When children fall through the cracks

A more robust system for sharing information is essential to ensure that chances to protect vulnerable children are not missed, says Lucy Logan Green

IN BRIEF

- The recent case of Kaylea Titford proves the need for social services professionals to communicate effectively in order to protect children's wellbeing.
- Without strong and effective information-sharing between different professionals, children will continue to be let down by the system that is there to protect them.
- A more robust system is needed to ensure cases like Kaylea's do not happen again.

Recent cases which have hit news headlines have highlighted the potentially fatal effects of a lack of social services intervention with families in need. In particular, the case of Kaylea Titford from Newtown, Powys, has emphasised the need for professionals to communicate effectively with one another in the best interests of the children they are there to protect.

Considering just briefly what we know about Kaylea's case: she died about two weeks after her 16th birthday in the most squalid of conditions. She was morbidly obese at the time of her death, her legs were covered in sores, and reports from the police indicated there were maggots attached to her body. Her mother and father are in prison, convicted of gross negligence manslaughter. What or whom could have prevented this tragedy?

Missed opportunities

Information which emerged during Kaylea's father's criminal trial indicates that Kaylea was discharged from the local authority's 'children with disabilities' team back in 2017. Kaylea was born with spina bifida and had not had the use of her legs since birth. Previously, Kaylea had been discharged from a dietetics team due to her mother not arranging an appointment. Missed appointments leading to discharge from NHS services is, unhappily, a common occurrence, and one which we see all too often in public law cases. The significant pressure on all public services means that less leeway is given to those who miss appointments. The sad fact here is that it was only through third-party services observing the deterioration in her health that Kaylea's worsening condition could have been flagged up and addressed.

News reports have indicated that Kaylea's mother had spoken to her school on numerous occasions during the initial 2020 lockdown, revealing that she was struggling to care for Kaylea. One school call log is noted as saying 'mum struggling to support Kaylea at home while juggling work as a carer'. What could and/or should have been done at this point?

The most obvious route to be taken when Kaylea's mother was indicating that she was struggling to support Kaylea at home was a referral by the school to children's services. Once children's services receive a referral, they will decide what type of response is required, including whether, inter alia:

a. immediate protection is required;
b. there are reasonable grounds to suspect that the child is suffering, or is likely to suffer, significant harm; and
c. any further specialist assessments are needed to help children's services to determine what further action should be taken.

As to each of the above factors, which have been identified simply as examples of what children's services may do (among a long list of actions), (a) and (b) constitute the most immediate and emergent forms of protection. Each would involve applications to the Family Court under the Children Act 1989 (ChA 1989). In the case of (a), had, for example, children's services immediately visited the home upon a referral being made, they could have sought an emergency protection order under s 44, ChA 1989.

An emergency protection order grants a local authority parental responsibility for the subject child, allowing the local authority to make decisions about where the children should immediately be placed. This could be in foster care, in hospital (if required) or in alternative accommodation. Orders such as this and any other care orders can be made for any children who have not yet reached the age of 17.

As to alternative options: had children's services visited and concluded that immediate protection was not required, it could have carried out a multi-agency assessment pursuant to s 17, ChA 1989. This section provides as follows:

'(1) It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part)—
(a) to safeguard and promote the welfare of children within their area who are in need; and
(b) so far as is consistent with that duty, to promote the upbringing of such children by their families,

By providing a range and level of services appropriate to those children's needs.'

Failure of information

Unquestionably this was a family which was failing to care for a child with additional needs during a very difficult and trying time for the whole country. Had the school reached out to social services, there would have been interventions available which could have assisted the family. Kaylea's father's defence barrister intimated during his trial that Kaylea had been 'let down' by health and social services. A child practice review has now commenced to consider whether there were missed opportunities to talk directly to Kaylea in this case. No doubt there were. But in circumstances where the school had not seemingly made a referral to the local authority and where social services had no contact with the family themselves, it is sadly not surprising that Kaylea slipped under the radar for intervention. Without strong and effective information-sharing between different professionals, children will continue to be let down by the system that is there to protect them.

The Children's Commissioner for Wales stated following the review into the tragic case of Logan Mwangi: 'It's not clear how regional safeguarding boards are held to account on implementing recommendations in child practice reviews, and it's not clear how the learning from each child practice review is used nationally to make children safer. Repeated reviews highlighting information sharing as a failure is testament to this. I'm calling on the Welsh Government to review how Wales' existing child protection governance and accountability systems could be strengthened to make sure that the learning from each child practice review is implemented effectively, both locally and nationally.'

With Kaylea Titford's child practice review forthcoming, no doubt the same issue of failure in information-sharing will again be raised. The question is whether the authorities will finally take it upon themselves to implement a more robust system for sharing information which will not allow cases such as this to continue to hit the headlines in the future. NLJ

Lucy Logan Green, barrister at 4PB (*www.4pb.com*).