South East Wales Safeguarding Children Board
Bwrdd Diogelu Plant De Ddwyrain Cymru

Working Together For Children - Gweithio'n Gytûn Ar Gyfer Plant

Concise Child Practice

Review Report

in respect of:

Child K

(SEWSCB 2 /2015)

Date of Report: 20th June 2016

Child Practice Review Report

South East Wales Safeguarding Children Board
Concise Child Practice Review

Re: *SEWSCB 2 / 2015*

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*

Legal context

A Concise Child Practice Review was commissioned by South East Wales Safeguarding Children Board following the recommendations of the Child Practice Review Panel convened on 6th May 2015.

In accordance with the Guidance for Multi Agency Reviews the criteria for this review are met under section 5. **The Terms of Reference for the review are at annex 1.**

Circumstances resulting in the review

This review concerns the case of Child K who died on 3 March 2015 when she was found hanging in her bedroom closet.

The time period for the review was agreed from 4 March 2014 to 3 March 2015.

Prior to the commencement of the timeline it was understood that in 2009 Child K had spent 7 months in foster care under Section 20 arrangements and that there had been 2 periods of child protection registration (October 2009 to February 2010 and July 2012 to September 2013) for Emotional Abuse. There had been, in addition a history of Child K and mother being victims of anti-social behaviour.

Prior to her death, Child K had been an open case with the Child Adolescent Mental Health Service (CAMHS). At the time of her death she was not engaging directly with the support offered but her mother was receiving support from the psychology service. On 4 November 2014 Child K attempted to hang herself in her bedroom,

however, professionals were not made fully aware of this until 25 November 2014 when mother disclosed the incident to the psychologist who was working with her. Child K was then seen by a GP on 26 November 2014 and prescribed anti-depressants. For the next 3 months Child K continued to attend school and engage with her youth provision programme until the day of her death.

Following Child K's death, a Professional Response to Unexplained Death in Childhood (Prudic) was held and an Immediate Response Group convened with arrangements made to ensure support was available for pupils and teachers within Child K's school.

The summary timeline of significant events is at annex 2.

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

Response to Non-Fatal Hanging (4.11.14): Following the incident on the 4 November 2014 Child K was observed wearing a scarf to school and pupils reported that they had seen marks on Child K's neck. Education questioned Child K about potential self-harm and contacted mother. Child K and mother (initially) denied self-harm and gave another explanation for why Child K was wearing a scarf. There was no evidence via a direct disclosure that Child K had attempted to harm herself. Education relayed this information to Children's Services. When it subsequently came to light via health that a non-fatal hanging incident had occurred a further referral was made to Children's Services.

The learning event questioned what might have been the appropriate response to these events. It appeared that the concerns were not considered, at the time, in relation to the historical context, family functioning and Child K's history of self-harm. There was no multi agency assessment to determine the level of risk and Child K wasn't visited to talk to her about what had actually happened. Each agency addressed the self-harm in isolation and there was no bringing together of the wider picture to agree a safety plan. Practitioners identified that this could have been achieved through a multi-agency strategy meeting. Child K was undertaking very high risk behaviour and had done so since 2009. In hindsight, the non-fatal hanging incident did not trigger an adequate multi agency response.

Working without full knowledge of family history: The overarching view of the learning event was that professionals were over reliant on mother and 3rd party information. Professionals accepted information from mother without challenge and did not consider alternatives. Professionals did not assess mother's capacity and

motivation to take protective action.

Within the case it was assumed that professionals involved knew the family history and functioning. However, the historical overview was not always known by professionals and it was felt within the learning event that there were limited opportunities for this to be collectively shared and discussed. Practitioners felt that having greater opportunities to bring an historical overview to bear would have enabled a clearer analysis of risk.

Quality of referral and interagency communication: Each agency involved held a lot of information on the family but there were many inconsistencies which were not analysed by individual agencies or shared between professionals. Agencies made assumptions about other people's roles and responsibilities; how other professionals were responding and what they knew. This led to a presumption that risks were being addressed when in fact they weren't. For example, it was assumed that the GP was undertaking a mental health assessment. Perceptions about knowledge and expertise between agencies created a barrier to effective professional challenge.

The Learning Event questioned how professionals might feel more confident and enabled to ask pertinent questions of others, and to use supervision and support more effectively to reflect and analyse concerns. Practitioners discussed the benefit of having 'meaningful conversations' with others particularly around analysis of risk, referral processes and adherence to procedures. What constitutes a good quality referral, and how practice might be improved in relation to referrals was discussed. Practitioners stated that historical information is not routinely shared at Core Groups and there is an assumption that those present know of the historical and current concerns.

The child's voice: Child K lacked trust in professionals who faced many difficulties in engaging with her. Child K was a victim of bullying from within the community and her sense of victimisation exacerbated her mistrust. Child K was reported to be sad and withdrawn as far back as 2009. Professionals did not fully appreciate how family functioning might have created barriers to understanding Child K's world. Child K was a 16 year old adolescent who was able to disengage with professionals, deny incidents of concern and mask the true extent of her issues. Professionals recognised that Child K needed to speak to someone but found it difficult as she refused to engage. The Learning Event highlighted the difficulty in engaging with adolescents particularly with regard to emotional safety and wellbeing. Further consideration was given to how a child's presentation might inform the analysis of risk. The learning event highlighted the importance of sharing information and ensuring the child's best interests are the paramount concern.

Good Practice

1. Education made efforts to engage Child K and tried different approaches.
2. Following Child K's death Educational Psychology Service provided a co-ordinated response including facilitating the Circles of Vulnerability exercise with key members of school staff, structured group sessions for pupils and one to one counselling by Eye to Eye.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the LSCB and its member agencies and anticipated improvement outcomes:-

South East Wales Safeguarding Board

1. The SEWSCB should review the current training being delivered on issues of Self Harm and thoughts of Suicide in Young People for practitioners, to ensure that the training covers:

   - Assessing and managing risk of harm from a multi-agency perspective
   - Responding to young people who disengage from support services.
   - Consideration of the primacy of the young person's 'voice' and ways that young people might communicate with others both professionals and peers.

2a. Children's Services should provide evidence to the SEWSCB that they have procedures in place to ensure appropriate decisions can be made in response to referrals according to the level of risk of significant harm.

2b. Partner agencies should ensure staff are effectively trained regarding good practice in making child protection referrals to children's services and are confident in making professional challenge.

3. SEWSCB to identify and disseminate good practice in relation to responding to the death of a school age child.

Gwent Police

1. Should review their practices in light of this case around the identification of safeguarding actions when managing incidents of anti-social behaviour either when the young person is the victim or the perpetrator of anti-social behaviour.

Blaenau Gwent Children's Services

1. Address identified learning needs with staff via supervision and the development of individual training plans.
   Update: Completed.

2. To update internal training, 'Messages from child practice reviews' to include lessons learnt regarding the significance of historical information.
   Update: Completed.

Aneurin Bevan University Health Board

1. To assist in the supervision and support of staff when dealing with difficult Child Protection Cases by ensuring Multi -Disciplinary Meetings are more focused with an agreed Terms of Reference, chair, and for minutes to be produced.

   Update: Completed

2. To use the Welsh Applied Risk Research (WARRN) assessment within CAMHS with an agreed process for updating assessments.

   Update: Completed

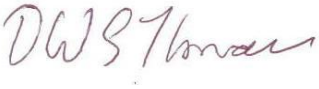
3. To develop a guidance pathway for working with non-engaging Children and Young people / Working with parents

   Update: In progress

4. To deliver specific training to CAMHS and Psychology Services regarding sharing information with other agencies, confidentiality issues and the impact on the therapeutic relationship

   Update: In progress

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** *(as appropriate)*	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Jane Rodgers	**Name** *(Print)*	Heidi Goodwin
Date		**Date**	

Chair of Review Panel (Signature)	
Name *(Print)*	David Thomas
Date	

Annex 1: Terms of reference
Annex 2: Summary timeline

Child Practice Review process

To include here in brief::

- *The process followed by the LSCB 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.*

Child Practice Review Process

The South East Wales Safeguarding Children Board (SEWSCB) Chair notified Welsh Government in June 2015 that it was commissioning a Concise Child Practice Review in respect of Case K.

External Reviewer: Heidi Goodwin, Children's Services Manager, IFSS Newport, Barnardo's

Internal Reviewer: Jane Rodgers, Service Manager, Social Services, Monmouthshire County Council

Chair of Panel: David Thomas, Service Manager, Children's Services, Caerphilly Social Services

The services represented on the panel consisted of:

- Gwent Police
- Children's Services
- Aneurin Bevan University Health Board
- Welsh Ambulance Service
- Education, Merthyr County Borough Council

The Panel met regularly from July 2015 in order to review the multi-agency information and provide analysis to support the development of the report.

Learning Event

A Learning Event took place in October 2015 and was attended by the following agencies:

- Aneurin Bevan University Health Board
- Education, Merthyr Tydfil County Borough Council
- Merthyr Tydfil School
- Gwent Police
- Children's Services

Family Members informed

Relevant family members were informed that the review was taking place and those deemed appropriate were offered the opportunity to meet, but no response was received.

☒ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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

Annex 1

Terms of Reference for Concise Child Practice Review
Case K

The terms of reference of this review have been approved by the Chair of the Review panel. This is a live document and may need to be amended during the course of the review.

The Review will be managed according to the SEWSCB Protocol for undertaking Child Practice Reviews. The Case Review and Practice Development group has established a review panel with a Chair and reviewer/s who will undertake the review.

Core Tasks.

The Review will consider practice and what overall lessons can be learnt from the case and will:

The following core issues were agreed for the terms of reference:

1. To examine inter-agency and cross-border working and service provision for Child MR through defined terms of reference.

2. To seek contributions to the review from the appropriate family members and keep them informed of key aspects of progress.

3. Identify particular issues identified for further clarification including:

- Agencies response to lack of engagement from adolescents / families.

- Managing anti social behaviour as it links to identification of vulnerability of young people

- Multi-agency response to suicide / self harm – risk management process.

4. To produce a report and an action plan for publication and to hold a Learning Event.

5. The SEWSCB Business Unit will be responsible for maintaining / facilitating links with all relevant agencies, families and other interests.

6. The Panel Chair will inform the Chair of the SEWSCB and the SEWSCB Case Review and Practice Development Sub Group of significant changes in the scope of the review and the TOR will be updated accordingly.

7. The Chair of SEWSCB will be responsible for making all public comment, and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the Final SEWSCB Report.

8. The SEWSCB and Panel will seek legal advice on all matters relating to the review. In particular this will include advice on:

• Terms of reference;

• Disclosure of information;

• Guidance to the panel on issues relating to interviewing individual members of staff.

9. To undertake the review giving consideration of the following parallel processes and how they will contribute to the findings:

- PRUDIC
- Coroner's Inquest
- Health Serious Incident Review
- Children's Services Internal Review

Specific tasks of the review Panel

- Identify and commission reviewer/s to work with the review panel in accordance with guidance for a concise review.
- Agree the time frame for the review of the incident from 4th March 2014 – 3rd March 2015.
- Identify agencies, relevant services, professionals, family members and significant adults involved with the children to contribute to the review.
- Each agency to produce a timeline of significant events.

- Each agency to produce a summary report which includes background information, previous incidents (where applicable) and a brief analysis to accompany the timeline.

- Produce a merged timeline and collective analysis.

- Identify key practitioners and plan how they will contribute to the review process and learning event. Ensure arrangements in place for providing support and arrangements for feedback.

- Plan with the reviewers contact arrangements with the family prior to the learning event.

- Following the learning event receive and consider the draft child practice review report to ensure that the terms of reference have been met and any additional learning is identified and included in the report.

- Agree conclusions from the review and an outline action plan and arrange for presentation to the SEWSCB for consideration and agreement.

- Following acceptance by the SEWSCB, plan arrangements to give feedback to family and to practitioners with involvement and share the contents of the report following the conclusion of the review and before publication.

Tasks of the South East Wales Safeguarding Child Board

- SEWSCB scrutinises draft report and action plan for revision by final Panel as necessary.

- SEWSCB signs off report before submission to Welsh Government.

- SEWSCB confirms arrangements for the management of the multi agency action plan by the Case Review and Practice Development Group, including how anticipated service improvements will be identified, monitored and reviewed.

- SEWSCB plans publication on SEWSCB website.

- SEWSCB agrees dissemination to agencies, relevant services and professionals.

- The Chair of the SEWSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Annex 2

Summary Timeline

March 2014	April 2014	May 2014
Psychologist meets with Mother School referral to Children's Services regarding concerns over self-harm and general presentation	Psychologist meets with Mother Child K's case closed on Children's Services system	Psychologist meets with Mother

November 2014	December 2014	January 2015	February 2015	March 2015
Non-fatal hanging incident Referral from school to Children's Services Mother discloses hanging incident to Psychologist Child K and her mother attend appointment with GP Referral from Psychology to Children's Services	Psychologist meets with Mother CAMHS contact GP to advise change in medication was required NEET team involvement Children's Services do not progress the referral regarding the hanging incident	Medication issued via GP surgery (Child K not seen) Child K meets with NEET worker	Medication issued via GP surgery (Child K not seen) Child K attends asthma clinic and GP is informed. Some concerns about presentation. Child K meets with NEET worker	Mother reports Child K absent from school due to illness. Fatal hanging incident.