Child Practice Review Report

Child Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Extended Child Practice Review

CTMSB 02-2020 Child M

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 has been undertaken by the Cwm Taf Morgannwg Safeguarding Board in line with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 2".

The guidance states that:

> A Board must undertake an Extended Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:
>
> - died; or
> - sustained potentially life-threatening injury; or
> - sustained serious and permanent impairment of health or development; **and**
>
> the child was on the child protection register or a looked after child on any date during the 6 months preceding the date of the event referred to above; or

The purpose of a Child Practice Review is to identify multi-agency learning for future practice.

The circumstances of this case are as follows:

M was a 16-year-old young person who, at the time of his death in 2019, was accommodated by the local authority under section 76 of the SS&WB (Wales) Act 2014. M was placed in an unregistered placement and received 15 hours of 2:1 social care support per week.

M experienced adverse childhood experiences, including neglect, throughout his life. Two half siblings were born into the family when M was 3 years old and 8 years old. There was a stark difference in how M was treated by his mother and stepfather in comparison to his siblings.

There was evidence of M frequently appearing unkempt, with dirty clothes, which was in total contrast to his siblings. He was told off for eating 'good food' meant for the siblings and was made to feel a scapegoat for family problems.

He was in and out of care throughout his short life and in one year he experienced 9 placements.

At the age of 14, an Enhanced Case Management report, completed by a clinical psychologist, found him to be physically appearing his age. However, his cognitive functioning was described as being comparable to an 11 year old and his estimated development age for social and emotional skills was comparable to a much younger child.

When his grandmother passed away in 2017, M experienced hostility and overt rejection at the funeral by the family. This resulted in him choosing to leave before the service commenced.

The timeframe for this review focused on a two-year period preceding his death, when his behavior deteriorated, resulting in numerous court appearances, missing episodes and numerous placements including back to his mother when nothing else was available. There were significant concerns each time M returned to the care of his mother, linked to neglect and emotional harm.

The Coroner's Inquest into M's death concluded that he died by his own hand, but there was insufficient evidence to establish intent on his part.

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 the Child Practice Review process, a multi-agency learning event was held with practitioners who had been involved with M and his family. The timeline of significant events was shared with practitioners who had the opportunity to identify learning, areas of effective practice and areas for improvement.

Attempts were made to engage with members of M's family to gain their views, however they did not respond.

The reviewers identified three key learning points from within this practice review:

Learning Point 1: The Importance of Permanence Planning

M's lived experience appears to be one of chaos and crisis and despite many professionals working together to offer an intervention to keep him safe, this was seemingly crisis led, with professionals dealing with each incident in isolation as it occurred. This resulted in ambiguity for M in the absence of personal and placement permanence arrangements.

Despite mother's inability to provide safe and consistent care to M, he was returned to her on numerous occasions as no alternative placements were identified, which would have been in his best interest. M was often reported to say he wanted to stay in care and a comment made by M about 'homes dropping him off at his mothers' had clearly become an inappropriate pattern of behaviour that he anticipated.

An Enhanced Case Management (ECM) Formulation[1] report prepared two years prior to his death noted "*There is a substantial risk of further emotional harm and rejection being caused to M should he return to his mother's care*" reinforcing his feelings of rejection, his style of attachment and his trust in professionals. This report resulting from the ECM process should have been an integral part of all of matters concerning M's care, emotional wellbeing and therapeutic planning within an overarching consideration for permanence. The report should have informed ongoing care planning and ensured that all practitioners from different services were coordinated and consistently using a trauma informed approach.

As a result of the formulation report not being the primary focus within the numerous multi-agency forums held to discuss M (Children Looked After meetings and Child Protection Conferences), the recommendations within the report and direct work were not able to be undertaken with Child M due to identified barriers around lack of attachment and permanence, which were a prerequisite of the trauma-informed model.

Despite the content in the formulation report and M's mother's inability to meet M's needs, social services still pursued a reunification plan to her care. This lack of permanence planning will have contributed in part to M's instability, chaotic and risk-taking behavior, poor attachment, and emotional wellbeing. The combination of these factors accumulated in the time prior to his death, resulting in a deterioration of M's mental health, emotional wellbeing, and resilience.

The messages to M about his permanence remained ambiguous, with him being told that he would return home, only for this decision to be changed and then changed again. M consistently stated he wanted to be in care however his actions led to each placement ultimately breaking down and his desire to be in his home area with his acquaintances superseded any professional advice regarding the associated risks.

M had 6 social workers during his last period of child protection registration. Although there was good evidence of agencies trying to engage M, we have to question whether the focus on the formulation plan itself was diluted as a result of the changes in allocated social workers.

During the period of CP registration experienced by M (covering 2 years) and up until the date that M died, he had 5 periods of being looked after, with placements lasting a few months at a time and him returning to parental care throughout, as no alternative placements could be identified. The parenting assessment of mother's ability to safely meet M's needs was not initially concluded and it is unclear how long it took to complete. Once it was finalised, it was recognised that she was not able to consistently meet M's needs and it was recommended that he should remain looked after. However, M did return to mother despite this recommendation.

There is substantial evidence of repeated searches being made for a placement for M. Fostering and residential searches were made, both framework and non-framework and in a 3-year period, 36 separate searches were undertaken (32 of which received no response), which made the task of finding M a suitable placement outside of his family, impossible at times. As an illustration, a placement search undertaken for M 4 months prior to his death, resulted in 45 negative responses and no offers.

Despite this exhaustive cycle of searches and poor alternative care options available to M, there appears to have only been one Public Law Outline (PLO)[2] threshold meeting held a year prior to his death. Whilst the record indicates the threshold was met, there is no evidence that

[1] An Enhanced Case Management meeting involves a psychologist and focusses on development causes which have given rise to current problems

[2] The Public Law Outline (PLO) sets out the duties local authorities have when thinking about taking a case to court to ask for a Care Order to take a child into care or for a Supervision Order to be made

this progressed or further reviewed within the PLO process, resulting in the cycle of reactive and crisis management continuing to facilitate M returning to his mother.

There is no evidence that secure accommodation was considered during the period of registration despite the escalating risks, which may have provided M with an opportunity for security and stability, to help him achieve the outcomes set out in his Care and Support Plan. It is important to adhere to practice around PLO threshold review. This would have helped to manage the cycle of reactive and crisis management and would have provided an opportunity to explore and secure permanency for M.

Learning Point 2: The Importance of Escalation and Professional Challenge

Whilst there were a significant number of PPNs[3], C1s and incident reports recorded against M's records, there was no evidence of challenge from other agencies that M's child protection plan was ineffective. Likewise, there was no evidence of agencies escalating concerns via their own internal procedures or via the Safeguarding Board's professional differences protocol (otherwise known as the CRISP) to escalate concerns of drift or ineffective planning. Practitioners in the learning event noted that they were not clear about how to approach the CRISP protocol.

Whilst there is evidence that the Independent Reviewing Officer used the local authority Resolution Process to escalate concerns on three occasions, they were not escalated to Stage 2 as Child M ceased to be looked after. Child M remained on the Child Protection Register (CPR), however, there is no evidence that the Safeguarding Board's Challenging Cases Protocol (which has since been replaced by the Core Group Guidance) was considered by the Conference Chair or Core Group members to escalate the increasing risk. The protocol could have been applied at any stage during the child protection process, at any point of involvement and regardless of the length of time M had been on the CPR. The Challenging Cases Protocol also recommended that in a Tier 1 or Tier 2 meeting, due consideration should be given to inviting legal representation from the local authority's legal department and a police representative, if there was significant involvement. Had this guidance been used by the Chair and/or Core Group members it may have allowed a holistic multi agency oversight of the risk of significant harm

The local authority Placement Panel is a weekly meeting attended by Heads of Service for Children and relevant Service Managers. Where required other staff attend by invite. The purpose of the panel is to agree appropriate placement for the child/young person, including a Family Arrangement, scrutinise and challenge unplanned admissions to care, ensure that all internal processes and procedures have been followed to manage risk and the required resources are made available to enable the child/young person to remain safely within their family and to reduce drift and delay in care panning by monitoring placement timescales. Senior managers were in situ at key meetings/panels considering M's case. M was discussed in placement panels when placement searches were underway, these meetings were attended by senior managers. There is no evidence of any further escalation meetings.

The reviewers found no evidence of any internal or external professional challenge to thresholds/decision making and the formulation plan was never considered to evidence the need to challenge decision making.

There was an occasion when M was placed in an out of county placement where a professional concern was referred to the hosting authority. The hosting authority considered the referral and

[3] Public Protection Notice

recorded that the threshold was not met for a professional concern. No professional challenge was made to the hosting authority regarding this decision however a child protection strategy discussion was held to consider the risk to M. There were no other strategy meetings held, including in regards his missing episodes during the time he was in this placement.

Some of the practitioners at the learning event raised that they did not have all the information from the formulation report available to them at the time, and if they had been in receipt of this information, they would have felt more able to challenge case management decision making. However, the reviewers have noted that the report was available as part of the multi-agency child protection and children looked after planning processes.

Theme 3: The Importance of Record Keeping, Decision making & Accountability

It is evident that during this review period there was critical information relating to M that was not recorded on the Welsh Community Care Information System (WCCIS) and therefore it is in question whether decision making at times may have been partially informed or risks minimised due to gaps in information. This information may have been crucial in accumulating evidence to reflect the lived experience of M and the presenting risks to keep M safe, including the risk of self- harm.

To note is that professionals or the allocated social worker involved with M may not have been aware or privy to the full extent of the information relating to M's mental health and therefore may not have had a full understanding of the emerging concerns about M's mental health. It is evident that some of the key areas of concern related to his mental health were not recorded on his file and it appears that some agencies had records of information that was either not shared or recorded on M's WCCIS file. Had this information been readily available and accessible, then this may have provided a more in-depth understanding of the presenting risks in respect of M, linked to self-harm and suicidal ideation. It appears that there was evidence accumulating that may have been a predictor in his ability to cause serious harm to himself. An opportunity was missed for multi-agency information sharing via the Safeguarding Board's escalation processes.

Despite there being numerous meetings held to discuss M, i.e. Child Looked After Reviews, Child Protection Conferences, Placement Panel and Youth Offending Service High Risk Panel, there was insufficient evidence of information sharing between these forums.

AREAS OF GOOD PRACTICE

- All front-line staff working with M made a concerted effort to support him, and should be commended for their work, investing a significant amount of time in working with him
- There were elements of good inter-agency communication and attendance at meetings
- Professionals actively sought the wishes and feelings of M in his care planning and encouraged him to participate in meetings
- Police responded to all reported incidents of concern and submitted a PPN where appropriate.
- There was a good relationship established between M and his YOS worker, to the point where he completed the Intensive Supervision and Surveillance period of his order successfully

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:-

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

Learning Point 1 Recommendations:

- The child's wellbeing should be central to the decision making involved in identifying realistic permanency options
- Updated plans to support placement should be informed by the child's multi-agency chronology, specialist reports, assessments, and research relevant to the child's specific circumstances.
- Clear handover arrangements should be in place when cases are transferred between teams and when there is a necessity to reallocate cases to a newly appointed worker.
- The evolving view of the child should be obtained, recorded and carefully considered as a critical element to permanency planning.
- A clear decision needs to be made by professionals regarding the use of the 'Enhanced Case Management' model and subsequent Formulation Reports, and clear communication provided to multi agency forums as to whether or not they will be used to inform care planning in the case, and/or a trauma informed approach.

Learning Point 2 Recommendations:

- Where a Care and Support Protection plan is not keeping the child safe all involved professionals have a responsibility to challenge using existing processes.
- IRO Resolution Processes should be used and followed by IROs, in line with their role and responsibilities.
- Proper consideration of Section 5 of the Wales Safeguarding Procedures (Concerns about Practitioners and Those in Positions of Trust) and Section 3 part 1 (Responding to a report of a child at risk of harm, abuse and/or neglect) must be followed.

  Where those concerns relate to a child placed in another local authority and the proper procedures are not followed, challenge must be made from the placing authority or other involved agencies towards the hosting authority. Challenges through Regional Safeguarding Boards can be used if necessary.

Learning Point Theme 3 Recommendations:

- Agencies to provide the CTMSB with assurances that record-keeping is robust and provides clarity of context, incorporates the voice of the child and includes records of decision-making

Statement by Reviewer(s)

REVIEWER 1	Eirian Evans	**REVIEWER 2**	Please see note in CPR process section below
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)*		**Reviewer 2** *(Signature)*	Please see note in CPR process section below
Name *(Print)*	Eirian Evans	**Name** *(Print)*	
Date	17/8/2022	**Date**	

Chair of Review Panel (Signature)	Jon Eyre
Name *(Print)*	Jon Eyre
Date	17/8/2022

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Child Practice Review process
To include here in brief:

- *The process followed by the RSB 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 review was carried out in accordance with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3" guidance and a Panel was convened attended by senior representatives of the following services/agencies:

- Children Services
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance NHS Service Trust
- YOS
- South Wales Police
- Education
- Barod Cymru

An Independent Chair and two Independent Reviewers were identified to oversee the Panel process and complete the Review. Unfortunately, the second reviewer, became unavailable at the final report stage, hence why there is only one reviewer named in this report.

A Learning Event was held on 16th September 2021, a little later than planned due to Covid-19 and attended by professionals involved in the case, representing the services/agencies as mentioned above.

Significant attempts were made to engage with family members via post which was unsuccessful.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to RSB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Appendix 1 - TERMS OF REFERENCE

EXTENDED CHILD PRACTICE REVIEW PANEL CTMSB

Case Reference details
Child M CTMSB 2/2020

Circumstances leading to the CPR
Child M was a 16 year old young person whom, at the time of his death, was accommodated by under section 76 of the SS&WB (Wales) Act 2014. Child M was placed in an unregistered placement and received 15 hours of 2:1 social care support per week. Child M completed suicide whilst in the care of the local authority. The case meets the criteria for a child practice review and there may be learning in respect of the understanding of needs, accommodation and support for vulnerable children from all agencies.

Agencies Involved
The following agencies were involved with Child M and will be completing a timeline and analysis of their involvement:

- Childrens Services
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance NHS Service Trust
- YOS
- South Wales Police
- Education
- Barod Cymru

Core Tasks

The Core Tasks of this Child Practice Review Panel are to:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the 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

For extended reviews, in addition to the standard review process, to have particular regard to the following:

- Whether previous relevant information or history about the child and/or family members was known and taken into account in professional's assessment, planning and decision-making in respect of the child, the family and their circumstances. How that knowledge contributed to the outcome for the child
- Whether the actions identified to safeguard the child 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 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. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the child 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 the child practice guidance
- Agree the time frame
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken
- Produce a merged timeline, initial analysis and hypotheses
- 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 family members prior to the event
- Receive and consider the draft adult/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 CTMSB 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

Any Parallel Reviews or Other Such Activity to be Noted
None recorded.

Timeframe for the CPR

The timeframe set for the Review is August 2017 to September 2019. Summary reports to be completed prior to this.

Learning Event

The learning event will ensure that the voice of practitioners directly contributes to the review and that practitioners can hear the perspectives of the family. Practitioners and managers are expected to attend if asked. All practitioners will reflect on what happened and identify learning for future practice.

The Review Panel has responsibility for supporting the reviewers in carrying out an effective learning event.

Tasks of the Safeguarding Board

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

Appendix 2 - SUMMARY TIMELINE

September 2018	Concerns around relationship with adult carer, C1 submitted, strategy meeting held, S47 initiated then closed and agreement to monitor via CP
October 2018	Returned to live with mother
November 2018	Moved to time limited placement 2:1
January 2019	Returned to live with mother
March 2019	Case transferred to 16+ Team
May 2019	Moved into unregulated semi independent placement
July 2019	Grandmother passed away. Concerns re self harm and missing episodes
August 2019	Numerous MISPERs
Sept 2019	Subject deceased