Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

Child Practice Review Report

Cardiff & Vale of Glamorgan Safeguarding Board
Concise Child Practice Review

Re: *CVSB CPR05/2019*

Brief outline of circumstances resulting in the Review

To include here: -

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

Legal Context

A Concise Child Practice Review was commissioned by Cardiff and Vale Regional Safeguarding Board on 22nd February 2020, on the recommendation of the Child and Adult Practice Review Subgroup in accordance with the Guidance for Multi Agency Child Practice Reviews 'Working Together to Safeguard People (Volume 2)'. The criteria for this Concise Child Practice Review are met under s3.4 of the above guidance issued under the Social Services and Well Being (Wales) Act 2014.

The criteria for child/adult practice reviews are that the child / adult has:

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

In accordance with the guidance, the criteria for a Concise Child Practice Review was met, as Toby was found murdered during August 2019. A Concise Child Practice Review was commissioned.

During August of 2019, Toby's body was discovered at an Industrial Unit in the Vale of Glamorgan. He had been fatally stabbed. Four individuals were subsequently convicted of murder, and three individuals were found guilty of manslaughter.

Toby was 17 years old at the time of his death, in the prior months there had been multiple concerning incidents including significant violent threats to Toby and his family, one incident included the sighting of a firearm. On at least two occasions Toby attended A&E with significant injuries which he disclosed had been sustained during assaults. Agencies

suspected that Toby was involved in the supply of drugs and criminal activity such as being involved in threatening behaviour with weapons. Information had also been provided to Children's Services that Toby was involved in County Lines drug distribution.

In addition, it is recorded, despite efforts to engage Toby he left mainstream education prior to statutory school leaving age.

Information provided from individual agencies highlights safeguarding concerns, including involvement and continued risk of child criminal exploitation (CCE). It appears that this information was not adequately shared between individual agencies.

Initial strategy discussions were held (following a red RAG rating by Children's Services), but they did not identify that Toby was at risk of significant harm and agreed that a well-being assessment should take place. This decision was reviewed by a single agency without considering history of concerns and multi-agency knowledge was not capitalised on. As a result, no care and support needs were identified.

It is unclear how Toby became involved in the distribution of drugs and whether he was trafficked between areas to supply drugs. Regardless of this, Toby was a child and the safeguarding measures in place to protect him were inadequate.

Key:

MARF - Multi Agency Referral Form.

RAG Rating – cases are sometimes rag rated (red, amber, green) indicating levels of concern / risk.

CCE - Child Criminal Exploitation.

CSE - Child Sexual Exploitation.

MASM - Multi Agency Safeguarding Meeting.

MDT - Multi Disciplinary Team.

Support 4 Families – A Children's Services Early Help Team, which provides early intervention and prevention services which aim to avoid families escalating to statutory services. The service works to ensure that families and young people receive the right help, at the right time and at the right level.

Think Safe – A Children's Services exploitation team, working with young people at risk of and who are experiencing sexual and criminal exploitation.

Well-Being Assessment – The local authority has a duty to offer an assessment in relation to any child where it appears that the child may have needs for care and support in addition to or instead of the care and support provided by the child family'.

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

Safeguarding during Adolescence

Between October 2017 up until his murder on the 28th of August 2019, Toby came to the attention of South Wales Police (SWP) on twenty occasions. Some of these contacts related to Toby being the victim of assaults and threats (involving knives and guns) which appeared to escalate in seriousness and severity. Others were in relation to involvement in criminal activity involving drugs, gangs, knives and as a passenger in the theft of cars. Toby was also identified as potentially being involved in County Lines. He had also been reported as a missing person. He disclosed on more than one occasion that he was using cannabis and that he felt unable to report threats/ assaults due to fear of repercussions. Intelligence showed that the individuals Toby was associating with had been heavily involved in criminal activity for some time. Toby's parents reported that they had been threatened with a gun from an individual who posed a threat to Toby, in addition they had their own concerns in relation to a change in his behaviour and what he was potentially involved in. Five days before his murder his family were threatened that their house would be burned down if Toby's whereabouts were not disclosed.

Public Protection Notices (PPN) used to share information by the Police with other organisations could have been completed on 12 occasions in respect of Toby and his interactions with SWP. PPNs were completed on 4 occasions, but on only two of those occasions were the PPNs shared with other agencies. The only conclusion that the reviewers could draw was that it appears that Toby's vulnerabilities were not recognised as he was not yet an adult.

In April 2018, Police submitted a PPN to Children's Services regarding an ongoing feud with another individual and threats to Toby including a video of his phone being smashed. As a result of this incident Toby was later placed on a Youth Referral Order, again his vulnerability was not recognised.

Between the 18th of March until the 28th of August 2019, Children's Services received information from the Police, Toby's parents and a third party that Toby was involved in drug use and supply, County Lines, being a passenger in stolen cars and driving illegally. It was acknowledged that Toby was involved with weapons and that his family had been threatened with a firearm. Despite this, there does not appear to have been any progression to look at multi-agency or historical concerns which may have demonstrated Toby was at risk of significant harm.

Information Sharing & Early Intervention

The review has identified that there were missed opportunities for all agencies to share information throughout the process. In October 2017, Police were involved after Toby was 'beaten up' by a gang of boys which left him with significant injuries including facial fractures. At that time Toby also shared that he had been threatened with a knife a week earlier, however no PPN was submitted by Police and no MARF was made from Health.

Prior to this in September 2017, following Toby's attendance at A&E, a MARF was submitted by Health itemising relevant safeguarding concerns, including the possibility that Toby was dealing drugs. Children's Services have no record of receiving this MARF. Toby's GP and school nurse were notified and the school nurse attempted to make contact with Toby.

In December 2017, Education documented that Toby had not attended tuition for 4 weeks. A letter was sent to his parents, but no follow up action was taken.

In April 2019, the family had moved house in an effort to minimise the risks of violence and threats to themselves and their home.

In May 2019, Toby and his parents met with the Support 4 Families support worker. It was at this time that Toby's parents raised that they were extremely worried for their children's safety (both Toby and his sibling) and were shocked when they were informed that information had been received that Toby may be involved in County Lines. All parties accepted that Toby had become an angry young person over the past 12 months.

At this point, the level of support that was being offered to Toby was on a voluntary basis and our records state everyone at the meeting agreed that the case could be closed.

Case recordings show that individual agencies were aware of numerous serious incidents in which Toby had been involved. This information was either not shared, inadequately shared or previous incidents were not compared and considered. It would seem that the escalation in criminal behaviour, known associations with others involved in crime, threats to Toby and his family, and the possibility of exploitation were not considered holistically at this time.

Disengagement from Education, Employment & Training

A positive that came out of the review, was the involvement of the Youth Worker attached to the school that Toby was referred to earlier whilst at high school, who appeared to have a positive input. However, once that support ended there was not the opportunity for Toby to be rereferred. The importance of the role of Youth Worker must not be underestimated, they are specifically trained and skilled to work with young people and could be the one key professional in the individual's life who are able to develop a positive relationship, identify concerns and engage the relevant professionals.

Reporting Concerns

Toby's parents reported that they did not know where to turn when they were concerned about Toby. In the Learning Event, it was acknowledged that professionals and members of the public (family, friends, associates) need to be aware of how they report safeguarding concerns, and the option to report anonymously through Crime Stoppers or other advice organisations.

In addition, if professionals share information and do not feel appropriate action has been taken, they need to be able to challenge decision making and escalate their concerns when required. In addition, Cardiff & Vale regional Safeguarding Board have a multi-agency escalation policy that can be used to resolve professional disputes.

Similarly, members of the public can follow individual agencies complaints procedures should the need arise.

Adolescent Safeguarding Considerations

Age can play a part in whether an individual is perceived as at risk. After the age of 16 there can be a tendency to not see the child when criminality and associated behaviours become an issue.

At this age there is a greater need for effective multi-agency chronology building including associations and escalation of criminality and risk. This should be alongside professional curiosity and appropriate professional challenge.

There should be consideration via the assessment process to ensure access to the appropriate support from key agencies. This is particularly important where parents/carers are seeking help for their adolescent child. Assessment should be holistic and consider sign posting to the appropriate agencies.

Recognising parents and children as the 'experts' in their own lives and listening to their voices is integral to managing and reducing risk.

Improving Systems and Practice

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

Agency Improvements in Practice

All practitioners who attended the Learning Event have shared their views on how practice has improved within their agencies since the tragic event of Toby's murder. Some actions have already been taken to improve practice in the time that has elapsed and these are listed below:

- **PPN Submission / Rationale**

Improvements are in place to ensure the appropriate submission and sharing of Public Protection Notices (PPN). It is now mandatory within South Wales Police for a PPN to be submitted for any child brought into custody, including those attending voluntary interviews. Any young person (aged 10-17) brought into custody is also offered access to a Custody Youth Worker. The receipt of high risk PPNs for young people result in an immediate response from Children's Services, MASH (Multi-agency Safeguarding Hub) assessment and a multi-agency plan. Child exploitation flags are used on the South Wales Police (SWP) system to identify concerns and direct officers to other individuals associated with a young person. Following continuous professional development days (CPD) on child exploitation, there is more awareness that all young people involved in an incident need to be included on a PPN and consideration given that involvement in criminality may be exploitation of vulnerabilities and therefore a clear safeguarding concern. In addition, there has been a restructure within South Wales Police to ensure a consistent and coordinated response to child criminal exploitation (CCE) across the force area, which will provide sufficient capability and capacity to investigate and disrupt CCE and to safeguard victims.

Arrests of young people in the South Wales Police (SWP) area are now reviewed by Youth Justice Service (YJS) staff who will request that arresting officers submit a PPN for those under 18 years of age, if one has not already been completed. Where SWP become aware that there is intelligence about the associations of young people which are of concern, a PPN

is requested and this is shared with MASH for assessment, discussion and intelligence sharing. Young people with suspected links to County Lines and other criminality can be seen by the St Giles Trust staff whilst in custody and offered support.

The Youth Justice Service (YJS) has developed a consistent way of recording contacts with children and young people, there are flags on their system for those involved with the Prevention Service and the Referral Order process has changed. Visits to children and young people involved with the YJS can now take place in more varied community settings to increase accessibility and engagement.

Since June 2021, Cardiff has taken part in a national pilot whereby the National Referral Mechanism (NRM) decision making process is devolved to Local Authorities. 10 Authorities are taking part nationally. The NRM decision process allows professionals to review evidence and information and then conclude as a panel whether they believe a child has been/is being exploited.

The NRM decision making panel is made up of core voting members who include senior staff from Local Authority (Children's Services), Health and Police. A representative from the Independent Child Trafficking Guardian (ICTG) service is also mandatory at panels but does not have decision making capabilities. In Cardiff, the social work case manager is also invited to present the case and submit any evidence for decision making but is not required to make decisions regarding the NRM. By building local mechanisms the quality and timeliness of decisions has improved, as well as improvements and increased connectivity between existing safeguarding mechanisms and the NRM process.

- **Information Sharing between Agencies**

Since 2016, there has been a Multi-Agency Safeguarding Hub (MASH) in Cardiff where all MARF referrals are received. Improvements have been made and now child exploitation meetings are held where the VOLT (victim, offender, location, theme) model is used for all types of exploitation, allowing professionals to identify victims and offenders, and to map and understand the associations and vulnerabilities within groups.

There is improving knowledge of criminal exploitation and an expectation that professionals from all agencies will look at the history of a child or young person and the context of an incident. Where cases are escalated, there is now an expectation that an analytical chronology will be compiled to enhance professionals' understanding of the child or young person and their situation.

Over the past year Cardiff City Local Authority and partners have developed the SAFE framework (Safeguarding Adolescents from Exploitation). An exploitation screening tool has been created and shared with all staff alongside a clear referral pathway in relation to exploitation for individual cases (exploitation strategy meetings/high risk panels/mapping analysis in conjunction with the police).

In a wider context work is being completed around school curriculum development, an exploitation training matrix for staff and development of the MISPER protocol. An action-focused SAFE partnership group is held monthly highlighting and responding to thematics from individual meetings and locality focus groups which then reports into the Children and Young People's Recovery Board.

- **Disengagement from Education, Employment & Training**

New safeguarding systems are now in place which allows all involved professionals to communicate concerns. These are triaged by a designated safeguarding lead who can assign tasks and ensures that safeguarding concerns are flagged up and escalated promptly. Education now has a 'Fresh Start Panel' to support children and young people who are moving between schools. The panel enables the needs of the child or young person to be identified and strategies to be put in place to support them through the transition process. Each child or young person has an Individual Development Plan (IDP) which includes the views of the child or young person and their parent / carer. There is a 'Fair Access Panel' (FAP) which supports children and young people with behavioural/emotional/social difficulties to move to alternative provision. 'Team Around the School' is now in place where there is a link for the secondary school and feeders from Children's Services who are available to support.

- **Attendance at Accident & Emergency Department**

Since November 2019, the C&V University Health Board has a Violence and Prevention Team based in the Accident and Emergency Department (A&E) who engage with patients who have been / are suspected to have been assaulted. The team has now increased its remit to include children and young people, and staff can refer to the team for immediate support and follow up of victims of assault. Their work includes reporting to Police, referrals to Children's Services and direct intervention work with children and young people. The team can also refer on to appropriate outside agencies for prevention and disruption work, including addressing involvement in different types of criminality.

There is now an adolescent documentation card (Blue Card) in use within the A&E Department, which prompts adult trained staff who see young people aged 16/17 years of age where drugs / alcohol are a factor, to the correct safeguarding procedures to be followed. Flags are added to the PMS electronic record system for domestic abuse, child sexual exploitation (CSE) and child criminal exploitation (CCE). The Blue Cards are reviewed within the regular Adolescent Safeguarding Review Meetings, where any additional vulnerabilities are assessed in conjunction with the young person's (PARIS) electronic records and the submission of appropriate MARFs can be checked.

Health staff receive training on County Lines and child exploitation as part of Level 2 and Level 3 study sessions, including information on indicators of exploitation and this forms part of the holistic safeguarding approach. Health staff are based in MASH and attend all relevant multi-agency meetings to provide information, and form part of the assessment and planning for those cases discussed.

- **School Nursing Service**

The School Nursing Service now has two Emotional Wellbeing Nurses in post (October 2021). They are from a school nursing background and are supporting children and young people who are not in mainstream schools. The nurses pick up any A&E attendances and safeguarding concerns for those pupils in alternative education provision and offer follow up support. The team are forging links with alternative education establishments to ensure effective information sharing for those children where there are concerns. Working relationships are being developed with staff in A&E, Education and the School Nursing Service to improve the support offered to children and young people.

Recommended Actions

1. **Safeguarding during Adolescence:**
   Cardiff and Vale Safeguarding Board to provide a multi-agency feedback event for this CPR to disseminate information for the wider workforce.

   Cardiff and Vale Safeguarding Board to further develop the training matrix to include specific training on safeguarding concerns that arise during adolescence.

   The Cardiff and Vale Safeguarding Board must ensure that the need to safeguard young people is promoted and strengthened. Professionals need advice and training on how a young person develops to understand risk and consequences.

2. **Information Sharing and Early Intervention**
   Children's services must consider the impact of exploitation on siblings as part of referral and assessment

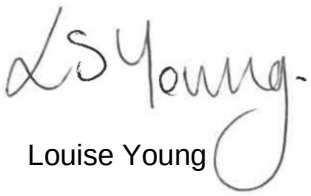
   Cardiff and Vale Safeguarding Board must review the current support available for young people at risk of exploitation, building upon the Safeguarding Adolescents from Exploitation (SAFE model in Cardiff). Resources, advice and support services must be promoted to the public more widely.

3. **Disengagement from Education, Employment & Training**
   Where there are concerns around a young person, it is essential that education is always part of the safeguarding considerations. This is particularly important where a young person is educated outside of mainstream school placements.

4. **Reporting Concerns**
   All agencies must ensure appropriate follow up by referrer when they make a referral in relation to a young person at risk and consider appropriate professional challenge if they do not agree with the decision making.

5. **Adolescent Safeguarding Considerations**

   All agencies involved in strategy discussions and meetings considering young people at risk of exploitation, must consider any relevant historical information, mapping of associations and identified escalations in concerning behaviours, held by their own agencies. This mapping/ history must then be considered jointly by all involved agencies, for decision making and planning.

Statement by Reviewer(s)	
REVIEWER 1	**REVIEWER 2** ***(as appropriate)***
Statement of independence from the case *Quality Assurance statement of qualification*	**Statement of independence from the case** *Quality Assurance statement of qualification*
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference
Reviewer 1 *(Signature)*  **Name** *(Print)* Nicole Devonish **Date** 2nd November 2023	**Reviewer 2** *(Signature)*  **Name** *(Print)* Louise Young **Date** 2nd November 2023

Chair of Review Panel (Signature) 
Name *(Print)* Melanie Roach
Date 2nd November 2023

Appendix 1: Terms of reference

Child Practice Review process

To include here in brief:

- *The process followed by the Safeguarding Board and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The Child Practice Review Panel included representatives from Police, Education, Children's Services, Health, Youth Justice Service and the St Giles Trust The multi-agency timeline attached considers involvement and events between the period of 1st August 2017 to 28th of August 2019. However, some historical information going back to 15th August 2012 was considered by the panel. Due to the time between the incident, the criminal proceedings and this review, many of the staff who had direct involvement with Toby and his family have moved on.

The Learning Event was held virtually on 20th January 2022 due to the constraints placed upon services resulting from the Covid-19 pandemic. The Learning Event included practitioners from all of the above services.

Toby's parents requested to use this pseudonym throughout the report.

The family were contacted prior to the learning event to talk to the reviewers about their experiences of working with agencies. These comments were discussed with professionals at the learning event. A further meeting was held with family prior to publication of this report. The following paragraph represents the family's view of Toby. Toby was a much-loved son and brother, an integral part of his family whose loss continues to be acutely felt. He was a loving son, a 'practical joker.' Whilst his parents recognise that Toby was engaging in some negative and illicit activity, they also highlight that he wanted to protect them from repercussions to the lifestyle he was part of, and despite their efforts and request for support and assistance from agencies, it was not always forthcoming or adequate. Toby's parents do not want another family to suffer the loss of a child in the way they have.

☐ Family declined involvement

Terms of Reference for a Child Practice Review (Concise)

Re: CPR 05/2019

Introduction

A concise child practice review will be commissioned by the Regional Safeguarding Board (RSB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 2. A concise child practice review will be undertaken where abuse or neglect of a child is known or suspected and the child has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; **and**

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

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

Terms of Reference

The terms of reference agreed for this review are:
The timeframe for the review will be **26th March 2018 – 02nd June 2019**
The following services will produce a timeline of significant events of its involvement with the Child, for the timeframe above.

- SWP
- Health
- Education
- Cardiff Youth Justice Services
- Social Services

A merged timeline will then be produced.

Core Tasks (for a concise practice review)

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.

- Examine inter-agency working and service provision for the individual and family.

- Determine the extent to which decisions and actions were individual 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 learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.

- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review not already requested by the Case Review Group, produce a timeline and an initial case summary and identify any immediate action already taken.

- To consider the recognition of response to and impact of Criminal Exploitation and the specific vulnerabilities of this case.

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the reviewer/s 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/s contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the Case Review Group and the RSB 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.

Tasks of the Regional Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- *Review panel* completes the report and action plan.

- RSB send Report and Action Plan 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 Case Review Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on RSB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the RSB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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