Concise Child Practice Review Report

CYSUR 1/2024

Date report presented to the Board:

15th July 2025

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Child Practice Review Re:
CYSUR 1 2024

A 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 CYSUR, the Mid and West Wales Safeguarding Board, on the recommendation of the Practice Review Subgroup under the Social Services and Well-being [Wales] Act 2014[1] and accompanying statutory legislation in section 139 of the guidance in Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).[2]

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 and/or was a looked after child (including a person who has turned 18 but was 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 child practice reviews are laid down in The Safeguarding Boards *(Functions and Procedures) (Wales) Regulations 2015*.[4]

This concise child practice review identified learning that will benefit future practice. It involved practitioners, managers and senior officers who explored the details and context of agencies' work with Child A and his family. The review's findings will generate professional and organisational

[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 refeed 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)

learning to promote improvement in future interagency practices with children and families. It includes the circumstances that led to the review, highlighting effective practice and what actions could 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 in **Appendix 1**.

Preamble

Maternal filicide, when a mother kills her child, is a rare, shocking and deeply upsetting event. While the likelihood of its occurrence is low, the consequences are irreversible, with an enduring effect on surviving siblings, parents, extended family, the practitioners involved, and the wider community. When maternal filicide occurs in response to a psychotic episode, the lack of premeditation can prevent the parent, family members and public agencies from identifying the potential risk to life[6].

Identification of the risk can be aided by its association with depression, parental separation, domestic violence and substance misuse[7]. However, many women causing the death of their children have no prior diagnosis of mental illness, making early detection further challenging.[8] Indeed, Mrs X had not presented to mental health services prior to the death of her son, in England or Wales, to allow an assessment to take place.

A review of previous serious case reviews in England[9] following incidents of maternal filicide, concluded that due to the nature of the phenomena, complete prevention may not be possible. Nonetheless, developing a deeper understanding of the circumstances in which such tragedies occur is essential to improving our ability to identify potential risk and safeguard children.

Circumstances that led to the review

One morning in January 2024, the police received a telephone call from Mrs X reporting that she had caused the death of her seven-year-old son, Child A. The police and ambulance service attended the family home. Tragically, despite extensive efforts to resuscitate Child A, he was sadly pronounced deceased, shortly after arriving at the hospital. The emergency services who attended to Child A in January made every effort to revive him and simultaneously protected his sibling.

The previous day, a member of the public contacted the Local Authority to report concerns about Mrs X's mental health, which had deteriorated over the previous week. The caller reported the children's mother had told them not to touch the grass because it was toxic and that the leisure centre had spies.

Mrs X admitted the manslaughter of her son on the grounds of diminished responsibility. The criminal proceedings against Mrs X concluded she was likely suffering from paranoid schizophrenia at the time of her son's death. Mrs X was given an indefinite life order.

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[5] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016)

[6] Stanton, J., Simpson, A., & Wouldes, T. (2000). A qualitative study of filicide by mentally ill mothers. *Child Abuse & Neglect*, *24*(11), 1451–1460. https://doi.org/10.1016/S0145-2134(00)00198-8

[7] Brown, T., Tyson, D., & Arias, P. F. (2014). Filicide and Parental Separation and Divorce. *Child Abuse Review (Chichester, England : 1992)*, *23*(2), 79–88. https://doi.org/10.1002/car.2327

[8] Porter, T., & Gavin, H. (2010). Infanticide and Neonaticide: A Review of 40 Years of Research Literature on Incidence and Causes. Trauma, Violence & Abuse, 11(3), 99–112. https://doi.org/10.1177/1524838010371950

[9] Sidebotham, P., & Retzer, A. (2019). Maternal filicide in a cohort of English Serious Case Reviews. *Archives of Women's Mental Health*, *22*(1), 139–149. https://doi.org/10.1007/s00737-018-0820-7

The time period of review and why

The agreed timeline for this review followed child practice review guidelines; the review panel recommended 24 months (10th January 2022 – 10th January 2024) to ensure the inclusion of significant familial events. Before its commencement, the review awaited the outcomes of the criminal proceedings regarding Mrs X and the death of her son.

Relevant Contextual Information

The review decided it was appropriate to consider relevant contextual information provided by the Local Authority in England, where Child A lived with his family prior to their move to Wales in April 2022. This context enabled an understanding of the experiences of Child A and his family, providing helpful detail to support the learning points identified in this review.

Child A was a happy and intelligent child who loved playing with Lego; he was enthusiastic about quizzes and fascinated by the universe, planets and outer space. He was close to his sibling, with whom he spent all his time. Child A and his older sibling were born in another country after their English father met their mother during a holiday. Mr and Mrs X married and came to live in England soon after their first child was born; they briefly returned to Mrs X's country of origin for Child A's birth. Thus, Child A had dual citizenship.

The only familial support in England derived from Mr X's parents, Mr and Mrs Y, who had been a source of significant financial support to the couple, and the family lived with them at various times. There were episodes when Mr X was violent towards Mrs X in her country of origin and England. In October 2017, while the family were living with Mr and Mrs Y in England, Mr X was arrested and charged after Mrs X reported significant domestic abuse by Mr X. Mrs X also alleged that Mr X's behaviour in the presence of the children had been abusive.

Mrs X was subject to a spousal visa that was due to expire in February 2018; she had no recourse to public funds. Mrs X asked her in-laws for money to return to her country of origin with the children. Mr X successfully obtained a prohibited steps order[10] from the family court to prevent the children from being removed from the UK. Due to their experience of domestic abuse, Child A and his sibling became the subjects of a child protection plan. The Local Authority in England provided Mrs X and her infant children with safe accommodation in a shelter for victims of domestic abuse. Mr X denied the abuse allegations, stating his wife had made these claims to strengthen her legal status to remain in the country.

Two months later, Mrs X reported she was struggling to care for her children alone and was advised the bail conditions prevented Mr X from contacting her. Mr X explained his abusive behaviour was due to the significant stress he experienced during protracted court proceedings to secure Mrs X's right to remain in the country by correcting an error with the spousal visa. Mr X pled guilty to assaulting his wife and resumed living with her and their children. Once reunited, the parents saw no reason for the continued involvement of the Local Authority; however, the children remained subject to a child protection plan and visits were undertaken every two weeks. The English Local Authority reviewed the child protection plan on 16 August 2018 and the children were then considered to be children in need, the Local Authority remained involved with the family until the 21 September 2018. Throughout that time, the Local Authority recorded the children's positive attachment behaviours towards their mother, also noting the family home that Mr and Mrs X were creating with the support of Mr and Mrs Y. In January 2019, Mr X informed the Local Authority in England of his intention to apply to remove the prohibitive steps orders as the family intended to travel to Mrs X's country of origin.

In February 2020, Mr X contacted his general practitioner in England after Child A had reportedly bumped his head in nursery. He had slight grazing to his head and a slightly bloodshot eye in the corner. Mrs X was worried about Child A's eye; Mr X was not concerned but wanted reassurance.

[10] https://www.legislation.gov.uk/ukpga/1989/41/contents

Advice was provided. A week later Child A was seen when he received his booster dose of MMR, and no concerns about his presentation were noted.

On 20 October 2021, the Local Authority in England informed the police of a safeguarding referral they had received expressing concern that Mr and Mrs Y were at risk of financial abuse from Mr X. Reportedly, Mr and Mrs Y had attempted to borrow a significant amount of money to finance the purchase of a home for their son and his family in Wales. However, it was thought Mr Y had dementia and might lack the capacity to make some decisions. The police did not respond to the concern, at that time.

On 27 October 2021, the police in England responded to a call from Mrs X following a verbal argument with her husband after the purchase of their house had fallen through. The police visited the family home and found the children were home-schooled (having left their previous school in September 2021); the police observed many toys in the untidy house. The police were aware of the prior domestic abuse and child protection concerns and requested that the Local Authority in England complete a vulnerable person assessment. There is no evidence of receipt of this request on the Local Authority timeline.

Timeline of Events in Wales and England

During the time period of the review, the family moved between two Local Authorities, one in Wales and the other in England. This review was commissioned by Wales as Child A's death occurred in their jurisdiction. During most of the timeline Child A and his sibling were home educated and had episodic involvement with Local Authorities in England and Wales. Thus, the exact dates of arrival and departure of the family in each area are not known but can be reasonably estimated based on case recordings. The review was able to identify the following history:

England	January 2022 – April 2022
Wales	April 2022 – May 2022
England	May 2022 – August 2022
Wales	September 2022 – September 2023
England	September 2023- November 2023
Wales	November 2023 – January 2024

<u>England</u>

At the start of the timeline, in January 2022, the family were living in England and Child A and his sibling were being electively home educated. In February 2022, Mrs X emailed the Elective Home Education team to provide an update regarding her children's home-schooling. On 22 April 2022, the police in England received a call from Mrs Y after Mr X had assaulted his parents in their home. Mr X was arrested was on suspicion of causing grievous bodily harm under section 18 of the Offences Against the Person Act 1861[11].

Mr X also alleged at this point in time that he had abused his children. Mr X was deemed to lack capacity and was detained in a secure mental health facility in England.

Later in the timeline, the police in England recognised missed opportunities to protect Mr Y and completed a Discretionary Adult Safeguarding Review as per the Care Act 2014[12].

[11] https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/18
[12] https://www.legislation.gov.uk/ukpga/2014/23/contents

Wales

On Saturday 23rd April 2022, Mrs X reported her husband missing to the police. She explained the family had just moved to Wales, and her husband had returned to his parents' home in England to fetch some of their belongings. The police in Wales visited Mrs X later that day to inform her of the assault. On 24th April, the police in England informed the out of hours service in the Local Authority in Wales of Mr X's arrest and that he had alleged past abuse of his children. Mrs X also contacted the police to report her husband had disclosed a few days earlier that he had abused their children when they were babies.

Later that day, Mrs X contacted the police in Wales to report that in October 2021 she had been psychologically and emotionally abused by Mr and Mrs Y. She also stated she had been a victim of Mr X's domestic abuse. The police in Wales noted that Mrs X had not made these allegations during their visit the previous day. However, they did follow up the allegations with Mrs X, who explained she was reporting these to the police in England.

Following receipt of the above information, a strategy discussion was held and the Local Authority in Wales initiated child protection enquiries as per section 47 of the Children Act 1989[13]. The Welsh Local Authority contacted the English Local Authority for further details. A joint visit was undertaken by police and children's services in Wales; both Child A and his sibling were spoken with, and they made no allegations or disclosures. Mrs X stated she had not seen her husband behave inappropriately towards their children.

The next day on 26 April 2022, a review strategy discussion took place, with the intent for the local authority in Wales to complete a comprehensive assessment of the needs of the family. The following week, before the agencies in Wales could complete their enquiries, Mrs X and the children returned to the paternal grandparents' home in England, without notifying the Welsh Local Authority.

England

On 4 May 2022 the Local Authority in England contacted their counterpart in Wales to provide the requested information regarding England's previous involvement with the family. On 15 May 2022, Mrs X contacted the police in England to complain that Mr and Mrs Y were financially abusing her and to make a complaint against the Local Authority. The police visited Mrs X and were concerned about her mental health, the home conditions and the possible developmentally delayed behaviours of the children. The police in England shared a Vulnerable Person Assessment (VPA) to alert the English Local Authority and Health Board of their concerns.

The Local Authority in England recorded receipt of the VPA on Thursday 19 May 2022 and noted the current section 47 involvement of the Local Authority in Wales, before returning the VPA[14] to the police in England for them to forward to the Local Authority in Wales. The Local Authority in England then ceased their involvement. Simultaneously, upon receipt of the VPA, the Health Board in England made efforts to locate the family and found that Child A was registered with a general practitioner (GP) in Wales. However, his mother and sibling were registered with a GP in England. On 23 May the Local Authority in England, having only provided information to their Welsh counterpart on the 4th May, believed the family were residing in Wales and advised their Health Board of the same. Multiple interactions occurred on 23 May between the Health Boards in England and Wales and the Local Authority in England, which established the family were living in England with Mr and Mrs Y.

On 25 May, the police and the Local Authority in England undertook a joint visit under section 47 of the Children Act 1989, and found the children in the care of a home childcare service. No immediate concerns regarding the children's welfare were identified. On 26 May, the Local Authority in England visited the family and although there were no immediate safeguarding

[13] https://www.legislation.gov.uk/ukpga/1989/41/contents

[14] The Welsh equivalent of a VPA is a Public Protection Notice.

concerns, it was identified that Child A and his sibling lacked social skills, boundaries and formal education.

On 27 May the Local Authority in Wales ceased its involvement with the family, recording that a comprehensive assessment was completed, and the section 47 information had been passed onto the Local Authority in England. On the same day, Mr X's social worker records a referral made to the Local Authority in England by the mental health facility in England, regarding concerns for the welfare of the children as noted by the Local Authority in Wales and the police.

Throughout June, the Local Authority in England continued their section 47 enquiries with Mrs X, Mr X and their children. On one occasion, they found the children in the care of a professional childminder who had just met them and cared for them as Mrs X was not expected back from work until 9 p.m. On 30 June, the police in England advised the Local Authority that Mr X had been remanded under s48 of the Mental Health Act, and was prohibited from having contact with Mrs X and his paternal relations. The Local Authority supported Mrs X in placing the children in a local primary school, which they commenced on 4 July 2022.

On 6 July 2022, the Local Authority expressed concern to Mrs X about address changes and suggested she displayed evasive behaviour; she responded by reporting that she was frightened of professional intervention. The same day, Mrs X and Mrs Y requested and attended a meeting with the school to provide contextual information about their family circumstances and express concern about the involvement of the Local Authority. The school encouraged Mrs X to engage fully with the Local Authority.

At the start of August, Mrs X advised the Local Authority in England that she was taking the children on holiday and requested three days' notice for any future visits. On the 10th August 2022, a Local Authority England manager spoke to Mrs X following her complaint regarding respectful communication, in which she requested that she be referred to as Mrs X. The Local Authority ceased its involvement on the same day after determining the children were safe in Mrs X's care with the paternal grandparents' support. Three days later, on 13th August, Mrs X contacted the police to report her in-laws were being unkind to her and she no longer wished to live with them. On 31st August, the Education service in England was advised Child A and his sibling had moved back to Wales.

Wales

On 1st September 2022, Mrs X informed the Education services in England and Wales of her move back to Wales and her intention to home-educate her children. The England education service notified their Welsh counterparts that the children had returned to their area. Child A and his sibling were added to the EHE database in Wales. Mrs X informed the Welsh EHE service of the family circumstances and their living arrangements outside of the UK. Throughout September and October, Mrs X kept in email contact with Education in Wales. On 29th September, the England Local Authority received a request for information from Mr X's mental health facility asking about the outcome of a serious case review. They were advised that none had been undertaken in respect of the children. The mental health facility advised the Local Authority that Mrs X and the children were living in Wales.

In October, Child A and his sibling were registered with a GP in Wales. In November, Child A was discharged from the school nursing service in England, but there was no handover, as he was not registered at a school in Wales. On 25th November 2022, the Local Authority in Wales received a referral from the mental health facility in which Mr X was detained to respond to Mr X's request to have contact with his children. Mr X also raised concerns that Mrs X was selling sex.

The Local Authority initiated a comprehensive assessment. Mrs X was spoken to regarding her work; although she did not explicitly admit to selling sex, Mrs X asserted that she ensured the children were cared for appropriately and not in contact with her clients. The Local Authority liaised with the Elective Home Education (EHE) team to monitor the children's well-being, asking them to undertake a home visit before ceasing its involvement. Following Mrs X's calls to police in April

and May 2022, there was a timely and coordinated response between agencies in Wales and England to ensure Mrs X and the children were visited. The police in Wales attended the home address; they had no concerns about Mrs X and noted Child A and his sibling were happy, clean and tidy.

In April 2023, the mental health facility where Mr X was detained sought clarity on the outcome of their initial referral regarding safeguarding concerns. In May 2023, virtual supervised meetings between Mr X, Mrs X and the children commenced and continued on a three-weekly cycle. In late September 2023, the Welsh EHE team contacted Mrs X to arrange their annual review visit. Mrs X said the family had returned to live in England and, as such, would not be providing an update. Education in Wales sought confirmation from Mrs X, conducted visits to the family home in Wales, and saw evidence of children's toys remaining; as such, they left a calling card.

<u>England</u>
Records from the England-based mental health facility in which Mr X was detained note that Mrs X and the children moved back to England on October 2, 2023. The family's first face-to-face supervised visit with Mr X occurred on October 6, 2023. The visit went well, and Child A and his sibling were pleased to see their father. Two further supervised visits occurred in November 2023; no concerns were noted.

<u>Wales</u>
On the 17th November 2023, Mrs X emailed the Elective Home Education team in Wales to inform them of her intention to return to Wales by the end of the month. On 27th November, Mrs X forwarded a detailed education report to the Welsh Education team. On the 13th of December, supervised face-to-face contact took place between Mr X, Mrs X, and their children at the mental health facility in England. On the 8th January 2024, the mental health facility received an email from Mrs X arranging a face-to-face visit for the 11th January 2024. That visit did not take place as tragically Child A died on the 10th January 2024.

Child Practice Review Process

To include here in brief:

- *The process followed by the board and the services represented on the review panel*
- *A Learning Event was held, and services that attended*
- *Family members were informed, their views were sought and represented throughout the Learning Event, and feedback was provided.*

The process followed by the safeguarding board and the services represented on the review panel

This review was undertaken per statutory legislation in section 139 of the Social Services and Well-being (Wales) Act 2014 and accompanying guidance Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).

Per the guidance, a panel chair and reviewer independent of the case management were appointed. They possessed the relevant experience, skills, knowledge, and abilities required for the case and its specific circumstances. The reviewer is wholly independent of Wales. The panel met on 11 occasions and consisted of representation from the following services, all of whom had had an involvement with the individuals at the centre of this review:

- Local Authority Children Services (Wales and England)
- Health Board (Wales)
- Police (Wales)
- Education (Wales and England)

In addition to the above, the Health Board and Police in England assisted in the review and liaised with their counterpart in Wales to support information sharing.

Family involvement in the review

Participating in a child practice review following the death of a child or grandchild is a complex and emotionally sensitive process for any parent or grandparent. This review has benefitted from the kind participation and thoughtful reflections of Child A's parents (Mr and Mrs X), and paternal grandparents (Mr and Mrs Y). Their views are presented in later sections of this report.

Prior to the learning event, the reviewer and panel chair visited Mrs X in person and spoke with Mr X via a video call to understand their perceptions and experiences. Mr and Mrs Y also agreed to participate to ensure their views were included in the analysis. Mr Y joined the discussion towards the end of the visit. Despite experiencing cognitive decline, Mr Y was able to ask questions and share reflections on his time with his grandchildren.

The learning event

Although Child A was a resident of Wales at the time of his death, he and his family had resided in England for most of his life. During the timeline, Child A was resident in both nations and thus, agencies from England were invited to participate in the learning event. It was decided that the learning event should be held in Wales, local to the practitioners and community who were affected most by the tragic death of Child A. Consideration was given to a request for some English agencies to attend in a hybrid design, but that was not deemed to be appropriate given the sensitive nature of the review.

All agencies from Wales were present at the learning event. Police and Education agencies attended from England. Those who attended the learning event were congruent, engaged, and reflective. Attendees valued the opportunity to listen, share, and learn from the experiences of Child A, family members, and the agencies they represented. Those agencies are detailed in the table below.

Practitioner Attendees	Manager Attendees
Local Authority (Wales)	**Local Authority (Wales)**
Education (Wales, England)	**Education (Wales, England)**
Health(Wales)	**Health (Wales)**
Police (Wales, England)	**Police (Wales, England)**

The format of the day consisted of a presentation of the Learning Event process. It conveyed the responses to the invitation to respond from family members. Practitioners were divided into two groups to identify further themes from the timeline, discuss areas of learning, and identify areas of good practice. Later in the day, a third group examined the specific cross-border learning points. All attendees then collectively share their group learning and identified themes, facilitated by questions based on the signs of safety approach.

1. What went well, and what good practice have you identified?
2. What could have been done differently by your organisation?
3. What are your most significant learning points?
4. What actions do you feel agencies need to take to ensure any learning informs future practice?

The reviewer is grateful to everyone who attended the learning event, which focused on crucial safeguarding matters, for their invaluable contribution to the process that has informed the learning identified in this report. Following the learning event, the panel chair and reviewer conducted separate online interviews with managers from the English Local Authority and Health Board.

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.

Complex safeguarding requires contextual analysis to help determine the likelihood of significant harm

Maternal filicide is a complex, statistically rare and tragic event with estimated rates ranging from 0.6 and 2.1 per 100,000, children.[15] When filicide occurs in the context of acute psychosis, the parent's perception of reality is driven by delusional beliefs[16]. More than half of first episodes of psychosis remain undetected by health services.[17] The rarity of the phenomena and its inherent sensitivity means there is little research to assist our understanding[18]. However, a recent academic literature review suggests emerging themes, such as poor maternal mental health and insufficient support systems[19].

Filicide disproportionately affects newborns and infants, however, children of primary school age, like Child A, are also affected. Given the often hidden, multifactorial nature of this risk, there is a need for targeted training for teachers, social workers and mental health practitioners working with mothers of primary school aged children[20]. This training should strengthen practitioners' ability to go beyond the assessment of presenting and improve the analysis of cumulative, historical and contextual factors, that could indicate concerns about the likelihood of future significant harm.

Contextual background

The pre-timeline information submitted to the review provides insight into the complex legal, financial and psychological challenges experienced by Mr and Mrs X. The relationships between Mr and Mrs X, and them and Mrs and Mrs Y, were complicated by the protective, dependent and insecure familial dynamics. The concerns of Mr X's domestic abuse towards his wife in 2017, while the family were living with Mr and Mrs Y, caused Child A and his sibling to be subject to a child protection plan. At this time of her life, Mrs X and her two infant children were living in homeless accommodation provided by the Local Authority in England. Mr X explained the stress of

[15] Herman-Giddens ME, Smith JB, Mittal M, Carlson M, Butts JD (2003) Newborns killed or left to die by a parent: a Population-based study. JAMA 289(11):1425–1429

[16] Resnick, P. (2016). Filicide in the United States. Indian Journal of Psychiatry, 58(6), 203–209. https://doi.org/10.4103/0019-5545.196845

[17] Fusar-Poli, P., Oliver, D., Spada, G., Estrade, A., & McGuire, P. (2021). The case for improved transdiagnostic detection of first-episode psychosis: Electronic health record cohort study. Schizophrenia Research, 228, 547–554. https://doi.org/10.1016/j.schres.2020.11.031

[18] Milia, G., & Noonan, M. (2022). Experiences and perspectives of women who have committed neonaticide, infanticide and filicide: A systematic review and qualitative evidence synthesis. *Journal of Psychiatric and Mental HealthNursing*, *29*(6), 813–828. https://doi.org/10.1111/jpm.12828

[19] Frederique, A., Stolberg, R., Estrellado, J., & Kellum, C. (2023). Maternal Filicide: A Review of Psychological and External Demographic Risk Factors. *Journal of Aggression, Maltreatment & Trauma*, *32*(1–2), 34–52. https://doi.org/10.1080/10926771.2022.2114394

[20] Giacco, S., Tarter, I., Lucchini, G., & Cicolini, A. (2023). Filicide by mentally ill maternal perpetrators: a longitudinal, retrospective study over 30 years in a single Northern Italy psychiatric-forensic facility. Archives of Women's Mental Health, 26(2), 153–165. https://doi.org/10.1007/s00737-023-01303-6

organising a successful legal challenge to help his wife remain in the country contributed to his deteriorating mental health, at that time.

Mrs X did not have permanent leave to remain in the country, and was prevented from taking her young children back to her country of origin after Mr X successfully applied for a prohibited steps order. The Local Authority remained involved with the family after Mr and Mrs X were reunited and living in a home that was sourced with the financial support of Mr and Mrs Y. Positively, documentation at that time details observations of the children and their relationships with their parents. Following the Local Authority's withdrawal, there were no further reported concerns until October 2021.

The timeline reflects missed opportunities to contextualise Mrs X's experience and the impact on her parental capacity, with the concern that Mr and Mrs Y were at risk of financial abuse from Mr X. These safeguarding concerns first arose in October 2021 when the paternal grandparents were reported to be at risk of financial abuse from Mr X, who wanted his parents' assistance to buy a home in Wales. A week later, Mrs X contacted the police following an argument with her husband after the sale of a house fell through. The police in England were aware of the previous child protection concerns and domestic abuse; they undertook a home visit and identified the children were being home schooled, the house was untidy and there were a lot of toys. The police requested a VPA.

<u>The compounding effects of Mr X's assault on his father</u>

Mr X assaulted his father in April 2022, shortly after the family had relocated to a new area in Wales, where they had no connections or sources of support. Mr and Mrs Y offered support to the family, inviting Mrs X and the children to live with them in their home. However, the timeline indicates tensions and complexities in relation to this, with the context of the financial disputes which had previously arisen. Mrs X subsequently contacted the police to request support and alleged she was a victim of emotional and financial abuse by Mr and Mrs Y. In response, the Police visited Mrs X and were concerned about her emotional wellbeing, poor home conditions, a lack of education and the family being socially isolated. The police requested a VPA but on that occasion did not consider the concerns regarding the financial abuse relating to Mr and Mrs Y. With regard to Mr and Mrs Y, the police in England, recognised they missed opportunities to respond to the safeguarding concerns and completed a Discretionary Safeguarding Adult Review, which identified several learning points, in addition to good practice.

<u>Impact on Child A</u>

Between April 2022 – July 2022 Child A, aged 5 years, and his sibling moved home three times, from living in England to Wales to their paternal grandparents' home. His father's mental health had been deteriorating before he left their new home in Wales to collect their belongings, and never returned. There were multiple visits from police and social workers, who observed Child A to be socially isolated with poor social skills. His mother was worried about the implications of her husband's behaviour and concerned about the family's financial security. Adults who visited the family home were initially concerned Mrs X was emotionally unstable. Child A's grandfather was suffering with injuries, and his mother was stressed and having arguments with his grandmother about money. After being home schooled for almost a year, he was required to attend a new school. The Local Authority in England's s47 enquiries concluded there were no safeguarding concerns. Their initial concerns regarding the children's social skills, isolation, boundaries and lack of formal education, were resolved by the children starting to attend school and the support Mrs X was receiving from Mrs Y.

During this period of crisis, Mrs X responded to multiple destabilising events. It is unsurprising that she was initially perceived to be emotionally unstable. Mrs X appropriately notified the police of her husband's remarks regarding their children. With her husband detained after the assault on his father, her future will have seemed insecure. She was concerned about money and that highlighted her ongoing expectation of financial support from Mr and Mrs Y. During those months, Mrs X may not have known where she intended to live with the children. She had lived in the UK for less than five years and England was the most familiar region of the country. In addition to the house in Wales, Mr and Mrs X were still renting a house in England. Additionally, Mrs X may have had concerns about her future legal status in the country and how she would manage being a single mother with no recourse to public funds.

In November 2022, Mr X, through the mental health facility staff, contacted the Local Authority in Wales to request contact with his children and to raise concerns that Mrs X was selling sex. This led to a care and support assessment by the Local Authority in Wales. The Local Authority visited the family home, and the children were spoken to alone. There were no concerns about the home conditions and an educational area and studio for arts and crafts was observed. When asked, Mrs X did not admit to selling sex but did provide assurances that her children were cared for and protected.

Practitioners in Wales are supported by the Ask and Act (2017) guidance[21], which encourages vigilance in recognising Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV). Practitioners must ensure that parents provide a nurturing environment for their children, have a support system, and are safeguarded. Mrs X provided those assurances to the satisfaction of the Local Authority in Wales.

Mrs X was advised of the services provided by the family support team, but did not want support, at that time. It was agreed the children could begin to have contact with their father via video call, to be supervised by the staff at the mental health facility. The Local Authority in Wales did not complete a full assessment. The Local Authority confirmed the children were registered with the EHE service on the 3rd January 2023. On the 5 January, the mental health facility made another referral on behalf of Mr X escalating concerns regarding Mrs X selling sex, the isolation of the children and any adverse impact on the children. The Local Authority in Wales responded that visits had been undertaken and no child protection concerns were evident.

Mrs X helpfully advised this review that she worked freelance selling sex and had clients in Wales and England. She would travel to England and her English clients would travel to Wales. Mrs X asserts her work took place outside the family home, and if on occasion, it took place within the family home, she organised childcare, so the children were unaware of her employment. The nature of working freelance provided Mrs X the flexibility she required to home educate her children. It also provided her sufficient income to be able to economically provide for her children, as a single parent with no recourse to public funds.

The demands upon Mrs X continued throughout 2023. The family home in Wales was purchased in the names of Mr and Mrs X, using funds gained from Mr and Mrs Y. That property became part of Court of Protection proceedings regarding Mr Y in 2023, leading Mrs X to be worried that she and the children would be unable to remain living in the house. Mrs X and the children to return to live with Mr and Mrs Y, notifying the EHE service in Wales that she was moving to England. On

[21] ask-and-act-guidance-leaders-co-ordinators-managers.pdf

6 October 2023 Child A and his sibling commenced the first face to face supervised visits with Mr X at the mental health facility in England. Two further visits take place on the 3rd and 14th November. On the 15th November Mr X is notified that the alarm of their house in Wales has been activated. Mrs X and the children return to Wales on the 17th November 2023. On 23 November 2023 there was a warm daily life updating email exchange between Mrs Y and Mrs X. During September and October, the EHE service in Wales was unsuccessfully trying to locate the children. They were reliant on information provided by Mrs X and had no awareness of the family circumstances. Mrs X emailed the EHE in Wales upon her return but refused to allow them to complete a home visit. However, she did comply with providing evidence of her children's education. During this time of heightened stress for Mrs X, there were no public services actively engaged with the children to note the events they were experiencing or the impact upon them. Being educated at home meant the children did not have a support network where they had trusting relationships with professionals with whom they could talk about their mother's well-being. They were not seen or heard.

On 13 December 2023, Mrs X took the children to visit their father. Mrs X did not drive, and this was a substantial undertaking with two children and required them to stay overnight with a friend in England. The mental health facility supervised the visit that day and Mrs X's presentation gave no cause for concern. The next planned visit to see Mr X was due on the 11th January 2024, the day after Child A's death.

The rights and responsibilities underpinning Elective Home Education

Attending school can contribute to a child's well-being and global development as schools provide opportunities for children to build resilient and significant relationships with their peers and teachers. Regular attendance also means teachers can readily report any concerns and act to prevent significant harm[22]. However, the protective factors identified by the Local Authority in England of the children attending school and the support of living with Mrs Y, before it ceased its involvement, were removed within weeks. Mrs X had a longstanding wish to home educate her children and recommenced this practice once she returned to live in Wales in September 2022. The Education admissions team in Wales were notified that the children had moved into their area in September 2022. However, no knowledge was shared regarding the previous involvement of the Local Authorities in England and Wales.

This learning point highlights the barriers experienced by home educated children in accessing policies designed to support the well-being of school age children. The learning point does not intend to position itself amid the tensions inherent in the sphere of home education[23] but consider Child A's experience, rights, and ability to access public services. The timeline notes that in England and Wales when the Local Authority ceases to be involved with a family, there is a reliance on education services to continue to see and hear children.

Children whose parents elect to educate them at home should not experience more barriers to their rights being served by public services than their peers educated at school or in another educational setting. The Welsh Government's EHE statutory guidance[33] is founded on UNCRC principles to promote and protect a child's rights. These principles are:

[22] Sharley, V. (2023). Responding to Child Neglect in Schools: factors which scaffold safeguarding practice for staff in mainstream Education in Wales. *Research Papers in Education*, *38*(6), 1008–1028. https://doi.org/10.1080/02671522.2022.2089211

[23] Holmes, S. E., & Pattison, H. (2024). Who controls the agenda? theological perspectives on state-controlled home education in the UK. *Journal of Beliefs and Values*, 1–18. https://doi.org/10.1080/13617672.2024.2324229

- non-discrimination (Article 2)
- best interests of the child (Article 3)
- right to life, survival and development (Article 6)
- respect for the views of children (Article 12)

Child A had the right to be seen and heard and to express his views about decisions that affected him. With support appropriate to his age and understanding, Child A had the right to participate in assessment processes. Child A had the right to expect decisions made about him to be in his best interests. Child A was reliant on his parents and, at the time of his death, his mother to act in his best interests. Child A was equally dependent upon public services to safeguard him from harm.

Legislative context

In Wales and England, Section 7 of the Education Act 1996 *provides parents with the responsibility to ensure their compulsory school-age children receive efficient full-time Education suitable*

(a) to his age, ability and aptitude, and

(b) to any special Educational needs (in the case of a child who is in the area of a Local Authority in England) or additional learning needs (in the case of a child who is in the area of a Local Authority in Wales) he may have, either by regular attendance at school or otherwise.[24]

Section 436A of the Education Act 1996 requires local authorities, as far as it is possible to do so, to identify school-age children in their region who are not receiving a suitable education. Historically, neither England nor Wales have monitored the number of children receiving elective home education (EHE), and research in England in 2021 estimated that 81,196 children were home-educated[25]. Following the introduction of monitoring in England in 2022, which became mandatory for local authorities in 2024, data suggests 111,700 children in England are home-educated[26]. Research published in 2021 suggests England has 250 EHE officers overseeing the education provision of home-educated children across 152 local authorities[27]. In one local authority, only one EHE officer was responsible for 500 children. Wales has regional systems in place to identify EHE children but has not introduced a mandatory register of home-educated children. As such, the exact number of children educated at home in Wales, is unknown.

In Wales, education is compulsory, but attending school is not. If a child is home-educated, there is an obligation on parents to cause their child to receive an 'efficient' and 'suitable' full-time education; this obligation is found in section 7 of the Education Act 1996. Parents who decide to home educate their children must be prepared to assume full responsibility, and this may have financial implications.[28] Balanced against this decision is the expectation that local authorities can assess the suitability of the education parents provide.

Once a child is identified as being educated at home, the local authority is responsible for ensuring parents are fulfilling their responsibility. However, the regulatory framework provides limited powers to local authorities to achieve this where parents do not fully engage with the service, requiring EHE officers to develop their codes of practice, which has been met with some

[24] Education Act 1996

[25] Purcell, C., Baginsky, M., Manthorpe, J., & Driscoll, J. (2023). Home Education in England: A Loose Thread in the Child Safeguarding Net? *Social Policy and Society : A Journal of the Social Policy Association*, *42*(1), 1–12.

[26] Elective Home Education, Autumn term 2024/25 - Explore Education statistics - GOV.UK

[27] Full article: Elective Home Education: a system without codes of practice

[28] Elective Home Education guidance [HTML] | GOV.WALES

disapproval[27]. The 2021 judicial review in Goodred v. Portsmouth City Council[29] examined the complexity of parental and local authority responsibilities and found the Council was entitled to seek additional information. Parents, in turn, are expected to respond meaningfully to those enquiries.

Current guidance and developing legislation

Non-statutory departmental guidance for local authorities in England was published in 2019[30] and is under review following the completion of a public consultation in January 2024. Parliament is currently considering the Children's Wellbeing and Schools Bill 2024[31], which proposes several reforms to protect children who are educated at home, including introducing compulsory registration and strengthening the role of local authorities if children are subject to a child protection plan. Notably, the Bill was tabled at the House of Commons report stage in March 2025, seeking to extend the Children Not in School provisions (Sections 30–35 and Schedule 2 in the latest version) to Wales. The Welsh Government has published a statement identifying how that Bill applied to Wales[32].

In May 2023, the Welsh Government published statutory guidance,[33] underpinned by the United Nations Convention on the Rights of the Child (UNCRC), to assist local authorities in meeting their responsibilities under section 436A of the Education Act 1996. The guidance sets out how local authorities should seek to understand how children not registered at school receive their education. The guidance acknowledges that home education is a positive choice for many families. At the same time, it highlights the value of schools and education settings as environments where children can be seen and heard. Although, the guidance notes that some children educated at home have suffered significant harm, it does not imply that home educated children are more likely to suffer significant harm. The All Wales Practice Guide: Safeguarding children who are home educated[34] (last updated in 2021) emphasised the importance of children being seen and heard. The guide requires Home Education-named officers to receive appropriate safeguarding training to identify any well-being or safeguarding issues during their visits. However, uncertainty remains regarding how to respond to children who have had no recent contact with public services. The Welsh Government is currently undertaking an evaluation of the effectiveness of the changes created by its 2023 statutory guidance regarding local authorities ensuring children are seen and heard.

If, as with school-based education, parents had to register their children, there would have been a process of handover for the children from Wales to England or vice versa. Equally, a registration process could have provided Mrs X with some guidance on under what circumstances a child's name would be removed from a register and transferred to another Local Authority. However, there is currently not a single Welsh database of EHE children or a single national EHE service. Rather, each individual LA has a support system for EHE learners in their area and a way of recording details of EHE families they are aware of.

[29] Goodred v Portsmouth City Council | [2021] EWHC 3057 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine
[30] Elective Home Education - GOV.UK
[31] Children's Wellbeing and Schools Bill - Parliamentary Bills - UK Parliament
[32] Written Statement: The Children's Wellbeing and Schools Bill (10 March 2025) | GOV.WALES
[33] Elective Home Education guidance [HTML] | GOV.WALES
[34] Safeguarding Wales

Child A was registered within Wales but the family's moves across borders meant that annual visits were easily missed. Arguably, current guidance is reflective of an unresolved tension between respecting family autonomy and the need for children to be seen and heard by public services as a preventative safeguarding measure.

It should be noted that neither the Children Missing Education database proposals currently being piloted, nor the Children Not in School register proposed under the English Bill, would be a full register of electively home educated children. However, the proposed Children Not in School register would include all electively home educated children, along with some children not in school but still in receipt of Local Authority-provided education, such as those in hospital for long-term care. Therefore, the implementation of this Bill would achieve the outcome of enabling Local Authorities in Wales to obtain a comprehensive picture of children not in school in their area, and support their duties under Section 436A of the Education Act 1996.

Children who are home educated have a right to be seen and heard

The Welsh Government has multiple policies to support school-aged children's health, well-being and education. In theory, children whose parents elect to home-educate them have access to the same entitlements and protections, but there are potential barriers in practice. This learning point does not challenge the legislative ability of parents to decide to educate their children at home. Additionally, it recognises that school-aged children's policies are applied through systems designed for the majority, i.e. in children in mainstream education, leaving children outside these structures with arguably limited access to their benefits. The Social Services and Well-being (Wales) Act 2014 is designed to empower people to have control over what support they need and to ensure that assessments are person-centred and proportionate. A key principle is for services to be preventative and timely with the right help at the right time and any assessment "*in relation to a child must have regard to the importance of promoting the upbringing of the child by the child's family, in so far as doing so is consistent with promoting the well-being of the child".*

Responding to the tension between parental autonomy and the responsibilities of the state

Mrs X had a longstanding wish to home educate her children and notified both education services of her intent to recommence this practice once she returned to live in Wales in September 2022. There was good communication between the two education services and Child A and his sibling were added to the Wales EHE database.

There was good email communication between Mrs X and Wales EHE services. She provided comprehensive information in respect of what this home education looked like, including links to resources accessed, family outings, as well as several photographs of the children completing projects. Mrs X also accepted the offer of a leisure pass to enable her and her children to access the local leisure centre and its facilities.

Mrs X provided the EHE service with an update on the family circumstances regarding Mr X. Mrs X advised the EHE services of living arrangements outside of the UK. Mr X advised this review that it had been the family's intention to travel with the children and educating them at home provided that flexibility. Mrs X shared with them more details about her previous spousal visa challenges, the two schools the children attended, social services involvement and described bullying from the school community and in-laws.

The EHE service in Wales did not suggest they visit Mrs X, nor were they required to contact either Local Authority to triangulate the information Mrs X provided them. When the EHE service was due to visit the children, as per statutory requirements, Mrs X informed them they were moving back to England. The EHE service visited the property in September and October 2023, and found no-one at home, although there was evidence of children's toys. They contacted the Local Authority in Wales, but they had no current information as they were not involved with the family, at that time. Without Mrs X's assistance the EHE service did not know where the children were.

When the EHE service offered Mrs X a home visit on her return to Wales, this was refused, with a detailed report sent in lieu of this. Mrs X engaged by email with Education services to demonstrate the suitability of the home education she provided her children. However, Child A and his sibling were not directly seen by Education services since their 4 week attendance at a school in England ended on 22 July 2022.

Electively home educated children should be seen and heard by health services

At the time of his death, Child A was registered with a doctor in Wales but had not been seen by a health practitioner since February 2020. The Healthy Child Wales Programme[35] recognises the importance of nurturing children's health during their early years and outlines the contact children under 7 years of age should have with health visitors and school nurses. That includes handovers between health visitors and school nurses and the provision of screening services to support a child's vision, hearing, and growth.

Some Health Boards in Wales have introduced named nurses for children who are educated at home and have provided online information about the school nursing service[36]. That information includes a phone number for children aged 11 years and above to text about their health needs and one for parents seeking support for their children's health. These policies and practices practice should be developed to ensure services are inclusive of home educated children and include a strategy to see and hear primary school age children.

Recording and sharing information

There were multiple examples of good information-sharing practices throughout the timeline. In particular, the police in England provided details of the observed behaviours of the children and Mrs X, in their vulnerable person request. Additionally, the Local Authority in England's case recordings were detailed and provided insight into the needs of the parents and their children. Health services in England demonstrated tenacity in ensuring clarification of the process of the vulnerable person assessment made regarding Mrs X in May 2022, before ceasing their involvement in the matter.

The children were referred to the Local Authority in Wales by the English mental health facility in November 2022 after Mr X raised concerns about his wife selling sex. The Local Authority in Wales visited the family and recorded Mrs X's non-committal response to the allegation but did not include their analysis of the family circumstances. The Local Authority in Wales's recordings had indicated, by using a tick box, that the children were seen and spoken to alone. However, there was no accompanying narrative of what had been observed or discussed with either child. The

[35] an-overview-of-the-healthy-child-wales-programme.pdf
[36] School Nursing - Cardiff and Vale University Health Board

analysis of the Local Authority in Wales notes that it took two months for the manager to approve the decision to cease involvement with the family.

The England-based mental health facility showed good practice in making a referral to the Local Authority in Wales and pursuing clarity on the outcome of that referral. Their need to seek clarity demonstrates that the Local Authority in Wales missed an opportunity to report back to the referrer on that occasion.

There were examples of good cross-border information sharing between the local authorities when the family moved between England and Wales. Mrs X had registered the children with a general practitioner in Wales in the spring of 2022. Thus, there was confusion as to where the family was living when the vulnerable person assessment was made in England in May 2022. Notably, in both May and October 2022, the Health Board in England recorded incorrect information regarding the children's location, having misidentified the appropriate region of Wales following the family's cross-border move. However, as detailed earlier in this report, health practitioners were tenacious in May 2022 to ensure the VPA was actioned and that Mrs X and the children were located and seen.

The context of the Local Authority receiving the referral regarding Mrs X's mental health

The day before Child A's death in January 2024, the Local Authority in Wales received a referral from a member of the public who wished to remain anonymous. The person raised concerns regarding Mrs X's mental health, which had deteriorated during the previous week. Working together, guidance and safeguarding procedures in Wales[37] and England[38] provide for the eventuality that emergencies will occur and require decision-making and action before initiating the usual child-safeguarding enquiries. The Local Authority in Wales received the referral and recognised its priority status but did not have sufficient information to determine if the children were at immediate risk of harm. They had already responded to multiple other referrals that day, which had required a same-day response. Child A and his sibling were being educated at home, which meant the Local Authority did not have a school from which to seek further information about the welfare of the children. The only agency seeing the family regularly in late 2023 was the mental health facility in England, which kept records of the visits Mrs X, and the children made to see Mr X. Those records reflect that there were no observable concerns regarding Mrs X's mental health in December 2023.

Members of the public are made aware of their ability to report concerns regarding children's agencies, including the police, children's services or charities such as the NSPCC[39]. National and local agencies have detailed information on websites to support the public in determining which agency to contact depending on their immediate concern. On reflection, the Local Authority considered they could have asked the referrer to analyse whether they thought the children were at risk of immediate harm. However, members of the public are not assumed to have the expertise to analyse complex risks, and any view they might express would still require professional analysis. The information shared by the referrer, who had only known the family for a short time, reflected deteriorating mental health. The referral information did not include any reports of threats of self-harm or harm to the children. No immediate concerns were evident when by chance, later that day, two Local Authority personnel saw Mrs X and the children walking down a street.

[37] Safeguarding Wales
[38] Working_together_to_safeguard_children_2023.pdf
[39] Report child abuse | NSPCC

It is a natural response for humans to reflect on their actions, and what decisions were made and not made, that preceded such a tragic event. The practitioners involved with Child A and his family have critically reflected on their participation, which is a vital part of professional learning and accountability. The rarity of maternal filicide and the complexity of predicting its occurrence must be recognised. Mrs X had no known history of mental illness and research[40] demonstrates that even specialist mental health services find it incredibly difficult to identify first time psychosis. However, the referral did include concerning reports of possible delusional thinking suggestive of Mrs X's deteriorating mental health.

In practice, when there are concerns regarding a parent with children, these are reported to Local Authority children's teams. That is appropriate, as these children could require safeguarding. However, this system positions these teams as an unrecognised triage service for adult and mental health services. When in receipt of multiple high-risk child protection referrals, referrals regarding parental mental health, may be viewed as less of a priority than already identified risk. That is a systemic issue rather than a criticism of individual professionals. The Local Authority team would have benefitted from having a mental health social worker with whom they could consult or to whom they could have passed on the referral for a same day visit to assess Mrs X's mental health.

Wider practice context

Building on the knowledge from a previous Child Practice Review[41] within the same region of Wales, the number of contacts and referrals received by Local Authority had increased from 5,092 in 2019 to over 10,000 in 2023. A specific point raised in this current review's learning event was the number of multi-agency referral forms the Welsh Local Authority received from the police. The experience of the Welsh Local Authority is not isolated. Positive action to identify children experiencing domestic abuse, and to ensure a reliable multi-agency response to their needs, has seen an increase in referrals to children's services.

During the learning event, both the police and the Local Authority recognised that some domestic incident notices were being sent to the Local Authority children's services even when the police determined there were no safeguarding concerns. That perception differs from practice guidance[42] which relates to adult safeguarding needs. In Wales, police officers are required to make a professional judgement and report only if there is, or likely is to be, a safeguarding risk and if the adult needs support services. The guidance also makes provision for consultation with a local authority when there is uncertainty. It is important that police notices of domestic incidents are used appropriately and a recommendation of this review is for this practice to be reviewed.

Family perspectives and reflections

Child A's mother

Mrs X said she chose to educate Child A and his sibling at home as she and Mr X were interested in education, and it suited their lifestyle. She developed connections with other parents through a Facebook group and found resources online. Mrs X said her children enjoyed home education with fewer rules and an unlimited curriculum. Mrs X did not feel that agencies

[40] Fusar-Poli, P., Oliver, D., Spada, G., Estrade, A., & McGuire, P. (2021). The case for improved transdiagnostic detection of first-episode psychosis: Electronic health record cohort study. Schizophrenia Research, 228, 547–554. https://doi.org/10.1016/j.schres.2020.11.031

[41] https://cysur.wales/media/qsghhuuq/cysur-1-2021-report.pdf

[42] practice-guidance-for-dealing-with-cases-of-domestic-abuse-and-sexual-violence.pdf

supported home education and thought she had to agree to have the children attend nursery or school in England. At those times, Mrs X felt her rights were taken away.

Mrs X was anxious that the Local Authority would remove the children from her care. However, at times of crisis, she contacted the police for support and intervention.

Child A's Father

Mr X felt that historically, the Local Authority in England could have done more to support his relationship with Mrs X, rather than requiring them to live separately during their child protection enquiries. He explained that he was supportive of his wife's desire to home-educate Child A and his sibling. However, he thought the children might have re-entered school when they were older. On reflection, Mr X suggested local EHE groups could assist with providing opportunities for children to socialise. He further reflected that the family's move to Wales did not best serve their expectations of economic well-being. His family's wellbeing was important and when Mr X had concerns about the children being protected when Mrs X was selling sex, he raised the concerns so the Local Authority could investigate these.

Child A's paternal grandparents

Mrs Y commented that their son, Mr X and daughter-in-law, Mrs X, worked hard to support their family's success. They had the full support of Mr and Mrs Y, although their age and associated frailties limited what they could do. They were aware of the multiple stressors upon Mr and Mrs X, including securing Mrs X's right to remain in the UK and the collapse of their business following the COVID-19 pandemic.

Mrs X and the children had lived with Mr and Mrs Y on several occasions, including the autumn of 2023, when they returned to Wales just weeks before Child A's death. They had no concerns about Mrs X's mental health at that time, describing her as a resilient mother who was busy going out to work and completing household chores. They explained Mrs X employed babysitters to assist with the care of the children.

Learning Events Themes

Education – Wales and England

- Child A's voice was missing due to home-educated status limiting opportunities for professionals to see, hear and understand his lived experience.
- Stronger legal frameworks are needed to support mandatory registration of home-educated children and to prevent deregistration without assurance of transition to a new local authority.
- National guidance should require professionals to engage with home-educated children directly, not only parents, and consider access to health, well-being, and safeguarding.
- Cross-border moves between local authorities can result in information loss unless EHE concerns and safeguarding history are specifically highlighted during transfer.
- Education professionals currently have read-only access to local authority records. Improved multi-agency data sharing protocols, particularly across borders, could support earlier identification of risk and better continuity of care.

Health – Wales

- Some Health Boards in Wales have introduced a named nurse for Electively Home Educated (EHE) children, enhancing support for a growing cohort of potentially unseen children.

- The school nursing service in Wales has expanded its online patient feedback forms to include child input – helping elevate the child's voice in the development of services aligned with the Healthy Child Wales Programme.

Police – Wales and England

- Effective joint visits were conducted by police and children's services to engage with Child A and his sibling.
- Following Child A's tragic death, timely safeguarding actions were taken to support his sibling, whose views and emotional needs were heard and documented.
- Information sharing between police forces is improving through use of shared national databases and collaborative working.
- Despite shared databases (e.g. four forces accessing the Police National Database), information is not always proactively flagged across regions, and national information requests may not be made unless a specific need is known.

Local Authority - Wales and England

- There was effective information sharing occurred between Mr X's mental health facility and the Welsh local authority.
- There was evidence of good cross-border communication between English and Welsh local authorities throughout the case.
- The introduction of monthly safeguarding meetings between education and social care teams facilitate improved inter-agency collaboration and ensure safeguarding issues are addressed early.

Learning – Organisational Analysis

Health - Wales

- The family had no ongoing engagement with health services in Wales. While they registered with a GP and were invited to a new patient appointment, this was not taken up. No safeguarding concerns were known to the Health Board.
- While some Health Boards in Wales now allocate a named nurse to support children educated at home, there are no mechanisms in place to engage families unless consent is provided.
- We should strengthen outreach pathways to Electively Home Educated (EHE) families, particularly where children are otherwise unseen.

Health – England

- There was good communication and information sharing with education.
- There was evidence of professional curiosity in response to a Vulnerable Person Alert.
- Appropriate professional challenge to children's social care about safeguarding actions, occurred.

- No handover took place between English and Welsh school nursing services when the family relocated, leaving the Welsh Health Board unaware of the children's presence.

- A formal handover protocol between school nursing services for EHE children across borders would improve continuity of care.

Education – Wales

- The EHE team was appropriately notified of the family's arrival by their English counterparts, but no safeguarding concerns or previous child protection history were shared.

- Mrs X declined home visits and current guidance does not permit enforcement. This limited the EHE team's ability to act on concerns.

- Verbal discussions between children's social care and EHE teams are essential when concerns are raised, to support shared understanding and risk analysis.

- Cross-border communication should explicitly include EHE concerns and historical safeguarding context.

- Discussions between the EHE advisor and the front door team were not recorded, creating gaps in the chronology.

- Greater professional scrutiny is needed when reviewing home education materials – e.g., understanding the educational relevance of website links provided by parents.

Education – England

- The short school attendance period coincided with a period of relative family stability. However, the brevity of their stay meant limited the school's understanding of the children's experience and assessment of their educational needs.

- There was a one-week delay in sharing information with Welsh colleagues after the children moved.

Police (Wales)

- Police involvement with the family was minimal. However, prompt and appropriate responses were given to all reports relating to the family. Notably, the 'appropriate' officer in terms of skillset and experience was dispatched to each call for service.

Police – England

- Effective multi-agency collaboration led to the identification of domestic abuse and vulnerable children within the family. A Vulnerable Person Assessment was completed, and referrals were made to the appropriate agencies as per policy. However, on occasion, when Mrs X requested assistance, there was scope for greater professional curiosity to consider other factors, including mental health.

Local Authority – Wales

- Assessments were completed during both periods of involvement and approved by managers. The manager's approval of one assessment occurred two months after completion, delaying closure. The Local Authority has since introduced new practice standards that ensure managers only approve the cessation of involvement when children have been seen by a social worker the preceding week.

- The children were seen, their wishes and feelings were recorded, and relevant agencies (including EHE and health) were contacted. Interaction and observation records could have been more detailed, particularly from individual visits and direct work with children.

- An onwards referral to Team Around the Family was discussed and information shared with police regarding the allegation that Mrs X was selling sex.

- More robust practice could have involved asking the member of the public who raised concerns in January 2024 for their analysis of risk.

Improving Systems and Practice

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

National Recommendations

1. Welsh Government to adopt the principles, powers and duties set out in England Children Wellbeing and Schools Bill in its own legislative framework for electively home educated children.

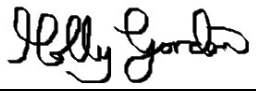
Regional Recommendations

2. Promote the rights and wellbeing of electively home educated children and young people, through co-produced resources designed with and for children and their parents.

3. Review multi-agency safeguarding training to ensure practitioners and managers understand the contextual experiences of EHE children.

4. Review arrangements for submission of Domestic Incident Notifications from the Police into Children's Services

5. Assess and review the availability of support and training for practitioners receiving and responding to concerns regarding parental mental health.

Statement by Reviewer(s)			
Reviewer 1	Dr. Donna Peach	**Reviewer 2** *(as appropriate)*	N/A
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1. *(Signature)* 		**Reviewer 2** ……. *(Signature)*	
Name *(Print)* Dr Donna Peach		**Name** …… *(Print)*	
Date 29/08/2025		**Date** …….	
Chair of Review Panel . *(Signature)* 			
Name *(Print)* Dr Holly Gordon			
Date 29/08/2025			

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

Terms of Reference for Concise Child Practice Review

CYSUR 1/2024 (Pembrokeshire)

- **Nominated Safeguarding Lead** – Helen Goodridge
- **Review Panel Chair** – Holly Gordon
- **Independent Reviewer** – Donna Peach

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.
- Whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child, the family and their circumstances. How that knowledge contributed to the outcome for the child?
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).
- Seek contributions to the review from appropriate family members where possible 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 managers and identify required resources.

Specific tasks of the Review Panel

- Identify and commission reviewers to work with the *Review Panel* in accordance with guidance for extended reviews.
- Agree the time frame.
- Identify agencies, relevant services, and professionals to contribute to the review, produce a timeline and an initial case summary, and identify any immediate action already taken.
- Complete additional information regarding Independent Reviewers and Panel membership
- Produce a merged timeline, initial analysis and learning outcomes.

- Obtain and consider relevant contextual information in respect of the family, where this supports exploration of learning in respect of the agreed time period for the review.
- Undertake cross-border liaison with relevant agencies as appropriate, to ensure the involvement of all agencies with the family is understood and reflected in the review.
- Plan with the reviewers a learning event for practitioners and managers, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewers contact arrangements with the individual and family members prior to the event, with appropriate consideration of parallel processes and in conjunction with relevant colleagues and agencies involved with the family.
- 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 draft report and an outline action plan, and make arrangements for presentation to the Practice Review 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 Practice Review 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

Tasks of the CYSUR Safeguarding Children Board

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

- 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 & Well-being [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.