Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

Child Practice Review Report

West Glamorgan Safeguarding Children Board
Concise Child Practice Review

Re: WB S37 2017

Brief outline of circumstances resulting in the Review

Legal Context:

A Concise Child Practice Review was commissioned by the Western Bay Safeguarding Children Board (WBSCB) on the recommendation of the Practice Review Management Group (PRMG) in accordance with the guidance for Multi-Agency Child Practice Reviews. The criteria for this review were met under Section 6.1 of the aforementioned guidance namely:

'A Board must undertake a concise 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:
(a) died; or
(b) sustained potentially life threatening injury; or
(c) Sustained serious and permanent impairment or health or development

and
the child was neither on the Child Protection Register nor a looked after child on any date during the 6 months preceding –

- *the date of the event referred to above; or*
- *the date on which the local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.'*

The criteria for Concise Child Practice Reviews are laid down in legislation – Part 7 of the Social Services and Wellbeing Act (Wales) 2014 specifically, *'Working Together to Safeguard People: Volume 2, Child Practice Reviews'.*

Scope of the Review

The scope of the Review was from 1st February 2016 – 6th February 2017.

Following the decision to carry out this Review a Child Practice Review Panel was formed;

Chair of Panel – Daphne Rose – Public Health Wales

Independent Reviewer – Chris Frey-Davies – NPT County Borough Council (Children's Services)

External Reviewer – Zoe Jones – NPT County Borough Council (Adults Services)

Circumstances Leading to the Review

This Review was commissioned following the tragic death of the subject (Y) who, *'…died as a consequence of self-administered overdose of drugs but her intent was unclear'* (Coroner's Narrative conclusion, dated 22nd June 2017). The Child Practice Review (CPR) was commissioned for the following reason: that a child died and those agencies working with Y, for which there were numerous, were not working together. Therein a Concise Review was commissioned to consider learning.

Panel members

Agency

Child and Family Services

Education

South Wales Police

Domestic Abuse Hub

Evolve

ABMU Health Board

NSPCC

Western Bay Business Unit

Contact with the Family

The CPR guidance clearly outlines the requirement for family engagement in the process. In this case mother was written to offering her an opportunity to contribute to the review. Mother and her partner were met at the family home and their views were ascertained in relation to the review and those working with Y prior to her

death. Father was contacted by telephone and letter but did not respond. Therefore, his views could not be ascertained prior to the review.

Family Background

Y resided with her mother, mother's partner and a half-sibling in the Swansea area prior to her death. She was the youngest of five children to mother and mother's partner: comprising three full siblings and two half-siblings. Y's biological parents were separated and she had regular contact with her father who also resides in the Swansea area. In respect of Y, the family had intermittent intervention(s) with services (Children's and Police) since 2008; however as Y was never Looked After (LAC) or on the Child Protection Register and it is for such reasons that a Concise CPR was undertaken.

The Learning Events

A Learning Event was organised and took place on 7th June 2018. The event was attended by practitioners and managers such was the small number of agencies involved with Y. The contribution from those agencies who attended allowed for a fuller and more accurate account of events for the purposes of the review. At the beginning of the Learning Event time was spent with practitioners to ensure that they understood the purpose of the event.

Some of the attendees only had limited involvement in the case but were invited because they were involved with the family and their contribution was considered necessary to fully understand the family and respective organisational approach(s) to Y.

The Practitioners Event was attended by 19 professionals from the following agencies:

Police
Education
Social Services
Health
Evolve
Domestic Abuse Hub

Practice and organisational learning

Communication and information sharing

School confirmed that Y was doing well in school and that she was a middle band student. This was also parent's perception of Y's academic performance; however, parents maintained that they were not informed of Y's perceived emotional immaturity, low self-esteem and frequent relationship breakdown with peers. It was suggested by the parents to Reviewers that they were not aware of the services that Y was receiving from school or the level of concern that professionals held in relation to Y. Mother did consent to Y engaging with the Derbyshire programme and the referral form for this programme did reference difficulties Y expressed with her peers and the anxieties she was experiencing. There was some evidence of communication of the issues between home and school. From the Learning Event, the reviewers confirmed that the work undertaken with Y, through the Derbyshire programme, was not shared with mother.

It is known, from the Learning Event, that mother gave written consent to Y engaging in *Derbyshire* sessions delivered by school but was not informed of the *Exchange programme* offer of support. School accepted during the Learning event that they should have updated the mother as issues arose. Through these sessions it was identified that Y had entered into a relationship with a young person of thirteen years that led to school staff highlighting concerns that may have arisen if the relationship ended. Partnership working between school and home would have strengthened relations between family and school and created an environment more conducive to resolving those *i*ssues identified. Furthermore, in working closely with parents, school and parents would have developed a consistent approach/response to Y's presenting and evolving needs. The reviewers did not see any record or rationale of why this information was not shared with parents. School shared that the mother did

not fully engage with them on matters pertaining to Y's academic performance and attendance.

School reported that following Y's death they are now using a database to track concerns, patterns of behaviour etc. of pupils. The information that is input into this system is regularly reviewed by staff with the option to share the records with other agencies if required i.e. to support a referral. This is a database that is currently being rolled out across schools within the Local Authority. This is considered a positive and the system is subject to audit.

Communication between agencies.

It quickly became apparent over the timeline and during the Learning Event that there were multiple agencies working with Y and Y's family: Equilibrium, school (pastoral support), Evolve and Children's Services with Y's half-sister. There was some evidence that these agencies were sharing information and collaborating in respect of Y's sister; however the information sharing and collaboration in respect of Y was absent. Each of these agencies was working in isolation with no one seeing the full picture. The issue of 'silo' working is a theme of this CPR as it is in CPRs and SCRs undertaken throughout Wales and England.

At the Learning Event Evolve shared that they have since changed their policy and practice in that reviews are on open cases managed by this service six weekly, which has resulted in a more joined-up approach when working with families.

Family history not being factored into decision-making

Children's Services held an extensive family history in respect of Y's family. School held information on the wider family and relating to Y's siblings. Evolve held information regarding Y's sister and wider family networks and it was Evolve who took a lead role in co-ordinating a response to the presenting information. The sharing of information sooner may have led to a greater insight into Y's situation and better informed interventions. Having the full picture in respect of Y, her family and her experiences at school and the community would neither have predicted or prevented Y's death; however it may have, and should have led to a more coordinated, joined-up response early on to those difficulties experienced by Y.

Early Intervention and Prevention (EiP) services need to ensure that when more than one agency is involved with a young person that links are formed to join-up work undertaken with the young person and family. EiP services should also think holistically when approaching cases.

Narrow response to domestic abuse

The Learning Event highlighted that Y was not considered by Children's Services when undertaking an assessment into incidents of domestic violence and abuse (DVA) between Y's half-sister and boyfriend. Y was not included or involved in the assessment process. An holistic approach may have identified the needs of individual family members at an earlier time and any impact could have been considered and relevant services been provided.

Sharing Safeguarding Information and Public Protection Notice (PPN) Submission.

Consideration needs to be given to how PPNs are received and distributed across the LA, namely across Education and Schools. Police shared at the Learning Event that information was brought to their attention that a registered sex offender was staying at the family home. This prompted positive action by the police who ensured this individual was no longer at the home but no PPN was forwarded to any agency following this. Had a PPN been shared by police, it would have been shared routinely with health and the LA, primarily children's services to consider a response.

Perceptions of young people who engage in sexual activity.

Information was shared at the Learning Event that Y may be sexually active, for example, information that Y's boyfriend was spending the night at her house. The Procedural Response to Unexpected Deaths in Childhood (PRUDiC) minutes evidenced that those working with her in school, considered Y was in an intimate relationship. A lack of professional curiosity led to this issue not being broached by those working with Y given the ages of the young people involved. The law in respect of this area is clear, the age of consent (the legal age to have sex) in the UK is 16 years old. The laws are there to protect children from abuse or exploitation, rather than to prosecute under-16s who participate in mutually consenting sexual activity. In cases of underage sexual activity this should be considered in the wider context of exploitation and it is an expectation on professionals working with young people to

have the knowledge base and skill set to broach this subject with young people and to seek advice within their own agencies for support to broach and from Children's Services.

Approach to programmes/intervention: recordings, structure of sessions, supervision and follow-up.

The information presented to panel from school was unclear and unstructured as there was no system to present this coherently. Guidance should be developed to ensure that future recordings are structured, clear, factual and evidenced based. A template should be devised to promote the clear recording of outcomes and goals, ensuring that they are reviewed regularly. Regular advice and support and a mechanism for escalating concerns arising though Derbyshire cases is key in reviewing services and support offered. The Derbyshire programme is a pastoral support service delivered across schools and is also known as the Derbyshire Project. A Boxall assessment should be undertaken to determine the work to be undertaken with the young person. Tools are then drawn upon to address identified issues and as matters arise.

The case of Y was complex in nature and too complex for a single agency. Practitioners accepted during the learning event that Y's emotional immaturity and relationship difficulties were deep-seated and too complex to unpick through such provisions as *Derbyshire*. There was no written evidence that practitioners working under the *Derbyshire model* were receiving regular advice and support; however, *Derbyshire* practitioners reported having regular supervision. The *Derbyshire* practitioner's account of what constituted supervision was shared to be: receiving advice from senior members of staff. This was not formal supervision in the sense that this is structured, recorded and held at regular intervals in line with an overarching policy to review the work undertaken through such a programme. On reflection a joint Learning event between practitioners and managers may have impacted upon the practitioner's ability to share their experiences openly.

When a programme, such as *Derbyshire* seeks to sign-post a young person to another service then this process should: involve the young person and the family where appropriate. Any subsequent sign-posting or referral should be made by the professional identifying the service.

Peer relations

There was no evidence found to suggest that the falling out with peers on a regular basis, in this case, constituted bullying and it is worth noting that the suggestion of bullying has been robustly investigated by police, a Coroner's inquest and through this Review. None of which found evidence to support the assertion that bullying was a contributory factor to Y's death.

This Review found that no universal definition of bullying is applied across the LA despite guidance from Welsh Government - Respecting Others 2011 & 2016 https://beta.gov.wales/anti-bullying-guidance. Each school has an anti-bullying policy that seemingly defines bullying locally and how to respond. This mirrors a key finding made by the Children's Commissioner Wales in *'Sam's Story'* (2017), that the material available nationally on this issue, *'…suggests a very diverse and uneven picture.'* (pg. 20). Schools across Wales share data on bullying with Welsh Government and therein it is possible that the issue of bullying is under-reported by schools so as not to create a negative impression of a school. Once again this was a key finding from Sam's Story (2017), *'…there were concerns about accuracy, consistency and honesty reporting. There were indications of disincentives for schools to monitor accurately…. There are risks also of a 'league table approach to this issue.*' (pg. 20). It is pleasing to note that an all Wales group is reviewing existing guidance for schools on bullying. Furthermore, there is clearly a gap in local policy for how schools and other organisations build resilience amongst children and young people in this technological age. The Reviewers would encourage LSCBs across Wales to develop guidance for practitioners to safeguard children and young people in this technological era and in anticipation of further rapid developments in the field. Technological developments i.e. Social media platforms, which are moving beyond existing guidance at an alarming pace.

Decision-making in isolation.

In addition to decision making pre-death as noted above agencies identified that there may have been missed opportunities for multi-agency decision making during the post-death police, and subsequently Coroner's investigation. It was also noted that school had opted out of support from the Local Authority i.e. legal advice and

HR etc. and this undoubtedly undermined the response and level of support available post death. As a consequence consideration will be given to these issues being subject of a MAPF following this review.

Improving Systems and Practice

Communication and information sharing

Communication between school and parents

When seeking consent from parents to allow children to engage in pieces of work, parents and guardians should be provided with information as to what the work entails and how they will be involved. If a service is identified during work undertaken with the child, in this case the Exchange Service, then the child and parents should be consulted to establish whether parents should be involved to ensure they arrive at an informed decision on whether or not to engage. The exception to this being when a professional holds a safeguarding concern. If the child and family are then agreeable to such a service then the professional working with the family should make and support the referral. This should not be left to the child and/or family to action.

Communication between agencies

During the learning event it became apparent that there was a lack of information sharing of significant information between agencies at key points. When considering what information to share partner agencies should consult relevant guidance such as, '*Information: Sharing advice for practitioners providing safeguarding services to children, young people, parents and carers.*' (DFE, 2018).

Guidance should be developed to assist agencies to identify an individual to co-ordinate a plan when there is more than one agency involved. The Reviewers formed the opinion that having the full picture in respect of Y, her family and her experiences at school and the community would neither have predicted or prevented Y's death, however it would have, and should have led to a more coordinated, joined-up response to those difficulties experienced by Y.

Sharing Safeguarding Information and PPN Submission

Specialist officers need to be reminded of the need to share information with partner agencies following safeguarding interventions.

PPN's are routinely shared by police with health and children's services but not with education. Consideration should be given to how PPN's can be received by Education Safeguarding leads across the LA.

Perceptions of young people who engage in sexual activity

There was information within the Support Records held by school to suggest that Y was sexually active. There were numerous entries in the chronology alluding to such, for example, Y's boyfriend was alleged to have spent the night at Y's house and that Y was suspected to be sexually active. It is recommended that when a practitioner becomes aware that a young person may be, has been or is sexually active and is under 16 there is an expectation that partner agencies holding such information should make contact with children's services. This will allow for the sharing of information and advice to be sought. It is imperative that conversations be had with the young people involved, and when deemed appropriate the family. This is professional judgement and advice may be taken from children's services as to how this should be approached by the practitioners. Upon receipt of such information Children's Services should consider undertaking an assessment on the young person's physical and emotional health, and their education and safeguarding needs.

Approach to intervention/therapy: recordings, structure of sessions, supervision and follow-up

The recordings shared with the reviewers were unclear and unstructured. Outcomes and goals set were not followed up on subsequent sessions. Those involved in delivering the *Derbyshire programme* spoke of using the '*Boxall assessment'* to establish a baseline for ongoing work/intervention: the Reviewers saw no evidence of this tool being used or being drawn upon in future sessions to review progress. It was clear that the work undertaken with Y was well intentioned however there was a sense that Y's needs were too complex for a single agency. Practitioners accepted during the learning event that Y's emotional immaturity and relationship difficulties were deep seated and too complex to unpick through such provisions as *'Derbyshire'*. There was no evidence that those delivering the *'Derbyshire'* programme were

receiving regular supervision and they were seemingly left to it and although this point was challenged during the learning event no documentary records were provided to evidence supervision had taken place. Referrals to Exchange and other agencies were not followed up and despite identifying what was believed to be an appropriate counselling service this was left to the young person to self-refer.

It is recommended that the delivery of the Derbyshire programme be reviewed to ensure it is delivered consistently across the Local Authority with appropriate governance and fidelity.

Early Intervention and Prevention (EiP) services working with families need to consider how they work together in a coordinated manner.

<u>Decision-making in isolation</u>

Guidance needs to be compiled following the learning from this incident to enable agencies to collaboratively manage cases involving the death of a student. Some key decisions were made as a single agency which had ramifications for other agencies. Any decisions taken that have a direct impact upon the functions of partner agencies should be considered as part of a multi-agency decision-making forum. As already noted, matters arising post-death will be considered via a Multi- Agency Professional Forum (MAPF).

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved.		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child 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 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)*	
Name *(Print)*	Chris Frey Davies	**Name** *(Print)*	Zoe Jones
Date	16.05.19	**Date**	16.05.19

Chair of Review Panel (Signature)	
Name *(Print)*	Daphne Rose
Date	16.05.19

Appendix 1: Terms of reference
Appendix 2: Summary timeline

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SCB Chair ……

Date circulated to relevant inspectorates/Policy Leads ……

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	