Child Practice Review Report

Child Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Extended Child Practice Review

Re: Child F

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 at paragraph 3.12 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.

NB Within the Cwm Taf Morgannwg Safeguarding Board area, different terminology is used when talking about a child taken into Local Authority care, including a 'Child Looked After' (CLA), a 'Looked After Child' (LAC) and 'Care-Experienced Child'. This report considers history and evidence from colleagues in Health, Education, Children's Services, the Police Service and third sector organisations. Therefore, the correct terminology <u>for each service</u> is used in this report, to remain true to their evidence/reporting.

The purpose of a Child Practice Review is to identify multi-agency learning for future practice. The timeframe for this review was 12 months prior to the date of incident that led to this review. The circumstances of this case are as follows:

Child F was a Child Looked After (CLA) from the Local Authority area, who had been in foster placement outside of that local area since March 2021. The Foster Carer reports that on 29.09.21 after returning home from McDonald's Child F went to her bedroom between 18:00 – 18:30hrs, there were no concerns. The Foster Carer called Child F to wake up the following morning but found the mattress had been removed from the bed and Child F was suspended from the upended bed frame, by a school tie.

The Welsh Ambulance Service notified Police that they were attending to a possible death by ligature of a 13-year-old just before 08:00hrs on 30.09.21. On Police arrival, Paramedics had completed Recognition of Life Extinct (ROLE) and life pronounced extinct at 08:05hrs.

The Foster Carer reported to police officers that she had heard a small noise around 21:00hrs after Child F had gone upstairs but had no concerns about it so did not respond. A note addressed to sibling was found saying 'sorry for doing this', a purse with £40 contained a note to father and a further note was found saying if Child F couldn't be with parents Child F didn't want to be here. Police reported no suspicious circumstances. Foster Carer reported that Child F had told her there was an alleged incident of bullying in school on 29.09.21 and the previous week.

Family Structure

At the time of the incident the family members identified were as follows:

1. Child F mother
2. Child F father

3. sibling under 14
4. Child F age 13
5. Older half-sibling over 17

Background information

Child F lived with her mother, father and sibling until her parents separated. Child F also had an older half-sibling who they reported to enjoy being around. All family members live in the local area.

Child F experienced several Adverse Childhood Experiences (ACEs). There was a history of domestic violence and ongoing conflict between parents, both before and after their separation several years ago. There were several incidents reported to police by both parents, making allegations or complaints against one another and a significant history of domestic violence between parents, which Child F would have been witness to, between 2009 and 2020. In June 2019, father physically assaulted mother and was remanded in custody. He was sentenced to a 24-month community order and took part in a Building Better Relationships programme in 2021. There were also two reported domestic incidents between older half-sibling and her partner at the family home.

In addition, there were reports of parental mental ill health, substance misuse, physical and verbal abuse. Mother was hospitalised in July 2020, after a suspected overdose.

Child F's sibling had significant social emotional and behavioural difficulties (in school and at home). Many of the occurrences Child F was linked to, were in relation to challenging behaviour displayed by the sibling.

There were several allegations by Child F and the sibling, of being physically chastised by their parents. In December 2020, Child F disclosed her mother would slap them if they misbehaved. This would now be a criminal offence due to legislative changes in March 2021, when smacking a child became a criminal offence and the defence of lawful chastisement was abolished.

Child F also disclosed at this time potential harmful sexual behaviour at age 10 with a 12-year-old boy. Due to limited information provided at the time, the enquiries were limited and there were no lines of enquiry identified to progress.

Local Authority

Local Authority Children's Services had significant historic involvement with the family since 2009, in relation to volatile relationships between adults, domestic violence, substances and alcohol misuse. There are also previous reports of service involvement with the older half-sibling. The children were placed on the Child Protection Register three times between 2014 and 2019:

- January 2014 – March 2015: Registration under the category Emotional Harm (concerns around the impact parents' volatile relationship on the children)
- Nov 2016 – July 2017: Child F's siblings placed on the Register, but it was not felt necessary to register Child F. Child F's two siblings were presenting with behavioural difficulties. Concerns were raised around mother's parenting capacity/ability to cope. Whilst Child F was described as delightful and quiet with a very strong bond with mother, she was also described in the strategy meeting as always appearing very sad.
- November 2019 – January 2021: Child F and her sibling were placed on the Register under the category Emotional Harm. Parent relationship described as very volatile, concerns that children are witnessing domestic violence. There were concerns father was breaching the terms of his Restraining Order.

Child F and her sibling were separated in 2019 – Child F stayed with their mother; initially her sibling moved to live with their father. Arrangements subsequently changed again in July 2020, with Child F moving to live with her father. There were multiple reports to Police at this time, in regard to concerns of Child F being at mother's address, with father reporting a court order in place for Child F not to be there.

A Children's Guardian was appointed in September 2020 and remained the guardian throughout 2021.

In December 2020, following a disclosure that father supplied cannabis to Child F to help with sleep, the children were placed separately, Child F in foster care and her sibling residing in a residential provision.

Initial private law proceedings around contact between the children and their parents converted into public family care proceedings involving the Local Authority at a Case Management Hearing in October 2020. These proceedings concluded in April 2021 with Child F and sibling subject of care orders to the Local Authority.

As part of these public law proceedings, the Local Authority requested solicitors instruct an independent psychologist to carry out assessment of the children's cognitive functioning, intellectual, educational, emotional, social, and behavioural development and comment on any matters of concern. They also requested comment on any harm the children may have suffered in respect of their psychological, intellectual, educational, emotional, and social and behavioural development and assessment of what the cause of such harm may be. Exploration of the quality of the relationship between siblings was also requested.

This assessment was carried out by a chartered clinical and forensic psychologist, who worked with Child F from December 2020 until February 2021 and produced a detailed report dated 10.03.21. A summary of findings is detailed below:

1. Psychometric assessment of Child F indicated that the Full-Scale IQ could not be interpreted, due to variability in performance but indicated some difficulties with verbal comprehension skills and processing skills.
2. Child F has difficulties in relation to low self-esteem, depressed mood, anxiety, self-harming behaviours, anger issues, and disruptive behaviour.
3. The report hypothesises that Child F's behaviours are likely to have been influenced by personal factors such as low self-esteem, poor emotional regulation, and impulsive behaviours. The social factors that are likely to have contributed to Child F's mental health difficulties are due to early childhood traumas.
4. During sessions with the psychologist, Child F indicated some positive involvement with father, followed by mother, followed by older half sibling. Child F expressed some negative feelings towards the sibling, with feelings of this being reciprocated.

Recommendations were as follows:

1. Schema-Focused Cognitive Therapy (SFCT).
2. Weekly or fortnightly leisure activities with sibling.
3. Unless the Court or the Local Authority has concerns about the parents' mental health or concerns about one or the other sabotaging / attempting to sabotage Child F's placement then contact can occur on a fortnightly basis. This is to ensure that Child F builds a relationship with prospective carer(s) but also maintain a relationship with birth parents. However, if one or both parents start to be inconsistent in their contact with Child F then there could be a consideration for contact to be decreased to once a month.
4. Weekly access to two female mentors who can act as positive female role models. One role model needs to be linked to education, and the other needs to be an

individual, (e.g., a very experienced youth worker used to engage with children that are / may be prone to challenging behaviour in the community).

5. Referral to the school Special Education Needs Coordinator (SENCo) for a detailed exploration of what could be done to help in formal education.
6. Child F requires a placement where:

- carer(s) needs to be very patient.
- the carers need to be prepared for the possibility that Child F will likely demonstrate challenging behaviour, (to test the commitment of the carers).
- the carer(s) have experience of working with children exhibiting self-harming and challenging behaviour.
- the carer(s) employ firm boundaries, which involves authoritative parenting and where Child F is fully able to understand 'house rules and sanctions for poor and where appropriate sanctions are employed for poor behaviour.
- child F is the only child in the placement so that the carer(s) can attend to emotional needs consistently.
- the carers have regular (at least monthly) supervision via a very experienced social worker.
- the carers have respite options available to them for Child F so that the carers can have a break from time to time.

This report was shared as part of court proceedings and discussed with the fostering agency as part of a care-planning meeting for Child F on 26.03.21. It is not clear whether this report was shared with GP, CAMHS or Education.

An amended final care plan was filed with the court on 12.04.21, with the following recommendations:

- Necessary therapeutic work with a trauma focus in place, funded by the LA
- further liaison between assessing psychologist and behaviour clinic to consider whether their work meets all requirements or whether Schema Focussed Therapy is needed in addition, and if so to be arranged and funded by the LA
- therapeutic life story work to be provided by Behaviour Clinic
- any therapist working with Child F will be made aware of the concerns (including self-harming)

- Child F having advised the Guardian that they will abscond if they cannot return to mother's care /increased risks of absconding if returning to school near mother's home
- Child F having advised feeling really awkward with people, watching in contact and not understanding why it needs to be supervised, Behaviour Clinic considering this further
- Further liaison needed in respect of the neurodevelopmental diagnosis process
- Issue of mentors for Child F to be considered, noting the number of people already involved
- Parents to be included in the therapeutic work
- Child F to be re-referred to reunification worker for support, when advised of plan
- Looked After Child Review within 4 weeks, with same IRO for both children.

The Guardian expressed in a Final Analysis report that there were concerns about gaps in planning around placement, educational and therapeutic needs, so felt unable to support the plan at that stage.

Child F had three foster placements in the period covered in the timeline:

1. Local area - December 2020 to March 2021
2. Out of county – 4 days in March 2021
3. Out of county – March 2021 – September 2021

There were eight missing persons reports recorded by South Wales Police (SWP) on Child F between July 2020 and March 2021, when living with father and subsequently in foster care:

- July 2020 – two incidents of leaving the father's home to see her mother, although contact was not permitted at the time.
- September 2020 – Child F and sibling ran from a placement after being told they were returning to their father's care. Located at a family friend's address, who was reported to be the instigator, trying to convince Child F to run away again but Child F reported being happy to be placed with dad.
- November 2020 – Child F absconded, later found safe and well at mother's address. Reported to have flagged down a stranger in a car. Due to the report of court order in place, Child F was conveyed back to father's address.
- December 2020 - Child F absconded from school after being told off. Located in the summerhouse of mother's address, returned to father's home.

- December 2020 - Child F left foster placement and was found walking towards mother's local area, stating unhappiness not to be like a normal 12-year-old, wanting to go back to live with mother and father and to see friends.
- January 2021 – Child F went missing from school and was located at mother's address where the older half-sibling was present. Returned to placement.
- March 2021 - Child F absconded from school and was located by her mother. Child F reported being on the way to mother's property, wanting to see her. Mother returned child to placement.
- March 2021 - two incidents of Child F absconding from foster placement and going to mother's address. Mother returned child to placement.

It was noted that mother was compliant with services in keeping her child safe and returning Child F to placement when she repeatedly left to seek out contact with her.

There is evidence in the timeline of the Local Authority seeking emotional support for Child F, primarily by confirming pastoral support in school (ELSA and school counselling). This support was dependent on Child F attending school regularly, which did not occur. Support was also sought from CAMHS. However, Child F was not ready to engage, therefore support consisted of signposting and advice, rather than direct support or intervention for Child F.

The out of area Local Authority was notified on 12.03.21 that Child F had been placed in their area. Children Services in the new area did not actively know Child F until 30.09.21, at the time of her death. Out of area Children Services attended two Procedural Review of Unexpected Death in Childhood (PRUDiC) meetings in respect of Child F on 01.10.21 and 13.10.21.

Health

Child F has a history of social, emotional and mental health needs. At an initial health assessment completed by the Looked After Children's Nurse over the telephone (due to COVID restrictions) in September 2020, father highlighted concerns around Child F's emotional health. Anxiety was noted to impact on attendance at school, but father reported that school was providing support. It was reported by Child F that she was missing contact with her sibling and there had not been contact with him since leaving the family home. Child F expressed no other wishes or feelings, and engagement via the telephone was reported as positive. Health issues identified were to support Child F's emotional health. Advice, resources and signposting were shared with father and a plan if concerns escalated to see

the GP. Referral to community dental service and vision check were also recommended. A copy of this report was sent to the Local Authority.

A Paediatrician carried out a medical review in October 2020, as requested by Children Services. Child F's height and weight were noted to be within normal range and she was noted to require dental input. This review also identified concerns regarding Child F's emotional health. The effect of significant family disruption was noted to have affected her emotional health, and a recommendation made that support currently in place may need to increase, if anxiety continues or increases. It was reported at this time, that Child F was concerned about attending school, due to a healing self-harm scar visible on her forearm. A copy of this report was sent to the Local Authority, this provided evidence of good communication of the concerns, also including a plan if emotional health deteriorates.

In November 2020, following periods of difficulty sleeping and poor attendance at school, father contacted the GP by telephone to request a letter explaining Child F's anxiety and Child F was prescribed medication as a short-term measure to help with sleep.

On 03.12.20, the Child and Adolescent Mental Health Service (CAMHS) crisis team saw Child F, following an ambulance call from her father. He reported that Child F had self-harmed by cutting her arms, neck, and 'smashed up' a bedroom after being asked to change out of her uniform. Child F would not engage with officers and refused to go to hospital initially but did eventually agree to attend. It was noted that there was no evidence of severe mental health needs. Initial follow up was via telephone to her father, who did not disclose that Child F was no longer in his care.

Subsequent follow up with the Crisis Liaison Team Nurse involved face-to-face discussion with Child F's foster carer and Child F, who was reluctant to engage. There was discussion about possibly exploring a neurodevelopmental disorder at this time. A safety plan and risk management was discussed with her foster carer.

Child F was discharged from CAMHS Crisis Team in early January 2021 as reported to be 'not ready to engage or talk about issues'. Shortly after, the foster carer requested a re-referral via GP, as Child F was reported to be hearing voices. No evidence of psychosis was reported or observed by the CAMHS assessment, so there was no further input in place.

At the end of January 2021, there was further contact between CAMHS Single Point of Access (SPOA), Social Worker and Foster Carer. An 'opt in' letter was received by CAMHS and Child F was placed on the waiting list on February 2021. Child F subsequently moved to a new foster placement, out of area. Local CAMHS therefore notified Local Children's Services on 18.03.21 that they would not be able to arrange an appointment, so discharged back to GP, with advice to refer to CAMHS in the new health board.

On 21.03.21, the local area GP made a referral to CAMHS in the new placement area, albeit with limited information available to them. It was noted that Child F would not engage in the discussion and that there was insufficient information, so the referral sent did not meet CAMHS criteria in the placement area. There is no evidence in Health records that the GP had received a copy of the Psychological report. It was subsequently noted at a LAC review recorded by the Local Authority on 10.05.21, that the GP in the new placement area did not consider the further need for a CAMHS referral. This is possibly suggesting not all information had been available or shared with the new GP.

In April 2021, Child F clearly articulated to the guardian that she used self-harm as a coping mechanism, expressed suicidal ideation and expressed being open to therapy. The guardian, who also agreed to make the foster carer aware, emailed this to the social worker.

Following reports of self-harm (cuts to throat and wrist) in June 2021, the foster carer took Child F to the GP in the out of area locality. The GP reported Child F did not engage well, she was unwilling to show areas of self-harm and was not supportive of a CAMHS referral, as she felt previous CAMHS support had not been helpful to her. The GP referred Child F to CAMHS on 21.07.21. The referral was discussed on 29.07.21, and a request for further information from the foster carer and the social worker was made (and copied to GP). When this information was not received from the foster carer and the social worker to CAMHS, the case was closed. No evidence of alternative intervention or discussion by the social worker with agencies in regard to Psychological report findings and recommendations.

In September 2021, school report Child F was reluctant to remove long sleeves for PE due to self-harm scars. At a Child Looked After Review on 14.09.21, Child F's social worker was tasked with following up on the CAMHS referral, as there was no health representative present at the meeting.

Education

Child F and her sibling initially both attended local primary schools, before transitioning to the local secondary school. Information shared by Child F with the clinical and forensic psychologist suggests some negative feelings about school from a relatively early age, related to: poor self-concept about learning ability; fear of failure; struggles with friendships; and some negative experiences with her sibling's behaviour.

Child F attended the local secondary school from September 2020 to March 2021.

Child F had a gap in schooling between March 2021 and June 2021, after the move between counties.

Child F's new school ensured they were fully briefed on her needs prior to transition, via the Child Looked After Coordinator of the school making contact with the social worker and foster mother. While at the school Child F accessed additional support including support by the pastoral team, the ELSA and trauma informed practitioners. Child F did not follow a full timetable because of her complex needs. It was decided that Child F would attend two lessons at a time on certain days and concentrate on the maths and English curriculum. The remainder of the time was spent with pastoral staff in the support centre. It was felt that Child F was responding well to the support that was provided. The school were able to provide this additional support early on because of the information that they had been provided by Child F's previous school.

Child F was excluded for two days due to pushing/physical contact with a member of staff. This exclusion had originally been five days, however following the use of restorative practices, discussions with Child F and considerations of challenges, this was reduced to two days. Child F had hoped this would be one day only.

Child F was reported by school to have difficulties maintaining friendships with a group of pupils; they would bicker in a 'teenage' way. The school therefore changed groups. Child F was reported to have been happy with this change and then found a 'nice little social group'. During Child F's time in this school, staff attended two Child Looked After reviews and the fostering agency and Education held three Team Around the Child meetings. Child F attended this school for a total of 20 days.

GOOD PRACTICE

- It is evident there were multiple agencies persistently involved with Child F and the family and they were raising concerns in the appropriate channels, they all attempted to engage and support Child F and the family members.

- Voice of the child considered in the Looked After Child Health Assessment, despite COVID restrictions at the time with maximum effort made by the assessing Nurse to engage with child and her father.

- Positive relationships with professionals were identified. It was reported via information shared that there was a good relationship with the foster carer in the out of area placement. There appeared to be a period of stability before the tragic incident occurred.

- There were periods when Child F settled into placements with positive intervention and support in place from the foster carers.

- Child F was seen as an individual in school – education settings were aware of what was happening in her life and attempted to provide the appropriate support to facilitate the identified needs.

- Good communication noted between parent, foster parent and school. Education trying to make it easier for Child F – evidence of robust communication between the two secondary school placements.

- Despite how difficult it proved at times for agencies to work together with so many professionals involved with the family, and with COVID restrictions, there were some positive outcomes for Child F throughout their involvement to reduce ongoing risks.

- Intervention and guidance were provided for Father as part of the Building Better Relationships programme, following domestic violence conviction. He was also supported by the Probation Service to self-manage during challenging situations.

- A thorough assessment was secured from a Clinical and Forensic Psychologist, to explore impact of Child F's lived experiences and advise upon appropriate support.

- Police response and actions recorded in both localities were timely and appropriate. Public Protection Notice's (PPN) shared with agencies in regard to concerns.

Parents' perspective

In line with the Child Practice Review process, both parents were visited to discuss their wishes and feelings regarding the support, intervention, and information they had received before and following the death of their child. It was explained to both parents of Child F, that this information would be shared with the Child Practice Review (CPR) Panel and that the purpose of this is to enhance the CPR process and ensure all professionals involved identify and share any learning within their agencies.

Father was visited at his home on the 14.11.22.

Father shared that he felt he was not supported or listened to by agencies; he felt they were all let down by services. He explained that he did not understand the process, whom to contact, or why his children had different social workers allocated. He expressed how he was reporting concerns for Child F when she was in his care as advised, due to concerns raised of attendance to mother's address.

He alleged that the on one occasion when Child F went to her mother's property, she returned intoxicated and under the influence of substances.

Contact with family and life for him and Child F was very hard after the move to foster care and he believes the risks were higher when his child was not near the family.

Father expressed that he feels the biggest mistake made was to take Child F to another county, he believes Child F was unhappy and he felt that he was being told to forget about her. He stated that Child F's poor mental health was not addressed or supported appropriately following the move away from home despite him asking for help.

Mother was met separately at the local Civic Centre on the 03.02.23.

She expressed that she was a victim of domestic abuse and felt she was not supported to look after her children, as she would have expected. She shared many happy times as a family unit before the relationship breakdown, she was resentful towards agencies that her children were taken away.

Mother felt let down by services and stated she did not trust anyone, she expressed that she felt harassed and bullied by some professionals over the past few years.

Mother did not feel that the information shared about her family was accurate and truthful, explaining that this was due to information shared in reports that she had viewed.

She expressed that Child F was deeply unhappy in foster care and wanted to be with her and near the family in a familiar area. She felt this was not considered and how it was affecting her and felt that services did not recognise the risks for her child and her mental health, and placement away from family and friends was a mistake.

Foster Carers feedback

Child F had three foster placements in the period covered by the timeline. Foster Carers from the first two placements were contacted online and by phone. They made the following comments:

It was reported that Child F repeatedly expressed unhappiness in local foster care and wanted to return home with family. Absconding was frequent (particularly when in the local area) and always with an intent to get back to mum.

Risk taking behaviours were reported to the relevant professionals by foster carers as a regular occurrence, this included reports of absconding to Police, substance misuse and general poor self-care.

Low mood, self-harm & suicidal thoughts were expressed to professionals by the foster carers. They felt agencies did not consider the escalation of concern regarding mental health.

The foster carer at the time of Child F's death, was met at the home address on the 27.06.23.

She described Child F as a quiet young person, who was easy to talk to and seemed 'old beyond her years'. Whilst at the placement Child F enjoyed spending time with the family dogs and goats, watching cartoons, and being out with the foster carer.

Another young person stayed with the foster carer for respite for a few nights per month. Child F was reported to be kind and helpful with her.

The Foster Carer shared that she received detailed referral information before Child F came to stay with her in March 2021. She was aware of the family background, incidents of self-harm and absconding, as well as the fact that a court case was pending in April 2021, to decide Child F's future placement. The Foster Carer received ongoing support and supervision by a Foster Carer therapist and supervising social worker, as part of the therapeutic placement arrangements.

The Foster Carer reported having a good relationship with Child F's social worker at the time of the move to placement with her, where regular phone calls were made to check how the settling process was going. Contact with subsequent social worker was less frequent; she reported that she often had trouble contacting the allocated social worker.

In addition to statutory Child Looked After meetings, Education arranged regular monthly 'Team Around the Child' meetings, which were attended by the Foster Carer, school, Foster Carer therapist, and Supervising Foster Carer Social Worker. It was reported by the foster carer that the Local Authority social worker for Child F did not regularly attend these meetings, as they were additional to the Child Looked After reviews.

Foster Carer reported Child F settled quickly into the placement, although there was an incident of absconding in the early days, when Child F attempted to return to her local area but she was returned to placement by police. There were no further incidents of absconding recorded.

The Foster Carer reported that Child F had regular supervised contact with mother, which took place with a support worker at an agreed location. It was reported that Child F's contact with father was via WhatsApp messages and phone calls, it was reported this appeared to be a positive and warm relationship. Child F and sibling would meet monthly with support workers near the allocated placement. Foster Carer expressed that she felt Child F felt a sense of responsibility for her sibling and worried about their well-being.

The Foster Carer also reported she facilitated visits from two friends from the home area. Child F's mother transported one of the friends', in order to attend an amusement park; another brought by her own mother to a local beauty spot and agreed a sleepover. Child F welcomed these visits from her friends, as Foster Carer reported she appeared desperate for friendship.

Relationships with peers within school were reported by the Foster Carer to be very difficult, despite the efforts of school staff to facilitate groups to join. The Foster Carer reported Child F did not 'fit' with any groups and she believes some individuals bullied her. She described

incidents of being 'blocked out' and physical aggression (a bottle being thrown, hit with a stick and phone being smashed). She therefore did not want to attend school.

The Foster Carer describes Child F as an introspective young person, who rarely giggled and laughed 'like a child'. She self-harmed whilst in the placement, most notably with cuts to the neck shortly before the April 2021 court hearing and again in June 2021, which the foster carer believed was potentially due to problems in school. The Foster Carer arranged for a GP appointment but reports Child F was reluctant to engage in counselling suggested by the GP. She believes that a CAMHS referral was made, but that Child F did not receive any interventions or therapeutic support outside of school.

The Foster Carer reported that Child F was ill on 27.09.21 and 28.09.21, so had not attended school. Child F had a difficult morning at school on 29.09.21, refusing to enter lessons, so a request was made to collect from school. Foster Carer reports she was unable to contact the social worker, so notified the duty officer at the local authority. The foster Carer described how Child F, the Foster Carer and child accessing respite collected McDonalds and ate at home later that day. Child F was not allowed a tablet device due to not engaging in school that day. Child F was reported to be quiet and went to her bedroom around 6pm. Foster Carer described hearing a noise but was not worried about this; she did not enter the room that evening, explaining that she assumed she was sleeping and that there was not a routine in place of checking or saying good night as this may have disturbed her, as Child F would often drift off, watching TV. The Foster agency confirmed that following a review of processes and all risk assessments, they have now put in place a process, which ensures any child with identified risks, is checked routinely at bedtime.

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

THEMES IDENTIFIED

Theme 1: **Domestic abuse and healthy relationships**

- Mother described herself as a victim of domestic abuse within the family home and felt she was not believed and appropriately supported by agencies. There is no evidence to suggest this was considered or support offered in the plan, despite confirmed reports of incidents and conviction of father for perpetrating domestic abuse, leading to a restraining order being put in place and him receiving support as the perpetrator.
- Child F was a witness to domestic abuse within the home with both parents, sibling and between the older sibling and their partner. The adverse effects of this on Child F and her emotional well-being should have been considered in all agencies assessments. The psychological report completed in March 2021 states the effect on the children. Child F was identified as expressing feelings of not being safe, experience of unhealthy relationships etc.
- There is no evidence to suggest Child F or siblings accessed support or therapeutic intervention around safe relationships and their experiences of violence in the home.
- Child F disclosed sexual activity with a boy two years older at age 10,. There is no evidence of therapeutic support or psychoeducation around healthy relationships.

Theme 2: Substance misuse and its impact on the outcomes for the individual and the family

- All family members (parents and children) were reported to be using some form of substances at different times.
- Child F reported first trying alcohol and cannabis age 10. There were multiple reports within the timeframe explored, identifying issues around substance misuse

for both Child F and sibling, with reports of parental use, enablement and supply. Child F was removed from father's care for this reason.

- There is some evidence that the GP was going to support Child F to give up smoking. The Probation Service notes that Father has engaged with drug and alcohol support agency, but there is no evidence to suggest Child F accessed support or education around substance misuse.

Theme 3: **Mental health support and assessment from a holistic approach**

- Significant concerns were raised for Child F around her mental well-being and self-esteem during the period covered by the timeline. Low mood, anxiety, poor appetite, difficulty sleeping, self-harm and suicidal thoughts were repeatedly reported to professionals by parents, foster carers, looked after children's nurse and guardian for Child F.
- Episodes of significant self-harm were reported during health assessments, at professional meetings and on presentation to Accident and Emergency.
- Initial advice consisted of signposting to resources and referral to the GP if concerns persisted. As concerns about mental health escalate to suicidal ideation and hospital admission for self-harm in December 2020, the CAMHS Crisis Team assessed Child F. It was noted that there was no evidence of severe mental health needs. Initial follow up was via telephone to father, who did not disclose that Child F was no longer in his care.
- CAMHS professionals spoke with Child F to assess and gain views, but there was repeated reluctance to engage. Input and advice from medical professionals therefore consisted of signposting to resources, risk management and safety plan, rather than therapeutic support.
- The Clinical and Forensic report recommended Schema-Focused Cognitive Therapy (SFCT) and suggests that if SFCT was not available in the NHS area that Child F resides in then private local options need to be considered. SFCT was not available via the NHS or privately for children in the UK. The psychologist suggested a therapeutic alternative, but this proved difficult to source. There is evidence to suggest that the Local Authority explored therapeutic support from the Behaviour Clinic, but there is no evidence that this was secured or provided. There is no evidence to confirm if all professionals had sight of the report.
- School was identified as a supporting factor for Child F's well-being before the change of placement area. This was further identified in the new placement, with

school recognising that there was a need for additional support. School counselling and Emotional Literacy Support Assistance (ELSA) were put in place for emotional support whilst in school. However, due to poor attendance at school this support was limited.

- The Forensic and Clinical Psychologist recommended weekly access to two female mentors who can act as positive female role models for Child F – one in education, one potentially a very experienced youth worker. The report recommended that these individuals work with Child F for a period of at least 36 months and where a mentor is to end their work, the new mentor must be prepared and work in tandem with the leaving mentor for a period of at least six months so that the new mentor-mentee relationship is developed. Whilst Child F was reported to have access to pastoral support in school, there is no evidence of an allocated Youth Worker or mentor outside school.
- The foster care placement was described as a therapeutic placement. This appears to be a commonly used term, but there is little clarification of what this means for the child. The foster carer explained that whilst she received supervision and therapeutic support as a foster carer, no therapeutic support was provided to Child F.

Theme 4: **Communication and information sharing between agencies and families.**

- There were four allocated social workers within the timeframe identified; this appeared to cause communication difficulties for all agencies involved and family members. Evidence of lack of handover between social workers on allocation of case.
- Information sharing is key to the safety planning of children, no matter how small the detail. There was evidence of good information sharing between all agencies, particularly between education services from the local geographical area to placement area. However, practitioners should ensure that all information is shared at every opportunity during assessments, especially when new information becomes available to them, ensuring the voice of the child is paramount in the process.
- In November 2020 father contacted South Wales Police to report Child F was at mother's address, it was identified Police had not been updated that there was an Interim Care Order in place stating that she was to live with her father. There were increased police contacts indicating escalating concerns, chaotic environment and concerns that Child F's voice was not being heard. A PPN being shared with

agencies reporting Child F did not want to return to her father due to cannabis use, she was initially returned under the care order condition and remained there for a further 2 weeks.

- Accessibility to different systems was a barrier to gain to updated information, when there are multiple agencies and practitioners involved, the information required was held on many platforms and this can be difficult to navigate. Strategy discussions taking place but information not accessible on WCCIS for all professionals involved. Systems appeared to be causing gaps in information sharing between professionals.
- Episodes identified where Child F would avoid direct contact with Mother and it was reported as ongoing issues of lack of communication from the Social Worker with the foster carer, resulting in Mother stating she will go back to Court in relation to this. Parental detachment would have had a significant impact on both parent and child. Good practice requires the Social Worker to maintain open communication with parents of a looked after child.
- Consideration should be given at every opportunity to how information is shared with parents, the assessment to whether they have capacity to understand what is being expected and their ability to contribute effectively in the process should be incorporated into the care plan. Child F's parents felt this did not happen consistently. Parents' distrust towards agency involvement is noted.
- To ensure effective handover for out of area placements for all agencies. Health had completed the Health Care Needs notification form and shared with the out of area Health Board within the 10-day period as Care Planning Placement and Case Review (Wales) Regulations 2015, as per guidance at the time. CTMUHB recognised that there was no risk assessment within the original national form, work has been undertaken at a national level by the National Safeguarding Team to insert a risk assessment into the new Health Care Needs form. This would have ensured a clearer Health picture of Child F's health vulnerabilities.
- An acknowledgement of what each agency can offer is required and not an expectation that something is happening, which may not be. There is clear evidence that agencies did not always explore alternative options for Child F in regards to her emotional needs, due to multiple changes in her situation and moves in foster care placements.

Theme 5: How agencies maintain family relationships and support, particularly when a child is placed out of area

- The child's wellbeing should be central to the decision making involved in identifying realistic placement options.
- Sibling and parental separation can have a negative effect on each child when families are not remaining together. The impact of this on the Child F was expressed regularly to all agencies. The voice of the child should be considered at every opportunity however it is evident Child F felt this was not happening, leaving feelings of isolation and frustration. Mother also reported difficulty in child F maintaining contact with friends from home (birthday visit) and family members; this caused her distress and further feelings of low self-esteem.
- Child F was reported to be struggling with friendships in school – allegations of bullying and peer concerns, unable to maintain friendships and the moves to different areas affected the ability to maintain friendships.
- Inconsistency in contact with parents, sometimes due to parental issues, also sometimes refusal by Child F. This was reported as having an ongoing effect on Child F, no clear evidence to how this was supported. Multiple reports of Child F expressing her wishes for increased contact with mother.
- It is reported in November 2020 Child F stated they did not want to stay with father as he is always checking up on Child F and offering cannabis, which he smokes a lot. Police investigated this. Police state that due to Court Order child was returned to father's address. Officers state this was clearly a difficult environment for the children. Child F reports she wants to be with mother.
- In November 2020 Child F reported ongoing struggles with the lack of direct contact with her mother and expresses experiencing mental exhaustion through lack of sleep. Child F initiates own contact with mother, placing her at risk of harm when absconding. Consideration for agencies of the benefit from advocacy support to uphold her wishes and feelings.
- Recommendation from Clinical Psychologist identified in the Bene-Anthony Family Relations Test she indicated positive emotions towards parents, recording unless the court or the LA has concerns with the parents' mental health or concerns about one or the other sabotaging/attempting to sabotage Child F's placement, then contact can occur on a fortnightly basis. This is to ensure that she builds a relationship with her prospective carer(s) but also to maintain a relationship with her birth parents. This did not remain consistent.

- The Bene-Anthony Family Relations Test indicated that there were some negative feelings identified towards the sibling. To build the quality of their relationship (taking into consideration whatever the government restrictions relating to the Coronavirus) both children could engage in weekly or fortnightly outdoor (or if possible indoor) leisure activities. The recommendation was that the children have fortnightly contact at the very least with each other, to help build a better relationship. Contact to be decreased to once a month if there are any increasing concerns. Foster carer reported visits in the out of area placement but was not clear on how often.

Theme 6: **The impact of COVID restrictions and challenges for all agencies**

- Agencies were under restrictions in periods of the child protection process affecting the ability for normal service, sight of the child and environment limited.
- COVID restrictions meant young people were spoken to by phone call/FaceTime. It was unknown to professionals who was in the room with them at this time. Family members not always seen in person.
- COVID policies were varied for each agency causing confusion for each agency, all children under safeguarding process should be the same. All agencies had different ways of working with different restrictions. There needed to be consistency for any children involved in the process.
- Agencies to recognise and maintain consideration of the impact on the family and how siblings should be brought together and contact maintained, in the process and under difficult restrictions.
- Staffing levels were affected in each agency, including redeployment of staff. This influenced the change of professionals and consistency of practice for the assessment of Children Looked After.

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:-

Recommendations

1. All Looked after Children need to have their histories understood, including their experiences of adverse childhood experiences. Appropriate intervention and support are to be considered, reviewed and implemented by all agencies involved with the child. All agencies to be mindful of their knowledge and experience of the child and to consider applying a trauma informed approach to their intervention. All assessments of the child and family should be available and shared to all agencies in a timely manner, particularly when indicating specific therapy or interventions. If during the assessment process, a history of substance misuse, domestic abuse and or sexual abuse is evident, relevant, targeted, specific support should be sourced and implemented in a timely manner.

2. All recommendations from identified specialists (such as Forensic Psychology) should be shared with foster carers, health and education colleagues to ensure a holistic approach for the child.

3. Pathways for CAMHS referrals need to be clear and communicated to all relevant professionals to ensure all relevant information is shared. Where self-harm and/or suicidal ideation is identified as a risk for the child, risk assessments and safety plans need to be in place and considered before discharge, particularly when the child is looked after and has previous history. When information is not immediately available from professionals, there should be a process for escalation within each agency. NB During the course of this review, new NICE Guidelines were published (October 2021).

4. When engagement of a child is limited, or specific therapies are not available, alternative therapies should be sought for the child and recorded in the documentation accordingly. Agencies can explore possible joint up work with

Health, schools and foster carers, with consideration for sessions taking place in environments familiar to the child, taking their views and wishes into consideration. Interventions around care-experienced children's needs should be prioritised for further consideration and escalation.

5. Where consistency of social care staff is not possible, handover should be detailed and chronologies available. Consistent process of communicating and sharing information, including the responsibility for referrals to other agencies. Social care workers need to ensure they are familiar with referral processes and that all requests for information are responded to in a timely manner. When staff are unavailable, there should be a clear pathway of alternative contact. A robust supervision process is required to support complex cases.

6. When a child is placed out of county in another Health Board, the Health Care Needs notification form should be completed and include a risk assessment undertaken by the Looked After Children Nurse. The School Nursing Team should be made aware of Looked After Child, on joining their Local Authority. A Health representative should be invited as standard practice to attend the Child Looked After Review Meetings. There is a gap with Children Young People placed from other areas when health are not routinely invited and this is a gap with supporting the care and support plan for child.

7. When a child is placed out of county in another local education authority, appropriate provision should be identified in a timely manner and school placement arranged as soon as possible.

8. It would be good practice to consider notifying the police of any identified risks or concerns when making a decision to place a child in an out of county placement, to enhance safeguarding opportunities.

9. When a Child Looked After is placed out of area, arrangements for maintaining contact with family and friends need to be robust and consistent for the child and the family, to maintain relationships and support networks. Advocacy for the Child Looked After must be offered by the allocated social worker and recorded by the Independent Reviewing Officer (IRO), to ensure their views are taken into consideration. Consideration should be given for advocacy for parents where

identified. Clarification of most appropriate means of contact to safeguard child (phone, FaceTime, WhatsApp, Snapchat to be assessed for suitability, given recommendations/conditions).

10. There needed to be consistency for any children involved in the process, despite COVID restrictions and distance between families and children. Safe and practical contingency plans need to be in place, ensuring that the family understand all forms of communication (verbally and in writing).

11. When a Child Looked After is requiring a therapeutic placement due to the child's identified needs, there needs to be the appropriate support and intervention in place for the child alongside the foster carer. There needs to be robust matching process for a foster placement and what therapeutic needs are required for the child and carer.

12. All foster carers are required to 'check in' with children with prior to sleep each night to provide an opportunity for emotional support and well-being.

13. An all-Wales model of practice is required to provide consistency and equity for children and families known to statutory agencies.

14. Child Death Review Group should explore work around child suicide in children who are a Looked after status and placed into out of county placements.

Statement by Reviewer(s)			
REVIEWER 1 Nadine Long		**REVIEWER 2** ***(as appropriate)***	Bronwen Parry
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)*	N Long	**Reviewer 2** *(Signature)*	
Name *(Print)*	Nadine Long	**Name** *(Print)*	Bronwen Parry
Date	28.08.2023	**Date**	28.08.2023

Chair of Review Panel (Signature)	S.M.Hurley
Name *(Print)*	Sue Hurley
Date	28.08.2023

Appendix 1: Terms of reference

Appendix 2: Summary timeline

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
EXTENDED CHILD PRACTICE REVIEW PANEL CTMSB 08/2021

Case Reference details
Child F CTMSB 08/2021

Circumstances leading to the CPR

At approx. 07:55hrs on Thursday 30/09/21, the Welsh Ambulance Service notified Police that they were attending to a hanging of a 13 year old female at an address in Dyfyd Powys. This is the address of the Foster mother. On Police arrival Paramedics had already completed role and life pronounced extinct at 08:05hrs

Child F is a Looked After Child from the Bridgend area and has been in foster placement in Carmarthenshire since March 2021. On 29/09/21 after returning home from MacDonald's she went to her bedroom between 18:00 – 18:30hrs, there were no concerns. The foster mother called Child F to wake her the following morning, and found the mattress had been removed from the bed and Child F was hanging from the bed frame.

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

- Childrens Services
- Cwm Taf Morgannwg University Health Board
- Hywel Dda Health Board
- South Wales Police
- Education BCBC
- Education Carmarthen
- CAMHS
- Children Services Carmarthen
- CAFCASS Cymru
- Calon Cymru Fostering
- National Probation Service

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

- Determine if the Coronavirus pandemic had any impact on the safeguarding arrangements for Child F.

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).
- Cross-boundary 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

Panel Members

NAME	TITLE	ORGANISATION
Sue Hurley	Independent Chair	South Wales Police
Nadine Long	Independent Reviewer	Cwm Taf Morgannwg University Health Board
Bronwen Parry	Independent Reviewer	Educational Psychology Service MTCBC
Bryan Heard	Vulnerable Persons Manager	South Wales Police
Marisa Douglas	GM for Practice and Improvement	BCBC Children Services
David Wright	Family Support Manager	BCBC Children Services
Sharon Coleman	CAMHS	Cwm Taf Morgannwg University Health Board
Nicola Jones	Public Protection Nurse	Cwm Taf Morgannwg University Health Board
Janet Edmunds	Lead Nurse Looked After Children	Hywel Dda University Health Board
Helen Chapman	Specialist LAC Nurse	Hywel Dda University Health Board
Caryl Davies	Education	Mid & West Wales
Rebecca Robertshaw	Child Protection Coordinator	Children Services Carmarthen
Andrew Purnell	Quality Assurance Manager	Calon Cymru Fostering
Kate Thomas	Head of Operations	CAFCASS Cymru
Kate Fitzgerald	Senior Operational Support Manager	National Probation Service

Additional Areas of Focus

Any Parallel Reviews or Other Such Activity to be Noted

Coroner's Inquest

Timeframe for the CPR

The timeframe set for the Review is 21/09/2020 – 30/09/2021. 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.

It is anticipated that the Learning Event will be held on 7th March 2023.

Completion Date
The completion date set for the Review is September 2023.

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.

SUMMARY TIMELINE

Historical Information

Between 2009 and 2020, Child F had been subject of Adverse Childhood Experiences (ACE's), she had been a witness to significant domestic abuse between her parents who made allegations against each other. In addition, alcohol and substance misuse was a feature within the family.

Between 2014 and 2019, Child F was placed on the Child Protection Register twice and her sibling 3 times under the category of emotional harm.

In 2019 Child F and her sibling were separated initially she remained in the care of her mother.

July 2020 she went to live with her father and during this time Child F would be reported as missing and she would be at her mother's address.

September 2020 a children's Guardian was appointed and remained in place throughout 2021

1.09.2020 -30.09.21 12 months prior to the incident that led to the review.

5th October 2020 Child F reported by father as missing found at mothers house.

15th October 2020 Interim care Order for Child F to remain with her father.

18th November 2020 Court order an independent psychologist to carry out an assessment of Child F.

30th November 2020 Child F absconded, later found at mother's address having taken a lift in a car from a stranger.

2nd December 2020 Child F absconded from school and found at mother's house

3rd December Child F had self-harmed and received hospital treatment for minor superficial injuries to neck and arms. Ambulance contacted

9th December 2020 Child F placed in Emergency Foster Care Placement following concerns about cannabis misuse whilst residing with father.

17th December 2020 left Foster Placement found safe and well and wanted to live with her parents and see her friends.

24th December.2020 Child F disclosed that her mother would slap both her and her sibling.

10th January 2021 Child F went missing from school, she was located at her mother's address and returned to school by police.

20 February 2021 Child F reported as missing. Her mother returned her to placement having located her at her (mother's) friend's house.

3rd and 4th March 2021 Child F absconded from school and attended mother's address who returned her.

7th March Child F absconded from Foster Placement and found at mother's address.

March 2021 Psychological assessment report received which provided recommendations for child F's welfare.

8th March 2021 Child F moved to an alternative Emergency Foster Placement.

10th March 2021 absconded from Emergency Foster placement and she was found at a train station by British Transport Police and returned to placement.

12th March 2021 move to an Out of Area placement and the Out of Area Local Authority were notified of the placement.

17th March 2021 Child F was found by the police early hours of the morning having jumped out of a window. She was returned to the foster carer.

13th April 2021 Long Term Care Plan for Child F to remain with Foster carer long term.

17th June Child F commences in new school.

29th June 2021 self- harm incident reported regarding Child F superficial injuries to throat and wrists.

30th June 2021 Child F having difficulties in school with friendships.

15th September Child F excluded from school for a few days following an argument with another pupil which resulted in her pushing a teacher.

29.09.21 Between 1800 hours and 1830 hours Child F returned home to the Foster Placement with Foster Carer having ate a McDonalds and went to her bedroom.

30.09.21 0800 hours Ambulance Service were called to the home after the Foster Carer had found child F suspended from the upended bedframe with her school tie.

30.09.21 0805 hours Child F's life was pronounced extinct by the attending paramedics, a note had also been left by child F in which she had recorded her wishes and feelings.