she was a victim of domestic abuse in a previous relationship. A DTR was submitted by ED staff (but not received prior to her death).

Theme 2: Lack of child centred safeguarding assessments

It was identified that there were missed opportunities to speak to Child L directly on multiple occasions, and that assessments were not child centred as a result of this. The learning event demonstrated that understanding Child L's lived experience was challenging and her voice was not clear at any point.

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 was a lack of consistency in approaches by professionals and there was limited evidence of her voice being considered in the assessments that were completed within the timeline period.

In October 2019 Gwent police responded to a report of Child L committing an offence of assault. Although Child L was only 15 years old, because she was not the victim of the crime, her wellbeing as a child was overlooked and wider safeguarding concerns were not recognised. A PPN was not submitted which may have prompted a holistic assessment where her voice may have been heard.

Also in October 2019 a DTR was submitted by Education to Children's Services confirming that Child L was residing with her 18 year old boyfriend at his parents' home. A multi-agency Strategy Discussion should have taken place but there is no record of this being considered. However, an assessment was completed and Child L's mother and Child L's partners mother were spoken to. Safety planning was discussed, however there was no discussion with Child L.

In February 2020 Education submitted a further DTR as Child L was residing at her adult partners address with mother's consent. Child L had disclosed that her partner was selling drugs and reported to education staff that she wanted to become pregnant.

The referral was closed by Children's Services 2 days later. There is no evidence of a Strategy Discussion being considered or of needing to speak to Child L. Concerns

were highlighted regarding Child L not being provided with the level of parental oversight she requires. Despite this, Child L's mother declined for Child L to be involved in the discussions and was noted to be the adult with parental responsibility.

At the learning event professionals raised concerns that the safeguarding assessment noted that there was a lack parental supervision. However, it was accepted that Child L's mother had the overarching say about Child L being spoken to. This appears to conflict the reason for DTR which was to understand Child L's lived experience and wellbeing. This was not felt to have been properly assessed.

Theme 3: Quality of safeguarding assessments

There were 2 assessments undertaken by Children's Services in the review period.

Assessment 1:
As detailed in Theme 2 above the first assessment was commenced following a DTR from Child L's education setting in February 2020. The DTR included information that Child L was, residing with her adult partner, he was selling drugs and that she may be pregnant, and was actively trying to become pregnant.

The referral was allocated for assessment. Lateral checks were undertaken with the police and maternity services and a 'proportionate assessment' was completed with Child L's mother.

The proportionate assessment with Child L's mother raised concerns that Child L was actively trying to become pregnant and that she was misusing cannabis with her adult partner. Concerns were also highlighted regarding Child L not being provided with the level of parental oversight she requires.

There was found to be no evidence of drug dealing and no evidence that Child L was pregnant in the lateral checks.

The assessment concluded in March 2020. It was found that there were no child protection concerns and that Child L's mother had declined a further assessment and declined for Child L be spoken to. Child L was considered to be safe and the case was closed.

It was felt that this assessment failed to fully consider the wider risk factors associated with Child L for a number of reasons. These included:

- It was not clear whether a request for information was submitted to the English Local Authorities Children's Services for the purposes of the assessment. No information was received and consequently there was no understanding of historical child protection concerns or family history in the assessment
- Child L's relationship with her partner had not been appropriately assessed and there was a lack of understanding regarding relationship dynamics
- Child L was not spoken to and mothers declining of this was not challenged as a concern

- Future sexual health and potential pregnancy did not form part of the assessment and next steps
- However, more importantly, Child L's safety was not considered under the Safeguarding Procedures

Assessment 2:
The second assessment was undertaken in May 2021 when Child L presented as homeless to the Local Authority. There was no evidence to indicate that the Southwark Judgement had been applied to the assessment.

The Southwark Judgement intends for homeless 16 and 17 year olds to be considered for accommodation under section 76 of the Social Services and Wellbeing (Wales) Act 2014 (previously section 20 of the Children Act 1989) in order to secure their entitlement to broader and longer term support. A child accommodated under section 76, post 16 years of age automatically becomes an 'eligible child' and receives the wider protections and entitlements of leaving care services.

Accommodating a 16 or 17 year old under section 76 requires the child's agreement, it is therefore crucial to ensure that they are fully and properly engaged and informed about the decision.

Where a child refuses section 76 accommodation children's services must be satisfied that the young person has been provided with all the information and is competent to make such a decision and that they do not need to take additional safeguarding actions.

The assessment took place in the COVID- 19 pandemic and comprised of a telephone call to Child L's mother and a telephone call to Child L. The assessment concluded that Child L's needs would be met via housing and by placing Child L in mixed age and sex supported accommodation placement.

A DTR was to be submitted to ensure Child L had support from appropriate services for young people living away from family, and other support agencies.

Theme 4: Missing safeguarding information and cross border sharing

Whilst residing in England Child L was known to a Local Authorities Children's Services and had been a CLA.

It is unclear what steps were taken, if any, to obtain this information by Children's Services 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.

It is also unclear as to whether the English Children Services failed to respond to requests for information and how this was dealt with by Children's Services in terms of escalating to senior managers.

Throughout the review period both Children's Services and supported accommodation staff referred in their records to missing information regarding Child L's history.

The information held by the English Local Authorities Children's Services about Child L was received by request after her death. As can be seen in the background section of this report, Child L's history was significant.

At the learning event professionals felt that if they had known Child L's background, earlier intervention may have occurred.

Theme 5: Covid-19 working arrangements

When the Covid 19 pandemic began in early March 2020, organisations were required to review working arrangements on a regular basis ensuring that they complied with government advice whilst continuing to provide key services.

The safeguarding responsibilities of agencies did not change throughout the pandemic. Statutory safeguarding agencies were expected to develop processes to ensure service delivery was not compromised due to the new ways of working.

It is however acknowledged that business continuity in safeguarding was not seamless for all statutory and non-statutory agencies. Staffing was impacted due to illness and shielding, people were fearful of the infection and children were less visible with schools and groups affected. It is recognised that many hidden harms will have occurred as result of professionals having reduced access and visibility to at risk children.

For Child L the pandemic impacted the offer of support that services gave her. This included:

- Education staff who appeared to have a good insight into the safeguarding concerns associated with Child L had reduced contact with her
- Housing assessment was undertaken through a telephone call
- Children's Services assessment was undertaken through a telephone call
- Supported accommodation staff at the learning event described significant staffing challenges due to staff sickness and the requirement for staff to isolate. As a result of this there was no consistent Key Worker supporting Child L, she was seen by different staff on a regular basis including agency staff.

Good practice:

- Education maintained regular contact Child L throughout Covid and were offering her support with academic tasks.

Improving Systems and Practice

Recommendations

Theme 1 - Missed opportunities to submit PPN's and Duty to Report referrals

Practice Updates

Gwent Police have confirmed that there have been considerable improvements to processes. This has included ACE and trauma informed training now being in place. At the learning event there was confidence amongst the Police Officers in attendance that should this happen again a referral would be submitted.

Aneurin Bevan University 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 provider has recognised that all staff require an adequate level of training in line with key safeguarding agencies. The Senior Management Team are reviewing the safeguarding training plan to ensure that all staff receive the correct level of training, this is to include ACE training, CSE training and domestic abuse training. The training plan is to be completed with oversight and input from the South East Wales Safeguarding Board. Staff also need to be engaged with multi-agency training that is provided by the South East Wales Safeguarding Board and management are encouraged to attend local learning and review group meetings.

Recommendation 1
The supported accommodation provider ensures there is a safeguarding training and development plan in place for all staff at all levels, with support from the South East Wales Safeguarding Board.

Theme 2 – Lack of child centred safeguarding assessments

Practice Update

Gwent Police have confirmed that training and knowledge around CSE and professional curiosity has since improved. There is a new role within Gwent Police of a Vulnerability Harm Reduction Officer and this role is to be the conduit between the neighbourhood policing teams and the public protection unit to ensure there is a more robust coordinated approach to child protection issues. There is also a dedicated Vulnerability Trainer for force wide training.

Homelessness Officer is based within Children Services to complete joint assessments for homelessness and support needs, including consideration of the Southwark Judgement.

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
Children's Services Practitioners must ensure children are seen (and seen alone if appropriate) as part of an assessment.

Recommendation 5
Children's Services Practitioners must escalate concerns if parents refuse or challenge the need for a child to be seen (and seen alone if appropriate) and to record that decision.

Recommendation 6
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 and to support effective action to safeguard children and young people.

Theme 3 - Quality of Safeguarding Assessments

Practice Update

Development of a Young Persons Housing and Homelessness Strategy between directorates in the Local Authority.

Recommendation 7
Children's Services and Housing to ensure that relevant staff are aware of the Southwark Judgement and how the key principles can be applied to assessments with homeless young people. Agencies may need to review their assessment tools to ensure they are child focused, promote the voice of the child and record that the child has capacity to provide informed consent.

Recommendation 8
The Safeguarding Board to request the All Wales Leaving Care Forum to consider the development of material such as videos or podcasts created by care experienced young people that can be used to support 16 and 17 year olds in understanding the Southwark Judgement.

Theme 4 – Missing information

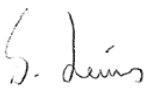
Recommendation 9
All agencies to ensure they have procedures in place to gather historical information from other areas where there has been known involvement with child or family and to

have clear escalation policies in place if this information is not provided in a reasonable timescale.

Theme 5 - Covid 19 Arrangements

Recommendation 10
In the event of a further pandemic or situation whereby service delivery is impacted all agencies need to have clear contingency plans in place for children and young people to ensure that they are seen face to face.

Statement by Reviewer(s)

REVIEWER 1		**REVIEWER 2** *(as appropriate)*	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Sinead Lewis	**Name** *(Print)*	Amy Bucknall
Date	14.10.22	**Date**	14.10.22

Chair of Review Panel (Signature)	
Name *(Print)*	Gareth Jenkins
Date	14.10.22

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Child Practice Review process
The South East Wales Safeguarding Children Board Chair notified Welsh Government on 16th February 2022 that it was commissioning a Concise Child Practice Review in respect of a child. Reviewer:. Sinead Lewis, Senior Probation Officer, Gwent Probation Delivery Unit, HM Prison and Probation Service Reviewer: Amy Bucknall, Head of Safeguarding , Aneurin Bevan University Health Board Chair of Panel: Gareth Jenkins, Head of Children's Services, Caerphilly County Borough Council. The services represented on the panel consisted of: - Social Services - Education - Housing - Youth Offending Service - Gwent Police - Aneurin Bevan University Health Board The panel met to review the multi-agency information and provide analysis to support the development of the report. A Learning Event took place 29 September 2022 and was attended by the following agencies: - Social Services - Education - Housing - Youth Offending Service

- Gwent Police
- Aneurin Bevan University Health Board

Relevant family members were informed that the review was taking place, the family declined involvement in the review.

☒ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	