Child Practice Review Report

CYSUR Mid and West Wales Safeguarding Children Board

Concise Child Practice Review

Re: CYSUR 2/2015

Brief outline of circumstances resulting in the review

- **Legal context from Welsh Government Guidance in relation to which review is being undertaken**

- A concise child practice review was commissioned by CYSUR Mid and West Wales Safeguarding Children Board in accordance with Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews (Welsh Government 2013). The criteria for this review are met under section 5.1 of the above stated Guidance, namely.

- A Board must undertake a concise child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has –

    - Died; or
    - Sustained potentially life threatening injury; or
    - Sustained serious and permanent impairment of health or development;

  and

  the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding –

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

- The purpose of a child practice review is to identify learning for future practice, and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and family. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency child protection practice, with a focus on accountability and not on culpability (Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government 2013).

- The criteria for concise reviews are laid down in the Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.

- **Circumstances resulting in the review**

Introduction

- The concise child practice review concerns a young child who tragically died, aged eight years old, in December 2011, and was educated at home by the child's parents. The child lived with his mother, his father and an older sibling.

- The post-mortem examination found that the child appeared to have been suffering from gross anaemia, dental abnormalities and soft tissue haemorrhage in the lower legs. There was no evidence of any medical input regarding the deterioration of the child's health.

- Between July 2003 and July 2004, all appropriate immunisations, including MMR, health checks and visits were satisfactorily carried out. The three year developmental check was declined by the parents in 2006 and, despite re-offering the appointment; the parents did not want any further contact.

- The child was educated at home and had no direct contact with any agency from the age of thirteen months. The child was not initially registered with Local Authority 1 (LA1) as an electively home educated child, where the family resided.

- In May 2010, adult protection concerns were raised with Local Authority 2's (LA2) social services directorate by an employee of LA2 as a result of an employment dispute involving the child's mother, who was employed within LA2. LA2's social services directorate took the view that the criteria for triggering the Protection of Vulnerable Adults (POVA) procedures were not met. This followed a case discussion between practitioners from both Local Authorities, from which it cannot be recalled whether the personal details of the family were shared. As a result of this telephone conversation, no referral to Adult Services in LA1 was made.

- The LA1 Education directorate were first made aware of the family in June 2010, after a Head teacher at a school in LA2 contacted the Education directorate in LA1, with a notification of a family with two children being educated at home.

- It was immediately confirmed by the manager of the Pupil Support Service in LA1 that the children were not on the elective home education database and were not known to the Education directorate in LA1.

- Due to the children not being on the elective home education database, the manager of the Pupil Support Service assigned two Pupil Support Officers to undertake a home visit to the family to clarify the context of the education provision. This is routine practice and relates to the LA1 elective home education process. The home visit was undertaken in early July 2010, but entry to the household was denied with the father stating that the family did not wish to engage with the LA1 in any capacity.

- Parents have a right to educate their child at home provided that they fulfil the requirements under Section 7 of the Education Act 1996. This places a duty on the parent to ensure that his/her child receives an efficient full-time education suitable to his/her age ability and aptitude either by regular attendance at school or otherwise. Under Section 437 of the Education Act 1996, the Local Authority has a legal duty to intervene if they have concerns, from whatever sources, about any aspect of home based provision. The authority does not, however, have the right to insist on seeing education in the home and some parents may not feel comfortable in allowing an education officer access to their child or family home. Where a parent elects not to allow access to their home or family this does not of itself constitute a ground for concern about the educational provision.

- It is recommended in the Inclusion and Pupil Support Document 47/2006 that the Local Authority contacts parent/s on an annual basis to request a meeting or an updated report in order to provide parents with information or support and would enable the authority to fulfil its duty in deeming the education as satisfactory. Parents whose children are registered at a school must ensure that their names are removed from the school admissions register when they withdraw them from school to home educate. If they do not do so they may be liable to prosecution. However, in this particular case, there is no evidence that the child and older sibling were ever registered at a mainstream school.

- The Law did not and currently does not state any general requirement for parents to inform the Education directorate if their child /children were never on a school roll. There is no express requirement in the 1996 Education Act for Local Authority Education directorates to investigate actively whether parents are complying with their duties under Section 7. These duties are reliant upon receiving parental consent.

- Between August 2010 and October 2011, further attempts were continued by the Education directorate in LA1 to establish meaningful contact with the family. However, all communications with the family remained unsuccessful.

Child Practice Review process

- In line with Safeguarding Children: Working Together Under the Children Act 2004 (Welsh Assembly Government, now Welsh Government), a recommendation for a serious case review was made to, and accepted by, the Chair of the LSCB in LA1 in March 2012, but mindful of the ongoing criminal justice process and HM Coroner's Inquest.

- In line with Safeguarding Children: Working Together Under the Children Act 2004, Individual Management Reviews (IMR) were completed by each respective agency as part of the serious case review process. It was decided that the overview report should not be completed, nor the process finalised, prior to the completion of the criminal justice process and HM Coroner's Inquest, as is often the practice in such circumstances.

- From 1 January 2013, the serious case review system was replaced with child practice reviews by Welsh Government. Pursuant to Section 34 of the Children Act 2004 & Local Safeguarding Children Boards (LSCB) (Wales) Regulations 2006 (as amended in 2012), the Welsh Government issued guidance, which was first implemented in January 2013 Child Practice Review Guidance: Protecting Children in Wales Guidance for arrangements in Multi-Agency Child Practice Reviews.

- Between December 2013 and February 2014, Care and Social Services Inspectorate Wales carried out an investigation into an allegation made under the Public Interest Disclosure Act. The allegation was that an IMR had not been completed in accordance with the relevant statutory guidance Safeguarding Children: Working Together Under the Children Act 2004. The Executive Summary of this investigation was published in May 2014 with its conclusions and recommendations.

- In June 2014, the LSCB in LA1, with the agreement of Welsh Government, ceased the serious case review process due to the protracted criminal justice process, but with agreement to recommend a child practice review upon completion of said criminal justice process.

- During 2014, and in accordance with section 135(6) of the Social Services and Wellbeing (Wales) Act 2014, the four LSCBs within the Dyfed-Powys region formally amalgamated to create one regional Safeguarding Children Board entitled CYSUR.

- A multi-agency regional Child Practice Review sub-group was also formed, with a mandate to receive, agree and provide governance for referrals, decision-making and recommendations up to, and for approval by, the Chair of CYSUR.
- In November 2014, following a detailed review of the case, the Crown Prosecution Service decided not to proceed with the case as it was felt that it was not in the public interest to pursue a prosecution.
- The Inquest in this matter reached a verdict of Open Conclusion on 29 January 2015.
- A concise child practice review was commissioned by CYSUR in March 2015 on the recommendation of the regional Child Practice Review sub-group, and following receipt of independent legal advice in February 2015.
- The requirement to undertake a child practice review is mandatory if the criteria set out, see page one, are met. Therefore, the Chair of CYSUR was under a duty to accept the recommendation.
- The review initially covered the thirteen month period immediately prior to December 2011 and with reference to earlier correspondence during 2010, from the Education directorate in LA1, in order to put the timeline into context.
- A significant period of time has elapsed since the death of the child (December 2011). This is due to three separate issues. The time taken for the criminal investigation to reach a conclusion; the time taken for the conclusion of HM Coroner's proceedings, and a change in the legislation relating to the undertaking of a child practice review in Wales.
- In January 2016, the CYSUR Safeguarding Children Board agreed to amendments on the terms of reference for the review, following new and, potentially unseen, information from LA2 and a recent communication with the father of the child.
- In line with the guidance, the parents were notified, in writing, of the review.
- Given the amendments to the terms of reference and, following independent legal advice, the CYSUR Board proceeded to commission a new author for the review. This decision was taken because the child practice review is being undertaken by an entirely new board since the original serious case review was undertaken and local boards amalgamated into a regional board in accordance with *section 135(6), Social Services and Wellbeing (Wales) Act 2014*.
- There was limited involvement of practitioners with the child, however representatives of all agencies involved, or who might have been involved, contributed to the learning event held on 10th June 2016.
- Many attempts were made to engage with the parents of the child and also a separate attempt to hear from the older sibling was made. This resulted in extensive written correspondence from the father of the child on behalf of the family, explaining their strongly held view that the review should not go ahead. Following a final attempt to seek their views ahead of the learning event the father wrote a lengthy response to restate their unwillingness to participate.
- Several attempts were also made to obtain information from a third party where it was suggested they may hold relevant information. The third party declined to share any such information.
- The parents have a number of ongoing and unresolved complaints regarding this and the previous review processes.

Practice and organisational learning identified from the learning event

The learning event took place on the 10th June 2016. The event was well attended and all of the relevant practitioners and agencies were represented. There were opportunities for consideration of all the key facts and related themes. An opportunity was provided for anonymous contributions to be made during and at the conclusion of the event. This did not lead to any new information coming forward.

It was very apparent that the circumstances leading to the death of the child were deeply distressing for those practitioners involved. Whilst it was acknowledged that in following the correct procedures there was nothing any individual agency or practitioner could have done differently to avoid this outcome, great regret and sorrow was expressed at this tragic loss.

There was overall agreement that the correct procedures were adhered to as far as the legal requirement regarding elective home education permitted. An important element of this event, therefore, focussed on the effectiveness of the current guidance and, in particular, the consultation document Welsh Government draft non-statutory guidance for local authorities on elective home education (2015).

There was an acknowledgement that parents have the right to choose to educate their child at home rather than at school. Home education is not, in itself, a risk factor for abuse or neglect. However, there is a potential that these children can become 'invisible' and this case has highlighted the safeguarding risk of isolation from professionals.

The review and learning event focused on the following:

Effective practice:
All efforts were made from an educational perspective to maintain contact with the family in line with the current legislation regarding the elective home education requirements.

Practice and organisational learning:
This case has a number of unique factors. These require consideration in order to understand the context of the learning.

The child was not seen by anyone from the agencies involved in this review from the age of thirteen months. He was home educated. The parents were known to some agencies and they had contact with a number of these agencies leading up to the time of the child's death. The post mortem report states that "these findings together are explicable through the effects of longstanding vitamin C deficiency (scurvy)". The parents dispute this as the cause of death

Neglect - omission of care (diet and health care)
Professionals struggle to identify and act on indicators of neglect *(Laming 2003; Gilbert et al, 2009).*

Neglect is a factor in 60% of serious case reviews (NSPCC) This is because of the:

- *Uncertainty – how to act?*
- *Thresholds – how much risk to tolerate?*
- *Mind-sets – e.g. fear of being judgemental, focus on parent, "not my area of expertise".*

Source: Brandon, 2015

The matter of whether the child died as a result of neglect is a key issue. The guidance from the Safeguarding Children: Working Together Under the Children Act 2004 and the All Wales Child Protection Procedures 2008, inform the local child protection processes. The local guidance states "an initial assessment must be undertaken following a referral in order to establish if a child is in need and requires protection". The guidance is clear that when there is an allegation or report of neglect where there are concerns about the child's welfare an initial assessment must be undertaken and Section 47 enquiries made, either by Social Services or jointly with the Police if more serious neglect is suspected. Where there are no immediate safeguarding concerns, a referral of a 'child in need' of help, requires parental consent in order for an assessment to be undertaken.

This did not happen in relation to this child as those practitioners who were aware of the children in the family did not have any reason to suspect the child may be at risk of harm or likely to be suffering as a result of neglect. The practitioners involved with the family were very much focused on the health needs of the parents. The only child care practitioners who visited the home were those related to the elective home education arrangements. They were not given access to the home and therefore did not see the child. He was not seen by any health, education or child care practitioners from the age of thirteen months, when he had his childhood immunisations. At that point there was no cause for concern noted. He appeared to be a healthy normal child. There was no further opportunity to assess whether his health was in any way impaired. Advice given about diet and nutrition during previous engagement in relation to the family's choice of having a strictly vegetarian diet appears to have been acknowledged.

The parents did not seek any further medical help for their child as they did not believe it was required. It is possible that had the child been seen or spoken to by a childcare or health professional in the later stages of his life they may have been alerted to the fact that he had some health issues that the parents were not seeking appropriate help for, particularly his dental health and aching limbs. It could be argued that in failing to seek such advice and assistance for their child the threshold for neglect would have been met and any lack of co-operation by the parents once concern was raised could have been dealt with under the child protection procedures.

In this case the family remained isolated from mainstream universal services. They lived in a remote community and chose to adopt a private and secluded lifestyle that included home educating their children. That does not mean the children were at risk of harm. Not seeing children through their access to universal services is not an indicator that all is not well. Understanding all the dynamics in this child's family was needed in order to understand if there were any risks to the children.

Working with families with diverse parenting and cultural styles is challenging for practitioners. There is no evidence to suggest that those who did have dealings with the family did anything other than acknowledge and try to work with the cultural and diverse circumstances. As identified below, the legislation makes clear the requirement that professionals should try to engage families such as this who remain 'hard to engage'. There is evidence that some practitioners did try hard to overcome the fathers unwillingness to co operate and made repeated attempts to gain access to the home.

"Cultural factors neither explain nor condone acts of omission or commission which place a child at risk of significant harm.

Professionals should be aware of and work with the strengths and support systems available within families, ethnic groups and communities, which can be built upon to help safeguard children and promote their welfare.

Professionals should guard against myths and stereotypes - both positive and negative. Anxiety about being accused of discriminatory practice should not prevent the necessary action being taken to safeguard a child".

Source: Safeguarding Children, Working Together under the Children Act 2004.

Multi-agency communication and working together (holding pieces of the jigsaw)

There were potential opportunities to see the child as a result of a protracted employment and litigation issue that involved the child's mother in which the father was heavily involved. A practitioner in LA2 raised their concern about the deteriorating mental health and vulnerability of the child's mother and the behaviour of the father in dealing with the professionals involved. The knowledge that there were two children living in the household, who were being home educated, was notified to LA1, where the child lived. This provided an opportunity for contact with the child's family to take place. At this point, knowledge of the children being home educated was not previously known to LA1 as the parents had not notified the authorities of these arrangements in accordance with the procedures on elected home education.

There is a lack of clarity in the review submissions surrounding whether there was a referral from LA2 to LA1 in relation to the child's mother as a potentially vulnerable adult. There is no record of such a referral being received. It was clarified that a phone call took place between the two authorities that is not recorded. Agreement was reached that the threshold for a vulnerable adult referral was not met. The learning suggests that any such discussions should always be recorded and any concerns should be referred in writing, as is the current policy. This allows for due consideration of any potential risks by the receiving authority.

During this period of time several practitioners were aware of the family from the following agencies:

Local Authority 1 (LA1)
Local Authority 2 (LA2)
The family GP
The independent consultant psychiatrist involved in assessing mother's mental health condition

Having been alerted to the existence of the child in their area, the LA1 Education directorate carried out their enquiries in accordance with the national and local policies for elective home education. The father was reluctant to engage with them and they were not allowed access to the home. As they had no information to suggest that there was any cause for concern in relation to the child, they satisfied themselves that the educational needs were being addressed in accordance with national policy and procedures and agreed to make contact in twelve months time. As they were not allowed access to the home and because they had found the child's father to be uncooperative they did report the non access to children's services in LA1. Children's services then made enquiries with the police to see if there were any concerns and when none were noted they took no further action in the belief that they had no remit to do so.

At this point had all practitioners shared their combined experience and knowledge of the family in a multi-agency approach, allowing all of the members of the family's needs to be considered, it is possible the level of concern may have been raised and further enquiries initiated into the welfare of the children. This is due to the following factors which when taken individually are not a cause of concern but when considered collectively may increase the level of concern:

- Mothers vulnerability – her deteriorating and debilitating mental health condition and inability to care for herself and her children
- Father's role in caring for his wife and the children as well as trying to educate them
- Fathers poor health and pre occupation with longstanding litigation claims
- Lack of engagement with health and education agencies and the reclusive nature of the family's lifestyle
- The children's potential isolation due to being home educated and not receiving health checks

At that time the national and local policy and guidance did not prompt practitioners to take this holistic family assessment approach.

Learning from other serious cases reinforces the need for consideration of a child's needs when an adult has a mental health problem "*the parents were treated in isolation, without considering the broader family context or the potential impact of their mental health problems on children. The response from health seemed often to be one of treating the symptoms, or addressing single issues, or individual incidents, rather than taking the broader view of the context"*

Source: Learning from Serious Case Reviews 2009. The same document also includes the following reference, which again was a feature in this case.

"*Parental hostility towards professionals or deliberate non-engagement with professionals may reflect an underlying controlling or authoritarian manner, which may also affect the parenting children receive".* It is clear that the father of the child was challenging in his dealings with practitioners and did not wish to engage with them. This might have prompted those practitioners to consider whether this was affecting his approach to parenting his children.

Mental Health

"Parental mental ill-health can have a major impact on children. Some estimates suggest a third to two thirds of children will be adversely affected".
Source: *Stanley & Cox, 2008*

It could be argued that the child's mother was a vulnerable adult by virtue of her mental health condition.

"Families with a parent with mental health problems often fall through the service net because:

- *Staff do not ask the right questions early on*
- *There are ambiguities with regard to the roles and responsibilities of different professionals*
- *There is a lack of signposting information – it is often the people who use services themselves who collect information and inform staff of other services and resources*
- *Parents with a mental health problem may be reluctant to identify themselves because they fear losing parental responsibility for their children and because of the stigma associated with mental health and social services; children are also reluctant to raise concerns as they fear being separated from their family".*

Source: Think child, think parent, think family: a guide to parental mental health and child welfare (SCIE)

Had a multi-agency meeting occurred prompted by mother's mental health condition and a key professional been identified to engage with the family, it is still likely that they would not have successfully engaged the father and gained access to the home and the children.

Without evidence of significant harm none of the agencies had the right of entry to check on the children. There may have been an opportunity to engage with the father if at least one practitioner had gained his trust sufficiently to act as the key worker for the family, but there was no opportunity for child care practitioners to do this.

It is clear that the child's father had limited trust or confidence in professionals and only dealt with them if he had to. He resisted professional help and had many complaints registered with different agencies. Adopting a different approach such as a Family Group Conference type of meeting is unlikely to have engaged father unless practitioners had statutory powers to promote co operation. Such approaches require family members to be willing to work co operatively with agencies in a voluntary capacity. Agencies have no statutory powers to compel families to engage in such interventions, when there are no clear child protection concerns being raised.

Family Group Conferences (FGC's)

"*FGCs may be appropriate in a number of contexts where there is a plan or decision to be made. FGCs do not replace or remove the need for child protection conferences, which should always be held when the relevant criteria are met*".

Source: Safeguarding Children, *Working Together under the Children Act 2004*

Young Carers

It is possible that the lack of consideration of the mother's mental health on her parenting capacity, along with the lack of a 'family plan' to consider all of the risks or issues in the child's family may have led the eldest child in the family to be overlooked as a possible 'Young Carer.' This issue was not explored or identified, either by adults or children's services. Given the mother's deteriorating mental health condition and the amount of time father needed to spend on caring for his wife, addressing his own health problems and his preoccupation with litigation issues, it is quite possible the children were left to care for themselves. This may have included looking after their own dietary needs. As the eldest child was eight years older it is possible he may have had caring duties for his younger brother and potentially his mother, when father was preoccupied or poorly himself.

"*The needs of this group of children and young people appear to remain the responsibility of 'everyone and no-one'. This is partly because these children will often not present with overt and visible behavioural problems during the periods of their parent's illness. As a result they are unlikely to be known to the children and families sections of social services".*

Source: 'Living upside down': being a young carer of a parent with mental illness Alan Cooklin.

The child and his older sibling did not have the opportunity to receive support from outside agencies because they did not access them either through school or leisure activities. Their main contact with the external world was 'virtually' through computer access. Whilst there is information and help lines available and they could have accessed these, it is unlikely that either child saw themselves as 'in need of help" and so did not pursue these avenues.

Professional curiosity and persistence – asking the right questions and persevering

Had the multi agency 'family plan' approach occurred and the professional curiosity of those with knowledge of the family persisted it is possible that the levels of concern might have escalated. The levels of potential risk to the children of the lack of parental capacity to respond to their needs would have meant the threshold for statutory intervention could have been met. It is possible that as individual practitioners concentrated on their own roles along with the challenging, non co operation of father that this opportunity to put all the pieces of the jigsaw together were missed. The national and local practice based on the policies and procedures at the time did not advocate strongly enough the need for practitioners to work collectively across adult and children's services. Vulnerable adults were not routinely seen in relation to their role as parents.

Current guidance as a result of the newly implemented Social Services and Well-being (Wales) Act addresses this and advocates for a much more integrated partnership approach. This does require practitioners to embrace these practice changes and include such integrated working in their everyday practice. Practitioners are still expected to gain parental consent and co operation wherever possible.

Elective Home Educated Children

There is evidence to suggest that most 'home educated' children are safe, well and achieving. But how do we know? There are conflicting views.

A number of Local Authorities (supported by the Chair of the Association of Elective Home Education Professionals) and the NSPCC, view home education as a safeguarding risk, based on a view that 'home educated children are isolated and lacking contact with professionals' and are calling for monitoring of home educated children.

A counter argument says this is not the case and that there is potential for misinterpretation of the law and 'consent' issues. Many parents who home educate their children feel strongly that there is no need for further monitoring or controls.

"*Analysis of Serious Case Reviews cited by the NSPCC as having home education as a 'key factor' demonstrated that all of the children were known to professionals and that there were multiple missed opportunities to act on concerns expressed by professionals, in each case. The home education factor was not the issue".*

Source: Home Education and Safeguarding Myth: Analysing the Facts behind the Rhetoric
Wendy Charles-Waner

A renewed focus on the law in relation to children who are home educated is taking place in England, as the following article expresses

"A change in the law is needed to force parents to declare when their children are being home-educated, councils say".

Currently, parents do not need to tell their local authority when a child is being taught at home, unless they have been removed from school.

Portsmouth and Reading are among the councils who want a register after the number of home-taught children in the UK rose by 65%, between 2009-15.

A Local Government Association spokesman said the majority of home educators worked with councils to provide a good education.

"[But] in the small number of cases where there are concerns for children being home-educated, gaining access to properties is extremely difficult, and councils need more powers to ensure children's safety," he added.
The Department for Education said home education needed to be "of suitable quality".
A spokesman said: "We are taking steps to ensure the system is as robust as it can be when it comes to protecting young people, while at the same time safeguarding the rights of parents to determine how and where to educate their children."

Source: BBC online news article 15th June 2016.

The debate on whether the current legislation in both England and Wales is sufficient continues, with parents lobbying hard in support of no further guidance and others arguing there should be new duties.

The current legislation and guidance does not require that children are seen or spoken to as part of the process. In this case, if the child had been seen it is possible those practitioners may have been alerted to his ill health and/or had an opportunity to explore with him his life style. It is clear that the practitioners followed the guidance and that it was in line with national guidance and practice. The involvement of these practitioners was not welcomed by the father in this case and they were not able to use a relationship with the parents to gain access and be satisfied that the children in the household were well and thriving. There is no doubt their professional curiosity was aroused as to what it might be like for the children living there, but they had no statutory duties to do more than they did. They did report the fact that they had not gained access to the home and that the father did not want to engage with them other than to provide the required information (which is evidence related to the academic input & curriculum offered to the children).

Rights to Action

The absence of any requirement to ascertain the wishes and feelings of children who are being home educated seems in stark contrast to the commitment made by the Welsh Government in adopting the United Nations Convention of the Rights of the Child in their work with children.

"*The Assembly Government has adopted the UN Convention on the Rights of the Child (Annex 1) as the basis of all our work for children and young people in Wales. We have translated this into seven Core Aims through which we will work to ensure that all children and young people:*

- *have a flying start in life;*
- *have a comprehensive range of education and learning opportunities;*
- *enjoy the best possible health and are free from abuse, victimisation and exploitation;*
- *have access to play, leisure, sporting and cultural activities;*
- *are listened to, treated with respect, and have their race and cultural identity recognised;*
- *have a safe home and a community which supports physical and emotional wellbeing;*
- *are not disadvantaged by poverty."*

This commitment is commendable and encapsulates learning from other serious case reviews when it has been clear children have not been seen or listened to. If they had been seen they may have avoided further harm. It is by no means certain that had the child in fact been seen alone and had an opportunity to have his views captured that his death may have been prevented but as a principle it is clear that such an action may have provided an opportunity for him to be seen by a child care practitioner who might have been alerted to some concerns. At this time it is known the child was showing signs of Vitamin C deficiency and his teeth and gums were in very poor condition. This in itself would have been noticeable and raised professional curiosity as to the cause and need for treatment. There is no way of knowing whether the father's attempts to keep his children out of the sight of any professional agencies was in any way designed to conceal their condition or prevent them from having a 'voice of their own".

It is important for this learning review to note that in being home educated and because of the parents' choice to live a rural and isolated lifestyle, the child did not have access to universal health and education facilities. It could be argued he was not having the opportunity to have his basic human rights met. He was not routinely having access to play, leisure, sporting and cultural activities along with friendships and age appropriate socialisation. When he encountered health problems he was not given the right to appropriate health care. It appears that his emotional and physical wellbeing was compromised. His parents had parental responsibility and a duty to provide appropriate care, including the need to seek medical attention for his health needs. This did not happen. No medical advice or assistance was sought for his dental health condition or for the other symptoms he experienced prior to his death. Practitioners therefore did not have the opportunity to assess his health needs and address any problems he may have been experiencing until emergency assistance was called at the point of his death.

It is particularly poignant that in conducting this review we have no sense whatsoever of this child. Who was he, what did he like, what were his thoughts and aspirations? There is a total lack of information on him other than very limited glimpses gleaned from the information presented by the family. It is tragic that there are many references in practitioner's submissions that the child was "invisible". There is much known about the parents from agencies records (mainly health) and almost nothing about both children.

Health checks for children beyond early years

In noting the 'invisibility' of the child, it poses the question of whether the introduction of routine health checks for children at developmental stages throughout their childhood should be introduced. Children are routinely screened in their early years with the consent and co operation of parents. There is no legislation or mandatory powers for this to happen. When children are in school they are routinely screened. The issue of whether such an offer should be made for

Elective Home Educated children needs to be considered. This would still require parental co operation and consent unless it was legislated as mandatory.

The child's family was known to the GP but this was not sufficient to ensure the child was seen. Unless he was taken to the GP there was no reason for the GP to consider him in his own right or for the GP to know that he may he require medical help. It would be reasonably assumed that had the child required medical assistance his parents would have alerted the GP during their many contacts. The GP was not aware that the child was being home educated and was not therefore being routinely screened through school. The GP was not aware that health practitioners did not see the child from the age of thirteen months and that he had not received any routine dental health checks.

This poses questions around the registering of children with GPs and whether follow up routine checks should be mandatory as described above. Also whether health agencies should be routinely informed of all children who are home educated

The following is taken from other serious case review learning:

"*Summary of risk factors and learning for improved practice for the health sector:*
GPs and primary healthcare teams are best placed to spot the early signs of abuse and neglect. They have an overview of issues affecting individual members of a family which in combination, may impact on a child's welfare. They are also in a position to co ordinate the work of different agencies supporting children and families.

GPs should be the 'lynchpin' in the network of services working with a family. They are best placed to get an overview of the issues facing a family and how these might impact on their ability to care for their children"

Source: NSPCC report on learning from case reviews 2015

In concluding this learning it should be noted that the full co-operation and engagement of all the agencies involved in this process has been forthcoming. Their valuable insight, reflections and contributions in such tragic and difficult circumstances is acknowledged.

Improving systems and practice

The CYSUR Mid and West Wales Safeguarding Children Board to:

1. Write to the Welsh Government, asking for changes to the legislation and statutory guidance on elective home educated children, to incorporate a requirement that parents and guardians annually register all such children with the Local Authority. In addition to this, that all such children should have to be seen and spoken to and their views and wishes are recorded annually. The legislation should state that the information held is also to be shared with the family GP and other relevant professionals.

2. CYSUR to further develop a regional multi-agency protocol for safeguarding children educated at home, incorporating the following key elements:

- to outline procedures for identifying those children who are being educated at home
- to describe levels of support and advice available from professionals to parents/carers and children and young people who are considering or who are already educating their child/children at home
- to ensure that all professionals involved with the family have the necessary skills to identify safeguarding concerns

- to describe the safeguarding procedures which aim to ensure that any child registered as being educated at home is not at risk of abuse, neglect or exploitation.
- all children registered with a GP who are home educated are offered the same access to health checks as those children attending school.

3. Write to the National Independent Safeguarding Board to ensure that there is consistent training for all practitioners working with children, adults and families on the implications of the new guidance for the Social Services and Well-being (Wales) Act 2014 to ensure that assessments on individuals also consider the wider family context, including the impact on parenting and the needs of carers.

4. CYSUR to review the provision of multi agency training and practice that supports practitioners in knowing how to deal with challenging and complex, resistant families and ensure there is evidence of professional management support.

Statement by the independent reviewer

INDEPENDENT REVIEWER

Gladys Rhodes White OBE
Independent Consultant

Statement of independence from the case

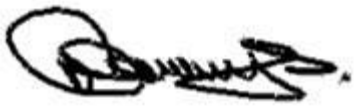
I make the following statement that prior to my involvement with this child practice review:-

- 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
(Signature)

Date 7 July 2016

Chair of the child practice review panel
(Signature)



Name DCI Anthony Griffiths

Date 7 July 2016

Annex 1: Terms of reference

Terms of reference for the child practice review

Core tasks:

- Identify recommendations to improve practice and ensure lessons are learnt in relation to the analysis of practice in the case.
- Determine whether decisions and actions in the case comply with the policy & procedures, statutory agencies/CYSUR (Mid & West Wales Safeguarding Children Board) and ensure lessons are learnt to promote a positive culture of multi-agency child protection learning.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions followed best practice at the time.
- Seek contributions to the review, wherever possible, from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event and identify required resources.
- The child practice review panel will manage the review process.

Specific tasks of the child practice review panel:

- Agree the membership of the panel.
- Detective Chief Inspector Dyfed-Powys Police will chair the panel.
- The CYSUR child practice review sub-group chair will support the panel chair in the child practice review process.
- The independent reviewer will be Gladys Rhodes White OBE.
- The time frame for the review will be no less than 21 months prior to the incident, to enable consideration of new information that has become available.
- Review the merged timeline, initial analysis and hypotheses and agree a genogram.
- Plan, with the independent reviewer, arrangements to engage with the family and other relevant persons.

- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action-plan, and make arrangements for presentation of the final report, by the independent reviewer and the chair of the child practice review panel, to the CYSUR Executive Board for consideration and ratification.
- Wherever possible and appropriate, provide feedback to family members

Annex 2: Arrangements for the review

Child Practice Review process

- The Chair of the CYSUR formally agreed to undertake a concise child practice review, and a review panel was established in accordance with guidance. The review panel included the following services:
    - Hywel Dda University Health Board
    - Local Authority 1
    - Dyfed-Powys Police
    - Local Authority 2
    - Welsh Ambulance Services Trust
- The review panel members, none of whom had had any prior involvement in the case, met on several occasions. The panel identified one independent reviewer, with appropriate knowledge but not involved in the case management.
- The review panel agreed a time frame of no less than twenty one months for the review. Individual agencies each provided a timeline of significant events. These were discussed by the panel, then merged and used to inform the learning event.
- The learning event, held on 10 June 2016, was facilitated by the reviewer. Attendees from all the involved agencies attended the learning event.

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 3

Summary Timeline

CYSUR Mid and West Wales Safeguarding Children Board
Re: CYSUR 2/2015

Type of activity	2010									
	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Social Services (LA 1)				LA1 received telephone call from an employee of LA2 regarding the family. No child protection concerns and no police information to suggest concerns. Therefore, no further action.						
Education (LA 1)				LA1 to contact family to ascertain education status as not known to LA1.	Home visit. Access refused by father. No details of anyone living in the house. No one else seen.	Letter sent to family.		Further letter sent to family.	Father cancelled arranged visit.	
Social Services (LA 2)			Decision taken that threshold is not met to trigger the Protection of Vulnerable Adults (POVA) procedures.							

Type of activity	2011											
	January	Feb	March	April	May	June	July	Aug	Sept	October	Nov	December
Health			Mother referred to GP.			Letter received from GP.						
Education (LA 1)	Request to family for education work samples.		Further letter sent to family.	Education plan and letter received from father requesting all family details be removed from the LA elective home						Reply to father. LA will contact him next year in line with LA procedure. Child's name to remain on		

				education database and for no further contact with the LA.						elective home education database.		
WAST												Call in to ambulance control: 20 21; emergency ambulance arrived 20.28 Child unconscious.