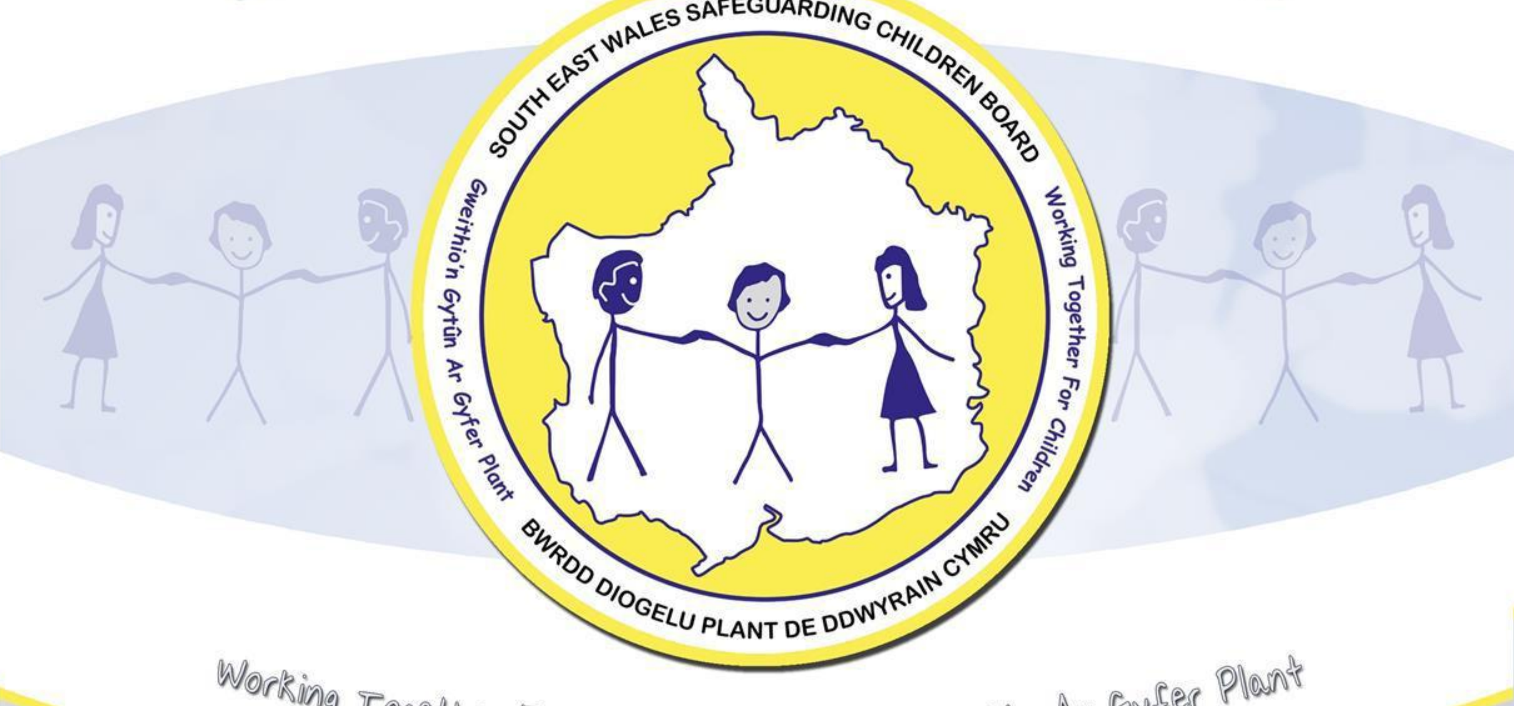

Historical Child Practice

Review Report

in respect of:

Child J

(SEWSCB 1 /2015)

Date of Report: 27th June 2016

Child Practice Review Report

South East Wales Safeguarding Children Board
Historical Child Practice Review –

Re: *SEWSCB 1 / 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 Historical Child Practice Review was commissioned by South East Wales Safeguarding Children Board (SEWSCB) in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi Agency Child Practice Reviews (Welsh Government, 2013) on the recommendation of the Case Review and Practice Development Sub-Group convened on 7th January 2015.

A Board must undertake a historical 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 care leaver under the age of 18) 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 criteria for historical reviews are laid down in revised regulations, under section 7 of aforementioned Guidance. A LSCB may decide that a review is required in

relation to a case involving historic organised or multiple abuse. The aim of such a review would be to examine what could be learned from past practice to ensure that current practice and organisational systems are strengthened and improved. There is an expectation in Chapter 9, Safeguarding Children Who May Be Particularly Vulnerable- investigating Organised or Multiple Abuse in the 2006 Working Together Guidance, that LSCBs will identify and learn lessons at the conclusion of an investigation of organised or multiple abuse

- put in place a means of identifying and acting on lessons learned from the investigation (e.g. in respect of policies, procedures and working practices which may have contributed to the abuse occurring) as the investigation proceeds, and;
- at the close of the investigation, assess its handling and identify lessons for conducting similar investigations in future

The terms of Reference for this review are at Appendix 1.

Circumstances Resulting in the Review

Background Information

Child J was convicted in 2008 (age 15 years and 7 months) for the rape of a male under the age of 13. He was sentenced to 6 years imprisonment and his release date was October 2013.

In early 2013 Child J contacted police and disclosed that he had committed further historical sexual offences against other victims. He also disclosed he had been the victim of historical sexual assaults by his father and his father's partner. As a result of the disclosure the police launched a major investigation, during which he was treated as both a victim and an offender.

Following the conclusion of the police investigation he pleaded guilty in 2014 to 29 sexual offences against children. The victims were his nieces, nephews, acquaintances and strangers. The age range of his victims was from 16 months to young adolescents. He was subsequently sentenced to life imprisonment. His father was convicted of 15 counts of sexual and physical offences. His victims include his son, daughters, step son and grandsons. He was sentenced to 19 years imprisonment.

His father's partner was convicted of 3 counts of sexual and physical offences and sentenced to 6 years.

This historical review concerns the steps taken to safeguard Child J from birth in 1992 up until late 2007. The remit of this review is specific to Child J.

Significant Events During the Period Under Review

Child J was the youngest child in the family, having 3 sisters aged 12, 7 and 6 at the time of his birth in 1992. His parents married in 1980, had their first child, divorced circa 1982 and then continued to have 3 children. Mid 1988 father moved out to live with his new partner and her 10 year old son (whose name was on the Child Protection Register). Throughout the period of this Review the family were known to statutory services, with concern about the emotional abuse and distress experienced by Child J due to the conflict between his parents, his mother's alcohol misuse and his behaviour at school.

An Initial Child Protection Conference in early April 1998 regarding the alleged physical abuse of a sibling did not lead to registration.

Later in April 1998, a second Initial Child Protection Conference was held where all children were registered under the category of emotional abuse and the likelihood of physical abuse. Child J was then aged 5 and his sisters were aged 11 and 13 years. The circumstances leading to this Child Protection Conference were an allegation that Child J's father had put a washing up bottle up Child J's bottom. Child J's older sibling, who was now an adult, provided a report for conference outlining her concerns.

In February 1999, all three children were deregistered and the reason given was that the father was no longer living at home.

In June 2000, all three children's names were placed on the child protection register for emotional abuse. The conference was convened regarding concerns about the mother's alcohol misuse. Child J was noted to be self harming.

Child J was placed in voluntary foster care due to mother's alcohol misuse in November 2000.

Child J went back to live with mother in June 2001, his name was still on the child protection register.

By August 2001, Child J was living with his father as his mother couldn't cope with his behaviour.

In September 2001, Child J's father was granted an Interim Residence Order for Child J.

Child J's name was removed from child protection register as he was deemed no longer at risk as he was now living with his father.

In October 2003 Child J's name was placed on the child protection register under the category of emotional abuse. The circumstances leading to the Initial Child Protection Conference were the bitter and hostile disagreements between both parents over Child J's care, and an allegation of physical abuse Child J made

against his father's partner.

In December 2003, Child J went back to live with his mother.

In January 2004, a Residence Order was granted to his mother for Child J. A Review Child Protection Conference was held a few days later where Child J's name remained on the child protection register.

Throughout this period, Child J moved frequently between family homes and there were other moves which were crisis led.

In November 2004, Child J's name was removed from the child protection register although no core assessment had been completed.

Child J's behaviour was violent during the first half of 2005, with police involvement.

Child J went missing on two occasions and was permanently excluded from school in 2006. Arrangements were made to start alternative educational provision for young people with emotional and behavioural needs.

In 2007, Child J was arrested regarding a sexual assault on a boy aged 11.

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

The Importance of the Voice of the Child Including the Process Following Alleged Retraction of Disclosure

Previous reviews (including the SEWSCB 2 / 2014 Children H Child Practice Review) have highlighted the need for children to meet on their own with practitioners, away from parents and carers in an environment where they feel safe, so that children can speak about their concerns. In this case, following the initial serious allegation of child sexual abuse, which resulted in a joint video interview with police and social services, Child J and his sibling gave sufficient information of sexually abusive behaviour which was later used in the recent trial to convict the father. However at the time, when the other parent and sibling retracted Child J's allegation this was accepted by the agencies working with the family and the sexual abuse issues appear to have become lost. Child J was left at home with both parents following the video interview. Six days after this, Child J's mother rang social services informing them that Child J had retracted this allegation. Practitioners did not appear to be mindful of the influence that the parents had over Child J. Following this, Child J's name was placed on the child protection register under the category of emotional abuse and likelihood of physical abuse. The next Review Conference was held 10 months later, and Child J's name was removed

from the child protection register. There was no reference to the child sexual abuse incident being considered in the review child protection conference minutes, the focus detailed in the conference minutes was school attendance and the father having left the home.

Child J's behaviour is described over a period of 10 years as aggressive, punching girls, kicking, hitting others at school. When he was 9, he was threatening to stab himself and making himself vomit after meals. When older, age 11, between May and July the police were called to six major incidents at home including swinging an iron bar, threatening his mother and siblings and swinging a dog lead, assault on his mother and self harming with a knife and pair of scissors, threatening suicide .There is a reason for a child's behaviour and it does not seem that agencies were inquisitive to understand the cause. He was charged with criminal damage in the home at the age of 11.

The school gave information at various times of him being "dirty" and 'sad', a 'loner' with low self esteem, demonstrating mood swings and aggression particularly towards girls.

There were five recorded incidents of Child J, and six recorded incidents of siblings, either running away or being reported missing from home during the 15 year period being reviewed. There was a failure to explore this behaviour as part of the ongoing neglectful parenting or to consider the context of possible child sexual abuse.

Practitioners need to recognise that children's behaviour is a means of communication. "They need to learn to listen attentively to children and young people when they are trying to tell us things that may be just too difficult to tell". (Child Abuse Review, BASPCAN, May - June 2015)

Professionals need to keep their focus on the child and be aware of being distracted. The father in this family presented to professionals as controlling and threatening. The review panel had the opportunity to view a non televised programme held by the police, which clearly showed the father as having an overwhelming and domineering personality with no sexual boundaries. There is no evidence that this was considered as having an impact on the ability of agencies to protect the child.

Information shared at the Multi Agency Professional Forum confirmed one agency was aware of the father's use of pornography being shown on the television in front of Child J, this was never referred to social services. Sexually inappropriate behaviour towards the older girls was known, for example one child in the family talked about being promised a vibrator for Christmas and she disclosed an occasion when her father had threatened to pull up her top in the street. As a result a Child Protection Conference was held. However, the Conference minutes indicate that this was seen more as inappropriate behaviour rather than a potential indicator of sexual abuse. There was a failure to see the context in which Child J was living.

Practitioners appeared to overly focus on the mother's alcohol misuse and overdoses. Child J and siblings had rung 999 on several occasions, when their

mother was unconscious. On occasion, there was good analysis of the impact on Child J of the mother's behaviour and Child J's caring role, but some of this was lost upon case transfer.

When the reviewers met with Child J as part of this review process Child J was clearly able to articulate that he didn't think he was being listened to as a child at the time. He asked why professionals didn't speak to him alone when he was living with his dad as they had done when living with his mum. Child J also commented "How come the professionals couldn't see what they (parents) were doing to me?"

ACTION 1

All agencies to remind their staff and include in training the importance of:

- Seeing the child alone, ensuring views and feelings are sought.
- Recognising a child's behaviour as a way of communicating and exploring its meaning.
- Progressing a response to behavioural indicators of child sexual abuse within their agency where there are concerns and suspicions of child sexual abuse.
- Being mindful of and understanding the context when a child's allegation is retracted.
- Being mindful of parental influence and behaviour.
- Considering the wider use of advocacy.

<u>Failure to See the Whole Picture</u>

Practitioners were working under challenging and complex circumstances where various family members made allegations, counter allegations and retractions. In addition, both parents presented in contrasting ways, for example, Child J's mother's misuse of alcohol and failure to engage with services and Child J's father's controlling and inappropriate behaviour towards professionals made it difficult to progress a care plan.

This family were well known to a number of agencies, but there was a failure to put the whole picture together. There were a number of incidents over 15 years, which had they been pieced together, rather than being treated as individual events, may have resulted in clearer assessment and planning. For example:

- Children running away from home.
- Overuse of health resources (average of at least monthly attendance at GP surgery over a period of 9 years and frequent visits to Accident and

Emergency Departments).

- There are 12 domestic abuse incidents recorded between1998-2007 of which all, bar one, the police say would have resulted in a MARAC referral if reported today.
- Attempts by family members were made to alert authorities of concerns. Childline, Police and Social Services were all contacted as well as anonymous referrals being made. An older sibling also went to the local police station to voice concerns. Concerns included sexual abuse, self harming and aggressive behaviour, assaults between siblings and towards mother. Overdosing and suicide attempts.
- There were frequent moves and even when either parent successfully had a Residence Order it did not result in stability for Child J.
- Violent offences by father were known, including assaulting adults outside the home.
- Sexually inappropriate behaviour by Father.
- When the child of an older sibling was displaying symptoms of child sexual abuse, the case was investigated and it is not clear from agency records if a link was made to the known wider family concerns.
- Poor school attendance.
- Incident of child telling professionals that dad had thrown hot tea over her.

The reviewers felt that the Child Protection Conference minutes did not reflect the child's life at the time; there was no real narrative, or analysis of risk and no underpinning chronology, which resulted in a loss of core focus on the actual safeguarding risks. For example, at one Child Protection Conference where education was in the majority, the minutes reflect the primary focus was on school attendance with no assessment of the risk of harm from child sexual abuse. There was further contact with the family following de registration and case closure which did not result in any referral to Social Services, despite repeated incidents of mother being hospitalised following overdoses or intoxication.

ACTION 2

All agencies to remind their staff and include in training the importance of:

- consistent attendance at Core Group and shared responsibility in developing the Child Protection Plan (in accordance with the All Wales Child Protection Procedures 2008)

ACTION 3

All agencies to remind their staff and include in training the importance of:

- considering how isolated incidents help to develop a fuller picture by use of a multi-agency chronology.

- ensuring effective communication across agencies.

ACTION 4

The SEWCB should introduce a standardised multi-agency chronology template to be completed at the time of the initial child protection registration, updated at every core group meeting and promptly circulated to all agencies, to support fully informed assessment of risk and sound decision making.

Recognition of Child Sexual Abuse Including the Failure to Consider Need for Child Protection Medical

The Reviewers felt the key missed opportunity in this case was the child sexual abuse incident. During the visit to Child J, he also indicated that he thought that this was a key missed opportunity too. Following a referral to the police, via a sibling, of alleged physical abuse within the family, there was an anonymous call saying that Child J's father had tried to put a washing up bottle up Child J's bottom. The child was 5 years old at the time. A strategy meeting was held and Child J and his sibling were video interviewed. A few days later the mother and Child J's sibling told the police that the children had retracted their statements. It is clear from records however that Child J did not retract his statement, and even though a Child Protection Conference was held following this incident and the child's name with siblings was placed on the child protection register, the categories under which the children were placed were for emotional and likelihood of physical abuse. At no time is there any evidence of any consideration given to whether Child J had been subject to child sexual abuse. It is relevant to note that in the later criminal proceedings the video interview of Child J at aged 5 was used in evidence to secure the father's conviction of historical sexual abuse of the child.

In March 1998, an older sibling of Child J stated she wished to make a complaint of both physical and sexual assault against her father. She was advised that as an adult she should report the matter at a police station. However, she was actually only 17 and a half years old at this time. This appears to be another key missed opportunity where sexual abuse could have been addressed.

There were also other behavioural issues over a number of years, e.g. obesity, abdominal pains, social isolation at school, frequent GP and Accident and Emergency attendances which might have alerted services to consider the possibility of child sexual abuse. Practitioners at the MAPF felt that clear signs of child sexual abuse were missed by agencies. There is a risk that this could happen now because agencies still wait for a disclosure rather than also considering the child's behaviour. The recent Children's Commissioners report from England, Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action (2015) highlights that sexual abuse which happens in and around the family is a significant challenge today for professionals working on the front line. However, it states that a system which waits

for children to tell someone cannot be effective. Professionals working with children and the systems they work within must be better equipped to identify and act on the signs and symptoms of abuse.

ACTION 5 (same as ACTION 1)

All agencies to remind their staff and include in training the importance of:

- Seeing the child alone, ensuring views and feelings are sought.
- Recognising a child's behaviour as a way of communicating and exploring its meaning.
- Progressing a response to behavioural indicators of child sexual abuse within their agency where there are concerns and suspicions of child sexual abuse.
- Being mindful of and understanding the context when a child's allegation is retracted.
- Being mindful of parental influence and behaviour.
- Considering the wider use of advocacy.

ACTION 6

Where there is a suspicion or possibility of child sexual abuse this should be noted explicitly in Child Protection Conference minutes and in any chronology.

There is no evidence of consideration of a child sexual abuse medical following the incident where Child J's father assaulted Child J with a washing-up bottle. Although a strategy meeting was held this did not include any health representative.

This review would like to reinforce the following statement taken from SEWSCB Child Practice Review 2 / 2014 Children H. A child protection medical examination should always be considered when there is a disclosure or suspicion of child abuse involving injury, suspected sexual abuse or serious neglect. The purpose of the medical examination is not merely forensic but also to assess the health and wellbeing of the child, to screen for infection and to initiate prophylactic and other treatment as required. Research has shown that many children and families feel reassured by the medical examination and find it to be therapeutic.

ACTION 7

Where there are concerns or suspicions about physical / sexual harm or injury Police and Social Services should ensure that their practitioners follow the All Wales Child Protection Procedures in relation to the involvement of paediatricians in strategy discussions, where child protection medical examinations may be required, so that children who may benefit are not denied the opportunity to benefit. Health to

ensure that there is a robust system in place for this to function efficiently.

Effective Practice

It is well established that effective practice in safeguarding is built upon efficient and effective information sharing between agencies. The review highlighted some good examples of information sharing between education and social services; e.g. education provided social services information about the Child J's presenting behaviours.

There was consistent representation of CAMHS apart from when moving across local authority areas. They chased up appointments ensuring Child J was seen and creative interactions with Child J were remembered as a positive when the reviewers went to meet with Child J.

The School Health Nurse evidenced some good individual work with Child J and his family, making appropriate referrals to other professionals.

When the family moved to another Local Authority area, there was evidence to suggest an effective transfer of the case by Social Services. However, this did not happen with the CAMHS service. The child had to be re-referred by the GP into the CAMHS of the neighbouring health board, there was no direct referral from one CAMHS to another.

Although it falls outside the timeline for this review, the police investigation which resulted in conviction of three family members for sexual abuse is to be commended.

ACTION 8

South East Wales Safeguarding Children Board to write to Health Boards asking them to consider an all Wales referral process within CAMHS when children move from one Health Board area to another which ensures there is no delay in continuation of services.

References:

1. Protecting Children in Wales – Guidance for Arrangements for Multi-Agency Child Practice Review, Welsh Government, 2012.

2. Extended Child Practice Review SEWSCB 2 / 2014 in respect of Children H, South East Wales Safeguarding Children Board, 2015.

3. Do no more harm: The psychological stress of the medical examination for alleged child sexual abuse, Susan Marks et al. Journal of Paediatrics and Child Health 45 (2009) 125–132

4. Multi-Agency Supervision Guidance, South East Wales Safeguarding Children Board, 2015.

http://www.sewsc.org.uk/fileadmin/sewsc/documents/regional/SEWSCB_Multi-Agency_Supervision_Guidance_-_revised_2016.pdf

5. Protecting Children from Harm: A Critical Assessment of Child Sexual Abuse in the Family Network in England and Priorities for Action, November 2015, Children's Commissioner for England.

6. Child Abuse Review, Volume 24, Issue 3, May – June 2015

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:-

Improvements Already Introduced

A number of areas for improvement were identified in this review which had this been a recent case would have been translated into actions. The reviewers were conscious however, that as this was a historical case it was more appropriate to ask agencies to consider what improvements/ changes to practice had occurred and were embedded in practice since the time the events of this review took place.

The reviewers facilitated a multi-agency professional forum which was well attended from a wide range of relevant professionals where they were asked to evidence how things are done differently now.

- **Concerns were identified regarding the Child Protection Conference process.** There were delays in conferences being held (e.g. 10 months between Initial and Review Child Protection Conference), lack of clear assessment and analysis of the issues, with no evidence of care planning when on the child protection register. There was a drift in the child protection plan, where there were gaps and delays in core groups being held and the child's name being removed from the child protection register without a completed core assessment. The child was subject to three periods of registration, over a period of 5 years, with no reference to a legal planning meeting being held.

  - This case would be escalated to a legal planning meeting under the Public Law Outline process today.
  - The All Wales Child Protection Procedures have been in place since 2008 which all agencies work to.
  - Local Authorities now report to Welsh Government on key performance indicators which include timescales for child protection conferences.

- **Child J experienced gaps in access to education especially when moving across different local authority areas.**
  - Files are now transferred between schools via the S2S system (school to school transfer)
  - Files contain information from the SIMS system and are called common transfer files
  - The documentation now in place which governs the process is The Schools Admissions and Appeals Code 2014 and Statutory Guidance to help children and young people from missing education (2010)
  - Education now has a safeguarding lead in place that practitioners can access for support and advice.

- **There were a number of domestic abuse incidents which resulted in no action.**
  - The introduction of The Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 has increased awareness across all partner agencies.
  - The implementation of Domestic Abuse Conference Call (DACC) in the South East Wales Safeguarding Children Board area and the introduction of Multi Agency Risk Assessment Conferences (MARAC) which facilitate information sharing, risk assessment and action planning.
  - There is training available for all Safeguarding Children Board member agencies specifically in relation to domestic violence.

- **Missing Children**
  - Gwent has an established multi-agency missing children team. The five local authorities, Gwent Police and ABUHB co-located their staff in a multi-agency team which is screening every child and young person reported missing or absent to Gwent Police. Each agency collects all available information held on the child and the collated data is discussed by the team in order to assess current and future risk. If this had been in place at the time, it would have identified all the occasions the child and siblings went missing, thus triggering a risk assessment and action.

- **Other Safeguarding Initiatives**
  - The Health Board has a safeguarding team providing training and supervision which all Health Board employees can access.

- Health visiting is now able to access some electronic child health records.
- In some areas, there are now integrated Health and Social Services staff based in the same building, with the aim of improving working together.
- Youth Offending Services would now intervene earlier with a focus on preventative work and a Restorative Justice approach, with direct access to social services records. Regular safeguarding audits are now undertaken.
- Increasing awareness by partner agencies of the role of the probation services and the relevant information they hold, and their contribution to DACC, MARAC and safeguarding.
- Multi agency supervision is now provided for cases on the child protection register where practitioners require a reflective time to consider future intervention in complex cases where practitioners feel unsure how best to proceed, or where no significant progress is being made.
- Advocacy services now provide the social worker with the children's views, wishes and feelings 48 hours in advance of any child protection conference or core group to ensure the appropriate management and delivery of this information is considered.

ACTIONS:

ACTION 1 (Same as ACTION 5)

All agencies to remind their staff and include in training the importance of:

- Seeing the child alone, ensuring views and feelings are sought.
- Recognising a child's behaviour as a way of communicating and exploring its meaning.
- Progressing a response to behavioural indicators of child sexual abuse within their agency where there are concerns and suspicions of child sexual abuse.
- Being mindful of and understanding the context when a child's allegation is retracted.
- Being mindful of parental influence and behaviour.
- Considering the wider use of advocacy.

ACTION 2

All agencies to remind their staff and include in training the importance of:

- consistent attendance at Core Group and shared responsibility in developing the Child Protection Plan (in accordance with the All Wales Guidance)

ACTION 3

All agencies to remind their staff and include in training the importance of:

- considering how isolated incidents help to develop a fuller picture by use of a multi-agency chronology.
- ensuring effective communication across agencies.

ACTION 4

The SEWSCB should introduce a standardised multi-agency chronology template to be completed at the time of the initial child protection registration, updated at every core group meeting and promptly circulated to all agencies, to support fully informed assessment of risk and sound decision making.

ACTION 5 (same as ACTION 1)

All agencies to remind their staff and include in training the importance of:

- Seeing the child alone, ensuring views and feelings are sought.
- Recognising a child’s behaviour as a way of communicating and exploring its meaning.
- Progressing a response to behavioural indicators of child sexual abuse within their agency where there are concerns and suspicions of child sexual abuse.
- Being mindful of and understanding the context when a child’s allegation is retracted.
- Being mindful of parental influence and behaviour.
- Considering the wider use of advocacy.

ACTION 6

Where there is a suspicion or possibility of child sexual abuse this should be noted explicitly in Child Protection Conference minutes and in any chronology.

ACTION 7

Where there are concerns or suspicions about physical / sexual harm or injury Police and Social Services should ensure that their practitioners follow the All Wales Child Protection Procedures in relation to the involvement of paediatricians in strategy discussions, where child protection medical examinations may be required, so that children who may benefit are not denied the opportunity to benefit. Health to ensure that there is a robust system in place for this to function efficiently.

ACTION 8

South East Wales Safeguarding Children Board to write to Health Boards asking them to consider an all Wales referral process within CAMHS when children move from one Health Board area to another which ensures there is no delay in continuation of services.

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)*	Kathy Ellaway	**Name** *(Print)*	Diana Binding
Date	11th May 2016	**Date**	11th May 2016

Chair of Review Panel

(Signature)
Name: Mike Sloan
(Print)

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 January 2015 that it was commissioning a Historical Child Practice Review in respect of Case J.

External Reviewer: Kathy Ellaway, Designated Nurse, Safeguarding Children Service, Public Health Wales

Internal Reviewer: Diana Binding, Head Gwent Local Delivery Unit, Wales Community Rehabilitation Company

Chair of Panel: Mike Sloan, Social Services

The services represented on the panel consisted of:

- Social Services (Chairperson)
- Wales Community Rehabilitation Company (Reviewer)
- Public Health Wales (Reviewer)
- Police
- Children's Services
- Aneurin Bevan University Health Board
- National Probation Service
- Education
- Youth Offending Service
- SEWSCB Business Unit

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

A Multi Agency Professional Forum in November 2015.

MAPF was attended by representatives from the following agencies:

- Aneurin Bevan University Health Board (GP, Paediatrician, Health Visiting Service, School Health Nursing Service, Safeguarding Lead, CAMHS)
- Police
- Children's Services

- Wales Community Rehabilitation Company
- National Probation Service
- Educational Psychology Service
- School Counselling Service
- Educational Welfare Service
- Other Education Provider
- Youth Offending Service

The subject of the Review was visited in prison in November 2015 to seek his views prior to the MAPF.

The Reviewers have undertaken to share the learning from the report with Child J prior to publication.

☐ 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	☐	☐	

Appendix 1

Terms of Reference – Child Practice Review
Child J

Overall Aim:

The aim of the review is to examine the multi–agency working in respect to the steps taken to identify risk and safeguard Child J; to identify issues arising from practice and to ensure learning has informed current practice so that improved systems are in place.

Scope:

This review covers the steps taken to safeguard Child J during the period from his birth in September 1992 up until November 2007.

During some of this period, Child J would have been part of the same extended family unit as his siblings and half siblings.

Consideration of any agency involvement with these siblings will only occur if it is clear that there was an impact on Child J.

Core Tasks:

The core tasks are as follows:

- To ensure current policy, procedures and practice of the named services and the LSCB have been informed by the issues and learning arising from the case, by examining:
  - decision making across agencies and through the whole authority as related to this case
  - the extent to which decisions and actions were child-focused
  - inter-agency working and service provision for the children concerned and their families
- To consider:
  - whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. How that knowledge contributed to the outcome for the child;
  - whether the child protection plan (and/or the looked after child plan or pathway plan) was robust, and appropriate for that child, the family and their circumstances;
  - whether the plan was effectively implemented, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency plan;
  - the aspects of the plan that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the plan, including progress against agreed outcomes

  - for the child. Whether the protocol for professional disagreement was invoked;
  - whether the respective statutory duties of agencies working with the child and family were fulfilled;
  - whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (and this should include consideration of both organisational issues and other contextual issues).
- To seek contributions to the review as appropriate or available from children and family members, and to provide them with feedback.
- To take account of the learning from parallel investigations or proceedings related to the case at the time of the incidents and subsequently. In particular the to consider links with the MAPPA SCR in respect of sharing findings, learning outcomes and action plans where relevant and to establish links with the Serious Further Offence Case Review (Probation internal review) that will also be examining practice in relation to the management of Child J in custody and in the community. The review will also need to establish links with the Cwm Taf Safeguarding Children Board and how to conduct the review over the two areas.
- To hold a multi-agency learning event to identify where practice has already changed or should be different in future.
- To prepare a report of the review.

Key Responsibilities:

The responsibilities of the *Review Panel* members during the review should be to:

- act as a link to their respective agencies to facilitate the work of the reviewers and keep their agencies informed of issues arising from the review in line with its organisational reporting arrangements;
- confirm or amend the terms of reference as required including time period to be reviewed;
- commission agency timelines and analyses of involvement;
- present their agency timeline and initial analysis to the panel;
- offer professional expertise and challenge to the practice identified in the merged timeline and agency analyses;
- identify issues to be explored in a learning event;
- following the learning event, the *Panel* should consider the learning issues identified when the report has been drafted by the reviewers;
- contribute to developing a report and action plan as required.

The LSCB Co-ordinator will be responsible for maintaining links with all relevant agencies, families and other interests.

The Panel Chair will inform the Chair of the LSCB and the LSCB sub-group of significant changes in the scope of the review and the TOR will be updated accordingly which will be updated in the TOR

The Chair of LSCB 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 LSCB Report.
The LSCB 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.

Appendix 2

South East Wales Safeguarding Children Board

Summary Timeline – Child J

1992-97	March 1998	April 1998	August –December 1998	1999
Child Born	Initial Child Protection Conference held. No registration.	Child is placed on Child Protection Register under categories of emotional and physical abuse.	Behavioural issues in school identified. Child referred to CAMHS by GP.	**February** Review Child Protection Conference. Child's names deregistered. **November** GP makes urgent referral to CAMHS.

January-September 2000	October- December 2000	January-September 2001	October-December 2001	January-September 2002	2003
June Initial child protection conference. Child registered under category of emotional abuse. **September** Review CPC Children remained on CPR.	**November** Child accommodated for 7 months. **December** Review Child Protection Conference. Child's name remained on Child Protection Register.	**June** Review Child Protection Conference. Child's name remained on child protection register. **August** Child went to live with father. **September** Father granted Interim Residence Order.	**December** Review Child Protection Conference. Child's name removed from Child Protection Register.	Child moved areas with father. **August** Moving to different area. Child discharged by CAMHS and family told to ask GP to make referral to CAMHS in new area	Child seen by CAMHS, family agreed to referral to social services for support.

August- December 2003	January 2004	June –July 2004	August-December 2004	2005	2007
Child's name placed on child protection register.	**January** Residence Order granted to mother. Child's name remained on child protection register.	**July** Review child protection conference. Remained on child protection register.	**November** Review Child Protection Conference. Name removed.	**September** Social Services close case.	**April** Child missing. Referral made to social services.