Child Practice Review Report

South East Wales Safeguarding Board
Extended Child Practice Review

Re: SEWSCB 1/2022

Brief outline of circumstances resulting in the Review

Legal Context

An extended review was commissioned by the Chair of the South East Wales Safeguarding Board on the recommendation of the Joint Case Review Sub-Group, in accordance with the Guidance for Multi Agency Child Practice Reviews. This was in accordance with 'Working Together to Safeguard People: Volume 2, Child Practice Reviews, Social Services and Well-being (Wales) Act 2014, following the death of a 9-year-old child who will be known hereafter as Child E.

A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- died; or
- sustained potentially life-threatening injury; or
- sustained serious and permanent impairment of health or development; **and**

the child was on the child protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) on any date during the 6 months preceding –

- the date of the event referred to above; or
- the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

Circumstances resulting in the review

This review considers the circumstances of a male child who sadly died aged 9 years and 11 months.

Child E was born in November 2011. Prior to his birth, 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 his parents and to safeguard Child E, it was agreed that Child E and his mother would reside with maternal grandmother. However, the situation deteriorated quite rapidly with

mother leaving the family home. In 2013 a Residence Order was granted by the Court, affording maternal grandmother equal parental responsibility and the power to decide where Child E resided.

Concerns regarding Child E's behaviour emerged as early as 2015 when he started nursery as a rising 3; he was described as boisterous, using bad language and had difficulty following rules and focussing on tasks. Within two years of the Residence Order being granted, two referrals were received by Social Services, one concerning mother's substance misuse and possible pregnancy and another regarding grandmother being late to collect Child E from school with suspicions that she was intoxicated.

In 2017, following several school exclusions due to verbal and physical aggression towards staff and pupils and disruptive behaviour, Child E was dual registered, in his mainstream school and with a school for children with social, emotional and behavioural difficulties.

From 2017 to May 2021 Child E and his family were supported by Social Services on a Care and Support Plan. During this time there were numerous referrals to Social Services, largely from Education, concerning 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.

On the 24th of May 2021, Child E's name was placed on the Child Protection Register under the categories of neglect (primary) and physical abuse (secondary). There was a recommendation from the Initial Child Protection Conference that the matter be progressed to a legal threshold meeting.

A legal threshold meeting was held on the 21st of June 2021. The meeting concluded that as this was the first period of registration, time should be given to allow the new tools identified as part of the Child Protection plan to work.

At the Core Group meeting in October 2021, all professionals agreed that a further *'What Matters' meeting should be held due to concerns about the lack of progress being made. The 'What Matters' meeting took place on the 2nd of November. The meeting agreed that the matter should progress to legal threshold meeting.

On the 7th of November 2021 Child E was found hanging in the family home with a scarf around his neck. He was unresponsive. Child E was transported to hospital but sadly died on the 10th of November 2021.

Time Period Reviewed

The time period for the review was agreed as from 1st November 2020 to the 31st of December 2021 in order to include the PRUDIC and Immediate Response Group processes following Child E's death.

Practice and organisational learning

In undertaking this Review, we are grateful for the agency chronologies submitted and the information and time given by family members. We would particularly like to thank the professionals who attended the learning event.

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

- Co-ordination of assessments and plans
- Over optimism in grandmother's ability to manage and effect change
- Understanding of Child E's lived experience
- Professional differences
- Systems and processes

Any review completed that considers systems and practice from March 2020 needs to consider whether there was any impact due to the Covid 19 pandemic. We have therefore sought to understand, as far as is possible, whether the circumstances of this global crisis affected Child E, his family and the response of professionals to what was happening in their lives.

Theme 1 - Central co-ordination of assessments and plans

Prior to his name being placed on the Child Protection Register in May 2021, Child E and his family were supported on a Care and Support Plan for four years. During this time, concerns regarding Child E's behaviour were escalating.

Review panel members and practitioners at the Learning Event, identified that despite regular communication between professionals working with Child E and his family, assessments and plans lacked co-ordination in the time prior to Child E's name being placed on the Child Protection Register.

Learning point:

- The absence of a comprehensive and co-ordinated plan made it difficult to assess whether any progress was being made.

Theme 2 - Over optimism in grandmother's ability to manage and effect change

The family had been known to Social Services for a number of years. Child E's mother had been known to Social Services as a child, with the concerns regarding Child E mirroring the concerns 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.

Learning point:

- The significance of family history was given insufficient consideration until it was raised by the Chair of the Initial Child Protection Conference in May 2021 who had previous knowledge of the family.

Despite leaving the family home in 2012, Child E's mother continued to have significant influence in his life and over grandmother's parenting of Child E. Despite this, grandmother was given the responsibility of managing and supervising Child E's contact with mother and was relied upon heavily to effect change, with little consideration as to whether she had the skills and ability to respond appropriately.

Grandmother suffered with poor physical health and was in the clinically vulnerable group during the early stages of the covid 19 pandemic. Schools were closed for a significant period during the pandemic, with parents/carers expected to home school their children. Whilst Hubs were open for vulnerable children and the children of key workers, Child E was not considered to be eligible for this provision which was reserved for those on the child protection register and Children Looked After.

Learning point:
During the period of the second lock down and subsequent lock downs, discretion could have been used to provide Child E with a place at the Hub, providing grandmother with respite and ensuring that Child E was regularly seen by professionals.

In February 2021, grandmother suffered the bereavement of a close family member. Whilst grandmother was asked whether there was any support she wanted at this time, there is no evidence that consideration was given to the impact that the bereavement had on grandmother's ability to parent Child E.

Theme 3 - Understanding of Child E's lived experience

At the heart of child protection is the need to really understand what life is like for a child. Children who are experiencing abuse and neglect may be reticent or unable to speak out about their experiences. Practitioners need to actively hear what the child has to say or communicate, observe their behaviour in different contexts and hear what family members/significant adults/carers and professionals have said about the child. Practitioners need to have the right skills and expertise to develop a trusting relationship with the child, ask the right questions and to critically reflect upon what the child is saying or expressing through their words, actions or behaviours. Effective practice also necessitates understanding the impact that the histories of those involved in their life may have on the child's experiences.

Child E's father died in 2019. ELSA (Emotional Literacy Support Assistant) support was provided to Child E by the school, as well as an offer of a referral to bereavement counselling. Child E did not engage in this support and did not wish to take up the offer of bereavement counselling. This was not revisited despite Child E regularly vocalising the significance of his father's death.

Learning point:

- Where support services are declined but unmet needs remain, the offer of support should be revisited on a regular basis.

In October 2021, Child E's mother was hospitalised twice following attempts on her own life. In response to this, contact between Child E and his mother was suspended.

Learning point:

- There should have been earlier consideration of the impact on Child E of his mother's hospitalisation, particularly given the loss he had already experienced.

Good practice:

- The Social Worker arranged a consultation with CAMHS to consider the restoration of Child E's relationship with his mother.

Throughout the timeline considered by the reviewers, panel and learning event attendees, there were several missed opportunities identified to see and speak to Child E alone and outside of the home.

In March 2021, a referral was received from the Registered Social Landlord reporting a disturbance at Child E's mother's home. Child E's mother was reported to be heard to shout, "don't hit my son". In response to this, both grandmother and mother were reminded that Child E should not be visiting mother's address. There was no evidence that Child E was spoken to, to ascertain his views of what happened.

Also in March 2021, a report was made by a member of the public that Child E had made allegations of physical and sexual abuse against family members. In response to this, Child E was visited and spoken to at home.

In April 2021, Child E alleged that he had been physically assaulted by mother and that he was hungry as there were only crisps in the house. A strategy discussion was convened resulting in a single agency s47 investigation as Police did not have sufficient resources to undertake a joint investigation. Grandmother and mother were spoken to prior to any discussion with Child E. Again, Child E was spoken to at home.

In July 2021, a referral was received from school reporting that Child E had an injury to his back and said that he fell down the stairs. Again, Child E was spoken to at home. He said that he tripped on the last few steps and hurt his back on the door handle. Grandmother explained that she forgot to inform the school, and this wouldn't happen again.

Learning point:

- Children should be seen on their own with practitioners, away from parents and carers in an environment where they feel safe, so that the child can speak about the impact that the circumstances which have prompted safeguarding concerns are having on them. It is unclear whether the home

was checked for food supplies given Child E's comment about the lack of food at home.

Good practice:

- The YOS Case Manager arranged a psychology informed case discussion, and a psychology informed formulation was produced.

Child E was regularly engaging in behaviours and using language that would not be expected of a child of his age. There was a sense that professionals may have become desensitised to this and lost sight of his young age.

Recommendation:
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 4 - Professional differences

The protection of children fundamentally depends on effective joint working between professionals and agencies. This requires an open and honest approach and the recognition that in some instances this may involve professional challenge and the need to resolve professional differences of opinion. Research and case reviews have consistently emphasised the need for good inter-agency communication, constructive professional challenge and the swift resolution of professional differences of opinion.

Child E was supported on a Care and Support Plan from 2017 – May 2021 when his name was placed on the Child Protection Register.

In April 2020, consideration was given to stepping support down to preventative services (Families First). This was not supported by Education professionals, and Child E and his family continued to receive support on a Care and Support Plan.

Early in 2021, it became apparent that Education and Youth Offending Service (YOS) professionals were concerned about the lack of progress being made on the Care and Support Plan and the emerging child protection concerns. Whilst these concerns were communicated between the professionals working with Child E, there is no evidence that concerns were escalated when professionals remained dissatisfied with the responses received and progress being made.

Learning point:

- It is the responsibility of all professionals to escalate concerns if they cannot resolve the issue and they remain concerned.

Recommendation:
The Safeguarding Board should consider raising awareness across all agencies of the Multi-Agency Practice Guidance: Resolving Professional Differences.

When Child E's name was placed on the Child Protection Register in May 2021, there was a recommendation from conference that the case should proceed to a legal threshold meeting. Following a 'what matters' discussion, the case proceeded to a legal threshold meeting. At the legal threshold meeting, the decision was made to continue working with Child E and his family on a child protection plan due to it being in its infancy.

Learning point:

- There was a missed opportunity to consider initiating PLO at the legal threshold meeting. Whilst the Child Protection plan was in its infancy, Child E and his family had been supported on a Care and Support Plan for four years without progress and concerns regarding Child E were escalating.

Good practice:
Social Services hold a 'what matters' meeting prior to legal threshold meeting. This provides all practitioners working with the child with the opportunity to contribute their views as to whether the matter should progress to consideration of legal threshold. Where there is a split decision, a legal threshold meeting is held.

Whilst a Social Services chronology was compiled and considered by the legal threshold meeting, it would have been beneficial to consider a multi-agency chronology, particularly given that professionals working with Child E had differing views as to the need to progress to legal threshold meeting.

Recommendation:
The Safeguarding Board should consider raising awareness across all agencies of the Multi-Agency Chronology Guidance.

Critical thinking and robust challenge within and between agencies are key to effective safeguarding practice. Professionals are required to consider a range of evidence from many sources and to produce meaningful working hypotheses within a very short time frame. This relies on professionals engaging in critical thinking both individually and as a collective. The right support and opportunities are required to do this well.

Recommendation:
The Safeguarding Board should consider strengthening the written guidance around Multi-Agency Supervision.

<u>Theme 5 - Systems and Processes</u>

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 in May 2021. During this time, Child E and his family were supported by a Support Worker. The review panel and practitioners attending the Learning Event identified that there were opportunities missed to consider Child E within the child protection arena earlier.

Recommendation:
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.

In March 2021, the panel noted three referrals where opportunities were missed to progress to strategy discussion and child protection enquiries under s47. This would have provided the opportunity for multi-agency input and is likely to have resulted in progression to Child Protection Conference at an earlier stage.

The first referral reports that Child E had allegedly sexually assaulted two females. It was reported that Child E had been encouraged by older youths who were bullying him. A strategy discussion was held with an outcome to commence a child protection assessment. This was the terminology used by the responsible Local Authority at the time to refer to a more comprehensive assessment under Part 3 of the Social Services and Wellbeing Act 2014. It was highlighted by the review panel and by practitioners at the Learning Event that the use of this terminology had caused some confusion amongst practitioners who thought that a 'child protection assessment' meant that Social Services were undertaking enquiries under s47.

The reviewers, panel and practitioners attending the Learning Event identified that there had been concerns regarding Child E's use of sexualised language and behaviours since he was 5 years of age.

Learning point:

- The presence of inappropriate sexual behaviour, especially in younger children, may be an indicator that they are experiencing or have experienced child sexual abuse. This was a missed opportunity for multi-agency strategy discussion/meeting to consider what may have been influencing these behaviours.

Good practice:

- In October 2021, following continued concerns regarding Child E's use of sexualised language, the YOS practitioner referred to Better Futures Cymru (Barnardo's) for a consultation.

Recommendation:
The Safeguarding Board should consider developing a regional protocol for responding to harmful sexual behaviour by children and young people.

The second referral in March 2021 reports that a member of the public had removed a knife from Child E. The management decision in response to this referral was for the Care and Support Plan to continue.

The third referral reports that Child E had made allegations of physical and sexual abuse against family members. The management decision noted that Child E was being supported on a Care and Support Plan and single agency s47 enquiries were ongoing. There was a recommendation for a MyST (My Support Team) consultation due to escalating concerns.

Learning point:

- When concerns regarding significant harm emerge or accumulate whilst a child is subject to a Care and Support Plan, enquiries must be considered, commencing with a strategy discussion/meeting. At this meeting, the plan in place should be assessed and reasons why this is not keeping the child safe from significant harm explored.

The review child protection conference was rescheduled and took place during the school summer holidays. As a result, Education was not represented at the review child protection conference.

Recommendation:
Local Authorities should consider how the views of education and school can be represented in child protection processes that take place during school holidays.

There were further opportunities missed to progress to strategy discussion in September 2021. A referral was submitted by Education reporting concerns regarding Child E's sexualised language and behaviour. The management decision in response to the referral was for the child protection plan to continue and MyST consultation to be arranged. The management response also noted that the Team Manager should attend the next Core Group meeting to gather views regarding progression to a 'what matters' meeting. A second referral was received from Education reporting that Child E was soaking wet having been riding his bike in the rain prior to attending school. Grandmother had reported that she could not stop him going out. The same management response was recorded to this referral with no progression to strategy discussion.

Learning point:

- Multi-agency strategy discussions should always be held whenever it is suspected a child may be at risk of suffering significant harm.

Despite submitting a large volume of referrals, there were some incidents and information that was not formally referred to Social Services by Education. These incidents were instead reported by email between professionals. Practitioners attending the Learning Event reflected on the differences between sharing information and submitting a referral for a child who is receiving support from Social Services and acknowledged the importance of doing this irrespective of the response to previous referrals.

Learning point:

- The statutory duty to report concerns about a child who is experiencing or is at risk of abuse, neglect or other kinds of harm applies whether or not the child is receiving support from Social Services.

In September and October 2021 there were reports of Child E saying that he wanted to kill himself. Child E's mother also reported that he had been purposely trying to hurt himself in the community. When Child E was visited by his Social Worker, he said he wanted to be with his father. The response was to complete a safety plan with grandmother and to chase up the SPACE (Single Point of Access for Children's Emotional Wellbeing) referral.

Learning point:

- Routine access to ABUHB services including Specialist CAMHS is through SPACE-Wellbeing. Where professionals have emergency concerns about a child's mental health and emotional wellbeing, they should call the CAMHS Emergency Liaison Line.

The impact of the Covid 19 pandemic

When the Covid 19 pandemic hit in March 2020, organisations were having to constantly respond and adapt to changing government guidance to ensure continuity of service delivery. The safeguarding duties of statutory partner organisations remained unchanged during the Covid 19 outbreak. Local Authorities and safeguarding partners established clear processes for risk assessment, the prioritisation of cases and the implementation of covid safe practice.

In Gwent, Heads of Children's Services issued regional guidance setting out the operational arrangements informed by Welsh Government guidance. In practice, this meant that face to face visits were prioritised to children where there were safeguarding concerns or who required statutory visits by virtue of their name being placed on the child protection register or them being looked after, subject to risk assessment. For Child E, this meant that there was a period prior to his name being placed on the Child Protection Register in May 2021, when visits and meetings were largely conducted virtually.

There were increased pressures on Child E's grandmother as a result of disrupted routines. There were periods of time during the pandemic when schools were closed, and Welsh Government guidance meant that Child E was not offered a place at one of the Hubs which had been reserved for the children of key workers and vulnerable children (defined as those on the child protection register or looked after). When Welsh Government guidance for vulnerable learners changed, discussions regarding Child E accessing Hub provision were revisited but did not progress.

Good practice:

- School maintained regular contact with Child E's grandmother during periods of school closure. When Child E was not accessing online learning and there were difficulties contacting grandmother via telephone, arrangements were made for the Education Welfare Service to visit.
- To further compound the issue, Child E's grandmother was not confident in the use of technology.
- The YOS Case Manager sought management authorisation to undertake face to face appointments with Child E due to a lack of engagement/progress with virtual appointments.

Child E's grandmother suffered with poor health and was considered highly vulnerable to Covid 19. This was an additional consideration for professionals during periods when restrictions around face-to-face contact were relaxed.

Improving Systems and Practice

Agency improvements in practice:

The Local Authority are no longer referring to assessments under Part 3 Social Services and Wellbeing (Wales) Act 2014 as a 'child protection assessment'. These assessments are now referred to as a 'comprehensive assessment'.

As part of the ongoing learning the Local Authority are in the process of independently reviewing their adherence to statutory safeguarding procedures including undertaking an internal audit review of current practices.

Recommendation 1:
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.

Recommendation 2:
The Safeguarding Board should consider raising awareness across all agencies of the Multi-Agency Practice Guidance: Resolving Professional Differences.

Recommendation 3:
The Safeguarding Board should consider raising awareness across all agencies of the Multi-Agency Chronology Guidance.

Recommendation 4:
The Safeguarding Board should consider strengthening the written guidance around Multi-Agency Supervision.

Recommendation 5:
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.

Recommendation 6:
The Safeguarding Board should consider developing a regional protocol for responding to harmful sexual behaviour by children and young people.

Recommendation 7:
Local Authorities should consider how the views of education and schools can be represented in child protection processes that take place during school holidays.

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)*	Jacalyn Richards	**Name** *(Print)*	Guy Browett
Date	17//05/2023	**Date**	17/05/2023

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

Date 17/05/2023

Child Practice Review process
The South East Wales Safeguarding Children Board Chair notified Welsh Government on 16th February 2022 that it was commissioning an Extended Child Practice Review in respect of a child. Reviewer: Jacalyn Richards, Group Manager, Children and Family Services, Torfaen County Borough Council. Reviewer: Guy Browett, Deputy Head, Gwent Probation Delivery Unit, HM Prison and Probation Service 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 - Youth Offending Service - Gwent Police - Aneurin Bevan University Health Board - Phoenix Domestic Abuse Services The panel met to review the multi-agency information and provide analysis to support the development of the report. A Learning Event took place in September 2022 and was attended by the following agencies: - Social Services - Education - Youth Offending Service - Gwent Police - Aneurin Bevan University Health Board - Phoenix Domestic Abuse Services Relevant family members were informed that the review was taking place and a meeting was held with the Reviewers.
☐ 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	☐	☐	

*Rational for convening a What Matters Meeting

In less urgent circumstances, a recommendation to seek legal advice is made by the practitioner who should then schedule a discussion with their team manager. The team manager will review the child protection plan, consider whether it can be strengthened and request a multi-agency What Matters Meeting to be chaired by the service manager. The service manager will take responsibility for the record of that meeting and ensure that this is attached to WCCIS.

The purpose of this multi-agency meeting is to work with partner agencies to pinpoint what matters to the child, the strengths of the family, to define areas of risk and barriers to change, consider shared resources for risk management and establish whether accessing intensive support or commissioning expert assessment or intervention could affect change or reduce risk.

If, during that meeting, it is agreed that further work can be attempted, then the case will continue to be managed via a child protection care and support plan. If, during that meeting, it is agreed that the child protection care and support plan cannot be further strengthened and there is limited motivation for change, then the service manager will agree that the case should be presented at a legal meeting and the practitioner will contact business support to schedule the threshold discussion.

The practitioner must be mindful of the need to work openly and transparently with families and to minimise obstacles to co-productive working. The practitioner will therefore have a conversation with the child (if of an appropriate age and understanding) and the parents to explain the decision to hold a threshold meeting and the potential outcomes of that meeting.