Child Practice Review Report

North Wales Safeguarding Children Board

Concise Child Practice Review Re: NWSCB 2018 CPR Wrexham 1

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*

Legal Framework

A Concise Child Practice Review was commissioned by the North Wales Safeguarding Board in March 2018. The criteria for Child Practice Reviews are laid down within the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. Regional Safeguarding Children's Boards have a statutory responsibility to undertake Multi Agency Child Practice Reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected.

A Safeguarding 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:

- Died; or
- Sustained potentially life-threatening injury; or
- Sustained serious and permanent impairment of 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 agency identifies that a child has sustained serious and permanent impairment of health and development.

The purpose of a Review is to identify learning for future practice and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child or family. The output of a Review is intended to generate professional and organisational learning and promote improvement in future interagency child protection practice.

Methodology

- A Review Panel was convened with a Chair.
- Two Reviewers were appointed.
- Timelines were developed for each agency identified.
- A summary/analysis of each services' involvement were produced.
- The child's parents and maternal grandparents were interviewed.
- The child was seen at the current placement.
- A Learning Event was held for practitioners.
- A Review Report produced with learning points and presented to the Review Panel.
- Review Panel met to finalise the report.
- Action plan developed from recommendations.
- Review Report presented by Reviewers and Chair of the Review Panel to the Regional CPR Subgroup and the North Wales Safeguarding Children's Board.
- Submission to Welsh Government.
- Feedback to Family.
- Publication of Report on NWCSB website.

Timeline

The timeline for the Review was one year from March 2017 (when the school presented two Child at Risk Reports, the first for some time) to March 2018 when the child was removed; Agencies were also asked to consider their involvement prior to the timeline, if relevant.

Circumstances resulting in the review

A 14-year-old child, with a diagnosis of Autism was removed from the family home with the support of the Police. On the 5th March 2018, professionals gained access to the whole house and it was evident the mother had been hoarding for some time and neither parent had sought support in relation to this. Most of the upstairs was uninhabitable with the hoarding spilling over into downstairs areas. Parents and child were sleeping downstairs on a sofa and both parents had made attempts to conceal the extent of the hoarding from professionals. The child presented as thin and had been observed over more than one visit, in a similar position on the sofa under a blanket. The child's hair was matted and appeared dirty. These conditions appeared replicative of conditions during historic proceedings in 2007, when the Local Authority

obtained a Supervision Order, in respect of the child.

The child had not attended education since 2015, however some home tuition was provided after this point. The child had not seen a GP since 2013 and parents reported the child had not left the family home for 12 months. After removal it was ascertained the child had suffered physical and emotional neglect.

Background Information

The child had been subject to Care Proceedings in 2007, due to the mother's parenting capacity, mental health issues and hoarding behaviour. The parents were separated prior to the proceedings and the child went to live with the father. The child was subject to a Supervision Order for one year.

From 2011 referrals began to be received by Social Services noting concerns regarding parental alcohol use and alleged arguments between parents. Parents were visited by Social Services and it was found the parents had reconciled their relationship. There is no evidence to suggest any parenting assessments were undertaken at this time as indicated in prior proceedings. Subsequent referrals appear to have been dealt with in isolation, with agencies appearing to have responded to the referrals, however the case appears to have been closed each time, with no evidence to suggest the situation had been resolved or improved. In 2015, a referral was received from the parents asking for support; however, the parents did not engage with the services offered, including the Learning Disability Nurse and sleep clinic. The records note the parents cancelled many appointments.

The child's attendance at school began to decline in 2014 and the child did not attend school after March 2015. A home tutor was provided from February 2016 until November 2016. In November 2016 the school were unaware that they had become responsible for the child's reintegration plan. From November 2016 and onwards the child was marked as being authorised as absent therefore non-attendance was not noted and responded to by either the School or the Education Department. Social Services' analysis note that they were not aware of the child's non-school attendance until 2018.

The child had been open to Together Achieving Change (TAC). The TAC process is a way of organising and co-ordinating extra help for children, young people and their families between the ages of 0–25 years who have a number of different additional needs requiring preventative support. The intervention involved multi-agency meetings with the parents.

From July 2015, until the beginning of the timeline in March 2017, there had been 5 TAC meetings, the last TAC meeting being held on 7th of June 2016. The child's father attended all five meetings. The child's mother only attended one of the meetings.

Despite appearing to be asking for support with the child, the parents' engagement with the TAC service was poor and the TAC service could not be delivered. The agency analysis stated the lack of engagement by the family was consistently recorded by TAC, but it appeared that due to the poor engagement with the family, it had not been possible to hold a conversation with the family to find out why.

In March 2017, a member of staff at the child's school had seen the child and the mother in the community and were concerned about their presentation. The Education Social Worker (ESW) had attempted to visit the home but was not allowed access. The ESW was also concerned the father appeared under the influence of alcohol.

Two Child at Risk Reports were made by the school in March 2017. These Reports did not contain any of the background and context to the child and family's needs. Initial enquires were conducted by Social Services and did not identify safeguarding concerns, however the family were open to TAC and the ESW was working with the family.

TAC continued to attempt to engage with the family and due to the anxiety reported about the child not liking strangers, a decision was made to undertake a joint visit with someone the child knew. Attempts were made by the TAC officer to organise joint visits, firstly with the ESW and then a representative from school, but some difficulties were encountered during the organisation of the home visits due to annual leave and other commitments. A lack of response from parents when calls were made to arrange a date to visit also delayed the process. It was acknowledged due to these difficulties there was a 3-month delay in being able to visit the house and see the child.

It was not normal practice by TAC at the time to carry out unannounced visits, however due to the lack of engagement by the parents and no one seeing the child it was agreed that an unannounced visit was appropriate. The visit resulted in a Child at Risk Report and the case was opened to the Assessment and Intervention Team. (AIT) and a Comprehensive Assessment was instigated in July 2017.

During the Assessment the child was seen, and the Social Worker was allowed access to the house and saw the child's bedroom. Advice was given on the suitability of the child's bed and the need to de clutter. It was agreed at the Learning Event the parents had cleared enough of the house and the child's bedroom in preparation for the social worker's visit, however the whole house had not been seen to ascertain the fuller picture.

The Comprehensive Assessment concluded in September 2017 that there were no safeguarding concerns at the time. The parents appeared open to support and referrals were made to the appropriate services. Referrals were made to both TAC, the School Age Learning Disability Team and other community services.

The case had been open to TAC since 2015, however since this time the case was deemed to be too high a need for what was considered the preventative nature of their service. Between 2015 and July 2017 a conversation was not held regarding the need to escalate the case from TAC to Social Services.

From September 2017 to December 2017 the timeline shows there was a disagreement between agencies/ teams regarding who should take responsibility for the child's case.

Agencies continued to try and engage the family; however, the family continued to cancel appointments and restrict entry to the house and access to the child. It was

noted that the parent's reasons for cancelling were usually plausible and it had been accepted that the child reacted badly when people visited the house.

The TAC service is based on a consent model and relied upon cooperation from parents. Social Work visits were also reliant upon consent from the parents as the threshold of risk of Significant Harm had not been met until the 1st of March 2018.

There appeared to be a general acceptance over the years that the child and the family needed services in order to help the family meet the child's needs.

All Child at Risk Reports were accepted and processed within the required guidelines. However, as noted in the Social Services' analysis, reports were possibly considered in isolation and closed without apparent resolution to raised issues. The difficulties in accessing archived paper files was raised as a potential barrier to gaining a full picture.

The Comprehensive Assessment completed in September 2017 concluded that on the information available at the time, there were no safeguarding concerns. Much of this assessment also appeared to rest on the fact that parents were asking for help and amenable to all services. Referrals were made to those services and the case was reallocated to TAC once again.

This Assessment also identified the need for disability specific services in terms of behaviour management; referrals were made to the Disability Health Service and the Local Authority Social Work Disability Services. On the 15th of November 2017, this referral was declined by the Disability Health Service, due to the view that a care coordinator was needed. The TAC officer was once again identified as being the care coordinator. This is contradictory to the information on the Local Authority Data Base outlining that needs are too high for TAC. On the 24th of November 2017, the TAC Service were informed of concerns regarding the lack of engagement from the family with services again, and it was assessed the TAC Service was not the appropriate support for the family. A request was made for the referral to the Local Authority Social Worker Disability Service to be considered. On the 14th of December 2017 the Disability Specific Social Work input alongside behavioural support was agreed, however, as the case was passed over with no safeguarding concerns initial contact was delayed.

It was agreed at the Learning Event the situation would have benefited from escalation to a senior manager in order to consider the issues and to make an earlier decision regarding who should take responsibility of the case.

On the 14th of December 2017 the Child Health and Disability Team agreed to receive the allocation of the case and on the 8th of January 2018 a Social Worker from the team was allocated. On the 18th of January 2018 a home visit was made, and the child was seen and the extent of the condition of the property was understood. Concerns were expressed that the child was severely isolated and there were concerns around the child's mental health and development. Previous involvement has highlighted concerns around parent's alcohol and substance misuse. Three out of the four bedrooms in the property were inaccessible due to the number of belongings. The parents confirmed they and the child slept on the sofa.

On the 1st of February 2018 the Social Worker contacted all relevant agencies and a multi-agency meeting was held. Joint visits were undertaken between the Social Worker and either Health or Education Representatives. Parents attempted to cancel or restrict visits, however the workers persevered, and both the child and the property were viewed on each visit.

On the 24th of February 2018, a Child at Risk Report was received from the Fire Service, following a small fire in the property. The Fire Service crew were concerned about the condition of the house and the presentation of the parents and the report was made in accordance with the North Wales Safeguarding Board's Hoarding Protocol. Due to the number of belongings within the house, the source of the fire could not be easily identified.

On the 1st of March 2018, a Strategy Meeting was held (All Wales Child Protection Procedures 2008) and a Section 47 investigation (1989 Children Act) was commenced. On the 5th of March 2018, concerns escalated, and a further strategy discussion was held. A joint visit between the Police and Social Services was requested and the consideration of a Police Protection Order (PPO) was discussed, however this was declined by the Police, as it was felt that the threshold for PPO was not met.

Social Services requested a Legal Planning Meeting and continued to request joint visits with the Police. On the 7th of March 2018 Social Services also requested a child protection medical to be undertaken within the home as the child became anxious and had not left the family home for many months. This was considered by the Paediatrician, but it was deemed to be in the best interest of the child, for this to take place in a more appropriate environment. This was undertaken on the 8th of March 2018, following removal of the child, in a clinic setting.

On the 7th of March 2018 the child was removed with the support of the Police, following the parents agreeing to a voluntary placement under S76 of the Social Services and Well Being (Wales) Act 2014.

View of the family

Since the child was removed the parents have separated. Both parents agreed to be interviewed and were seen independently by both Reviewers.

Both parents independently confirmed that whilst the child lived with them, the father was alcohol dependent and drinking heavily, seldom sober. Both parents confirmed that the mother's hoarding behaviour was out of control. The mother alleged the child was witnessing domestic violence between the parents. The father alleged the relationship with the child's mother was variable and that he could not account for his behaviour when he was drunk but he understood he was prone to violent outbursts.

Both parents acknowledged the child's life was not as it should be, in that they wanted the child to be happy and in school with friends. They also acknowledged they were very worried that if people found out about the alcohol abuse, hoarding and domestic violence the child would be removed, as the child had been removed in

the past.

Both parents acknowledged they asked for help but then turned away help when it was offered. They confirmed they refused to let people into the home and that they would cancel appointments in order to conceal both the hoarding and the extent of the father's alcohol abuse. They said they became good at sending people away and were often amused to see how easy it was to 'fob people off'. They felt that once they had sent someone away, they seldom came back.

The child's mother also confirmed they had told the child to scream if people came into the house. The child's mother also confirmed that they cleared items off the landing and hall into other rooms if they knew someone would be visiting.

Both parents now feel it was the right decision for the child to be removed. They feel the child is receiving much better care and is developing well.

The child

The child was seen by both Reviewers at the residential home. The child does not have enough understanding to understand the purpose of the Child Practice Review or the role of the Reviewers, therefore the visit was to observe the child to get a feel for the child's needs.

The information about the child received from the paperwork, as part of this review, was that the child was distressed by strangers, isolated, fearful of going out, anxious about school and had poor communication and self-care skills.

During the visit the reviewers were pleasantly surprised to meet a delightful young person, who was very sociable, chatty and curious. The child now attends school regularly and has a very good relationship with peers. The child has a good relationship with the social worker and is enjoying exploring the local area and undertaking activities.

Learning Event

A learning event was held on 11/7/19. The Chair of the Review Panel, both Reviewers and the Business Co-ordinator of the North Wales Safeguarding Children's Board attended the learning event.

At the Learning Event, the process of detailed examination of inter-agency working and the facilitated learning provided for reflection by practitioners and as a result, wider learning emerged about the ways services work together.

Nine representatives of the following agencies attended the learning event:

- Social Services
- Health
- TAC
- Fire Service
- School

- Education Social Welfare

The learning event highlighted good practice, which included the joint working between Social Work, Health and Education staff towards the end of the timeline.

It also specifically identified TAC supervision with clear action plans as good practice.

The multi-agency meeting on the 1st of February 2018 was pivotal in moving the case forward. The perseverance of the social worker was also noted and acknowledged by the parents.

Several of the professionals at the meeting have commented on the value of seeing the multi-agency chronology produced as part of the review. It was felt that this could be a useful tool to be used by agencies in reviewing other cases.

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

Disguised Compliance / Professional Curiosity

Throughout the timeline, there is evidence of sporadic engagement by the parents, generally through agency engagement with the father. Disguised compliance involves parents giving the appearance of co-operating with agencies to avoid raising suspicions and allay concerns. In the Victoria Climbie Inquiry (2003), Lord Laming suggested that Social Workers needed to practice 'respectful uncertainty' applying critical evaluation to any information that they receive and maintaining an open mind. Although Lord Laming refers only to Social Workers this applies to all professionals working with families.

Within this review, areas of critical evaluation could have taken place in respect of the rationale for poor engagement, parents' reluctance to allow professionals to access the home and acceptance of services then disengagement. It is not clear that professionals asked the 'why' question.

There are several periods within this review when the TAC team should have escalated to managers regarding the poor engagement of the family in their service. This allowed the case to drift for long periods of time.

It would have been beneficial for an element of professional curiosity to have been exercised within the case. Lord Laming defines professional curiosity within the Victoria Climbie Inquiry 2003 as "The capacity to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This includes identifying and exploring what is not discussed as much as what is". This review has identified that professionals did not adopt an open mind, inquiring and curious mind set in relation to gaining access to the home and seeing the child. Parents stopped professionals from entering the property with various excuses and professionals readily accepted these.

During the Reviewers' interview with the mother, she openly admitted that staff were

'easy to fob off'. Also, professionals too readily accepted the parent's rationale for the child screaming and becoming distressed which was a deterrent to professionals accessing the home.

Hoarding

The family were known historically, and issues of Hoarding, Substance Misuse, Parental Mental Health and Domestic Violence were highlighted in the past, although concerns had not in recent years escalated beyond initial referrals and TAC meetings. During this time the TAC service did not include a visit to the family home. The Home Tutor was gaining access to the family for some time but her views on the child's needs and home circumstances were not sought.

Attempts made to visit the house were often unsuccessful, the parents would make excuses to deny professionals access. This would be either in the form of not opening the door; claiming they had no key to the front door; allowing access to the hallway only; clearing certain areas in anticipation of visits and claiming that the child was ill, or too anxious to allow anyone in. Claims were made that the child became distraught if anyone went upstairs. No one had been able to access the whole house during the timeline in order to ascertain the nature of the Hoarding issue.

On the 24th of February 2018, the Fire Service attended the property and following their assessment of both the property and the presentation of the parents, made a safeguarding referral in accordance with the North Wales Safeguarding Protocol on Hoarding.

The extent of the Hoarding was not fully understood, nor was the extent of the parents' substance misuse, especially the father's dependence on alcohol. The parents were not in receipt of any mental health or substance misuse services in their own right.

It was felt that there were significant risk factors present to potentially alert services to the underlying issues:

- Social Exclusion
- Domestic Abuse
- Poverty/ poor housing
- Witnessing arguments
- Noncompliance with treatment/ medication
- Children's basic physical needs not adequately met
- Children's emotional needs not being met
- Health appointments not sought
- Disruption to child's education
- Child's own needs unacknowledged by care givers

Reference: The North Wales Safeguarding Board's, Supporting Children, Supporting Parents; A North Wales Multi Agency protocol – Parents with severe mental health problems and/or substance misuse. 14/7/17

The TAC service has since reviewed their practice and routine initial home visits are

undertaken now when referrals are received. Ongoing home visits, including unannounced home visits, are also part of current practice, when an assessment shows that these visits are justified and part of the management of the case.

Education

The child began to miss school in September 2014 and last attended school in March 2015. The school staff and the ESW at the time worked closely to support the family with the child's attendance. They took a sympathetic, non-punitive approach to manage the child's attendance. This decision meant that the child was deemed "beyond parental control" and therefore no attempts were to be made to prosecute parents for the child not receiving education. The school referred the child to Health Services and stepped back once this referral had been made.

The child was allocated a home tutor in February 2016. Between February 2016 and July 2016, the child received 25 sessions of home tuition and the parents cancelled 11. On many occasions the child was asleep when the tutor arrived. The child was often still in night clothes and the tutor commented that the parents were reluctant to get the child up and dressed. The tutor was chosen as an experienced home tutor who could provide a sensitive insight into home life. The tutor emailed weekly reports regarding the home tutoring sessions and her concerns about the situation. It is unclear what use was made of this information.

In September 2016 to August 2017 the child's attendance was marked as 99.47% authorised absence. During this time the child received 6 sessions of home tuition and the parents cancelled 9 sessions.

The home tutor stopped in November 2016, as the Education Department were not responsible for the provision and a decision was made that it was the school's responsibility to provide for the child's education. The School were not aware that home tutoring had come to an end and were not aware the responsibility for the child's reintroduction to school had been passed to them.

In 2017/18 the child's attendance was marked down by the school as being 99.46% present with approved educational activity, when the child was at home not receiving any education.

Being marked present meant the child was not highlighted as a child who required an ESW service for non-attendance. The school remained responsible for the child's attendance plan. During the period in question there had been significant changes in the personnel and/ or roles at the school and the ESW service.

Since this time the School and the ESW Service have reflected, and changes have been made. The school have appointed an attendance officer who also leads on safeguarding issues. There is a new protocol for managing attendance plans and a handover process has been instigated to ensure a seamless transition of responsibility between the school and the ESW service. There is an agreed protocol for recording absences and a new Pastoral Policy has been launched enabling the ESW service to

monitor children absent from school and those recorded as present but with approved educational activity.

Home tutoring services have now been outsourced and provision has been made within the commissioning to ensure that all home tutors receive supervision and attend safeguarding training.

Disability

The child was diagnosed with Autism and Learning Disability. The child is subject to a Statement of Special Educational needs.

The parents made claims that the child became distressed and anxious when visitors entered the house and especially when the visitors went upstairs. The child could be heard screaming. Professionals visiting the house expressed concern about causing the child distress and this acted as a barrier to accessing the property and seeing the child. The parents explained that the child's anxiety and behaviour was symptomatic of the child's disability.

The school's view of the child when the child attended the school was very different to the view of the child portrayed at recent times. School's view was that when the child attended school the child appeared happy and settled and there were no issues.

There had been sympathy expressed with the parents regarding the fact that the child dominates and controls the home environment and that this must be difficult for the parents to manage.

Education services had previously chosen a non-punitive approach to the parents' situation which meant the child was not recognised as being absent from education.

The North Wales Safeguarding Board's – Safeguarding Disabled Children Policy recognises difficulties in attributing indicators of abuse or neglect or a reluctance to act on concerns in relation to disabled children, including:

- Over identifying with the child's parents/ carers and being reluctant to accept that abuse or neglect is taking or has taken place or seeing it as attributable to the stress and difficulties of caring for a disabled child.

- A lack of knowledge about the impact of disability on the child

- Confusing behaviours that may indicate the child is being abused with those associated with the child's disability.

Regardless of whether the child's behaviour was symptomatic of the disability or whether the child was instructed to behave in that way by parents, the child's behaviour influenced the actions of professional visitors to the house and possibly detracted from early assessment of the underlying causes or concern, and possibly masked or deterred an appropriate professional curiosity regarding concerns.

On the 5th of March 2018, the parents once again tried to restrict access by professionals to the child, due her presentation as being anxious demonstrated by her screaming. It was noted at the Learning Event that the Learning Disability Nurse pointed out to the parents the child was already sounding distressed regarding their presence therefore nothing was to be gained by not seeing the child. The Learning Disability Nurse and the Social Worker observed the child on the 5th and 6th of March 2018 and found her lying in a similar position on the sofa both days, her hair was matted and dirty and she appeared thin for her age.

Voice of child

Every professional working with children and young people should ensure the child's voice is heard, considered and taken into account on matters that affects them and those that impacts on their families. It also aims to improve the quality of decisions being made by professionals in their day to day work, resulting in improved outcomes along with the better use of resources and greater consistency across the service. From a legal perspective children and young people have a right to be heard. This is reinforced in the UN Convention on the Rights of a Child (1989) which states it is a child's right to be heard and to have their views taken into account regarding decisions that affects them.

Children aged 11 – 25 years of age within the Local Authority can access the Second Voice Advocacy Service. The child was offered this service by Social Services, but the service was declined by the parents and the child did not have the ability to access the service independently due to the learning disability.

During this Review there is very little evidence to suggest professionals considered the voice of the child. It is evident that limited contact with the child due to the behaviours of the parents hindered this. But there does not appear to have been consideration of how the child presented when accessing full time education, which was one of a happy child, and the rapid change in behaviour whilst at home.

Legal advice

Towards the end of the timeline, several discussions were held between Social Services and the Police regarding the process of removing the child from the home and the appropriate legal process to remove the child. Had the parents not consented for the child to be removed, the options being considered was either a Police Protection Order or an Emergency Protection Order.

It was agreed that legal advice would have been beneficial in order to advise the officers on the appropriate course of action and whether removal under another order would be more appropriate e.g. under the Mental Capacity Act: Mental Health Act.

Similarities with previous Serious Case Review

The panel considered the Serious Case Review undertaken by the Flintshire Local Safeguarding Board published on 11/1/12.

The case of SD had many similar features to this case:

- Parents initially appeared open to guidance and support
- Diminution of level of engagement by parents over time
- Limited professional contact with family
- Child's lack of engagement with health and education.
- Professional's reluctance to intervene in ways that would increase stress to the family.
- Desire to act with sensitivity to the parents' feelings
- Lack of communication between agencies

The report in 2012 concludes:

Practitioners need to be aware of the increased vulnerability of disabled children to abuse and neglect and of the early indications suggestive that a child with disabilities might suffer significant harm.

Parents need to be supported to help them meet the needs of their disabled children. However, they also need to be challenged where there are concerns that they do not have the capacity to do so.

Parents electing to educate their child at home does not mitigate the responsibility of the Local Authority to safeguard and promote the welfare of children in need.

Those in children's social services receiving initial safeguarding queries or referrals in respect of disabled children should have sufficient experience and competence in child protection work to ensure that disabled children are afforded the same degree of professional concerns as non-disabled children.

A number of recommendations were made in relation to the review of the policy in relation to Children Educated Other than in School and the development of better links between Education and School Age Nursing Team.

Reference Serious Case Review, SD. Flintshire Serious case Review Published 11/1/12.

Conclusion

This review clearly highlights a child with a disability who suffered emotional and physical neglect whilst in the care of parents with substance dependence and mental health issues.

There was clear evidence identified throughout the review process that the child and family needed help in order to meet the child's needs but despite the help being offered by professionals there appeared to be a lack of agreement about which service would best meet their needs. The evidence also suggests the parents requested help but when services were offered, they found these difficult to accept. This appears to be in relation to having to allow professionals access to their home and the child as they feared the consequences. These fears were based on that their alcohol dependence and hoarding behaviour would be exposed and result in the child being removed.

The Reviewers found the lack of scrutiny of the educational plan for the child was a critical part of the case and acknowledge that both the school and the ESW service have reflected upon this and changes have already been made.

It was also identified this case was allowed to drift by TAC without any evidence of escalation to managers. Following no response from the family the attempts to contact became less frequent.

The Reviewers have identified lessons for practice improvements in the following areas:

- Disguised Compliance and Professional Curiosity
- Safeguarding Children with a Disability
- Recognising and Dealing with Hoarding Behaviour
- Recognising and dealing with Parental Substance Misuse.

There were several factors within the review that contributed to delays in being able to identify and respond to the child's needs and it is regretful the child's situation could not have been identified earlier. These factors also contributed to the child's voice not being heard.

The reviewers would like to record their appreciation to the engagement of both parents who provided their own account on their parenting, substance misuse, hoarding activities and domestic violence and how this potentially impacted on the child. They additionally provided confirmation regarding their insistence on thwarting professional's attempt to assess the situation and to help. The reviewers acknowledge that this behaviour had an impact on service delivery by practitioners.

The reviewers would like to acknowledge the contribution made to this process by all agencies. Their involvement and co-operation have been appreciated.

To add a final conclusion, the reviewers felt it would be pertinent to end this review on a positive note and give a clear picture of the wellbeing of the child. The child is now happy and thriving, enjoying school and all activities. Both parents acknowledge the child is now receiving the care that is needed and being provided care that they sadly could not provide.

Improving Systems and Practice
In order to promote the learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:

Recommendations

1. To develop a Multi-Agency Protocol – Working with Families Who Display Disguised Compliance - NWSCB
2. To Establish a Regional Protocol for the recognition of children not in education and monitoring attendance plans. - Education
3. To promote the awareness of the NWSCB Hoarding Protocol. Multi Agency
4. To review the NWSCB Safeguarding Disabled Children Policy and ensure the

inclusion of the voice of the child - NWSCB

5. For TAC to review their current processes in managing non engagement of families and subsequent escalation of cases to managers.

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 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 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.
Reviewer 1: *(Signature)* Chris Weaver	**Reviewer 2:** *(Signature)* Valerie Ann Owen
Name: Chris Weaver *(Print)*	**Name:** Val Owen *(Print)*
Date: 11/02/2020	**Date:** 11/02/2020

Chair of Review Panel: *(Signature)*	
Name: *(Print)*	**Claire Lister**
Date:	**13/02/2020**

Appendix 1: Terms of reference

For Welsh Government use only

Date information received……
Date acknowledgement letter sent to Board Chair……..
Date circulated to relevant inspectorates/ Policy Leads…….

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Terms of reference for a Concise Child Practice Review (Annex 1)

Introduction

This Concise Child Practice Review has been commissioned by the Chair of the North Wales Safeguarding Children's Board on the recommendation of the North Wales Regional CPR Group in accordance with the Social Services and Well-being (Wales) Act 2014.

A multi-agency Review Panel and Review Panel Chair, Claire Lister has been identified by the Regional CPR Group. Two Reviewers have also been identified, Chris Weaver and Val Owen. The Chair of the Review Panel will regularly report progress to the Regional CPR Group.

Review Panel Members:

- Francine Salem, Children's Services, Wrexham
- Sophie Chance, North Wales Police
- John Grant, Education, Wrexham
- Jane Owen, Health
- Sue Aston, Health
- Paula Preece, Health
- Lawrence Dixon, Health
- Julie Francis, Housing
- Jason Lean, TAC

Core Tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the NWSCB.
- Examine inter-agency working and service provision for the child 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.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and extended reviews.
- 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 individual and family members prior to the event.
- Receive and consider the draft 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 Board 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.

Tasks of the Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Review Panel complete the report and action plan.
- Board sends 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.