Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

EXTENDED CHILD PRACTICE REVIEW

CHILD M

1 Background

M was a 16-year-old young person who, at the time of his death, 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 was in and out of care throughout his short life and in one year he experienced 9 placements.

2 Context

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.

3 Key Learning Points

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 permanence arrangements.

The Importance of Record Keeping, Decision making & Accountability - there was critical information relating to M that was not recorded on WCCIS and therefore it is questionable whether decision making at times may have been ill-informed or risks minimised due to gaps in information

4 Key Learning Points

The Importance of Escalation and Professional Challenge

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.

5 Effective practice:

- All front-line staff working with M used a concerted effort in supporting him
- 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

6 Recommendations:

- Child's wellbeing should be central to decision making in identifying realistic permanency options
- Updated plans to support placement should be informed by the multi-agency chronology, specialist reports, assessments, and research relevant to the child's specific circumstances.
- Handover arrangements should be in place when cases are transferred between teams & 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.

7 Recommendations:

- Where a Care and Support Protection plan is not keeping the child safe all professionals have a responsibility to challenge.
- 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)
- 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