CHILD PRACTICE REVIEW REPORT CHILD Y

Cwm Taf Morgannwg Safeguarding Board
Extended Child Practice Review

CTMSB 04/2022

Practice and organisational learning

Practice and organisational Learning

Covid-19 impacted making informed and accurate assessments of young people in the school environment. Attendance was inconsistent due to periods of isolation which meant that Child Y was not seen as consistently as he would have been under non-Covid-19 circumstances. Concerning behaviours were evident pre-covid, and although school recognised his vulnerability, it is possible that the level of vulnerability was not recognised during this period because he was perceived as one of many children who were struggling with the situation and displaying similar behaviours.

An opportunity to assess Child Y's safety and wellbeing within the family arrangement was missed when the injury of another child within the household did not progress to a S47 investigation. When the concerns about potential non-accidental injury disappeared, it seems that all other concerns relating to Adult A's historic convictions, domestic violence and child protection disappeared also.

Adult A was perceived as a reliable narrator of events, and Child Y's mother was perceived as an unreliable narrator, possibly because of her mental ill-health. Adult A's narrative dominated, and this clouded initial judgement about the potential risk that Adult A posed to Child Y and the other children in the household, despite evidence of coercive control of Child Y's mother and violent offending in the past.

The child protection medical was delayed and the presence of Adult A enabled him to provide a narrative about Child Y's injuries and appeared to influence Child Y's conduct when questioned.

Child Y's mother was villainised, and her views about the longer-term care of her son were dismissed or ignored.

Significant weight was given to Child Y's wishes and feelings about whom he lived with, without sufficient exploration of what was motivating him.

Though some individuals in different agencies were speaking with each other, a forum for systematic multi-agency information sharing was not present outside of the Child Protection or Child Looked After reviewing process**.**

There was a four-week timescale to complete a Parenting Assessment within the

Family Court proceedings. This is much shorter than the usual time allowed, and there was an absence of challenge to the Court.

Assessments were insufficiently analytical and did not look in depth at the complexities of the adult relationships, Child Y's needs, and little attention was paid to Adult B's parenting, whilst attention was given to finding what was positive. Gaps in assessment were not challenged.

it is not evident that there was sufficient managerial oversight of the assessment, or that there was time given to reflective discussion about the complexity of the situation. An opportunity within the Local Authority Children's Services for senior managerial oversight of the plan was missed - Adult A's criminal history was not presented to the Agency Decision Maker because it was not necessary to do so when Adult A was no longer being considered as a foster carer for Child Y.

The planning for the transition of Child Y from foster care to Adult A was undertaken against a backdrop of significant pressures on finding and keeping suitable placements for children and young people who are looked after by local authorities. Significant efforts were being made to maintain Child Y's second foster placement, and it would not have been easy to identify and maintain another suitable placement to meet Child Y's particular needs.

Insufficient arrangements were in place to support a transition from foster care to Adult A; not enough time was allowed for a phased increase of contact and overnight stays before Child Y returned to live with Adult A.

After a significant event involving another child in the household, a multi-agency strategy discussion including health should have taken place earlier in the day, and this might have influenced the decisions that were taken to leave the children in the care of Adult A and Adult B.

Processes for young people in custody are not child focused in unusual circumstances. The placement options were restricted because only some information could be shared with providers due to their being a live police investigation. Furthermore, specific restrictions were imposed by the Court which further limited the type of placement that could be identified. This meant that Child Y was in police custody for longer than would be usually expected.

Areas of effective practice

During the Covid-19 Pandemic, school maintained regular communication with Child Y's mother, and kept him in education through the provision of work to do at home, or in school hubs. The positive educational input was maintained despite various challenges with Child Y's conduct. During November 2020, Adult A contacted the school to say that he was unhappy with the school plan and that he wanted to be the first point of contact. The school response was appropriate and did not agree to have individual meetings or calls with Adult A and kept Child Y's mother as the primary contact. School maintained regular contact with Child Y's foster carers, and they worked together to manage Child Y's behaviours.

Generally, Police Protection Notices were appropriately submitted to Children's Services, and information relating to potential risk was shared between these agencies. Police officers were responsive when contacted, shared information, made welfare checks, and liaised with Children's Services about case management arrangements.

There was regular contact between the mental health unit and MASH/Children's

Services where information was shared about disclosures made by Child Y's mother.

In January 2021 when it was concluded that due to the concerns for Child Y's safety, and because Adult A did not have parental responsibility for Child Y, the Local Authority made an urgent application to the Court, requesting an Interim Care Order and that Child Y be placed within the care of the Local Authority.

Attempts were made to support Child Y's mother with the recovery of bank cards that Adult A refused to surrender, and in finding out about housing options. The Adult Social Care Team sent a further 'opt in' letter to Child Y's mother on 13th August 2020. The team had received a PPN regarding Child Y's mother on 15th March 2020 and an Opt in Letter offering assessment and support was sent out, but due to the onset of Covid Lockdown, the case was left open. The extended period to opt-in to services was a good safeguard due to the unprecedented impact of Covid.

Relevant information about Adult A's history was shared with Adult B, so that she could be informed and make decisions relating to her own safety, and that of her children. MARAC[1] referrals were made in respect of Child Y's mother, and Adult B.

Child Y's social worker recognised his conflicted feelings, and ensured he knew that he could establish a level of contact with his mother when he was ready to do so.

Child Y's Guardian engaged with him regularly to discuss his wishes and feelings, introduced him to his solicitor, and arranged for him to meet the Judge.

Efforts were made to support placement stability for Child Y through the provision of a reunification worker, and placement stability meetings, when it was evident that the foster carers were struggling with Child Y's behaviours. At the time that Child Y was allegedly assaulted by his mother's partner, the foster carer concerns about vulnerability and potential exploitation were shared with the social worker, and then the police, and the issues were enquired into.

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: -

The following key points of learning and recommendations are made:

<u>Key learning point 1</u>

Though some individuals in different agencies were speaking with each other, a forum for systematic multi-agency information sharing was not present outside of the Child Protection or Child Looked After reviewing process, meaning information from other services or agencies involved with the adults was not systematically shared and used to inform assessment. Assessments were insufficiently analytical and did not look in depth at the complexities of the adult relationships, Child Y's

[1] Multi Agency Risk Assessment Conference – this is a meeting where information is shared on the highest risk domestic abuse cases.

needs, and little attention was paid to Adult B's parenting, whilst attention was given to identifying what was positive. Gaps in assessment were not challenged. Child Y's mother was ignored and did not have a voice; she was perceived to be untruthful about various matters, so her narrative was not seen as credible. Significant weight was given to Child Y's wishes and feelings without sufficient exploration of what was motivating him.

Recommendation 1

Multi agency training on assessment is needed to address the following areas:

- Identifying gaps in knowledge and information, and recording the implications of this for the assessment
- Determining the credibility of information and balancing competing and conflicting information through processes of testing assumptions and beliefs, checking and challenging information, and documenting rationale for conclusions and decisions
- Taking an exploratory approach that applies curiosity about the motivation underpinning what children say, whilst maintaining a rights-based approach that recognises and upholds the importance of children's wishes and feelings informing all decisions that affect them
- The impact of control and coercion by others on what people say and do

Key learning point 2

There is not the same robust process in place for convening strategy meetings out of hours, as there is during usual working hours. Although there was contact from the Police to EDT during the morning of 31st July 2021, a strategy discussion did not take place until 17.12hrs. By this time, a decision had already been taken that the family was to remain together, and EDT had not been party to that. Notwithstanding this, The SCG which had taken place at 16.00hrs recorded that there was "No suggestion for the family to be housed in alternative accommodation" and no agency recorded at this time any suggestion that the family should not be together.

Furthermore, health representatives were not invited to that strategy discussion, reducing the quantity and quality of information that could have informed decision making. A multi-agency strategy discussion should have taken place earlier in the day, and this might have influenced the decisions that were taken to leave the children in the care of Adult A and Adult B.

Recommendation 2

The CTMSB develop multi-agency practice guidance on the convening of strategy discussions outside of usual weekday working hours where there is a significant incident such as a child death, regardless of how that death is initially perceived. The guidance should:

- address the actions to be taken when a child is or has been known to local authority social services because of concerns about their protection or welfare, and
- provide for ensuring that key relevant partner agencies are invited to out of hours strategy meetings, and have access to the information that will inform robust decision making

Recommendation 3

A previous Child Practice Review made the following recommendations which are

relevant to this Review but are not repeated as recommendations here. It is recommended that the CTMSB satisfy itself that as much progress as possible has been made in respect of these recommendations:

- The Local Authority should develop, embed, and maintain a Quality Assurance Framework and an associated Framework of Management Oversight to ensure that there is high quality supervision, guidance, and oversight of practice. This should ensure there is a focus on addressing the inconsistencies in the quality of practice and variable quality assurance systems for assessment oversight, that have been identified within this Review.

Since the review of another child, the local authority has appointed a Quality Assurance Officer since this review. A new QA framework has been developed with regular reviews of case work and audits on specific case issues being undertaken. The framework ensures that regular reporting of the findings is presented to HoS and DHOS for consideration and action plans and support put in place in respect of any findings.

In addition, there is increased management oversight of service activity with weekly performance meetings chaired by service Group manager, fortnightly performance meetings chaired by Corporate Director/HoS. Quarterly performance meetings are also held to ensure that any issues within specific teams are addressed and responded to efficiently and effectively. Further to this permanent recruitment into Senior Manager, Team Manager and Social work positions leading to improved performance across teams.

- The Local Authority needs to improve its approach to analysing and managing risk through adopting a clear model of practice. This should include a clear framework for management oversight of safeguarding decisions and risk management plans.

The local authority implemented the Signs of Safety[2] approach in April 2023. Since this time, the whole workforce has undertaken extensive training in the approach. The model is providing social workers with the opportunity to ensure the child's lived experience is considered and family members are a part of care planning for their children. The model has also assisted in developing a shared understanding of risk across partner agencies. Partner agencies have also undertaken aspects of the training and will continue to be engaged in this work moving forward.

- That the President of The Family Division considers the imposition of a twelve-week minimum for any Social Work assessment within Public Law Proceedings. With clear guidance on any circumstances where there might be a case specific variation.

[2] Signs of Safety is a strengths-based, safety-organised approach to child protection work

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2**	
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)*	Colette Limbrick	**Reviewer 2** *(Signature)*	A Coles
Name *(Print)*	Colette Limbrick	**Name** *(Print)*	Alichia Coles
Date	09.08.2024	**Date**	09.08.24
Chair of Review Panel D Rees **Name** Damian Rees			

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Child Practice Review process

The circumstances of this case were considered by the Cwm Taf Safeguarding Board's Joint Review Subgroup on 15th August 2022 when it was decided that an Extended Child Practice Review would be undertaken.

The Review was carried out in accordance with Section 139 of the Social Services and Wellbeing (Wales) Act 2014 and accompanying guidance and a Panel was convened attended by senior representatives of the following services/agencies:

South Wales Police
Health Board
Local Authority Adult Services
Local Authority Children's Services
Social Services Emergency Duty Team
Local Authority Youth Justice Service
Local Authority Education Services
Local Authority Housing, and Social Housing Provider
CAFCASS Cymru
Domestic Abuse Services
Probation Services

An Independent Chair and two Independent Reviewers were identified to oversee the Panel process and complete the Review.

Learning Events were held on 27th September and 4th September 2023, attended by professionals involved in the case, representing the services/agencies as mentioned above.

Family and Significant Adult Engagement:

Relation Offered Interview	Engaged	Declined
Child Y's Father		Deceased
Child Y's Mother	√	
Adult A		√
Adult B	√	

Timelines, chronologies, and analysis submitted by all agencies were reviewed and discussed in detail during the Review Panel meetings.

Two multi-agency Learning Events were held, one for practitioners and one for managers.

Child Y, his mother, and Adult B have engaged with the Review. All these elements have informed the learning included in this report.

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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	☐	☐	