Child Practice Review Report

Cardiff and Vale of Glamorgan Regional Safeguarding Children Board

Extended Child Practice Review

Re: C&VRSCB 02/2016

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

An Extended Child Practice Review was commissioned by Cardiff and Vale of Glamorgan Regional Safeguarding Children Board (CVRSCB) on the recommendation of the Child Practice Review Sub-group in accordance with Social Services and Well-Being Wales Act 2014 Part 7, Volume 2 Child Practice Reviews guidance. The criteria for this Review were met under section 3.12 of the above guidance namely:

A Board must undertake an extended 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 on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding

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

The terms of Reference for this review are at Appendix 1.

Incident Leading to Referral

March 2016 – The child who is subject of this review was aged three when discovered hanging at the home address by an older sibling. The child was unconscious and described as pale and lifeless having become trapped in a soft toy that was hanging off the top rail of a bunk bed. The child was at home with mother and siblings at the time of the incident. The child's sibling was asked to call an ambulance but the phone was not working. Mother went outside and a second call for an ambulance was made, but only the location was confirmed before Mother left the scene with the child and one of the child's siblings. A third call was then received five minutes later from an address belonging to the child's grandfather. This third call with more precise information enabled the paramedics to attend promptly and provide immediate medical attention before conveying the child to hospital. The child made a full recovery.

When police officers attended this incident there were significant concerns about the home conditions, namely little food, a multitude of dead flies in the kitchen, no toilet paper or tooth brushes and a make do kitchen prep area in one of the bedrooms. Police considered using Emergency Powers of Protection to safeguard the children. However, Children's Services had arranged for the children to stay with their grandmother for the night.

There were concerns historically around domestic abuse within the family home. File recordings show a social worker had visited the home address in mid-March 2016. The social worker's recording of this planned home visit describes difficulty entering the house due to *'a wardrobe being on its side in the passage area'*. Apart from the front room, the social worker did not access other rooms in the house during this visit.

Whilst professionals in attendance at the strategy meeting called in response to this incident expressed their concerns over the domestic violence, mother's lack of engagement with services and her showing *'…little willingness to make changes',* they agreed there was *'no evidence to suggest this* (the incident) *was anything other than accidental'.* The minutes to the strategy meeting conclude *'This near fatal incident cannot be attributed to mother directly although professionals feel it is symptomatic of her poor boundaries, lack of supervision and inability to meet her children's needs safely'.* Hence, it was agreed that the child had sustained a potentially life threatening injury and it was recommended that a referral be made with regard to a Child Practice Review.

Significant Events Prior to the Period Under Review

Cardiff Children's Services had been aware of this family since 2007 following police reports concerning a lack of appropriate supervision of the children. Upon investigation, the child's mother denied the allegations made – resulting in no further action by Children's Services. A further referral received in 2007 reported similar concerns around the children's supervision in addition to allegations around the mother's substance abuse. Children's Services carried out an initial assessment in response the second referral – the outcome of which was no further action and the case closed. In December 2012, Children's Services received a referral following a domestic incident between the child's parents. The initial assessment completed following this referral highlighted a number of

other worries in respect of the child's developmental needs, parenting capacity and environmental factors. Due to the number of concerns identified, the case progressed and in February 2013, the children became subject to child protection plans following registration on the Child Protection Register (CPR) under the categories of Emotional Abuse and Neglect.

To help the family establish routines in the home and offer advice on parenting, Children's Services provided a Family Support Worker (FISS) – who visited on a regular basis. A Tenant Support worker was in place to help with the family's housing issues, the mother was encouraged to seek support from her GP for her health needs and the father was signposted to services for support with substance misuse. As a means of safeguarding the children from the risks associated with substance misuse, the father's contact was managed and supported by family members. All parties signing a Written Agreement to that effect. During the time that the child protection plans were in place, home conditions fluctuated, parental engagement with support services was sporadic and Children's Services received 17 police reports all in relation to domestic abuse between the parents and other family members. The children were present during all of the domestic incidents. Around this time, Children's Services file notes show that the FISS worker was raising concerns with regards poor home conditions and the mother *'not being vigilant in her supervision'* of the children. Furthermore, a number of anonymous referrals from persons within the community were received highlighting concerns in relation to arguments at the home address, shouting and use of foul language by both parents towards the children. By March 2014, a Written Agreement was in place to safeguard the children from further altercations. Child protection planning continued and in April 2014, the Public Law Outline (PLO) commenced. By October 2014, the mother admitted breaching the Written Agreement and Children's Services file notes made at the time show the mother gave inconsistent stories regarding the contravention. Although file notes show the social worker discussed this breach with the mother during a child protection visit, the notes do not show the actions taken as a result.

In complying with his licence conditions for a previous offence (Possession of Class A drugs), by July 2014 professionals in attendance at the Review Child Protection Conference agreed the father could assist the mother with the children in the home *'for a 4 week period of observation'.* Probation supported this decision by agreeing to vary the father's licence conditions to allow him daily access to the family home. The PLO process ended in August 2014 due to the *'improvements'* (good school attendance, better home conditions and positive observations of mother's interactions with the children). The father continued to comply with his licence conditions until it ended in October 2014. The children's names remained on the CPR until the latter part of April 2015.

<u>Significant Events During the Period Under Review</u>

April 2015 – Abandoned 999 call to the police and tracked to the family's home address. Father was intoxicated and had sustained injuries during an earlier pub fight. The 999 call stemmed from an altercation involving the father and mother's sibling. The father was arrested for being 'drunk and disorderly' and later charged with this offence. The police shared the incident information with social services' Emergency Duty Team and both parties agreed that the mother had acted appropriately to safeguard the children. No further action taken.

April 2015 – Mother makes two 999 calls to the police during the course of the day reporting the father to be outside the family home and causing a disturbance. Mother alleges the father was subject to bail conditions that stipulate he is not to be near the location. Mother refuses to provide a statement and the police take no further action.

April 2015 – Multi-Agency Review Child Protection Conference (RCPC). Father attended, mother did not. Independent Reviewing Officer's (IRO) report states the parents had made positive changes. For example, the home conditions had improved to a *'satisfactory'* standard; there were *'huge improvements in school attendance…both parents have engaged with services and appointments and professionals have noted improvements in all areas'.* Unanimous decision to remove the children's names from the CPR with ongoing case management on a 'child in need' basis.

April 2015 – Children's Services Supervision recording. File notes show some discussion around the improvements made by parents over the previous 6 months, leading to child's name coming off the CPR. This decision reflected the improvements noted by agencies who had attended the RCPC. Guidance offered as follows: *'A short period of child in need monitoring is required to ensure the changes are continued, then professionals to take over the monitoring and case to be closed'.*

May 2015 - Initial Child in Need meeting. Attended by social worker, health visitor and teaching professionals. Parents did not attend. It is usual practice to arrange the date of the Initial child in need planning meeting at the RCPC. It is therefore assumed the child's father was aware of this meeting date given he attended the RCPC. There is no evidence on file to show how – or whether - the child's mother was informed of the date. Professionals in attendance at this 'attempted' meeting shared concerns regarding a decline in school attendance, the children's presentation and the emotional wellbeing of the older sibling. Social worker advises of need for further meeting given parents' non-attendance. File notes show meeting re-arranged for July 2015 so professionals in attendance presumably took note of the rearranged date. File notes do not show how or who informed the parents – although some dialogue must have been had with the mother as she did show up at the rearranged meeting.

During the intervening period further Public Protection Notifications (PPNs) were submitted by police following incidents of domestic abuse. In addition, agencies received further anonymous referrals reporting similar concerns in respect of substance misuse and anti-social behaviour.

May 2015 – Complaint from neighbour. Further report of Anti-Social Behaviour (ASB), arguments and substance misuse taking place at home address, shared by housing. Social worker advised caller to phone police and update them of a result of a home visit.

June 2015 – Domestic abuse incident reported by a member of the public to police. Children sighted as safe and well by police officers. A PPN was completed and mother assessed as 'Medium' risk in terms of further domestic violence incidents occurring. The form was shared with Cardiff Women's Centre (CWC), NHS and Intake & Assessment. The PPN was also tasked to South Wales Police Child Abuse Investigation Unit. An officer from the South Wales Police Child Abuse Investigation Unit (CAIU), contacted social

worker to make her aware. Upon receipt of the PPN – social worker has recorded –*"It is a concern that mother is in touch with father and this needs to be discussed with mother by the social worker."*

July 2015 – Mother made two calls to police reporting domestic incidents involving father attending her address and 'smashing it up'. It transpired that father was trying to retrieve property. PPN's completed and shared. Mother also contacted Children's Services stating that father's behaviour had become erratic over the previous weeks. Referred to police and Cardiff Women's Aid.

July 2015 - Rescheduled 'Initial' Child in Need meeting. Attended by social worker and a teaching professional. The child's mother arrived late (towards the end of the meeting) and stated that she has been having issues with the child's father and had been advised to contact Women's Aid/Women's Safety Unit. The child's father did not attend this meeting. File notes show meeting re-arranged for September 2015. As with the previous meeting, the teaching professional in attendance presumably knew of the rescheduled date but notes do not specify how the parents and other professionals were informed.

August 2015 – Children's Services supervision recording meeting - Mother does not want any support services but school are not happy for the case to be closed due to the children being tired and older sibling's behaviour in school being challenging. A child in need planning meeting has been arranged for early September and case to be closed if no significant concerns arranged. This was the second recorded formal supervision session in over 3 months (the first supervision having taken place in April 2015).

September 2015 – Further re-scheduled 'Initial' Child in Need meeting. Children's Services file notes from this date only state *'No one attended'.* As stated above, as there is no evidence on file to show how parents and professionals were invited, it is unclear as to whether people knew of this meeting. This was the 3rd 'failed' meeting in terms of full attendance and ongoing 'child in need' planning. Subsequent Children's Services file recordings in respect of a timely follow up to this failed meeting are lacking in detail. However, in a recorded 'child in need' visit undertaken in October 2015, mother is noted to have stated she did not *'turn up at the last meeting due to childcare'* and when offered a follow up meeting it is stated that the mother declined. There are no file recordings to show any communication with the child's father at this time.

December 2015 – Children's Services close the case. The closure report provides the following reasons behind the decision: *'Children's Services had not received an incident report since July 2015. During the 'child in need' period* (father) *has not been observed under the influence of drugs during visits to the family home'.* The children were described as *'happy and calmer than previously seen'* and *'well-presented and appropriately dressed'.* The Mother informed social worker she does not want support from social services. The mother declined further support and the report concludes *'There is no current role for the social worker and it is apparent that mother is able to meet the needs of the children without Children's Services involvement at this time'.* Whilst the remarks within the closure report regarding the children's emotional wellbeing and general presentation can be verified from the home visit recordings around the time, the timeline clearly shows the comment regarding 'no incident reports' being received is incorrect. In October 2015, Children's Services received a call from a neighbour reporting the child was playing unsupervised in her garden with a dog and raised concerns regarding a potential injury.

There was no follow up to this report. On consecutive days in December 2015, Children's Services received communication from the Anti-Social Behaviour team regarding multiple complaints from neighbours. There is no evidence on file to show the student social worker (allocated to work with the family at the time) brought this to the attention of her practice assessor and due to the lack of recording, it appears the information prompted no further action at this time. In December 2015, Children's Services received an anonymous call regarding the mother's sibling, reporting concerns over the individual's *'aggressive and volatile'* behaviour and alcohol misuse. The neighbour reported hearing doors slamming, *'shouting and screaming'* whilst the children were present. The unannounced 'child in need' visit recording from the same day shows these concerns and those of the Anti-Social Behavioural team were discussed with the mother. The mother denied the allegations against her sibling and told the student social worker she *'did not care'* about the reports of anti-social behaviour potentially leading to her eviction. Later that month, which was the day before the case closed, Children's Services received a further call regarding the mother's sibling alleging the individual a threat to kill him approximately 5-6 months ago. The caller stated he had not reported the matter to the police because he feared the mother's sibling.

January 2016 – A new report of domestic abuse received by police following a 999 call from mother. Father arrested by police but as the mother refused to provide a statement of complaint a prosecution could not proceed. As such, police released the father with no further action. The incident prompted further involvement from Children's Services and child protection enquiries commenced.

February 2016 – Initial Child Protection Case Conference (ICPCC) held in respect of all the children. Those in attendance unanimously agreed the children were at risk and their names subsequently placed on the CPR under the categories of Neglect and Emotional Abuse.

Practice and organisational learning

Identify each individual <u>learning point</u> arising in this case (including highlighting <u>effective practice)</u> accompanied by a brief outline of the <u>relevant circumstances</u>

<u>Practice and Organisational Learning</u>

As part of this Child Practice Review a Learning Event was held engaging practitioners involved with this child. The reviewers would like to thank all those who attended the learning event and their contribution to the learning from this review. Incidents where a child could have potentially died or come to significant harm can be distressing and we are grateful to all the practitioners for their attendance, candour and willingness to share viewpoints and learning. However, it was clear to the reviewers at the start of the learning event that certain staff members had not received appropriate preparation to attend and were anxious expecting it to be 'about blame'. This anxiety was further exacerbated by the fact that some attendees mistakenly believed that the child subject of this review had died. Some practitioners had not seen their timeline prior to attendance and it is worth noting

that those who had earlier access were able to bring additional information to the event and thereby enhance the learning experience.

The presence of a Local Authority legal representative would have potentially added additional value to the event and provided context to some of the threshold decision making in this particular case. Legal representation should be a consideration when planning future learning events.

Recommendation 1:

Panel members representing Agencies at Child Practice Reviews should consider requesting a timeline from its Legal team in cases where legal involvement formed part of the case management.

Much of the practice and organisational learning considered below was raised at the learning event.

The Voice of the Child

Previous reviews have emphasised *'…the importance of seeing, hearing and observing the child'.* (Ofsted, 2011:6) and highlighted the need for children to meet on their own with practitioners, away from parents and carers in an environment where they feel safe so that the children can speak about their concerns. In this case, during the first period of child protection planning between February 2013 and April 2015, the social worker demonstrated good practice and saw the child at home during planned and unannounced visits completed at various times of the day. However, although the child was seen during each visit, a parent was always present and there is no reference in social worker recordings of the child having been spoken to alone. As such, the child's 'voice' was difficult to find. It is acknowledged that throughout the period identified in the timeline the child was of a young age (2-3 years old) and known to have some speech and language delay - making it difficult for the child to express feelings in words. Yet, there is little evidence of practitioners using alternative approaches such as direct work using playful activities to obtain the child's views. Other reviews involving young children have stressed the importance of practitioners listening to what older children in the home had to say with findings concluding the failure to speak to all children in the home resulted in *'vital components'* being missed in assessments (Ofsted, 2011:7). Here, other than general conversations with the child's siblings around school, hobbies and favourite items of clothing it is unclear as to whether any of the children's worries, wishes and feelings were fully explored until January 2016. Attention to the reporting and recording of observations made by the social worker during home visits throughout 2015 is evident. For example, practitioner notes described the child's behaviour as *'boisterous'* and *'erratic'* with incidents of head-butting the sofa, hitting out at siblings, attempts to pull down curtains and playing dead on the floor being observed frequently. Practitioners need to recognise that children's behaviour can be a means of communication (Wilson *et al,* 2008) with research (Stanley, 2011) suggesting that a child's lively and unpredictable conduct could be indicative of exposure to domestic violence. Given the practitioner's observations of the child's rowdy behaviour, this arguably presents as a missed opportunity to have talked to the child about personal feelings.

Cardiff Council has since introduced the Signs of Safety model of working across Children's Services. One of the key aims of the Signs of Safety model is to ensure the voice of the child is clear, and the tools the approach adopts underpins this requirement.

Recommendation 2:

All agencies to consider training to ensure alternative approaches to capturing the child's voice forms part of any 'direct work with children' training and the concept forms part of the mentoring process for social workers in their first year of practice.

Recommendation 3:

Cardiff and Vale Regional Safeguarding Board via the Child Practice Review/Adult Practice Review (CPR/APR) Sub Group need to be satisfied that Social Workers are actively offering an advocate to children in receipt of Local Authority care and support.

Family involvement with the review process

The parents of the child were informed in writing of the decision to undertake this Child Practice Review. However, both parents claimed to have not received/seen the letters when contacted by the reviewers.

Recommendation 4:

CPR Panels to consider if letters or other more suitable forms of communication depending on their particular needs, advising families of the decision to conduct a Child Practice Review are delivered by the most appropriate person.

During the telephone call to the child's mother in September 2017, she explained that since receiving a mental health diagnosis, she opens no mail and possesses no mobile phone as she finds *'communication and messages stressful and upsetting'.* She was critical of Children's Services involvement reporting more could have been done to keep the child's father away from her, suggesting Children's Services representatives could have taken *'…the kids to school every day'.* That said, Children's Services file recordings made in July 2014 clearly show both parents (and professionals involved) agreeing with the plan of the father providing help with the children in the home.
The child's parents have now separated and are no longer in contact with each other. In an attempt to include their views in this review, both parents had the opportunity to meet independently with the reviewers on two occasions. Regrettably, despite the parents choosing the dates, times and venues of the meetings, each failed to attend and neither attempted to re-establish contact with the reviewers thereafter. It is unfortunate, that other than the mother's comments noted above, the family's views are missing from this report.

Debatably, the experience the reviewers had in their attempts to engage the parents in the review process mirrors that observed throughout the timeline with the concept of *'disguised compliance'* (Brandon *et al,* 2008:106) being noted by the panel and identified by practitioners at the Learning Event - the risk factors and learning of which is discussed later in this report.

Interagency Communication and Information Sharing

Research and findings from previous child practice reviews has well established that effective practice in safeguarding stems from efficient and effective information sharing between multi-agency partners (Munro, 2010). It is clear from the timeline that agencies involved in this family were receiving a great deal of intelligence regarding the family's activities and the review identified a number of instances that evidenced good practice of information sharing. For example, the incident of domestic violence between the child's parents during January 2016 prompted swift action from Children's Services upon receiving the report from the Police. However, the timeline also demonstrates instances where information sharing did not occur. For instance, the complaints received by Cardiff Housing during April, November and December 2015 from the family's neighbours over domestic violence, cannabis use, drug dealing, use of foul language in the street and shouting at the children was not shared with the Police. Likewise, there is no record of the social worker talking to the police in response to the reports of drug use. Further missed opportunities were highlighted at the learning event with practitioners drawing attention to times where information was passed to some partner agencies that either resulted in no action or a delayed response. For example, the information from the complaint received during April 2015 passed from the Anti-Social Behaviour team to Children's Services within 3 days. However, the extent of the telephone call appears limited to whether the case was 'open' or not and there is no record of Children's Services requesting or receiving a Multi-Agency Referral Form (MARF) in response to this information – perhaps highlighting a lack of understanding around the referral process. Equally, although the Anti-Social Behaviour team did pass on the information in the telephone call to Children's Services, this bypassed the established route for sharing information via its single point of contact – the Social Inclusion Unit (SIU). In response, the review has since learned that Cardiff Housing is currently assessing its process to ensure it is more robust and its staff are to receive refresher training.

Recommendation 5:

Practitioners at the learning event identified that the Housing teams are a particularly useful source of information with extensive case recordings highlighted as an example of good practice. Cardiff Local Authority senior management teams to develop effective mechanism for ensuring appropriate Housing representation (including Tenancy support workers) at multi-agency meetings to promote the sharing of information and the operation of the Multi-Agency Safeguarding Hub (MASH).

The learning event highlighted a further missed opportunity for agencies to intervene sooner when discussing the 999 call made by the child's mother to the Police in early July 2015. Here, Children's Services received the police report because the attending officer was concerned over the *'…state of the house and that children live there'.* This was the second reported incident to Children's Services in a week and the receiving team manager subsequently identified the need to assess the status of the parents' relationship and the home conditions. The review identified that clearer case management advice giving specific timescales and instructions regarding intervention, may have prevented more incidents occurring and triggered further child protection enquiries and the need for legal advice – particularly given the children were no longer subject to child protection plans as their names had been removed from the CPR 10 weeks previous.

As part of the Signs of Safety model of working, the project 'Steering Group' is producing a new online referral form that will include an additional question relating to whether agencies have made previous referrals – thus providing an additional prompt to the individual responsible for determining subsequent actions from the referral.

Feedback from the learning event further identified the inconsistent approach to requesting and use of police welfare checks. The term 'welfare check' has become widely established across many agencies and used when an external agency requests that police visit someone who is believed to be vulnerable, or at risk for a wide variety of reasons. The learning event heard that in the majority of cases the responsibility for these checks, or the management of the specific risk or vulnerability, should not fall to police. A typical 'welfare check' occurs where police officers are requested to attend an address and speak to a named occupier to check they are alive and well, that is, to determine the 'existence of life' and report back to the requesting agency. This type of request is entirely appropriate and in line with core policing duty and skills. However, a wide range of other requests are now being made of police including:

- Checks on individuals who have failed to attend routine medical appointments.
- Checks on individuals who are not reported or classed as 'missing' but apparently absent from a place they should be or are expected to be.
- Checks to establish if an individual has taken their medication.

Police are unlikely to have a role in the above scenarios – unless the requesting agency is able to explain and evidence an immediate risk to life. Practitioners at the learning event also highlighted that the mere presence of police can have a negative impact for those who are living with mental health issues or recovering from crisis – particularly when there is no reason for police involvement.

Practitioners from Housing and Independent Domestic Violence Advocacy (IDVA) services highlighted the positive support their departments had received from police when requests for welfare checks had been made and where good evidence of immediate risk that something serious was about to or already occurred had been presented. The procedures were less clear regarding 'non-emergency' welfare checks with practitioners from Children's Services voicing problems in having such requests accepted by the police – a matter that typically causes tension amongst agencies. Arguably, the friction is exacerbated given the Emergency Duty Team do not undertake such checks due to its resources and the team's remit in covering Cardiff and the Vale for matters regarding children and adults.

Recommendation 6:

Cardiff & Vale Regional Safeguarding Board's Policies, Procedures & Protocols Sub Group to develop a local policy relating to welfare checks and produce guidance around requesting such checks for partner agencies to follow.

The panel meetings and learning event held in respect of this review highlighted the need to ensure that when managing a case on a multi-agency basis there needs to be an opportunity to share information, discuss it, reflect, challenge and agree actions together. This generated much discussion around partner agency attendance at Children's Services meetings. The reviewers recognise that there is no statutory requirement for police to

attend all meetings – RCPCs providing an example. Yet, given the amount of police involvement during the 26-month period of registration, consideration should had been given to police attending the RCPC in respect of this family in April 2015 - particularly as the child's father had allegedly breached his bail conditions around the same time by attending the family home in an intoxicated state. The RCPC report produced by the Independent Reviewing Officer (IRO) at the time shows some discussion of the incident took place with those in attendance. Unlike the child's mother, the father attended the RCPC yet his response when asked about the incident was *'I had gone to the football with friends and been drinking. At home-time, I automatically went to the house but* (the mother) *said I had no chance of being allowed in if I'd been drinking. I didn't go there to cause trouble and police just moved me on'* appears to have gone unchallenged. Furthermore, there is no indication of attendees at the RCPC having full knowledge of the father's bail conditions. Hence, the view of practitioners at the learning event was the police would have been in a position to contribute substantially to the RCPC and the decision to remove the children's names from the Child Protection Register may had been disputed. That said, the learning event highlighted the issue of invitations to some Children's Services meetings either not reaching the recipient or arriving too close to the event or indeed after the meeting had occurred.

Recommendation 7:

South Wales Police representatives to review procedures and policy around police officer attendance at RCPCs.

The reasons behind the mother's absence from the RCPC held towards the end of April 2015 is somewhat unclear – although the calls she made to emergency services on the days leading up to the conference probably offers some explanation. There is no evidence in the form of documentation to show the risks associated with the domestic abuse history between the parents was considered and a 'split' conference proposed as a means of reducing potential danger. Furthermore, file recordings show no reference to a follow-up meeting with the child's mother to discuss the outcome of the RCPC and decisions made thereafter. In contrast, the social worker allocated at the time of the child's second period of child protection registration (February 2016) demonstrates good practice in terms of documentation and risk management. The timeline shows the risks associated with the parents' domestically violent past was considered (in the context of them both being invited and needing to attend the child protection conference). It is unfortunate therefore, that despite the mother expressing a reluctance to attend the same conference as the father the request for a 'split' conference, was declined by the IRO. A file recording made in February 2016 outlines the discussion between the social worker and the IRO whose view was that unless a specific Order stipulating the parents were not to have contact was in place, then the 'split' conference would not be agreed. The IRO did agree to speak to both parents prior to the RCPC but there is no recording on file to show this discussion occurred. For clarity, a different IRO chaired the RCPC.

Recommendation 8:

Cardiff and Vale Regional Safeguarding Board to review current practice and procedures for addressing the needs of vulnerable persons and victims who are required to attend Child Protection Conferences. Consideration to be given as to whether the use of facilities that would enhance the ability to be more effective

participants through the implementation of 'special measures' such as the use of Live-link technology and screens.

Disguised Compliance

The practitioner discussions stemming from their reflection of the timeline demonstrated a clear consensus over the family's disguised compliance with perhaps the most notable example of this being the parents' almost immediate disengagement when the children's names came off the Child Protection Register with each failing to attend the Initial Child in Need Planning meeting in early May 2015. By this time, the Health Visitor was already raising concerns over the family's need to re-register with a GP and Education professionals were worried over the decline in school attendance by the child's siblings.

Recommendation 9:

Once GP's are aware that a family is off-listed from their practice due to lack of engagement, the Primary Care Team, Cardiff and Vale University Health Board must be notified immediately. The Primary Care Team will notify Children's Services within 1 month of the de-registration to ensure that any children's needs within the family are not compromised.

Moreover, the timeline shows a series of further complaints made from neighbours in respect of anti-social and alleged criminal behaviour at the home – which to the credit of the Anti-social Behaviour Officer, was brought to the attention of Children's Services. It is apparent the mother maintained a level of cooperation with the Housing teams, for example, making herself available for a home visits and returning calls to Tenancy Management. This is perhaps an indication of the good relationship the child's mother had with Housing and as indicated in research, an attempt to deflect attention from her lack of engagement with other services and avoid raising suspicions (NSPCC, 2014). Here, a seemingly over optimistic view of the parents' progress and their ability to manipulate or deceive services into believing they were sustaining positive change caused delays with case management. The rescheduled dates of the Initial Child in Need planning meetings perhaps providing evidence of the drift.

Previous reviews have highlighted situations where professionals have delayed or avoided interventions owing to parental disguised compliance. This review is consistent with previous findings and emphasises the need for agencies to ensure adequate training is provided to frontline staff in relation to recognising and implementing strategies around the issue of non or disguised compliance at an early stage.

Recommendation 10:

Cardiff and Vale Regional Safeguarding Board to consider circulation of the Multi-Agency Protocol on Working with Families who are not Cooperating with Safeguarding Issues amongst Children's Services staff and its partner agencies on an annual basis.

Recommendation 11:

Cardiff and Vale Regional Safeguarding Board's Training Sub-Group to consider making 'Disguised compliance/Dealing with Difficult, Dangerous and Evasive Parents' training mandatory for all practitioners. Alternatively, consideration that the said training forms part of the first 3 years in practice programme for newly qualified social workers.

Thresholds and Decision Making

The multi-agency decision to continue working the case on a 'child in need' basis – despite the concerns of some agencies and the parents' non-engagement - prompted much debate at the learning event around thresholds and decision making in terms of case management, worker allocation and legal input. In this case, practitioners from some partner agencies expressed confusion over the legal processes associated with pre and care proceedings with others questioning why child protection procedures were not initiated again when the child's parents - and indeed some of the professionals involved - failed to attend the third rescheduled Child in Need meeting in early September 2015. In October 2015, the time the student social worker took on the case, the Child in Need planning meeting was still outstanding and as discussed earlier in this report, agencies and members of the community were still raising concerns for the child's welfare. Practitioners at the learning event heard that as a final year social work student, this case is typical of the type that would be allocated – particularly given the student was soon to qualify. Furthermore, the social work student's practice assessor was the previously allocated social worker – thereby providing consistency in terms of case management and knowledge. That said, there is clear evidence of oversight in terms of Children's Services file recordings showing no formal handover of the case.
Despite the continued referrals from members of the public, towards the end of December 2015 the case closed to Children's Services. As with the initial case allocation to the student social worker, there is no recording to show a formal supervision discussion took place regarding case closure. Practitioners attending the learning event heard the decision to close was taken by Children's Services management and not the student – a decision made despite the Child in Need meeting never taking place.

This review demonstrates the crucial involvement members of the community play in safeguarding children. Throughout the period under review, there are clear examples where members of the public have contacted agencies - including Children's Services – to express significant concerns regarding the children and the behaviour and fitness of the parents. Yet, it was not always clear what action (if any) was taken and the decision to close implies that referrals made by members of the public are not taken seriously - the fact that a further incident of domestic violence took place four weeks after the case closed perhaps substantiates this point.

It is recognised that as a 'child in need' case, the parents had the right to choose not to engage or accept services. Yet, this review arguably demonstrates the importance of compiling a chronology of significant events. Chronologies can greatly assist multi-agency assessment of a child's circumstances and provide evidence of past parenting experience, including possible former instances of disguised compliance. There is no evidence that an up-to-date chronology was produced or maintained by Children's Services staff allocated

to work with this family. The absence of a chronology may be a systemic issue linked to the limitations of the electronic records systems and/or a wider training issue more linked to professional practice.

Recommendation 12:

The Cardiff & Vale Regional Safeguarding Board should consider introducing a consistent standardised multi-agency timeline template that becomes the responsibility of each agency to complete when attending the initial child protection conference. The agency timeline should be maintained and updated at each core group meeting by individual agencies and presented as part of the report to the review child protection conference.

Recommendation 13:

All agencies to ensure a standardised approach for gathering, risk assessing and disseminating information from all sources – including members of the community is in place. If this information is considered within a triage or assessment model, organisations would be better placed to manage associated risk, make prioritised and defendable resourcing decisions as well as formulate tactical plans to coordinate further activity.

Key examples of effective practice

In compiling this report, the reviewers have noted a number of examples of good professional practice. Child protection plans evidence the identification of appropriate interventions linked to domestic abuse, substance misuse and mental health for the child's parents. A focus on these areas was seen as a route to retrieving and building the parenting skills of the mother and father and the initial separation of the parents was pivotal in ending the children's exposure to domestic violence in the short term.

Although not noted in the main body of this report, the effectiveness of the Cardiff Multi-Agency Risk Assessment Conference (MARAC) meeting was identified as a further example of good practice by practitioners at the learning event. In this case, the up-to-date, risk focussed information enabled a richer picture to be formed – aiding safeguarding decisions and relevant interventions. It was recognised that since the introduction of the Cardiff Multi-Agency Safeguarding Hub (MASH), such information is now routinely shared at a far earlier stage – demonstrating one of the key aims of implementation.

Practitioners attending the learning event were also keen to commend colleagues from the Welsh Ambulance Service on their lifesaving work. Responding promptly from the time of the initial call, the ambulance crew reacted to a rapidly changing scenario having to gather information en route to trace the mother and child who had moved from the scene of the original incident.

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Improving Systems and Practice

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

(What needs to be done differently in the future and how this will improve future practice and systems to support practice)

1. **Panel members representing Agencies at Child Practice Reviews should consider requesting a timeline from its Legal team in cases where legal involvement formed part of the case management.**

2. **All agencies to consider training to ensure alternative approaches to capturing the child's voice forms part of any 'direct work with children' training and the concept forms part of the mentoring process for social workers in their first year of practice.**

3. **Cardiff and Vale Regional Safeguarding Board via the CPR/APR Sub Group need to be satisfied that the Social Workers are actively offering an advocate to children in receipt of Local Authority care and support.**

4. **CPR Panels to consider if letters or other more suitable forms of communication depending on their particular needs, advising families of the decision to conduct a Child Practice Review are delivered by the most appropriate person.**

5. **Practitioners at the learning event identified that the Housing teams are a particularly useful source of information with the extensive case recordings highlighted as an example of good practice. Cardiff Local Authority senior management teams to develop effective mechanism for ensuring appropriate Housing representation (including Tenancy support workers) at multi-agency meetings to promote the sharing of information and the operation of Multi-Agency Safeguarding Hub (MASH).**

6. **Cardiff & Vale Regional Safeguarding Board's Policies, Procedures & Protocols Sub Group to develop a local policy relating to welfare checks and produce guidance around requesting such checks for partner agencies to follow.**

7. **South Wales Police representatives to review procedures and policy around police officer attendance at RCPCs.**

8. **Cardiff and Vale Regional Safeguarding Board to review current practice and procedures for addressing the needs of vulnerable persons and victims who are required to attend Child Protection Conferences. Consideration to be given as to whether the use of facilities that would enhance the ability to be more effective participants through the implementation of 'special measures' such as the use of Live-link technology and screens.**

9. **Once GP's are aware that a family is off-listed from their practice due to lack of engagement, the Primary Care Team, Cardiff and Vale University Health Board must be notified immediately. The Primary Care Team will notify Children's Services within 1 month of the de-registration to ensure that any children's needs within the family are not compromised.**

10. **Cardiff & Vale Regional Safeguarding Board to ensure circulation of the Multi-Agency Protocol on Working with Families who are not Cooperating with Safeguarding Issues amongst Children's Services staff and its partner agencies on an annual basis.**

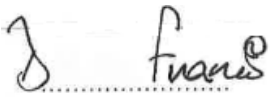
11. **Cardiff & Vale Regional Safeguarding Board's Training Sub-Group to consider making 'Disguised compliance/Dealing with Difficult, Dangerous and Evasive Parents' training mandatory for all practitioners. Alternatively, consideration that the said training forms part of the first 3 years in practice programme for newly qualified social workers.**

12. **The Cardiff & Vale Regional Safeguarding Board should consider introducing a consistent standardised multi-agency timeline template that becomes the responsibility of each agency to complete when attending the initial child protection conference. The agency timeline should be maintained and updated at each core group meeting by individual agencies and presented as part of the report to the review child protection conference.**

13. **All agencies to ensure a standardised approach to gathering, risk assessing and disseminating information from all sources - including members of the community is in place. If this information is considered within a triage or assessment model, organisations would be better placed to manage associated risk, make prioritised and defendable resourcing decisions as well as formulate tactical plans to coordinate further activity.**

Statement by Reviewer(s)			
REVIEWER 1	Karen Haslett *Principal Social Worker, Child Health & Disability Team, Cardiff Children's Services*	**REVIEWER 2 *(as appropriate)***	Dinlle Francis *Detective Chief Inspector, Professional Standards Department, South Wales Police*
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		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	

analysis and evaluation of the issues as set out in the Terms of Reference	• 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)*	Karen Haslett	**Name** *(Print)*	Dinlle Francis
Date	13.08.18	**Date**	09.08.18

Chair of Review Panel (Signature)	
Name *(Print)*	Linda Davies
Date	August 2018

Appendix 1: Terms of reference

Child Practice Review process *To include here in brief:* • *The process followed by the SCB and the services represented on the Review Panel* • *A learning event was held and the services that attended* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
The Cardiff and Vale Regional Safeguarding Children Board (CVRSCB) Chair notified Welsh Government in 2016 that it was commissioning a Child Practice Review in respect of Case CPR 2/2016. The services represented on the panel consisted of: • South Wales Police • Cardiff Children's Services • Cardiff and Vale University Health Board • Cardiff Council Housing • Cardiff Council Education • Community Rehabilitation Company (Wales) • Welsh Ambulance Services NHS Trust (WAST) • C&V RSCB Business Unit A learning event was held on 19th October 2017 and was attended by representatives from the following agencies: • Cardiff Children's Services • FISS • Cardiff and Vale University Health Board • South Wales Police • Cardiff Council Housing • Community Rehabilitation Company (Wales) • Welsh Ambulance Services NHS Trust (WAST) The parents of the child were informed in writing of the decision to undertake a CPR. Both parents had the opportunity to meet independently with the reviewers on two occasions in order for their views to be sought and represented. However, despite the parents choosing the dates, times and venues of the meetings, each failed to attend and neither attempted to re-establish contact with the reviewers thereafter. It is unfortunate that other than the mother's initial comments noted within the report, the family's views are missing from this report. The reviewers and Chair will attempt to share the learning from the report with the parents prior to publication.
x☐ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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

Appendix 1 – Terms of Reference

Bwrdd Diogelu Plant Rhanbarthol Caerdydd a Bro Morgannwg
Cardiff and Vale of Glamorgan Regional Safeguarding Children Board

C&V RSCB Child Practice Review 02/2016

Extended Review Terms of Reference

Background

On 22nd March 2016 the child was discovered at their home address by their sister and had been found hanging, after becoming trapped in a monkey toy which was hanging off the top bunk of a bunk bed. The child was unconscious described as being pale and lifeless. The child was ice cold to touch. The child was at home with his mother at the time and siblings. A sibling was asked to call an ambulance but the phone was not working. The mother went outside and asked to use someone's phone. The mother deemed the ambulance to be taking too long so drove to her mother's address around the corner and paramedics attended sometime later. The child was taken to hospital where he escaped with no lasting injuries.

The child and sibling's names at the time of this incident, were placed on the child protection register under the categories of emotional abuse and neglect. There are concerns historically around domestic abuse within the family home and when officers attended this incident there were significant concerns about the home conditions.

A strategy meeting took place on 24/03/16 and there were significant concerns raised by all professionals that this incident was accidental in nature but linked to a lack of supervision. The paediatrician described the incident as a near miss and that the strangulation was a near fatality but concerned about the lack of care/supervision. The home conditions were a concern for children on the child protection register. The lack of engagement from mum historically was concerning and exposed safeguarding risks. The outcome could have been detrimental and professionals believed that the information shared at the strategy meeting reached the criteria for CPR.

Timeframe for Review:

22nd March 2015 – 22nd March 2016

Criteria for an extended review

The criteria for extended reviews are laid down in the Social Services and Well-being (Wales) Act 2014; Working Together to Safeguard People Vol. 2 – Child Practice Reviews are:

3.12 A Board must undertake an extended 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 on the child protection register and/or 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 which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

In addition to the review process, to have particular regard to the following:

- 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 did that knowledge contribute to the outcome for the child?
- Whether the child protection plan (and/or the looked after child plan or pathway plan) was robust, and appropriate for that child, the family and their circumstances.

- Whether the plan was effectively implemented, monitored and reviewed. Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?
- What aspects of the plan worked well, what did not work well and why? The degree to which agencies challenged each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the child and family were fulfilled.
- 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).

Specific tasks of the Review Panel

- Identify and commission a reviewer/s 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.
- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Safeguarding Children Board

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

- *Review Pane*l complete the report and action plan.

- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on Board website.

- 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.