Gwent Safeguarding Board
Concise Child Practice Review Report
Re: SEWSCB 4/2022

Brief outline of circumstances resulting in the Review

An extended child practice review was commissioned by Gwent Safeguarding Board following the recommendations of the Case Review Group convened on 25th October 2022. This was in accordance with the 'Working Together to Safeguard People' Guidance for Multi-Agency Child Practice Reviews, the criteria for this review are met under Section 6. The Terms of Reference for the review are at Appendix 1. This review was undertaken following the death of a 4-year-old male in December 2021 who will be referred to as Stanley within this report as requested by the family.

At the time of his death Stanley was residing with his mother and younger brother aged three months at the family home. His parents were separated, and he spent one night every weekend with his father and paternal grandmother. Stanley was at his father's home address when he became unwell, a decision was made by his father and paternal grandmother that he would be returned to the care of his mother. He was conveyed by car to his home address where his mother was at the door waiting for him. They did not take Stanley to the hospital as they believed that father did not have parental responsibility as his name was not on the birth certificate and that in such circumstances he may not be seen. Stanley was extremely unwell when he returned home and unresponsive, his mother phoned for an ambulance, and he was conveyed to hospital where he sadly died. The cause of death is unexplained however it was noted that his bowels were impacted.

Background

Stanley was born in 2016 and resided with his mother and baby brother. The parents had previously had another child who died at 6 months old in 2018. The father had woken in the middle of the night to feed the baby and placed her in a bouncer chair and went back to sleep. He next woke at 10.30 am and checked on the baby who was still in the bouncer but sideways, face down. CPR was attempted but the child had passed away. The father was interviewed by the police on a voluntary basis for an alleged offence of neglect. The post-mortem results were inconclusive, and a police decision was made of no further action.

Following this, both parents were drinking heavily, and the father suffered an amount of mental health issues. The relationship later broke down.

The father subsequently rekindled a relationship with a female whom he already had a daughter (now aged 20), and Stanley's mother formed a relationship with a Registered Sex Offender (RSO) and subsequently became pregnant by him and gave birth to their child in 2021, three months prior to Stanley's death.

The family were open to children services and both Stanley and his younger brother were on the child protection register at the time of Stanley's death. The main area of concern was mothers' relationship with a Registered Sex Offender, however there were other contributing factors which included domestic abuse between Stanley's Father and maternal grandfather which occurred following the death of Stanley's sister in 2018. There had also been concerns regarding allegations that Stanley's father had sexually abused his niece (which he self-reported and subsequently suggested he had dreamt, police investigated, and no disclosures were made) and also the mental health of both parents.

In the months leading up to Stanleys death his father had reported to his family and mental health professionals that he was hearing voices and having suicidal thoughts, it was also reported he was carrying a knife in his car, he received mental health treatment via a short period as an inpatient in a psychiatric hospital. Following his short admission, he received extensive support from the crisis team and early intervention team as a result of this psychotic episode.

On 09.12.2020 social services received a referral from the police regarding mothers contact with a Registered Sex Offender and a child assessment is undertaken, this assessment concluded 7 weeks later, and the outcome was for a written agreement to be drawn up and signed by mother stating that she would not allow Stanley to have unsupervised contact with her partner.

On 01.04.2021 The probation practitioner for mother's partner submitted a duty to report due to concerns that he continues to pose a risk of serious harm and is not complying with his probation order and that his partner (Stanley's mother) may be pregnant. The outcome of the referral was lateral checks with education and probation and telephone contact with mother to reiterate the terms of the written agreement that was already in place. The case is then closed to children services

On 27.04.2021 The mother's midwife submitted a referral confirming that Stanley's mother is pregnant. The outcome of the referral was for an assessment to be undertaken prior to the baby being born.

On the 06.05.2021 A PPN is submitted to Gwent Police as Stanley's father was arrested for an alleged sexual offence against a female child (mother's niece), A strategy meeting is held, and a section 47 assessment commences.

On the 28.07.2021 an Initial Child Protection Conference is held. It was unanimously agreed that Stanley's name should be placed on the child protection register under the category of emotional abuse and that the unborn babies name should also be placed on the child protection register under the same category at birth.

During a statutory visit by the social worker and the family support worker on the 12.08.21 Stanley and his mother are observed to have a good relationship, Stanley's

mother spoke about how bad his constipation can get, and that he is prescribed medication. Mother was encouraged to seek further advice and guidance from the GP.

On the 01.09.2021 the local authority held a legal meeting the outcome of this meeting was to convene Public Law Outline meeting as mother has reported that she would like her relationship to continue. The due date of their baby was October 2021, and her partner was due to be released from custody in November 2021.

The Initial Public Law Outline meeting was held with mother on the 17.09.21. Stanley's mother agreed to the local authority's Public Law Outline agreement which stated that Stanley and the unborn baby were to have no contact with her partner when he is released from prison unless approved by the local authority beforehand.

On 19.12.2021, police and ambulance received a call that a 4 year old boy was in cardiac arrest at the home of his mother. Paramedics were already in attendance when police arrived and were providing medical intervention to try and save Stanley's life. Stanley was conveyed by ambulance to hospital where he died.

There were no concerns that he was unwell in the days leading up to his death; apart from the background history of constipation for which he was on medication (Movicol).

Engagement with the family for the purpose of the review

As part of this review the family have been contacted. Both reviewers met with mother and paternal grandfather during a visit to the family home and met with Stanleys father on a separate occasion.

Time Period Reviewed.

The time - period for the review is 19.12.2020 - 19.12.2021

Practice and Organisational Learning

The reviewers would like to thank panel members and the practitioners who attended the learning event for their contribution to the review. We would also like to thank the family for the information provided.

Themes and Learning Points

There were three overarching themes identified which have informed the learning points from this review:

- Quality of safeguarding assessments
- Missed opportunities to submit safeguarding referrals.
- Domestic Abuse concerns being overlooked and missed opportunities to refer to Independent Domestic Violence Advisers (IDVA) services.

As stated above the timeline period is December 2020 – December 2021 during the Covid 19 pandemic. 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, and agency practices and procedures were subject to regular change and staff reported at the learning event that this had an impact on the way in which they risk assessed. Children services were Red, Amber, Green (RAG) rating cases based on risk assessment and undertaking much of their contact over the phone.

Theme 1: Quality of safeguarding assessments

Within the timeline period four child protection referrals were submitted to children services, two from police, one from a midwife and one from the probation service. However only one proceeded to strategy discussion and Section 47 child protection enquiries despite the significant safeguarding concerns. There are also concerns that the vulnerabilities of Stanleys mother were overlooked in the safeguarding assessments, she had suffered a stroke in childbirth, suffered mental health problems and had lost a child previously, these factors were not fully considered.

Clarity as to how decisions were made in relation to closure is missing from children services case notes. There also appears to be a lack of understanding of the daily lived experience of Stanley, he is not in the centre of the assessments, it is only when his mother becomes pregnant does there appear to be a need to share information and a consideration of the safeguarding concerns. Decisions regarding outcomes of referrals were made without multi-agency strategy discussions/meetings taking place, despite the threshold for strategy meetings being met.

It was felt that the assessments failed to fully consider the wider risk factors associated with Stanley for several reasons. These included:

- No contact with the probation service to discuss risk.
- No multi agency strategy discussion
- Mothers' relationship with her partner had not been appropriately assessed in terms of how they were manging the no contact, who if anyone was permitted to supervise the contact.
- No reference to domestic abuse despite her partner being a previous perpetrator.
- There was no visit to the family home to further explore mothers understanding of the risks or the written agreement that was in place, and to meet Stanley.

The first Public Protection Notice (PPN) submitted in the timeline period was downgraded to preventative services however the referral for this was never submitted and this was not picked up when subsequent referrals were received and processed.

Given the concerns highlighted it is assessed that the case should have progressed to Section 47 child protection enquiries[i] at an earlier stage.

The fourth and final referral was submitted on the 6th May 2021 which did proceed to Section 47 child protection enquires which concluded on the 29th June 2021 with an outcome to proceed to child protection case conference. The initial conference took place on the 28th July 2021. Although a strategy meeting was held it was only attended by police and social services, no other agencies such as health or probation were invited to the meeting.

The timescales as outlined in the 'Wales Safeguarding Procedures' states that Section 47 child protection enquiries need to be coordinated within 10 working days of the strategy meeting. If the outcome of the Section 47 child protection enquiries is to proceed to initial child protection case conference, then this needs to be held within 15 working days of that decision, however these timescales were not adhered to as detailed above. This delay meant that the risk posed to the children was not sufficiently managed by means of a statutory child protection plan.

When the children were placed on the child protection register, they were subject to ongoing assessment and review by children services. The Community Mental Health Team were sharing information with children services regarding the mental health of Stanley's father. Between June 2021 and October 2021 there were concerns about Stanley's father requiring an urgent mental health assessment, not taking his medication, presenting as psychotic, believing the government were going to kill him and were tampering with his food, drink driving, carrying a knife in his car and receiving a short period of inpatient treatment.

Despite the above concerns there was no thorough assessment of Stanley's father and his ability to protect, care and to safeguard Stanley. Although Stanley's father attended the core group meetings and case conference meetings his voice doesn't appear to be present within the timeline information.

During the time, the children were on the child protection register Stanley's mother made several references to her struggling to cope with his toileting and frequent accidents however support was not provided. Following the discharge of Stanley from health visiting services on the 11th August 2021 there was no health representative present for Stanley in the subsequent child protection case conference meetings or the core group meetings.

Good Practice

As part of the Section 47 child protection enquiries there are a number of visits made by the social worker to Stanleys school and there appears to have been a good channel of communication with Education.

There was good multi-agency attendance at the case conference meetings and core group meetings.

The were good information sharing from mental health who were providing children services with frequent updates on the mental health concerns of Stanley's father.

Theme 2 : Missed opportunities to submit safeguarding referrals

Within the one year period leading up to Stanleys death there were missed opportunities to submit safeguarding referrals.

Health Board missed opportunities.

In January 2021 Stanley's father contacted the Health Visitor to report concerns about his son's health and wellbeing, specifically his appearance which he described as grubby. He was advised to raise concerns with children services and to have open lines of communication with Stanley's mother regarding cleanliness.
Following the phone call with Stanley's father an opportunistic home visit was made by the Health Visitor. It was documented that home conditions were described as unclean but satisfactory. The health visitor also noted that Stanley looked pale and tired and advised his mother to increase iron enriching food such as red meat and green vegetables and if no improvement seen to take Stanley to the GP.

It is assessed that the health visitor should have had ownership of the concerns and submitted a duty to report to children services. Despite the advice given to Stanley's father there was no follow up action to confirm whether he had reported his concerns.

Probation Service Missed opportunities.

During February 2021, the probation service documented that the relationship between Stanley's mother and her partner is continuing, and he reports they are spending considerable amounts of time together and that he is having contact with Stanley when his mother is present. He also discloses he was using approximately £50 worth of Cannabis a day.

In the learning event practitioners advised they were unclear as to whether Stanley's mother was assessed as being suitable to supervise the contact, her partner advised that this was the case however this was never clarified with children services by the probation practitioner. Given his risk level a duty to report should have been submitted during this time.

Good Practice

When the pregnancy was disclosed to the probation practitioner a duty to report was submitted and there was evidence on the probation case notes that the practitioner submitted a further referral when new information came to light and also follow up enquiries being made about the status of the referral.

Theme 3 - Domestic Abuse concerns being overlooked and missed opportunities to refer to Independent Domestic Violence Advisor (IDVA) services.

As highlighted throughout this report the relationship between Stanley's mother and her partner was a concern for professionals due to his sexual offending and also his history of Domestic Abuse, however it is evident that on occasions the domestic abuse concerns were overlooked and the focus appears to be on the risk of sexual harm only. There were missed opportunities to refer to IDVA (Independent Domestic Violence Advisors) services. At the commencement of their relationship professionals confirmed that she had knowledge of his sexual offending but not his domestic abuse history.

Between November 2020 and October 2021 there are three Multi-agency public protection arrangements (MAPPA) meetings held. Within the first meeting it was documented that a Claire's Law disclosure had not been undertaken but relevant information about the offences had been disclosed by a Management of Sexual or Violent Offenders (MOSOVO) officer. It is not clearly recorded what the level of disclosure was and whether it included the full extent of the domestic abuse history.

It is not until October 2021 that there is reference to an IDVA referral being required despite IDVA Services attending the Multi-agency public protection arrangements (MAPPA) meetings. The referral is submitted by the probation practitioner; however, it was not processed due to an error on behalf of the Independent Domestic Violence Advisor (IDVA) service.

In addition to the above this report has referenced the various assessments undertaken by children services. However, within these assessments it is clear that the concerns of domestic abuse were overlooked and not appropriately assessed. These assessments were missed opportunities to submit Independent Domestic Violence Advisor (IDVA) referrals.

Improving Systems and Practice

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

Recommendations

Theme 1 – Quality of safeguarding assessments

Practice updates

Multi-agency safeguarding hubs are now in operation and aim to help vulnerable adults and children access the services they need to keep them safe. The hub sees a number of agencies including police officers, social workers, health and education professional, probation officers and staff from the voluntary sector – working in partnership to share information and address safeguarding concerns. The safeguarding hubs ensure that relevant safeguarding meetings including strategy meetings are multiagency.

Recommendation 1

Gwent Safeguarding Board to develop business continuity guidance for agencies to follow in an event or situation whereby service delivery is impacted. Regional guidance will ensure that all agencies are working to an agreed set of standards ensuring that the safeguarding of children, young people and adults is not compromised.

Recommendation 2

Gwent Regional Safeguarding Board to develop a Quality Assurance framework to ensure the correct process is being followed when closing cases and to ensure compliance with 'Wales Safeguarding Procedures'.

Recommendation 3

Local authorities need to increase the availability and effectiveness of training for frontline practitioners to improve their awareness and understanding of engaging meaningfully with fathers with the aim of empowering fathers to understand their Rights. In some instances, fathers may not be aware of their rights as a parent to their child/ren. Practitioners working with families can offer clear, concise explanations as to what a father's rights are, i.e., explaining Parental Responsibility and what this means in the life of a child.

Recommendation 4

Strategy Discussion attendance should comply with recommendations set out in the Wales Safeguarding Procedures.

Theme 2 – Missed opportunities to submit safeguarding referral.

Practice updates

The Safeguarding Board are in the process of developing Children Duty to Report Threshold Guidance.

Recommendation 5

Gwent Safeguarding Board to disseminate Duty to Report Threshold Guidance to agencies and monitor the implementation within each organisation. Individual agencies will be responsible for sharing the guidance with its staff and providing key updates to the safeguarding board.

Theme 3 Domestic Abuse concerns being overlooked and missed opportunities to refer to Independent Domestic Violence Advisor (IDVA) services.

Recommendation 6

Gwent Multi-agency public protection arrangements (MAPPA) unit to provide training for Gwent Independent Domestic Violence Advisor (IDVA) Services to ensure they understand what is expected of them when attending Multi-Agency Public Protection Arrangements (MAPPA) meetings.

Recommendation 7

Gwent Multi-Agency Public Protection Arrangements (MAPPA) unit to provide briefings to all Multi-Agency Public Protection Arrangements (MAPPA) chairs regarding disclosure discussions and decisions and accurate recording of agreed disclosures

Recommendation 8

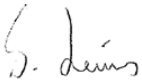
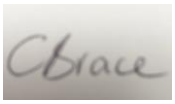
7 minute briefing on Independent Domestic Violence Advisor (IDVA) Services to be formulated and shared with organisations. The briefing should include what the service can provide and the referral process.

References:

The Social Service and Well-being (Wales) Act 2014
Https://www.legislation.gov.uk/anaw/2014/4/contents

Statement by Reviewer(s)			
REVIEWER 1	Sinead Lewis	**REVIEWER 2**	Clare Brace
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,		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	

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	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		Clare Brace
Date	27.03.2024	**Date**	27.03.2024

Chair of Review Panel (Signature)	
Name *(Print)*	Alison Ramshaw
Date	27.03.2024

Appendix 1: Terms of reference

Child Practice Review Process
Child Practice Review Process The South East Wales regional Safeguarding Children Board (SEWSCB) Chair notified Welsh Government on 21st February 2022 that it was commissioning a Extended Child Practice Review in respect of a young child. Reviewer: Sinead Lewis, Senior Probation Officer Reviewer: Clare Brace, Lead Safeguarding Nurse Chair of Panel: Alison Ramshaw, Head of Service The services represented on the panel consisted of: • Gwent Police PPU • Children's Services • Aneurin Bevan University Health Board • Welsh Ambulance Service Trust • Education The Panel met regularly in order to review the multi-agency information and provide analysis to support the development of the report. Learning Event A Learning Event took place in September 2023 and was attended by the following agencies: • Aneurin Bevan University Health Board • Gwent Police • Gwent Probation • Children's Services Family Members Relevant family members were informed that the review was taking place and meetings were held with Reviewers where requested.
☐ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads ……

Agencies	Yes	No	Reason
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

[i] The purpose of the Section 47 enquiry is to establish whether a child is suffering or is likely to suffer significant harm and requires intervention to safeguard and promote their well-being. Social services have lead responsibility for the enquiries. Other practitioners, such as the police, health, education and other relevant partners have a duty to co-operate and help social services undertake its enquiries.

Appendix 1

Terms of Reference

EXTENDED CHILD PRACTICE REVIEW IN RESPECT OF SEWSCB 4/2022

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.

- Hold a learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and extended reviews.

- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.

- Produce a merged timeline, initial analysis and hypotheses.
  (scope 19.12.2020 - 19.12.2021)

- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.

- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Safeguarding Children 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.

- Board sends 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 Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on Board website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.