South East Wales Safeguarding Children Board
Bwrdd Diogelu Plant De Ddwyrain Cymru

Working Together For Children - Gweithio'n Gytûn Ar Gyfer Plant

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY
of the Overview Report of the
Serious Case Review of the

Circumstances Concerning Chelsey (dob 13.12.1994) and Mary (dob 10.03.2012) who both died in a house fire on 18.09.2012

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Date of publication: 26th February 2015

Executive Summary

Introduction

In the early hours of the morning on 18 September 2012 a lady, her 17 years old daughter, and the daughter's daughter, aged 6 months, died in a house fire set by Carl Mills, a 28 years old man. Following his conviction for murder Mills was sentenced to life imprisonment, to serve a minimum term of 35 years.

In this Executive Summary, with the agreement of the family, the lady is referred to as Sharon. Sharon's daughter is referred to as Chelsey. Chelsey's daughter is referred to as Mary.

The fire was set during the first night that Mary, who was Mills' child, had spent at home. She had been born prematurely and required specialist neo natal care in hospital.

Mills was from Bolton, Lancashire. During October and November 2010, when he was aged 26 years, he targeted and groomed Chelsey, then 15 years old, using social networking sites and mobile phones. He travelled to Cwmbran.

Sharon was so worried that she contacted the police and social services. Teachers also involved social services.

Concerns about Mills' influence, drunkenness, extreme jealously and threatening behaviour and texts to Chelsey and other members of the family led over the next twenty one months to child protection referrals, strategy meetings and child protection enquiries. Sharon asked for help and co-operated fully with the agencies.

In October 2011 Chelsey was found to be approximately 6 weeks pregnant with a twin pregnancy. The difficulties with Mills increased throughout the pregnancy.

On 10 March 2012 a baby girl was still born and Mary was born very prematurely at 24 weeks. She weighed only 715 grams (1.6 pounds) and was admitted to the Special Care Baby Unit where she was cared for until the day before the fire.

Health staff made a child protection referral to social services because of concerns about the behaviour of Mills and Chelsey in the hospital and concern about future arrangements for Mary's care.

At the end of August 2012 Sharon complained to the police that Mills had caused damage at her home, stolen her keys, cut electrical leads and let family dogs out of the house and garden. There was dog mess in the baby's bedroom which the family said was put there by Mills. The police contacted the housing association which changed the locks at the home.

On 17 September 2012 Mary was discharged home. Aged 6 months she weighed 5.2 kgs (11.5 lbs) and was extremely vulnerable. She had survived because of intensive skilled medical and nursing care. She could not see or hear, had great difficulty feeding and was dependent on oxygen.

In the early hours of the morning on 18 September Mills set the fire that killed three generations of the family.

The Serious Case Review and other Processes

Legislation and government guidance required two formal review processes to be carried out.

A Serious Case Review in relation to the murders of the children, Chelsey and Mary, was begun by Torfaen Safeguarding Children Board. From 1 April 2013, as a result of the Welsh Government's review and modernisation of strategic arrangements for Local Safeguarding Children Boards in Wales, the Serious Case Review became the responsibility of South East Wales Safeguarding Children Board.

Government guidance requires that an independent person with appropriate qualifications, knowledge or experience should be involved from an early stage and be commissioned to analyse the findings of the various reports from agencies and others, and make recommendations for future action in an Overview Report.

Mr David Spicer was appointed to carry out this function. He is a Barrister who has specialised in the law and practice relating to child welfare cases for over 35 years and has acted as the Independent Overview Report Author in relation to a significant number of Serious Case Reviews. Prior to his appointment he had no involvement directly or indirectly with the children or any members of the families concerned or the delivery or management of services by any of the agencies. He attended all meetings of the Serious Case Review Panel following his appointment.

On 17 September 2014 the South East Wales Safeguarding Children Board accepted the Overview Report of the Serious Case Review and the recommendations that Mr Spicer made in the Report.

This document is an Executive Summary of the Overview Report.

The Recommendations made in the Overview Report are referred to in the text of this Summary.

The Overview Report confirmed that the Serious Case Review was carried out in an open and thorough manner.

A **Domestic Homicide Review** was also carried out on behalf of the Community Safety Partnership because the circumstances involved the murder of two people over the age of 16 years, Chelsey and Sharon, by a person who had a close relationship with them. The purpose of that Review was to learn lessons about what action to take to improve arrangements for identifying and responding specifically to

domestic abuse. The recommendations of that Review were supported by the Serious Case Review.

Following complaints by members of the victims' family concerning the handling of aspects of the case by police officers, the **Independent Police Complaints Commission** carried an investigation into the actions of Gwent Police.

The Serious Case Review Process

The purpose of the Serious Case Review was to identify steps that might be taken to prevent similar harm occurring by:

(a) Establishing whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;

(b) Identifying clearly what those lessons are, how they can be acted upon, and what is expected to change as a result;

(c) As a consequence, improving inter agency working and better safeguarding children and

(d) Identifying examples of good practice.

The Review covered the period from 10 October 2010, when concern first arose about Mills' contact with Chelsey, until 18 September 2012, the date on which Sharon, Chelsey and Mary died.

The following agencies took part in the Review:

Education Service, Torfaen County Borough Council
Aneurin Bevan University Health Board, by Public Health Wales
Bron Afon Community Housing
Torfaen Children and Family Services, Torfaen Social Care and Housing, Torfaen County Borough Council
Gwent Police Force

A Serious Case Review Panel was established with the following membership to carry out the Review and quality-assure the process:

Safeguarding and Equality Officer, Education Service, Torfaen County Borough Council.
Designated Nurse, Safeguarding Children Service, Public Health Wales.
Named Nurse, Aneurin Bevan University Health Board.
Solicitor from Torfaen County Borough Council.
Group Manager, Children and Family Services, Torfaen County Borough Council.
Safeguarding Manager, Torfaen County Borough Council.
Detective Chief Inspector, Gwent Police.

Head of Community Housing, Bron Afon Community Housing.

The Panel was chaired by Ms Anne Sheehan, an experienced social work practitioner and manager.

Prior to travelling to Cwmbran, Mills lived in Bolton, Lancashire. Bolton Safeguarding Children Board co-operated fully with the Review and reports were provided by agencies in Bolton concerning their knowledge of and involvement with Mills.

In accordance with government guidance no persons involved in the review had been directly concerned with the child or family, or given professional advice on the case, or been the line manager of any practitioners involved.

There was no indication in the material available for the Serious Case Review that issues relevant to religious persuasion, racial origin and cultural and linguistic background were factors that should have been addressed in this case.

Meetings took place with three members of the victims' family and with a close family friend. Despite the distressing circumstances they were anxious to contribute. Everything that they contributed was considered in the Review and included in the Overview Report.

A meeting was also held with Mills' mother. She was anxious to contribute and what she had to say was considered within the Review and included in the Overview Report.

Carl Mills refused to agree to a meeting.

Delay

Some officers involved in the case from Gwent Police were unavailable for interview or otherwise to take part in the Serious Case Review until the investigation into their conduct by the Independent Police Complaints Commission was complete. This inevitably led to considerable delay in completing the Serious Case Review.

The Serious Case Review Panel and the agencies were determined that lessons would be acted upon without waiting for the completion of the Review process. As a consequence recommendations for future action in Agency Reports and the Overview Report are fewer than would otherwise have been the case because action has been taken to address weaknesses.

The actions taken by agencies are referred to in the text of this Summary.

Summary of the Background

During November 2010 teaching staff at the school that Chelsey attended became very concerned about Chelsey and other girls receiving text messages from Mills, who was known to be an adult man, and made a child protection referral to social services.

Sharon was “at her wits end” and called the police.
A Strategy Discussion was held between social services and Gwent Police. Mills was recorded as being resident in Bolton, born on 19 September 1984 and therefore 26 years old.

Police checks carried out on Mills recorded that there was “no trace”, that is, he had no criminal convictions or antecedent involvement with the police.

Enquiries carried out locally by social services and police and contact with the family indicated that Mills was already making threats against family members and controlling Chelsey.

In December 2010 further checks were carried out by the police who told Sharon that Mills posed a “significant risk,” that he had been to prison but they did not know why and as he had committed no offences in Cwmbran, no action could be taken.

The police made a child protection referral to social services and child protection enquiries were carried out that concluded with a decision that work would be undertaken with Chelsey. This was ineffective as Chelsey refused to co-operate or accept that her contact with Mills should end.

On 13 December 2010 Chelsey was 16 years old and thereafter she was treated by the agencies as capable of consenting to sexual acts and responsible for the choices she made.

Mills’ influence detrimentally affected Chelsey’s school attendance as she approached school leaving age in June 2011 and, afterwards, the ability to give her careers advice.

In October 2011 it became known that Chelsey was pregnant with twins and that Mills was the father.

On 10 March 2012 a twin baby girl who had died was delivered, and Mary was born after 24 weeks and six days of pregnancy, weighing only 715 grams (1.6 pounds). Mary was admitted to the Special Care Baby Unit.

Health staff at the hospital became concerned about risks to Mary’s safety and welfare because of the attitude and behaviour of Mills and his influence on Chelsey. In April 2012 they made a child protection referral to social services.

Over the following period until the night of the fire Mills slept rough in the Cwmbran area and on occasions stayed at the family home as Sharon, frightened of losing her daughter, tried to develop a reasonable relationship with him. He was frequently drunk and threatening. Sometimes Chelsey slept rough with him. The extent of this was unknown to the agencies.

The police made further enquiries concerning Mills’ record and disclosed that there were:

"25 pages of offences of aggressive nature on record."

A Strategy Discussion took place between social services and Gwent Police regarding risks to Mary. Child protection enquiries were carried out by social services and a Child Initial Assessment begun. The social services staff asked the police to do further checks on Mills' criminal record.

The social worker provided Mills with details of how to access support for alcohol problems and homelessness but Mills took no effective action.

A decision was taken by social services to close the case until Mary was near to discharge from hospital which, if she survived, was not expected to happen for several months. The case was quickly reopened at the end of April 2012 when Gwent Police informed social services that Mills' record included offences in Bolton concerned with:

"Firearms/weapons, threats to kill."

Health staff at the hospital were informed.

Another assessment was carried out by social services and it was decided to arrange an interagency Child Protection Conference. This decision was changed because it was thought that it would be helpful to involve staff from a particular team within social services. The team provided intensive support for families but its terms of engagement at the time did not allow involvement with cases involving children whose names were on the child protection register, a likely outcome of holding a conference.

During August 2012 Mill's mother in Bolton made contact with the family because Mills had told her that Mary had died, presumably intended to discourage her discussing anything about his history in Bolton.

As a date for Mary's discharge from hospital approached a "Safety Plan" was made by social services that required Mills not to stay at the family home and all contact with Mary to be supervised by an adult member of the family.

Mills' drunken and threatening behaviour continued and following an argument he made threats to turn on the oxygen supply in cylinders in place at the family home to support Mary and which was highly combustible.

He did not carry out this threat but on 27 August 2012 did cut cables to the television sets and the fish tank and let family dogs out of the house and garden and according to the family's account put dog mess in the nursery.

When informed about this, social services made a decision that family members should not supervise the contact by Mills with Mary.

Sharon made a 999 call to Gwent Police and reported the criminal damage and theft of her house keys by Mills. The case was allocated to a Probationary Constable who

made a request to Bron Afon Community Housing, the landlord of the property, for the locks to be changed, which was done immediately.
Sharon expected that action would be taken against Mills but he was not arrested or interviewed by the police in connection with this incident.

Sharon sought advice from a solicitor to apply for a residence order in relation to the care of Mary but although correspondence was sent to the local authority the fire occurred before this could be taken forward.

At this time Mills and Chelsey had been sleeping in a tent close to the property.

At 0331 hours on 18 September 2012 Gwent Police received a call from the Fire Service that reported a house fire at the family address. The fire service prevented the fire spreading to other properties.

The Police made a referral to social services with the information that Sharon, Chelsey and Mary had died in the fire.

Findings

No deficiencies in the framework of legislation, procedures, guidance or expected practice standards were identified.

The central issue was the extreme dangerousness of Mills and the serious risk that he presented to Sharon, Mary and Chelsey. Other than the activities of Mills there was no reason for the police or social services to have had any involvement with this family.

A family friend described the impact that Mills had on Chelsey:

> *"Before Mills came Chelsey was brilliant. Afterwards Chelsey would not listen to anyone."*

and

> *"Sharon tried to do something – everything she could to stop it".*

Mill's predatory, controlling and abusive behaviour was not recognised and addressed by the agencies as sexual exploitation and domestic abuse. No formal action was taken to prevent the abuse and decisions intended to restrict Mills' contact with Mary lacked any legal authority.

The risks were not fully understood because information about Mills' background was not sufficiently accessed and considered and did not inform the judgments reached and actions taken. No enquiries were made of agencies in Bolton and elsewhere that had previously had involvement with Mills.

Expected processes and procedures were not followed effectively and arrangements within Gwent Police for accessing police information and intelligence held by other police forces were inadequate.

The circumstances did not attract the testing and challenging that should arise from good interagency working and which should have identified these weaknesses. The approach lacked the professional curiosity that should be present throughout child protection cases because the work was being undertaken outside the framework of child protection processes.

It is rarely possible to assert that had matters been handled differently the serious incident that has led to the deaths of children would not have occurred.

However in this case if the information available in Bolton concerning Mills' history had been properly researched and considered, and appropriate interagency processes and planning had taken place, the risks would have been better understood and it is likely that action would have been taken that was more likely to protect Mary, Chelsey and Sharon from the extreme act which caused their deaths.

Sharon asked for help from the agencies that she thought could help her and did not receive the services that she needed.

The staff involved did not lack commitment but the work related to the safety and welfare of Chelsey and Mary did not take place in accordance with statutory, guidance and procedural requirements or standards of good practice.

Legal and Procedural Framework
Inter-agency Procedures and Child Protection Processes

Child protection referrals were made to social services by school staff, police officers and health staff. Strategy discussions took place between social services and police officers, statutory child protection enquires and assessments were carried out.

However, none of these processes met statutory, guidance, procedural or practice requirements. In particular none identified the need to contact agencies or members of Mills' family in Bolton to obtain full information about the background of Mills.

If enquires are not sufficient and judgments and assessments are not sound, the decisions and plans based on the conclusions will be flawed and are likely to be ineffective or dangerous.

The Review learnt that there were at least 45 incidents of violence committed by Mills in Bolton which included serious offences committed against his mother involving setting fire to her bed believing her to be in it, threatening her with knives, interfering with electricity supply and physical violence.

The decision not to arrange a child protection conference reflected a lack of understanding of the purpose of and benefits that flow from agreed interagency processes. A conference would have involved child protection specialists who would have been more likely to challenge the lack of background information, identify weaknesses, and provide a focus on the appropriate responses to child sexual exploitation and domestic abuse.

It would also have ensured that the events that followed, including the incident of criminal damage committed by Mills three weeks before the fire, would have been considered within a multiagency framework for child protection and involved experienced child protection officers from all agencies.

The responsibility for the effectiveness of safeguarding processes does not lie with a single agency. All agencies have a responsibility to take action through established escalation procedures in the event that expected processes are not taking place.

The Overview Report recommends that there should be a review of procedures and protocols to ensure that there is sufficient emphasis on the responsibilities of partner agencies to take action if interagency processes are not followed and that agencies should report to the Board on the actions taken to ensure that their staff are aware of this obligation.

In order to check whether departure from interagency procedures requires further action to be taken by South East Wales Safeguarding Children Board, the Report recommends that an audit or review of cases should take place.

Mills' mother stated that the offences Mills committed against her were much more serious than his convictions suggested because she could not bring herself to pursue the complaints.

The case illustrates how important it is to approach these issues with professional curiosity and enquire into the full background from every source that is available.

Action to address this issue has been taken in social services. The Safeguarding Manager has developed a "Lateral Check Framework" for use within the department by staff involved in child protection processes to require adequate enquiries to be made and full information gathered. **The Overview Report recommends that an audit of child protection cases should, be carried out when the form has been in use for 12 months to ascertain its impact and the conclusions reported to South East Wales Safeguarding Children Board.**

The family friend explained that Sharon may not have shared the full extent of the threats and behaviour of Mills to police and social services officers because she was extremely worried that Mary would be removed from the family. Sharon also persistently tried to reach an accommodation with Mills because she could not overcome her daughter's infatuation and convinced herself that Mills' threats made when drunk would not be carried out. She was unaware of the information in Bolton that illustrated Mills' capacity for committing serious acts of harm. She thought nothing could be done.

Family members will not always disclose everything that they know or appreciate what is important. The responsibility for ensuring that they have full information concerning the risks lies with officers carrying out enquiries and assessments.

High quality child protection enquiries are an essential element of the safeguarding framework. **The Overview Report recommends that the Head of Children and**

Family Services should review the arrangements for training and authorising staff to undertake or supervise statutory child protection enquiries and audit enquiries previously carried out to ascertain the quality and to identify any issues.

The Head of Torfaen Children and Family Services has taken action to ensure that Managers satisfy themselves that social work staff have the necessary skills and knowledge before requiring the staff to carry out or contribute to any assessment and that supervisors have undertaken training on carrying out effective assessments.

A Risk Assessment and Risk Management Plan has been developed to assist staff to evidence the assessment and management of risk and reflect the expectation that decision making including the rationale should be evidenced and documented.

Processes are in place to ensure consistency and quality of practice and to identify quickly where weaknesses might be developing and require attention. These include an auditing framework involving formal, regular supervision and monthly file audits by senior managers and a departmental Quality Assurance Framework. Inspections are carried out by the Care and Social Services Inspectorate Wales and Performance Indicators are in place and monitored and reported on a structured basis to the Departmental Manager's Group, Senior Management Team and to the Welsh Government.

A number of multi-agency Panels discuss the most complicated cases.

Audits of cases that are carried out in accordance with standards set by South East Wales Safeguarding Children Board usually involve examination of files and records. **The Overview Report recommends that there should be consideration of whether the current arrangements sufficiently involve direct examination of practice and face-to-face accounts of how work has been done.**

Weaknesses in the approach to strategy meetings or discussions are being addressed through work being undertaken by a working group set up by South East Wales Safeguarding Children Board to review and recommend improvements to ensure involvement of and effective sharing of information with all relevant agencies utilising available technology.

The Review identified that some delay took place in implementing a case decision because a member of staff was on leave. Action has been taken by the Head of Torfaen Children and Family Services to reinforce through a formal process the expectation that unavailability of staff is addressed by the appropriate manager to ensure continuity of work or action during absences.

After the decision was taken not to arrange a child protection conference the case was allocated to a team within Torfaen Children and Family Services that had been recently established as an innovative initiative bringing forward the benefits of a practice model not expected by the Welsh Government to be implemented until June 2013. An independent evaluation of the work undertaken by the team was commissioned by the Head of Torfaen Children and Family Services and was completed in November 2014.

The allocation to this team was not considered as expected by a Multiagency Panel, when the weaknesses in the case may well have been identified, including the lack of an effective assessment to inform its work. The Review identified uncertainty among partner agencies about the role and status of this Panel.

These issues have been addressed. The referral process has been strengthened and a guidance leaflet produced which clearly outlines the process. The arrangements require involvement of safeguarding leads previously uninvolved in a case to provide a consultancy, testing and challenging role in complex cases particularly when it is likely the case will require legal proceedings.

The Overview Report recommends that the Panel should also consider cases in which despite safeguarding interventions no or insufficient progress is being made towards reducing the risk of harm to a child.

The Torfaen Children and Family Services Safeguarding Unit functions well by providing services that encompass adult and child protection work and managing both adult and child protection processes through the single line management of the Safeguarding Manager and the Domestic Abuse Co-ordinator. Discussions during the course of the review considered how the benefits might be extended. **The Overview Report recommends that the Lead Director for Children and Young People should consider the potential benefits for safeguarding children that might arise from the integration of Education Service personnel in the Safeguarding Unit.**

The review of arrangements within the school identified that records had been removed from the school for consideration within the criminal investigation and copies were not retained and so not readily available for any on-going reference. **The Overview Report recommends that interagency procedures should make clear the need for all agencies to retain copies of working documents in these circumstances.**

Child Sexual Exploitation

From early contact with Chelsey, Mills made clear his intention to have sex with her but “not until she was 16 years old”.

The family friend commented that Sharon:

> *“did not know what to do. They said that there was nothing they could do but just told her to keep them apart – it was her responsibility but she did not know how.”*

The family were advised that nothing could be done because Mills had not committed an unlawful act.

The staff involved identified that Mills was grooming Chelsey but the circumstances were not considered within the growing knowledge of and appropriate responses to child sexual exploitation or in accordance with the All Wales Child Protection

Procedures and statutory guidance on Safeguarding Children and Young People from Sexual Exploitation which addresses “Disrupting perpetrator behaviour.”

In common with high profile cases and cases considered through other Serious Case Reviews, Chelsey was perceived to be making bad choices that she was entitled to make or at least could not be prevented from making. It is a feature of sexual exploitation that the perpetrator exercises control over his victims and undermines the ability to make properly informed choices or to recognise that what is occurring is abusive. There is overlap between domestic abuse and sexual exploitation.

This case illustrates the need to act early and decisively against perpetrators. The time to act was when Mills was establishing his control and before Chelsey became pregnant, after which the case became much more difficult to manage.

Extensive training on identifying and addressing child sexual exploitation had been provided in Torfaen. Cases were expected to be dealt with in accordance with procedures and guidance and by accessing specialist assessment services.

Nevertheless none of the staff in the agencies involved with this case considered the possibility of taking any legal action to prevent Mills continuing to contact, meet and groom Chelsey or advising, encouraging and assisting Sharon to do so.

The breach of a court order restraining Mills would have probably led to Mills’ imprisonment.

The Overview Report recommends that South East Wales Safeguarding Children Board should consider how to raise the awareness of frontline staff across agencies of the range of options to be considered to address circumstances when young people become the target of predatory grooming.

It is important to ensure that training is provided to the staff that require the knowledge and skills. **The Overview Report recommends that the training records of staff within social services should be reviewed to ensure that appropriate members of staff including supervisors have attended training on the recognition of and response to child sexual exploitation.**

Action has been taken within social services to improve the knowledge of practitioners in this area and provide oversight of cases to improve consistency and quality of practice and identify weaknesses.

All strategy meetings held in relation to child sexual exploitation are chaired by the Safeguarding Manager which ensures continuity and oversight and quickly identifies emerging patterns or trends.

Aneurin Bevan University Health Board provides staff with training in respect of sexual exploitation as part of a rolling programme.

The issue has received considerable interagency attention. Building on the work undertaken by the previous Local Safeguarding Children Boards that have come

together, South East Wales Safeguarding Children Board has a Strategy for 2013 to 2016 to address child sexual exploitation.

The “missing children’s project” involving a multi-agency team was established in 2011 with the aim to improve the services to missing children and has provided a model for the development of services elsewhere.

It is a challenge to ensure that strategies and training have the intended impact on practice and survive changes of staff and structures and any focus on new priorities. South East Wales Safeguarding Children Board strategies and training will be reviewed in the light of experience and growing knowledge.

The Overview Report recommends that South East Wales Safeguarding Children Board should review strategy and policy documents, guidance to frontline staff and training to ensure they sufficiently identify the range of legal processes available to disrupt a perpetrator’s activities.

The nature of safeguarding of children is constantly developing in the light of experience and research and the innovative use of legal processes previously not or rarely used to safeguard children needs to be considered. In order to encourage early consideration and discussion of legal processes and strategic issues **the Overview Report recommends that South East Wales Safeguarding Children Board should consider how liaison with the local Designated Family Judge might be established and that a local authority legal representative should attend South East Wales Safeguarding Children Board meetings.**

So that social work staff have access to advice on the range of legal options available in individual cases **the Overview Report recommends that the Head of Torfaen Child and Family Services and the Head of Torfaen Legal Services should review the arrangements for social work staff to access legal advice.**

The Review identified that references in agency records to describe the abuse that was occurring to Chelsey detracted from the seriousness, normalised what was occurring and allocated an inappropriate level of responsibility to the victim. Chelsey was described as having a “relationship” with Mills and having a “regular partner” when she was 15 / 16 years old and being abused, controlled and exploited by a man in his late twenties.

The Overview Report recommends that South East Wales Safeguarding Children Board should arrange for interagency training and guidance to be reviewed to include the need to accurately record and describe sexual abuse and exploitation with an appropriate use of language that never allocates the responsibility to the child.

Vulnerable Children Reaching 16 years

When Chelsey reached 16 years of age there was evidence in all agencies that she was not considered to be a child at continuing risk of abuse by Mills. She was treated as a young person making bad choices and a young mother who required support and an assessment of her capacity to be a mother.

The concern that young people are treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age-appropriate facilities, has been identified in other Serious Case Reviews and national guidance and research. Children are children until they reach 18 years.

The Overview Report recommends that partner agencies should emphasise to their staff that the All Wales Child Protection Procedures must be followed in relation to all children without discrimination according to age until they reach the age of 18 years and report to the South East Wales Safeguarding Children Board on the action taken to ensure that the Procedures are followed in relation to adolescents.

It is important that there is understanding among staff across all agencies about what the impact in law of child reaching 16 years actually is. **The Overview Report included a section outlining common misunderstandings about the impact of reaching 16 years and recommends that South East Wales Safeguarding Children Board should arrange for staff in all agencies to be provided with a fact sheet that addresses statutory duties, powers and responsibilities and clarifies areas of misunderstanding.**

Professional staff have a duty to advise, guide, support and intervene and control and in doing so may be in opposition to the wishes of a young person. The skills required to work effectively with adolescents are very different from those required for working effectively with younger children. **The Overview Report recommends that South East Wales Safeguarding Children Board should review interagency training to ensure sufficient inclusion of issues relating to safeguarding adolescent children and the practice and skills required.**

Social services have already made arrangements to audit cases to consider the quality of responses for young people aged between 16 and 18 years and if they have become parents to confirm whether their needs remain in focus alongside the needs of their child.

Gwent Police

The information obtained by Gwent Police about what was known about Mills in response to requests from social services and information available to its own officers dealing with incidents was incomplete. Information concerning previous convictions and intelligence held by Greater Manchester Police Force, the British Transport Police, West Midlands Police Force and Cheshire Police Force was not obtained.

The arrangements within Gwent Police for accessing information from other police forces did not comply with recommendations made in the Bichard Inquiry Report published in June 2004.

Also the volume of information from checks resulted in difficulties with administering the collection of data and a considerable backlog. A local decision was taken to 'switch off' and not to progress the accumulated data which then became irretrievable.

It has not been possible to establish how this decision was taken or by whom it was taken. Correspondence sent to a former senior officer who has retired was not answered and he did not take part in the investigations and enquiries.

The Overview Report recommends that the Welsh Government should consider legislating to ensure that individuals with relevant information must co-operate with enquiry and review processes concerned with learning lessons and improving the quality of services for vulnerable children and families.

The Review found that across the Gwent Police Force area:

Information given by Gwent Police in response to requests for convictions and intelligence in relation to individual child protection cases will not have been complete, has been known to be incomplete but this has not been made clear to other agencies;

Other agencies will have assumed that they have received a complete record, have not been given the opportunity to consider themselves researching data bases and will have made inappropriate assumptions in past cases;

The cases in which incomplete information has been disclosed cannot be identified which has serious implications for on-going cases and the reliability of previous assessments of risk.

Gwent Police have taken action so far as it can to address these issues.

The multi-agency information sharing form used by police officers has been amended to record what police intelligence checks have taken place and whether the information has gaps or is otherwise incomplete. **The Overview Report recommends that after 6 months an audit should take place to review the quality of the content of the police multi-agency information sharing forms.**

The Chief Constable of Gwent Police has written to the Chair of South East Wales Safeguarding Children Board to explain what has occurred historically so that this can be disseminated to partner agencies and inter-agency consideration given to how practically the issue of incomplete historical information can be addressed. **The Overview Report recommends that South East Wales Safeguarding Children Board should consider how to address the issues and partner agencies should report on the actions that they have taken.**

The Police Report gives details of the recent developments in data systems intended to improve information collection and accessibility. Action taken by Gwent Police in June 2011 ensures that information held on other police forces data systems will be fully accessed and locally generated information available.

The systems are complicated and arrangements were made for the Overview Report Author and members of the Serious Case Review Panel to receive practical demonstrations of the operation of the data systems. **The Overview Report recommends that a demonstration should be provided for South East Wales**

Safeguarding Children Board and, so that there is no uncertainty, that the Chief Constable of Gwent Police Force should report on the current position with regard to accessing information held locally and by other forces.

It was surprising that, so long after the publication of the Report of the Bichard Inquiry, the problems with police forces accessing information held by other forces appeared not to have been wholly resolved, despite commitment by Government. **The Overview Report recommends that the Home Office should review whether the recommendations of the Report of the Bichard Inquiry have been implemented across all police forces in the United Kingdom.**

The Independent Police Complaints Commission Investigation upheld the family's complaint about the handling of the incident of criminal damage and theft by Mills on 27 August 2012 three weeks before the fire. If interagency processes had previously been followed and a child protection conference held at any stage this would have led to the involvement of safeguarding expertise in the police management of the case. The criminal damage allegation would have been considered within the context of all that was known about Mills in Bolton and Cwmbran and should have generated a more proactive response by all agencies. Instead within the police the case was handled by a Probationary Police Constable supervised by a Sergeant who had been acting up in post for a week in circumstances in which there was no framework of child protection processes.

Within Gwent Police Force there has previously been a lack of clarity in training, instruction or internal procedures, about when an officer should consider referring to specialist departments. Probationary Police Constables only receive one classroom input on Domestic Abuse Stalking and Harassment assessments, one on protection of children and vulnerable adults plus an additional input once they are out on their Local Policing Unit.

Chief Officers of Police must make arrangements for ensuring that all police functions are discharged having regard to the need to safeguard and promote the welfare of children (s28 Children act 2004). **The Overview Report recommends that the Chief Constable of Gwent Police Force should review the training arrangements within the Force in relation to safeguarding of children with particular reference to Probationary Training and the circumstances in which consultation with the Public Protection Unit should take place by other serving officers.**

Gwent Police Authority
Gwent Police and Crime Commissioner
Her Majesty's Inspectorate of Constabulary

Gwent Police Authority ceased to exist in November 2012. The Authority had a statutory duty to ensure that it discharged its functions having regard to the need to safeguard and promote the welfare of children (s 28 Children Act 2004).

It does not appear that the Authority inquired into or reviewed the extent that the arrangements in Gwent Police Force met the expectations in the recommendations

of the Bichard Report or satisfied itself about the adequacy of the arrangements for sharing police information with partner agencies.

The Police and Crime Commissioner for Gwent was elected in November 2012 and had no responsibility for arrangements during the period of the scope of this Review.

The Police and Crime Commissioner holds the police force to account and has a statutory duty to make arrangements to ensure that all his functions are discharged having regard to the need to safeguard and promote the welfare of children (s 28 Children Act 2004). **The Overview Report recommends that the Police and Crime Commissioner should report to South East Wales Safeguarding Children Board on the approach that he will take to carrying out statutory duties under the Children Act 2004.**

The Review has not considered the approach of Her Majesty's Inspectorate of Constabulary (HMIC) when inspecting Gwent Police Force and the extent to which inspections considered the carrying out of the statutory duty under section 28 Children Act 2004 to ensure that its functions are discharged having regard to the need to safeguard and promote the welfare of children, or the extent to which the recommendations of the Bichard Report were implemented in Gwent or the extent to which the arrangements for sharing antecedent information with partner agencies were satisfactory.

It is, however, reasonable to assume that no inspection considered these issues.

HMIC is currently carrying out a rolling programme of child protection inspections of all police forces in England and Wales. The Children Act duty, however, applies to all policing functions and is therefore relevant to the inspection of any function. **The Overview Report recommends that Her Majesty's Inspectorate of Constabulary should clarify how during inspections of police forces account is taken of the statutory duty of Chief Officers of Police under the Children Act 2004 to make arrangements to ensure that in the discharge of their functions they have regard to the need to safeguard and promote the welfare of children.**

Domestic Abuse

Issues arising from this case concerning Domestic Abuse have been thoroughly considered through the Domestic Homicide Review process. The Review highlighted issues relevant to safeguarding, recognising that Chelsey at the time of her death was a child and that significant risks to Mary arose from the threats to and abuse by Mills of Sharon and her daughter.

If a child protection conference had been held, it would have been more likely that professionals would have recognised the circumstances of Mills' behaviour as domestic abuse that required a response.

The Overview Report supports the recommendation in the Domestic Homicide Report that flagging of perpetrators on the Police National Computer and the Police National Database should be extended to include those who use fire as a weapon in a domestic context and fire setting should be included in assessments.

There had been considerable training and emphasis on domestic abuse within agencies but the conduct of Mills was not effectively addressed as domestic abuse by staff within health, social services or the police.

Action has been taken to address this within social services and a rolling programme of training is now in place which addresses the use of the assessment tool for domestic abuse.

Torfaen Children and Family Services has appointed a Domestic Abuse Co-ordinator who is located within the Safeguarding Unit and has been a member of the Domestic Homicide Review Panel considering the circumstances of this case. She carries out an extensive programme of training within the department and attendance is entered into the training records of staff.

The police investigation of the incident on 27 August 2012 led to a referral to housing staff who responded to the immediate domestic abuse issue and the locks were quickly changed but thereafter the staff failed to follow interagency domestic abuse procedures and assessment processes.

Action has been taken by the Housing Association to ensure that all reports of Domestic Abuse are passed to the officer who is responsible for interagency arrangements. Training developed in partnership with Torfaen County Borough Council Domestic Abuse Coordinator and awareness raising for identifying and risk assessing Domestic Abuse has taken place with all Community Housing Officers and Association's Community Safety Team and frontline staff. The role in identifying and supporting victims of domestic abuse has been strengthened and recognised by the Minister of Housing and Regeneration.

Security measures are offered to tenants and links with the Police, Women's Aid and other agencies have been strengthened. A support officer within the Community Safety team to ensure tenants who are victims of domestic abuse are supported has been appointed.

The Overview Report recommends that Bron Afon Community Housing should carry out an audit to ascertain the impact of domestic abuse training and administrative changes and report any conclusions to South East Wales Safeguarding Children Board.

If Domestic Abuse Stalking and Harassment assessment procedures had been followed by the police it would have prompted questions about the need to involve the specialist officers within the Public Protection Unit.

Gwent Police Force has taken a lead on Domestic Abuse in Wales but in 2012 an inspection by HMIC identified that the Force did not have a specific domestic abuse policy or procedural guidance.

Action has been taken since that Report. An action plan was developed that has clear timelines for resolution and practices and procedures have been improved since the formation of the Domestic Abuse Investigation Unit in November 2012.

Identification and response to domestic abuse referrals includes the introduction of the Domestic Abuse Conference Call which ensures that all domestic abuse incidents in a local policing area are discussed. Police and partner agencies view and share information. A Daily Management Meeting is held at Police Headquarters and the conference call facility allows staff from all areas and work streams to participate.

The Domestic Abuse Conference Call process has recently been reviewed and a new Protocol drafted which will be considered by the South East Wales Safeguarding Children Board.

The difficulty in ensuring that carefully developed training is delivered to appropriate staff within agencies, that arrangements take account of improving knowledge and changes in staffing structures and personnel and have the intended impact on and raise the quality of practice, is a persistent theme of Serious Case Reviews. **The Overview Report recommends that all agencies should report to South East Wales Safeguarding Children Board on their arrangements for identifying and ensuring relevant staff and independent contractors receive training necessary to ensure good practice in relation to safeguarding children and the arrangements in place for providing effective monitoring and oversight of practice.**

The circumstances leading to this Review illustrate the need to consider the arrangements within schools to address these issues with pupils. **The Overview Report recommends that the arrangements within schools to assist young people to develop awareness and resilience against domestic abuse and sexual exploitation should be considered and a report made to South East Wales Safeguarding Children Board.**

Parallel Processes

Arrangements were made for the Serious Case Review and Domestic Homicide Review to link and share relevant information, to avoid duplication and to ensure that the impact on the family was minimised. Despite these efforts, ensuring good liaison and areas of common interest were addressed jointly was difficult and the family was confused about the different processes. **The Overview Report recommends that only in exceptional circumstances should a Child Practice Review and Domestic Homicide Review that consider events within the same family be carried out as separate processes.**

The carrying out of the Independent Police Complaints Commission Investigation also had a significant impact on the ability to carry out the Serious Case Review effectively and significantly delayed the process because police officers under investigation were not available to be interviewed.

It is Important that lessons concerning arrangements for safeguarding children are learnt as quickly as possible and action taken to implement recommendations.

The arrangements for carrying out Child Practice Reviews effective from January 2013 require that a Learning Event should be arranged involving frontline practitioners. The effectiveness of these arrangements will be significantly undermined if some professionals do not attend. **The Overview Report recommends that the Welsh Government should consider the likely impact on carrying out effective Child Practice Reviews when Independent Police Complaints Commission Investigations are carried out simultaneously.**

Mental Health Services

The Review received information from Mills' mother that a court had ordered that Mills should see a psychiatrist but he only attended once. Health records in Bolton also indicated that an appointment with adult psychiatry had been arranged but not taken up.

Attempts to verify this to consider any issues that arise for courts and professional services were not successful.

The issue is sufficiently serious for further inquiries to take place and **the Overview Report recommends that the Chair of South East Wales Safeguarding Children Board should write to the Chair of Bolton Safeguarding Children Board and request that further local inquiries be made concerning the involvement of Mills with mental health services and consider any the implications for interagency working.**

Practitioners and Managers involved with the Case Disseminating Lessons.

Arrangements for the lessons from this Serious Case Review to be shared with staff involved in the case and wider staff groups have been made in social services.

Within the Health Board meetings have been held with the staff involved and wider learning will be shared throughout Aneurin Bevan University Health Board.

South East Wales Safeguarding Children Board has established arrangements to analyse and interpret thematic learning and dissemination of findings and effective learning from the Review process.

The Education Service and social services have carried out a safeguarding review at the school attended by Chelsey and reported findings to the Governors. Consideration is being given to how to raise the awareness of the issues arising from this Serious Case Review in all schools in Torfaen. **The Overview Report recommends that the Education Service should report to South East Wales Safeguarding Children Board on the arrangements in place for reviewing the issues that have arisen from this Serious Case Review in schools throughout Torfaen.**

The Child Practice Review process requires that a Learning Event is held, bringing practitioners together to consider the issues arising from the case. This might be a useful process to carry out to maximise learning from this tragic case. **The Overview Report recommends that South East Wales Safeguarding Children Board should consider arranging a Learning Event to be attended by practitioners involved in the case considered by this Review.**

Supervision and Senior Managers

There is no evidence that the circumstances of this case were drawn to the attention of senior staff in any agency.

A purpose of supervision is to provide challenge and testing of the work being undertaken, ensure that legal, procedural and practice obligations are being met and to identify weaknesses in approach. There is no evidence that supervision in this case met these objectives.

Aneurin Bevan University Health Board has strengthened the safeguarding advice and support to the area service involved. Safeguarding lead nurses now attend all discharge planning meetings for children and families who are open cases to the local authority children's services.

If the case had received a greater degree of supervision and ownership in the police it may have led to greater coordination of service. Statutory guidance includes within the strategic issues for chief officers of police a duty to ensure the effective supervision of all aspects of policing child abuse. **The Overview Report recommends that the Chief Constable of Gwent Police Force should report to South East Wales Safeguarding Children on the arrangements for supervision of policing child abuse within the Force.**

Torfaen Children and Family Services staff undertake and receive supervision in accordance with the department's Supervision Policy. In response to the circumstances of this Review, the Head of Torfaen Children and Family Services has made arrangements for the supervision of staff record template to be reviewed. Specific issues concerning legal, procedural and practice obligations are to be considered by the Divisional Management Group for inclusion in a template and incorporated into the Quality Assurance Framework.

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