**Introduction to the Press Conference - Paul Mee, Chair of the Cwm Taf Morgannwg Safeguarding Board**

Good afternoon.

I’m Paul Mee, the Chair of the Cwm Taf Morgannwg Regional Safeguarding Board, and the statutory director for Social Services in Rhondda Cynon Taf County Borough Council.

I am joined by…

• Jan Pickles, Chair of the Child Practice Review in relation to Logan Mwangi

• Claire Marchant, Director of Social Services at Bridgend County Borough Council

• Dom Hurford, Medical Director at Cwm Taf Morgannwg University Health Board

• Superintendent Marc Attwell of South Wales Police

The Safeguarding Board is the multi-agency partnership that has the responsibility for safeguarding people of all ages living in Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.

The Board has the statutory responsibility to carry out Child Practice Reviews in cases when abuse or neglect of a child is known or suspected and the child has either:

• died;

• sustained a potentially life-threatening injury; or

• sustained serious and permanent impairment of health or development.

Today, the Board has published the Child Practice Review in relation to Logan Mwangi.

This Press Conference has been arranged to share with you the findings of the review, which has been led by an Independent Chair, Jan Pickles, and to respond to any questions that you may have.

Our services work with many vulnerable children and adults and our staff work tirelessly to care and support people and do everything they can to protect the most vulnerable from harm.

In most cases, the systems and services designed to safeguard vulnerable people work.

When a tragedy like this happens, it is essential that we fully understand whether there are any further measures we need to take to improve or strengthen our safeguarding arrangements.

Logan is sadly no longer with us due to the horrendous actions of the individuals responsible for his unnecessary and untimely death. The very people who should have cared for him, his mother Angharad Williamson and her partner, John Cole, are now serving lengthy prison sentences for their appalling crime.

However, it is vitally important that we fully understand the circumstances that preceded Logan’s murder and the role of our services so we can ensure our safeguarding arrangements are as effective as possible.

The Board and the agencies that were involved with Logan Mwangi and his family during his short life, have accepted in full the findings of the Child Practice Review that has been published today.

This review, amongst a number of other findings, identifies service failures where agencies could and should have acted differently. For these failures, we take full responsibility and apologise.

We have engaged with Logan’s father, Ben Mwangi, throughout the process and have offered him an apology on behalf of the key agencies involved, for the things that we recognise that should have been done differently by the agencies involved in the care of his son.

What we must and will do as a Safeguarding Board, is fully implement the recommendations made in this review and in doing so improve our safeguarding practice to prevent this from happening again.

I will now hand over to Jan Pickles, the independent chair of the multi-agency panel that undertook the Child Practice Review, who will present the findings and recommendations of the report.

 **Statement from Jan Pickles, Independent Chair**

1.As Chair of this Child Practice Review, I will today present our findings into the circumstances that led to the murder of Logan Mwangi.

2.The purpose of a Review is to identify learning to improve and support future safeguarding practice. To this end, the Child Practice Review Panel was made up of senior representatives of all of the agencies involved with Logan. The role of the Panel was to look at what happened and how services responded to those events, Panel members have scrutinised in detail multiagency information. The review held two learning events one with the frontline workers involved directly with Logan’s case and a second with their managers

3. Logan’s primary school teacher remembered him as a child with a ready smile who was “inquisitive, enjoyed lessons, especially when these were outdoors, where he could have fun with his school friends. Logan loved games like ‘hide and seek’ or playing at being super-heroes, he always wanted to be Spiderman.

4. The lead reviewer and I met Logan’s father Ben, Logan’s paternal grandmother and Logan’s Aunt and Uncle to hear from them, what their questions were of the agencies and also to feedback our findings and recommendations. They have through this whole time responded with immense dignity despite the overwhelming sense of loss, grief, and incomprehension they have over Logan’s murder. On behalf of the Panel, I want to thank them for the steadfast help they were ready to give us, despite the obvious pain and suffering they were having to endure in doing so.

5.In the course of this investigation, the lead reviewer and I interviewed Logan's mother in prison and his maternal grandmother. We spoke also with Child Y’s mother as she had lived briefly with Logan.

6.Logan was murdered on 31st July 2021. In June 2022 Angharad Williamson, Logan’s mother and her partner John Cole and Child Y who had been raised by John Cole, were sentenced for the horrific murder of this little boy. Both of these adults were found to have repeatedly lied to services, they used every opportunity to actively hide their abuse and their murder of Logan.

I will now turn to the findings of the Panel.

7.The Panel has identified areas of learning that are addressed in our recommendations. However, this afternoon I will focus on the four key themes of the review.

8. The first of these themes was the significant and immediate impact of Covid 19 restrictions on general working practices.

9. The impact of Covid 19 affected all organisations’ ability to deliver and maintain services and respond to need. In terms of this case, the following areas were significantly affected by the pandemic:

10. Covid- 19 and the need to restrict contact to prevent the spread of infection was believed to have been used instrumentally by the family to evade scrutiny from agencies. The Covid restrictions meant that behaviour that would normally have led to a response, such as children missing school, a delay in seeking medical assistance following injury-were seen as a consequence of Covid.

11.The Pandemic also resulted in significant changes to how duties were carried out due to the need to protect staff and the public from infection in line with Government guidelines. Remote contact by phone or other digital platforms were used in place of face-to-face meetings to an extent never seen before, and in many circumstances for a time became the norm. This undoubtably had an impact on the robustness of assessments. These limitations were mirrored within the broader structure of the child protection environment, for example, Child Protection Conferences, Core Groups and GP visits most of which were carried out remotely.

11 The second theme identified by the Panel related to Systems and Processes

12.Logan was first taken to Hospital in mid-August 2020 following him reportedly ‘falling down the stairs’. Hospital staff notified Children’s Services Emergency Duty Team they had concerns in respect of delayed presentation. Upon further examination, further injuries were noted. The explanation provided by his mother was apparently accepted. The further injuries observed were not shared or referred to Children’s Services. This was a significant missed opportunity for Logan. Had further information from Health been shared it most likely, though we cannot say for sure, in hindsight would have triggered a child protection assessment in line with joint agreed guidelines as the nature of those injuries clearly met the threshold.

13.This tragedy has shown that the Multi-Agency Safeguarding Hub was not able at that time to deliver information sharing, case discussion and decision making within the relevant agencies as well as it was intended to do. This critically affected the ability of agencies involved to respond to this case, as no agency was ever able to develop a full picture of what was happening. Despite all agencies having important pieces of information.

14.We learnt from the trial that family were well known within the local community and many neighbours had concerns for the children within that family. It is important that the general public have the confidence to report such concerns and a clear route to do so.

15.The third theme identified by the Panel relates to Multi-Agency Practice and Practice Knowledge.

16.During the time period of this review, other than his limited time in school Logan was not seen on his own outside of the family environment, due to covid.

17.Children’s Services made a decision not to notify Logan’s father of their involvement with Logan, despite there being a statutory duty for them to do so.

18.This family was complex and known to be volatile, with a number of agencies involved. The Panel believe that this case has shown an inconsistent approach to the quality assurance of case work and assessments within Children’s Services. There were inconsistencies within the risk assessments undertaken. There was a variable quality of analysis, and challenge evident within the assessments viewed by the Panel. Multiagency Care and Support plans appear to have been stepped down and oversight correspondingly reduced with no change in circumstances evident to the Panel that would have justified it.

19. John Cole it seems was able to effectively manipulate those around him, as did Logan’s mother.

20. The Panel found no evidence that Logan was treated differently by professionals due to his race. However, the fact that Logan was of a different race and ethnicity within his family and wider community and what that might mean for Logan was not considered by professionals. The allegations that surfaced in the trial that John Cole was part of a far-right organisation were not known to services at that time.

21.Finally, the last theme the Panel identified was Leadership and Culture

22.This case has highlighted a lack of opportunities for professionals to reflect upon cases. Multi agency forums for example Case Conference Meetings, Strategy Meetings and Discussions are task focussed and highly structured. The Panel believe that multiagency supervision would have supported case management. Logan’s case has highlighted the critical importance of Discharge Planning Meetings being undertaken for children, where safeguarding concerns have been identified and a child attended hospital.

23.Despite the Multi Agency Safeguarding Hub colocation, staff maintained their agency identity and culture and the Panel found this created a ‘silo’ mentality.

24. Within the University Health Board concerned, the Panel believes to have seen evidence of a culture in which staff are reluctant to challenge the clinical assessments and decisions made by more qualified professionals. The Panel has found that some staff were not happy with the way Logan’s attendance at the Accident and Emergency Unit in August 2020 was managed but did not feel able to express their concerns, either to the clinician or another party.

25.It was clear to the Panel that all agencies working with the family in this case were doing so under severe multi-facetted pressures during Covid.

26.There were some examples of positive practice identified by the Panel, it is important this is built upon.

27. Within the context of this Review there are recurring areas of learning that have been identified in reviews throughout Wales and England, which has led this Review to make both Local and National recommendations. These are in summary.

1.That Cwm Taf Morgannwg University Health Board should commission an Independent Review into its practice and management of identifying and investigating non-accidental injuries in children and adolescents.

2.The Cwm Taf Morgannwg University Health Board should ensure that practitioners who work directly with children and young people understand their roles in identifying safeguarding concerns and of their duty to report.

3.The Cwm Taf Morgannwg Safeguarding Board should review and relaunch their existing multi-agency training.

4.The Cwm Taf Morgannwg Safeguarding Board should develop guidance for practitioners working to support individuals with Personality Disorders.

5.The Local Authority ensure that all employees receive high quality supervision, guidance, and oversight of their practice.

6.The Local Authority improves its approach to analysing and managing risk.

7.The Local Authority needs to ensure that all safeguarding staff are clear on the rights of all persons with parental responsibility for a child to be informed of a safeguarding concern.

8.Cwm Taf Morgannwg Safeguarding Board should review their information sharing platforms with a particular focus on the Multi Agency Safeguarding Hub information sharing platforms.

9.Cwm Taf Morgannwg Safeguarding Board should consider the recommendations of the COVID-19 Public Inquiry and ensure that it informs future contingency planning

10.Cwm Taf Morgannwg Safeguarding Board should develop a regional campaign to raise public awareness on how to report safeguarding concerns, with an immediate focus on how to report and a public awareness campaign targeting the signs of coercive and controlling behaviour.

The 5 National Recommendations are

1.The Wales Safeguarding Procedures Project Board to include specific guidance to child protection practitioners about their duty to inform all parents with parental responsibility of child protection assessments and processes.

2.That the Welsh Government considers commissioning an all-Wales review of Child Protection Conferences.

3.That the Welsh Government considers commissioning a campaign to raise public awareness on how to report their safeguarding concerns.

4. That the Welsh Government considers a full review of Health, Social Care, Education and Police recording, information gathering and sharing systems.

5.That the President of The Family Court Division considers the setting of a twelve-week minimum period for any Social Work assessment within Public Law Proceedings as a standard.

**Statement by Claire Marchant, Director of Social Services and Wellbeing**

**for Bridgend County Borough Council**

The murder of five-year-old Logan Mwangi remains a distressing and terrible tragedy - first and foremost for those who knew and loved him best, but also for his school friends and teachers, the people of Sarn, and the wider community of Bridgend County Borough.

The fact that we were unable to protect Logan will always remain a source of great sadness, and we are deeply sorry that our safeguarding and child protection endeavours did not prevent his death.

The review has identified that there were opportunities to share information and better analyse and act on the risks to Logan.

Mr Mwangi, Logan’s dad, was not told his son was on the child protection register. As a council, we apologise unreservedly to Mr Mwangi that this was the case.

At Bridgend County Borough Council, Logan’s death continues to affect us all deeply.

For those of us who have dedicated our lives and careers towards the safeguarding and protection of children, Logan’s murder was the exact opposite of everything that we and our partners strive to prevent.

The impact of his passing will remain with us always. It will be a driving force - a determination -to strive to improve our practice for the benefit of vulnerable children and adults alike.

In this, we fully accept and are grateful for the work of the Independent Child Practice Review panel.

While their report makes for tough reading, it highlights opportunities where practice can be developed, strengthened and enhanced.

We are already taking action to deliver this, overseen by an Improvement Board. We are working to improve our practice, and how practice is both overseen and quality assured.

This will remain our highest priority as a council.

However, we cannot do this alone.

Working alongside our partners, we will improve the effectiveness of safeguarding arrangements.

We will improve the ways in which we work with children and families, and the ways in which agencies work together to share and act on information to safeguard and protect.

We are similarly determined to work with our local communities and partners to regain their trust and confidence, and to ensure that people know how to report any safeguarding concerns that they may have.

Throughout all of this, our thoughts remain with Logan, and all who knew, loved or cared for him.

Those convicted of his murder were brought to justice and faced the consequences of their crimes.

Evidence revealed their efforts to misdirect the authorities, and to misinform the services that were trying to help and support them.

We owe it to Logan and his loved ones now to commit towards implementing the review’s findings in full, and to provide the most effective safeguarding and child protection arrangements possible, for all of the people that we serve.

Thank you.

**Cwm Taf Morgannwg University Health Board – Dom Hurford, Medical Director**

The death of any child is deeply tragic, and for Logan to have lost his life at the hands of those closest to him is something that will forever affect his family, friends and his community.

Firstly, we apologise to Logan’s father. We apologise to his family, and all of those who knew him, and love him. We apologise for the failures in our systems that could have presented earlier opportunities to recognise abuse and to protect Logan.

We fully accept the recommendations and actions in the review. A number of actions are already in progress to improve safeguarding practice within our Health Board, and with our partners.

These include:

 Improvements in safeguarding training compliance and monitoring for all health professionals working with children, young people and their families;

 increasing the provision of safeguarding supervision, improving documentation standards and ensuring the reporting of child protection concerns; and

 strengthening a culture of professional curiosity, where colleagues are encouraged, empowered and required to report, challenge and escalate any concerns.

We welcome the commissioning of a multi-agency Independent Review by the Cwm Taf Morgannwg Safeguarding Board into the practice and management of identifying and investigating non-accidental injuries in children and adolescents. This will provide agencies with a focus on improving safeguarding services collaboratively to help prevent any other child experiencing harm and abuse.

Colleagues across our Health Board have also been deeply affected by Logan’s murder. We will never forget what happened to Logan and we will honour his memory through our commitment to improve our services, systems and processes, and to ensure the safety of our most vulnerable children.

**South Wales Police, Superintendent Marc Attwell**

 Firstly, our thoughts remain with Logan and everyone who knew and loved him.

His murder shocked and appalled the community, both here in Bridgend and more widely, and it is inconceivable that his young life was taken by those who should have protected him.

I am grateful to all the police officers who have been involved – from the initial attending officers who were faced with the most traumatic scenes imaginable, to the team of detectives who worked tirelessly on the investigation to bring those responsible for this terrible crime to justice.

In keeping with our determination to protect those who need us most, South Wales Police has co-operated fully with the review commissioned by the Regional Safeguarding Board and we welcome the opportunity for all agencies to build on the arrangements we have in place to protect children from harm. That remains our over-riding priority.

The review found that police responded to all requests for help, concerns from agencies involved and members of the public in a sensitive and timely manner.

We will continue to work with a range of professionals to ensure that informed decisions can be made about children and individuals at risk of abuse.

Communities have a key role to play too and must have confidence in being able to report any concerns they may have about a child, safe in the knowledge that the information provided will be dealt with.

We can only imagine the suffering Logan experienced prior to his death and we owe it to him to ensure that everything is done to protect children from harm.

**Closing Statement - Paul Mee, Chair of the Cwm Taf Morgannwg Safeguarding Board**

I am now going to bring this press conference to a close.

But before I do, I want to re-emphasise what this Child Practice Review is about.

Logan has been the central consideration in this entire process. This CPR is about how agencies work together in partnership, our systems and practice and identifying learning to inform and strengthen our future safeguarding practice.

It is not about apportioning blame or the individual staff in our agencies.

The people who are responsible for Logan’s murder have been brought to justice for their appalling crime.

We will now ensure that the recommendations contained in this report are acted upon to prevent this from happening to another child.

Board will not be making any further statements or responding to further requests for interviews. If you have any further enquiries these can be made directly to the Regional Safeguarding Board through our usual arrangements at ctmsafeguarding@rctcbc.gov.uk

Thank you for your questions.