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

Extended Child Practice Review

C&V CPR 04/2016

Contents

1. Legal Context of the Review

An Extended Child Practice Review was commissioned by Cardiff and Vale of Glamorgan Regional Safeguarding Children Board (CVRSCB) on the recommendation of the Child and Adult Practice Review Subgroup in accordance with the 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 included in Appendix 1.

The Timeframe for the Review

The timeline for this Review begins at 1 September 2014, two months before the child was born, and ends on 29 May 2016, the date of the child's death. The Review takes account of significant events prior to the child's birth which are relevant. The approval process for the adopters was considered as part of this Review.

This has been a complex Review which has required the completion of the criminal investigation to ensure all the learning has been fully identified.

Methodology

- A Review Panel was convened.
- A Chair was appointed at the outset of the Review. Following the retirement of this Chair, a new Independent Panel Chair was appointed in January 2018.
- Two Independent Reviewers were appointed.
- Reviewers undertook a literature review.
- A review of the case files was undertaken.
- Timelines were developed for each agency and an integrated timeline was produced.
- An analysis of each service's involvement was included in the timeline.
- Eight panel meetings were held.
- Reviewers met with one parent of the child.
- Reviewers met with the Birth Maternal Grandmother.
- Reviewer met with the Birth Mother.
- Two learning events were held, one for practitioners and one for managers.
- Reviewers completed a draft report.
- Review panel met and considered the draft report on two occasions.
- Action plan developed from the recommendations.
- Report presented to the Child and Adult Practice Review Subgroup.
- Report presented to the CVRSCB by the Panel Chair and Reviewers.
- Submission to Welsh Government.
- Report published.

For clarity, throughout this report the term "the child's parents/family" refers to the child's adoptive parents. The primary parent refers to the parent who had the main caregiving responsibilities. The term "birth family" is used when referring to birth family members.

It should be acknowledged that the Review has been a particularly difficult and emotional process for members of the child's family, birth family and for the professionals who have supported and assisted in the Review. Their involvement and cooperation is greatly appreciated.

2. Circumstances Resulting in the Review

Background Information

The child subject of this Review was initially considered under the All Wales Child Protection Procedures and the child's name was added to the Child Protection Register, at birth, in November 2014. The child became looked after by the local authority following birth. A period of assessment ensued to consider the child's permanent care plan. The child was placed in foster care in November 2014, where the child remained until placement with the adoptive family in September 2015. The placement in foster care was with the Birth Mother's voluntary consent until an Interim Care Order was granted, a month later, in December 2014.

A Care Order and a Placement Order were granted in May 2015 and the child was placed in September 2015, with a two-parent family and a previously adopted older child. One parent assumed the majority of the caring responsibilities for the child.

The child remained as a looked after child following their placement with their family until the making of the Adoption Order. The Adoption Order was granted in May 2016.

Later in May 2016, the child suffered injuries at home and died in intensive care.

Initial investigations identified that the child had sustained extensive bilateral subdural haemorrhages with evidence of acute and chronic bleeding. There was also evidence of severe hypoxic ischaemic brain damage on admission. Medical assessment and post mortem noted that *"in the absence of a medical cause or obvious major trauma the medical findings as stated... would be highly suggestive of a non-accidental head injury."*

In accordance with procedures, a Family Liaison Officer was appointed to the family. Due to the complexities of this case the information provided to the birth family was at the direction of the Court.

The parent who had assumed the role of primary carer was convicted of the murder of the child following a three-week criminal trial that concluded in November 2017. The parent received a life sentence to serve a minimum of 18 years.

The Child

Information from case records and the family provide a picture of a child who, at twelve months old, was bright and alert and who responded with obvious pleasure to attention. On occasions, the child was assertive and beginning to develop a personality described as both wilful and playful, often being able to articulate needs appropriately. The child particularly enjoyed musical toys and singing, as well as cuddles, and was showing an interest in other children. The child was observed to be happy and relaxed with known adults. An early favourite hobby was an activity mat that allowed for floor play and rolling about. The child was later beginning to enjoy active and vibrant environments, often attending outside play activities.

Significant Events in Child's Life

The following is not a detailed account of all events in the child's life. This section covers the key events that are relevant to the review.

The Child's Care Planning

Date	Significant Event
Sep 2014	Pre-birth Child Protection Conference. Agreement for child's name to be registered at birth
Nov 2014	Child is born The Local Authority issue care proceedings
Nov 2014	Mother signs voluntary consent and the child is accommodated with a Local Authority Foster Carer
Dec 2014	The child's name is removed from the Child Protection Register as the child is accommodated in foster care
Dec 2014	An Interim Care Order is granted
Jan 2015	Referral is made to the Adoption Team
Jan 2015	Adoption Medical Assessment is undertaken and the child is meeting all milestones
Feb 2015	Child is reviewed by Consultant Neonatologist
March 2015	A Child Looked After Review takes place and the Local Authority confirm application for a Care and a Placement Order
March 2015	Final Care Plan is submitted to the Family Court and recommends a care plan of adoption
March 2015	The Agency Decision Maker makes the decision for the child to be placed for adoption
May 2015	A Care Order and a Placement Order are granted by the Family Court
June 2015	Child is seen by the Health Visitor in foster care. The child's weight gain is good and the child is progressing well
July 2015	Adoption medical assessment is undertaken and there are no concerns for the child's general health
August 2015	Child is seen by the Health Visitor. Developmentally the child is progressing as expected

Reviewers' Commentary

- The All Wales Child Protection Procedures 2008 were followed in a timely way.
- The care planning for the child was rigorous and well implemented with no delay.
- The child received good quality care from the Local Authority Foster Carer.
- The Health Visitor provided a good service to the child and supported the Foster Carer to a good standard.
- All the evidence suggested that adoption would be in the child's best interests.

The Child's Parents

Date	Significant Event
August 2013	The parents are approved as adoptive parents for the first time.
Oct 2013	The parents have their first child placed with them.
April 2014	The Family Court make an Adoption Order for the first child.
Feb 2015	The assessment of the parents as second time adopters begins.
July 2015	The Adoption Panel recommend approval as adoptive parents.
July 2015	The Agency Decision Maker makes the decision to approve the parents as second time adopters.
August 2015	Adoption Panel make recommendation that match with adoptive parents proceeds.
Sep 2015	The Agency Decision Maker approves the match between the child and the parents.
Sep 2015	Introductions between the child and the parents begin.
Sep 2015	Child is placed with the prospective adoptive parents.

Reviewers' Commentary

The Reviewers were able to access key documents for full consideration of the adoption assessment as well as the matching and placing process for the child. The Reviewers note that:

- The assessments of the parents as first and second time adopters were robust, detailed and comprehensive. There was evidence of appropriate analysis of the information gathered.
- The parents had successfully adopted a first child.
- The second assessment of the parents was completed in a timely fashion and built on the first assessment.
- The Adoption Panel recommended the parents' approval as second time adoptive parents and the Agency Decision Maker made the decision to approve them.
- The Adoption Panel recommended the match between the child and the parents and the Agency Decision Maker made the decision to approve this match – these decisions were all made within the required timescales.
- The introductions took place over a period that was appropriate for the child and with the full support of the Foster Carer.
- The Foster Carer was very experienced, particularly in helping children move into adoptive placements. The Foster Carer reported the introductions went well.
- At the time, the parents worked well with professionals and attended all training offered during assessment and placement. They were described as welcoming people with

valuable child care experience. Both were reported to nurture and maintain long-term friendships and regard family networks highly.

- There was a supportive, extended family network.
- All the evidence suggested that there would be a positive outcome for the child.

The Child's Placement with the Adopters

Date	Significant Event
Sep 2015	The child is placed with the parents and parental responsibility is shared between the Local Authority, the parents and the birth parents.
Sep 2015	The first review of the child's adoptive placement takes place within the statutory timeframe.
Nov 2015	The child is taken to the GP by one of the parents. The child is non-weight bearing for five days on the right leg following a reported injury. The GP refers the child to a Trauma and Orthopaedic Consultant for review.
Nov 2015	The child is seen at Trauma and Orthopaedics Clinic. An x-ray reveals a fracture to the distal tibia (lower end of leg bone close to the ankle). The explanation given by the parent (it is not clear which parent was present) for the child's injury was consistent with the fracture seen on the x-ray. The child is placed in a polymer cast and advised not to weight bear for the following three weeks. A follow up appointment at the Trauma Clinic to be arranged.
Dec 2015	The day before the second Adoption Review the primary parent sends a text message to the Adoption Social Worker. The message indicates the child has a large bruise on the forehead. The Adoption Review record makes no reference to the bruise. Five days later the child is seen opportunistically by a health professional who documents a large bruise to the child's forehead and eye. The primary parent reported that he had sought medical advice for this injury. The observation of the bruise is not shared by the health professional.
March 2016	The primary parent telephones 999 reporting that the child has fallen through the stair gate at the top of the stairs as it was not closed securely. The parent reports no loss of consciousness but two episodes of vomiting. The child is taken to hospital by ambulance and observed in hospital for 4 hours. The child has sustained superficial bruising and is discharged home the same day. The health professionals responded appropriately and the information was shared with Children's Services. The explanation from the parent was accepted.

April 2016	The primary parent reports to the Adoption Social Worker that the child has a turn in the eye. The Social Worker advised the parent to arrange a GP appointment.
May 2016	The child is taken to the GP by one of the parents. A referral to ophthalmology is made. Whilst a referral was made, the child does not see the Ophthalmologist and died before the date of the appointment. There is no evidence that the Adoption Social Worker shared this information with the child's Social Worker.
May 2016	The child is taken to Consultant Neonatologist by the parents for a routine follow up. No health concerns were identified. This is the final health appointment for the child prior to death.
May 2016	The Family Court makes an Adoption Order; the couple are now the child's legal parents.
May 2016	The primary parent telephones 999 at approximately 6pm reporting the child is limp, floppy and unresponsive. Resuscitation instruction is provided to the primary parent pending arrival of the ambulance crew. The primary parent provides different explanations to the call handlers, the Ambulance Crew, the Police and the Doctors concerning the events of the evening. The child remains unconscious upon admission to hospital and never regains consciousness. The child has a CT Scan which reveals bilateral subdural haemorrhages (bleeds on the brain). The Police enquiry begins on this date.
May 2016	The child dies in hospital and Procedural Response to Unexpected Death in Children (PRUDiC) procedures were initiated.

Reviewers' Commentary

- The child was visited and was seen regularly by professionals and extended family members.
- All of the evidence from the medical professionals indicated that the injuries the child sustained between November and March were accidental. No safeguarding concerns were raised.
- There were opportunities to consider the pattern of the child's injuries and accidents that were not explored.
- The second Adoption Review was attended by the Child's Social Worker and the Adoption Social Worker and chaired by the Independent Reviewing Officer (IRO.) The professionals and the Review record make no reference to the child having a bruise. However, we now know that a bruise on the child's forehead was observed some five days later by a health professional not directly involved with the child. The primary parent advises that he has sought medical advice and the observation of the bruise is not shared with any other agency. Given the child was still a child looked after, there is an expectation that the cause of the bruise would have been considered, and then recorded.
- In November 2015 there was a five-day delay in the parents taking the child to the GP, following an accident that parents reported had taken place. The explanation given by the

parent for the child's injury was accepted by the Registrar at the Trauma and Orthopaedic clinic as a typical fracture resulting from an accidental injury. The x-ray identified two fractures to the child's leg. The fracture to the lower leg was identified by the Registrar at the Trauma and Orthopaedic Clinic. The second fracture to the distal femur (top leg bone) was identified post mortem.

- The child was not seen in A and E and was therefore not seen by the Paediatric Team. One of the child's parents informed the Adoption Social Worker of the child's injuries via telephone who shared this information with the Children's Services Social Worker.
- If the original examination of the x-ray had identified both fractures, safeguarding concerns would undoubtedly have been raised and child protection procedures instigated. This was the opportunity where agencies could have reasonably and tangibly intervened. Following the child's death, a review of the x-ray was undertaken by an expert Consultant Paediatric Radiologist. This review indicated that it would be highly unusual for two separate bones to be broken from one minor fall. The Consultant Paediatric Radiologist's report presented to the criminal proceedings indicates that the explanation provided by the primary parent of a minor fall would not result in two separate fractures. Immediate organisational changes were made and have been referred to under 'Agency Improvements in Practice – Health' changes.

The Learning Events

The Learning Events for this Child Practice Review were held over two separate days. There was a total of 26 participants. The participants involved in the first day were operational practitioners who had day to day involvement with the child and the second was for managers. The purpose of the two events was to:

- Give practitioners and managers the opportunity to directly contribute to the Review.
- Allow practitioners and managers to reflect and listen to one another whilst contributing to the learning.
- Clarify the detail within the merged multi-agency chronology.
- Recognise effective practice.
- Inform both the findings and recommendations for this Report.

The programme for the Learning Events was divided between scene setting, including key details presented within the timeline, and the direct contribution of the participants. The child's story was considered in terms of pre-placement planning, care planning and post-placement.

The Reviewers recognised the sensitivities for the practitioners and managers involved in these learning events. The Reviewers recognised the emotional impact of working with a child who had died. However, participants were able and willing to share rich detail informing the final report and the Reviewers thinking.

The Agencies represented at the Learning Events were:

- Vale of Glamorgan Children and Young People Services
- Vale of Glamorgan Safeguarding and Service Outcomes
- Vale, Valleys and Cardiff Regional Adoption Collaborative
- South Wales Police

- Cardiff City Council Education Services
- Cardiff City Council Children's Services
- Cardiff and Vale University Health Board
- Welsh Ambulance Service, NHS Trust

Family Views

The Reviewer met with one of the child's parents on two occasions. A member of their extended family was present on both occasions. The parent shared that during the process of the adoption assessment and subsequent placement of the child, there were positive relationships between the family and all the professionals. There was a good degree of contact with the Social Workers who they confirmed made announced and unannounced visits to the family home. They considered the relationship between them as a family and the Social Workers as being very open and honest. It is acknowledged that the death of the child will have lifelong consequences for the family.

The Reviewers met with the Maternal Birth Grandmother on one occasion. The Birth Grandmother shared her concerns regarding the impact of the child's death upon the birth family particularly given that the child had been adopted.

The Reviewer met with the Birth Mother on one occasion. The Birth Mother shared her concern that it was several months before she was informed of the child's death. She indicated that she would have preferred to have been informed of her child's death by somebody that was known to her. Following being informed, she felt she received information from several sources in an ad hoc fashion.

Understandably the emotional impact of the child's death on the birth family has been very significant.

The comments of the child's parents and the birth family have informed the findings of the report and contributed to the learning.

3. Practice and Organisational Learning

The identification of the practice and organisational learning has been drawn from:

1. Production of the merged timeline
2. Learning events
3. Family perspectives
4. Discussion at panels
5. Literature review
6. Case records
7. Reviewers' analysis

Some of the learning points have only been able to be identified through the process of this Review and following the child's death. However, the purpose of the learning is to improve future practice and ensure the robustness of our services in protecting children.

Following the learning events, the Reviewers had an increased understanding of the child's experiences at home. Some of these were:

- The parents presented as a well-educated and articulate couple who had been able to access resources and support previously. They were very well regarded by each of the agencies as good parents who had already successfully adopted.
- During this period there were new factors in the family's circumstances that potentially could have added stress. These include a house move, one parent working away from the home a few nights per week, and the stresses of caring for two young children as a sole parent for parts of each week.
- There was no information shared by either parent to suggest that the family were experiencing any difficulties. Further to this there was no suggestion by any of the extended family members that there were any concerns about the parents, including the parent who was the primary carer at home. This was verified in the third-party references taken as part of the Adoption Order application. There was also no information from the community that there were any noted difficulties. Concerns from neighbours became apparent during the criminal investigation, however; these were not shared with any agencies at the time.
- The child had an adoption support plan that did not identify any ongoing support needs over and above those needed by any child. The parents' openness and willingness to share information about their home life and the multi-agency information sharing did not identify further adoption support needs or safeguarding concerns.
- The parent who was the primary carer for the child and adopted sibling was clearly under stress. This was known by the second parent and some of the extended family. However, this information only became evident through the criminal investigation and was not shared by them with the professional agencies. The overall presentation to the agencies was one of a happy and united family.

The section below identifies the themes emerging from the Review and the learning that can be gained from them.

Key Learning Identified

Adoption does not negate the need for safeguarding awareness.
Always check… Do not assume

The Adoption Assessment and Approval Process

1. Adoption is viewed positively by Social Workers and multi-agency partners. There is good evidence that adoptive parents will provide quality care for the children that they adopt. Potential adoptive parents undergo rigorous assessments to establish their suitability to adopt. However, this does not negate the safeguarding role that all professionals have when working with children, including those who have been placed for adoption. It is important to remember that a child placed for adoption remains a child looked after until the making of the Adoption Order.

2. There was nothing throughout the adoption assessment process that could have predicted that one of the child's parents was to injure and eventually kill the child. The parents were second time adopters and the adoption of the first child was viewed very positively.

3. The approval of the parents as first time and second time adoptive parents by the Social Worker, the multi-agency Adoption Panel and the Agency Decision Maker provided layers of quality assurance. The quality of the adoption assessments and their scrutiny by Panel and the Agency Decision Maker were good. However, with the benefit of hindsight, the monitoring and review of children placed for adoption can be strengthened by ensuring that safeguarding responsibilities are given due emphasis.

The Child's Injuries

4. The significance of the injuries that the child sustained were minimised to be compliant with the professional's view that the child was an active toddler and receiving good care. The explanations provided by the parent were considered by health professionals as being consistent with accidental injury.

5. The parent who was convicted of the child's murder did present the child to health professionals, and inform Children's Services of the injuries that the child had suffered. There were however two incidences of delayed presentations and one incident where the primary parent informed a Health Visitor he had sought GP advice on the large bruise to the child's head, which he had not.

The Professionals Response

6. The family provided a positive and united front to the professionals working with them. At no stage did they indicate they were experiencing any difficulties in the parenting of the child.

7. The evidence in this case highlights that the professionals working with the child did not either consider or raise the possibility that the child was being harmed by a parent.

8. The professionals involved with the child viewed the adoptive placement as being very successful; the events in the child's life were viewed through a 'positive lens'. This is the case for the majority of children placed for adoption.

When children are seen at hospital, Paediatricians are key professionals in recognising the possibility of injuries being caused deliberately

1. On the first occasion the child presented to the hospital this followed GP referral to the orthopaedics outpatient clinic. The child was subject to an x-ray but this was not overseen by a Paediatric Radiologist. The Registrar viewing the x-ray could not have been expected to identify the second fracture as they were not sufficiently experienced or trained.
2. The x-ray revealed a fracture to the child's lower leg and upper leg, however, the Registrar identified one fracture only to the lower leg.
3. Had both fractures been recognised on the x-ray this would have raised safeguarding concerns that would have instigated the child protection process.

Professional judgements should be based upon consideration of all the evidence available rather than individual events

1. Significant events in a child's life should not be viewed in isolation but seen within the context of their histories and their current environment.
2. The child was presented to hospital on two separate occasions and in addition suffered a large bruise on the forehead.
3. There is evidence of a second bruise to the child's forehead that is not documented in the timeline as this was not seen by, or reported to, any professionals.
4. The child was presented to the GP with a unilateral squint to the eye.
5. There is no evidence to suggest that any of the professionals working with the child considered these injuries together or what this could have meant for the child.

Professionals need to ensure the details of a child's injuries are recorded as significant events

1. The recording of the injuries that the child suffered both by Health and Children's Services professionals were contained within the body of the case recording.
2. The style of the recording at the time of the child's injuries did not support professionals taking a more holistic approach and seeing the pattern of emerging injuries.
3. The large bruise to the child's forehead was not recorded by Children's Services.
4. The Adoption Review report makes no record of a large bruise to the child's forehead.
5. It is important to record the parent by name in any contact they may have with agencies. It was not possible to identify which parent was being referred to as in some occasions either parent was referred to as father or dad.
6. The Adoption Hearing provided the last opportunity for external scrutiny of the child being adopted by these parents. The Report presented to the Adoption Hearing did not include full details of each of the child's injuries. The Report recorded the fracture to the leg as well as the fall down the stairs. These had been accepted as accidental injuries by professionals at the time. However, it omitted details of a large bruise to the child's forehead and a unilateral squint to the eye.

Each agency has a professional responsibility to ensure they are aware of all the significant events in a child's life

1. No one agency or worker held all the relevant information on this child.
2. The evidence suggests in this case that there is no one electronic health record for the child that all health professionals can access. The GP, the Health Visitor, the Registrar and the Paediatricians all had some medical information but not all the information. This did not promote any of the health professionals having a full picture of the child's health.
3. The sharing of information between the child's Social Worker and the Adoption Social Worker following the child's fall down the stairs did not take place until three weeks after the incident.
4. The child was presented to the GP with a unilateral squint. There is no evidence this was formally shared with Children's Services.
5. There is no evidence of any formal record from Health to Children's Services regarding the child's presentations to hospital following injury.
6. The child, while still legally a child looked after, was considered an adopted child and so this shaped the way in which professionals shared information.

Adoption Reviews should provide opportunities for robust professional scrutiny and challenge

1. The child was subject to two Adoption Reviews post placement.
2. The meetings were not multi-agency; they were attended only by Children's Services, the family and the Independent Reviewing Officer (IRO) lessening the degree of scrutiny.
3. The Adoption Review template did not promote the IRO to capture a full picture of the significant events in the child's life since being placed with the parents. A holistic understanding of the child's story was not gained.

The recording and retention of information received via text and other messaging services are an increasingly important source of information

1. Information gained at the Leaning Event confirmed that the child's parents used text messaging as a form of communication between themselves, extended family and professionals.
2. This raises issues of how these text messages are incorporated into the child's records and stored in a way that is easily retrievable and any action taken concerning the same is auditable and will stand scrutiny.

Learning post the child's death

1. The child was admitted to hospital on 25th May 2016 and died on 29th May 2016.
2. At the point of admission, the professionals were considering this to be a tragic accident.
3. At the point of the child's death, it remained difficult to establish a timeline of the child's health presentations. This was due in part to a number of different Information Technology systems, and the child being known by four different combinations of the birth and adopted name.

4. When a child is adopted, an application for a new NHS number is created and old health records are sealed. A delay in the creation of a new NHS number in this case resulted in difficulties accessing the full health record of an adopted child. This resulted in the gathering of information for PRUDiC more limited.

Effective Practice Identified

- The Foster Carer provided excellent care for the child prior to the placement with the parents.
- The assessments of the parents as suitable to adopt were of sound judgment and would stand up to scrutiny.
- The adoption process was followed in an appropriate and efficient manner.
- There is evidence that a plan of permanency was identified and achieved in a timely manner.
- The Medical Advisor to the Adoption Panel met with the parents prior to the matching to discuss the child's long-term health needs.
- There is evidence that Children's Services undertook statutory visits to the child in accordance with procedures.
- On the occasions where 999-assistance was required, the Call Handlers provided expert knowledge and advice in a sensitive way.
- The Ambulance Crew on both occasions provided a service of an excellent standard.
- Following the child's final admission to hospital the Police allocated the case to a Senior Police Officer.

Conclusion

This is a tragic and untimely death of a child who had been subject to statutory intervention since birth. There was no information during the assessment stages of the parents that could or would have predicted what happened to this child. The assessment of them as adoptive parents was strong and robust and was compliant with good practice standards.

It is clear from the evidence presented in the merged timeline, and through the messages from the Learning Events, that this family were perceived to be very positive parents for this child. Given how strongly this view was held, the injuries that the child sustained were never considered as anything other than childhood accidents.

Adoption is a positive outcome for almost every child. It is extremely rare for any child placed for adoption to be harmed by their parents. The parents, their extended family nor any of the professionals working with the child had recognised any concerns regarding possible harm. There were no reports to Children's Services of any such concern. As a result, there was a lack of professional curiosity regarding the child's experiences and injuries.

The child was not invisible to agencies at any time. There is good evidence that the child and family were seen in line with statutory guidelines and further that information was sought from extended family members as a second source of information in preparation of the report for presentation at the Adoption Hearing. In addition, the parents did not indicate at any stage that they were struggling to care for this child and did not require any additional support services.

It is evident that during the child's placement with the parents, the child was seen on many occasions by several professionals within the agencies.

- The omission of identifying the second fracture to the child's upper leg on the x-ray was a missed opportunity to raise safeguarding concerns and instigate child protection procedures.
- The observations and recording of the large bruise to the child's forehead both by Children's Services and Health was absent. This resulted in the large bruise becoming "invisible" to professionals and did not form part of building an overall picture of what was happening to the child before the final report to the Court prior to the Adoption Order Hearing being made.

There is always learning to be gained and this case is no different. Some new information, and the learning from it, has been gained from other proceedings, primarily through the criminal trial. The conclusion is that there are some systems and practices that should be improved.

4. Improving Systems and Practice

The following actions have already been made by Cardiff and the Vale Safeguarding Children's Board and its member agencies.

Agency Improvements in Practice

Agencies have already implemented improvements in practice in advance of this Review. Agencies need to be commended for this.

Health

- All professionals are now encouraged to refer children directly to Accident and Emergency. This ensures they are reviewed by a Paediatrician.
- All children aged under two years who present to Trauma and Orthopaedics for x-ray examination will be reported on by a Paediatric Radiologist with expert knowledge of assessing the possibility of a non-accidental injury.
- The Accident and Emergency Department have a weekly safeguarding meeting to consider head injuries and burns in children aged under one. This has now been extended to include fractures in children aged under two years old.
- A reminder has been placed in all child heath notes in Trauma and Orthopaedics reminding staff to be aware of safeguarding issues.
- There is now a process of sharing information between Health Visiting Managers and the Looked After Children's Teams that allows for Paediatricians to be aware of all injuries to a Looked After Child.

Vale of Glamorgan Council

Children and Young People Services

- Development of a Practitioner Manager who has a lead role in providing support, advice and guidance to the wider Social Work team in relation to adoption cases. This role sits within the Children and Young People Services and provides additional support to Social Workers outside of normal supervision methods.
- If a match between a child and prospective adopters is being considered, an initial visit is undertaken by both the Social Worker for the child and the Practitioner/Team Manager from that team. This provides an opportunity for a wider professional consideration and discussion of the proposed match, above and beyond standard practice.
- Following a child being placed with adopters, an unannounced visit is scheduled into the visiting pattern.
- Once a child is placed with adopters, if either parent works or is away from the home for any length of time, the Social Worker will arrange an out of hours visit to ensure that both adopters are regularly seen and spoken with. This is to ensure there is not a reliance on information or focus on only one parent.
- A model of supervision has been implemented that ensures all adoption cases are discussed in the same way as child protection cases. This ensures consistent oversight and robustness around information sharing and decision making.

- When children of school age are in adoptive placements, Social Workers ensure that a visit outside of the placement is undertaken to strengthen opportunities to see the child alone.
- Development of a case recording exemplar in Welsh Community Care Information System (WCCIS) for all statutory visits to standardise what and how information is recorded.
- Any reported accidents/injuries that a child sustains whilst in an adoptive placement will be shared and clarified with the relevant health professionals. This will ensure there is a level of check and balance to the incidents being reported by parents.

Safeguarding and Service Outcomes

- Development of the adoption review paperwork to ensure it captures accidents/injuries within the format of the minutes.
- Roles and responsibilities of the Independent Reviewing Officer revisited, to ensure there is clarity and understanding around the importance of considering all relevant information during reviews.

Regional Adoption Collaborative

- Adopters are expected to report injuries and significant events from day one of placement. This is explained to them in the pre-placement meetings chaired by a Manager from the Collaborative prior to the child being placed. This expectation is also contained as part of an information pack provided to adopters upon matching.
- The Collaborative has put in place a revised recording format for Adoption Social Workers to complete when supporting adoptive placements. This includes specific questions to ask when Social Workers are undertaking visits to placements and details of who was present, whether the child was seen, any concerns, injuries or significant issues discussed in respect of the child and the actions taken.
- Supervision sessions contain discussion of potential safeguarding concerns/ welfare matters/ significant events in respect of the child placed, and direct questions are asked of Social Workers as to whether there have been any issues/incidents of concern.
- Clear expectations that Social Workers from both Children and Young People Services and the Regional Adoption Collaborative share information in relation to any injuries/accidents a child sustains whilst in placement. This ensures effective communication of significant issues and ensures information is known by all relevant professionals involved with the child and parents.

National Adoption Service

During the timeframe of this Review, changes were made as to how adoption services in Wales were organised and structured. A national collaborative, known as the National Adoption Service for Wales was launched in November 2014. The accountability for adoption services remains with each local authority, but they are now directed to deliver certain functions through regional collaboratives and a National Adoption Service Central Team. The Vale, Valley's and Cardiff regional collaborative became operational in June 2015.

On a national basis, a range of development work is underway these include:

- A “framework for adoption support” has been developed and this includes effective adoption support planning and review.
- Advice has been provided from the National Adoption Service Central Team to Association for Fostering and Adoption (AFA) Cymru on the adoption related elements of a revised “practice guidance and good practice guide for reviewing and monitoring of a child or young person’s care and support plan” This has been commissioned by Welsh Government.
- The National Adoption Service has provided advice to Welsh Government about the adoption (and fostering) for inclusion in the additional codes of practice linked to the new safeguarding statutory guidance.

Recommendations for the Regional Safeguarding Board

The recommendations set out below refer to children placed for adoption due to the specific circumstances of the child subject to this Review. The Board may wish to consider their wider application to all Looked After Children and or Children in Need of Care and Support.

1. Develop and implement safeguarding raising awareness and learning mechanisms to ensure all staff are equipped to identify safeguarding concerns when children are placed for adoption. Similar mechanisms for raising awareness within the wider community should also be considered.
2. A child who has been placed for adoption and presents at hospital with an injury should be overseen by a Paediatrician with safeguarding experience and training.
3. A child who is placed for adoption should have a multi-agency chronology of significant events including any physical injury regardless of the cause. This chronology should be considered at each Adoption Review.
4. Develop a multi-agency set of professional standards for children who are placed for adoption, including expectations regarding the sharing of information which should be compliant with the All Wales Child Protection Procedures 2008.
5. Agencies to review their local implementation of the Social Services and Well-being (Wales) Act 2014, Code of Practice Part 6 which sets out the role of the Independent Reviewing Officer, including their role in reviewing children placed for adoption. The review should ensure compliance with the requirements of the Code of Practice.
6. Development of a policy across all agencies to ensure a consistent approach in the recording and retention of information received and sent through any form of technology.
7. A child’s name should remain the same on each agency record until the making of an Adoption Order.
8. A child’s NHS number provided at birth should remain the same throughout the child’s life.
9. There is a dissemination plan to ensure that the learning from this review is widely shared and considered amongst the Safeguarding Children Board agencies.

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Statement by Reviewer(s)

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

Chair of Review Panel *(Signature)*	……
Name *(Print)*	Wendy Rose OBE
Date	……

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.*
☐ Family declined involvement

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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

C&V RSCB Child Practice Review 04/2016

Extended Review Terms of Reference

The 04/2016 Child Practice Review (CPR) referral was received by the Cardiff and Vale CPR Sub Group in November 2016, where it was agreed that the case met the criteria for a Child Practice Review. It was agreed by the RSCB that this would be an Extended Review.

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

Rationale for Extended Review and External Reviewers

Due to the complexities and sensitivities of this case it was agreed by the RSCB Chair, Vice Chair, and the RSCB CPR/APR Sub Group that two reviewers would be more appropriate than the one required in a concise review. It was also agreed that there should be a premium on independence, that this case justifies unassailable independence and that both reviewers should be external.

Timeframe of Review

The timeline for this review begins at **1 September 2014**, two months before the child was born, and ends on **29 May 2016**, the date of the child's death. The review takes account of significant events prior to the child's birth which are relevant. The child was adopted by parents who had previously adopted a child in 2013 and the first adoption process was considered as part of this review.

The Purpose and Principles which Underpin this Extended Review

Core Tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and RSCB.
- Examine inter-agency working and service provision for the child and family.

- Determine the extent to which decisions and actions were child focused.
- Seek contributions to the review, as considered appropriate by the Panel from, both adopted and birth family 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/s for practitioners and managers and identify required resources.
- This Review is not about the child care plan to remove from the birth family and placed for adoption.

In addition, as an extended review, the Panel will have particular regard to the following:

- Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child, their family and their circumstances? How did that knowledge contribute to the outcome for the child? The 'family; in this extended CPR is the 'adopted' family.
- Was the looked after child plan or adoption plan robust and appropriate for the child, the family and their circumstances?
- Was the plan for the child effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of the multi-agency plan(s)?
- What aspects of the plan(s) worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan(s), including the progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked? Were the respective statutory duties of agencies working with the child and family fulfilled?
- Were there 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.
- Were the statutory duties of all agencies fulfilled?

The Specific Tasks of the Review Panel

- Agree the timeframe for the review including any necessary reference to any significant background information or previous incident.

- Identify agencies, relevant services and professionals to contribute to the review not already requested by the Child Practice Review Sub Group, produce a timeline and an initial case summary and identify any immediate action already taken. The Panel has determined that the appropriate agencies to be engaged in this review and therefore participate as members of the review panel are:

    - Health: Cardiff and Vale University Health Board
    - Children Services: Vale of Glamorgan Local Authority/ Regional Adoption Service
    - Children Services: Cardiff Local Authority
    - Education Services: Cardiff Local Authority
    - South Wales Police
    - Welsh Ambulance Service, NHS Trust
    - National Adoption Service

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the reviewer/s learning events for practitioners and managers, to include identifying attendees and arrangements for preparing and supporting them pre- and post-event, and arrangements for feedback. Based upon the timeframe within which the Panel will conclude the review the learning events will be scheduled for the **March 2018**.
- Plan with the reviewers contact arrangements with the child and family members prior to the event. Advice will be sought about how to engage with the family/birth family subject to the review and any relevant family members.
- 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 CPR Sub Group and the RSCB for consideration and agreement. It is proposed that the report will be shared with the Child Practice Review Sub Group at its meeting scheduled for the **June 2018** and at the RSCB meeting scheduled for the **June 2018**. It is proposed that the final report will be signed off by the end of **July 2018** and submitted to Welsh Government by **July 2018**.

It should be noted that due to criminal investigations, the timescale for this Review is subject to change.

Confidentiality Statement
During the process all members were reminded of the confidentiality requirements of a Child Practice Review. All members signed a confidentiality agreement.

The Tasks of the Regional Safeguarding Children Board:

- To consider and agree any Board learning points to be incorporated into the final report or the action plan. This will take place no later than the scheduled meeting of the RSCB in **June 2018**.
- To send the Final Report and Final Action Plan to relevant agencies for final comment before sign-off and submission to Welsh Government. This will be scheduled to take place in **July 2018**.
- To confirm arrangements for the management of the multi-agency action plan by the Child Practice Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- To plan the publication of the report on the RSCB website. The date of publication will be confirmed by the Chair of the RSCB.
- To agree dissemination process to agencies, relevant services and professionals.