Child Practice Review Report
Cardiff & Vale Safeguarding Board
Concise Child Practice Review
Re: CPR 05/2018

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*

A concise review was commissioned by Cardiff & Vale of Glamorgan Safeguarding Board on the recommendation of the Case Review Subgroup in accordance with the Guidance for Multi Agency Adult/Child Practice Reviews. The criteria for this review are met under section 3.4 of the above guidance.

A board must undertake a concise 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 neither on the child protection register nor a looked after child in the six months preceding
- The date of the event referred to above: or
- The date on which the local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health or development.

For this concise review, the Regional Safeguarding Board Child and Adult Practice Review Subgroup agreed the criteria was met in relation to serious and permanent impairment of health or development.

The purpose of a Child Practice Review is to identify multi-agency learning for future practice and this report focuses specifically on the practice and organisational learning.

This report identifies the practice and organisational learning following an incident where the children were removed from their primary caregiver, who they resided with whilst subject to a special guardianship order. The review also considered relevant historic information about the children's early years and previous removal from their biological parents.

In accordance with the Welsh Government's guidance on the publication of Child Practice Reviews and Adult Practice Reviews, released in August 2019, the Regional Safeguarding Board has redacted the parts of this Child Practice Review that describe the details of the case.

Panel Membership

There was good representation by agencies on the panel. The panel consisted of:

- Housing and Communities, Cardiff Council
- South Wales Police
- Cardiff and Vale University Health Board
- Education Services, Cardiff Council
- Children's Services, Cardiff Council
- National Probation Service

The panel were supported by a Safeguarding Board legal representative.

The Learning Event

A virtual learning event was held over a two-day period due to the Covid 19 restrictions on attendance at the workplace.

The event was attended by:

- Education (including representation from both Primary and High school)
- South Wales Police
- Children's Services, Cardiff Council
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- Housing and Communities, Cardiff Council
- Barnardo's
- National Probation Service
- Snap Cymru

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 identification of the practice and organisational learning has been drawn from:

- Production of merged timeline
- Learning Event
- Discussion at Panels
- Agencies Historical Summaries
- Reviewer Analysis
- Child A & Child B perspectives

The purpose of the learning is to improve future practice and ensure the robustness of our services in protecting children from neglect, harm and abuse.

Safeguarding is Everyone's Responsibility

The learning event and information contained within the timeline indicated that no safeguarding referrals or concerns were made or identified. There appeared to be little understanding or knowledge from those staff about the abuse and neglect the children were experiencing.

Learning Point

It is important that practitioners, irrespective of their role, feel supported and know how to report, respond and record concerns, disclosures or allegations relating to safeguarding. This should further be supported by awareness of signs and indicators of abuse and neglect.

Home Schooling/Elective Home Education

Both Child A and Child B were known to have an educational statement and neither attended educational provision following primary school setting.

Child A became invisible to services when she left primary school. Despite being on roll for a local comprehensive school, home schooling requests were not received until after at least 18 months of her non-attendance, and this was as a result of arrangements for their younger sibling being discussed at that time. There were no formal arrangements in place for review of the educational statement or clarity of what the home-schooling arrangements were.

Child B did transition to High School with annual review taking place to inform these arrangements. However, despite transport and support arrangements being put in place, Child B eventually became subject to home schooling arrangements. Alternative provisions such as tutoring or alternative settings were discussed but were not formalised.

There is no evidence to suggest that the primary carer had the ability to support the home schooling arrangements. It was well documented that the aunt struggled to manage the children's behaviour. It is known that attempts were made for Child A to receive an alternative provision, but these were not formalised.

A situation was therefore created where neither child was receiving any formal education and the arrangements of home schooling were not reviewed or monitored. Given that there had been extensive education involvement at primary school level, it was known that the children required a high level of support and that the aunt was not able to provide this.

In 2025, Cardiff Local Authority are piloting a bespoke educational provision at a local secondary school to support curriculum and enrichment activities for learners. A designated teacher was appointed to work with some families to signpost the children to explore the options and benefits of remaining in school. Enhanced transition activities are also planned to encourage learners in Year 4, 5 and 6, to transition to secondary school.

Whilst Cardiff Local Authority are confident their local processes are clear and robust; it is important to note that there are limitations within the current Welsh Government guidance and it is not always possible to provide opportunities to see children when reviewing Elective Home Education arrangements.

Learning Point

The monitoring of Elective Home Education (EHE) for all children should be rigorous and consistent. Any safeguarding issues identified for children receiving EHE should be reported. The opportunity for safeguarding responses to these children or an opportunity for them to speak to someone outside of their family setting was not available as they were largely contained within their home environment with little to no professional contact.

Impact of Cultural Differences & Professionals' Responses

There were incidents of professionals fearing reprisals and consequences of making reports. These were shared via panel members and also within the Learning Event.

Visiting arrangements for some agencies had been withdrawn for a time following an incident. It became apparent that this had not been a co-ordinated partnership approach and had resulted in different approaches being taken in terms of risk management for staff and inconsistent information about risk assessments/risk management that varied across agencies.

This was also evidenced through safeguarding reports that had been made where individuals expressed their wish to remain anonymous for fear of reprisals. Whilst all attempts should be made to support the safety and confidence of professionals making reports, this should not prevent action being taken and safeguarding duties being undertaken.

Learning Point

Irrespective of the family circumstances, where children live or their cultural context, the need to ensure protection from abuse, harm and neglect is the same for all. It is apparent that for these children a number of factors limited the opportunity to support and safeguard them.

Impact of Early Childhood Trauma

Both children experienced early trauma in relation to inconsistent, neglectful and abusive parenting. As a result of this they were removed from their parents' care and were placed with their aunt, initially as a temporary measure, which then became formalised and subject to a Special Guardianship Order.

The children were known to CAMHS and displayed behaviours that could be attributed to their early experiences. CAMHS worked with education and were part of their annual reviewing process, there were a number of referrals to children's services that indicated that the emotional and psychological challenges could not solely be attributed to past experiences and there were social/environmental concerns that needed to be explored. These referrals did not result in assessment from children's services and there were no opportunities for a holistic assessment with multi-agency input.

Learning Point

The challenges and issues in relation to the children and their behaviour came from the perspective of their aunt, with her deflecting from any responsibility from a parental perspective. There was no indication of the situation from the child's perspective and no documented occasions where children were spoken to alone or away from their aunt or the environment where they lived.

Special Guardianship Arrangements

The aunt was the special guardian for both children and allegations of the abuse and neglect the children experienced were attributed to her and other family members.

This review considered all referrals that were made to children's services during the review period. There were a number of referrals made that indicated there were concerns about the aunt's ability to provide appropriate care for the children; allowing the mother of the children to have contact and live with them; anonymous referrals about her treatment of the children were received and the final report resulted in the children being removed.

There were no recorded annual monitoring of the arrangements and there did not appear to be any special guardianship support plan in place. Whilst the aunt was receiving an SGO allowance, there was no additional support or monitoring in place during the review period.

At no point was the suitability of the arrangement or the aunt's ability to meet the children's needs and provide care re-assessed, despite the referrals/reports that had been received.

Learning Point

There was insufficient monitoring of the special guardian arrangements with no evidence of review or considerations of the ongoing suitability of these arrangements. It is acknowledged that there has been change in statutory requirements in relation to monitoring and reviewing of special guardianship arrangements.

Effective/Good Practice Identified

The review panel identified evidence of some effective and good practice as below:

- Continued efforts of Headteacher in making referrals; seeking support and advice.
- Timely and co-ordinated response of agencies responding to the anonymous report in 2018 that resulted in the children being removed.
- National Referral Mechanism report was submitted as a response of the child protection investigation into exploitation/ modern slavery (domestic servitude).
- Improvements to information sharing was evident that enabled positive action to take place. Weight was given to the referral source which hadn't been evident in previous referral outcomes.
- Information shared with the health visitor.

Since the time of the incident considered within this review, it is acknowledged that there have been changes made within individual agencies and these will be reflected within the recommendations and actions made.

Improving Systems and Practice

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

(what needs to be done differently in the future and how this will improve future practice and systems to support practice)

Safeguarding is everybody's responsibility

Learning Point
It is important that practitioners, irrespective of their role, feel supported and know how to report, respond and record concerns, disclosures or allegations relating to safeguarding. This should further be supported by awareness of signs and indicators of abuse and neglect.

Recommendation

1. Cardiff Local Authority should review and audit the safeguarding training provided to staff where there may be similar barriers to reporting concerns to ensure that practitioners have the knowledge, skills, confidence and understanding to recognise and report abuse, harm and neglect and understand their responsibilities to report concerns.

Cultural Differences & professional responses

Learning Point

Irrespective of where children live or their cultural context, the need to ensure protection from abuse, harm and neglect is the same for all. It is apparent that for these children a number of factors limited the opportunity to support and safeguard them.

Responses from practitioners appeared to be influenced by the challenges, barriers and perceived risks to themselves due to historic events that had taken place. There is a need to ensure that consistent responses and safeguarding action is taken irrespective of the cultural context and environment.

Recommendation

2. Cardiff Local Authority must ensure that support is in place for practitioners who work in environments where there are barriers to reporting concerns and encourage the use of community leaders and community connectors in supporting reporting.

3. Cardiff and Vale Safeguarding Board and Cardiff Community Safety Partnership should work together to understand what the current arrangements and challenges are when working with families.

Elective Home education

Learning Point

The monitoring of Elective Home Education (EHE) for all children should be rigorous and consistent. Any safeguarding issues identified for children receiving EHE should be reported. The opportunity for safeguarding responses to these children or an opportunity for them to speak to someone outside of their family setting was not available as they were largely contained within their home environment with little to no professional contact.

Recommendation

4. Cardiff and Vale Safeguarding Board should recommend that Welsh Government reviews current Elective Home Education guidance and practice to ensure it takes account of how safeguarding concerns are reported and escalated for children who are subject to Elected Home Education, The Guidance review should consider how robust the monitoring requirements are, or should be, to support the ability to identify and respond to safeguarding issues.

5. The Safeguarding Board should ensure that processes and procedures relating to EHE children in the region are rigorous and include checks and balances to ensure that all arrangements are fit for purpose and opportunities to review and monitor these arrangements are in place.

Impact & understanding of early childhood trauma

Learning Point

The challenges and issues in relation to the children and their behaviour came from the perspective of their aunt, with her deflecting from any responsibility from a parental perspective. There was no indication of the situation from the child's perspective and no documented occasions where children were spoken to alone or away from their aunt or the environment where they lived.

Recommendation

6. Trauma informed approaches and practice should be adopted across board agencies so that practitioners understand the impact of early childhood experiences of neglect and abuse and have an awareness of how this can be observed within their behaviour. The lived experiences of children should be recorded and understood by professionals.

Special Guardianship Arrangements

Learning Point

The children were subject to special guardianship order to a family member in the period leading up to the incident considered within this review. There was insufficient monitoring of these arrangements with no evidence of review or considerations of the ongoing suitability of these arrangements. It is acknowledged that there has been change in statutory requirements in relation to monitoring and reviewing of special guardianship arrangements.

Recommendation

7. The Safeguarding Board should receive assurances that where safeguarding reports are being made in relation to children who are subject to special guardianship arrangements, that relevant decision makers understand and respond to these reports appropriately and record rationale and decision making in terms of safeguarding response.

8. The Safeguarding Board should receive assurances that Special Guardianship Order monitoring, and review arrangements are in place and being adhered to.

Child Practice Review process

To include here in brief:

- *The process followed by the SCB 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.*

Panel Membership

There was good representation by agencies on the panel. The panel consisted of:

- Housing and Communities, Cardiff Council
- South Wales Police
- Cardiff and Vale University Health Board
- Education Services, Cardiff Council
- Children's Services, Cardiff Council
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- Cardiff & Vale University Health Board
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- Barnardo's
- National Probation Service
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Family involvement

The children were given the opportunity of meeting with the reviewer of this CPR. Child A was initially keen to do this but later made the decision not to do so. Child B did not wish to engage in this. Child A did speak with their social worker and wanted their views shared with the panel.

This review received updates in relation to both children's progress since they became looked after. Both children have remained in the same foster placement. It is reported that the children have thrived and flourished.

Both Children have now moved into supported/independent accommodation and continue to receive support as care leavers.

☐ Family declined involvement

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Date information received …….

Date acknowledgment letter sent to SCB Chair …….

Date circulated to relevant inspectorates/Policy Leads …….

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