Adult Practice Review Report

[redacted]

Brief outline of circumstances resulting in the Review

To include here: -

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

An extended review was commissioned by the Cwm Taf Safeguarding Boards (CTSB) on the recommendation of the Adult Review Sub-Group in accordance with the Welsh Government guidance on Adult Practice Reviews. The criteria for this review are met under Part 7 of Social Services and Well-being (Wales) Act 2014, Volume 3 –Adult Practice Reviews.

The subject of the review is a white welsh male from the South Wales valleys. He was from a large complex family and Board partner agencies had significant involvements with the subject and his family.

Concerns about parenting and conditions in the home led to the subject and younger siblings becoming looked after when the subject was 15 years old. The level of risk was such that at an Initial Child Protection Conference all of the children's names were included on the Child Protection Register and there was a multi-agency plan of work with the family to reduce the risk.

In keeping with his wishes, the subject returned home after 4 weeks of being looked after by foster carers. His name was removed from the Child Protection Register, but his younger siblings remained looked after, and care proceedings followed in respect of those younger children.

At the age of 17 the subject was charged with, and later convicted of serious sexual offences against a minor. The subject was initially remanded in custody and later received a custodial sentence.

Whilst in the Secure Estate, (which includes the 2 Young Offender Institutes, and the Secure Training Centre where the subject was detained), there were concerns

about the subject's vulnerability and mental health, he had self-harmed and threatened to commit suicide. He experienced 3 moves whilst in the Secure Estate. On the morning following the third move, prison staff found the subject had hanged himself in his cell overnight.

The Coroner has recorded a narrative verdict which has been shared with the Review Panel Members who have also considered the report by the Prison and Probation Ombudsman in relation to the death of the subject.

The timeframe for the review was 01/11/2012 to 03/09/2015 in light of key events that took place in September 2015. The rationale for this timeframe was due to the subject being a looked after young person in the two year period prior his death.

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 decision to remove a child's name from the Child Protection Register should be informed by re-assessment and evidence of the reduction of risk.

In this case, professionals found that the subject didn't engage in the multi-agency plan to reduce risk once his name had been included on the Child Protection Register. The subject had displayed aggressive behaviour in the foster placement and had run away. He expressed a wish to return home from foster care. The multi-agency decision to remove the subject's name from the Child Protection Register was based upon the challenges associated with implementing a plan and the age of the subject who was nearly 16 at the time, rather than evidence of reduced risk.

Despite concerns about the subject's emotional well-being, behaviour and circumstances, the case was closed to children's services once an offer of a preventative service was made and declined.

Practice has changed and services have developed since the time of these events. The Safeguarding Board multi-agency guidance Challenging Cases has been implemented and offers practitioners tools and opportunities to resolve or escalate cases where risk is not reducing despite a multi-agency plan of work being in place to reduce risk.

This learning leads to the Review making the following recommendations:

- Agencies should remind staff that a recommendation to remove a child's name from the child protection register should be informed by re-assessment which evidences that risk has reduced.
- The Safeguarding Board should ensure that there is reporting under the Challenging Cases Protocol to provide assurances that it is being effective in achieving positive outcomes for children and young people.

Harmful sexual behaviour in young people requires a well-coordinated multi-agency response under child protection procedures which puts the young person's well-being and risk management at the centre of decision making and responses.

In this case there was no strategy meeting coordinated under the Sexually Harmful Behaviour Protocol to support the multi-agency practice in managing risk and coordinating responses to the subject's needs. This was a missed opportunity for coordinating services and assessment in relation to the young person's well-being.

This learning leads to the Review making the following recommendations:

- Board partner agencies should remind practitioners about procedures and protocol in relation to the management of harmful sexual behaviour.
- Board partner agencies should ensure that the learning from this case is integrated into any revised or new procedures and protocols in relation to the management of harmful sexual behaviour.

Pre-sentence reports should consider the full range of options available to the Court in Sentencing.

In this case, the Pre-Sentence Report did not include the option of a Detention and Training Order. Acknowledging that sentencing is a judicial decision, in seeking to achieve positive outcomes for young people, authors of pre-sentence reports should include all options that are available to the Court.

This learning leads to the Review making the following recommendations:

- Cwm Taf Youth Offending Service should review the quality assurance process for concluding Pre-Sentence Reports to ensure that all sentencing options are included.

Transitions to new services when a young person becomes 18 should be managed effectively to ensure a good outcome for young people.

This Review has highlighted the additional vulnerability of becoming 18 years of age within the criminal justice system. The Youth Justice Board (YJB) Youth to Adult (Y2A) Transitions Principles and Guidance 2015 points out that:

> *The transition process must be acknowledged as a critical period of heightened risk and must not focus on one organisation relinquishing responsibility of a young person. Instead, the transition process must be seen as a critical time in the young person's journey through the criminal justice system where extra effort, early planning and accurate assessment is required to cater for the individual needs of the young person and to manage any risks.*

In this case, there was no face to face meeting between the relevant staff from the Youth Offending Service, National Probation Service (NPS), HMP Parc and the subject either pre or post sentence, to agree plans or plan the transition with a period of joint working. This omission represents a missed opportunity to highlight the subject's specific vulnerabilities and (at post sentence stage) ensure the early undertaking of a psychiatric assessment which was recommended as part of the pre-sentence psychological assessment.

It is an area of learning that led to the Ombudsman making a recommendation that:

> *The Chief Executive of the National Offender Management Service, the Chief Executive of the Youth Justice Board and the Director of the National Offender Management Service in Wales should ensure that transition arrangements for young people moving to adult custody include a jointly agreed management plan covering at least the first six months after transfer, outlining how their needs will be met, and how their risks and vulnerabilities will be managed.*

This learning leads to the Review making the following recommendations:

> • Cwm Taf Youth Offending Service, HMP Parc and National Probation Service (NPS) should ensure that the Youth to Adult (Y2A) Transitions Principles and Guidance is having a positive impact for young people who are experiencing the change from working with professionals from the Youth Offending Service to working with professionals from the National Probation Service for adults.

This Review has sought to retain focus upon Cwm Taf multi-agency learning but found that the following critical events as published in the Prison and Probation Ombudsman's report were of particular significance:

> *On 20 March, the Secure Estate Provider received the subject's psychology report, dated 9 February 2015, and it was scanned into his medical records that day. The report had recommended an urgent psychiatric assessment as the psychologist had concluded that the subject had a serious mental illness. However, there is no record that anyone in the healthcare team read the report when it arrived. No one referred the subject for a psychiatric assessment.*
>
> *On 12 August, a psychiatrist saw the subject at the prison, for the assessment required by the Court of Appeal. The psychiatrist reviewed the subject's GP and prison medical records, but noted that the Secure Estate Provider had not provided him with the psychology report of 9 February prepared for his trial. The psychiatrist considered that the subject's main difficulty was coping with stress and he possibly had a conduct disorder. He assessed him as at high risk of suicide or self-harm, as he had very limited coping skills. There is no record that the psychiatrist discussed this assessment with anyone from the healthcare team at the time and the prison did not receive a copy of the psychiatric report until after the subject had died.*

This learning leads to the Review making the following recommendations:

- Vulnerable prisoners who are reported by professionals to be experiencing mental illness should have access to psychiatric assessment without delay.

Effective and Positive Practice

The review noted the following positive and effective practice:

Education: The subject did well at the Pupil Referral Unit where he was supported by positive male role models, and responded to a structured and nurturing environment. The provision of door to door transport was viewed as key to this success.

Children's Services: One family member described how the 16 plus service had made a difference to her, and whilst this service was not available to her older sibling, having somebody you can trust and talk to like a normal person was greatly valued as a quality that enabled her to access support from this service.

Welcome to our Woods: Welcome to our Woods is a community based woodland project. Family members talked to reviewers about the benefits of this service that provided trusting, non-judgemental and stimulating activities that were valued by the subject and his family.

Improving Systems and Practice

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

- Safeguarding Board member agencies should remind staff that a recommendation to remove a child's name from the child protection register should be informed by re-assessment which evidences that risk has reduced.
- The Safeguard Board should ensure that there is reporting under the Challenging Cases Protocol to provide assurances that it is being effective in achieving positive outcomes for children and young people.
- Board partner agencies should remind practitioners about procedures and protocol in relation to the management of harmful sexual behaviour.
- Board partner agencies should ensure that the learning from this case is integrated into any revised or new procedures and protocols in relation to the management of harmful sexual behaviour.
- Cwm Taf Youth Offending Service should review the quality assurance process for concluding Pre-Sentence Reports to ensure that all sentencing options are included.
- Cwm Taf Youth Offending Service, HMP Parc and National Probation Service (NPS) should ensure that the Youth to Adult (Y2A) Transitions Principles and Guidance is having a positive impact for young people who

are experiencing the change from working with professionals from the Youth Offending Service to working with professionals from the National Probation Service for adults.
- Vulnerable prisoners who are reported by professionals to be experiencing mental illness should have access to psychiatric assessment without delay.

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 individual 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 individual 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)*	Annabel Lloyd	**Reviewer 2** *(Signature)*	Neil Smith
Name *(Print)*	ANNABEL LLOYD	**Name** *(Print)*	NEIL SMITH
Date	7.10.17	**Date**	16/10/17

Chair of Review Panel (Signature)	N Kingham pp Jean Harrington
Name *(Print)*	NICOLA KINGHAM
Date	16/10/17

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Adult Practice Review process

The process followed in carrying out this review was in line with the Welsh Government guidance on Adult Practice Reviews.

An independent chair was appointed from the voluntary sector and two independent reviewers (one from another local authority and the other from a department not involved in the case) were appointed.

The Panel comprised of the following services:

- Police
- Children Services
- Health
- Education
- Youth Offending
- Probation
- Ambulance Service
- Legal (local authority)

Invites were also extended to the Secure Estate establishments.

A learning event was held and attended by representatives from the following services :

- Safeguarding Business Unit
- South Wales Police
- National Probation Service
- RCT Education – EOTAS and Educational Psychology
- RCT Independent Reviewing Service
- RCT Children's Services' 16+ Team
- Cwm Taf Youth Offending Service - Health Board and Social Services employees
- FACTS/ Inreach
- Secure Estate Provider

The practitioners who attended and contributed to the learning event worked hard without defensiveness to identify individual and organisational learning. They demonstrated a commitment to making changes to improve future practice.

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☒ Family were involved in the Adult Practice Review and met with the Reviewers to offer their views and experience of the services. The experiences of the family members were shared with learning event participants. There was a further meeting with a family member prior to publication of this Review in order to share and discuss its findings.

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Date information received .....

Date acknowledgment letter sent to SAB Chair .....

Date circulated to relevant inspectorates/Policy Leads .....

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