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

Child Practice Review Report

Cardiff & Vale of Glamorgan Safeguarding Board
Extended Child Practice Review

Re: C&VSB 042019

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*

An extended child practice review will be commissioned by the Regional Safeguarding Board (RSB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. An extended child practice review will be commissioned where an child at risk has, 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 between **30th June 2018 and 31st July 2019.**

The following services were involved, and each produced a timeline of significant events of its involvement with the child for the timeframe above:

- South Wales Police
- Dyfed Powys Police
- Health/CAHMS
- Welsh Ambulance Services NHS Trust
- Education
- Children's Services
- Residential Care Home Provider

Background information

In accordance with the Wales Safeguarding Procedures, a report to social services is referenced throughout this document as a referral.

Throughout this document the child subject to this Child Practice Review is referred to as a young person, it must be emphasised however that legally this young person was still a child. We have intentionally used the language young person, as to those that knew them, they were a vibrant young person with a full life ahead of them. Tragically this life ended early at the age of 16.

This young person had difficulty in managing emotional regulation from a young age and was receiving professional support. This was in part due to adverse childhood experiences and developmental trauma experienced within the family unit.

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood; such as experiencing or witnessing violence, abuse or neglect in the home or aspects of the child's environment that can undermine their sense of safety, stability, and bonding.

ACEs can have lasting, negative effects on health, well-being, as well as life opportunities such as education and job potential. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide.

Toxic stress from experiencing ACEs can change brain development and affect such things as attention, decision-making, learning, and response to stress. Children growing up with toxic stress may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, jobs, and depression throughout life.

Some three months prior to the young person's death, they had been placed in an out of county residential therapeutic care home, following a decision to place them in the Care of the Local Authority. The young person was accommodated under Section 76 of the Social Services and Well-being (Wales) Act 2014.

Prior to the move to the residential home, the young person was living with Mother, Stepfather and siblings and attended a local school. The young person was engaged with local child and adolescent mental health services CAMHS (Child and

Adolescent Mental Health Services) and was prescribed medication to support with low mood and emotional regulation. During the period reviewed it was evident that the young person would regularly deliberately self-harm and would also make frequent verbal and behavioural statements about being intent to end their life.

The school were very active in providing support and care for the young person, and it was evident when completing this Child Practice Review that the young person responded positively to the relationships formed with staff and saw school as a supportive, safe and stable environment. The young person would often disclose to school staff suicidal thoughts and incidents of self-harm; staff were prompt at sharing this information as well as seeking appropriate help and support. On reviewing the chronology, it was clear that weekends were of heightened concern to the young person and there were occasions where the school sought additional support for the young person on a Friday in advance of the weekend in order to further support and safeguard them.

Throughout this review it became apparent that the young person's family home was a difficult environment, and that the young person had experienced complex and challenging emotions regarding contact with the family following the move to the residential home.

During the period reviewed there were Police call outs to the home address following arguments and occasions whereby the young person would leave the address and be reported as missing. There were also concerns regarding Mum's own emotional regulation. The young person also spent a period residing with the step paternal grandparents following an incident of self-harm.

The residential home that the young person was placed in offers a therapeutic Children's residential home provision and is based in West Wales. It operates on a Therapeutic Community model with additional ESTYN registered Education provision if required. It is registered with and inspected by the Care Inspectorate for Wales (CIW) and operates to CIW National Standards. The care home does not provide mental health treatments or medical services. The home where the young person lived was shared with three other young people. During the period that the young person resided there, they expressed a range of emotions from feeling happy and content having been placed there to expressing guilt that as a result of the placement they were away from their siblings. The young person responded well to the staff and key work sessions and had obtained a part time job during the time there.

During the period of the residential placement, the young person did however express frustration at the need to transfer services from one area to another, in particular the CAHMS support and there was concern regarding the subsequent gap in provision of mental health treatment. The young person attended a CAHMS appointment for an initial assessment and was asked to talk about living in the residential home, where they have been placed two months earlier. The young person also expressed concern as they had previously been meeting with CAHMS three times a week and this has come to an end at the point of transfer and also at

having to articulate their personal history to professionals repeatedly. The need to enable seamless transfer across area and between services is a significant issue which emerged during this Child Practice Review.

Three months after moving to the residential home, the young person was found by staff in the bedroom of the home hanging. Emergency services attended the scene, and the young person was transported to hospital. Subsequently they died three days later.

Family engagement

Initial attempts were made to engage with the young person's family to discuss the review and its findings, these were not successful.

The professionals involved in this Child Practice Review agreed that making contact with the young person's family would be beneficial, to inform the findings of this report and contribute to the learning. Towards the latter part of the review, contact was made between the Panel Chair and the young person's mother.

The young person's mother felt that she had benefited from the more targeted support services, which were put in place to assist her. However, there were multiple issues within the family unit, which she was unable to resolve for herself and the young person.

The professionals involved in this Child Practice Review appreciate the comments which have been made by the young person's mother and these have formed part of this report. Understandably the emotional impact of the young person's death has been significant for the mother and other family members.

Significant events prior to review

The family were known to professionals as requiring additional support for a number of years prior to the start of the timeline. The family moved into the locality from another local authority area, where they were already receiving Social Services involvement. The family needs were complex and not understood immediately by professionals, meaning that agencies sometimes lacked clarity on what the issues were and how to address the family needs.

Significant events during review

- September 2018 - School note recent and historic self-harm cuts on the young person's arm.

- October 2018 - The young person reported to school that they had taken a number of pills and this is noted as an attempted overdose. The young person is taken to Accident and Emergency and a Safeguarding referral made. The referral is noted by Social Services for information.

  The young person is seen by CAMHS (Child and Adolescent Mental Health Services), whereby it is noted that they are described as feeling sad and

intent on ending their life. The young person is discharged with safety plan to care of mum and stepfather. A Wales Applied Risk Research Network (WARRN) risk assessment was completed by CAMHS and risk indicators identified which included:

- low mood
- impulsive behaviour
- difficulty with emotional regulation
- impulsive thoughts
- will not communicate with family members
- will not warn anyone of risk.

Later that month there is a 999 call made by family and the young person is reported as missing. The young person later returned safe and well. A Safeguarding referral was made by Police officers.

- November 2018 - The young person attended school and was very upset and was worried the medication prescribed to aid emotional regulation and low mood was not having an impact. They also expressed that they were tired of having suicidal thoughts.

  The young person reported to school that they had taken an overdose due to this low mood and suicidal thoughts. The young person attended Hospital where self-harm marks were noted and reported that they had self-harmed since the age of 13/14 years old. The young person was subsequently discharged to the care of their mother and stepfather, and Safeguarding referral form completed.

  Later that month the young person disclosed to the school that they had a plan to take their own life, had set a date but did not disclose further details. The Designated Safeguarding officer within the School appropriately shared this information, and a CAMHS appointment with the Consultant is arranged and the WARRN risk assessment is updated. The safety plan is discussed with the young person's mother.

  The young person also reported to school that they had attempted to take their life some days prior, however had stopped. This information was shared appropriately with CAHMS.

- December 2018 - The young person attended school and disclosed that they had drunk bleach and is taken to the Accident and Emergency Department at the hospital. The young person is subsequently discharged home to mother and safety planning discussed.

  Community Intensive Therapy Team (CITT) sessions commenced with clinical psychologist, following involvement with CAMHS. During this session, the young person makes disclosures regarding negative family dynamics at home.

- January 2019 - There is a physical altercation at home between the young person and mother and Police were called. Police attended address and

were told that razor blades were found in the young person's room. The young person remained at home and Police Public Protection Notice (PPN) submitted.

The CITT sessions continue and during a session the mother raised concerns regarding the young person's behaviour, the young person left abruptly during the session and was reported as missing to Police however is subsequently sighted safe and well. The young person later disclosed to school that during this time they had thoughts about jumping from a bridge. Consultant Psychiatrist submitted a Multi-Agency Referral Form (MARF), and this is noted on Social Services case records.

School note the growing concerns for the young person's safety, and there is an emerging pattern of increased concern regarding heightened anxiety building towards the weekend and the need to ensure sufficient safeguards in place outside of the working week.

The young person disclosed further periods of wanting to self-harm and school note two cuts to the neck, and they admit self-harming in school toilets. Appropriate liaison and activity took place following this incident.
999 call made by Stepfather reporting an argument between the Mother and the young person. He stated that razor blades have been found in the bedroom which had caused the start of the argument. Police attended the family home and the young person states they often feel sad and suicidal, and that they self-harm.
CIIT session and family intervention held and Psychologist submitted Safeguarding referral form. Concerns noted within the referral form were physical abuse, emotional abuse, and neglect.

The school note increased concerns heading towards forthcoming weekend, and the young person disclosed intent to self -harm. Arrangements were made to stay with a friend for the weekend.

Two parallel cuts are seen on the young person's neck, and the young person disclosed self-harming in the school toilets. Appropriate liaison took place and a risk management plan was put in place.
999 call received, and the caller described a dad who appeared to have thrown belongings out of a car, the young person's sibling was running away and him chasing.

CITT intervention and initial family therapy sessions were held, and the young person described that there is anger within the family home, and step father discloses incidents of physical abuse towards the children, and mother stated that there was difficulty communicating with the young person without anger or upset.

Further incident of self-harm is noted by the school including cuts around the neck area and inside of the arm.

Safeguarding referral is made by CAHMS and notes high level of tension and emotion within the family. Referral is allocated to Social Worker and strategy meeting is held between Police and Children's Services. Joint Section 47 investigation was completed, and it was agreed that further Police involvement at this time would be detrimental.

Police call out to home address and the young person had locked themselves in the bathroom and was threatening to smash up the property.

- February 2019 - Referral to Social Services from Mental Health Nurse regarding mother's own mental health and incident whereby she held a knife to her throat which the children witnessed.

  CITT and family therapy sessions continue and note that young person reported less family conflict and demonstrated good ability to express views openly.

  Sibling attends school with bruising, and S47 investigation commenced. A number of appropriate multi-agency actions are undertaken in response to this, included Child Protection medical, and joint Police and Social Services visit to the address. It is arranged for stepfather to reside elsewhere, and he subsequently received a caution for this matter.

  School phone 999 due to the young person disclosing having drunk bleach and alcohol before attending school that morning. Strategy discussion arranged in response to the incident. The young person was admitted into hospital and makes further attempt to self- harm with razor blade in hospital. Strategy meeting held at the Hospital and decision made to discharge the young person from hospital to reside with step grandparents as a temporary measure.

- March 2019 - School document a change to the young person's behaviour and mood; described as fluctuating between hyper-activity and depressive state. School also note further self-harming behaviour which include cutting clumps of hair and threatening to pour boiling water on hands.

  Decision made for the young person to be placed in the care of the Local Authority and become a Child Looked After. The search for an appropriate placement commences.

  999 call made at the home address alleging the young person's sibling had assaulted the mother.

  The placement with the step- grandparents ends, and they return to the family address. The young person expresses upset to school staff, stating they felt rejected and did not want to return home.

  An Initial Child Protection Conference is held, and the young person's name placed on the Child Protection Register under the Category of Physical and

Emotional abuse. During conference, school is noted as being a safe place and that the young person is protective of mother and siblings.

The young person was seen to be looking up topics of alcohol poisoning and chemicals in nail varnish remover on the internet at school, and subsequently disclosed drinking nail varnish remover that morning. The young person is taken to Accident and Emergency, and upon arrival was found to have concealed razor blade in underwear. The young person described this as a purposeful attempt to end their life. Discharge plan discussed with the young person and mother and stepfather, and the young person was subsequently discharged home.

Following this incident, there were discussions about the most appropriate placement for the young person and whether it would be suitable for them to move into a hospital facility placement, specifically for young people suffering with mental health problems. There were also discussions around accessing an emergency foster placement or a potential residential placement. Professionals identified that the young person's mother and stepfather may be struggling to provide a safe and secure home environment following this suicide attempt.

- April 2019 - The young person continues to actively engage with the CIIT worker and expressed hope that a move to the residential setting may assist. During the final session with the CIIT worker before the move, the young person is described as appearing bright in mood but nervous about the forthcoming changes. At this time the young person also disclosed a number of difficulties with their mother.

  The move to the residential home commenced at the end of April and the young person appeared to settle in well.

- May 2019 - A number of key worker sessions are held in the residential placement, and the young person engaged well and was open in discussing family and other matters that were of concern.

  A core group meeting is held, and the allocated Social Worker visits the residential home. The young person is described as in a happier mood, but stated they felt sad and expressed a feeling of responsibility towards mother and siblings now that they had left the family home.

  The young person showed scratches to their arm. Following a room check by staff, a safety pin was removed. A note was also found which stated that they hate life and want it to end.

  Letter between CAMHS services referring the young person for services in the area they are now resident in. Letter also sent to GP outlining medication and why it is prescribed, providing background information and requesting repeat prescription for medication.

A CAMHS appointment is scheduled later that month however is cancelled on the day by CAMHS.

Arrangements were made for the young person to sit exams in a school local to the residential placement.

- June 2019 - The young person expressed concern that they are not receiving the same level of support from CAMHS services in the new locality and asked to access the previous CAMHS intervention. The young person subsequently cancels their planned appointment.

  The young person disclosed to residential staff that they were tired of pretending to be happy and that they wished to end their life. The young person is subsequently observed with a blister on their arm caused by an aerosol spray, and days later they are observed to have superficial scratches on their arms. Residential staff continue to respond well, providing support and conducting room searches and removing items of concern.

  The young person spoke with residential home staff and indicated they were excited about attending their school prom, but also conflicted about seeing their mother and friends. Staff at the residential home noted the young person was sad and withdrawn leading up to this event.

  The young person attends the school prom in their home locality, and this was facilitated by the residential home staff.

  Within the residential home the young person is observed with fairy lights wrapped around their neck and described to be in a heightened and excitable state. Staff removed fairy lights and contacted GP for advice and support.

  The young person completes several drawings depicting people wanting to end their own lives and described these drawings as helping manage pressure inside their head.

  Social Worker maintained telephone contact and raised concern regarding the young person's low mood and suicidal ideation. Social Worker requested that the young person access Mental Health crisis team through A&E and also contacted CAMHS to advise them. They contacted CAMHS services in the new locality to enquire about crisis support available locally to the new placement. An appointment had been arranged for early July and it was agreed to wait until this assessment takes place to agree what support is available.

  The young person informed staff at the residential home that they had placed a bag over their head, and the bag was subsequently removed from the room.

- July 2019 - CAMHS appointment held within the new locality, with attendance supported by staff from the residential home. An initial

assessment was undertaken and the young person was asked to talk about their time in the residential home over the last two months. The young person stated that previously they were meeting with CAMHS three times a week and since moving to the out of county placement this interaction had come to an end.

Discussion within the residential home regarding a forthcoming planned visit for the young person to see family and to review risk assessment reflecting the observed change in behaviour following previous meetings with family.

Staff completed risk assessment and agree safety plan with the young person. During this conversation the young person stated they wanted less frequent contact with family, and a conversation between Residential home staff and Social Worker discussed this further.

Family contact session was held in family home following this risk assessment and safety planning and the young person subsequently returns to the residential home.
The following day the young person leaves the residential home and was found in a lane close by looking at the fields and livestock. Upon request they returned to the home and were under 15 minute observations by staff. Later that evening and during the ongoing observations, staff heard a noise from the young person's room and they were found hanging in their bedroom by staff.

The young person was taken to hospital and subsequently they died three days later.

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

As part of this Child Practice Review, a Learning Event was held via Microsoft Teams, for agencies who were directly involved in working with the young person. Also present at the Learning Event were the Panel Members who contributed to the merged timeline, to provide support to their colleagues from their own agency. The Reviewers would like to thank all those who attended the Learning Event for their contribution and identifying learning from this review.

- **Multi-Agency Working**

  There is a need for agencies to ensure they undertake a multi-agency approach, to carry out joint effective planning to ensure the young person's needs are fully met.

  The timeline shows that agencies involved with the family had received detailed information regarding the family dynamics and home environment. The learning event identified a number of areas of good practice where agencies were working together. Examples of this is, following an overdose incident and incidences where the young discloses that they had a plan to end their own life and the general decline in their presentation. School staff were able to recognise this and made the decision to contact CAMHS to discuss their concerns.

  The timeline also shows examples where multi-agency working could be strengthened. There appeared to be a lack of multi-agency working around the period of time where it was decided to transfer the young person to the residential home out of county. There seemed to be a lack of communication between agencies in trying to establish and plan what was required within the therapeutic environment for the young person and how to fully meet their needs.

- **Information Sharing**

  Agencies to be reminded that information in relation to safeguarding concerns are shared with other agencies. There is a need for clear and effective sharing of information and particularly in this case, where the young person experienced several changes and transitions in professionals working with them and their surroundings.

  Risk assessments were completed throughout the time working with the young person. It was acknowledged during the learning event that previously there wasn't anything in place to share these assessments with education or other agencies, unless prompted. Practitioners at the Learning Event expressed the need for WARRN (Wales Applied Risk Research Network) risk assessments to be shared with all agencies concerned as standard practice in future. This point had been highlighted in panel discussions prior to the Learning Event and Health have already changed their practices to ensure sharing of these risk assessments, with other agencies including Children Services.

  By the time a placement was found for the young person, there was a significant amount of information available with regards to the mental health needs of both the young person and mother. There was also a substantial amount of information about the family dynamics and home environment. Throughout the learning event it was highlighted that although each agency

involved with the young person held a large amount of information, it was difficult to establish a lead agency to bring all of this information together in one forum. Subsequently, the information held was not shared with the residential home, who were unaware of the extent of the family difficulties and the significant risks concerning self-harm that had previously taken place, in respect of the young person being placed. This case would have benefited from the sharing of risk management plans to ensure the child was effectively safeguarded.

- **Moving to other Local Authority Areas**

  When moving a child or young person out of county agencies must work together to plan and implement a smooth transition. Ensure there is clear communication and transfer of information, through a multi-agency panel consisting of agencies in both Local Authority areas. Consideration to be given to the education, mental health and medical needs in order to respond to any identified risks.

  In this case, the young person was transferred to a residential placement in another Local Authority area. This was mainly due to there being no appropriate placements within the locality. In the short time before the move took place, there was a lack of communication between agencies and time, due to the escalating concerns for the young person to plan a smooth transition. Concerns were raised at the learning event in relation to the medical needs and education requirements of the young person and when placing a child or young person out of county, clarification is required on who holds responsibility for ensuring the transition is successful.

  A referral was sent to CAMHS in the new Local Authority area, containing information on risks, level of safeguarding concern for the young person and their currently prescribed medication. A hard copy of the WARRN risk assessment was requested by the Social Worker to hand-deliver to the residential home, however the residential home did not receive this information. It was unclear at the learning event, what had happened to this information.

  Clarification is required around the entire process, including the procurement of appropriate placements when moving a child or young person to another Local Authority area and how agencies should work together to ensure a smooth transition.

- **Quality and Accuracy of Information**

  Agencies to ensure quality and accuracy of information and referrals made in relation to safeguarding concerns and potential risks. There is also a need for agencies to consistently complete the Multi Agency Referral Forms (MARF), every time an incident occurs and ensure sufficient detail is included within these referrals.

In some instances within this case, safeguarding referrals were submitted where there was a lack of information and in one instance a referral was submitted containing a single sentence. This does not provide enough information and as a direct result potential risks may have been overlooked. The quality of the information shared with agencies and within safeguarding referrals, enables us to create a full and holistic picture, including understanding the family dynamics and the mental health needs of the young person and their mother in this particular case. Agencies and professionals are faced with growing pressures and demands on their services, however there is significant importance in referrals being submitted in emergency situations, which contain vital information for risk management.

At the learning event the quality of the information in referrals was discussed. Representatives from Education stated that learning identified for their organisation is to submit a MARF following every incident that occurs, despite the submission of previous safeguarding referrals.

- **<u>Person and Family Centred Approach</u>**

  Agencies to establish, understand and implement approaches based on the young person and family needs. Parents need access to assessment and support to assist them to understand how they can provide effective emotional support and safeguard their children.

  In this case there were growing concerns from several agencies regarding the decline in the young person's presentation. There were several indicators that the mother of the young person was suffering with her own mental health concerns and possibly not able to provide adequate emotional support to the young person. Although these concerns existed, the young person was repeatedly returned home into their mother's care. This was discussed at the learning event, however it is not clear whether the mother was receiving appropriate support for her own needs.

  In the learning event is was highlighted that the young person began engaging in the CITT and family therapy sessions and disclosed incidents of historical physical abuse within the family unit both towards them and directly impacting their mother. The step-father made disclosures about violence towards the children at home. The mother also disclosed that the young person would disappear from the family home for long periods of time and not return until the early hours of the morning and she did not know how to manage this. Education stated that the mother had attended the school while emotionally distressed and had broken down. There was a picture building of how the family were unable to support the young person and their escalating needs and in order to safeguard the children, a holistic approach was required. There was a pattern emerging where there were several suicide attempts made by the young person, which appear to have been triggered by the stress and incidents that occurred within the family home. There was also a pattern emerging of increasing concerns prior to the weekend.

At the point where the young person went to stay with the grandparents, Education stated they were more settled and started to talk about progressing with exams and finishing school. School was a protective factor in this case and provided the support and safe environment required for the young person. This should have been considered when decision-making was being carried out for a placement outside of the Local Authority area.

- **<u>The Voice of the Child or Young Person</u>**

  Agencies to ensure that the voice of the child or young person is considered when dealing with safeguarding concerns. All agencies should aim to ensure that children, young people and their families are listened to and are enabled to fully engage and this be consistently reflected in their care planning.
  It was clear from the practitioners throughout the learning event that the young person would engage with professionals and had built positive relationships. Although, there were occasions when the young person admitted to lying to everyone and only telling professionals some of their thoughts and not everything they had been thinking and feeling. The young person also stated they felt they were not included or consulted in the development of safety plans.

  In this case the young person and one of their siblings attended the initial case conference meeting. This was intended to include the voice of the child but as the Wales Safeguarding Procedures state, attendance alone at a conference is not participation or giving the child a voice. This experience caused a considerable amount of distress to the young person. There were lots of professionals present, many of whom were unknown to the young person and their sibling. The meeting meant the young person was listening to conversations about themselves and their family, resulting in them becoming very protective of their mother. At the learning event, discussions took place about how the child's voice is included in this process, however consideration needs to be given on any impact this may have on the child or young person. It was proposed they may not need to attend the meeting and if they do, that a de-brief should be provided to discuss their thoughts and feelings following the experience.

  It is expected practice that a child has the option to take an advocate with them to a case conference, who may speak on their behalf and support the child or young person. This is usually offered at the time where the child or young person is being considered to attend a case conference. Following the learning event, panel members discussed whether some form of preparation could be carried out with the child or young person and a session for them to articulate their views to an NYAS (National Youth Advocacy Service) advocate who would represent them at a case conference meeting.

- **A Child or Young Person should not have to re-tell their story**

  Agencies to be aware of the impacts on children and young people when they transition between working with different agencies or move to another Local Authority area. The child or young person should not have to keep re-telling their story.

  There were several professionals who worked with the young person, who were starting to develop a full picture of them and their family life. The young person had disclosed they were scared of working with new professionals and agencies, prior to moving to the residential home. Also, the young person stated they were 'sick of speaking to different people'. Following moving to the residential home, the young person cancelled an initial appointment with the CAMHS services in the new locality. The young person advised the residential home staff that the reason for this was that they did not want to repeat their story again.
  At the learning event, transitions were discussed and how there is now a young person's passport, which belongs to the young person and they can share this with professionals when transitioning to a new location. The young person should not have to repeat their story unnecessarily, the use of a passport will enable a smooth transition process and handover of their care arrangements, providing professionals with context without the young person sharing.

Effective Practice

- School provided the protective factors for the young person. School staff maintained a good relationship, communicated consistently and effectively with them, meaning they were able to identify when there was a decline in the young person's presentation.

- The residential home staff were organised and communicated effectively with emergency services when faced with a challenging and emotive situation.

- Welsh Ambulance Services NHS Trust attended the residential home promptly and maintained communication with the residential home staff, in spite of several challenges.

- It was demonstrated that the intensive CAMHS care the young person received prior to being moved out of the area was effective. This shows effective practice and there was a good working relationship between the young person and the professionals involved at that time.

- Police Officers continued to search and make enquiries to find the young person, when they had been reported as missing. For some Officers this was outside of their working hours and when they were considered to be off duty.

Practice improvements from early learning

The following information displays changes and improvements to agencies practices, which have been implemented during the process of carrying out this Child Practice Review. Agencies had already identified where changes could be made to their services internally and these were highlighted as part of the panel meetings and at the learning event.

- WARRN risk assessments are now being shared for concerns about young people who are known to both CAMHS and Children's Services.

- Children Services have changed their referral forms to focus more on the child's lived experience. The Multi-Agency Referral Forms (MARF) are now screened by a Team Manager.

- The residential therapeutic care home no longer accept a placement of a young person without the full information surrounding the young person's circumstances. The therapeutic programme provided by the home can take place over an eighteen month period. Having reviewed their admissions procedure and following guidance, regarding education transfer, the home have indicated they would not generally accept placements for young people who are close to their sixteenth birthday or after this date.

- Where a child is now transitioned to an out of county placement, Children Services have introduced a 'Brighter Futures' panel, which is a legal obligation and part of the care planning regulations. This allows senior management within Children Services the oversight on some of the out of county placements. Also, a 'Starting Well' partnership is currently being developed, where delivery groups are taking forward priorities to join up emotional mental health services for infants, children and young people.

- Welsh Government recently consulted on 'Transition and Handover Guidance'. Included within this document was the need for a 'Passport' to be held by the young person. This will include information about what is important to them, the care and treatment required and expected health and well-being outcomes. This will allow the young person to transition between agencies or to a new placement without the need to constantly re-tell their story.

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:-

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

Recommendations:

- **Multi Agency Working Chronology**

  A child or young person who is being considered as a child looked after and where placements are being sourced, should have a shared multi-agency chronology. Each agency should prepare their own chronology, which will detail significant events in the child or young person's life and will ensure that no information is lost, which could have a detrimental impact on them being safeguarded. The chronology should detail the risks and triggers for the child or young person and should be shared with agencies who will have direct involvement, to ensure they can plan and respond effectively. This should be considered at the time of making a decision on a placement and sent to the proposed placement in order for them to assess whether they are able to meet the child or young person's needs. This model should be audited to ensure its quality and effectiveness.

- **Transfer of Services and Care Arrangements**

  All agencies should review the multi-agency arrangements for information sharing and planning for an effective transition of a child or young person into an out of county therapeutic placement, to ensure it is fit for purpose. There should be a responsibility on the placing Local Authority to provide all the necessary information to safeguard the child or young person. This may include comparing risk management plans to ensure they are fit for purpose in respect of the risks highlighted.

  All agencies to be accountable for the transfer of services and care arrangements. No service should discharge their involvement until the receiving area has engaged and there is a continuous service between local authority areas. Use of a multi-agency checklist ensuring that every aspect of work is handed over to the receiving Local Authority area and allows agencies to take responsibility and ownership of the tasks, which will provide a smooth transition.

Where there are issues meeting the service delivery within the new local authority area, there should be a clear escalation route in these instances. All agencies will be accountable for their own transfer of service and take the lead on implementing a transition plan for continuous service delivery in receiving area, whilst trying to minimise any delays in service.

- **Voice of the Child or Young Person**

  All agencies to ensure that a child, young person and their families are listened to and are able to fully engage in the care planning process. All agencies to review what is currently in place to ensure the voice is captured at all stages of working with a family.

  All children and young people who are being considered to attend a child protection case conference are to be offered an advocate as standard practice. Where the parents have legal have responsibility for the child or young person, appointing an advocate should be discussed with them and also with the child or young person. The child or young person should be given the opportunity to articulate their views and feelings to the advocate in preparation of a case conference meeting.

- **Informed Practice**

  All agencies to receive training and fully understand the relevance of Attachment theory, Trauma, and Adverse Childhood Experiences (ACEs) and for this to be evidenced as embedded into practice.

  Practitioners should clearly demonstrate throughout their practice an awareness of the significance of these theories, and that they are using an informed approach when assessing and monitoring risks of a child or young person.

Next Steps

Following on from the completion of this report, the next stage will be for the panel to reconvene, consider and agree any learning points which will be incorporated into an action plan. The action plan process will focus on more specific and targeted actions from the learning which has taken place throughout the review. Along with the specific actions which are required, these will be assigned to a group or agency who are responsible for ensuring the actions are achieved and outline a set timeframe for the actions to take place.

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 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		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	
Reviewer 1 *(Signature)*	D Hatcher	**Reviewer 2** *(Signature)*	……
Name *(Print)*	Danielle Hatcher	**Name** *(Print)*	……
Date	23 May 2022	**Date**	……

Chair of Review Panel (Signature)	……
Name *(Print)*	Chris Alders
Date	2 May 2022

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult/Child 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.*
☐ Family declined involvement

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	☐	☐	

Terms of Reference for a Child Practice Review (Extended)

Re: CPR 04/2019

Introduction

An extended child practice review will be commissioned by the Regional Safeguarding Childrens Board (RSCB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. An extended child practice review will be commissioned where an child at risk has, 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 **30 June 2018 – 31 July 2019**
- The following services will produce a timeline of significant events of its involvement with the Child, for the timeframe above.

  - SWP
  - Dyfed Powys Police
  - Health/CAHMS
  - WAST
  - Cardiff Education
  - Cardiff Children's Services
  - Birribi

  A merged timeline will then be produced.

Core Tasks (for an extended Child 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 including coroners investigation or proceedings related to the case.

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

For Extended review ONLY. In addition to the review process, to have particular regard to the following:

- Whether previous relevant information or history about the child at risk and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child at risk, the family and their circumstances. How that knowledge contributed to the outcome for the child at risk.

- Whether the actions identified to safeguard the child at risk were robust, and appropriate for that child and their circumstances.

- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.

- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the child at risk. Whether the protocol for professional disagreement was invoked.

- Whether the respective statutory duties of agencies working with the child at risk and family were fulfilled.

- Whether there were 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).

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 Case Review Group, produce a timeline and an initial case summary and identify any immediate action already taken.

- 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 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 Case Review 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 Board (RSB)

- 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 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.