Concise Child Practice Review Report

CYSUR 6/2018

Date report presented to the Board: 14th July 2020

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Child Practice Review Re:

CYSUR 6/2018 (Powys)

Brief outline of circumstances resulting in the Review

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]).

The Terms of Reference for this Concise Child Practice Review are at **Appendix 1.**

[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

Family Y consists of Mr and Mrs Y and their seven children: AY, BY, CY, DY, EY, FY, and GY. At the time of the critical incident in 2017, the children were aged between 1 and 14 years old. On the 8th December 2017, the Police received a call from Mrs Y stating that Mr Y had made threats to shoot their daughter CY, who was nine years old. The referral stated that Mr Y had been drinking and he believed that CY had put snow in his shoes, which is what had triggered the incident. Mr Y discharged the air rifle on three occasions within CY's bedroom, whilst CY was present and made threats to kill. All the children were present in the household and were aware of what was happening although it is likely some of the younger children would have been too young to know the exact nature of the events taking place.

Mr Y was subsequently arrested and at that time the older children made further disclosures that they were hit by a wooden spoon by Mr Y when he believed they needed to be punished. The eldest child AY also disclosed that she self-harmed and there was evidence of cuts on her forearms and legs.

Mr Y pleaded guilty to two counts of assault, one of a threat to kill and possession of a firearm with intent to cause fear or violence. He was sentenced in February 2018 to three year's imprisonment. A ten-year restraining order was imposed protecting both Mrs Y and the children. Initially the children remained living at home with their mother but due to continued concerns regarding the safety and well-being of the children, care proceedings were initiated, and the children were removed into the care of the Local Authority in March 2018.

Time Period Reviewed and Why

In a Concise Child Practice Review (CCPR), the learning is focused on a twelve-month period. The Review Panel chose the period 9th December 2016 to December 2017 in order to capture the events leading up to the critical incident in December 2017. However, in order to understand the necessary context, the Chair and the Independent Reviewer have taken account of relevant historical contextual information dating back to 2008 and specifically to events in 2011. This contextual information was also considered by the agencies who attended the learning event.

The Children

The Independent Reviewer, Panel Chair and members of the panel, want to acknowledge the contributions of the two children who agreed to participate in this review process. It must have been a hugely challenging and painful process. We would like to thank them for their bravery and offer our hope that they will find healing and positive outcomes in the future.

Children's Family History and Contextual Information

Mr and Mrs Y, who are both UK residents, originally met in Europe where they both lived at that time. Mr Y had been married twice before and has two grown up children from his first marriage, but has had no contact with his former wives or children. Mrs Y shared that it was their mutual interest in Christianity and Evangelical beliefs that had brought them together. They were both keen followers of the BC faith (anonymised reference) preachings at the time of the critical incident, and this strongly influenced how they chose to live. Mrs Y lived with Mr Y's parents at their home in Europe until the relationship with Mr Y's mother broke down and she was asked to leave. Mrs Y was already in a relationship with Mr Y by this time and they decided to leave together.

Mr and Mrs Y returned to the UK and moved to Wales where they married in 2003. According to medical records and from Mrs Y's input they conceived nine children in total, but Mrs Y suffered two miscarriages. Mrs Y stated in her meeting with the Independent Reviewer that she was kept pregnant by her husband for most of their marriage. She felt this was part of Mr Y's controlling behaviour and a way of keeping her dependent on him. Mrs Y describes Mr Y as isolating the family and justifying it because of the teachings of the Bible. Mrs Y says she now realises that "this was just Mr Y's interpretation of the Bible".

The family moved several times between 2003 and 2017. During this time, the family remained very isolated and all the children were electively home educated. Mr and Mrs Y became estranged from any extended paternal and maternal family members. They lived under the rules of Mr and Mrs Y's strict religious beliefs. The preacher whom they based their beliefs and practices on, Mr AB, has since distanced himself from the family and has asked that both Mr Y and Mrs Y no longer contact him. During the criminal and civil proceedings, it has been suggested that AB would not support Mr and Mrs Y's treatment of their children as inkeeping with his teachings. He wrote separately to Mr and Mrs Y to say that they had failed their children.

Mr Y appears to have developed his own interpretation of the AB faith. He was known to preach his religious beliefs in the town centre near where the family lived. There is evidence that Mr and Mrs Y shared their religious beliefs with professionals that they met and were keen to encourage them to convert to their faith, sharing information and leaflets with them.

The court noted as part of the care proceedings that the critical situation *"was not an isolated incident, the children had suffered various forms of physical and emotional abuse*". Since they have been removed from Mr and Mrs Y's care, the children have been able to share much more information about the daily abuse they have suffered.

A court judgement in 2018 stated that Mr Y "*asserted dominance over the children*". In her meeting with the Reviewer, Mrs Y described herself also as a victim of Mr Y and indicated that she believed she was a victim of Domestic Abuse. There are no records of Mrs Y trying to leave with the children or of her sharing this concern with agencies who

provided opportunities for her to do so when she was seen alone. In her interview, Mrs Y explained that she could not do this as she was totally dependent on Mr Y and she did not have a 'trusting' relationship with any of the health agencies she met. Mrs Y alleges there were opportunities when agencies might have been alerted to the abuse; once when she called the Police about Mr Y attempting to drive the car with the children in whilst very drunk, and secondly when the family were evicted and social services visited the family. She felt the agencies were easily convinced not to pursue any lines of enquiry and should have been more persistent at seeing her and/or the children alone, and developing a relationship with them so they could speak about their situation. Mr and Mrs Y kept contact with agencies to the bare minimum for both themselves and the children. Mrs Y stated that she was expected to isolate herself and the children from outside "worldly" influences.

During the care proceedings, the extent to which the children had been abused became more apparent, with evidence of daily physical, emotional and psychological abuse leaving the children severely traumatised. The psychological assessment indicates that some of the children are suffering from Post-Traumatic Stress Disorder (PTSD), eating disorders, self-harm, attachment difficulties and behavioural problems. All but one of the children are receiving therapy and will need long term intervention to develop basic trusting relationships.

Prior to the critical incident in 2017, there were two referrals to Children's Services. In 2008, Mrs Y contacted the Police due to Mr Y driving with AY and CY whilst under the influence of alcohol. Mr Y received a caution for neglect and there was no further action taken by the Police or Children's Services. The second occasion was on 16th May 2011, when housing sent a referral to Children's Services, due to concerns regarding Mr Y's alcohol use and the isolation of the children, who it was known were electively home educated and subjected to frequent house moves. Mr Y had preached to the housing officers about his devout Evangelical Christian beliefs. Despite asking about the children, the officers were not able to see them.

A single agency section 47 enquiry[6] was initiated which later agreed a core assessment was needed. Several review strategy discussions took place up until October 2011 with appropriate multi-agency partners represented. The case was eventually closed in January 2012, without the children ever being seen or spoken to as part of any assessments.

The family had limited engagement with services in Mid and West Wales, and were known only to the following agencies:

- GP
- Midwifery Services & Obstetrics
- Health Visiting
- Paediatric Services

[6] A **Section 47** enquiry means that CSC must carry out an investigation 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.

- Housing
- Education (elective home education team)

Police

Prior to the critical incident and in the time for this review the Police were not involved with the family. In the contributions to the review and particularly after the critical incident when the Police were involved, they have considered their role and input and have identified some positive practice and learning that sits outside the remit of this review. This learning needs to be captured internally by the Police.

Education

The parents chose to electively home educate their children and in doing so were compliant with the requirements of Section 7 of the Education Act 1996[7]. AY and BY became known to Education in 2011. Section 436A of the Act only requires the local authority to maintain a system which allows it, as far as possible, to identify children who may not be receiving a suitable education. There is no requirement for parents to inform the Local Authority that they are electively home educating their children, except where they withdraw them from school. As the children were never enrolled in a school, Mr and Mrs Y were not required to notify the Local Authority that the children were to be home educated. There is also no requirement for parents to evidence that an appropriate curriculum is being delivered.

Nevertheless, records indicate that Mr and Mrs Y were very diligent regarding communicating with the Schools Service and gave no cause for concern. The annual monitoring of elective home education identified no areas of concern. The legislation also does not require the children to be seen at home or spoken to, nor is a home visit to check the learning environment required. Mr and Mrs Y were able to use their understanding of the legislation and guidance regarding elective home education as a mechanism to prevent professionals from gaining access to the children.

There is emerging evidence of both parents manipulating the Health and Education systems and processes to superficially comply with legal requirements whilst keeping tight control over any potential access to the children, and actively seeking to keep them hidden from professionals who may have been able to identify the abuse. This behaviour is not uncommon in families who seek to deliberately deceive professionals whilst superficially appearing to co-operate. Evidence of similar behaviour has featured in many high-profile public inquiries and safeguarding reviews, and is often referred to as 'disguised compliance'.

[7] Section 7, Education Act 1996 sets out the parents' duty to cause their child to receive full-time education suitable to age, ability, aptitude and special needs

Learning Actions

In 2012, consent was not given for the children's names to be given to the school nursing service and so they were unable to make any contact with the family. This is not a mandatory requirement and the family chose not to participate.

On the 23rd January 2013, it is noted that the Local Authority was satisfied with the children's academic provision but highlighted concerns regarding a lack of opportunity for social interaction. A request was made for further information regarding this to which the parents responded. There was however no evidence of any concern at the level that would have allowed for a referral to Children's Services.

It is worth highlighting that a previous Concise Child Practice Review[8] was undertaken in Wales, following the tragic death of a child who was electively home educated and sadly, who remained 'invisible' to the authorities. The recommendations included a request that the Welsh Government review the guidance on electively home educated children, to include the requirement that children should be seen and spoken to, so that their wishes and feelings can be acknowledged.

The Welsh Government has recently issued a consultation process in relation to its draft revised Guidance on Home Education (30th January 2020). Responding to this, the Children's Commissioner for Wales said:

"*In calling for more statutory regulation of elective home education in Wales I have had three aims. Firstly, that for all children in Wales can be accounted for and that none slip under the radar of universal services, and society in general. Secondly, that every child is receiving a suitable education and their other human rights including health care and safety. This cannot be achieved without the third aim that every child should have the opportunity to be seen and their views and experiences listened to".*

The report in relation to the responses to the new Guidance, "*Consultation on Home Education – Statutory Guidance for Local Authorities and a Handbook for Home Educators"* unsurprisingly contains a strong mix of supporters and those not in support of the recommended changes. There are those that argue against the need for children to be consulted with and seen as part of the process. They also argue that home educated children are at no greater risk of safeguarding concerns and should not be viewed as such. The following quote from the consultation response illustrates the strong views that some parents share:

"I am not aware that the LA are instructed to speak with every school child to check they are happy to be in the school system. Forced visits to home educated children will cause distress and are intrusive, breed distrust and are quite frankly discriminatory to home educated children." (Individual).

[8] CCYSUR 2/2015

- It is worth noting at this point the views of Mrs Y and the two children on home education. In their contribution to the review, the children believe that they should have had a choice about being home educated. In AY's words, "*every kid should attend school. If not, then education officers should come to the house. There must be a suitable living and learning environment. It should be the kids' choice whether to be home educated".* In her interview Mrs Y stated that she believes "*there should be statutory guidance that states that home educated children should have to interact with other home-schooled children, maybe at a library or similar where social workers could observe them."* AY further stated *we "we didn't really exist"*

Health

The family moved into Mid and West Wales in 2008, and since then there has been limited involvement with the local Health Board and services. Mr and Mrs Y limited their contact with health professionals, but records show that Mr and Mrs Y and the children were seen at different times by Health Visitors, hospital staff and Midwifery services. The children were up to date with immunisations and some health checks were carried out in line with the required guidance for example the *Healthy Child Wales Programme Quality Assurance Framework – Universal Services for Children and Families 2016*. It is documented that Mrs Y only had health visitor visits at her request and declined health assessments. Mrs Y directed conversations with health professionals to the Bible and religion. The records reflect repeated attempts to arrange appointments. There were several home visits and the children were observed but not spoken to alone.

In 2011, one of the children, aged 9 months old was seen in the Health Visitor Clinic with bruising to the face. The explanation from Mrs Y was that he had fallen down some steps in the garden. Mrs Y requested that he was weighed clothed. At the time there was an open section 47 enquiry and ongoing strategy meetings, and the social worker allocated to the family was contacted and informed of the bruise by the Health Visitor. Records indicate however, there was no follow up written Multi Agency Referral Form (MARF) or letter sent regarding the bruise, but this information was made available to the multi-agency strategy meeting. It is unclear from the records what action was taken if any respect of this.

The Leeds Support and Intervention Tool[9] (LSIT) was completed on the 29th August 2015 by the Health Visitor who remained concerned about the family's isolation. This was an internal tool routinely used by Health staff at the time to help identify families who were in need of secondary support and services in addition to universal Health services and would often be used to identify 'children in need.' The LSIT is an assessment process to inform and guide practice. It is important to note this is not a diagnostic tool and does not override professional judgement. There is no evidence to suggest, however, that the outcome of

[9]PTHB/SGP027Leeds Support and intervention Tool Guidelines for Health Professionals

this assessment and the need for extra support was discussed with the parents. On reflection, if the Health Visitor was unable to do this because of the lack of engagement with the family and given the isolation of the children, a discussion with Children's Services should have been undertaken. The following is taken from the tool guidance:

LSIT Level 2 Secondary Intervention

Definition: *Work with and services for children, young people and families identified as 'at risk' or under stress/pressure, that aim to minimise risks of children being abused. These may include 'Child in Need' interventions, voluntary work and specific self-protection strategies for children. This may also include referral to Children's Services as Child in Need. (Please refer to All Wales Child Protection Procedures, Safeguarding Children: Working Together under the Children Act 2004 and the Framework for the Assessment of Children in Need and their Families, DoH 2000)*

Records indicate there is a pattern of engagement with the Midwifery service in the immediate post-natal period, but limited engagement with the Health Visiting service. For example, one of the children as a young baby presented with a clinical concern (jaundice) and the parents refused to take the baby for screening. There is nothing recorded to suggest that further medical advice was sought to ensure the baby was appropriately managed in the community.[10]

Health records further indicate several of the children were presented to A and E at various times over a number of years. Whilst it was noted at the time that Mr and Mrs Y could be difficult to engage, there was insufficient evidence to alert anyone that the parents might be neglecting or abusing their children.

Concealed Pregnancy

The SATH Guidance on Concealed Pregnancy (2013)[11] defines a late booking as a woman presenting to maternity services after 24 weeks of pregnancy. A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone or those who are told conceal the fact from all caring and health professionals.

The late reporting by Mrs Y of her 8th pregnancy fits with the definition of a concealed pregnancy. This again may have been an indicator of avoiding professional intrusion into their lives, which information provided as part of this review suggests and Mr and Mrs Y have always actively sought to do. Mrs Y presented as a late booking (34 + weeks gestation on her 5th child (7th pregnancy) and concealed her 6th child (8th pregnancy).

On the 1st August 2014, Mrs Y contacted the Supervisor of Midwives at a neighbouring District General Hospital to inform her of her pregnancy, that she would not be accessing any antenatal care and that she only wanted to access maternity care when she was in labour. Mrs Y had received midwifery care from the Powys midwifery team previously and would know that her midwifery care should be accessed via her GP or

[10] Powys Teaching Health Board Quick Reference Guide on the management of Prolonged Jaundice

[11] SATH Guidance on Concealed Pregnancy (2013)

the local midwifery team. This suggests that this was a further attempt to conceal the pregnancy from the local midwifery and health visiting teams.

The risks of not attending for an antenatal scan were fully explained to Mrs Y. She stated that she did not have any transport and she was confident that "*God would take care of her and her baby*". She explained that she would not be accessing any antenatal care and would only be accessing maternity care in labour.

There is a letter from Mrs Y dated the same day detailing her birth plan, and outlining her wishes and how she would like the birth managed. Of significance is that she indicated she will not have a birth partner and that she wishes the hospital to arrange transport home following the birth for her and the baby.

It is also noted Mrs Y declined two Health Visitor contacts during this time.

Housing

The family have lived at various addresses. Between 2010 and 2017, there were five known changes of accommodation, sometimes due to arrears in rent. There are reports by housing officers about poor home conditions and on one occasion, an issue regarding soiled mattresses in the home was recorded. It was not explored further by any agencies whether the soiling was due to the children or from Mr Y, who it was known was drinking alcohol excessively. Housing made a referral to Children's Services in 2011, due to reported patterns of uncooperative behavior from the parents, the fact that there were a lot of children in the home all being electively home educated, issues regarding debt, family poverty, the family moving around a lot and Mr and Mrs Y seeking social isolation. This referral did result in a child protection enquiry being initiated, but it did not progress to a completed core assessment or the offer of support services to the family. There is no record to suggest that the Housing Officers received an outcome of the referral they made letting them know that the case was later closed without a full assessment of the children's needs having taken place.

Children's Services

Events that sit outside of the timeline to this review are relevant in relation to significant learning.

From May 2011 through to October 2011, Children's Services became involved with the family following a referral by Housing. This period of time was a missed opportunity for the agencies involved with the family to take a holistic view of the collective concerns, to further consider the safety and welfare of the children and to take actions that would have enabled the children to be seen and spoken to, so that their daily lived experiences could be explored and understood. Due to incomplete recordings and some key information missing on the file, it has been difficult in parts to be fully assured of the exact sequence of events, decisions made, and actions undertaken. A thorough application of the All Wales Child Protection Procedures in place at the time should have been sufficient to ensure the children were a central part of the investigations and assessments required.

The closure of the case when such investigations had not been properly pursued was not in keeping with required standards at the time and is poor professional practice.

Records indicate a multi-agency strategy meeting was first held on the 19th May 2011. The minutes indicate the reason for the referral appropriately made by Housing regarding the social isolation of the children and the controlling nature of both parents. The housing support worker indicated that she did not meet with any of the children until her third visit to the family home. On this occasion, the worker met CY who she stated looked to her mother to obtain permission to speak. The worker told the strategy meeting that on this occasion she noticed 'yellowing' bruising on the side of the child's head and arms.

A further strategy meeting was held on 27th June, where it was decided there would be a single agency Children's Services Section 47 enquiry. It was noted that the children were not on the home education register. The family had been offered a four-bedroom property but had turned it down because it was not on its own.

The outcome of the enquiry concluded that the children were at severe risk of social isolation and that legal advice would be obtained. The records indicate that the parents practiced an Evangelical religion and that the children were experiencing a high level of control by their parents in line with their religious beliefs. Records however indicate the enquiries at the time did not suggest any concerns in respect of non-accidental injuries or deliberate physical abuse.

The minutes of this meeting indicate that the focus of concern was the social isolation of the children and the impact that this would have over time on their emotional wellbeing. Furthermore, there was discussion regarding the potential social/educational disadvantage the children were experiencing by being educated at home. The legal advice recorded in the minutes suggests a view that individuals have a right to live their lives as they choose and the role of the Local Authority only comes into play when that lifestyle is placing a child or children at risk of significant harm, and to live in isolation is a choice that an individual can make without unnecessary intrusion by the state. The only avenue considered to be worth exploring was the Education aspect, as it was noted that the parents had not complied with requests from the department for information regarding the children's educational provision.

It was recommended the legal representative from the strategy meeting was to discuss the matter further with the Education solicitor.

A review strategy meeting was convened on the 7th September 2011. The minutes indicate Mr and Mrs Y would not participate with the Core Assessment. The Chair stated that there were no legal grounds to take any further action from a child protection perspective, but a Legal Planning Meeting would be convened to explore the possibility of obtaining a Family Assessment Order. The minutes reflected the ongoing concerns held by the agencies for the children and their isolation. However, there is no record of any further discussion regarding an application for a Family Assessment Order or the convening of a legal planning meeting. On reflection, this would have allowed professionals the opportunity to consider how they could see the children to assess their needs. The legal advice appears

to have strongly influenced the outcome of the multi-agency discussions, and focussed solely on the educational requirements as opposed to the safety and welfare of the children. It is important to note it is the prime responsibility of the statutory agencies to determine the level of concern and risk to the children, and to act accordingly to safeguard them, and it is not appropriate to defer to those offering purely legal advice.

Another review strategy meeting was held on the 5th October 2011. The education of the children at home was discussed at the meeting, and records indicate that the parents had been interviewed in the office and were deemed to be compliant with elective home education requirements. The minutes indicate that the Health Visitor had observed bruises on the face of nine-month-old DY, however there is no evidence in the records that any analysis into the risks of physical abuse was undertaken as a result of the Health Visitor raising these concerns.

The case recording on 16th September 2011 for DY states that the Health Visitor telephoned the social worker and informed her that bruising had been observed on DY's cheek and forehead. The record states that the Heath Visitor accepted the explanation from the mother that DY had fallen down some steps. It was also noted that the mother refused to have the child undressed to be weighed. There is no record of a strategy discussion regarding this information or of any further involvement from Children's Services.

The case was subsequently closed in January 2012. There is limited case information to indicate what, if anything, happened in the intervening time from September 2011 to the case being closed. There is no case summary to indicate that the original concerns had been fully addressed.

Domestic Abuse

Since the children have been removed from her care, Mrs Y has described herself as a victim of Domestic Abuse, citing Mr Y's behaviour towards her and the children as coercive, abusive, and controlling. If we consider the Home Office statutory guidance[12] on controlling or coercive behaviour in an intimate or family relationship, we can see that the types of behaviour exhibited by Mr Y meets the definition as set out in the guidance. It includes the following:

- isolating a person from their family and friends
- depriving them of their basic needs
- monitoring their time
- enforcing rules and activity which humiliate, degrade, or dehumanise the victim
- threats to hurt or kill
- threats to a child
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities

[12] Controlling or coercive behaviour in an intimate or family relationship – Home Office Statutory Guidance Framework , December 2016

- taking control over aspects of their everyday life, such as where they can go, who they can see, what they wear and when they can sleep
- enforcing rules and activity which humiliate, degrade or dehumanise the victims

Mrs Y acknowledges that this is how she and the children lived and that she was a party to this way of living. She alleges that this was due to her being controlled by Mr Y. The children were very much victims of coercive and controlling abusive behaviours as described above. The extent to which Mrs Y was a victim versus a perpetrator is difficult to distinguish. Input from AY describes Mrs Y as equally culpable in maintaining the abusive lifestyle for the children, and alleges that Mrs Y was a willing participant rather than a coerced victim. She describes herself as having to take on the adult household chores and duties and was made to shoplift in order to provide essential items for the family.

Both children who contributed to the review described the extent of the strict rules that they had to live by, that when breached, resulted in severe punishments. They lived in fear of Mr Y and were regularly warned of speaking to anyone outside of the family. Such actions would lead to punishments, meaning the children had no way of telling anyone what was happening to them. Their limited exposure to the outside world also meant that they were not able to understand what was deemed to be a normal family life. They were in fact brought up to fear the outside world. Mrs Y acknowledged that the harsh regime was introduced to the children from a young age. In interview AY stated *"Knew not to talk to anyone"* and *If we spoke to others outside the house we would get beaten".*

In their interviews, the children and Mrs Y talked about the roles of females within the religion they followed. Women and girls were the property of the males and husbands and fathers "owned" them. The females were not allowed to imitate men and could not, for example, wear trousers, or have their hair cut. They were expected to obey Mr Y as the dominant male figure. It is difficult to know for certain whether Mrs Y or the children identified themselves as victims and as such, whether they were able to seek help and support. Even with well-trained staff who encountered Mrs Y it may still have been hard to make this identification.

Within the Mid and West Wales Region, there has been significant attention given to the impact of Domestic Abuse and there are positive examples of training and awareness raising for practitioners. The Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 has been an important factor in helping to influence local policies and practice.

Religious/Spiritual Abuse

It is important that this review considers the context of the extreme religious beliefs followed by Mr and Mrs Y, and how that was used to instil fear and create severe recriminations for the children. Choosing to follow a faith in a strict and dedicated manner is something many families do. This does not normally become something that could be viewed as 'abusive'. However, in this situation it could be argued that Mr and Mrs Y used

their interpretation of their chosen religion/faith to go beyond the teachings of that faith to exercise total control and influence over their children. They used rules that they described to the children as essential to their religion to coerce and control all aspects of the children's lives. This included severe emotional and physical abuse.

Spiritual or religious abuse is not a term commonly referred to and it does not exist in any child protection procedures as a standalone category of abuse. It has, however, featured in high-profile reports of abuse where children have died. It was a feature in the serious case review of Victoria Climbie, whose carers believed she was "possessed by demons".

A vicar in Oxfordshire, the Rev. Timothy Davis was convicted by a church tribunal of 'spiritual abuse'. He was found guilty by the religious court of abusing his "spiritual power and authority" over a teenager. Whilst this was not a criminal conviction, it does allow for consideration of the impact of spiritual abuse of children.

In a book published in 2018[13], Lisa Oakley, originally argued that spiritual abuse should be regarded as a separate category, distinct from other forms of abuse, such as psychological and emotional abuse. Since then she believes a separate category is not needed as spiritual abuse is characterised by a systemic pattern of coercive and controlling behaviour, it shares commonalities with psychological and emotional abuse. She argues that "*this abuse may include: manipulation and exploitation, enforced accountability, censorship of decision making, the requirements of secrecy and silence, coercion to confirm, control through the use of sacred texts or teachings, the requirement of obedience to the abuser, the suggestion that the abuser has a 'divine' position, isolation as a means of punishment and superiority and elitism*". It is worth noting that these elements are present in this case and therefore worthy of consideration within this context. The Learning Event provided an opportunity to reflect on this as a potential factor that practitioners may need to be sighted on if any such similar scenarios arise in the future.

There is a need for practitioners to be alert to the impact on children of living with parents who exercise extreme beliefs so they can consider what, if any, potential harmful impact this may have on the children. We are more familiar now with extremist views linked to terrorism and radicalisation, but potentially less so when it comes to other faiths that may lead to children to be harmed. Professionals in this case felt uncomfortable about the way in which Mr and Mrs Y shared their extreme views and how they tried to impose them on them, but they did not feel they could make any judgement as it was how they as a family chose to live. The question to be posed was whether it was 'acceptable' or 'reasonable' parenting or whether it led to potential harm for the children. There is no evidence that anyone had the 'right' or opportunity to interact with the children to explore that question with them.

[13] Escaping the maze of spiritual abuse , creating healthy Christian cultures by Dr Lisa Oakley and Justin Humphreys

The National Online Resource Centre in an article on Violence Against Women and the Role of Religion[14] by the Rev. Dr Marie M. Fortune explore the positive and potential damaging effects of religious teachings on violence against women and state:

"The task for both religious and secular leadership is twofold: 1) to recognise that religious beliefs, texts, and teachings can serve both as barriers and as resources for victims of abuse and 2) to deepen our examination of religious texts and teachings and explore interpretations so that we minimise the barriers and maximise the resources for women. No woman should ever be forced to choose between safety and her religious community or tradition. She should be able to access the resources of both community-based advocacy and shelter and faith-based support and counsel. For her to do so, she needs these two resources to work collaboratively so that they can provide consistent advocacy and support for victims and survivors and participate in the process of holding perpetrators accountable". It could be argued that this also applies to children and that they should be enabled to practice a chosen faith without the involvement of abuse.

[14] Violence against Women and the role of religion by Rev Dr Marie M Fortune

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 & agency analysis
- A Learning Event
- Meeting with Mrs Y (Mother)
- Meeting with two of the children (BY and AY)
- Discussions within the Review Panel meetings
- Case record review
- Independent Reviewer and Panel Chair's analysis

Learning points have been identified throughout the review process. It is important to note that these points 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.

Housing

Identified Good Practice
• Over several years, housing officers offered good support to the family and tried to ensure the children were not left homeless. • The Housing Officers were sufficiently concerned about the children living with Mr and Mrs Y to make a referral to Children's Services in 2011. They outlined several issues that were of concern including the social isolation of the family, repeated house moves, issues with rent arrears, Mr Y's use of alcohol and the extreme religious beliefs exercised by the family.

Family Perspective
• The children were instructed not to trust 'strangers' outside of the immediate family and would have been unlikely to share with housing officers the extent of their abusive experiences.

Learning
• Housing Officers to continue to operate in accordance with the safeguarding procedures and to report concerns where they believe children may be at risk of significant harm. If they do not believe that their concerns are dealt with sufficiently, then they must escalate their concerns in line with the agreed escalation policy as identified by the Mid and West Wales Safeguarding Board's *Resolution of Professional Differences Protocol.*

The Local Health Board

As a universal service, there is a recorded history of regular access to Mrs Y and the children during the period of this review and throughout the children's lives. Due to a high number of pregnancies, Mrs Y is seen by Midwives and Health Visitors both at home and in health settings over several years. There is a record of seven attendances at the Minor Injuries, Accident, and Emergency Department due to injuries and accidents to several of the children. On all these occasions, the injuries were felt to be consistent with the explanation given.

The children are seen regularly for immunisations and for some development and health checks. However, the records also indicate several access visits that are denied, checks that are declined and failed appointments. There is nothing to indicate in any of the health records that any of the children are seen or spoken to about their daily lived experiences, or that any agencies have concerns for the safety or wellbeing of the children. The interaction of health staff is predominantly adult-centric. The only health professionals visiting the home were Health Visitors and Midwives. The remit of the Health Visitor is the pre-school child; the role of the Health Visitor does not include older children who are home educated. It is not within the scope of Health Visitor practice to speak to the older children about their daily lived experience. The family were contacted by the School Nurses who offered a service, but this was not taken up.

There is evidence of some good agency interaction following concerns regarding the high-risk pregnancy, however, concerns regarding the concealment of pregnancies is less well explored.

The concealed pregnancy of baby number 6 and the refusal of the mother to have any antenatal intervention prior to the birth was recognised as a clinical risk both to the mother and unborn baby, and was escalated within the District General Hospital. There is no documentary evidence that safeguarding concerns were considered, even though there were five other young children in the family and ongoing concerns about lack of access and their isolation. There is no evidence of any liaison between the District General Hospital and the Health Board Safeguarding team. The Health Board Safeguarding Team were not informed by practitioners of the concealment of the birth. The family had not been seen since October 2013 (ten months prior to the birth) and did not attend one appointment with the Health Visitor and refused another. The Health Visitor had discussed the lack of access to the children at this time with the Specialist Nurse for Safeguarding Children and had considered an unannounced visit. On reflection, this may indicate the intention of the family to conceal this pregnancy.

The chronology demonstrates a consistent pattern of engagement and non-engagement by the parents of the children with the Midwifery and Health Visiting Service. There is no evidence that a formal letter was sent to the parents asking them if they wished to receive the Health Visiting Service. This would have included some oversight by the Health Visitor's line manager. Because of this, the parents continued to engage with the Health

Visiting Service on '*their terms'* and outside the recommended contacts with the Health Visitor. There was little compliance with the Service and there is no evidence that the use of the *'Was Not Brought' Policy* was considered when access to the children was refused. The Leeds Support and Intervention Tool was used as part of safeguarding supervision. However, the Health Visitor did not have the opportunity to discuss the findings of the tool with the family, which indicated that the children needed support, due to the parents' non-engagement. This should have triggered a discussion with the Health Board's Safeguarding Team and Children's Services.

Identified Good Practice

- Health workers faced a professional dilemma in remaining available and supportive to the family whilst recognising the constraints the family imposed to remain 'isolated' and private in keeping with their religious beliefs. They still managed to continue to offer services despite the sometimes 'hostile' response from Mrs Y to their attempts to support her.
- The Health Visitor who reported the bruising to DY and the refusal to have the child undressed acted appropriately in sharing her concerns.

Family Perspective

- Mrs Y in the meeting with the Reviewer suggests that had she been able to develop a 'trusting' relationship with health workers over a period of time when she was seen by them, then she may have felt able to disclose the abusive relationship she and the children were in with Mr Y.
- The children believed that health professionals should have been alerted to their situation when they visited the home as they felt their behaviours were alerting factors, for example, their unwillingness to talk or engage with outsiders unless expressly permitted by Mr or Mrs Y and evidence of their injuries should have alerted agencies to be concerned.
- There was resistance from Mr and Mrs Y to engage fully with all the Health services offered which hampered the ability of professionals to form a trusting relationship with them.

Learning

- Regular supervision and support are required for practitioners whose role brings them into contact with challenging and reluctant parents. This should include considering all policies/approaches available to assist practitioners.
- The chronology indicates a consistent pattern of potential 'disguised compliance' from the parents and indicates possible '*drift'* in the management of the case.

- The need to consider safeguarding concerns alongside escalating or cumulative clinical issues. Taking account of history is important when faced with current concerns.
- Further consideration is required of the current guidance in relation to concealed pregnancy and late booking when there are other young children in the family.
- The need for professional curiosity to be shared or acted on, when there may be concern about the impact on the children of parental behaviours and choices.
- There needs to be a recognition that children have a right to a view on the impact of being electively home educated. This needs to form part of the guidance for all agencies who may have contact with children in such circumstances.

Disguised compliance

Identified Good Practice

- Referral for consultant obstetric care as a high-risk pregnancy by the midwifery service
- Evidence that the risks of Mrs Y's preferred birth plan were clearly reinforced by the professionals responsible for her care
- Good communication between the Health Visitor and Midwife
- The Health Visitor was aware of previous concerns around isolation of the children and 'no access' visits
- Continued attempts to offer the Health Visiting service

Family Perspective

- Mrs Y shares that she felt her husband was able to influence the situation so that she and the children were able to avoid alerting any professionals to the situation they were in, as he knew 'how to play the system'.

Learning

- There is a continued pattern of engagement with the Midwifery service in the immediate postnatal period and limited engagement with the Health Visiting service. The records show that engagement is only ever on the terms dictated by the parents.
- Training on 'disguised compliance' should be available to practitioners so they are able to distinguish when parents may be using this to hide abusive or non-compliant behaviours.
- The baby presented with a clinical concern (jaundice) and the refusal of the parents to take the baby for screening appears to have been accepted by the Health Visitor and Midwife. There is no evidence that further medical advice was sought, which could have been conveyed to the parents and would have supported the management of the baby in the community.

- Concern regarding two bruises to a child's face were reported to Children's Services, but no follow-up occurred either in writing or in a further phone call to determine the outcome. When referrals are made, these need to be followed up in line with the Wales Safeguarding Procedures. In addition, the lack of consent by Mrs Y to have the child weighed without clothes given the facial bruising should have raised a line of questioning with Mrs Y as to the reasons why and alerted a further note of concern to be included in the referral. Good practice would have been to make a new referral, but there is no evidence that the Health Visitor was advised to do this by the Social Worker. This was at the third review strategy meeting on the 05/10/2011, when the incident was raised by the Health Visitor – there is no record of any actions being taken by the SW in relation to this or the views of the multi-agency partners who attended the strategy meeting about what should happen next.

Elective Home Education

The children received a home education that complied with the requirements of the Education Act 1996, and it was noted at the Learning Event that Mr and Mrs Y went beyond what would be considered a minimal response to Local Authority requests for an annual update. They were seen to be fully cooperative and able to demonstrate that they understood the requirements of the Act and guidance on how to provide an appropriate curriculum for all their children who were of school age and home educated. When the issue of social isolation was raised with the family, Mr Y asked where in the guidelines it stated that the children had to socialise, knowing that no such guidance exists.

Given that there is no requirement for the children to socialise, be seen at home or be spoken to about their education, there is little that the Education team felt they could do or have done that may have alerted them to the predicament of the children.

Identified Good Practice

- All the necessary checks and balances in line with the legal requirements of the Education Act and inkeeping with the Elective Home Education guidance were adhered to, and it can be seen from their subsequent admission to schools on being taken into care that the children have received an appropriate academic education.

Family Perspective

- Mr and Mrs Y believe that they had the right to educate their children at home and were keen to ensure that their children were not taught outside of the religious faith that they had chosen.
- In their contribution to the review the children believe that they should have a choice about being home educated in AY's words "*every kid should attend school. If not, then education officers should come to the house. There must be*

a suitable living and learning environment. It should be the kids' choice whether to be home educated"

- In her interview Mrs Y stated that she believes "*there should be statutory guidance that states that home educated children should have to interact with other home-schooled children, maybe at a library or similar where social workers could observe them"*

Learning

- The current legislation and non-statutory guidance in relation to elective home education does not make any provision for children to be seen or spoken to about their parents' choice to home educate them. Nor does it contain any guidance in relation to socialisation for children who are home educated. The wishes, feeling or views of home educated children do not factor in any reviews of the elective home education arrangements. The guidance allows only for a review of the appropriateness of the curriculum being taught. If parents choose to isolate themselves and their children and use home education to promote this lifestyle then there is nothing to stop them doing so. In addition, if they wish to raise their children in an extreme religious faith that is also not addressed in the guidance on suitable elective home education. The potential for children to be radicalised in such circumstances needs to be explored as part of elective home education and safeguarding children procedures. There is far greater awareness in safeguarding procedures of radicalisation linked to potential terrorism, but this is rarely seen in the context of other extreme religious views.
- There is a strong case for changes to the guidance on elective home education to ensure, that as part of the process, children should have their views, experiences and wishes considered, if they are of a sufficient age and understanding to contribute.

Children's Social Care

The involvement of Children's Services for the timeline of this review did not occur until after the critical incident, which is not relevant to this review. However, events that occurred outside of the timeline for this review have been considered, as they are relevant. However it should be noted as many of the key events identified happened several years ago and both practice and staff personnel within the local authority have changed significantly in the intervening years, it is acknowledged direct lessons in respect of professional safeguarding practice within the current context will be limited.

Of significance is the referral received from housing in May 2011. This led to appropriate safeguarding actions taking place in accordance with the local safeguarding policies. A core assessment was completed, which concluded that "*even though the family had an alternative approach to their lifestyle and strong religious beliefs the care of the children was good enough and they appeared healthy*." It is acknowledged that the parents would

not consent for the children to be seen and spoken to alone or for advocates to be appointed on their behalf. It is regrettable that this was not viewed at the time as a heightened risk factor along with several other concerning factors:

- The isolation of the family
- The number of times the family had moved addresses
- Mr Y's use of alcohol
- Mr and Mrs Y's extreme religious views
- Children home educated
- Resistant parents who may be offering disguised compliance
- Lack of social contact for the children
- The history of family debt
- Housing concerns regarding soiled mattresses in the home as reported by housing officers
- No one with whom the children were able to have a voice

Any one or two of these factors may not in itself have been a cause for concern, but in adding all of the factors together, a more worrying picture emerges which might have alerted a core group of professionals to consider whether the daily lived experience of the children in the household was "good enough". This may, at least, have enabled a further exploration of how the children may be communicated with in a way that might have exposed what all the above meant for them.

Identified Good Practice
• There was a degree of tenacity demonstrated between May 2011 and December 2011 where it was felt there was a possibility of abuse within the family. The All Wales Child Protection Procedures 2008 were followed, and strategy discussions, meetings and reviews took place in accordance with these procedures. The records state that appropriate legal advice was obtained that concluded that the threshold for significant harm was not met. • There is evidence of supervision between the allocated social worker and team manager.

Family Perspective
The family members have not commented on this period.

Learning
• Children who are home educated and socially isolated are potentially vulnerable if no one can ascertain what their daily lived experience is like. Including the views and wishes of children in such circumstances should be part of the national

guidance for elective home education and should form part of safeguarding procedures.

- Triangulating professional concerns and instincts that abuse may be present, with a detailed picture of the family, using chronologies and genograms alongside input from children themselves (including seeing them alone) is vitally important to be able to assess risks to children. The guidance for undertaking core assessments needs to be specific in this respect and training for practitioners needs to reinforce the use of chronologies and genograms on informing analysis of risks.
- The use of advocacy to engage children when parents are resistant is a helpful way of ensuring children's voices are heard. The current Wales Safeguarding Procedures 2019 are much clearer in acknowledging the need to consider the daily lived experience of children.

Domestic Abuse – controlling and coercive behaviour

Identified Good Practice

- There is a reference to a Midwife/Health Visitor trying to explore with Mrs Y the issue of Domestic Abuse in line with local procedure "*2008 Domestic Abuse notification – home visit by HV – Mrs Y stated it was a misunderstanding – she was given advice about how to contact Women's Aid."* In April 2011, it is documented that the Health Visitor did not have the opportunity to ask about Domestic Abuse. In December 2012 during a routine enquiry, Mrs Y was asked about DA and gave a negative response. This was an attendance at an antenatal clinic which Mrs Y attended alone and would have been an ideal opportunity to raise any concerns.
- The guidance around VAWDASV has changed significantly over the timescale of the review. Current guidance is that, if possible, Midwives should enquire at every contact.
- Health Visitor guidance is that all women should be routinely asked before 6 weeks of their pregnancy. All Health Visitors and Midwives in Powys are trained to complete the Safe Lives Risk Assessment if there is a positive response to the routine enquiry.
- Health Visitors and Midwives would not be able to follow the routine enquiry if the woman is accompanied or there are concerns that the partner is within the home.

Family Perspective

- As described earlier in the report, Mrs Y has presented herself as a victim of Domestic Abuse following the period when the children were removed. She believes that if agencies had developed a less judgemental view of her, she may have developed a relationship of trust and disclosed her abuse to them. The

children have shared examples of their experiences of being victims of Domestic Abuse, both witnessing abusive behaviours between their parents and of receiving controlling and coercive abuse.

Learning

- There is no evidence that any of the professionals who were involved with the family managed to successfully explore the possibility of Domestic Abuse within the household. Any attempts to do so with Mrs Y were quickly rejected. This is not unusual as research tells us that victims of Domestic Abuse find it hard to disclose.
- Whilst legislation such as the Human Rights Act (1998) and the Crime and Disorder Act (1998) place obligations on Health Visitors to respond proactively to signs of domestic violence, they may face practical difficulties in doing so. A literature review[15] taken from the Health Visitors' Journal examines the willingness of clients to disclose that they are victims of Domestic Abuse to Health Visitors and other health professionals. Findings indicate that clients may seek to repress signs of abuse and will only disclose when asked directly, emphasising the need for active encouragement and reassurance to allow clients to feel safe in talking about more general experiences. They also highlight factors such as lack of confidence, knowledge or training in preventing questions about domestic violence being asked. The review identifies a need for further research to gauge how Domestic Abuse is tackled in specific health visiting situations.

Religious/Spiritual Abuse

Identified Good Practice

- It is positive that practitioners at the learning event were able to explore with an open mind the possibility of the presence of 'spiritual abuse' within the contextual information relating to this family. This is a contentious area and not one that is widely understood or debated.

Family Perspective

- The two children interviewed described their experience of the family's religious views being dictated by Mr Y. It was based on rules, obedience and fear. As BY stated "*The main issue was Dad's strong religious views and how he used them to control the family. He needed to realise that he was allowed his beliefs, but he couldn't force other people to believe them as well*".

[15] Barriers to disclosure of domestic violence and abuse in health visiting, Helen Elliott. Published Online: 20 Jul 2016 https://doi.org/10.12968/johv.2016.4.7.354

Learning

- Practitioners need to be encouraged through training and guidance to explore with children their experience of living in a household where parents exercise extreme behaviours, based on religious/spiritual beliefs, to check if it is potentially falling into the category of abuse.

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 1:

Housing Officers to continue to operate in accordance with the safeguarding procedures and to report concerns where they believe children may be at risk of significant harm. If they do not believe that their concerns are dealt with sufficiently then they must escalate their concerns in line with the agreed Escalation Policy as identified by the Mid and West Wales Safeguarding Board's *Resolution of Professional Differences* Protocol.

Learning 2:

A review of the current guidance in relation to concealed pregnancy and late booking, particularly when there are other young children in the family, needs to be considered by local Health organisations.

Learning 3:

The Local Authority responsible for the children needs to satisfy itself that the training it currently provides is effective and can assist managers in supervising practitioners whose role brings them into contact with challenging and reluctant parents. This should include considering all policies/approaches that are available to assist practitioners in these circumstances.

Learning 4:

The Local Authority responsible for the children needs to be assured that the training and awareness raising for practitioners working with complex families is effective in helping practitioners to understand the importance of using chronologies, a whole family context and case histories to inform assessments and risk assessments.

Learning 5:

The Regional Safeguarding Children's Board to consider formally writing to the Welsh Government to highlight the potential increased risks of social isolation for some electively home educated children, and to request that forthcoming statutory guidance includes the requirement that children should be seen and spoken to by professionals to ensure their wishes and feelings are obtained and understood.

Learning 6:

The Mid and West Wales Safeguarding Board to lead a review of the training programmes that are available to partner agencies and their effectiveness in promoting the value of professional curiosity, understanding 'disguised compliance' and cover the importance of information sharing in keeping children safe.

Learning 7:

The Mid and West Wales Safeguarding Board to review and consider the need for training and guidance for practitioners and managers on the impact of children living in a household where parents demonstrate extreme behaviours based on religious/spiritual beliefs and to understand the nature of its impact on the children and the family.

Learning 8:

All agencies to be reminded when receiving legal advice that this should be considered and viewed as part of the overall decision-making process, led by the statutory agencies responsible for safeguarding children. It is not the role of legal services to make safeguarding decisions.

Child Practice Review Process

The Regional Child Practice Review sub-group considered the referral in respect of the seven children on the 29th March 2019. The case had been considered by the regional Subgroup on several occasions previously throughout 2018. The complexity of the case necessitated more in-depth information and multi-agency analysis to be provided before a final definitive view could be reached by the group. The absence of any statutory involvement, apart from universal services in the years immediately preceding the critical incident, resulted in significant deliberation by the group as to the benefits of conducting a full review and how consistent this would be with the statutory CPR framework, which recommends timelines of no longer than 12 months, or 2 years in exceptional circumstances are considered.

The Chair of the Board decided to proceed with a Concise Child Practice Review in May 2019. This was because of the very significant level of harm the children experienced. He concluded there needed to be a structured and systematic analysis, evaluation and assessment of how the family were able to avoid agency intervention, with particular consideration given to the current powers available to agencies to fulfil their responsibilities and obligations, and include the fact that the children were known to be electively home educated.

The services represented on the Review Panel were as follows:

- Police
- LA Children's Social Services
- Health
- Regional Safeguarding Board
- Housing
- Probation

A 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 family and circumstances under review.

Learning Events

A Learning Event was held on the 12th March 2020. This was jointly facilitated by the Panel Chair and the Independent Reviewer.

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

- Community Midwives
- Police
- LA Children's Social Services
- Health (GP, Midwifery and Health Visiting)
- Regional Safeguarding Board

- Housing
- Probation

The Learning Event allowed the professionals concerned the opportunity to consider their involvement, practice, assessments and decision-making processes. It is hard to know what, if anything, agencies could have done differently, particularly in the preceding twelve months. It was clear that in sharing all of the information known by professionals at different times, a clearer picture of the circumstances of the family emerged. However, during the twelve months leading up to the critical event, there was no evidence of sufficient concerns to justify any safeguarding interventions. 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 children and were keen to consider in an open and self-reflective manner any potential learning.

The following questions were used to facilitate discussions and identify learning:

1. What went well, what good practice have you identified?
2. What do you feel did not go well, are there things that 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?

Evaluations and feedback for the Learning Event were very positive.

The Panel Chair and Independent Reviewer have experienced good support in respect of the completion of this Child Practice Review and would like to thank the Mid and West Wales Safeguarding Board administration team and Powys Business Support Team. Their contributions have been invaluable.

Family Engagement

Engagement with Father (Mr Y)

Initially the review panel members agreed it would be appropriate to write to Mr and Mrs Y to invite them to participate in the review.

The Independent Reviewer and the Panel Chair subsequently wrote to the father and mother to explain 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
- Report timescales

Initially, a meeting was arranged for the Panel Chair and the Independent Reviewer to meet with Mr Y. However, following advice from a multi-agency professional involved with

the family, about Mr Y's declining mental health and threats that had been made to those involved in the removal and care of his children, it was felt on balance not appropriate to continue with a face to face meeting. Mr Y was contacted to explain that he could submit his views in writing to be considered at the Learning Event. When no correspondence was forthcoming prior to the Learning Event, a second letter was sent to Mr Y inviting him to share any written contributions to the review.

Engagement with Mother (Mrs Y)

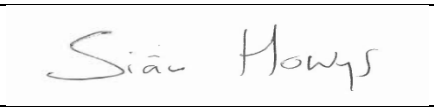
Mrs Y agreed to meet with the Independent Reviewer, and a visit took place in March 2020 at a neutral venue near to Mrs Y's home address. Mrs Y was accompanied by her support worker (who did not contribute but merely observed). A minute taker from the Panel was present with the Independent Reviewer. This allowed for a comprehensive record of the meeting to be taken.

In preparation for the visit, a letter was sent to Mrs Y explaining why there was a review, how it would be conducted, the role of the Independent Reviewer and Panel Chair, the Learning Event and the report.

The visit was very helpful in being able to hear Mrs Y's views about her relationship with Mr Y and how they had parented the children. Mrs Y was very insistent that she, as well as the children, had been a victim of Mr Y's coercive and controlling behaviour. She wanted to share that her learning from undertaking parenting programmes subsequently and from receiving support herself, had shaped her current thinking about how children should be parented. She mentioned the Incredible Years programme, which she believes should be available to all parents. She said she would parent her children differently now and commented that "*if children are brought up in a strict religious environment they don't get an opportunity to learn how to socialise, so home educated children need to learn how to socialise with other children and participate in learning social activities".*

Mrs Y's perspective and responses were shared at the Learning Event and, where appropriate, are included in the section on Practice and Organisational Learning.

Statement by Reviewer(s)			
Reviewer 1	Gladys Rhodes White	**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 G Rhodes White *(Signature)*		**Reviewer 2** ……. *(Signature)*	
Name Gladys Rhodes White *(Print)*		**Name** …… *(Print)*	
Date 14th July 2020		**Date** …….	

Chair of Review Panel *(Signature)*	
Name *(Print)*	Sian Howys
Date	14th July 2020

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 6/2018 (CCPR)**

Terms of Reference for Concise Child Practice Review

CYSUR 6/2018 (Powys Concise CPR)

- **Nominated Safeguarding Lead** –
- **Review Panel Chair** – Sian Howys
- **Independent Reviewer(s)** – Gladys Rhodes White, Rhodes White Consultancy

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 child and outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a 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 timeframe.
- 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 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 2018 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.
- Adhere to timescales for completion, as per statutory guidelines.
- Receive and formally approve 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.
- Send the report 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.