South East Wales Safeguarding Children Board
Bwrdd Diogelu Plant De Ddwyrain Cymru

Working Together For Children - Gweithio'n Gytûn Ar Gyfer Plant

Extended Child Practice Review Report

in respect of:

Children H

[SEWSCB 2/2014]

Date of report: 22nd December 2015

Child Practice Review Report

South East Wales Safeguarding Children Board
Extended Child Practice Review

Re: *SEWSCB 2 / 2014*

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

Legal context

An Extended Child Practice Review was commissioned by South East Wales Safeguarding Children Board (SEWSCB) in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi Agency Child Practice Reviews (Welsh Government, 2013) on the recommendation of the Case Review and Practice Development Sub-Group convened on 3rd September 2014

The criteria for this review are met under section 6.1 of the Guidance namely:

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 care leaver under the age of 18) 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.

The criteria for extended reviews are laid down in revised regulations, *The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.*
The terms of reference for this review are at Appendix 1.

Circumstances resulting in the review

Background information

This review concerns four children from the same family, two boys and two girls. The children were known to services from before the eldest child's first birthday because of concerns around domestic abuse, poor home conditions and neglect. As the family grew concerns continued and expanded to include physical abuse which resulted in the first, 16 month, period of child protection registration. Later, when the eldest child was 11 years old, a police investigation uncovered evidence that the girls had been sexually abused during visits to two immediate family members, who were later convicted and received custodial sentences.

Significant events during the period under review

A second period of child protection registration began shortly after the sexual abuse was discovered which lasted 8 months. During it, and subsequently, the children continued to experience neglect and alleged physical abuse and to display escalating aggressive and sexualised behaviour.

At the beginning of the following academic year, on returning to school the older girl disclosed that she had been sexually abused by an adult male extended family member. There was a criminal investigation however the decision was made not to proceed to trial.

These events led to a third period of child protection registration during which an anonymous referral was made to social services by a member of the public regarding the behaviour of mother towards her children. This resulted in all four children being accommodated by the local authority under Section 20 (Children Act 1989). They remain in foster care.

The timeframe for this review is from 7th February 2012 to 21st March 2014 that is from the beginning of the second period of child protection registration to the date when the children were first accommodated by the Local Authority.

The summary timeline of significant events is at Appendix 2.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

The importance of 'The voice of the child'[1]

Previous reviews have highlighted the need for children to meet on their own with practitioners, away from parents and carers in an environment where they feel safe, so that the children can speak about their concerns. In this case, when that good practice was followed, the children were able to share information which led to them

[1] The voice of the child: learning from serious case reviews, Ofsted, April 2011

being accommodated. However prior to them being removed, even when they were being spoken to about allegations of abuse, the children were seen in a busy home environment and/or in the presence of their sometimes distressed and disruptive parent/s. The children initially shared their concerns with professionals but later retracted them and over time shared less. When questioned about reported allegations they said that they did not know or directed practitioners to ask their mother.

Practitioners need to recognise that children's behaviour can be a means of communication. Although the children said less, they displayed escalating aggressive behaviour and sexualised behaviour and language. The children had been exposed to sexual abuse and practitioners initially attributed these behaviours to previous abuse without considering the possibility of further abuse as an explanation for these behaviours.

Practitioners need to be alert to parents who prevent access to their children. They can use a variety of means to achieve this. In this case the mother used disguised compliance and threats; when one of the children had anogenital symptoms, possibly related to sexual abuse, and she was advised to take the child to the doctor she agreed but then failed to do so. When another child asked to see her counsellor mother prevented her from doing so and told her that if she told the counsellor about the abuse she had suffered she would be removed from her parents' care. Mother then denied knowing about the abuse when spoken to by professionals. The father figure in the family was assessed as being controlling, and a practitioner on reflection, said that she had been frightened of him. He was challenging and made complaints about workers' practice deflecting attention from the safeguarding concerns under consideration.

Practitioners need to keep their focus on the child and be wary of being distracted by the parents' needs. Practitioners in this case described becoming 'task oriented' and 'fire fighting and visiting the home where the children were described as 'feral'. Their efforts were focused on trying to help the parents cope with the children and their behaviour rather than trying to find out what those behaviours meant.

Practitioners need to listen to children and what they say in order to protect them. In this case for example when one of the girls had blood in her underwear professionals assumed that she was menstruating, however the child clearly said otherwise and her symptoms may have been related to abuse but were not investigated.

Physical abuse and neglect, risk of sexual abuse and re-victimisation

At the learning event practitioners said that they were aware that the girls in this family had been sexually abused but expressed uncertainty about whether or not the boys had been sexually abused. They thought the children's difficult behaviour was a consequence of this previous trauma and that the parents were struggling and needed support to cope.

The parenting of these children was rarely good enough without intensive support from agencies. The children had suffered chronic neglect and episodic physical

abuse from birth. This put them at increased risk of becoming victims of sexual abuse[2] and the girls did indeed suffer penetrative sexual abuse during visits to two immediate family members. However, sexual abuse is defined as 'forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact including penetration or non penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways'.[3] Practitioners became aware that at least one of the boys had witnessed the abuse of his sisters and by definition had also been sexually abused. The boys' behaviours were also strong indicators of their own probable sexual abuse. Although the girls accessed a specialist post sexual abuse service, to which the boys could also have been referred, they were in fact referred to generic Children and Adolescent Mental Health Services (CAMHS) as they were not seen as victims of sexual abuse.

Having once been victims of sexual abuse children are then at increased risk of future sexual abuse[4] and at least one of these children went on to be sexually abused by an extended family member whilst her name was on the child protection register. Had practitioners had a better understanding of the nature of sexual abuse, the increased vulnerability of these children and their increased risk of further sexual abuse, then they may have been more curious about this man and his role in the family and been more alert to his grooming behaviours. Instead, he was viewed as a support for mother.

Interagency Information Sharing

It is well established that effective practice in safeguarding is built on efficient and effective information sharing between agencies. The review highlighted some good examples of information sharing; for example education provided social services with a great deal of information about the children's presenting behaviours. However, this was not always acted upon, leaving the schools to manage unacceptable behaviours and exclusions. The learning event highlighted the need to submit a Multi Agency Referral Form (MARF) to ensure that information shared is treated as a child protection referral on an open case and to ensure it receives senior management oversight, strengthening the level of supervision of the case.

Lack of information can often frustrate interventions and prevent professionals recognising patterns of behaviour affecting the well being of children. Effective information sharing with other agencies must include a thorough assessment of historical information, assessment of parenting capacity and an understanding of family dynamics. The information held by the lead agency on this family was long and complex; access to this information was not readily given to all agencies involved with the family. The practitioner learning event highlighted several agencies whose knowledge of the case was limited by a lack of information sharing. Trust in how other agencies would utilise information was raised as a barrier to

[2] Changes in the prevalence of child sexual abuse, its risk factors, and their associations as a function of age cohort in a Finnish population sample. Laaksonen T et al. Child Abuse Negl. 2011 Jul;35(7):480-90. doi: 10.1016/j.chiabu.2011.03.004. Epub 2011 Aug 6.

[3] All Wales Child Protection Procedures 2008

[4] Sexual and physical revictimization among victims of severe childhood sexual abuse. Barnes JE et al. *Child Abuse & Neglect* 2009;33 (7): 412-420

effective information sharing. The managers learning event highlighted that social services now place a greater emphasis on the use of chronologies, including multi agency chronologies, which are requested when proceeding to child protection conference. These are discussed at conference and core group, however it was not clear what process is used to ensure all agencies have access to the multi agency chronology outside of this formal arena.

Whilst the use of advocacy to represent the views and wishes of the child is best practice, careful consideration is required as to how this information is shared to ensure that children are able to express their views, wishes and feelings on an ongoing basis. One of the children shared with her advocate a vivid description of neglectful conditions which was shared in core group. Following this disclosure the child retracted her account and disengaged with the service. Since these events advocacy services now provide children's views wishes and feelings to the social worker 48 hours in advance of child protection conference and core group meetings to ensure appropriate management and delivery is considered.

Children's interactions and disclosures during counselling sessions were sometimes of concern and this was not always shared with other agencies. There appeared to be a tension between the therapeutic relationship, safeguarding and trust in how other professionals would use information. The learning event highlighted that at times practitioners assumed that other agencies were aware of key information. There would be a clear benefit to additional training and professional discussion of when safeguarding over rides the therapeutic relationship.

During the review period, social services requested a Police National Computer (PNC) check on a man who became involved with the family to ascertain if he was known to present any risk to children. The check was negative and this information was duly disclosed in a timely manner. The man was later arrested for an alleged sexual offence against one of the children which was subsequently discontinued. The learning event highlighted that the level of detail provided by PNC checks does not include "softer" intelligence. Whilst it is not suggested that softer intelligence would have assisted in this case it is important to highlight the benefits of co-ordinated, sufficient and timely intelligence sharing. It was noted that due to limited police involvement at Child In Need meetings, there is a need for all agencies to continue to share relevant intelligence with police.

Whilst information was shared between education and social services, the learning event raised concerns regarding whether sufficient weight was given to the information being provided by the schools. The children's school attendance across the review period was often above 95% demonstrating the high level of interaction and engagement education services had with the children. As early as March 2013, the educational psychologist requested assurance from social services that "sufficient weight" was being given to the information provided by education. The review noted that on occasion not every school was able to attend core group and child protection conferences. It was not clear if the respective schools shared concerns with each other or co-ordinated their response amongst each other as this may have given additional weight to their initial challenge and ongoing involvement.

Child Protection Medical Examinations

A child protection medical examination should always be considered when there is a disclosure or suspicion of child abuse involving injury, suspected sexual abuse or serious neglect. The purpose of the medical examination is not merely forensic but

also to assess the health and wellbeing of the child, to screen for infection and to initiate prophylactic and other treatment as required. Research has shown that many children and families feel reassured by the medical examination and find it to be therapeutic.[5] The panel heard that the Sexual Assault Referral Service provided by New Pathways can provide a crisis worker to prepare the child and family for the medical examination and support them through it and the police interview process. Statutory agencies were not fully aware of the range of services which New Pathways was able to offer child victims of all forms of abuse.

When the older girl disclosed that she had been sexually abused by an extended family member she was not referred for a child protection medical examination, and a paediatrician was not included in the strategy discussion, contrary to the All Wales Child Protection Procedures (AWCPP);

"The discussion should include other relevant professionals such as health and education. Where a medical examination may be required a consultant paediatrician from the providing service should be involved".

AWCPP 'Scope and Purpose of the Strategy Discussion'

This omission was explored in the managers' learning event, and there was discussion about the variation in service offered by different paediatric services across south-east Wales. The utility of the opinions and reports received, and the difficulties experienced by police and social services in arranging and accessing child protection medical examinations, especially after hours, was discussed. Managers concluded that the difficulties described discouraged practitioners from requesting child protection medicals examinations**.** It was acknowledged that child protection medical examinations should be considered, and where appropriate arranged, as per the AWCPP.

Making Use of Guidance and Policies

Practitioners should be mindful of guidance and policies designed to assist them in working both with families and within a multi agency setting. Throughout the review period there were issues that would have benefitted from the application of established policies and procedures.

The review highlighted a number of significant issues for example, difficulties engaging with parents who displayed superficial compliance and in working with a father who was described as "controlling". Practitioners will often tolerate uncooperative parents where they would not put up with hostile parents. South East Wales Safeguarding Children's Board multi agency guidance on working with hostile and uncooperative parents policy was not utilised. This would have enabled practitioners to focus on the potential reasons for non compliance and its impact on the children. The guidance suggests, a multi agency response to working in such circumstances can achieve a positive outcome, and reduce the chance of division between professionals *"who adopt an approach of appeasement and those who seek to challenge"*.[6]

During the period of this review, the management of the case by social services was

[5] Do no more harm: The psychological stress of the medical examination for alleged child sexual abuse, Susan Marks et al. Journal of Paediatrics and Child Health **45** (2009) 125–132

[6] http://www.sewsc.org.uk/fileadmin/sewsc/documents/regional/SEWSCB_Working_with_Hostile_and_Uncooperative_Parents.pdf page 7.

challenged on two occasions; once by Education, which was not under the resolving professional differences guidance, and a later challenge by health. At the practitioner learning event, it was clearly indicated that the South East Wales Safeguarding Children's Board Resolving Professional Differences Guidance was invoked by health due to disagreement with how the family was being managed. However, at the managers' learning event it was clear that this perception was not shared by social services. The review highlighted that despite this "debate" the guidance was not properly adhered to and the lack of a timely response could be attributed to this. Practitioners and managers in all agencies should ensure that they understand and use this guidance to ensure a timely and adequate response to any interagency challenge.

"It is essential that professional differences are resolved as swiftly as possible so as not to lose focus on the safety and welfare of the children or young people."[7]

The South East Wales Safeguarding Children's Board Resolving Professional Differences Guidance may benefit from review. Key considerations in any review may include;

- whether it remains fit for purpose in its current format
- whether the guidance contains sufficient detail
- whether the process for formal challenge is clear and widely known by staff from all relevant organisations, including the informal and formal responsibilities of each agency involved

A review of the guidance, and consideration to a formal re-launch as a protocol that must be adhered to in cases where professional difference has occurred, may provide a more robust audit trail and a clearer, more accountable process which may alleviate some of the issues raised in the use of the guidance in this instance.

During the review period, a "Contract of Expectations" was drawn up with the family on a number of occasions. Such a document is a mechanism for managing risk. Practitioners should be aware of the requirement to review and monitor contracts and ensure they form part of the overall planning and review process. Contracts of expectations should be explicit as to what action will be taken if there is a breach of contract and this should be clearly explained to parents. They should be advised to seek appropriate legal advice prior to signing and be advised that these documents are shared with all agencies involved. This will ensure that the contract's value is not diminished, through failure to review or incorporate into the overall plan, should the case progress to legal proceedings.

Assessment and Analysis

'Serious case reviews frequently highlight the importance of assessment and analysis. Assessment is the process by which information is collected, collated and analysed. Effective assessment seeks overall patterns that explain what has happened to a child and provides a framework for understanding and analysing need, risk and the danger individuals pose for children. Particular care needs to be taken that assessments do not become over optimistic or minimise risk to children. The focus needs to be on gathering evidence to make judgements about whether a

[7] http://www.sewsc.org.uk/fileadmin/sewsc/documents/regional/SEWSCB_Multi_Agency_Guidance_Resolving_Professional_Differences.pdfpage2

child is safe from injury, neglect, and emotional or sexual abuse.'

AWCPP Good Practice in Assessment

Practitioners should ensure that the assessments they undertake are informed by the information held by all agencies involved. It is the responsibility of agencies to share all relevant information which they hold. This should include analysis and not merely consist of highlights from case recordings. This can at times be difficult to achieve; at the managers' learning event it was indicated that the children were recorded under 26 different names by police. In 2014, Gwent Police changed their case recording system, which now provides a single nominal view. This has gone some way to alleviating issues with recording. However, recording issues occur in all agencies and all practitioners should ensure they maintain a consistent level of quality recording to ensure robust assessment and decision making.

The core assessment is the first opportunity for all agencies to contribute to multi agency assessment. It was highlighted at the practitioners learning event that the core assessment's 35 day timescale can often make this assessment retrospective, whilst the Child Protection Plan is considered to be the "living document".

The review highlighted that changes in social worker led to repeat assessments being carried out; for example a parenting assessment was requested on three separate occasions. Staffing changes appeared to lead to 'starting over' with the family rather than utilising the wealth of information already held by the lead agency. The review highlighted social workers starting over, repeating assessments and interventions and offering further support to give the family opportunity to engage and achieve change. Although it was noted that case recording was up to date, some "soft" information was lost. It was the view of a number of practitioners that, in hindsight, opportunities to intervene were missed.

AWCPP 1.2.2 Sharing Information with Families

There are improved outcomes for children when effective partnership working is achieved with children and families combined with a clear focus being maintained on the child's safety and welfare. It is good practice to share information with families and there should be a presumption of openness, unless to do so would compromise a child's safety. Some information known to professionals may have to be treated confidentially and not be shared in front of some children or some adult family members such as information about a particular member which might compromise a criminal investigation.

The individuals jointly working with a family should reach a common understanding at each stage of their intervention about what information is shared with the family. The reasons for withholding information from the family needs to be clearly recorded in these circumstances safeguarding and promoting the welfare of the child must always be the overriding consideration.[8]

Both the practitioners' and managers' learning events highlighted the need to ensure that when managing a case on a multi agency basis there needs to be an opportunity to reflect together and challenge each other. During the review period practitioners only met at formal meetings, despite some practitioners finding the parents' level of cooperation to be superficial and to some extent frustrating to the safeguarding process. Practitioners should be aware that if parents' conduct is such

[8] All Wales Child Protection Procedures 2008

that it prevents or compromises full safeguarding discussions and planning then it is perfectly reasonable that the multi agency core group members meet without the parents to discuss a way forward in order to properly safeguard the child. If the outcome of such a meeting is that certain information needs to be withheld so as not to compromise the safeguarding arrangements/planning for the child/ren then would be defensible in the best interests of the child/ren.

Whilst a number of assessments were carried out, practitioners need to ensure that their analysis is robust and evidence based. The opportunity and time to reflect both formally and informally are crucial to effective analysis. Management supervision can be an effective method of allowing time to reflect and analyse, particularly in more complex cases with multiple children with different needs. Multi-agency supervision sessions are used by some local authorities in Gwent. Another method employed within Probation case management is the buddy system, a cooperative arrangement whereby individuals are paired or teamed up and assume a joint responsibility for more complex cases. This provides a further degree of support and knowledge and opportunity to reflect on a more informal and ad hoc basis. It is worth noting that at the managers' learning event, the move to local teams is perceived to have provided some of the benefits outlined in the buddy system.

Practitioners need to be mindful of the role and scope of each agency's involvement with a family and the value of such information. One practitioner perceived that the validity of their information was not seen as important, despite the fact their engagement with the family was more frequent and longer in duration than that of the lead agency. Complex case work requires a coordinated approach, valuing the contribution of all agencies involved.

At the practitioners learning event, the police reflected that with hindsight they could have obtained their own psychological assessment of the older girl at the start of the criminal investigation into the alleged sexual abuse by an extended family member. This may have prevented the case being abandoned only a week before the trial because of concerns about her emotional state and the effect of giving evidence.

Thresholds and Decision Making

It was clear at the practitioners' learning event that there was not a common understanding of threshold between agencies with some practitioners saying that they did not know what threshold was. There was frustration expressed that there is no multi-agency discussion about threshold (for care proceedings); the issue is discussed by the social worker and her manager and never discussed in core group. Further frustration was expressed about the fact that only social services had the opportunity to meet with childcare legal and that other agencies did not get the opportunity to 'put their case' in person.

At the managers' learning event, thresholds were discussed and the group were informed that whether the threshold for 'significant harm' has been met is a multiagency decision made at a strategy discussion whereas the threshold for care proceedings is a legal one and childcare legal will advise social services as to whether or not it has been met. There was then discussion about the courts' need for primary evidence and how difficult that was to gather in neglect cases.

In this case a legal meeting was held shortly after the second initial child protection conference, the outcome of which was that threshold had not been met but that progress would be monitored via the child protection plan. Following the meeting

some small improvement was noted in the children's behaviour and personal hygiene and they started to attend 'after school' activities. The legal meeting was reconvened after six weeks and because of this positive progress it was decided that there was no case to put before the court and there would be no further action. No account seems to have been taken in this decision making of the 12 year history of abuse and neglect which preceded this very short lived period of positive progress. Six months later, the children's names were removed from the register, despite the fact that improvements had not been maintained, the children were displaying very concerning behaviours and there were reports of neglectful and abusive parental behaviour made both by the children and independently by others.

Effective Practice

Although it falls outside of the timeline for this review, the police investigation which uncovered the sexual abuse by close family members is to be commended. Without the police identifying the children, safeguarding them and playing their part in securing the conviction of the perpetrators, the abuse of these children, and perhaps in time of others, may have continued undiscovered.

The local authority's child and family services conducted their own review of this case and held learning events for staff, in advance of the South East Wales Safeguarding Children Board Child Practice Review process being completed, so that there was no delay in the learning from the case being utilised to improve practice.

The advocacy service was very effective in obtaining and sharing the children's views, wishes and feelings.

The children's school attendance was excellent and their schools endeavoured to support the children despite them displaying some very difficult and challenging behaviour. Staff utilised a number of imaginative techniques to help the children: a special 'secrets' drawer where one of the children could write down her worries and post them, in order to share them with school staff, and which allowed her to disclose sexual abuse; a teacher playing whale music to one of the children who reported that it calmed him and introducing origami to the same child for the same purpose. One of the children's schools helped him to craft shields and swords and play with them to fight his 'demons' as a form of play therapy.

As previously mentioned the practice of the social workers on the day the children were accommodated (i.e. speaking with the children individually and on their own away from the home environment) was effective practice.

Following the second episode of alleged abuse, one of the children was interviewed but was unable to talk about the abuse she had allegedly experienced. Police employed an intermediary to help her and she was then able to talk about it.

New Pathways provided consistency through the relationship between the counsellors and both girls. They were sensitive to the needs of the family and flexible around appointment times. Mother was offered support by a different worker in order to keep the work with both girls child centred and focussed.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the LSCB and its member agencies and anticipated improvement outcomes:-

Improvements already introduced

During both the practitioners' and managers' learning events social services staff advised that an internal review of the case had already been undertaken and a learning event had been held for staff. Much had been learned and changes have been made to systems and practice as a result.

During the period of the review three different team managers had oversight of the case and a number of social workers and support workers were also involved with this family. Children's Services underwent a team restructure during December 2013 and are now generic and locality based. There are no longer transfer points built in to the system with the intention of reducing the number of changes to the allocated social worker for families. As they hold the case for longer, both social workers and their managers are now more familiar with families and their history. They no longer wait for a significant or trigger event but, in cases of neglect, look at the case cumulatively. A peer mentoring system has been introduced which was identified as being particularly helpful in the management of complex cases.

A multi-agency chronology and a graph to plot progress over time are used and this sits alongside good quality supervision on request to improve decision making around thresholds.

At the manager's event, health reported that the 'Signs of Safety' model has been introduced to staff to help them be more analytical in their reports for conference and court.

Advocacy services now provide the social worker with the children's views, wishes and feelings 48 hours in advance of any child protection conference or core group to ensure appropriate management and delivery of this information is considered.

In January 2015 the South East Wales Safeguarding Children's Board introduced multi-agency supervision guidance. Multi-agency supervision provides practitioners with an opportunity to consider a case in detail with independent, experienced facilitators to establish a common understanding of the case, common thresholds for intervention and to enhance the effectiveness of child protection plans, thereby improving outcomes for children and young people.

In April 2015 Gwent Police undertook a reorganisation of its resources which means that Investigators and their supervision are now located in two Local Policing Areas (LPAs) Public Protection Units (PPUs). This provides the opportunity for more localised sharing of information and the development of closer working relationships between "frontline" professionals. There still remains a centralised function that is responsible for conducting initial strategy discussions and sharing of information on a formal basis.

Key organisations and agencies involved in safeguarding children across the pan

Gwent area are currently involved in researching how improvements can be made to the quality and timeliness of information sharing. One option currently being explored is the creation of a Multi-Agency Safeguarding Hub (MASH) where all agencies and their respective IT systems and data are housed in the same premises enabling “real time” information sharing and decision making.

Currently within Aneurin Bevan University Health Board, the Child and Adolescent Mental Health Service is reviewing the level 3 training for practitioners to ensure that they are fully informed and understand the need to meet their safeguarding responsibilities. The service has recognised the need for, and is in the process of identifying, a safeguarding children champion for the service.

Identified Actions

1. The responsible Local Authority should ensure that it has an action plan in place to address the issues raised in this Child Practice Review taking into account research and best practice regarding the voice of the child as well as the increased risk of sexual abuse for children who have suffered other forms of abuse, including previous sexual abuse.

2. The SEWSCB should introduce a standardised multi-agency chronology template to be completed at the time of initial child protection registration, updated at every core group meeting and promptly circulated to all agencies, to support fully-informed assessment of risk and sound decision making.

3. Aneurin Bevan University Health Board should ensure that mental health services practitioners are provided with training and support in how to manage safeguarding concerns within a therapeutic relationship.

4. Social services should ensure that their practitioners follow the AWCPP in relation to the involvement of paediatricians in strategy discussions, where child protection medical examinations may be required, so that children who would benefit are not denied the opportunity to access services.

5. The SEWSCB should ensure that all partner agency staff have the understanding and the confidence to invoke the multiagency practice guidance on Resolving Professional Differences.

6. The Protocols and Procedures Subgroup should ensure that its ‘Working with Hostile and Uncooperative Parents’ Protocol includes specific guidance on the following:

- The ‘Working with Hostile and Uncooperative Parents’ Protocol can be invoked as a consequence of breaching the Contract of Expectations used by Local Authorities.
- The ‘Working with Hostile and Uncooperative Parents’ Protocol is also aimed at working with parents whose behaviours, whilst not overtly hostile or uncooperative, prevent the effective safeguarding of their children. This should include guidance on when practitioners may legitimately meet without parents present to reflect on progress and the child protection plan.

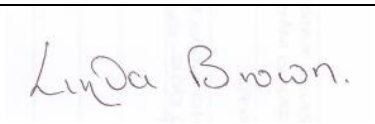
7. Partner agencies should have systems in place to ensure that practitioners are supported in working with cases involving large sibling groups (3 or more children in a family).

8. The SEWSCB should develop a fact sheet and training to brief practitioners in all agencies on their roles and responsibilities in respect of the Public Law Outline and threshold for care proceedings in order to promote better understanding of the requirements of the law.

9. SEWSCB should recommend to the Local Family Justice Board that themes from SEWCB Child Practice Reviews are placed on its agenda, with the offer of a presentation of those themes to be delivered by SEWSCB in order to share the learning identified.

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)*	Lorna Price	**Name** *(Print)*	Terry Reddington
Date	30.11.15	**Date**	30.11.15

Chair of Review Panel (Signature)	
Name *(Print)*	Linda Brown
Date	30.11.15

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Appendix 1

Terms of reference

SEWSCB
Terms of Reference for Concise Child Practice Review

Case H

The terms of reference of this review have been approved by the Chair of the Review panel. This is a live document and may need to be amended during the course of the review.

The Review will be managed according to the SEWSCB Protocol for undertaking Child Practice Reviews. The Case Review and Practice Development group has established a review panel with a Chair and reviewer/s who will undertake the review.

Core Tasks

The Review will consider practice and what overall lessons can be learnt from the case and will:

- Determine whether decisions and actions in the case comply with the policy and procedures of the services and the SEWSCB.
- Examine inter-agency working and service provision for the children and the family.
- Determine the extent to which decisions and actions were child focussed.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of the progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.
- Ensure the involvement of practitioners in the review process

As an Extended review to have particular regard to

- Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessments planning and decision-making in respect of the child and family and their circumstances? How did that knowledge contribute to the outcome for the child
- Was the child protection plan (and/or the looked after child plan or pathway plan) robust and appropriate for that child, family and their circumstances?

- Was the plan effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?
- What aspects of the plan worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked? Were the respective statutory duties of agencies working with the child and family fulfilled.
- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues?
- Were the statutory duties of all agencies fulfilled?

Specific tasks of the review Panel

- Identify and commission reviewer/s to work with the review panel in accordance with guidance for a concise review.
- Agree the time frame for the review of the incident from 7th February 2012 – 21st March 2014
- Identify agencies, relevant services, professionals, family members and significant adults involved with the children to contribute to the review. Each agency to produce a timeline of significant events and initial agency case summary and identify any immediate action to be taken.
- Produce a merged timeline, initial analysis and hypotheses.
- Identify key practitioners and plan how they will contribute to the review process and learning event. Ensure arrangements in place for providing support and arrangements for feedback.
- Plan with the reviewers contact arrangements with the family prior to the learning event.
- Following the learning event receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypothesis addressed and any additional learning is identified and included in the report.
- Agree conclusions from the review and an outline action plan and arrange for presentation to the SEWSCB for consideration and agreement.
- Following acceptance by the SEWSCB, plan arrangements to give feedback to family and to practitioners with involvement and share the contents of the report following the conclusion of the review and before publication.

Tasks of The South East Wales Safeguarding Child Board

- Consider and agree any Board Learning points to be incorporated into the final report or the action plan.
- Review Panel complete the report and action plan.
- SEWSCB send to relevant agencies for final comment before sign off and submission to Welsh Government.
- Confirm arrangements for the management of the multi agency action plan by the Case Review and Practice Development Group, including how anticipated service improvements will be identified, monitored, and reviewed.
- Plan publication on SEWSCB website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the SEWSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Appendix 2

Summary Timeline

South East Wales Safeguarding Children Board
Re: *CASE H (SEWSCB 2 / 2014)*

Type of activity	2012											
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Health		Failed appointments for all children. Family Therapy Session	Family Therapy Session	G4 Referred to SALT. Family Therapy Session	Family Therapy Session	Family Therapy Session	Family Therapy Session		Family Therapy Session		B1 DNA CAMHS	
NYAS		Children's view wishes and feelings gathered and shared	G3 retracts VWF refuses further advocacy, VWF gathered for others	Children's VWF gathered and shared	Children's VWF gathered and shared	Children's VWF gathered and shared	Children's VWF gathered and shared		Children's VWF gathered and shared	Children's VWF gathered and shared		Children's VWF gathered and shared
Police			PPU Contact with SS Copy of PNC print for C received		F2 verbally abusive to school children							
Social Services		Child Protection Conference held. Views and wishes shared at Conference. Children placed under category of Neglect and Emotional Abuse. M described as vocal and aggressive. Core Group held, M indicated to be more co operative	HV to family. Legal meeting held, decision to reconvene to review progress of CP plan. Contract of expectation to be signed. Core Group held. F2 refused to sign contract of expectations, later agreed.	Case Transfer to new SW, Reconvened Legal meeting, considered progress made, any deterioration PLO process to resume Core Group M and F2 sign contract of expectations Child Protection Conference	Core Group New SW allocated.	Case transfers back to previous SW, Core Group M disengaged	Anonymous Referral allegation M assaulted by B2 Core Group SW Home Visit		Child Protection Conference, Children's names removed from register. Case allocated to Support Work (SpW) On Child in Need basis.	Core Group	Referral to SS SpW visit to family, children not present.	Child in Need meeting M and F2 DNA

Type of activity	2012											
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
New Pathways		Report for Case Conference	Report Session for G3, G4	Counselling G3	Counselling G4	Therapy Session G4	Therapy Session G4 G3 DNA		Therapy Session G4		Therapy Session G4	Therapy Session G3 and G4
Education		Aggressive behaviour B2 MARF submitted	Self Harm behaviour B1 displayed in school		MARF B2 Sexualised behaviour		T/C to SS concerns regarding B1 Physical and Emotional Well Being		3 x MARF submitted. B1 threat to harm himself			Deterioration in Children's behaviour

Type of activity	2013											
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Health		Family Therapy Session	Family Therapy Session		Family Therapy Session	B1 and B2 DNA				Referral G4 DNA SALT	Family Therapy Session	HV
NYAS										New referral, VWF gathered and shared	VWF gathered and shared	
Police			Strategy Meeting with SS			Strategy Meeting			G3 alleged Sexual Abuse		B1 arrested for	

Type of activity	2013											
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
											assault on M. NFA. Referral to SS	
Social Services	SpW visit to family home, SpW raises concerns with TM	Child in Need meeting. M attended.	Social Worker visit to school, s47 enquiries. M agitated and angry with SS Child in Need meeting cancelled. Social Worker conducts parenting assessment.	HV to read parenting assessment to M and F2. Unannounced HV. Parenting assessment distributed.		Single Agency s47 conducted.	Child in Need meeting agreed to transfer to Families First.		Referral received x 2 HV undertaken, further contract of expectations signed, S47 investigation .	HV Initial Child Protection Conference held, registered sexual abuse and secondary category of Neglect Core Group.	Threshold meeting HV PLO Meeting. Core Group	Parenting session x 4 held, Core Group.
New Pathways												
Education		B1 excluded from school (3 days)	B1 excluded from school (3 days) MARF			MARF submitted			MARF x 3 submitted	MARF	MARF x 2	Exclusion B1 x2

Type of activity	2014											
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Health	Paediatric overview for all children Family Therapy	Home Visit	Family Therapy									
NYAS	Children's VWF obtained	Case closed.										
Police	Strategy Request											
Social Services	Child Protection Conference remain on register. Strategy discussion . Parenting sessions 5,6,7,8,9,10,11,12 Referral received.	Parenting session 14,15 Core Group, Anonymous referral, Children removed under Section 20	Core Group									
New Pathways		Counselling G3 and G4										
Education	MARF	MARF X2										

Key:

DNA: Did Not Attend
SpW: Support Worker
PLO: Public Law Outline
SALT: Speech and Language Therapy
TM: Team Manager
MARF: Multi Agency Referral Form
VWF: Views, wishes and feelings
s47: Section 47 enquiry
SS: Social Services
HV: Home Visit

Child Practice Review process

To include here in brief::

- *The process followed by the LSCB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members' had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

Child Practice Review Process

The South East Wales Safeguarding Children Board (SEWSCB) Chair notified Welsh Government in September 2014 that it was commissioning an Extended Child Practice Review in respect of Case H.

External Reviewer: Lorna Price, Designated Doctor, Safeguarding Children Service, Public Health Wales

Internal Reviewer: Terry Reddington, Deputy Head Gwent Local Delivery Unit, Wales Community Rehabilitation Company

Chair of Panel: Linda Brown, Head of Safeguarding Children, Aneurin Bevan University Health Board

The services represented on the panel consisted of:

- Aneurin Bevan University Health Board (Chairperson)
- Wales Community Rehabilitation Company (Reviewer)
- Public Health Wales (Reviewer)
- Gwent Police
- Children's Services
- Aneurin Bevan University Health Board
- South East Wales Emergency Duty Team
- National Probation Service
- National Youth Advocacy Service
- New Pathways

The Panel met regularly from November 2014 in order to review the multi-agency information and provide analysis to support the development of the report.

Learning Events

Two Learning Events took place; a practitioners' event in April 2015 and a managers' event in June 2015.

The Practitioners' Learning Event was attended by the following agencies:

- Aneurin Bevan University Health Board
- Child and Adolescent Mental Health Services (CAMHS)
- Local Schools
- New Pathways
- Gwent Police
- National Youth Advocacy Service
- Children's Services

The Managers' Learning Event was attended by the following agencies:

- Children Services
- Aneurin Bevan University Health Board
- Gwent Police Public Protection Unit

Family Members informed

Relevant family members were informed that the review was taking place and those deemed appropriate were offered the opportunity to meet, but no response was received.

Panel were advised it was not appropriate to contact the children at this time.

☒ 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	☐	☐	