Child Practice Review Report

North Wales Safeguarding Children Board

Extended Child Practice Review 2021/1F

Brief outline of circumstances resulting in the Review

To include here:

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

An Extended Child Practice Review (ECPR) was commissioned by the North Wales Safeguarding Children's Board on 06/05/2021 on the recommendation of the Child Practice Review Sub-Group in accordance with statutory legislation set out in section 139 of the Social Services and Well-being (Wales) Act 2014 and accompanying guidance Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).

The criteria for this review was met under Chapter 7, Extended Child Practice Reviews:

The Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; and the child was on the child protection register and/or was a looked after child (including a person who has turned 18 but was 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 a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development

The purpose of the review is to identify learning for future practice. It involves agencies, practitioners and families in a collaborative undertaking to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability not culpability. The objective of the review is to generate professional and organisational learning and promote future interagency and child at risk practice. (Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).

The review is undertaken by two reviewers working closely together, appointed by the Review Panel. They will have responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the Review Panel and the Board.

Methodology:

- Review Panel convened with a Chair.
- Two Reviewers appointed.
- Terms of Reference agreed
- Timelines were developed by each agency
- Panel members produced a summary/analysis of each services' involvement.
- A letter sent to the family providing the opportunity to participate in the process.
- A Learning Event 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 Child Practice Review Subgroup and the North Wales Safeguarding Children's Board.
- Submission to Welsh Government.
- Feedback to Family.
- Publication of Report on NWCSB website.

The services represented on the Review Panel were as follows:

- Education
- Health
- Police
- Local Authority Children's Services

Timeline

The timeline for this ECPR is from the 1st May 2019, when the first period of Child Protection Register registration ended up to the 17th March 2021 which is the date of

the death of the child. Agencies were also asked to consider their involvement prior to the timeline, if relevant.

Information was made available in regards to professional involvement with the child and the child's siblings. This provided a clearer picture of the functioning of the family and what the child's daily lived experience was in the context of the family.

Circumstances resulting in the review

On the 17th March 2021, North Wales Police (NWP) received a call relating to a 10-year-old male found hanging at his home address. NWP were informed that CPR was being performed by the child's father. The Welsh Ambulance Services NHS Trust (WAST) had been informed and were enroute while NWP officers were also dispatched to the scene. The child was taken straight to Ysbyty Glan Clwyd by paramedics. At 13:29hours, the child was pronounced deceased.

The child did not have any known history of mental health issues, or any self-harming behaviour and was understood to be in good health.

The Coroner's report determined the medical cause of death was death by misadventure.

The Childs Family History and Contextual Information

The child was a middle child in a sibling group of eight. The two older siblings did not have the same biological father as the child. All eight children lived with the child's birth parents, however at the time of the child's death the eldest sibling was residing with his girlfriend. The child had a close relationship with his two older brothers, with whom he shared a bedroom. The three brothers would enjoy spending time together on their bikes riding around the local community, or building dens in the nearby woodland. The child particularly enjoyed the challenge of playing with Rubik's cubes. School records also note that the child equally had a close relationship with his father, with occasions recorded of the child being upset and crying for his father. The child was described by school as having friends, he interacted well with others, enjoyed talking to adults around school and he loved helping out and presented as someone who wanted to please his teachers.

Between 2018 and 2019 the children were subject of Child Protection (CP) Registration under the categories of Neglect and Sexual Harm with concerns dating back to 2017. The concerns highlighted at the time centred on the parent's inability to meet the needs of the children in addition to reports that the mother was using drugs whilst pregnant. There were also concerns that the children were associating with a Registered Sex Offender (RSO). It must be noted that during this period no disclosures were made by any of the children regarding having suffered harm by the Registered Sex Offender in question.

The timeline of professional involvement shows that from the point of removal from the CP register in May 2019, the parents appear to rapidly disengage with services and concerns are raised in relation to:

- The children having head-lice
- Children missing health appointments
- Children taking food from other children and teachers in school
- Children displaying challenging/bullying behaviour in school
- School attendance significantly deteriorating
- A child suffering injuries such as a bruised rib and broken hand
- Emerging concerns about domestic abuse
- A lack of boundaries and associated consequences in place for the children

All concerns are recorded within six months of de-registration.

By November 2020, ongoing concerns about the children's school attendance, health appointments being missed, poor home conditions, mum's substance misuse and mental health, led to the appropriateness of the Care being questioned, a decision was made that the case should again be presented to an Initial Child Protection Conference. During the conference the decision was taken that the children, with the exception of the eldest who was approaching adulthood, should again be placed on the Child Protection Register, under the category of Neglect and Emotional Harm. The emotional harm was attributed to the behaviour of the eldest sibling having a negative impact on the younger children's emotional wellbeing.

The timeline clearly shows that between the periods of de-registration in 2019 and the point of re-registration in November 2020, the child's behaviour and demeanour changed. A child who was once described as someone wanting to help and please his teachers, who was well behaved in class and on the school yard, with a good group of friends, was later described as a child who on more than one occasion injured his peers; with one incident recorded where he was alleged to have thrown his peer to the ground and assaulted him. It is important however to note that between the date of the CP registration in November 2020 and his death in March 2021 there are no notable concerns raised in relation to the child, with the exception of his poor school attendance and the reported reluctance to attend school (note: this is reported by the parents and school). It is reported by school that when he was in school he appeared fine, presented clean and well, had lots of friends and worked well with others. It is important to note that in reading the core group minutes following the CP re-registration in November 2020 there is no explicit reference to the child other than the concern in relation to his school attendance and the support he requires to complete school work (as shared by mother at the CP review conference in February 2021). The last sighting of the child was two days before his death during a CP statutory visit in which the children were seen together under the supervision of the parents as they would not allow the social worker access to the home. During the learning event it was shared that during a supervision session on the 9th March between the child's Social Worker and the manager a discussion did take place as to whether the case should be escalated to a resource panel meeting

to consider proceeding to a Legal Gatekeeping Meeting due to the little progress having been made by the family and restricted access to the children.

On the 23rd of March 2020 the nation was instructed to stay home due to COVID 19. Schools were forced to close their doors to the majority of pupils with only those children whose parents were key workers or those children who were considered vulnerable were permitted to attend an educational setting; a Hub. The child and their siblings were offered places at the Hub however due to concerns about the transmission of COVID-19 the offer was declined by the parents the education department did attempt to complete welfare visits and did make a computer available to the family for on-line learning, however both actions were refused. In response to this the school did produce hard copy work packages for the children however these were rarely collected from the school and were not completed.

A feature throughout the timeline was the behaviour of older siblings and it appears that much attention and support was given to one of the older siblings and to the parents in relation to his behaviour. A considerable amount of direct work was completed with the older sibling on anger management, while parenting support was also provided due to mother sharing that she struggled to manage his behaviour. It is important to note that there are a number of occasions documented by professionals that indicate a tension and inconsistency in the parenting styles of mother and father. The child's mother was observed as not instilling boundaries and consequences, whilst father did try to put these in place. At the core group in March 2021 it is noted that father shares that he feels he and the mother are not united in their parenting and that he has taken the decision to "take a step-back" from parenting. The timeline shows there had been significant incidents within the home relating to the older sibling, which in the view of the reviewers would have impacted on the child in question as the incident involved the police being called to the home following the sibling threatening to physically harm the parents. It is felt that this was especially significant given the child's positive relationship with their sibling. It is also evident that the older sibling at times took on a caring responsibility for the younger children and felt that as he was the oldest child, and the father being notably older than his mother, it was his responsibility to care for his younger siblings.

Practitioners involved in the review have also shared that it was known that the family were ostracised by the local community, with several incidents where the children were accused of misdemeanours and the family publicly shamed on social media platforms. There was also an incident of the child's older siblings being verbally abused by a member of the public.

Another feature identified in reviewing the case were the concerns raised by a number of professionals in relation to mother's mental health. The schedule of expectations developed in April 2020 clearly states that mother is to engage with mental health support and request a medication review with the GP, which mother did action in relation to recommencing her anti-depression medication. However, by September 2020 mother is reported to have finished taking her medication without

consulting the GP. Professionals involved in the review did note that they found it difficult to assess the extent of mother's mental health and its impact as mother would either refuse visits to take place or if they did take place they would take place on the doorstep or in the alleyway at the side of the house, thus limiting the detail of conversation. It is evident that professionals from health and social care were proactive in encouraging and supporting mother to access support in relation to her mental health, using regular text reminders and phone calls to ensure medication was being taken and appointments were attended.

Concerns were also raised in relation to mother's substance misuse with a number of different professionals sharing their concerns and its impact on mother's mental health. Between July and November 2020 (the point of re-registration of the children on the Child Protection Register) there are a number of occasions in which professionals believe mother is under the influence of substances including an instance in July 2020 when mother shares with a social care worker that she has been taking drugs (which she subsequently asks the worker not to share with the child's Social Worker). In November 2020 the Police report at the initial Child Protection conference that mother is self-medicating with amphetamines and is keeping her drug use away from her partner. The schedule of expectations clearly requires mother not to be under the influence of substances when around the children. In support mother was offered a referral to the substance misuse service but she declined the referral being made.

View of the family

The parents of the child were informed of this child practice review and invited to meet with the reviewers, mother agreed to meet and father chose not to.

The reviewers met with the mother at her home address during the early afternoon of the 30th September 2022. The reviewers explained the purpose of the visit and explained that this was an opportunity for her to share her views. Mother welcomed the reviewers into her home and presented as being comfortable in speaking openly about her experience.

The mother shared with the reviewers that her son, the child subject to this review, was a happy loving boy, who enjoyed going out with his brothers riding his bike around the local area. The mother shared that she had also at one time liked to ride a bike with the children but since the loss of her son she felt this would bring back too many memories which were too painful at present.

The mother shared that although her son did have friends he did not like big crowds in school and did not like the fact he was often kept back after class for not finishing his work, not liking this he would often refuse to attend school.

The mother felt that the COVID 19 pandemic was a pleasant time for them as a family in terms of them spending time together as a family, however the home

schooling which was expected of her was difficult as she felt she did not have the literacy skills to complete the work.

The mother shared that in regards to the child protection process and the care and support protection plan, she felt the plan was in place to ensure the children's attendance in school, to attend all appointments and to keep the children safe; the mother made reference to her own family and that she did not associate with some of her own family members in order to safeguard the children. When asked about whether she felt the child protection conference addressed each child individually the mother felt this was done and shared that the children's school attendance was addressed individually.

The mother shared the tension the family had had within the community and how her children would often be blamed for any antisocial behaviour within the community and that the difficulties with the neighbours were known to the children.

The mother shared that her and the children's father are no longer in a relationship (the relationship having come to an end after the death of their child), although he is still very much part of the children's lives. Interestingly the mother shared that friends of hers have commented she appears more confident now that they are no longer together, and she shared herself that she feels more comfortable in questioning or challenging the father now if she doesn't agree with him, whereas while in a relationship she may not have felt able to do this. It must be noted that no domestic abuse was disclosed to the reviewers but this does provide some insight into the dynamics of their relationship.

It was clear from conversations that there was a lot of love and emotional warmth between the mother and child and she spoke fondly about her son and shared happy memories, as well as the painful memories of his last hours. The mother's grief was evident and the pain and loss she felt from no longer having her son with her was felt by the reviewers.

The family have not as yet received any therapeutic support to address their loss and the mother shared this is something she felt would be beneficial to support them moving forward.

Learning Event

A Learning Event took place on the 25th January 2020 via a virtual platform due to the restrictions of COVID 19. The Panel Chair and two Independent Reviewers facilitated the day. Practitioners with direct case involvement with the child and the family were invited to the Learning Event, which supported practitioners to consider their involvement, practice, assessments and decision-making processes.

Agency representation attending the Learning Event included:

- Education

- Health
- Police
- Social Services

The Learning Event highlighted good practice between all professionals involved with the family and it was clear that all professionals had strived to engage and support the family. All professionals working with the family were experienced practitioners and communicated with their partner agencies.

The Learning Event also recognised the limitations to creating meaningful change for the family while working through the constraints of a pandemic.

During the Learning Event, professionals highlighted key learning areas which will be detailed within the body of this report.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

Themes

Voice and daily lived experience of the child

Positively, during the learning event practitioners were able to describe the child, share that he had a close bond with his two older brothers, and provide the reviewers with some insight into his hobbies and interests. It was shared during the learning event that Children's Services were persistent in attempting to engage the family and during the Care and Support Plan being in place eleven visits were attempted although many of these were unsuccessful, and only one visit where the children were spoken to individually. Once the children were placed on the Child Protection Register in November 2020, despite agencies working within the limitations of the pandemic, visits continued in line with statutory timescales.

Although statutory visits were completed within timescales, the child was not seen or spoken to alone; as stipulated in the Wales Safeguarding Procedures 2019. In this case it was reported that visits were conducted in accordance with the guidance of the temporary emergency measures of the local authority in response to the COVID 19 pandemic. In following this guidance visits took place in the form of door step visits, where all the children were seen together and briefly through the doorway.

With the practitioner having to remain outside the property and not wanting to breach the family's confidentiality (for example if a neighbouring family were to overhear the conversations) visits were brief and each child was not spoken to individually.
The children not being in any educational setting during lockdown and low attendance once school re-opened also created a barrier to Children's Services and other professionals being able to speak independently to each of the children and restricted the opportunity for relationships to be developed.

Several attempts were made to capture the child's views for the Child Protection Conference through the local authority conference buddy scheme, however all were unsuccessful as the mother did not make the child available and claimed the child did not want to speak with the buddy; this was not confirmed by the child. It is worthy of note that the child's siblings did on occasion engage with the buddy.

It was shared during the learning event by the child's social worker that they felt visits were "not natural" with the children appearing to have been prepared for the visit and possibly told by the parents what to say.

It would appear that the quality of visits had been impacted by a number of factors:

a) The constraints of working through a COVID 19 pandemic, where social distancing was mandatory.
b) Parents' fear of the transmission of the disease, the father being in his senior years and a carer to his mother-in-law resulted in them not allowing professionals to enter the family home despite professionals being prepared to use all necessary PPE equipment.
c) The child being one of a large sibling group; all with differing needs due to their age range.
d) Mother's mental health difficulties and substance misuse
e) Disguised compliance by the mother.

The absence of the child's individual voice is a notable theme throughout the child protection documentation reviewed. With the exception of the concerns in relation to school attendance there is no reference to the specific daily lived experience of the child and there is no evidence of the voice of the child being captured. It should be acknowledged however that the information shared by the school during CP meetings does provide some insight into the child's personality and presentation however this does not appear to be considered and discussed explicitly during core group and CP conference meetings.

This is a theme that is often noted in other Child Practice Reviews across England and Wales. Despite legislative and policy frameworks identifying the voice of the child as paramount, the application of this in practice has been the subject of much debate. Research undertaken in Scotland on child protection documentation and case conferences noted professionals filtered and interpreted the child's view rather than presented it in its pure form (Bruce, 2014). Professor Eileen Munro in her review of child protection in England, emphasised *"Children and young people are a key source of information about their lives and the impact any problems are having on them in the specific culture and values of their family. It is therefore puzzling that the evidence shows that children are not being adequately included in child protection work" ([10], p. 25).*

The Wales Safeguarding Procedures 2019 also recognise the importance of developing an insight and understanding of the child's daily lived experience and

hearing their voice and stresses it is essential that practitioners engage with every child within the family who is on the CP register to establish whether the plan is improving the quality of their lives and protecting them from harm. The Procedures put emphasis on 'seeing' the child as being much more than physically seeing them, it means engaging with the child to understand what life is like for them, ascertaining their wishes and feelings, enabling them to communicate in a way that is comfortable to them, so to understand the world of the child from their perspective.

Large sibling groups

A feature of a number of Serious Case/ Child Practice Reviews are concerns in relation to families of a larger size (with four or more siblings) compared with the general population. The NSPCC identify that this is more pronounced where children have a CP plan for neglect where almost one in five families were large in size (NSPCC 2013).

Horwath & Tarr (2015) note that Social Workers often find it difficult to keep a focus on individual children who are members of large sibling groups. It can be challenging for both the family and practitioners and so the Wales Safeguarding Procedures 2019 suggest that when it comes to Child Protection Conferences, for conference members to be able to consider the needs of each child in a large sibling group, consideration should be given to holding two conferences to ensure sufficient time is given to each individual child. This did not take place in the case of the child's family.

Adopting this format for conferencing may have allowed for greater discussion around the individual needs of each child. Horwath & Tarr (2015) advise that when children become categorised as a 'neglected child' priority for interventions become focused on parental problems and behaviours and it becomes less likely that their individuality, and that of any siblings, is properly explored and considered. Horwath & Tarr (2015) suggest this could explain why child protection plans often include general actions for parents where success is measured by their completion of tasks.

As has already been referenced earlier, a review of the key care and support and CP documentation show that the profile and understanding of the child is limited and they appear to be lost amongst wider concerns relating to the siblings and those of the mother. During the learning event social care staff described the process of case recording in relation to the lead child and in this case the lead child was an older sibling. As a result, the focus has been placed on the older child in particular in relation to targeted intervention for them and the mother in respect of her parenting capacity. Whilst it should be acknowledged that concerns relating to other siblings in the family are noted and captured within assessments and both care and support plans and care and support protection plans there is no reference and focus on the child who is at the heart of this review.

Multi-agency Communication and Documentation

The timeline shows regular and comprehensive communication and information sharing between all agencies involved with the family. Examples of this include:

- School nursing liaising with the Health Visiting service and education, regarding a younger sibling having head lice and the children's school attendance.
- The school nurse liaising with the community dentist regarding a younger sibling requiring fourteen teeth to be removed, with the school nurse subsequently advised the dentist to inform Children's Services.
- The school nurse providing a report for the Strategy Meeting held under the Wales Safeguarding Procedure to ensure school nursing information was considered when considering if the children were at continued risk of significant harm.
- The Health Visiting service were proactive in trying to engage the family. They conducted numerous home visits and endeavoured to support the family in other areas, rather than just focusing on child health e.g. the Health Visitor provided the mother with housing support details due to home conditions needing improvement
- The Health Visitor liaising with the family GP and Children's Services to share information/concerns.
- The Health Visitor attending the Strategy Meeting held under the Wales Safeguarding Procedure ensuring the Strategy Meeting was a multi-agency decision making forum.
- The school attempting multiple ways to communicate with the family, including numerous attempts to contact the family via telephone, letters and offered meetings with the parents. The school also attempted to conduct welfare checks to the children during lockdown, albeit mother often refused/ prevented the visits from taking place.
- The school liaising with other agencies and referring a sibling to CAMHS for additional support.
- The school database for capturing concerns was used effectively with a vast amount of information captured. Equally, the Education Welfare Service also kept an up-to-date and in-depth log of all contact with the family, phone calls were made, letters were sent and meetings arranged. A bus pass was provided for an older sibling to address punctuality. When the Education Welfare Office had concerns over mother sounding drowsy on the phone contact was made with Children's Services to share their concerns.
- The Police providing a detailed report for the CP conference which reflected previous involvement when analysing the risk of harm to the children. Police expressed their views clearly within the initial CP conference and made it clear they felt the case needed to be escalated to senior management due to the children having been placed on the Child Protection Register for the second time. During the learning event it was highlighted they did not believe this happened however a representative from Social Services described the

process for meeting the threshold to escalate the case further and why the case was not escalated further.

- Children's Services ensuring they communicated with all partner agencies and that each had a copy of the Schedule of Expectation that was in place regarding an older sibling. Care and Support meetings took place while trying to support the family on a voluntary basis prior to registration. Evidence based tools were used by the social worker to inform practice e.g. home conditions tool, Risk 2 assessment. There was evidence of regular Core Groups ensuring information sharing on a regular basis. There was evidence of creative methods in attempting to communicate with the children; on one occasion the social worker had bought the child a Rubik's cube as he had shown an interest in them.

It is appropriate however, to make the observation that in meetings such as Child Protection Conferences and Core Groups each agency kept their own record of the meeting, leading to some inconsistencies within record keeping. For example, the notes of the core group in March 2021 taken by Education note that the mother was seen to have a black eye during the meeting yet this information was not recorded within Children's Services Core Group minutes, which is of significance given the known concerns of relationship tensions between mother and father.

Within the timeline there were further indicators of inaccuracies within documentation. For example, there were three entries in the Children's Services timeline on the same date in relation to the decision taken in response to a 'combined referral because of care and support received from Education' where one entry stated 'No Further Action', another stated 'Closed', while the third stated 'Case Allocated'.

It was also evident from the timeline and from the Child Protection Conference minutes that some key information relating to the child's behaviour in school was missing from the initial conference. The school had logged a number of incidents within the twelve months prior to conference where the child had been disruptive in class, numerous reported incidents of the child having hurt other pupils and fighting with peers. This information was not presented to the initial conference by Education and it was noted within the conference that the child's "behaviour is really good and he can follow rules... He can be a bit silly but it is nothing of concern".

During the learning event, professionals from agencies external to Social Services did state that they are required to make their own notes as there are delays in the minutes of core group meetings and CP conferences being issued, with examples of delays of six weeks provided. The Wales Safeguarding Procedures (2019) state that "The conference chair should agree the records including who should receive a full or partial copy before they are distributed. A summary and outline plan should be circulated within 5 working days or by the first meeting of the core group.

A copy should be sent as soon as possible after the conference to all those who attended or were invited to attend, including family members, except for any part of

the conference from which they were excluded. Good practice would aim for circulation no later than 20 working days”

Disguised compliance/Non-engagement of parents

Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement, it is a common feature within North Wales Child Practice Reviews (North Wales Safeguarding Children’s Board (NWSCB) 2020).

The NWSCB identifies the following as some of the indicators of disguised compliance;

- A lack of measurable progress at reviews, despite apparent effort and co-operation from parents;
- Parental agreement to change but not completing agreed actions to achieve it;
- Frequent missed appointments;
- Attempts to minimise professionals’ concerns;

All of these were evident within the timeline and supporting documentation.

There was evidence of the mother expressing a need for support during conversations with professionals but then refusing referrals to the appropriate services. Examples of this include:

- The home conditions were in need of repair and the Home Conditions tool identified clutter and rubbish in the garden with the schedule of expectations of April 2020 stating a need to address this, yet parents declined a referral to Care and Repair to support with this.
- Mother consented to a referral to CAMHS for the older sibling but did not engage in any follow up and so the referral was closed.
- Despite a referral to Substance misuse service having been agreed and drawn into the Care and Support Protection Plan, mother later declined the service.
- Numerous reminders were given by health professionals on the importance of mother following up a paediatric review for a younger sibling, an asthma review for another child and a GP appointment to review mothers own mental health difficulties, with mother consistently failing to follow up on these.
- There were numerous Attendance Strategy Review Meetings organised by the Education department which parents failed to attend.
- Mother was offered an advocate but declined the offer

Despite this it was evident in the learning event that professionals did challenge the parents in relation to concerns such as the impact of mother’s mental health on her parenting capacity and meeting the children’s needs; mum’s substance misuse;

school attendance of the children and the parents not signing the schedule of expectations.

Engagement within the Child Protection process was also minimal. Neither parent attended the Initial Child Protection Conference in November 2020, although mother did try to phone in part way through but due to interference with the line she was advised to leave and that the Social Worker would update her following the meeting. Mother did attend the Review CP conference in February 2021, but only attended one of the core groups (out of the four core group meetings the reviewers had sight of). The father did not attend the Initial or Review Conference, or the four Core Group meetings. Social care practitioners did however share during the learning event that they were proactive in ensuring that parents were informed of all meetings, provided with relevant paperwork in advance of meetings to ensure they would be able to contribute to discussions and to ensure they fully understood any decisions made during meetings and the expectations on them as parents.

The literacy skills of mother were also highlighted during the review. Mother had shared with the Social Worker that she had difficulty with reading and writing and that both her and her partner struggled with technology. This was shared in the core group and agreement was made that all reports would be shared verbally. Practitioners from all agencies also shared that they were proactive in contacting the parents via telephone calls and text messages. The GP did share during the learning event that she was not aware of this and was mindful that correspondence with the family from the GP surgery was often via letter, however other professionals (particularly those in health) provided examples of making regular contact with mother in particular to remind her of planned appointments.

Engaging the father

The NSPCC (2015) highlight that men play a very important role in children's lives and have a great influence on the children they care for. Despite this, they can be ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers and female carers. Their analysis of Serious Case reviews found that fathers who were capable of protecting and nurturing the child were often overlooked by professionals. Although the NSPCC review considered the estranged fathers, the principles of engaging fathers in the CP process also apply to those fathers who remain in the home but allow the mother to attend all statutory meetings.

This review identified that the father did not attend a number of child protection meetings regarding his child and identified an additional concern noted by professionals that the mother may have been concealing some information from him.

Prior to the initial CP conference mother had requested she discuss the Social Worker's reports for conference separately without the father as it contained information regarding mother's substance misuse, which the father was not aware

of. Within the initial CP conference minutes, it states the father had lost a family member to substances and would not tolerate any drug use. There was also historical information detailed in relation to sexual abuse the mother had experienced and during the learning event it was shared that when this was discussed during the initial CP conference in 2018 (father was in attendance but mother was not) father was seen to be shocked about the information that was shared.

The first core group minutes note that mother was not being open and honest with father as he was not aware the children were on the CP register and that mother wanted to hide information from father through fear of him ending the relationship. It was also shared in the learning event that it was believed the mother had signed the Schedule of Expectation on behalf of the father, as it had been left with the mother overnight and upon return had the same handwriting on each signature.

With professionals mindful that the mother may have been deliberately holding back information from the father, and it being logged that the father was more engaging than the mother, the Health Board agency analysis raised the question of if professionals had tried to engage the father more would this have led to support services being more accepted. During the learning event this was discussed and there were a number of examples provided of professionals engaging with father, including: meetings prior and post CP conferences and core groups; during statutory visits and telephone conversations (particularly with school). A number of professionals also recounted conversations with father about parenting boundaries with the children in which he is reported to have shared his frustrations that he was the one who would try to implement boundaries but that mother had a softer approach to parenting and that he felt that he was perceived as being too firm.

Neglect and home conditions

Neglect is the persistent failure to meet a child’s needs. It is not a one off event but is rather an accumulation of issues over time (NWSCB 2021).

The NSPCC (2020) explains that neglect can be a lot of different things, which can make it hard to spot. They identify four main categories of neglect to assist practitioners:

- Physical neglect; a failure to meet a child's basic needs, such as food, clothing or shelter, are not met or they aren't properly supervised or kept safe.
- Educational neglect; where a parent doesn't ensure their child is given an education.
- Emotional neglect; when a child doesn't get the nurture and stimulation they need. This could be through ignoring, humiliating, intimidating or isolating them.
- Medical neglect; when a child isn't given proper health care, this includes dental care and refusing or ignoring medical recommendations.

These definitions of neglect were evidenced several times in respect of the child and the family including:

- Physical neglect; the child and his sibling were found taking food from other children and teachers when in school, indicating they were hungry. Poor home conditions were noted several times within the timeline, on one occasion it was described as appalling and on another described as the walls and living room being in a state of disrepair with all surfaces visibly dirty, the cooker not accessible due to the amount of 'stuff' and items in the way.
- Education neglect; the child's attendance had dropped to 23% with his siblings also with low attendance resulting in a Fixed Penalty notice being served to parents but not actioned.
- Medical/health neglect; a younger sibling required fourteen teeth to be removed, parents failed to attend the dental appointment numerous times. Parents failed to ensure another sibling had his Asthma review resulting in him requiring emergency services due to respiratory distress. The children also suffered continuously with head lice.

The review found little evidence or consideration given about the impact neglect may have had on the child's health, development, behavioural and emotional wellbeing. The individual voice of the child may not have been heard but the information held by various agencies did provide an insight into the child's lived experiences. The timeline evidences periods of neglectful parenting, but its impact on the child was not explored or recorded within any of the documentation viewed by the reviews.

Again this is not an uncommon theme within child protection work, as research by Community Care and the NSPCC found that social workers lacked confidence when it comes to identifying and responding to child neglect. The research revealed that child neglect is not a priority for social workers, with 60% saying they feel pressure to downgrade neglect cases (Community Care 2022). It must be noted there was no evidence to suggest any down grading of this case, but the research does provide some insight into how neglect cases may be perceived by statutory agencies with demanding caseloads.

Professional Curiosity

Within the timeline the reviewers identified several missed opportunities for further curiosity and exploration from professionals. These include:

- The incident where the child and his sibling were taking other pupils snacks in school. This would imply the children were hungry, raising the question had they been adequately fed at home. There was an opportunity here to ask the child why they needed snacks in school, had they had breakfast that day or tea the evening before.
- The child and a sibling began to display bullying behaviour in school. The change in behaviour raises the question what had changed for the children for

their behaviour to change. There was an opportunity here to ask the child what was going on for him and why was he hurting other pupils.

- The older sibling falling asleep in class and sharing he had been babysitting his younger siblings as the mother did not trust the father. The question is around why did mother not trust the father caring for the children and what impact the caring responsibilities were having on the older sibling but also for the other siblings.
- During one home visit by the Police it was noted that the mother appeared to visibly shrink when the father returned home. This raised the question was the mother afraid of the father or was there information the mother was keeping from the father.
- There were two occasions where the older sibling had sustained an injury, one being an injured rib and the other being an injury to his hand. How these injuries occurred was not explored and there is no reference to them within health records.
- The local community were concerned that the child and his sibling were injuring animals in the woods. Further discussions with the child would have allowed for a better understanding and if there was any intent or motive to inflict an injury.
- There were several references within the timeline to mothers' drug use, from a neighbour having called the mother a "smack head", the mother openly admitting having taken "wizz", and it being noted within the Initial Child Protection Conference that mother appears to be self-medicating with amphetamines. There is however, no clear picture of the mothers' substance misuse, in terms of how many different substances, how often it was used and how this then impacted her day to day functioning, behaviour and parenting capacity.

Agencies Fulfilling Statutory Duties

Under the 'Was Not Brought' procedure of Betsi Cadwaladr University Health Board there were eleven logs of 'not brought' made between the period of time of the children being removed from the CP register in May 2019 and being placed back on the CP register in November 2020. With a further three logs to Was Not Brought whilst on the CP register. The Health Boards procedure to use Was Not Brought, The Standard Operational Procedure for monitoring children who were not brought (WNB) (2015), is a safeguarding process to monitor all children who were not brought for appointments and health surveillance. It identifies failure to attend health appointments can be an indicator of a family's vulnerability, potentially placing the child's welfare in jeopardy. The procedure states if the second appointment is verbally agreed but not attended, then staff should consider contacting Safeguarding Specialists for advice. BCUHB identified within their agency analysis that this procedure was not followed by some internal services and that had it been followed then the Local Authority would have formally been aware of the non-engagement sooner. At the time of writing the report this procedure is under review.

The Schools Attendance Policy, approved and adopted in October 2019, notes that schools have a duty to promote the safety and well-being of all students; however, this becomes difficult when students do not attend school. The policy highlights that The Education (Penalty Notices) (Wales) Regulations 2013 gives Local Authorities the power to issue Fixed Penalty Notices (FPNs) to the parents; these are issued by the Local Authority, not by the school, and can only be issued if a student exceeds 20 sessions of unauthorised absence within a term. In March 2020 the Education Department within the Local Authority did authorise a Fixed Penalty Notice be sent to parents in response to the child's poor school attendance and a Fixed Penalty Notice served in regards to a sibling's poor attendance. The school however were soon instructed to close due to the COVID 19 pandemic and so any significant change in attendance had become unattainable. Upon the reopening of schools in September 2020 the child's attendance had dropped to 32.5% with a further drop to 23% by the beginning of term following the Christmas period of 2020; by this point the school had entered a second lockdown. Despite numerous attempts and strategies being used to try and improve the school attendance of the child (and their siblings) it is felt that the disruption to education through national lockdowns obstructed further action being taken by the Local Authority to address the poor attendance.

In accordance with the Wales Safeguarding Procedures (2019) the Care and Support Protection Plan, developed by Children's Services should be developed in two phases; an outline plan drawn up at the initial child protection conference and developed into a more detailed plan at the first core group meeting. In addition, each child in the family should have their own plan that recognises and addresses their own specific needs. However, common practice within the Local Authority is said to be if the core group feels the outline plan is sufficient it is agreed as the final plan.

There was no evidence within any of the records the reviewers had sight of, of there being a standalone detailed Care and Support Protection Plan nor there being an individual plan specific to each child as the actions identified are contained within the CP conference and core group minutes and subsequently reviewed at each meeting.

On reviewing the actions identified as part of a plan for the family it is evident that they were predominantly focused on the older children and on the concerns relating to the mother in particular and were notably service focused with no reference to the specific care and support needs, risks and outcomes for the child. During the learning event professionals did share that they felt the existing arrangements worked effectively as it is clear who is responsible for what actions and that these are reviewed at every meeting to monitor progress. However, there was agreement that there needed to be more time devoted to the development of the child's care and support protection plan in relation to each child within the CP conferences and that this should be developed as a multi-agency group and with the family, as opposed to the Social Worker being responsible for developing the plan. The Wales Safeguarding Procedures (2019) state that the local authority is required, in partnership with other agencies including the parents and the child), to prepare and maintain the care and support protection plans. The care and support protection plan

co-ordinator, also referred to as the Social Worker, takes lead responsibility for the plan on behalf of the Local Authority.

The Wales Safeguarding Procedures (2019) also state the child is to be seen at least every ten working days and at home at least every four weeks, to ensure the child is seen alone whenever possible and as a minimum this should be every six weeks. The child's bedroom is to be seen at least once between CP conferences. It is understood that the restrictions of the COVID 19 pandemic impacted on the ability to meet all these requirements and the Local Authority had implemented temporary measures for managing statutory visits throughout the pandemic, which included a risk assessment approach to determining which families there would be attempts to enter the family home. Whilst initially the decision was taken to undertake door step visits (in order to adhere with social distancing and COVID restrictions) with the child and the family there was a decision taken to conduct visits within the home due to the escalating concerns, however as has already been noted despite PPE equipment being used and social distancing measures in place mother refused entry for professionals into the family home and instead the children were often spoken to on the door step of the home or in the garden with the parents frequently with them.

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:

In considering the evidence considered during the review and the reflections and learning presented during the learning event the following have been identified as the key learning points:

- What Matters Conversations conducted by Social Services should be undertaken with each child individually at the earliest point possible.

- All assessments undertaken by professionals should seek to establish and understand the daily lived experience of each child

- Section 47 enquiries;

    - ✓ The what matters conversations with individual children and the parents to be commenced at this point
    - ✓ The level of literacy of each parent to be understood at this stage
    - ✓ The outcome of the Section 47 enquiry to be shared with all partner agencies.
    - ✓ Information obtained within the S47 to be available on each child's case file.

- Care support and protection plans;

    - ✓ The learning event identified that more time should be allocated to developing the care support and protection plan within the child protection conference. It is felt that due to the length of time spent discussing the family and the noted concerns leaves little time to develop the plan, resulting in it predominantly being a Children's Services plan, rather than being a multiagency plan that is developed co-productively with the family.
    - ✓ Care and Support Protection Plans must not to be governed by the lead child. Having an individual plan for each child within the family would support practitioners to remain focused on each individual child.
    - ✓ Care and Support Protection Plans to be written in a way that reflects the parents' literacy skills and understanding

- Timeliness of minutes being distributed to partner agencies;

    - ✓ Core group minutes to be distributed to partner agencies within five working days

- Compliance with the Wales Safeguarding Procedures needs to be monitored by all agencies involved in supporting children who are supported through the procedures.

- In large sibling groups and in complex families with multiple issues it is important that a proportionate approach is taken to developing care and support protection plans so that support and intervention can be managed in a timely, staged and co-ordinated manner so as not to overwhelm the parents and the family with multiple expectations, interventions and services being provided at the same time. This would allow for the impact of interventions to be monitored and measured to ensure they are having the required impact in improving the child's daily lived experience in that they help meet the care and support needs, manage and mitigate identified risks and enable the child to achieve their outcomes (what matters to them).

- BCUHB to ensure all internal services working with children and families consistently follow the 'Was Not Brought' procedure.

Conclusion

When examining how the statutory duties of all relevant agencies were fulfilled, there were a number of areas identified where practice had been impacted by the COVID 19 pandemic. All the practitioners within the learning event accepted they were operating under very exceptional circumstances balancing safeguarding alongside the risk of COVID 19, for example visits to the family were challenging due to having to have doorstep conversations. Professionals identified that alternative means of

communicating with the children would have been beneficial, such as through the use of iPad or video calling so they could see family and home conditions, would have been beneficial. However, it was not noted that internet access was not always reliable, the parents were reluctant to have computer equipment in case the children damaged or misused it and the parents' admission that they did not feel confident using technology.

When considering recommendations in relation to child protection practice, there needs to be consideration of what is currently available to support the desired outcomes. In regards to the identification of the child's voice and lived experience being one area for development, the North Wales Safeguarding Childrens Board have created Guidance and Case Studies for Professionals on Capturing the Daily Lived Experience of Children, Parents and Carers Guidance. It is recommended that this guidance is adopted by all professionals working with children and young people.

In response to neglect having been identified as a theme, the North Wales Safeguarding Childrens Board have created an Information leaflet on Recognising and Responding to Neglect. In response to disguised compliance, again the North Wales Safeguarding Children's Board have developed a Practice Guide for Working with People Displaying Disguised Compliance. It is recommended that this guidance is adopted by all professionals working with children and young people.

Consideration needs to be given to the value of reproducing what is currently in existence and any action plan moving forward needs to be innovative and meaningful.

The reviewers would like to thank all those practitioners who took part in the review and to reassure them that from examination of all the documentation presented to the reviewers and the discussions and reflections during the learning event there is no evidence to suggest or indicate that the death of the child could have been predicted nor prevented.

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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): Vicky Allen

Date: 19/12/2022

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): Lisa Cappa

Date: 16/12/2022

Chair of Review Panel

(Signature) 

Name
(Print): Sophie Chance

Date: 16/12/2022

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Child Practice Review process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

Family declined involvement ☐

For Welsh Government use only
Date information received
Date acknowledgment letter sent to Board Chair
Date circulated to relevant inspectorates/Policy Leads

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			