Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

Adult Practice Review Report

Cardiff and the Vale Regional Safeguarding Board
Concise Adult Practice Review

Re: APR 03/2020

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 Adult Practice review was commissioned by Cardiff and the Vale Regional Safeguarding Board on the recommendation of the Adult and Child Practice Review Sub-Group in accordance with the Guidance for Multi-Agency Adult Practice Reviews. The criteria for this review are met under *Section 139 of the Social Services and Wellbeing (Wales) Act 2014:*

A board must commission an adult practice review where an adult at risk
who has not, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

Died, or
Sustained potentially life threatening injury or
Sustained serious and permanent impairment of health.

The timeframe for this report is from 26/03/2018 until the date of the incident which occurred on 02/06/2019. The decision was made to begin the review on 26/03/2018, as this was the first contact where concerns of knife crime is recorded.

The person subject to this review, who shall be referred to as B, was stabbed to death at the age of 18 in Cardiff. Three adults were charged with his murder. B had been deemed previously to be at risk in relation to criminal exploitation and associated possession of weapons and drug dealing offences. He had been arrested in possession of weapons and had been in possession of large amounts of cash when previously apprehended by the police. It was suspected, therefore, that he was involved in organised crime. He had expressed fear for his safety in the community just a few weeks before his murder.

There was a lack of multi-agency meetings to assist with safety planning or structured activities to help him disengage from a criminal lifestyle. It seems that his age was

one of the factors that contributed to a lack of coherent planning from agencies. He was murdered two weeks after his 18th birthday. There were missed opportunities to engage him and his family via a Child in Need of Care and Support Plan and a missed opportunity to ensure that a referral was made and received by St Giles Trust (a charity that helps divert young people from organised crime). It is of note that when he was made subject to a Youth Justice Service Intensive Referral Order, three weeks before his murder, he kept every appointment with professionals. It is also of note that there was sporadic contact with B's family. The Youth Justice Service did not speak to B's parents during their preparation of a Pre-Sentence report and other opportunities to engage with his parents were missed or happened without a translation service.

The purpose of this practice review report is to identify the key learning points and make recommendations for practice from the multi-agency review and learning event. The review panel for this case included representatives from the South Wales Police, Children's Social Services, Youth Justice Service, Health, Education, St Giles Trust and a Housing Association. The learning event was attended by multi agency professionals directly involved in this case. It was regrettable that due to unforeseen circumstances we did not have a current representative from Cardiff Social Services however the allocated social worker who moved to another local authority during the timeline did attend. All professionals participated well in the event and were open and reflective about their actions and recommended a number of ideas for improvements for future practice which are contained in this report.

The family members were contacted prior to the learning event. Significant efforts were made however, contact was not achieved to allow involvement in the process of the review. The family will be contacted again prior to the publication of this review.

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

Missed opportunities for multi-agency information sharing

B came in to contact with the police on a number of occasions during the timeframe of this review. These contacts included stop searches and arrests. Two Public Protection Notifications (PPNs) were submitted in relation to B and shared with Children's Services. One of these led to a strategy discussion. On other occasions it appeared that officers dealing with B did not recognise that the context of their contacts with him indicated that he was potentially vulnerable to exploitation. Submission of PPNs in relation to these incidents may have provided the opportunity for agencies to reassess the risk to B in light of this additional information. The panel were assured that work is ongoing within South Wales Police to address the emerging issue of Child Criminal Exploitation (CCE) which have been noted in the **Practice Changes** section of this report.

A Multi-Agency Safeguarding Meeting (MASM) was requested by a Think Safe Worker within Cardiff Children's Services, but this did not happen. Records do not

clearly explain why this did not take place. This was a missed opportunity for agencies to collectively consider the risk to B and offer support to him and his family.

Record keeping and documentation

Professionals in the learning event did comment that the Child in Need of Care and Support Plan should have contained clear objectives with time limited actions assigned to named professionals. The plan for B did not follow these guidelines and therefore it has been difficult to track why a referral to St Giles Trust, referenced a number of times throughout agency documentation, was not undertaken.

B's care plan should have been transferred to another social worker as his initial social worker moved to a job in a different local authority. This did not happen. Records do not clearly explain why this did not take place.

Accessibility of advice and information for young people and their parents/carers on organised crime and criminal exploitation.

There can be an obvious reluctance for parents and carers to bring a young person's illegal activity to statutory agencies' attention. Hopeful messages need to be communicated to young people and their families as to how they can extricate themselves from **organised crime** and criminal exploitation. There are a number of resources available to support families. More information can be found within the glossary and resources page of this report.

Professionals in the learning event said that these resources need to be publicised by social media means as well as more traditional means so that the right audiences are reached.

Multi agency training opportunities

Staff at the learning event stated that they would benefit from having more opportunity to complete safeguarding training alongside other agencies. They all felt that this would help with the quality of the safeguarding referrals that they submit. Professionals from outside Social Services have said that they would like to gain a better understanding of why certain cases progress to child protection case conferences and others don't. Even though the death of this young person happened before Covid, there is a concern that agencies have become more insular since the pandemic and multi-agency training such as the old training programme, Working Together, would help strengthen communication between agencies and again raise the importance of child protection referrals containing comprehensive detail of all concerns about vulnerable young people. Where multi agency training is offered in the region, the importance of such events needs to be reiterated to managers to ensure that staff are released to attend.

Transition from child to adult safeguarding services

B was nearly 18 when he was in Youth Court. The dangerous situation he was in still needed to be addressed. Professionals at the learning event did say that a

National Referral Mechanism (NRM) form would now be considered, which should generate multi agency meetings where safeguarding interventions for an individual who is being or is suspected of being criminally exploited are discussed, safety plans formulated and opportunities to disrupt perpetrators identified. Young people continue to be at risk from exploitation when they turn 18 however there can be fewer opportunities to engage and much of the support on offer is on a voluntary basis.

Professionals did not have sufficient awareness of cultural differences when dealing with B and organisations seem to have responded to B as an adult before he reached his 18th birthday.

Working with parents/carers with limited English

It seems in this case that B's parents (only mother is mentioned in the timeline) spoke limited English. B's siblings were routinely used to translate. This may have resulted in B's parents not hearing the full information about B and his contact with the police. This arrangement also placed too much responsibility on siblings only a little older than B; they were not his registered guardian.

There are concerns that a sibling could try and protect their brother or sister by minimising the trouble their sibling is in. There is no evidence to suggest this happened with B but it is a concern that has been raised during this practice review. Whilst it is understood that families are sometimes reticent to use independent interpreters due to concerns that their community may find out about a child's wrongdoing, the use of an independent interpreter should be considered where parents have a limited understanding of English.

It was also noted that B's parents were not contacted by the author of the Pre-Sentence Report. All YJS reports and assessments have to specify whether they've spoken to parents/carers and other sources of information – the YJS monitor this as part of their Management gatekeeping and Quality Assurance processes that every case is subject to. It is not clear why this did not happen in this case.

Youth Justice Service and allocation of new cases when officers are on leave

As previously mentioned, B was made the subject of a Youth Referral Order but his allocated Youth Justice Service Officer was on leave for a number of weeks. Consequently, his first sessions with the Youth Justice Team appeared brief. There was little evidence of professional curiosity and the officer did not follow up on safeguarding concerns voiced by B during his Pre-Sentence Report interview. He was sadly murdered before his allocated YJS worker had an appointment with him. It is recommended that in future, new cases are allocated on a permanent basis to an officer that will be in work. An allocated officer missing a week with a new case would be acceptable but several weeks was not deemed to be good practice.

Improving Systems and Practice

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

All practitioners at the learning event showed dedication and commitment to their various roles. Their open and honest contribution to the learning event must also be commended.

The consensus of staff at the learning event was that communication between agencies should have been better and there were missed opportunities to have multi agency discussions or strategy meetings and a missed opportunity to provide a Care and Support Plan to B and his family due to the departure of a social worker and a failure to transfer to another social worker.

The Multi-Agency Safeguarding Hub is now far more embedded in practice than it was in 2019 and there is also an enhanced knowledge of the extreme danger that young people are in if they are involved with organised crime. Children and young people's experience of significant harm outside the family was not widely understood in 2019; it now seems to be at the forefront of many statutory agencies' safeguarding agendas.

From discussion at the learning event and information provided to the panel, it is clear that the support for young people being criminally exploited and their families is now more comprehensive. All staff said that they would welcome more multi agency safeguarding training.

Practice Changes:

South Wales Police

A restructure has been implemented within South Wales Police to ensure a consistent and coordinated response to Child Criminal Exploitation (CCE) across the force area which will provide sufficient capability and capacity to investigate and disrupt CCE and to safeguard victims. Since the time period of this review, Criminal Exploitation flags have been introduced to highlight to officers those children at risk and a policy change implemented to mandate the submission of a PPN for any child in custody. Additionally, within Cardiff and the Vale, daily meetings are held between South Wales Police and the Youth Justice Service to discuss any young person known to YJS who has been involved in an incident in the previous twenty-four hours. This ensures that YJS case managers and colleagues in Children's Services are kept as up to date as possible and assists with keeping assessments and intervention support as relevant as it can be. A process is also in place to share information with schools if one of their pupils is linked to an incident involving a knife.

Custody Youth Worker Service

Since the Autumn of 2021, it has been mandatory for any young person (10-17 years old) arrested within the South Wales Police force area to be offered access to a Custody Youth Worker for them to provide additional support. This a free service (funded by the Wales Violence Prevention Unit). provided by an independent organisation that focusses on improving life chances of children across Wales. They provide motivational interviews both in and outside of the custody environment, helping young people reflect on their life trajectory and support access to positive opportunities within their communities. Since July 2022 this has now been extended to any young person attending a Voluntary Police Interview.

Youth Justice Service and allocation of new cases when officers are on leave

The current system for the allocation of reports happens within 24 hours of receipt of the Pre-Sentence Report request from court. In the majority of cases, the report writers would then continue to manage the case following sentencing. The management team would take time to look at availability and capacity when writing reports and take into account any planned leave to ensure consistency of relationship-based practice throughout the team. Whilst staff absence is sometimes unavoidable; in the case of planned leave, there would be a documented handover between workers to ensure clear outlines of expectations and delivery of work whilst the responsible case manager is absent.

Organised crime and criminal exploitation

South Wales Police and the Violence Prevention Unit are currently running a campaign #nottheone around knife crime. This is aimed predominantly at males aged 11-16 and seeks to serve as an early intervention resource that teachers, youth group leaders, parents, friends and family can use to educate young people on the dangers and consequences of carrying a knife. The Board should look to promote this and other campaigns across their communication channels. Home - NotTheOne

Over the past year Cardiff City Local Authority and partners have developed the SAFE framework (Safeguarding Adolescents from Exploitation). An exploitation screening tool has been created and shared with all staff alongside a clear referral pathway in relation to exploitation for individual cases (exploitation strategy meetings/high risk panels/mapping analysis in conjunction with the police).

In a wider context work is being completed around school curriculum development, an exploitation training matrix for staff and development of the MISPER protocol. An action-focused SAFE partnership group is held monthly highlighting and responding to thematics from individual meetings and locality focus groups which then reports into the Children and Young People’s Recovery Board.

Multi agency training opportunities

Cardiff and Vale Safeguarding Board (CVSB) have developed a multi-agency training package that will be available to be delivered internally but will also be delivered by CVSB on a multi-agency basis.

Care and Support Plans

A Care and Support Plan reviewing team is now in place. There is also a new case transfer policy in operation in Cardiff. There are also additional resource assistants in place that help with capacity and demand issues in frontline teams.

Weekly data sets are also seen and acted upon by managers with regards to resourcing issues. This all feeds into the recruitment and retention of social care staff.

Learning Points and Recommendations:

The learning points throughout this review have resulted in the following recommendations. Agencies have made some progress on some of these recommendations during the time that has elapsed since B's murder.

1. Cardiff and Vale Safeguarding Board need to be satisfied that all agencies are aware of how to identify exploitation and the appropriate pathway/ referral mechanism to ensure multi-agency meetings (MASM) take place. This would include the appropriate professionals also being present at MASM's, who are trained and equipped to care plan around reducing the risk of exploitation to children.

2. B missed out on an opportunity to engage with St Giles Trust as there seemed to be confusion as to who was referring B to that charity. Effective Care and Support Plans must have clear outcomes with time limited actions assigned to named professionals. Cardiff and Vale Safeguarding Board to be assured that all Care and Support Plans are appropriately managed and reviewed.

3. The Care and Support Plan for B should have been transferred to another social worker after an agency social worker left. This did not happen. There needs to be robust management oversight of any unallocated families and systems need to be in place to ensure those families are kept in contact with or children may be detrimentally affected together with their families.

4. Practitioners across all agencies should be reminded of the importance of accurate record keeping including management decision making.

5. Concerns were raised at the Learning Event about the retention of social workers, and the over reliance on agency staff who can leave positions with little notice resulting in gaps in provision for vulnerable children and young people. Cardiff and Vale Safeguarding Board need to provide assurances that the challenges surrounding retention and recruitment are being met

robustly and with resilience and that risks are highlighted to Welsh Government.

6. Currently there is little content on the Cardiff and Vale Regional Safeguarding Board website on avenues for help for criminally exploited children and young people and their carers. The Board need to ensure that they are effectively publicising resources and support to young people and their carers as to how and where they can seek support and advice around exploitation and organised crime. The Learning Event participants also voiced that advice and support needs to be offered via other social media platforms.

7. Professionals at the learning event highlighted that multi-agency training events supported less insular working practices and would help improve the quality of their safeguarding reports. Cardiff and the Vale Safeguarding Board should ensure that multi-agency safeguarding training events are made available to staff. Where multi-agency training is offered in the region, the importance of such events needs to be reiterated to managers to ensure that staff are released to attend.

8. A newly developed exploitation training matrix provides bespoke opportunities for staff to upskill in this area. Cardiff and Vale Safeguarding Board should be assured that this matrix has been shared across agencies to enable individual agencies to identify staff required to attend training.

9. The learning event spoke about the challenges around transitioning from child to adult safeguarding services for the criminally exploited. Young people continue to be at risk from exploitation when they turn 18 and there can be fewer opportunities to engage. Cardiff and the Vale Safeguarding Board should ensure that there is an effective multi-agency approach to transitional safeguarding within the region.

10. There was no mention in the timeline about what the parents' first language was, and no professionals were recorded as asking about which translation service the parents required. Concerns were raised that Bs adult siblings were often used to translate for their parents. This could have resulted in B's parents not being fully involved and informed of B's troubles. B's parents were also not contacted by the Youth Justice Service worker who wrote the Pre-Sentence Report. A review of the use of translation/interpreter services by Cardiff Social Services should be undertaken.

11. B expressed concerns for his own safety in a pre-sentence report interview and there was no documentation to support that a safeguarding report had been made. The Youth Justice Service need to provide further assurance that relevant safeguarding reports are made if safeguarding concerns are raised in any interactions with young people.

12. The panel were assured that work is ongoing within South Wales Police to improve the response to Child Criminal Exploitation. A progress update on this work should be provided to the Safeguarding Board within 6 months.

<table>
<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>REVIEWER 1</td><td>Jane Foulner</td><td>REVIEWER 2 (as appropriate)</td><td>Nicole Devonish</td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td></tr>
<tr><td colspan="2">I make the following statement that prior to my involvement with this learning review:-

• I have not been directly concerned with the individual 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</td><td colspan="2">I make the following statement that prior to my involvement with this learning review:-

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<tr><td>Reviewer 1
(Signature)</td><td>………………….</td><td>Reviewer 2
(Signature)</td><td>……………………</td></tr>
<tr><td>Name
(Print)</td><td>Jane Foulner</td><td>Name
(Print)</td><td>Nicole Devonish</td></tr>
<tr><td>Date</td><td>………………….</td><td>Date</td><td>……………………</td></tr>
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Chair of Review Panel (Signature)	………………….
Name *(Print)*	Melanie Roach
Date	

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Adult Practice Review process

To include here in brief:

- *The process followed by the SAB 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.*

The Cardiff and Vale of Glamorgan Safeguarding Board chair commissioned an Adult Practice Review in respect of case APR 3/2020.

The services represented on the panel consisted of:

- South Wales Police
- Cardiff & Vale University Health Board
- Cardiff Children's Services
- Cardiff Education
- Cardiff Youth Justice Service
- St. Giles Trust

A learning event was held on the 11th May 2022 and was attended by representation from the following agencies:

- South Wales Police
- Cardiff Children's Services
- Cardiff Youth Justice Service
- St Giles Trust
- Cardiff Education

Extensive efforts were made to contact the family who declined to be involved.

☐ Family declined involvement

Glossary of Terms

- **Think Safe -** A Children's Services exploitation team, working with young people at risk of and who are experiencing sexual and criminal exploitation.
- **YJS –** Youth Justice Service.
- **PPN –** Public Protection Notification
- **CCE –** Child Criminal Exploitation
- **MISPER –** Missing Person
- **MASM –** Multi-Agency Safeguarding Meetings

Useful Resources

St Giles Trust - Child Criminal Exploitation - St Giles (stgilestrust.org.uk)

Childline - Child trafficking | Childline

Fearless (Crimestoppers) - Home - Fearless

#nottheone - Home - NotTheOne

Children's Society Guide for parents - Guide-for-parents-worried-about-child-being-criminally-exploited.pdf (childrenssociety.org.uk)

For Welsh Government use only

Date information received ………………………..

Date acknowledgment letter sent to SAB Chair …………………………

Date circulated to relevant inspectorates/Policy Leads ………………………….

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

Appendix 1: Terms of reference

Cardiff & Vale of Glamorgan Regional Safeguarding Board

Terms of Reference for a (Concis)e Adult Practice Review Exemplar

Re: APR 03/2020

Introduction

A concise adult practice review will be commissioned by the Regional Safeguarding Adults Board (RSAB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. A concise adult practice review will be commissioned where an adult who has not, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

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

Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be 26 March 2018 – 02 June 2019

- The following services will produce a timeline of significant events of its involvement with the Adult, for the timeframe above. A merged timeline will then be produced.

  - SWP
  - Cardiff Youth Justice Services
  - Social Services
  - Health
  - Housing

  A merged timeline will then be produced.

Core Tasks (for a concise practice review)

- 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 individual 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 not already requested by the CPR/APR Sub Group, produce a timeline and an initial case summary and identify any immediate action already taken.
- **To consider the recognition of, response to and impact of Criminal Exploitation and the specific vulnerabilities of this case.**
- Produce a merged timeline, initial analysis and hypotheses.
- 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 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 Case Review Sub Group and the RSB 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 Regional Safeguarding Adult Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review panel* completes the report and action plan.
- RSB send Report and Action Plan 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 Sub Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on RSB website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the RSB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.