Concise Child Practice Report

Strictly Private & Confidential

CYSUR 7/2018

Date report presented to the Board:

8th July 2021

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Child Practice Review

Re: CYSUR 7/2018

Legal Context

A Concise Child Practice Review was commissioned by CYSUR: the Mid & West Wales Safeguarding Children Board in accordance with statutory legislation set out in section 139 of the *Social Services and Wellbeing (Wales) Act 2014*[1] and accompanying guidance *Working Together to Safeguard People – Volume 2 – Child Practice Reviews*[2] (Welsh Government, 2016).

The criteria for this review are met under Chapter 6, *Concise Child Practice Reviews*:

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 (LA) or relevant partner[3] identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for concise reviews are laid down in *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[4].

The purpose of the review is to identify learning for future practice. It involves practitioners, managers, and senior officers in exploring the detail and context of agencies' work with a child and a family. The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and child protection practice. It should include the circumstances which led to the review, including highlighting effective practice and considerations about what needs to be done differently to improve future practice. (*Working Together to Safeguard People – Volume 2 – Child Practice Reviews* (Welsh Government, 2016[5]).

[1] Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)
[3] Local Authority or relevant partner means a person or body referred to in S.28 of the *Children Act 2004* or body mentioned in s.175 of the *Education Act 2002*.
[4] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015
5. Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)

Circumstances Resulting in the Review

The young person (B) was a male of fourteen years of age, who was pronounced dead at the hospital after being found in the school toilet cubicle after he had been reported missing from a lesson. This was a totally unexpected death and one which has caused all of those who knew him overwhelming sorrow and grief.

The Coroner's Inquest concluded on the 29th of June 2021 when the Coroner concluded that: *"In my view, whether out of upset, frustration or anger, this was clearly an intentional act on B's part but one that went wrong. It can properly be described as a deliberate human act which unexpectedly and unintentionally goes wrong, which is how the Chief Coroner's Guidance No 17 defines a conclusion of misadventure. As to whether B took this step as a cry for help and was expecting to be found in a short period of time, I cannot say. There was clearly a significant lapse of time before he was tragically discovered but I cannot be sure that this period of some 56 minutes sadly made a difference to the outcome. In my view, the school did everything they reasonably could in that period to locate B.*

In the circumstances, I find that:

(a) the deceased was B,

(b) that he died on the 12th September 2018 in the toilet cubicle adjacent to the technology department at S1 and

(c) that he died as a result of self-suspension using a ligature from a leather strap that had been attached to a hook on the inside of the toilet door.

I record the medical cause of death as 1(a) Hanging and I formally record a short form conclusion of misadventure". [6]

In the immediate weeks prior to his death, B was described by his family as 'being the happiest that he had ever been'. He had enjoyed a good summer, had been on holiday, and was doing well in external equine competitions of a prestigious standing. He was also noted to be 'growing up fast'. The night before his death, B had been in the company of his extended family who were staying in the area, and plans had been made to go for a Chinese meal at B's favourite restaurant at the weekend. The day of B's death started as usual; B was the first to arise, there was the usual family banter, medication was taken, and B was focused on his horse and a forthcoming Derby.

School attendance was good, and B had been excited about attending the school prom. He was also engaging well with school pastoral staff.

B demonstrated a degree of maturity beyond his years, gained from spending considerable time with adults in the equestrian world. It was incomprehensible to his family, friends and school staff the reason why the tragic incident occurred.

In accordance with procedures, a Procedural Response to Unexpected Deaths in Childhood (PRUDiC)[7] meeting was held. It was the decision of members at that meeting that based on the circumstances of the sudden death, there should be a referral under the Child Practice Review Process (CPRP).

[6] Findings and conclusions – Inquest into the Death – Pembrokeshire and Carmarthenshire Coroner's 29th June 2021
[7] Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

Time Period Reviewed and Why

In a Concise Child Practice Review (CCPR), the learning is usually focused on the last twelve months prior to the death or serious incident in a young person's life. At the request of B's family and after consideration by the Review Panel concerning the importance of the inclusion of all transition arrangements, they confirmed an extended timeline of the period 1st September 2016 to 12th September 2018, which also captures the events leading up to B's death in September 2018. However, to understand fully the necessary context, the Panel, the Chair, and the Independent Reviewer have considered relevant historical contextual information. This contextual information was also further acknowledged by the agencies who attended the Learning Event.

The Family

The Independent Reviewer, Panel Chair, and members of the Panel want to acknowledge the significant contributions of B's family (his father, stepmother and sister) and close family friends who willingly participated in the CCPR. They met initially with the Chair of the Review Panel prior to the pandemic restrictions, and then subsequently with the Chair and the Independent Reviewer via Microsoft Teams and Zoom. The Review Panel recognised what a hugely challenging and emotionally painful process it has been for them, and would sincerely like to thank family members and friends for helping them to get to know B as a unique, special, cherished, talented and precious member of their family, who was 'larger than life'. He remains sadly missed by his heartbroken family, his many friends, school staff and the equestrian community in which he lived and socialised.

The family have raised significant queries and questions that this review process has endeavoured to address, but this process may not be able to provide all of the answers. The input from the family was included and explored at the Learning Event, but the most compelling question for them is they want to know "*the truth about what happened that day and to understand why in their perception the system failed B*".

The Child

B was the eldest sibling in the family, and was described as a much-loved son, brother and stepson who had a lot to celebrate in his life. He was an accomplished horse rider, competing at a high standard nationally. B enjoyed being part of the Hunt[8] and spending time on his quadbike. He was part of a close family unit and a pivotal member of the equine world. Outside of school, he had a lot of friends; he was described by his family as "*wonderful, charismatic, kind, loving, and funny, he was a young man that liked to ask questions and push the boundaries, he would also chat to anyone and everyone*." B had a diagnosis of Attention Deficit Hyperactive Disorder (ADHD)[9] and was supported through medication (Elvanse).[10] He

[8] Hunt – "clean-boot" hunts which see dogs following a human scent. Membership of the Three Counties Bloodhounds.

[9] ADHD - Attention deficit hyperactivity disorder is a condition that includes symptoms such as inattentiveness, hyperactivity and impulsiveness. Symptoms of ADHD include a short attention span, constantly fidgeting and acting without thinking.

[10] Elvanse – Medication used as part of a treatment programme for attention deficit hyperactivity disorder aged 6 years or over.

also had a hearing impairment. B did not have a Statement of Educational Needs (SEN)[11], but did receive additional support as requested in school through a Teaching Assistant (TA), but not on a 1:1 basis; there was in most classes a TA for B to call upon if he needed support. Throughout his education B attended mainstream school, transitioning twice in his secondary education years at the age of 11 and 13 respectively. (Initially progressing from primary school to secondary and then at the age of 13, because of concerns around bullying, alongside a feeling that B would be more likely to succeed in a smaller secondary school setting).

B, struggled at times, when in school, and there are records of incidents in the review timeline of bullying taking place in school and whilst travelling on the school bus, causing B distress and concern. He was academically capable and was on target to achieve a number of GCSEs. B was emotionally intelligent, and particularly enjoyed practical work (he was following a construction course one day per week), he was 'hands on', he loved to pull things apart (especially mechanical things), and also enjoyed art and design. Feedback that was received from the Former Pupils Voice Events informed the review that B would start the morning in the registration form by telling a 'funny story'.

It is important that the CCPR panel has been able to see B through the eyes of his family, friends and those who knew him well. In addition to the challenges B faced due to his ADHD, adverse childhood experiences(ACEs)[12] and history of bullying, he was also a young person facing the challenges of transitioning into adolescence and puberty. The CCPR panel considered the impact for B of the added difficulties that such a transition could involve and have sought to understand whether this may have contributed to B's vulnerability at the time of his death. It has not been possible to draw any firm conclusions regarding this, but from considering academic studies on such matters, it is highly likely it may have been a further complexity that B was experiencing. Dahl, R.E., Allen, N.B.,Wilbrecht,L.,& Suleiman,A.B., in their work on the Importance of investing in adolescence from a developmental science perspective summarise the case for investing in adolescence as a period of rapid growth, learning , adaptation, and formational neurobiological development and state the following:

"Developmental changes during adolescence include structural and functional changes in the brain—particularly neural systems involved in cognitive, emotional, social and motivational processes. These neural changes are associated with behavioural changes such as increases in sensation-seeking and a re-orientation of attention and motivation (towards peers, social evaluation, status and prestige, and sexual and romantic interests). Adolescent development also involves profound changes in social contexts, social roles and social responsibilities. Importantly, there are complex interactions between and among these levels of change. Indeed, learning and brain development are inextricably intertwined throughout this period as learning affects brain development, and maturational changes in the brain in turn affect learning and motivation. Research tells us that when ADHD, adolescence, and puberty collide, the teenage years can be even more difficult than usual. The emotional and social changes of adolescence, compounded by the

[11] Statement of Educational Need (SEN)– *The special educational needs code of practice gives detailed guidance on how to identify and help pupils with SEN. Maintained schools and LAs must always consider what the code says, when they make a decision about a pupil with SEN. The code states that a child with SEN should have their needs met*. Special Educational Needs Code of Practice for Wales. Welsh Government 2004.

[12] Adverse Childhood Experiences (ACEs) are traumatic events particularly those in early childhood that significantly affect the health and well-being of people. – NHS Public Health Wales

hormonal and physical symptoms of puberty, can add layers of new complexities for teenagers with ADHD."[13]

Silver's work on what parents of boys with ADHD should watch out for as their sons pass through adolescence states, "*Adolescence is a critical period for children with ADHD."* Joel Nigg, Ph.D., clinical psychologist and professor in the departments of psychiatry and behavioural sciences at Oregon Health & Science University, wrote: *"First, it's the period when the most serious risks for negative outcomes occur — for example, substance abuse, engagement in delinquent behaviour, problems with regrettable internet use, or serious accidents such as traffic accidents. Changing testosterone levels during puberty is associated with greater risk-taking behaviour among boys. Testosterone also interacts in complex ways with dopamine and other hormones that are relevant to ADHD.*

Individuals with ADHD can face an increased risk for comorbid disorders (two or more conditions that occur at the same time). Mood disorders and anxiety often first show up between the ages of 8 and 12, and again in early adolescence.

But perhaps more dangerous is the fact that ADHD impulsivity — exacerbated by peer pressure and disrupted treatment — may prompt teens to make some very unwise and potentially fatal decisions. Research overwhelmingly concludes that long-term use of ADHD medication lessens the risk of poor and/or impulsive decision making among adolescents."[14]

The review panel also further considered the potential impact on B of having experienced some early childhood trauma when his parents separated, and he spent time living with his mother. If a young person is diagnosed with ADHD and the impact of neglect, abuse or other trauma on their behaviour is missed or not fully explored, they may not get the support they need – reducing or delaying their chance to recover from trauma, while their "challenging behaviour" continues. The panel are clear that the diagnosis that B was given of ADHD is a medical matter and not one open to debate as part of this review. However, in the light of research and in trying to extract learning from what happened to B, we have considered an article by Laura Hanbury about ADHD and trauma, published in a social work journal 2020.

The article considers the environmental influences on behaviour development**.** Thapar and colleagues (2015) have warned that environmental influences and genetics should always be considered alongside each other when a diagnosis of ADHD is being investigated.

It also suggests that complex trauma can create the same types of behaviours that we see in children with an ADHD diagnosis and that levels of ADHD diagnosis are three times higher for children in the child protection system. And with no genetic markers or conclusive tests to say whether a diagnosis is correct, it is very possible that ADHD is being wrongfully diagnosed in children who *may* have been maltreated in some way.

What Does the Research Say?

In the early 1990s, researchers started to make links between how experiencing adverse childhood adversity, ACEs can shape some behavioural responses. They found that early experiences can have a huge effect on the developing brain and the connections forming within it. In cases where a child has been subjected to ongoing danger and threat, their brain may form stronger connections when it comes to

[13] Dahl,R.E.,Allen,N.B., Wilbrecht,L.,& Sileiman,A.B.(2018) Importance of Investing in adolescence from a developmental science perspective. Nature, 554 (7693),441-450.

[14] Boys 2 men when puberty and adolescence collide – Additude 2020

paying attention to sights, sounds and smells (hypervigilance), but weaker connections for impulse and emotional control. Or where an infant has grown up with an emotionally absent/inconsistent or unpredictable caregiver, this can create difficulties when the child tries to form close and trusting relationships with others. This is due to their inability in the past to understand or predict the behaviours of their caregivers.

Since the 1990s, research has consistently found that high rates of impulsive, hyperactive and inattentive behaviours exist in those with complex trauma histories (Boney-McCoy and Finkelhor)[15]. If a child or adolescent is displaying extreme high or low levels of emotion, whether they have ADHD or complex trauma symptoms, they will be experiencing a reduced tolerance for stress. Whether a child is hyper-reactive or unresponsive, this may mean that they have been pushed outside of their 'window of tolerance' (Ogden and Minton, 2000; Siegel, 2010)[16].

Everybody has a certain level of stress that they can cope with until it becomes too much to handle. In children with emotional regulation difficulties, their windows can be a lot smaller than others.

A 1996 study found that nearly a third of severely maltreated child met the diagnostic criteria for ADHD[17]. In 2011, another study found that a group of hospitalized children with an ADHD diagnosis all had chronic trauma histories. 76% of those children had also previously been in care system, with a further 50% reporting previous physical abuse.[18]

There is no suggestion that B was severely maltreated. It is possible that his ADHD diagnosis may have 'masked' some unresolved emotional response to his early childhood adverse experiences, and along with the reaction to the car crash (see page 24) for which he did receive help, there may have been ongoing stressors affecting his emotional state that were not addressed. It is not possible to draw any firm conclusions on this matter but from a learning perspective, it may be helpful for practitioners working with children with ADHD to consider whether they have experienced trauma or stress and to consider their history from an environmental perspective.

Whilst this information provides a helpful insight into potential factors that may face teenage boys with ADHD, it could not offer the CCPR panel any conclusive evidence that these were influences in B's life, and the reference to this material is purely for awareness and consideration of academic adolescence speculation and research.

Child's Family History and Contextual Information

There had historically been some involvement with Children's Services in the early part of B's life.

The genogram provided to the review by the family illustrated that B initially lived with his birth parents and younger sister in South Wales. In 2009, whilst B was still young, his parents divorced. For a time, B lived between both parents. Eventually, in 2012, it was agreed by the Court that B and his sister D would live with their father and his partner, K. Contact with his birth mother ceased after this time. B is described as having been very fond of and close to his father, his sister, and his stepmother; it was stated that B

[15] Psychosocial sequelae of violent victimization in a national youth sample, Boney-McCoy and Finkelhor
[16] For an overview of the "Window of Tolerance" model, see here
[17] Psychiatric comorbidity in childhood posttraumatic stress disorder, Famularo, Fenton, Kinscherff and Augustyn (1996)
[18] Trauma and ADHD — Association or diagnostic confusion? A clinical perspective, Szymanski, Sapanski and Conway (2011)

thought the world of his stepmum, K. B had not maintained contact with his natural mother for a substantive period of time.

Contextual information would indicate that during the period of time that B had lived with his mother and her partner, he may have been exposed to domestic abuse and other harmful experiences. B was known to Children's Services at this time, but was at no point ever in the care of the Local Authority (LA) or subject to a Child Protection Plan. There had been three separate Section 47[19] investigations where it was suspected that B may have been at risk of, or suffered significant harm, due to domestic abuse and neglect in the home. An Edcuational Psychologist's report written in 2013, (whilst B was in primary education) indicates that B's behaviours could be attributed to the impact of his early ACEs. The concerns at the time related to B's behaviours at home and in school. Mr J sought support and help to manage B's behaviours over a number of years. It is difficult to know whether this was purely as a result of his ADHD or other factors, such as his difficult early years experiences.

Mr J described what a difficult start in life B had, and that his mother was disappointed at his birth as she had wanted a girl. This was something B was aware of, and understandably, this was difficult information for him to process. It was something Mr J had raised as something B had been concerned about.

During the timeline of the review, B saw a Cognitive Behaviour Psychotherapist (CBP)[20], who worked in both private practice and in Child and Adolescent Mental Health Services (CAMHS) in the NHS. She met with B on eight occasions for private Cognitive Behavioural Therapy (CBT)[21] sessions for severe psychological symptoms related to a car accident that had occurred in 2015. The CBP wrote a letter to SS2 copied to Mr J, dated the 31st October 2017 in which they stated that "*whilst meeting B, it has also come to light that he has been experiencing bullying from another student and I am concerned at the continued impact of this on B's emotional and mental wellbeing. On my last meeting, there was a clear change in B's presentation, which corresponds with a reported increase in difficulties with a particular boy at school*." The CBP went on to state "*as I am sure you are aware, B has had a number of difficulties from an early age*." The school (SS2) noted receipt of the letter, but did not respond to it directly with the CBP or discuss it with them. They did, however, discuss the letter with B's father, and noted that they were aware that the pupil that B was having difficulties with had since moved to another school. The school believed that they had put all the necessary measures in place to deal with B's vulnerability and the bullying issues/concerns. The extent of this support is described in the review report section pertaining to Education and SS2's revision of their bullying policy as a source of learning.

The CBP states*; "It is likely B is predisposed to mental health vulnerabilities due to his difficult early years whilst living with his biological mother and continuing poor relationship with her. There have also been precipitating factors including bullying in his previous school, leading him to leave, in the hope of starting afresh in your school".*

[19] Children Act 1989, Section 47 is a LA's duty to investigate when they have reasonable cause to suspect that a child who lives or is found in their area is suffering or is likely to suffer significant harm.

[20] Cognitive Behavioural Therapy Practitioners use talking therapy to help patients change negative patterns of thinking or behaviour. National Careers Service

[21] Cognitive Behaviour Therapy (CBT)- is a talking therapy that can help a person to manage their problems by changing the way they think and behave. It is based on the concept that their thoughts, feelings, physical sensations and actions are interconnected and that negative thoughts and feelings can trap a person in a vicious cycle. CBT deals with current problems rather than focusing on issues from a person's past. It looks for practical ways to improve a person's state of mind on a daily basis.

The CBP concludes *"I am aware legally, all schools have bullying policies and I would urge that this is followed in this case, as my thoughts are that if this bullying continues, B's mental health will deteriorate. There are already reported changes to B's presentation at home and B himself reports that he is not working well at school due to this".*

In the period leading up to B's tragic death, the family reported that whilst there had been ongoing difficulties with B's expressed unhappiness at SS2, they, alongside B, were considering and had discussed informally other opportunities which B could potentially explore. Most directly, this included the possibility of B attending 14-16 gateway provision at the local Further Education College (FEC) where he could pursue his interest in equestrian and/or motor vehicle studies, and it was noted by the family that he was excited about that potential opportunity. These plans, however, were not agreed or formalised. Mr J recalled mentioning the consideration to B's Assistant Head Teacher, but matters had not been mandatorily progressed/referred to Careers Wales in accordance with the protocols for accessing such provision and the necessary formal panel considerations made to the FEC. Information provided to the Review indicates that B himself appeared undecided as to what he wanted to do in this regard, and was determined to continue to attend school whilst considering his available options.

At the time of B's death, Mr J and the family report that he had not given any indication that he was planning to take his own life or harm himself. There had been no warnings or previous incidents of self-harm. B had been "fine" the evening before and in good spirits. He was also in the company of a family member who is a mental health professional, who did not see any presenting concerns in B's demeanour, or in relation to his mood. On the final morning as he left for school, B was chatting animatedly about the weekend ahead, and the plans the family had made. The last conversation with his father was jovial, the camaraderie name they used was spoken and B's focus was on reminding his father not to forget to "buy petrol" for his quadbike as he had plans for that evening.

Agencies that were involved with the Young Person

The agencies involved are listed on page 24.

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 identification of the practice and organisational learning has been drawn from the following key elements of the review:

- The production of a merged multi-agency timeline and agency analysis;
- A pre-Learning Event for school staff, held in the school and facilitated by the Review Panel Chair;
- A pre-Learning Event for health professionals held remotely via Microsoft Teams facilitated by the Independent Reviewer and Review Panel Chair;
- Learning Event for Professionals (held remotely via Microsoft Teams under COVID-19 regulations),

- Former Pupils Voice Events x 2 (for learners registered in two FECs, who had previously attended SS2 and who were in B's year group);
- Children/young people and their parents from B's year group who chose to share their experiences;
- The young man's family's and friends' perspectives;
- Consultations with individual professionals who knew him well and who had worked with him/or had had a conversation with him at specific times in his life, pertinent to the timeline of the review and also its contextual information;
- Discussions within the Review Panel's meetings;
- Case record review;
- Independent Reviewer and Chair's analysis; and
- Literature Review.

Education and Transitional Arrangements

Prior to enrolling at SS2, Mr J, his partner K, and B's sister D attended an Open Evening in June 2016. The evening was advertised for prospective primary aged pupils; however, the family used the evening as an opportunity to visit the school. Mr J introduced himself to the Headteacher, Miss R, the Head of Transition/Year 7, and they discussed B and his situation. Mr J was looking for an alternative secondary school as B had experienced numerous difficulties at his first secondary school (SS1), which he was currently attending. Mr J explained that B was 'no angel' but that he would benefit from a 'fresh start'. Mr J explained that he had heard SS2 had an excellent reputation in the community and that with the benefit of hindsight, he wished he had applied for B to attend SS2 from the start of Year 7. At that time, the school was not able to offer a place for B immediately, as the Year 7 group was over-subscribed and out of courtesy, the Headteacher would also need to speak to B's current school (SS1).

In response to Mr J's enquiry, the school offered a unique three day 'taster visit' on 27th/29th June 2016. This is not something the school routinely does, however, on this occasion it was felt that this would help B to get a better experience of the school, prior to committing to it fully.

On 22nd June 2016 Miss R, Head of Year 7 at SS2, contacted the Local Authority Education Welfare Department to ask if the school could offer B a taster period. They raised that this would need to be agreed between both schools (SS1 and SS2); this was discussed/agreed by the Headteachers and therefore facilitated, enabling B to take up the unique offer of the three-day taster period.

During the three-day period, the Headteacher spoke to B on numerous occasions. Whilst B did not know many other pupils at SS2, he seemed content and happy to engage in conversation.

On 30th June 2016, Miss R met with Mr J and offered B a place to start at SS2. B enrolled at SS2 on 5th July 2016. He had remained on roll at SS1, despite him not attending SS1 after 12th April 2016.

The transition for B and introduction to SS2 was a well-planned and bespoke one, which appears to have gone beyond what is normally available. This bespoke transition arrangement is highlighted as an example of 'good practice', which may be useful to capture for other schools to follow when admitting vulnerable

pupils. The school nursing service sharing of information between the different schools, however, was not as timely. It is acknowledged that this may have been better facilitated, to enable those supporting B to be familiar with his individual health needs at an earlier opportunity.

Identified Good Practice

- SS2 offered a bespoke, unique and individually tailored positive transition process for B, with taster sessions taking place for three days prior to B enrolling at the school.
- Staff and parental communications throughout the transition process were positive as were conversations with B.

Family's Perspective

- The family acknowledged the professionally managed introductory sessions arranged by SS2 to help the transition for B from his previous school.
- They felt that the new secondary school (SS2) was a smaller school, they also considered SS2's performance data and felt that it was a much better environment for B than a larger school.
- The family wished that they had made an application in year 7 for B to SS2.

Learning

- A Health Board procedure in relation to the handover of children when moving to another practitioner within the school nursing service has been developed and implemented.

Education and Support for Special Educational Needs (SEN)

B attended three schools; primary school from 2007 to 2015, SS1 from September 2015 to April 2016, and SS2 from July 2016 until September 2018. B was identified as having Special Educational Needs (SEN) in Year 3 of Primary School, when he had a diagnosis of ADHD. Resources were provided to him through School Action Plus. B's difficulties appear to have been apparent throughout his school life. It is important to note these, even though they sit outside of the review timeline, as they provide pivotal contextual information.

School records evidence that B encountered several behavioural issues throughout his school attendance. Additionally, school records set out several issues reported to have taken place at home. An Educational Psychologist's report sets out that B was referred to the Education Psychology Service when he was in Year 5 in November 2013. The main areas of concern from the school were his behaviour, aggression and being physical towards peers and staff. The Educational Psychologist report refers to numerous issues and ACEs.

If we focus on the events within the timeline of this CCPR, we can see that there were ongoing difficulties for B in school, and whilst travelling on the school bus, in being both the victim of bullying and a perpetrator of such behaviours. Given the historic information in relation to B's previous experiences, this appears to follow a familiar pattern. It should be noted however, that for a period prior to his death, B was receiving fewer interventions from school for behavioural issues. He was also reported to be making good

academic progress and had in the spring and summer terms of 2018, been befriended by an older pupil, who was noted to be a positive influence on B.

To assess his cognitive ability, B, like all pupils, sat a Cognitive Ability Test on 21st September 2016. B ranked 67th out of 100 in his year group. His mean score of 94 indicated he could achieve at least 5 GCSE qualifications grades A*-C. In terms of Spatial Awareness, his score of 117 was above the national average of 100.

B sat his Welsh Government tests in Literacy, Numeracy and Mathematical Reasoning in Years 8 and 9. B made particularly good progress academically whilst at SS2. By May 2018, B's score of 117 placed him in the 'more-able' category. Whereas B was placed in a lower band at SS1, at SS2 he was placed in different sets for different subjects. This would allow B to make progress in different subjects at a rate appropriate to his ability. B was in sets 2, 3 and 4 (4 being the lowest) depending on the subject.

The duties of Local Authorities (LAs) arise from the Education Act 1996[22], the Education (Special Educational Needs) Regulations (Wales) 2002[23] and the Special Education Needs Code of Practice for Wales 2002[24]. The Code focuses on removing barriers to participation and learning. It provides practical advice to local authorities, maintained schools, Early Years settings and others on carrying out their statutory duties to identify, assess and make provision for learners' SEN.

In his discussions with the Independent Reviewer and Panel Chair, Mr J suggested that B's special educational needs were not appropriately met under the above legislation and code of practice. He believed B should have had a statement of SEN and an allocated TA, particularly at break times, when according to Mr J, B could be more vulnerable.

Mrs J, the Head of Learning at SS2, met with Mr J on 29th September 2016, soon after B had started at the school. SS2 reported that there were no references to SEN assessments being planned or required in respect of B. There is no record of any request from Mr J for B to be statemented and no application for a statement was made. No SEN assessments were carried out on B. The school report that academically, B was not performing as a SEN pupil. He was classified as SEN and entitled to School Action Plus Wales[25] due to his ADHD diagnosis and his hearing loss support from external agencies.

In addition to the Education Act 1996 and associated Code of Practice, reference has been made to the guidance taken from "Screening, assessment and intervention for learners with specific learning difficulties" - (Guidance document no: 164/2015 Date of issue: August 2015 Welsh Government)[26].

This guidance provides information to LAs and educational providers on how to identify effective screening, assessment and intervention methods that are currently available for learners with specific learning difficulties (SpLD). This enables LAs and teaching practitioners to ensure greater consistency in

[22] https://www.legislation.gov.uk/ukpga/1996/56/contents
[23] https://www.legislation.gov.uk/wsi/2002/152/contents/made
[24] https://gov.wales/sites/default/files/publications/2018-03/special-educational-needs-code-of-practice-for-wales.pdf
[25] School Action and School Action Plus Wales - individual help for maths/literacy from a teaching assistant. small group support to help develop social and communication skills. special equipment to help with writing. a particular teaching programme.
[26] Screening, assessment and intervention for learners with specific learning difficulties (Guidance document no: 164/2015 Date of issue: August 2015 Welsh Government)

both identifying learners with SpLDs and applying appropriate interventions to help meet their learning needs.

Within this guidance, ADHD is the umbrella term used to describe a condition that affects individuals' attention, concentration, impulsivity, activity levels and memory (ADD is included in this). The school were cognisant of B's ADHD diagnosis and were informed that B was medicated for his ADHD which he took before school. Whilst B did not have a SEN statement and therefore did not qualify for support from a one to one TA, the school report that B was able to access such support from TAs who were present in most of his lessons. The school report that B's academic ability was assessed in relation to all subject areas and that he was placed in teaching sets accordingly. The Former Pupils Voice Events held as part of the CCPR process informed the review that TAs were present in many of B's classes and were accessible by all pupils.

The school reported that, in B's first full year of enrolment at SS2 (from September 2016 – August 2017, which was Year 8), B was able to access support from a TA in 68% of his lessons (34 hours out of a possible 50 in a two-week timetable). This would have included all his core subjects, including Maths, English, Science, Religious Education, and Welsh, as well as most other subjects, such as History, Geography and French. The school also offered a lunchtime club for any pupils requiring additional support.

In Years 9 and 10, B was able to access support from a TA in 76% of his lessons (38 hours out of a possible 50 in a two-week timetable).

From reviewing the information submitted by SS2, it is reasonable to conclude that B was receiving tailored support for his individual learning needs and that the school reported that they were following appropriate guidance and procedures. However, if we consider 'best practice' in supporting pupils with additional needs, then the school could have strengthened their support by involving B and his family more in the planning, recording, and reviewing of B's Individual Development Plan (IDP) . A written record signed by all parties explaining how B's individual needs were being met, with specific contributions from B and his family may have helped avoid any confusion or ambiguity regarding the level of help and support required for B. It would also have helped to manage the family's expectations and understanding of the support provided by SS1 and SS2. A clear timetable on how the plan would be monitored and reviewed would also have offered further clarity and reassurance for B and his family. Mr J reported that he was assured by SS2 that following a number of incidents of bullying that B would receive support at break and lunch times when he was felt to have been most vulnerable. The school reported that B could have accessed help from a number of sources if he required it and that this included lunch and break times.

In order to hear directly from pupils who had attended SS2 at the same time as B, the CCPR Independent Reviewer and Panel Chair facilitated a feedback/consultation event in which former pupils could participate 'virtually' or contribute their views in writing. The feedback from those young people who chose to share their experience of attending SS2 was mostly very positive. There was an overall view that SS2 catered well for children with additional learning needs and that there were support staff available to assist pupils that required extra help.

One young person stated "*teachers were aware of and gave support, there were a couple of lessons where a Teaching Assistant was present, there was one in a learner's form, and they were there to help anyone. There was also emotional support".*

The young person said that there had been times when they had relied on a learner's Teaching Assistant to help them.

Another young person said "*I always thought my school was doing its best to support pupils with additional needs, I think they had extra classes for those pupils where there were staff to help them with things*".

A parent who also came forward after her daughter (who was in the same year as B) was invited to join the consultation event. She was very keen to offer her experience of SS2 as the parent of a child with additional needs (Asperger's). Her eldest son had previously attended SS2 and is now aged 20. She described her son as "different from his sister, who is a high achiever" and that her son was more of a "loner". She described how SS2 had been able to meet both her children's needs in different ways and that because of the support her son and the family received from SS2, her son had been able to make progress. In her view SS2 supported the children both emotionally and educationally, following B's death and stated that "*there is a warmth and kindness in the school*". She asked to have the following statement included in the CCPR Report: "*My son had transferred to SS2 from a different secondary school and this change had such a positive impact on him. He had been able to make "good" progress both educationally and socially with his peers due to the caring and supportive environment within the school*".

Identified Good Practice

- The tailored approach to learning meant that B made good academic progress whilst at SS2 – his last progress report demonstrated that he no longer required interventions for literacy and numeracy.
- Pastoral and wellbeing structures in SS2 at the time were good. Pupils had access to form tutors, Heads of Learning, Heads of Department, two external counsellors and a wellbeing team. B had several 'safe' places to use dependent on the situation – K, L, M, Wellbeing team, and M G were identified as 'go-to people' for B. There were also lunchtime clubs running, with IT clubs in the library, and two rooms staffed every day for more vulnerable children who were reluctant to go outside and mix. B had engaged well with a new pastoral lead and they were going to meet on a regular basis.
- Attendance monitoring was recorded at every lesson in SIMS (school registration system). The register was taken promptly at the start of every lesson.
- First aid – all SS2 staff received training for defibrillators and in cardiopulmonary resuscitation (CPR). This had taken place two weeks prior to B's death. This allowed CPR to be administered and the defibrillator employed within seconds of staff arriving at the scene of the tragic incident.
- Despite the high level of shock and anxiety that staff were facing, the incident was managed and communicated to parents effectively on the day. No pupils, (apart from B's sibling), were exposed to the incident itself, and SS2 was able to commence operating again before the end of the day.
- SS2 is the only secondary school in Carmarthenshire currently classed as ASD friendly[27].

[27] ASD Friendly - means being aware of social engagement and environmental factors affecting people on the autism spectrum, with modifications to communication methods and physical space to better suit individuals' unique and special needs.

- SS2 is a recognised Encompass[28] School.

Family's Perspective

- Retrospectively, the family feel that their relationship with SS2 had been lacking in openness/trust and they had lost confidence in the school from April 2018. This was mainly due to a series of incidents and no feedback on matters that they understood to be under investigation.
- The family felt that information in relation to accessing relevant policies, procedures and processes within the school was difficult and that communication should have been better in this regard.
- Mr J and family do not believe that B received adequate individual support from SS2 as a pupil with additional needs and that all incidences of bullying against B were not adequately recorded or dealt with by SS2. It was their understanding that he had 1:1 support.
- The family have concerns regarding the involvement of D (B's sister) in finding B and how that was managed and allowed to happen.
- The family also felt that there had been a lack of communication with them post B's death and an unwillingness to answer their questions or provide clarity about the day of the tragic incident.
- The family could not understand why B stayed behind in the classroom to tidy up after his last class ended as B never tidied up anything.

Learning

- The registration system at SS2 has been further developed. Every classroom now has a phone. Some staff did not have access to SPARK (previous system). Now all staff can access the new email-based system.
- At the time of B's death, SS2's anti-bullying policy was not robust or reflective of current guidance and best practice. The school has since developed a new policy which has been formally ratified by the Governing body and is now in use. It should be noted that this is compatible with the most up to date national guidance.[29]
- There is a need to strengthen the voice of children and pupil participation in SS2 and to include pupils in reviewing relevant school policies. This will need to be actioned by SS2 and their governing body, to become an integral part of the "sign off" process.
- B was involved in several incidents on the school bus. The LA may wish to consider the use of alternative transport arrangements for non-statemented pupils in exceptional circumstances such as this.

[28] Encompass -Operation Encompass is a unique Police and Education early intervention safeguarding partnership which ensures that a child's school is informed, **prior** to the start of the next school day, that there has been an incident of Domestic Abuse to which the child or young person has been exposed.

[29] Rights, respect, equality: Statutory guidance for governing bodies of maintained schools, November 2019

- The accessibility of health and wellbeing supportive information and services for pupils e.g., bullying, depression, stress etc. was not widely available or accessible enough for all pupils. SS2 needs to ensure such information is regularly updated, is accessible, and is widely promoted across the whole school campus.
- Education staff may benefit from training from a specialist organisation such as PAPYRUS (charity for the prevention of young suicide). This could be coordinated at a LA level enabling all schools to participate. It is noted that the Pastoral team in SS2 have already accessed suicide and self-harm training following B's death.
- Following the sudden and tragic death of a pupil, emotional and practical support is needed for staff in the school. Whilst this is generally good, in the immediate aftermath it is required on a longer-term basis, along with good supervision to focus on the residual impact, with ongoing occupational health support easily accessed if and when required.
- The introduction of EduKey and ClassCharts is a welcome development, but this needs to be sustained and embedded. A review of its impact should take place after twelve months post implementation, alongside its use in transition arrangements with partner providers and compliance with Keeping Learners Safe 270/2021.[30]

Restorative Practice

"Unlike punitive approaches, in which a 'third party' acts as judge, jury and executioner, restorative practice predicates upon ownership of behaviour and conflict resting with those directly involved, who also retain responsibility for resolution of the problem"[31]. 'Restorative practice' is used effectively in schools. Based on research and analyses of behaviour management, it sets out to provide schools with a clearly defined strategy and mechanism to support and encourage positive behaviour in the classroom and whole school community.

A key concern for the family and for those involved with B was the occurrence and reporting of "bullying"[32] and behavioural issues in which B was both a victim and an antagonist. "Every learner in every school has the right to learn, free from the fear of bullying, whatever form that bullying may take. Everyone involved in a learner's education needs to work together to ensure that this is the case."[33] ('Respecting Others: Anti-bullying Overview,' Welsh Government, September 2011)[34]. The management of these incidents fell predominantly to the school and the family. The opportunity for adopting a restorative approach by the school was desirable, but not always evident as such to the family, who perceived that B did not always receive this approach.

As was the case at B's previous two schools, B was involved in numerous behavioural and bullying incidents, both as the antagonist and the victim whilst at SS2. The school believe that all such incidents were investigated appropriately, and B's family were informed as required. During his time at SS2, it is

[30] Welsh Government Keeping Learners Safe Guidance 270/2021 issued 4th March 2021
[31] Restorative Practice in Schools – Paul Howard 2009
[32] Bullying - Behaviour by an individual or group, usually repeated over time, that intentionally hurts others either physically or emotionally (see Welsh Government guidance)
[33] Respecting Others: Anti-bullying Overview, Welsh Government, September 2011
[34] https://beta.gov.wales/sites/default/files/consultations/2018-11/respecting-others-schools-inspiring-rights-respect-and-equality-preventing-and-challenging-bullying_0.pdf

reported that he did make progress. As well as his improved academic performance, the school reported that there was a noticeable reduction in the number of behaviour incidents (particularly in the spring term) that B was involved in and records indicate this as tabled below:

Year 8	Year 9
Autumn term – 14 incidents	Autumn term – 14 incidents
Spring term – 9 incidents	Spring term – 1 incident
Summer term – 3 incidents	Summer term – 5 incidents

In a meeting that the Independent Reviewer and Panel Chair had with Mr J, he raised an alleged incident whereby B had been inappropriately touched by another pupil. This alleged incident had caused B and his family significant distress. However, this alleged incident was not easily identifiable in the timeline records submitted by SS2 for the CCPR. Due to Mr J's concern about this incident, SS2 were asked about the incident and they confirmed that they understood the matter had been dealt with appropriately in accordance with their relevant procedures.

In exploring this incident as part of the CCPR process, it was apparent that the nominated Designated Safeguarding Lead (DSL) and the Headteacher were not made aware of the incident at the time it happened. The Head of Year who dealt with the incident felt the situation had been investigated and resolved satisfactorily, without the need to escalate or invoke safeguarding procedures. Looking at this incident retrospectively with the Headteacher, it was acknowledged by him that had he, or his Safeguarding Lead, been alerted to the situation at the time, they would have advised that the incident be reported and investigated under the school's safeguarding and local multi agency procedures, as this was an alleged 'peer on peer' abuse situation[35] and an alleged sexual assault. This may have allowed a deeper understanding of the impact on B of this particular incident and provided the family with essential information regarding the outcome of any investigation**.** It would have also facilitated the involvement of other agencies, and allowed for a professional strategy discussion to take place under the All Wales Child Protection Procedures 2008[36]. During this incident it was reported by the family that B incurred an injury to his hand that required treatment at the hospital. Confirmation of B's attendance was included within the GP's records. Attendance had been at a neighbouring Health Board Minor Injuries Department, where it was recorded that B had attended the hospital with his dad and stepmum. The explanation provided for the hand injury had been that B was playing basketball and had hit his hand against another player.

The school records have been given due consideration. They clearly outline the numerous incidents as noted above, in detail and the records include the school's actions in response to these. The Independent Reviewer has specifically referenced a letter from the CBP (Cognitive Behavioural Psychologist) dated the 31st October 2017, as this was of particular concern to the family. They suggest that this letter was not given any significance by the school and believe it offered a clear insight into B's difficulties due to bullying. The CBP explained she had met with B '*on eight occasions for private CBT (Cognitive Behavioural Therapy) sessions for severe psychological symptoms related to a car accident in 2015.'* The letter sets out that B was being bullied by a child, X. The school state they were aware of, and dealt appropriately with,

[35] https://gov.wales/sites/default/files/publications/2020-10/guidance-for-education-settings-on-peer-sexual-abuse-exploitation-and-harmful-sexual-behaviour.pdf
[36] https://www.basw.co.uk/resources/all-wales-child-protection-procedures

various incidents between B and X. X was a child with a complex home background who was also struggling to manage his behaviours. Early in November, X's carer decided to move him to another school. His last day at SS2 was 23rd November 2017. The issues raised in the letter had effectively been resolved by the time of its receipt by the school, as by that date the school were aware that X was leaving. Following this period, the school reported that B continued to have access to the school-based youth worker and was encouraged to make use of their services as required.

Whilst at SS2, the school reported that B was provided with regular opportunities to access pastoral support from a range of staff. These included access to the Head of Learning, Form Teacher, senior staff members, class teachers, 'A' counsellor (A is an independent schools-based counselling service), school-based youth worker, Head of Wellbeing, mid-day supervisors and support staff, illustrating that there was by any school standard a comprehensive range of care, support and guidance staff available for all pupils to access. It would have been important, however, for this support to be clearly outlined to parents. In his meetings with the Independent Reviewer and Panel Chair, Mr J was not able to describe the various strategies being deployed by the school to support B, and from his perspective he was clear that B needed more support than he was receiving. He was particularly concerned about break times and what was happening to B on the school transport. It is fair to state that recollections and entitlements are varied in the perceptions of Mr J and SS2.

B accessed support from the school-based Youth Worker, Ms G. B attended 12 one-to-one sessions with Ms G between 15th September 2016 and 5th July 2018. These were supplemented by 7 drop-in sessions with Ms G between 15th May 2017 and 6th September 2018.

B attended counselling from the 'A' Counsellor on 12th October 2016, 3rd November 2016, 7th December 2016, 15th December 2016, and 25th January 2017. B later chose to opt out of counselling, with his last session taking place on 25th January 2017. B continued to access support from the Youth Worker, and Ms. G, up until 6th September 2018.

SS2 and key members of staff report that they enjoyed a constructive and positive relationship with Mr J and his partner K throughout B's time as a pupil at the school. They believe that communication with the family was open and honest. They stated that most of the time, B's family were supportive of any sanctions that were applied to B. The main disagreement in terms of sanctions given was for a one-day exclusion B was given in March 2018 linked to an incident on the school bus. It was in April 2018 that the family, owing to an accumulation in what they perceived to be unresolved situations, began to feel disillusioned with how matters pertaining to incidents with B were being dealt with, and how their resolutions were being fed back by SS2.

At the start of the new academic year in September 2018, a new Head of Wellbeing and Pastoral Care, Mrs E, had been appointed and she dealt with an incident where B was involved in an argument where he was alleged to have been verbally abusive to another pupil. The incident was such that Mrs E determined B would benefit from additional pastoral support in the form of one-to-one conversations. One such conversation took place the day before B's death on 11th September 2018 and Mrs E's notes of that meeting state:

"*I asked him how things were with his peers. He said that nobody was bothering him, and things were the best they had ever been. I told him that if he ever had any concerns to come and see me or Mr G in the Pastoral Office."*

The following information is taken from the Anti-Bullying Alliance:

"*Children and young people with Special Educational Needs and/or Disabilities (SEND) are more likely to experience bullying, including online bullying. Children with disabilities are sometimes* ***more likely to be bullied*** *than children without disabilities. Bullying, teasing, and harassment should not be considered normal rites of passage or "kids just being kids". The effects of bullying can be serious, including depression, low self-esteem, health problems, and even suicide*".[37]

The antibullying alliance guidance provides advice on dealing with bullying involving children with special educational needs (SEN) and disabilities. It is designed to help schools to:

- support learners with SEN and disabilities
- understand, prevent, and respond to bullying of children with SEN and disabilities
- eliminate disability-based discrimination and harassment
- develop a non-bullying ethos, and by doing so raise achievement and participation in safe, positive environments
- meet legal safeguarding obligations and comply with the Disability Discrimination Act (DDA)[38] and other legislation
- build on the requirements of the SEN Code of Practice
- uphold the fundamental human right of children to be free from abuse. It is relevant to all types of school.

The Minister for Education in the Welsh Government launched statutory guidance for governing bodies of maintained schools and local authorities with responsibility for children and young people's safety, wellbeing, and education ahead of Anti-Bullying Week in 2019[39]. There is evidence that a 'whole school approach' (Cambridge Education, 2005)[40] where the whole school community, including the pupils, teachers, support staff; parents and board of governors, are involved in confronting the issue of bullying is the most effective approach to tackling bullying in school.

Reports from the Children's Commissioner for Wales, the National Autistic Society and Mencap show that children with SEN and disabilities are more likely than their peers to be bullied. A 2007 Mencap survey[41] found that eight out of ten respondents had been bullied and six out of ten had been physically hurt.

Children with SEN and disabilities are a diverse population. They have many skills and talents. They also have a wide range of vastly different needs. This includes children with complex health needs, children with learning disabilities, children with sensory impairments and children with social and behavioural needs.[42]

[37] https://www.anti-bullyingalliance.org.uk/
[38] https://www.legislation.gov.uk/ukpga/1995/50/contents
[39] https://gov.wales/new-guidance-will-challenge-bullying-welsh-schools
[40] See more on whole-school approaches here
[41] https://www.communitycare.co.uk/2007/06/15/mencap-finds-80-of-children-with-learning-disabilities-are-bullied/
[42] https://beta.gov.wales/sites/default/files/publications/2018-05/respecting-others-bullying-around-special-educational-needs-and-disabilities.pdf

The fact that B suffered difficulties at school is not in dispute and both SS1/SS2 and the family appear to have been keen to address such incidents in a supportive and collaborative manner. It is possible that looking back on these events that Mr J and his family do not believe this now to be the case. They have stated that they believe that SS2 "let B down" and that B was "very unhappy at school", because of his experiences of being bullied. Information provided, indicates that the school dealt with all incidents in accordance with the procedures that were available to them at that time. The school have, however, acknowledged that at the time of B's death, their policies relating to Bullying and Safeguarding Pupils were due to be reviewed and updated. It is pleasing to note that since then, (2019), Welsh Government guidance and SS2's policies in relation to bullying and safeguarding have been strengthened and the school has further developed and embedded its pastoral care offer.

Excluding the report of B's death, the Police had only one incident relating to B recorded on their systems, which was a potential racially aggravated assault whereby B was the reported offender, and the victim was another pupil at the school; the incident was alleged to have taken place on the school bus.

The investigation fell outside the 'School Beat protocol'[43] and was investigated by territorial officers, rather than through the 'All Wales School Liaison Core Programme'(AWSLCP), which was introduced in 2005, with an aim to avoid wherever possible the criminalisation of young people. Although the School Police Liaison Officer was involved in the investigation and liaised with the school in respect of the incident, a Hate Crime Support Officer had been allocated to support the victim and their family. Liaison with the school meant that the school was sighted in respect of the incident and were able to appropriately address within the school environment. Liaison with B and his family was undertaken to identify if there were any extremist/idealist views held, which were negated by officers.

A proportional review was undertaken and identified that under the circumstances the incident did not warrant the criminalisation of a child (namely, B) and no further action was taken. There was however learning, which arose out of some confusion as to which arm of the Police should deal with the matter, which led to a delay occurring in the resolution process.

The Police have now introduced a new Vulnerability Hub (VH), which will oversee safeguarding processes and will disclose and receive referrals to and from partner agencies. Pathways for signposting lower-level incidents and vulnerabilities have improved, as have links with neighbourhood policing teams in the policing area associated with the CCPR.

There is evidence of appropriate responses from SS2 in relation to dealing with B's difficulties in line with the guidance[44] that was available at the time[45]. As can be seen from the information included above, there is new guidance and information available now that was not available at the time B was attending SS2. This will enable all schools to be more aware and able to respond accordingly to the needs of pupils involved in bullying, particularly those with added vulnerabilities such as B. The school have already willingly acknowledged and embraced this new guidance and have further developed their welfare offer to pupils who attend SS2 now. Also revising their policies which needed attention and updating in September 2018 at the time of B's death.

At the Learning Event for the CCPR there was an overwhelming sense of loss/grief expressed by the staff at SS2. They articulated a deep regret that they had not been able to prevent his death. Pastoral staff under

[43] https://schoolbeat.cymru/fileadmin/public/schoolcrimebeat/eng/School_Crime_Beat_2016.pdf
[44] Respecting Others: Anti-Bullying Guidance (National Assembly for Wales Circular No: 23/2003).
[45] https://gov.wales/sites/default/files/publications/2018-03/respecting-others-anti-bullying-overview.pdf

the school's restructured well-being team appeared to have had a close relationship with B and were able to demonstrate a level of insight and empathy that was both touching and profound.

Identified Good Practice

- Whilst there appears to have been some delays and complexity in dealing with the school bus incident in which a child was assaulted by B, it is positive that ultimately a proportional review of the incident was undertaken. This identified that under the circumstances the incident did not warrant the criminalisation of a child (namely, B).
- The school provided many different bespoke opportunities for B to receive support and help from a range of sources within the school and at the time of his death there was evidence of a strong rapport with pastoral staff who were highly supportive of B.

Family's Perspective

- The family state that they believe SS2 "let B down" and that B was very unhappy at school because of his experiences of being bullied, he felt that he was accepted everywhere, and could not understand why he felt that he was not accepted in school, and he wanted to be.
- The family believe that the relationship with SS2 following B's death has irretrievably broken down and that this is in part due to a lack of willingness from the school to "reach out to them" and answer their many questions about what happened on the day B died.
- The family believe that investigations that took place into reported incidents concerning B were not satisfactorily fed back to them. They noted a particular incident where B wrote on a toilet wall, when he had been verbally told that the matter would not be taken further.
- The family understood SS2's Safeguarding and Bullying Policies to be out of date.

Learning

- SS2's policies need to be regularly reviewed and updated to meet national/local guidance and legislation. They should involve pupils' voices in the review process**.** Upon publication, their accessibility should be made widely known to parents and pupils. It is noted that the school is due a Local Authority safeguarding audit (the previous one being in 2017). This will involve checking that all policies and procedures are up to date.
- All agencies need to be diligent in scrutinising their records to ensure all relevant information is included in their submitted timelines.
- The Police have now introduced a new Vulnerability Hub (VH), which will oversee safeguarding processes and will disclose and receive referrals to and from partner agencies. Pathways for signposting lower-level incidents and vulnerabilities have improved, as have links with neighbourhood policing teams in the policing area associated with the CCPR.
- Police Officers are briefed to provide signposting to appropriate support agencies where vulnerabilities are identified. They are also required to record any concerns about a child on a

MARF (Multi-agency referral form) which can be shared with partners for consideration of further action. This complies with their duty to report under the requisite legislation.

- SS2 may wish to consider how it can adopt a restorative approach to dealing with pupils and families when there is a critical incident and associated post trauma conflict. The option for Mr J and family to meet with the school to follow such an approach may still be possible and may help to heal the current strained relationships.
- SS2 should adopt as good practice a more formal reporting back process regarding the outcome of bullying concerns that are raised and investigated.
- The alleged peer on peer abuse was not investigated by SS2 according to the All Wales Child Protection Procedures 2008. Therefore, SS2 needs to ensure that all staff are familiar with Keeping Learners Safe 270/2021 and the Wales Safeguarding Procedures (2019) and are able to apply these procedures consistently.

Children's and Young People's Voices and Influence

Children who can form views have a right to receive and have made known to them information, to express an opinion, and to have that opinion considered in any matters affecting them. The views of the child should be given due weight according to the age, maturity, and capability of the child (see Articles 12 and 13, The United Nations Convention on the Rights of the Child)[46].

"Every child has the right to say what they think in all matters affecting them, and to have their views taken seriously".[47] The Well-being of Future Generations (Wales) Act 2015 guidance 'Shared Purpose: Shared Future' makes specific references to the National Participation Standards for Children and Young People, whilst Annex B of the guidance for Public Service Boards sets out the expectation of adopting the National Participation Standards in working with partners to enable children and young people to have a voice[48]. LAs have been under a duty to enable the participation of children and young people since the Children and Families (Wales) Measure was passed in 2010 and statutory guidance has been in place since 2012. Listening to 'Learner Voice' in schools in Wales has focused very effectively for many years on the crucial agenda of ensuring a clear and strategic voice for children and young people.

Children and young people with SEN have a unique knowledge of their own needs and circumstances, and their own views about what sort of help they would like, to be able to make the most of their education. They should, where possible, participate in all the decision-making processes that occur in education, including the setting of learning targets and contributing to Individual Development Plans (IDP), discussions about choice of schools, contributing to the assessment of their needs and to the annual review and transition processes. They should feel confident that they will be listened to and that their views are valued and practice is person centred in accordance with the CYSUR/CWMPAS Mid and West Wales Regional Safeguarding Board's adoption of 'Signs of Safety'[49].

The information shared by Mr J and the family suggests that they believe B did not have his voice heard sufficiently within the school and that the school could have done much more to facilitate this for B and

[46] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/
[47] UNICEF UK, 1990 as referenced in ESTYN: Pupil participation: a best practice guide (Dec 2016)
[48] https://gov.wales/sites/default/files/publications/2018-02/Bilingual-Participation-Standards-poster2016.pdf
[49] https://www.signsofsafety.net/

for other vulnerable pupils. Whilst it is true that there is more SS2 could do to enhance and develop the voice and influence of their most vulnerable pupils, it is also the case that B did spend time with a number of adults in the school with whom he appears to have had a safe and trusting relationship in which he could express himself. The school did not provide evidence of B's contribution to his IDP and annual review. SS2 may wish to consider how they can ensure the voices of their most vulnerable pupils are better represented. Looking at becoming a "child friendly"[50] school with pupil participation given a higher profile might be something they could consider.

The Learning Event provided a safe and protected space in which staff who had worked most closely with B and his family could reflect on their relationships with both him and the family. Those staff who knew B the most were able to describe their relationship with him, and to share their acute sense of loss and grief. They expressed sincere heartfelt condolences for the family. They talked about B with genuine warmth, compassion, care and understanding. Some staff gave examples of spending individual time with B and hearing from him directly his views and perspectives on what was going well in his life, and they discussed strategies with him for coping when things had not gone well. They gave examples of how B's sense of humour shone through and how he was able to hold very mature and interesting conversations. There was a strong sense that B managed adult relationships much easier than he did with those of his peers.

Having their voices heard is vitally important for all children, but especially so for those with vulnerabilities. Whilst it may be an area of contention for Mr J and B's family that he was unhappy at school prior to his death, there is much evidence that he had several people there with whom he enjoyed a positive relationship and that there were opportunities for him to have his voice heard and to be supported in times of difficulty. However, SS2 have acknowledged that this is an area that they will continue to review and develop.

As described earlier in the report, the Review Panel both supported and promoted the need to include the experiences and voices of young people. Specifically, from those pupils who were in the same year as B at the time of his death at SS2. Although there were only a small number of pupils who chose to participate, their contributions were extremely welcomed and pertinent comments relevant to the CCPR are represented below:

One of the young people who joined the consultation event and who knew B did talk about the difficulties B faced because of bullying. She stated that "*B would sit at the front of the bus"* and she and her friends were aware that *"B was a little different".*

Another young person who knew B said she had sat next to him in the registration form. She couldn't say that she knew him well. They did have "*small chats*" but didn't become great friends. She figured out who B was "*as a person*" and described him as "*a nice boy*". She said he always had stories, how his boiler had broken or other stories of things that had happened. She said B "*was very proud of what he did*". She remembered him talking to his teacher and "*he was very proud of his art*". In her friendship group *"we would tell the boys to stop bullying – it was a small form. B wasn't one to hang out with us, he would have friends of his own. It was love/hate with B and the boys – sometimes he would get on with them. He was a genuinely nice person to talk to."* She stated that B would sit next to her on a table where there was just the two of them.

[50] Child Friendly Schools - aim to develop a learning environment in which children are motivated and able to learn. Staff members are friendly and welcoming to **c**hildren and attend to all their health and safety needs. Teacher training is a central part of encouraging a child friendly and inclusive school environment.

Other pupils stated that because it was a small school, "*teachers in the school knew all the pupils and the pupils knew all the teachers. You could just go to anyone and tell them anything*".

The following extract is taken from a written submission from one of B's year group, in response to the Review Panel's invitation to participate in the feedback event*:*

"*I always thought my school was doing its best to support pupils with additional needs, I think they had extra classes for those pupils where there were staff to help them with things.*

For bullying, we had assemblies in place where they talked about bullying and how it's not tolerated at all and I think most people knew where to go if/when we were experiencing bullying, mainly the head of years (I forgot what it was called) and any issues were dealt with as soon as possible.

There was help if there was a problem anywhere, they always talked about how you can talk to any of the staff especially your tutor, there was also the school's counsellor (again forgot what the exact title was), where you could go and talk 'whenever' and they will help.

Although there was some help, I think there should be more counsellors in school to help more and more students because my friend went to the counsellor and she talked about the counsellor being quite busy".

A parent wrote to the Independent Reviewer and included the following response from their son, referring to how the school responded in the aftermath of B's death:

"*after the incident we were offered support through the school, there were people sent around the registration classes asking the class if anyone needed it, but I do not think that anyone took up the offer like this, I believe that the school should have asked the people close to B in a more direct manner, it would be difficult to come out in the registration class asking that person for help, or at least, I feel that it would be very difficult for someone to ask for help in front of the class. I also want to add that the school did deal with the protests relatively well, under the difficult circumstances that the protestors put on the school, it still functioned well under that pressure and did its best to prevent the protests from affecting the students".*

Identified Good Practice

- There is evidence of opportunities for pupils to access and receive support and to have their views and influence included at SS2. Pupils noted the importance of the school counsellors, youth officer and welfare staff, noting that there was always someone to go to, SS2 staff knew all the pupils well.
- SS2 has a well-developed PSE programme that includes inputs from outside agencies such as Health and Police. SS2 follows the Welsh Government's National Curriculum and will be adopting the revised Welsh Government curriculum when it is implemented in 2021. Wellbeing and pastoral care was also noted to be a focus of the RE curriculum.
- The statements from staff and pupils at SS2 indicate that B did have individual time with staff who tried to support him, and that there were bespoke and flexible arrangements in place for him to seek additional help when he needed it.

Family's Perspective

- Mr J and family believe that B's voice and influence were not captured sufficiently by SS2 to ensure that his needs were adequately responded to.
- They do not feel B was listened to and noted that when he wrote on the toilet wall , B stated 'finally someone is listening to me'.
- B did not always perceive that all members of staff wanted to help him or act on his concerns.

Learning

- Since B's death it is noted that there has been a greater emphasis placed on support for pupils who may require additional help. This has been developed through a revised pastoral structure, wellbeing notice boards, clear signage as to where pupils are to go for help, talking sessions, a revised curriculum which focuses on wellbeing and pastoral care.
- SS2 is also part of the ACEs aware schools and has a programme of staff development to equip staff to manage pastoral issues that arise.

Health

Within the period of the timeline of this review there are several health entries. These relate to the management of B's ADHD and concerns in respect of B's behaviour both at home and in school. Health records also indicate that B received regular prescriptions for Elvanse[51], a drug commonly used to support children with ADHD[52]. Medication in this regard was prescribed from September 2016 where the plan had been to try Elvanse daily five days per week or seven days a week. This would be trialled for 6 weeks. Following the initial six week trial period Mr J coud request a perscription, which in acordance with the guidance would be reviewed in six months.

In October 2016, the school received information from the Sensory Impairment service informing them that B had a high frequency hearing loss in his right ear. He was given a hearing aid for his right ear. This guidance was shared with all staff by the SENCO.

B's Head of Learning, Mrs J, and Mrs G met with Mr J on 3rd October 2016 to discuss this and several other issues; these were also shared with all staff. The importance of B's seating position front and centre of class was shared. Mr J said that doctors from the hospital had advised not wearing the hearing aid in school as it is 'too noisy and signals get mixed'. Mr J also explained B had a turn in his eye which was not operated on until he was eight years old and that this may affect his vision at times. He also added B was involved in a serious car accident in October 2015 and was still having physiotherapy. Mr J spoke about B's ADHD and said B had 'no filter' and could get 'obsessive and paranoid'.

[51] Elvanse – Medication used as part of a treatment programme for attention deficit hyperactivity disorder aged 6 years or over.

[52] ADHD - Attention deficit hyperactivity disorder is a condition that includes symptoms such as inattentiveness, hyperactivity and impulsiveness. Symptoms of ADHD include a short attention span, constantly fidgeting and acting without thinking.

B met with DR, a regional teacher for the deaf, on several occasions as set out below:

27th September 2016 – it was reported that a hearing aid had been provided, however B had said he did not find it useful

10th January 2017 – it was reported again that B was not wearing his hearing aid and that he was to wear it if the hospital advised it at his next visit; and

18th May 2017 – B explained he felt the hearing aid was too noisy. An appointment was to be arranged with Audiology to discuss his hearing aid.

In February 2017, B attended G Hospital Emergency Department with a nosebleed and a query regarding concussion. It was reported that he had been punched by a boy at school. There was a small wound to his nose.

In March 2017, B missed attending two Audiology appointments and was therefore discharged. The Health Board has developed and implemented a procedure for monitoring vulnerable people who "were not brought" or "did not attend" appointments and "no access" visits.

In August 2017 B was seen by the Community Paediatrician for his review and it was reported by Mr J that B was still struggling with behaviour, mainly at school break times and at home when his medication was wearing off. Mr J said B sometimes struggled to manage his anger.

A letter from the family's privately appointed Cognitive Behaviour Psychologist (CBP) dated the 31st October 2017 to the school sets out:

'*Unfortunately, B is not meeting criteria for Sp-CAMHs but I have advised his father to contact his GP to discuss a possible referral to Sp-CAMHs (Primary care mental health service for children and young people), if this is available in his area. We discussed the possibility of engaging with the school counsellor, but at present B is hesitant, as he has not found this beneficial in the past. It may be that support from school regarding a safe place to discuss things with a particular and named teacher 1:1 may be helpful, as this will help B's feeling that he is being listened to and understood.'*

There are no references within the Health timeline to indicate that a referral to Sp-CAMHS (Children and Adolescent Mental Health Services) via B's GP was ever progressed as per the above suggestion.

Drug treatment in school-age learners

NICE[53] indicates that in school-age learners with severe ADHD, drug treatment should be offered as the first-line treatment, along with a group-based parent training/education programme. The guidelines go on to say that drug treatment (e.g. methylphenidate or atomoxetine) for learners with ADHD should always form part of a comprehensive treatment plan that includes psychological, behavioural, and educational advice and interventions.

NICE guidance with respect to ADHD (NG87)[54] recommends a review every 6 months to check and record height and weight. In accordance with the guidance, every 12 months there should be a review by a medical practitioner. ADHD clinics in the Health Board have traditionally attempted to offer appointments with a paediatrician every 6 months.

[53] https://www.nice.org.uk/guidance
[54] https://www.nice.org.uk/guidance/ng87

In 2019, acknowledging a lack of capacity to meet increased demand, the Health Board initiated monitoring clinics managed by HCSW (Health Care Support Workers) to document growth (height and weight), blood pressure and heart rate as well as to record the presence or absence of adverse side effects by means of a standard questionnaire. Any parental questions or concerns are passed on to the Paediatrician. With this resource parents and their child would see the HCSW or doctor alternately every 6 months.

In his discussions Mr J explained that he did not give B his medication during school holidays and it is possible that this may have interrupted the cycle of B's reaction to the medication, particularly when he resumed taking it. The administration of the medication would be the responsibility of Mr J and if he chose not to give it to B during the school holidays then this would not always have been something that school or Health staff would have been aware of at the time. Exploring with families how they manage prescribed medication would appear to be essential in understanding any potential impact on children when families choose to alter the advised dosage.

The issue of a referral to Sp-CAMHs for B appears to have been a potential missed opportunity. The psychologist suggested that Mr J might progress this through his GP but this was not followed up by Mr J or anyone else. The Independent Reviewer has considered the document "Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales"[55] to see if there was anything that could have assisted Mr J or the family in accessing emotional health and wellbeing support for B. Together for Mental Health is a cross-Government Strategy setting out the goals for improving mental health and mental health services in Wales. It is the first Mental Health Strategy that covers all ages; children and young people, adults of working age and older people.

For children and young people, the strategy states:

"*We will be working with schools via the Healthy Schools network, youth clubs, colleges, Youth Offending Teams, and other groups to raise awareness about mental health issues and wellbeing. We will work with children and young people to make sure that services meet their needs, that they are involved in decisions that affect their lives when possible, and that they get the information in the right format in the places that they go.*"

Spotting the signs of a mental health problem and providing help as soon as possible is important. Tier 1 Children and Adult Mental Health Services (CAMHs) work with others such as School Nursing services and School-based Counselling and Youth Offender Teams to meet these needs and improve appropriate access to CAMHs. A referral via his GP, as recommended by the private psychologist, was not progressed for B. Whether this would have provided any more insight into his frame of mind and been able to identify any potential suicidal ideation is difficult to know. What was known, however, was that B was receiving pastoral support from a range of people from within the school network.

In June 2018, B missed his standard immunisations in school due to not completing the consent forms. The school nurse contacted Mr J to inform him that the immunisations could now be administered at the surgery for B. The Health timeline evidenced that the immunisations did not take place. B's last Health appointment was in August 2018, for help with his acne and shingles.

[55] https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf

The Health Board's school nurse attended to B on the day of his death, assisting school staff with attempts to administer CPR to B. School and Health staff were up to date with training and knowledge on how to adminsiter CPR which is noted as good practice.

Identified Good Practice

- SS2's Health Board Nurse actively sought consent from B's father to share information with the Additional Learning Needs Coordinator to promote the best possible outcomes for B within the school environment.
- The Health Board School Nurse contacted the father directly to offer an alternative place to receive immunisations that had been missed, due to the late return of the consent form.
- On the day of B's death, the Health Board School Nurse offered professional assistance and acted within her scope of practice.
- The Health Board School Nurse and School Staff in SS2 had received up to date CPR training.

Family's Perspective

- The family were concerned that B did not get support and help from Specialist CAMHs. They believe such services should be readily available and easily accessible for vulnerable children.

Learning

- A Health Board procedure in relation to the handover of children when moving to another practitioner within the school nursing service has been developed and implemented.
- The Health Board had developed and implemented an all-age 'Monitoring Vulnerable People Who Were Not Brought or Who Did Not Attend Appointments and No Access Visits Procedure'. It has been identified as a priority area for review to monitor compliance.
- Emotional health and wellbeing support for children with ADHD and other vulnerabilities such as ACEs or bullying needs to be explored as part of a holistic approach to a CAMHs offer, in line with the guidance in the 'Together for Mental Health Strategy'.
- The impact of families self-adjusting prescribed medication for their children needs to be explored as part of the review process and parents encouraged to share with professionals any changes of normal application.
- In 2019, acknowledging a lack of capacity to meet increased demand, the Health Board initiated monitoring clinics managed by Health Care Support Workers (HCSW) to document growth (height and weight), blood pressure and heart rate as well as to record the presence or absence of adverse side effects by means of a standard questionnaire. Any parental questions or concerns are passed on to the paediatrician. With this resource parents and their child would see the HCSW or doctor alternately every 6 months.

- Education Department School Health Care Plans[56] should be reviewed at minimum on an annual basis, involving appropriate school staff and parents at all points of transition.

Adverse Childhood Experiences (ACEs)

It is noted within this report that B experienced difficulties in his early years. Such experiences are often referred to by professionals as 'Adverse Childhood Experiences' (ACEs). ACEs, as defined by Public Health Wales, are stressful experiences that occur during childhood that directly hurt a child (e.g., maltreatment) or affect them through the environment in which they live (e.g., growing up in a household with domestic violence). ACEs may impact on a child's health throughout their life. The World Health Organisation also include bullying and bereavement as ACEs.

In 2019 a report was published entitled "*Responding to Adverse Childhood Experiences, an 'evidence review' of interventions to prevent and address adversity across the life course*"[57] which sets out some of the learning around types of impactful adverse experiences in childhood and how these might be addressed.

Awareness raising and training on ACEs has been widely available to practitioners across the range of professions that sit under the Mid and West Wales Regional Safeguarding Board (CYSUR). It is not clear from the information shared for this report whether the full implications of B's early ACEs were considered in any detail by any professionals working with him, other than the psychologists who both refer to it in their reports. Based on what professionals know of ACEs continuing to affect children into adolescence and adulthood, it is possible that B was still affected by his early experiences. A greater emphasis on the impact of ACEs needs to continue to be cascaded across all agencies. Ensuring families are provided with an understanding of the potential impact of ACEs is required to enable them to provide the necessary support to their children who may be affected by such early adverse experiences.

Identified Good Practice

- Awareness raising and training on ACEs has been widely available to practitioners across the range of professions that sit under the Mid and West Wales Regional Safeguarding Board (CYSUR).

Family's perspective

- B's father was able to articulate his own understanding of the potential impact on B of his difficult early childhood experiences, and felt as a family they had done much to overcome this with B by providing him with many positive and nurturing experiences.
- B's father spoke of the importance of B's grandparents in his early life and the stability they offered him.

[56] https://gov.wales/sites/default/files/publications/2018-12/supporting-learners-with-healthcare-needs.pdf
[57] https://phw.nhs.wales/news-and-publications/news/responding-to-adverse-childhood-experiences-an-evidence-review/responding-to-adverse-childhood-experiences/

- B's father spoke with warmth and gratitude regarding the support that B's earlier Social Worker had provided to B and his family at the time of his parents' divorce and the support they provided at the time of B's death and during the CCPR.

Learning

- Greater recognition of ACEs needs to continue as part of ongoing training for professionals and information about ACEs shared with families for whom it is relevant.
- SS2 was pleased to learn more about 'Signs of Safety' through the pre and actual Learning Event and how that could be incorporated into their practice.
- A whole school/college approach is required for all educational institutions to become Trauma and ACEs informed (TRACE).
- Professionals working with children need to recognise that those who have experienced ACEs or severe trauma may show the characteristics of ADHD; conversely those children considered as having ADHD may in fact be displaying behaviour that is the result of ACEs or trauma.

Unexpected Deaths in Childhood

Dealing with an unexpected child death is probably one of the most harrowing and difficult experiences a family or professionals will ever have to deal with. It combines the impact of grief and loss with the searching questions and desire to understand, what, if anything, might have been done to prevent the death. In this review it is clear that B's death has had a significant, profound and lasting impact on all those who knew him.

The Learning Event associated with this CCPR highlighted the very difficult task for the family and professionals who are continuing to grapple with their grief, which was compounded due to the delays in a Coroner's Inquest taking place and the completion of this review. The opportunity to make sense of what happened to B and to reach a point of closure is still heavily in abeyance, pending both processes concluding. The impact on all those involved is significant. The division and lack of trust that the family have articulated towards the school has not aided the process of healing and closure for either party. It is hoped by the Review Panel that there may still be an opportunity for a restorative process to occur.

In relation to the events that occurred on 12th September 2018 and the SS2's response to events that occurred, these have been considered as part of this CCPR to consider any learning relevant to their policies that were in place at the time. The school's register printout shows that B's lesson 3 science teacher sent a 'SPARK' message to MH at 11.20am on 12th September 2018 when she noted B was missing following taking the sessional register. The register was subsequently submitted online at 11.23am on 12th September 2018. Mr J suggested in a meeting with the Independent Reviewer and Panel Chair that B left the technology classroom at the beginning of the morning breaktime on 12th September 2018 in a distressed state and that "*he was also seen in the corridor by another pupil, saying he had had enough, and he had to get out of this place.*" The CCPR was unable to see any evidence to affirm this observation/claim and therefore it remains unsubstantiated.[58]

[58] Wales Safeguarding Procedures – It simply means that there is insufficient identifiable evidence to prove or disprove the allegation. The term therefore does not imply guilt or innocence.

There is CCTV footage of 12th September 2018 (viewed by the Independent Reviewer), which shows that at 10:52am, B leaves the technology classroom and heads immediately in the direction of the technology block toilets. The inquest transcript states that as B left the classroom, "none of the three staff members felt that B was holding back for any reason nor that there was or had been any form of trigger for what would then take place."[59] B is not seen on any other camera after leaving the technology lesson at 10:52am, as he makes his way to the technology block toilets. Whether B was upset or not is not visible on the CCTV, as B's back is to the camera. The inquest findings stated: "it is extremely difficult to get a clear image of his body language; however, I can say that there is certainly the appearance of someone who was less animated than he had been on his arrival at school and that it was not consistent with his demeanour in the lesson."[60]

The combination of his ACEs and his SEN due to his ADHD will have created some additional vulnerability for B. The psychological reports make reference to this. It is possible that the full implications of this may not have been fully understood by the family and professionals who were trying to support B. This was something professionals reflected on during the Learning Event. It is also possible that B himself may not have fully appreciated or been able to comprehend the complexity of the feelings he experienced because of this complex mix of influences. Mr J commented that sometimes B acted 'on impulse' and always 'in the moment'; this may have been the case on that fateful day. The actions B took may have been reactive and 'in the moment', without a full appreciation of the final outcome.

In the period leading up to his death, B had shown no signs to either his family or those professionals who knew him well, that such a tragic incident could take place, either purposefully or accidentally. His family and professionals were all aware of his vulnerabilities but saw no signs at all that might suggest B had any suicidal/harmful intentions or ideation. The challenges B faced in relation to his emotional health and wellbeing were known to those around him and strategies were in place to try and support him. During the period immediately prior to his death, B's family and school staff report that B was not unnecessarily unhappy or showing any indicative signs of acute distress. Those who engaged with him on the day of his death report he was looking forward to events that were planned ahead.

From the information available regarding the sudden unexpected deaths of children, it is hard to know, what, if anything, may have helped those involved with B to anticipate his actions. The issue of unexpected childhood deaths and suicide in children has been an area of concern and interest across Wales involving health, education, and social care professionals. It is an area of work that the Mid and West Wales Safeguarding Board, CYSUR, has commissioned work into and been fully involved with. The work remains ongoing across all partner agencies.

The question of whether B's death was accidental or intentional remains unanswered.

However, in his findings the Coroner stated ; 'The toilet block was his safe place where he would go when upset, frustrated or angry and I think that what he did was to go there in an attempt to calm down and that the step that he took was borne out of such upset, frustration or anger. In my view, whether out of upset, frustration or anger; this was clearly an intentional act on B's part but one that went wrong.'[61]

[59] Findings and conclusions – Inquest into the Death – Pembrokeshire and Carmarthenshire Coroner's 29th June 2021
[60] Findings and conclusions – Inquest into the Death – Pembrokeshire and Carmarthenshire Coroner's 29th June 2021
[61] Findings and conclusions – Inquest into the Death – Pembrokeshire and Carmarthenshire Coroner's 29th June 2021

It poses for those who knew B, a challenging task to understand how best to consider what relevant appropriate learning may be taken from his death. With that question remaining unanswered, it is worth looking at what is already known about unexpected deaths and suicide in children.

A thematic review on the deaths of children and young people through probable suicide was led by Professor Ann John and supported by the Child Death Review Programme Team, Public Health Wales.[62] This review was also supported by the Welsh Government and Children's Commissioner for Wales. It rightly stresses the enormous impact that the suicide of a child can have. "*Whenever someone takes their own life it is a huge tragedy and causes distress for many people - family, friends, professionals, and the wider community. That impact is multiplied when a child or young person dies by suicide".*

The Children, Young People and Education Committee's *Mind Over Matter* report[63] called for the emotional and mental health of children and young people in Wales to become a stated national priority.

The thematic review 'Talk to me 2 - Suicide and Self-Harm Prevention Strategy for Wales 2015-2020'[64] informed the Welsh Government's consultation strategy on suicide and self-harm prevention. Children and young people from vulnerable backgrounds, particularly those not in education, training and employment were a priority group for action in Wales and the Child Death Review Programme was referenced as a mechanism by which deaths through suicide in young people would be regularly reviewed in Wales.

'Talk to Me 2' is the suicide and self-harm prevention strategy for Wales for the period 2015-2020. It builds on the original 'Talk to Me Strategy' and identifies several objectives and an action plan to achieve these.

The opportunity that 'Talk to me 2' brings to help raise awareness and understanding of suicide amongst young people is highly welcomed but it is hard to know whether even with this helpful knowledge, training and awareness those who knew B would have been better equipped to anticipate or prevent his actions.

From considering the agency information and the family's contributions, there is nothing to suggest that those professionals involved with B could have predicted or prevented B's death. Whilst there are areas of learning to acknowledge, there is no procedure or policy that can be identified, as having contributed to any specific failings that directly contributed to B's death.

Whilst the developments noted above are significant and highly valuable, it is not possible to draw specific learning from these to identify gaps in agencies' policies that may have helped to predict or prevent B's death.

Identified Good Practice

- All agencies follow the PRUDiC Process (2018) in relation to all unexpected child deaths under the age of 18 years, which provides a clear process for family support and referral to bereavement services.

[62] https://phw.nhs.wales/news/averting-tragedy-suicide-prevention-in-welsh-children-and-young-people/thematic-review-of-deaths-of-children-and-young-people-through-probable-suicide-2013-2017-main-report/
[63] https://senedd.wales/laid%20documents/cr-ld11522/cr-ld11522-e.pdf
[64] https://gov.wales/sites/default/files/publications/2019-08/talk-to-me-2-suicide-and-self-harm-prevention-strategy-for-wales-2015-2020.pdf

- First aid – all SS2 staff received training for defibrillators and in CPR. This had taken place two weeks prior to B's death. This allowed CPR to be administered and the defibrillator employed within seconds of staff arriving at the scene of the tragic incident.
- Despite the high level of shock and anxiety that SS2 staff were facing, the incident was managed and communicated to parents effectively on the day. No pupils, apart from B's sibling, were exposed to the incident itself, and the school was able to commence operating again before the end of the day.

Family's Perspective

- The family continue to grieve and ask questions about what happened and why. They understandably continue to struggle to come to terms with B's unexpected death and the loss of a much-loved member of the family.
- The family do not believe they have been told the truth about B's last movements on the day of his death.
- The family have struggled to deal with the aftermath of D finding her brother in the toilet cubicle.
- The family find it unfathomable from B's presentation when he left them that morning how this tragic incident could have occurred.

Learning

- The work already undertaken in the 'Mind over Matter' report and within Wales on self-harm and suicide prevention needs to continue to inform practice to strengthen support and help for children's emotional health and wellbeing.
- Awareness raising and training needs to continue for all staff in relation to the suicide of children with reference to the 'Talk to Me 2 Strategy' for Wales.
- Whilst this was a unique incident, the involvement of B's sister in finding her brother on the day of his death needs to be considered, and a system introduced to ensure the exposure of pupils to potential harmful incidents during a critical incident is better managed.
- The work currently being undertaken in this very important area via the University of Swansea needs to continue, and it must be ensured that awareness and learning from it is embedded in professional practice.

Improving Systems and Practice

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

Learning has been identified throughout the review process. It is important to note that the points below are identified with the benefit of hindsight. Any learning should contribute to improving future practice and

ensure services are robust in protecting children. The section below identifies the themes emerging from the review and the learning that can be gained from them.

Learning 1: The Mid and West Wales Safeguarding Board will coordinate and support its members to develop and introduce a rapid response model, to provide a timely and enhanced level of support to families, peers and the wider community when unexpected deaths occur.

Learning 2: Panel members need to ensure that practitioners who are responsible for completing agency timelines are aware of the need to include all significant information contained within their agencies' records, and the timeline guidance will be reviewed to reflect this.

Learning 3: All agencies will need to be compliant with the implementation of the new Additional Learning Needs (ALN) Code for Wales, December 2018 and the Additional Learning Needs and Educational Tribunal (Wales) Act 2018, (the ACT). In order to strengthen (using a person-centred approach), the voice and inclusion of children, young people and their families in their Individual Development Plan (IDP), evidence will be required to demonstrate that their participation in decision making has been encouraged, and the views, wishes and feelings of both the child/young person and their parents/carers have seriously been considered in all meetings/reviews.

Learning 4: All schools and Local Authorities need to ensure that their practice, training and policy guidance on bullying, is compliant and acknowledges the added vulnerabilities of children, who may have additional learning needs, emotional mental health and well-being issues, have experienced ACEs, or have disabilities. They need to be compliant with Welsh Government Guidance, Keeping Learners Safe 270/2021[65] and Rights, Respect, Equality: Statutory guidance for governing bodies of maintained schools.[66]

Learning 5: All Local Authorities and educational institutions must demonstrate, through their annual audit and accountability processes, their compliance with the Keeping Learners Safe 270/2021 audit tool, and 'must demonstrate how they review their safeguarding arrangements and identify strengths and weaknesses to ensure they are exercising their legal safeguarding obligations'[67].

Learning 6: Consideration should be given by the Local Authority to reviewing their current process in relation to school transport arrangements, to ensure that any children or young people with vulnerabilities are adequately safeguarded, particularly where there are reports/concerns of bullying raised.

Learning 7: All schools need to consider how they ensure communication with parents is timely, proportionate and effective, in addressing any concerns that parents may have in respect of their child's wellbeing, and where possible an outcome is achieved and recorded.

Learning 8: Following a traumatic incident, all agencies should develop a plan that considers the short and longer term wellbeing needs of their staff, and any others affected by the incident.

[65] Welsh Government – Keeping Learners Safe – The Role of Local Authorities, Governing Bodies and Proprietors of Independent Schools Under the Education Act 2002 (270/2021) March 2021

[66] https://gov.wales/sites/default/files/publications/2019-11/rights-respect-equality-statutory-guidance-for-governing-bodies-of-maintained-schools.pdf

[67] Welsh Government – Keeping Learners Safe – The Role of Local Authorities, Governing Bodies and Proprietors of Independent Schools Under the Education Act 2002 (270/2021) March 2021, p12, 1.39

Child Practice Review Process

In accordance with procedures, a Procedural Response to Unexpected Deaths in Childhood (PRUDiC)[68] meeting was held. It was the perspective of members at that meeting that based on the circumstances of the sudden death, the matter should be referred for consideration under the Child Practice Review process. The Chair approved that a Concise Child Practice Review should be undertaken.

The services represented on the Review Panel were as follows:

- Police
- LA Families and Children's Social Services
- Health
- Education
- Regional Safeguarding Board

An Independent Panel Chair and Independent Reviewer were commissioned who were, in accordance with the guidance, independent of the case management and had the relevant experience, abilities, knowledge and skills as required by the case and circumstances under review.

Learning Events

In accordance with the guidance a virtual Learning Event was held on the 1st December 2020. This was jointly facilitated by the Independent Panel Chair and the Independent Reviewer.

The Learning Event for practitioners and managers was attended by the following agencies:

- Police
- Education (school staff)
- Local Authority Children's Services
- Health (GP, Consultant Paediatrician, School Nurse, Safeguarding Children's Lead)
- Regional Safeguarding Board (Represented by the Board Manager

The Learning Event allowed the professionals concerned, the opportunity to consider their involvement, practice, assessments, and decision-making processes that concerned B's life. It was clear that in sharing all the information known by professionals at different times, a clearer picture of the circumstances surrounding B emerged.

Ensuring that practitioners did not feel judged or blamed was an essential part of the Learning Event. It should be acknowledged that all those present at the event were touched by the plight of the family and were keen to consider in an open and self-reflective manner any potential learning. The impact of B's unexpected death was expressed by those participants who knew him and their grief and loss is still acutely palpable.

[68] Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2018

Participants at the Learning Event were able to consider the following questions using the 'Signs of Safety' methodology and framework, to facilitate their discussions at the Learning Event and identify learning:

1. What went well, what good practice have you identified?
2. What do you feel did not go well, are there areas which concern you?
3. What do you feel agencies could have done differently?
4. What actions do you feel that agencies need to take going forward, to ensure any learning informs future practice?
5. Has there been learning for you/your agency?
6. What are the actions you need to take to ensure things we have learned, change what we do in the future?
7. Any other comments or observations you would like to make?

Evaluations and feedback for the Learning Event were extremely positive and included comments from all participants, a sample of the comments are illustrated below:

From the Head Teacher:

"*Whilst very demanding emotionally and mentally both in the build-up and on the day, the event was a positive experience for me and those staff who have commented since. All staff commented they viewed the event as well organised and very worthwhile."*

From members of staff from the school:

"It was important for me that B's wonderful personality was captured, and that the day was all about him."

"I was blown away by everyone's compassion and willingness to learn."

"Reflecting on the day, I have realised how therapeutic it was as well as a day of learning."

From Health colleagues:

"*Excellent. Professional and empathetic. Extremely well facilitated. Thank you for the experience and the learning."*

Former Pupil Voice Events

The voice of B's year group was very important to the CCPRP and on the 1st March 2021, the Independent Reviewer and the Panel Chair supported by Gower College Swansea and Coleg Sir Gar/Coleg Ceredigion held two Former Pupil Voice events. There were 3 participants in attendance alongside the respective Colleges' Designated Senior Safeguarding Leads. 2 former pupils provided written responses. The parental voice was also heard, and their perspectives have also been encapsulated within the Concise Child Practice Review Report.

Family Engagement

B's immediate family were fully engaged with the review process. The Chair of the panel, together with a Social Worker from Children's Services (whom the family hold in the highest regard, and who supported

them following B's death) met with the family, initially at the family home, to discuss the process for the review and to hear from them their views about what had happened and to offer the panel members sincerest condolences. The Chair explained the following:

- Why there was a review and how it would be conducted;
- The role of the Independent Reviewer and Panel Chair ;
- The Learning Event; and
- Report publication timescales.

A face-to-face meeting was not possible with the Independent Reviewer owing to COVID-19 restrictions being in place; therefore, the meetings with the Independent Reviewer, the Panel Chair and the family took place virtually using Microsoft Teams and Zoom. The views from the family have been considered by the Review Panel and the Independent Reviewer in the compilation of this review report. The family's views are quoted directly within the main body of the report. The family were also kept updated of the progress of the review and had open access to the Panel Chair. They were afforded the opportunity to submit any information that they wished to the Panel Chair and the Independent Reviewer, and to inform them of any additional family members or close family friends that they would wish them to speak to. The family have been offered a further meeting with the Independent Reviewer and the Panel Chair prior to the publication of the Concise Child Practice Review Report.

Engagement with Sibling

B's younger sibling had a close relationship with her brother, therefore it was important that she was offered the chance to participate in the review. The Independent Reviewer and Panel Chair were able to speak with her virtually, using Microsoft Teams. D had also met the Panel Chair at the initial family meeting prior to the pandemic restrictions.

Family expectations of the review

The family raised significant queries and questions that were included and explored in the Learning Event and within the Concise Child Practice Review Report.

With Immeasurable Gratitude

The Independent Panel Chair and the Independent Reviewer have experienced exemplary support in respect of the completion of this Concise Child Practice Review and would like to sincerely thank the CYSUR Mid and West Wales Regional Safeguarding Board and their Administration Team, Carmarthenshire Children's Services Support Team, and Children's Social Worker, Cognitive Behaviour Psychologist, Pembrokeshire College's Principal, SEED & IT leads, Coleg Sir Gar/Coleg Ceredigion and Gower College Swansea's Principals and Designated Senior Safeguarding Leads.

Their support, contributions, facilitation of resources and flexibility have been invaluable in what has been an unprecedented time, to conduct, sustain and complete a Concise Child Practice Review, more latterly, since March 2020 under COVID -19 regulations.

Statement by Reviewer(s)			
Reviewer 1	Gladys Rhodes White OBE	**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, 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, 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 ……..*Gladys Rhodes- White OBE* *(Signature)* G Rhodes White		**Reviewer 2** …….. *(Signature)*	
Name **Gladys Rhodes White OBE** *(Print)*		**Name** …… *(Print)*	
Date ……8th July 2021……		**Date** ……	
Chair of Review Panel ……*Maxine Thomas*…… *(Signature)* Maxine Thomas.			
Name **Maxine Thomas** *(Print)*			
Date ……8th July 2021……			

For Welsh Government use only

Date information received: *(date)*

Acknowledgement letter sent to Board Chair: ……*(date)*

Circulated to relevant inspectorates/Policy Leads: ……*(date)*

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Appendix 1 **Terms of Reference for CYSUR 7/2018 (CCPR)**

Terms of Reference for Concise Child Practice Review

- **Nominated Safeguarding Lead** - Stefan Smith
- **Review Panel Chair** - Maxine Thomas
- **Independent Reviewer(s)** - Gladys Rhodes White

Core tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine the effectiveness of inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were in the best interests of the children and outcome focused.
- Seek contributions to the review from appropriate family members/identified others and keepthem informed of key aspects of progress.
- To give consideration, to any relevant contextual information linked to the identified themes emerging from the Review process.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a multi-agency learning event for practitioners and identify required resources.

Specific tasks of the Review Panel:

- Identify and commission a reviewer to work with the *Review Panel* in accordance with guidance for concise reviews.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewer and Panel membership
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewer a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer contact arrangements with the individual and family members/relevant others prior to the event.
- Receive and consider the draft Child Practice Review report to ensure that the terms of reference have been met and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the CPR Sub Group for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- *Review Panel* members will adhere to the principles of the Data Protection Act 1998 when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the CPR Sub Group:

- Agree and approve draft ToR for each case recommended for CPR
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Monitor CPR action plans to ensure all recommendations are carried out on behalf of the Board

Specific tasks of the CYSUR Safeguarding Children Board:

- Inform Welsh Government of the undertaking of a CPR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Information Sharing and Confidentiality

Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned or originated by them.

Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel, as appropriate.

A statement of confidentiality (as below) will be signed at each Panel meeting by all attendees to reaffirm the boundaries within which information is being shared:

- In working with sensitive information in relation to a Child Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
    - The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 2 – Child Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
    - The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
    - If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
    - However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.