Concise Child Practice Review Report WREXHAM 2020/1

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
* Summary timeline of significant events to be added as an annex

A concise review was commissioned by the North Wales Safeguarding Children's Board on the recommendation of the Child Practice Review Sub-Group in accordance with the Guidance for Multi Agency Child Practice Reviews.

The criteria for this review are met under Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 which are that 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.

In line with the Children Act 1989 a child is anyone up to their eighteenth (18th) birthday.

The child was found unresponsive at the family home. The Ambulance Service was called, and Advanced Life Support was initiated and continued until a decision was made by the Consultant on the Emergency Medical Services Retrieval and Transfer Service Helicopter to cease resuscitation attempts. A subsequent Coroners Inquiry recorded a verdict of death by misadventure.

Following the unexpected death of the child the Procedural Response to Unexpected Deaths in Childhood 2018 (PRUDiC) was initiated. The aim of the PRUDiC is to ensure that the response is safe, consistent, and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths.

The PRUDiC process identified that the child had been questioning his or her gender and had exhibited some self-harming in the past. There had also been suggestions of bullying by peers. Information was shared that the child had been Looked After prior to being adopted and that the child had unplanned contact with their birth family. In line with the process and after considering the information, it was agreed to refer the information and findings for consideration for a Child Practice Review.

The time line for the review was extended to be 19 months prior to the death of the child as this would take the review back to the first recorded reports of the child self-harming. The period of the review was from January 2019 to October 2020.

It should also be noted that the period between March 2020 and October 2020 was within the Covid 19 lockdown restrictions.

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

It has been identified with the benefit of hindsight that the child was experiencing several challenging life events that may or may not have caused anxiety or unhappiness.

It is possible that no one fully understood the child's needs and the learning is mainly to consider whether anything could have been done differently to understand those needs better.

The main areas of focus are:

- The needs of a Looked After Child, subsequently adopted.
- The needs of a child self-harming and expressing suicidal thoughts.
- The needs of a child questioning their gender.
- The needs of a child potentially being bullied.

The needs of a Looked After Child, subsequently adopted.

The child was originally raised by birth parents and experienced Adverse Childhood Experiences. The child was initially accommodated under voluntary arrangements, until cared for under a Care Order. The child was first placed with foster carers at 3 years of age, within the Local Authority area close to the birth family's home. Contact with the birth family was being promoted at this time and the placement appeared to meet the child's needs.

The child benefited from a stable placement and only experienced one move after being removed from the birth family.

When the child was 5 years of age, the plan of care for the child changed to adoption and the current foster carers expressed their wish to be considered as the child`s adoptive parents. They submitted their application to be assessed for approval. In

accordance with the Adoption and Children Act 2002 the prospective adopters attended a preparation course and were subjected to a full adoption assessment and their application was presented to the Wrexham and Flintshire Adoption Panel and the records note that “a positive recommendation was ratified by the Agency Decision Maker”.

Also, in accordance with the Adoption and Children Act 2002 the proposed match for the child was presented to the Wrexham/Flintshire Adoption Panel and the records note that “a positive recommendation was ratified by the Agency Decision Maker.”

The proximity of the birth family was risk assessed at the time and for a few years this proximity had not proven to be an issue. It was unfortunate that after a few years this proximity became an issue, however it was felt the decision for the child to remain in a stable home was in the child’s best interest.

At the time of the adoption, the Adoption Social Worker completed an Adoption Support Plan in accordance with the Adoption Support Services (Local Authority) Wales Regulations 2005. The plan notes the work to be undertaken with the child as the adoption plan progresses and the work to be undertaken with the birth father and paternal grandparents regarding changes to the contact arrangements following the adoption order.

The report presented to court during the adoption application (Annexe A) notes that

“The positive support for the placement of the child with the adoptive parents was based on the progress the child had made since being placed with the couple and the very strong attachments the child had made with them. It was recognised that the child was a confident child and regularly had expressed wishes to the social worker to remain with the couple. It was also recognised that the foster carers had become attached to the child and felt they would be able to provide the security the child required, whilst not being afraid to address the need to continue some level of contact with the birth family. It was acknowledged that the birth family were aware of the placement where the child was placed and there had never been any breach of the arrangement and it was felt that this did not pose a threat to the placement.”

The child was 6 at the time the adoption order was made.

At the time of the permanency planning there was recognition that there was an opportunity for the child to be placed in a permanent placement with parents who wanted to care for the child and where the child wanted to be. There was no consideration at the time of moving to a different placement, the question considered was whether the child’s needs would be best served by an Adoption Order or Care Order.

The parents had a good relationship with the Adoption Social Worker who undertook their adoption assessment and the adoption support plan noted that the Adoption

Social Worker and the Fostering Social Worker would be available as a long-term point of contact for “advice, information and onward referral as necessary”.

When issues arose with the child self-harming, expressing suicidal thoughts, gender questioning and contact with birth family the parents chose to contact the Adoption Social Worker.

Regulation 16 of The Adoption Support Services (Local Authority Wales Regulations 2005 requires the Local Authority to review the Adoption Support Plan if they become aware of a change in the child’s circumstances and they deem a review necessary.

The Adoption Social Worker responded each time, spoke to the parents, and gave advice. As the situation appeared under the parents’ control no further intervention was felt to be needed.

The Adoption Social Worker at the time did not review the Adoption Support Plan as she did not deem it necessary.

The Adoption Social Worker was informed by the parents that the child had been seen by the General Practitioner (GP) and Child and Adolescent Mental Health Service (CAMHS).

The Adoption Social Worker noted that she felt relieved to hear that the child was seen by the GP and CAMHS to talk about gender questioning issues as she felt that this was outside her understanding and experience.

After the Adoption Order the parents remained foster carers for a few years and resigned as foster carers in 2019. The contact with the fostering social worker had dwindled over the years and attempts were made to contact the foster carers to discuss their resignation as they were no longer offering foster placements. It is unclear whether they had been part of any foster carers annual review and whether the child’s voice was considered as a member of the household. When the fostering service contacted the carers regarding the resignation, they were informed by the parents about the child self-harming and gender questioning and were informed that the child had been to see the GP and was on a waiting list for CAMHS. As the situation appeared under the parents’ control no further intervention was felt needed.

There was no contact between the Adoption Social Worker and the Fostering Social Worker. There appeared to be no mandate for them to contact each other to share information and their record keeping is kept on separate electronic systems. It was found that both the social workers had different information about the child’s circumstances and that it would have been beneficial if that information had been shared within both services.

It also became apparent that the child had a younger sibling and when the younger sibling became the subject of care proceedings a decision was made by the sibling's child care team social worker/manager and Independent Safeguarding Reviewing Officer to contact the parents to see whether they could also consider the placement of the younger sibling alongside the child. It would appear that the parents and the child had discussed this, and a decision was made not to offer the younger sibling a home.

The decision to approach the parents for the younger sibling had not been discussed with the Fostering Social Worker, who may have voiced their reservations had they been approached.

It was also found that discussions about the potential contact between the child and the younger sibling had taken place. The child was said to be keen for this to happen however following unplanned contact between the child and the birth mother, a decision was made not to proceed with sibling contact. It is unclear and there is no documented evidence to state how this was dealt with and whether the child had been seen to discuss the decision not to proceed with contact or whether the parents had talked to the child about this.

Learning point

- The Local Authority have identified that local adoption policies and procedures at the time were limited and all adoption policies across Wales are in the process of being gathered and collated under the National Adoption Service Wales (NAS) All Wales Adoption Policies.
- All agencies need to be aware that children who are or have been looked after, are fostered or subsequently adopted are likely to have additional needs as they are likely to have suffered Adverse Childhood Experiences prior to being Looked After. NAS have developed a Good Practice Guidance on Foster Care Applications which will be published in October/November 2022.
- The family had been in contact with the Adoption Social Worker, the Fostering Social Worker, the younger sibling's Child Care Social Worker, the younger sibling's Independent Safeguarding Reviewing Officer. All these social workers and their managers were satisfied that the child's needs were being addressed and none felt that they needed to raise any reports of concern regarding the child's welfare.
- It was identified that at the time there was a lack of guidance regarding contacting adopters about potential contact between adopted children and their siblings and especially about involving the child in the decision-making process, especially when contact does not proceed. The NAS Good Practice Guide on Contact now exists to provide guidance on this.
- There had been no consideration of further siblings within the Adoption Support Plan and the sibling was not born when the plan was produced, however the NAS Good Practice Guidance on Adoption Support, notes the need to anticipate potential changes in circumstances. There appears to be a lack of consistent guidance about the protocol around consultation with key

parties regarding contacting adopters about potential placements of siblings and especially about involving the child in the decision-making process.

- There was no electronic system in place which facilitated communication between the practitioners and there is no evidence to support ongoing verbal communication between the practitioners.
- When the Adoption Social Worker was approached by the parents for advice, there would have been a requirement under the Adoption Support Services (Local Authority) (Wales) Regulations 2005 to consider the need to review the Adoption Support Plan.

The review will either:

a) confirm that the current plan remains fit for purpose, and a further review date is agreed and noted on the plan;
b) amend the current plan, but without the need for a full assessment, and a further review date is agreed and noted on the plan; or
c) decide that a full assessment is required, in which case the plan will be amended following that assessment, and a further review date is agreed and noted on the plan.

If it was felt that the child's issues were broader than those arising from adoption matters, then consideration could also have been given to the need to the potential benefits of **advising the parents to request an assessment** of the child's needs under Section 21 of the Social Services and Wellbeing (Wales) Act 2014.

Section 21 Duty to assess the needs of a child for care and support

Where it appears to a local authority that a child may need care and support in addition to, or instead of, the care and support provided by the child's family, the authority must assess:

a) whether the child does need care and support of that kind, and
b) if the child does, what those needs are.

(4) In carrying out a needs assessment under this section, the local authority must -

a) assess the developmental needs of the child,
b) seek to identify the outcomes that –

I. the child wishes to achieve, to the extent it considers appropriate having regard to the child's age and understanding,
II. the persons with parental responsibility for the child wish to achieve in relation to the child, to the extent it considers appropriate having regard to the need to promote the child's well-being

c) assess whether, and if so, to what extent, the provision of –

I. care and support,
II. preventative services, or

III. information, advice or assistance,
could contribute to the achievement of those outcomes or otherwise meet needs identified by the assessment

d) assess whether, and if so, to what extent, other matters could contribute to the achievement of those outcomes or otherwise meet those needs, and
e) take account of any other circumstances affecting the child's well-being.

- The Adoption Social Worker was providing support for the family by visiting and offering advice as was noted in the Adoption Support Plan agreed as part of the adoption process.
- At the time the Adoption Social Worker did not believe that the Adoption Support Plan required reviewing as the requirement to provide the Child with therapeutic services (Reg 3 (d) of the Adoption Support Services (LA) Regulations (Wales)2005 was being met via the referral to CAMHS. The Adoption Social Worker based upon the information shared with her did not identify that there was any need to suggest to the parents that an assessment under Section 21 of the Social Services and Wellbeing (Wales) Act 2014 may have been advisable.
- An Adoption Support Assessment under the Adoption Support Services (LA) Wales Regulations 2005 or an assessment under Section 21 of the Social Services and Wellbeing (Wales) Act 2014 could have been an opportunity for either the Adoption Social Worker or the Local Authority social worker as part of their assessment to contact the school and the school nurse and this would have alerted the school to issues in areas in the child's life that they had not been aware of. The assessment could also have clarified which services the child had been referred to and when.
- It was also noted that the child's Adoption Support Plan Review or Section 21 assessment could have identified the impact of unplanned contact with birth parents was having upon the child and could have raised the need for prohibitive steps to be put in place by the parents to safeguarding the child, E.G. a non-molestation order.
- It is unclear from the records who if any of the workers had been able to speak to the child regarding any of the above matters or if the child was seen or if the child had been seen alone. There does not appear to be any records indicating whether a request had been made to the parents to speak to the child and if these requests had been declined.

Had a review of Adoption Support Plan been undertaken under Adoption Support Services (LA) Wales Regulations 2005 or an assessment been undertaken under the SSWB (Wales) Act 2014 both assessments would have required the Local authority to involve the child directly.

The needs of a child self-harming and expressing suicidal thoughts.

There had been occasions where the child had informed the school about self-harming behaviour and suicidal thoughts. A parent of another child had also

contacted the school to raise concern about the child self-harming. The child had also approached school staff to talk about feelings regarding gender questioning. Each time the school staff had responded to the child and spoken to the parents who appeared supportive. The parents had indicated that they would support the child by seeing the GP and that they would be making a CAMHS referral.

Many agencies/workers had been reassured that the child was receiving the correct services and there had been several references to the child receiving counselling and had been seen by CAMHS. This was during a time when the child had not yet been referred to either a Counselling service or CAMHS. It has been noted that the approved route to CAMHS would have required the school, GP or other professional to make the referral as opposed to the parent. This may have led to an earlier response.

The school appeared to be satisfied that they had responded to the child appropriately.

The school however were unaware that there were things going on in the child's life in relation to contact with the birth family or the consideration given to adopt a younger sibling.

The child was referred to the school nurse and based on what information the school nurse had at the time, she advised the school that the child should be referred to CAMHS. There is limited information regarding when the referral was received by the school nurse and there is no written record of the school nurse's actions at the time of the referral or after.

The school nurse did not meet the child.

On receiving the referral, the school nurse had difficulty in ascertaining the child's correct surname and in locating the child's correct records. As the records were not available at the time, the school nurse was not aware that the child had been adopted, and unaware of the issues with birth parents and sibling contact. It was noted that the school nurse could have been more aware of the child's circumstances if there had been a complex case hand over between the primary and secondary school nurse service, especially as the child was not from one of the usual feeder schools for this school.

Records indicate that the school nurse involved at the time of the adoption was aware of the adoption. However, there have been a number of school nurses allocated over the years and it is unclear where this information was lost in handover between school nurses.
Records also indicate that the Looked After Children's Nurse undertook some assessments for the child and her involvement ended when the child was adopted. At the time there was no process for any handover between Looked After Children Nurse and the School Nurse.

During the review it has been established that Social Services had informed health that the child had been adopted. This notification was found in a “Special Health File” held by the Consultant Community Paediatrician. This file contains information regarding Social Service involvement, safeguarding issues and court proceedings. This “Special Health File” does not always reflect the information held by the school nurse. There was nothing on the child’s school nurse file to indicate that there was a “Special Health File” held on the child.

Learning points

- The school did not follow the formal Self Harm Pathway as expected within the self-harm Pathway process.
- Had the school followed the self-harm pathway and completed the risk assessment and discussed with CAMHS Single Point of Access then this could have led to the parents being advised of the value of approaching the Local Authority for support.
- The notification of adoption should have been copied onto the school nursing file.
- The review highlights the limitations of paper-based recording within BCUHB, and that the absence of a clinical IT system may impact where children and young people are accessing multiple services during their health journey.
- The referral to the school nurse indicated the child’s self-harming and suicidal thoughts. This should have raised significant concern to indicate that the school nurse needed to have a further discussion with the pastoral lead at the school and to inform an assessment of whether she needed to see the child.
- Had the adoption notification and name change been recorded properly then the school nurse would have been able to locate the correct notes and had she received the relevant information, then there could have been a different response from the school nurse as she would have been more aware of the Child’s Adverse Childhood Experiences.
- There was a missed opportunity for the school nurse and the school pastoral support to liaise and identify what had and had not been done as regards referrals for services.
- Even though the school were unaware of certain elements of the child’s life they were aware of the self-harming, mentioning of suicidal thoughts, and gender questioning issues. There was an opportunity to consider whether this was a safeguarding issue and whilst it was recognised that it was not assessed to be a safeguarding issue at the time, there should have been a record of the decision not to make a safeguarding report and why.
- It was also felt that the school had sufficient information to be able to advise the parents to request support for the child from the Local Authority, or to gain the consent of the parents to make a referral on their behalf.

The needs of a child questioning their gender.

In 2019 the North Wales Police Child Sexual Exploitation Safeguarding Team had visited the child to discuss concerns that the child may have downloaded inappropriate content from the internet earlier that year. During the visit the child and parents shared information about the recent events in the child's life and additional safeguarding advice was provided. The parents appeared in control of the situation and due to officers being informed that the child had been referred to CAMHS, a safeguarding report was not shared by police with children's services.

The child had approached the school to talk about feelings regarding gender questioning and this appeared to be one of issues behind the self-harm.

The school does not have any guidance in relation to responding to learners who experience LGBTQ+ issues. There is no County, Regional or National guidance available.

Once it became apparent that a CAMHS referral had not been made, the school made a referral. It has not been possible to ascertain why the referral did not arrive in CAMHS for a further 5 weeks after the date it was referred.

CAMHS can either receive referrals via email or by paper referrals through the post. The preferred option is by email. Referrers who send in referrals by email receive an electronic acknowledgement of the referral. All referrals are date stamped when they are received and screened by the CAMHS Single Point of Access practitioner.

Some agencies still refer by post, and the CAMHS referral in respect of this child had been sent in by post. Referrers do not receive any confirmation that their referral had been received by post.

Once the referral is screened the CAMHS service correspond with the child and parent regarding appointments. The CAMHS service only contact the referrer after receiving the referral if the referral is not accepted. It must be assumed as they had not heard from CAMHS that the referral had been received and the child and parent contacted.

If the school wished to find out about the response from CAMHS they could have made direct contact with CAMHS as they were the referring agency.

However, it would be reasonable in the circumstances, considering the delay already experienced in making the CAMHS referral that the school could have been proactive in checking the referral had been received. There is no record of this happening.
For a period of 2 months no agency contacted the CAMHS service to establish if a referral had been made, and no agency confirmed the reference to access to counselling or what this provision entailed. After 2 months the school nurse realised

that the CAMHS referral had not been made and advised the school to make the referral which they did.

The child was offered a Choice Appointment at CAMHS. The child and mother attended the appointment, and it was felt that the parents were supportive, and the child was at ease with the mother during the assessment. At the “Choice Point” at the end of the appointment the child was offered the choice of receiving a service from CAMHS or to be referred to Inspire.

Inspire is a Youth Service especially for young people who self-harm, they have a youth group attached that has a Pride sub group that meets regularly. Inspire is provided in partnership with Flintshire and Wrexham Local Authority.

The child chose to access to the Inspire Service. The Inspire Service have a waiting list and the child’s name was added.

The child was given information about what services to access whilst waiting and what to do if support was needed before the service started. The waiting list was 6 months long and the child and parents were not made aware of this at the time. When the service became available, the Inspire Service contacted the parents who said the service was no longer needed.

Learning points

- Had there been guidance on LGBTQ+ issues school may have responded differently.
- North Wales Police’s review reflects that based upon their response to the child in 2019, whilst there were no concerns that the child was at significant risk of harm, the submission of a safeguarding report to social services relating to the child’s suspected internet use would have ensured that wider concerns were shared.
- Had the school initiated the approved route to CAMHS earlier then the child may have been seen earlier.
- The school staff assumed that the paper referral had been sent, received, and responded to. There appear to have been no attempts to follow up to check the referral had been received by CAMHS.
- Had the school sent in the referral by email, they would have received confirmation straight away.
- Had the Inspire service spoken directly with the child they may have received a different response than the response received from the parent.

The needs of a child potentially being bullied.

There has been information shared which suggests that the child had been subjected to bullying by peers. Parents and the school became aware of certain bullying, although the school were not made aware of any issues with peers until the

child had been seen by CAMHS. However, there does not seem to be clear understanding of the nature of the bullying. School felt the bullying was due to the gender questioning issues and the parents believe it was in relation to being adopted. Social Media featured in the bullying, and it was felt that there was bullying in and out of school.

The school are confident that they managed the situation confidently and although their bullying and behaviour support policies require updating, they feel that their response was supportive. They believed they were always vigilant; they addressed issues amongst learners, and they allowed the child to move tutor group. The pastoral leads made time to talk to the child.

The factor of how the school managed bullying in general was raised as part of the review and the decision making relating to fixed term exclusions.

The school feel that all exclusions were in line with the guidance within Section 1.7 of the National Guidance on School Exclusion issued November 2019 by Education Wales:

1.7 Length of fixed-term exclusions:

1.7.1 The regulations allow head teachers to exclude a learner for one or more fixed-terms not exceeding 45 school days in any one school year. However, individual exclusions should be for the shortest time necessary, bearing in mind that exclusions of more than a day or two make it more difficult for the learner to reintegrate into the school. Inspection evidence suggests that one to three days is often long enough to secure the benefits of exclusion without adverse educational consequences".

It was noted that there was possibly a lack of multi-agency understanding about the extent of bullying within the area.

The school noted isolated incidents of bullying incidents outside school and especially on social media, and advice was given. At the time all incidents of bullying were recorded on an Internal Conduct Log system. Since this time a new system has been developed to record bullying which leads to a more strategic approach.

It was also noted that the incidents of bullying that the school were aware of, were not reported to the police. During the period of the review no incidents of bullying had been reported to the school community police office via the School Beat Website Incident reporting page. The police note that there did not appear to be a perceived problem of bullying within the school during this review period.
This perception is contradictory to the research findings of the School Health Research Network (SHRN) which concluded that in May 2020 99.8% of the school's pupils completed a questionnaire and 39% said they had been bullied in the last two months. Weight and LGBTQ+ issues were stated as the common reasons for the bullying. The Local Authority SHRN Health and Wellbeing Plan 2019 – 2024 outlines

the plan to reduce bullying and to work collaboratively with the police to prevent and respond to incidents of bullying.

Learning points

- There would appear to be the need to promote a multi-agency response to bullying, in relation to specific incidents and in relation to the development and implementation of school and Local Authority action plans following the SHRN research. This would support agencies to have a more holistic view relating to wider safeguarding concerns.
- During this period of the review, whilst fixed term exclusions appear to comply with both the National Guidance and the school's behavioural policy, the National Guidance does suggest that the decision to exclude should include consideration of whether the incident may have been provoked, e.g., by bullying or by racial or sexual harassment. All incidents should consider if they are out of character for the child and those involved, which may provide an opportunity to be more inquisitive around the nature of the disagreement and or incident.

Good Practice identified in agency analyses

- Child was seen by CAMHS within 28 days of receipt of referral.
- CAMHS assessment was collaborative, and outcome communicated to Family, Referrer, and the GP.
- The Adoption support service met with birth mother and parents around the attempts to contact the child by the birth mother.
- Wrexham Education felt the correct processes were all followed as per the process for referrals to the Inspire Service at that time and signposting information was provided to the young person and parents.
- The child, parents and the referrer were notified via letter that the child's name had been placed on the Inspire waiting list, also stating that if they had any questions or concerns to ring Inspire. Additional suggestions for support were also shared with the child and parents should support be needed before the appointment came up.
- WAST followed the PRUDiC protocol and liaised appropriately with the Police and the receiving hospital in the management of the incident.
- BCUHB are working to appoint Senior Mental Health Practitioners to support Early Help/Primary CAMHS pathway to Primary Care/GP Services in both Wrexham and Flintshire. Working in more integrated ways to build capacity and resilience and offer training and consultation to primary care. To date 4 practitioners are in post and active in GP practices in the East.

The voice of the child

To reflect on the voice of the child a meeting was held with a group of young people whose circumstances were considered to be similar to the child's circumstances and it was thought this may potentially give insight to the child's life. This meeting was

facilitated between a reviewer and young people who currently make use of the Inspire Service.

12 young people were happy to sit and discuss a variety of issues regarding their lives. All 12 were happy to share how they felt as either emotionally challenged or socially anxious young people, some of whom were also part of the LGBGTQ+ community.

The two main issues were isolation and bulling.

- Isolation, feeling alone, and that you are the only one who has these feelings.
- Bullying – mainly name calling, either insensitive, homophobic, or transphobic and sometimes all three.

The young people shared the value of the Inspire service and potentially what the child could have been able to access.

Inspire and Inspire Youth Club.

- All the young people felt that the best help they have received was from Inspire.
- Inspire staff talk to you like humans and don't write everything you say down and use it as part of some assessment.
- The youth club is a safe space to come as it is by invite only. So, you know everyone will be kind and sensitive. You are not judged or laughed at as everyone comes from a similar place.
- You can relate to the other young people, and you see them every week and meet up with them outside youth club.
- Trips and activities are arranged so that people who were socially anxious can go out, try new things, and feel supported.
- The staff are amazing; they really know how to help.
- It's space to have fun and relax.

Conclusions

The child's behaviour, self-harming, voicing suicidal thoughts and acting out of character in fighting with peers was an indicator that the child may have been experiencing difficulties.

Several professionals had some information about the child's life, but no one appeared to have the full picture.

The parents had been requesting support and discussing events with several professionals.

The professionals working with the family were content that the correct support was being offered.

There was an Adoption Support Plan in place at the time of the Adoption however the plan was not reviewed in the light of more recent issues.

Whilst no one had a specific mandate to make enquiries as to whether the correct referrals and services had been accessed, any one of the agencies could have advised parents to ask for a review of the Adoption Support Plan or to access other statutory or preventative support for the child from the Local Authority.

All of the agencies had been made aware that the child was self-harming, mentioning of suicidal thoughts, and gender questioning issues. There was an opportunity for all agencies to consider whether this was a safeguarding issue and whilst it was recognised that it was not assessed to be a safeguarding issue at the time, this should have been considered and recorded.

It was also felt that all the agencies had sufficient information to be able to advise the parents to request support for the child from the Local Authority, or to gain the consent of the parents to make a referral on their behalf,

There appeared to be six areas of where more professional curiosity could have been exercised.

1) Why was this child acting out of character?
2) What was the impact of the Covid 19 lockdown on the child and agencies?
3) What effect was the contact with the birth family and discussions around sibling contact having on the child's emotional wellbeing?
4) Were the parents aware that they can approach the Local Authority for a review of the Adoption Support Plan or Care and Support Assessment?
5) What was the effectiveness of the support the child was supposedly receiving on the child's emotional wellbeing?
6) What information other agencies held about the child and the child's needs?

The child's voice

The school reported that the child had consistently spoken to the school about thoughts and feelings especially early within the time frame of this review. The school were in the ideal position to fully engage with the child, hear the child's voice and act on the child's behalf. As time went by the school would have been in a good position to listen and give the child the opportunity to voice thoughts and feelings with an enquiring mind and not only taking the voice of the parents into consideration.

It has been noted that many agencies did not speak directly to the child, and the young people consulted during the review who were considered to be in similar circumstances to the child shared that the two most common concerns for them was isolation and bullying.

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:

Changes already made as identified in the agency analysis.

- Consultation is taking place regarding National Guidance in relation to notifications of Adoption Orders within health and the retention of the National Health Number.
- The Looked After Children's Nurse now attends all pre adoption meetings to collate information and shares this with the school nurse.
- The school nurse's recording of receipt of referral and the recording of subsequent treatment plans have been reviewed.
- NWAS have appointed a Life Journey work coordinator.
- NWAS have appointed an Adoption Support Service Advisor.
- All Wales National Good Practice Guidance have been published in 2021 as follows: Contact; Working with Birth Parents; Transitions and Early Support and Adoption Support.
- The NAS Good Practice Guidance on Foster Care Applications has been produced and will be published in October/ November 2022.
- Local authority has reviewed practice to ensure Social Workers see the child as well as parents and that this is clearly recorded, especially if parents do not consent.
- Police review identified the need to inform SSD of any visit to a child.
- The Inspire Youth service waiting list letter now includes a potential waiting time.
- The Inspire Youth workers now speak directly to child regarding their appointments.
- Education have developed an electronic system to record and share information about bullying.
- The school has introduced a new electronic supporting system for all Safeguarding Concerns.

Recommendations

Recommendation	Lead agencies
Awareness sessions to be arranged to promote regional understanding of adoption support framework and good practice guidance.	NWAS
To develop guidance regarding approaching adopters when siblings require placing.	NAS
Secondary Schools to provide evidence to the Chief Education Officer regarding the dissemination and implementation of the CAMHS self-harm pathway. Review documentation and referral process from the school to the school nurse.	Schools/ Education Education BCUHB
Request update from Welsh Government regarding	NWSCB

the development of National guidance LGBTQ+ in schools.	
Raise awareness of who can refer to CAMHS and the preferred route for receipt and recognition of referrals.	BCUHB
Promote a multiagency understanding and escalation of the School Health Research Network data.	NWSCB Local Delivery Groups
Develop Multi agency guidance response to supporting the emotional health and wellbeing of children who experience bullying.	NWSCB
Assurance that the school policies around bullying and managing behaviour have been reviewed and updated.	Education
Review the process of information sharing between the school nurse and any “Special Health File”.	BCUHB

Reviewer 1

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.

Reviewer 1
(Signature)

Name (Print): Val Owen
Date: 09/01/2023

Reviewer 2

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.

Reviewer 2
(Signature)

Name (Print): Angela Mansell
Date: 09/01/2023

Chair of Review Panel

(Signature)

Name (Print): Michelle Denwood

Date: 09/01/2023