Child Practice Review Report

Child Practice Review Report

Cardiff & Vale Regional Safeguarding Children Board
Concise Child Practice Review

Re: C&VRSB 2/2018

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*

A concise review was commissioned by Cardiff & Vale Regional Safeguarding Children Board on the recommendation of the CPR/APR 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 3.4 of the above guidance namely:

A Board must undertake a concise 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 neither on the child protection register nor a looked after child 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.

Background Information

This concise child practice review was commissioned following a case of neglect concerning a four year old child. The outcome of this serious case of neglect was malnutrition and significant dental decay. The child had three elder siblings. Prior to the time of the incident that led to this review, the family had some involvement with the usual universal services, as well as involvement with speech and language therapists and ENT specialists in relation to the child. Over a period of months, school staff noted numerous concerns in relation to the child. The health visitor also experienced difficulties when carrying out a home visit to assess the child subject of this review. There had been four missed appointments, where prior arrangements had been made with the mother to attend the home address, but there was no reply on each occasion. In addition, the child was not seen by health professionals at numerous speech and language therapy appointments and ENT appointments. This was as a result of him not having been brought (to those appointments).

Following serious concerns raised by school staff, regarding the health and physical presentation of the child, a referral was made and the child was subsequently seen by Children's Services and Police at the school. The parents of the child were also present at that time. Police subsequently attended at the home address of the family and found the address to be in a very poor state of repair. There was no electricity. There was no food in the address, with the kitchen, living areas, corridors and bedrooms filthy. The bathroom was also filthy, with the toilet blocked and full of excrement.

The child was subsequently subject of an emergency child protection medical examination, as indeed was one of the siblings. The result of this medical examination was that the child had suffered neglect that met the threshold for significant harm. The child was described as being malnourished, with significant, advanced dental decay.

The parents of the child were subsequently arrested for criminal child neglect. Child protection proceedings were immediately invoked in relation to the child and siblings. Both parents subsequently pleaded guilty to child neglect, and as a result, both received a criminal conviction for child neglect.

The time period for this review is between 1st February 2017 and 28th February 2018. The Terms of Reference for this review are attached as Annex 1 and the summary timeline of key events is attached as Annex 2. As part of this child practice review, a learning event was held engaging practitioners involved with this child. The chair/reviewer would like to thank all those who attended the learning event and for their contribution to the learning from this review. Incidents where a child has come to significant harm are distressing, and we are grateful to all the practitioners for their attendance, candour and willingness to share viewpoints and learning.

The learning event for this child practice review was significantly delayed due to the ongoing criminal proceedings. This, in addition to the implications of the Coronavirus crisis, have led to a delay in the completion of the review.

The conclusions outlined in this report are informed by the chronology of events completed by the agencies involved in this matter (produced from electronic records held by each agency), as well as information provided by practitioners, managers and professionals at the learning event.

Significant events prior to review period

- September 2016 - Safeguarding log completed by nursery school staff with child observed as having bites on his legs and underpants that were too big for him. Staff subsequently discuss this with mother, who said that the child had chicken pox over the summer and that she had been advised by her GP that he was okay to attend school. Staff accept the explanation provided at that time and take no further action as a result.
- September/October 2016 – Staff at nursery school notice that the child has many more chicken pox and head lice. Additionally, the child was observed to be wearing aged 7/8 underpants and that these were on backwards. Flying start staff report concerns that the child was often dirty. The child bumps his head at nursery school at about this time. Staff observe head lice and speak to the mother, who confronts staff in an aggressive manner. Safeguarding officer made aware of these observations/concerns.
- November 2016 – Anonymous telephone call received by Children's Services stating that the child's mother is 'high on drugs' when collecting the child from school. Children's services subsequently speak to school staff, who state they had not witnessed the mother under the influence of drugs. No other concerns about the child/family are brought to the attention of Children's Services.

Significant events during review period

- February 2017 – School staff recorded concerns that the child looked 'odd' after his hair had been cut and that his needs were not being met (not specified as to what these needs were). Mother spoken to and claimed that her nephew had cut the child's hair, but that she had no concerns. School staff complete a 'neglect tool kit', the result of which was that the threshold for referral was not met. This decision was made by school staff and was not shared with other agencies.
- February 2017 – School staff speak to Health and raise concerns about the child's presentation. Health reassure school staff that the health visitor was due to see the child at home the following week and that he would remain on her caseload until he was five years of age. The child was four years old at that time. The child was at that time suspected to have additional needs (ENT/audiology) that required medical assessment.
- February/March 2017 – Health visitor attends family home as arranged on the 23/2/17, 1/3/17, 7/3/17, and the 8/3/17, with no reply. The child is by this stage overdue for his four year health visitor check. Health visitor sends a letter to parents requesting contact.

- March 2017 – Consultant Community Paediatrician writes to school, GP, and Health Visitor and informs them of two unattended appointments with her. Paediatrician queries in that letter, whether these unattended appointments should raise safeguarding concerns.
- March 2017 - Telephone conversation between health visitor and school staff in relation to concerns about the child's general presentation and his missed health appointments. Plans made to meet and discuss multi agency referral form and plans also made to discuss in joint Children's Services & Flying Start meeting, scheduled to take place on the 17/3/17.
- March 13th 2017 – Child starts at a different school. Staff at the new school already know the family/parents as the child's elder siblings had attended the school previously. The staff describe their relationship with the parents as 'not easy', but staff had dealt with some issues concerning the elder siblings successfully, after raising the issues directly with the parents. These previous issues concerned head lice and appropriate school uniform.
- March 23rd 2017 – Telephone conversation between health visitor and staff at the child's previous school. The health visitor was unaware that the child had changed schools and the school staff expressed surprise at this, given that their school was closer to the family home than the new school. The school stated that they had attempted to complete the neglect tool, but they had insufficient information in order to do so.
- 10th April 2017 – Home visit by health visitor for child's 3.5 year check. Home conditions were reported to have deteriorated. Nutrition, dental care arrangements and vitamin supplementation addressed with mother. Health visitor reinforced with mother the importance of taking the child to his medical appointments. Mother appeared preoccupied with expressing concerns over the behaviour of the child's elder sibling.
- April 2017 – Numerous appointments for the child to see audiology/ENT specialists are not attended (child not brought). Mother spoken to and claimed that she had not received the appointments (despite having been spoken to by professionals about them on occasion).
- May 4th 2017 – Child sees ENT consultant. Is found to have left side glue ear but no requirement for surgical intervention or hearing aids. A follow up appointment is made for six months. The child is brought to this appointment by his parents.
- May/June/August 2017 – Numerous issues concerning the child's non-attendance at SALT (speech and language therapy) appointments. Numerous appointments arranged but not attended (child not brought).
- September 2017 – Staff at nursery school notice that the child returns after the summer holidays looking 'pale, unwell, quiet and seeming ill'. His attendance at school was also considered poor. Staff decide to discuss these issues with the mother via the 'attendance route'.
- October/November 2017 – Continued non-attendance at numerous SALT appointments lead to the child being discharged from the service. The

mother subsequently contacts the service, and in an abusive manner, threatens to take them to court.

- November 2017 – Staff at school note numerous concerns. The child's attendance at school was poor. He was observed to look malnourished, he had head lice, his teeth were showing signs of decay, and he was showing what are described as 'nervous traits'. Staff also observed the mother shouting and swearing at the child outside the school, which upset the child. Staff speak to the mother about this incident and the mother blamed the child, stating that he had put her (the mother) in a bad mood as the child had made her late.
- January 2018 – Staff at school note further concerns. The child is noted to have a rash on his chin, which they subsequently speak to the mother about. The mother claimed that she had taken the child to her GP, but that the GP had not given her the cream that was needed to treat the rash. In addition, a sibling was observed to have large head lice. The mother was informed and asked to treat the entire family.
- 1st February 2018 – Staff at school note numerous concerns. The child had again been absent from school for a week and returned tearful and looking unwell. The parents had brought the child to school and informed staff that he had been off as he had been unwell, but they had taken him to their GP, who advised them that there was nothing wrong with him (the child). The parents also informed the staff that it didn't matter how many times they were warned about non-attendance, they would not be bringing the child to school if he was unwell.
- 1st February 2018 – Staff at school confirm via school nurse that the child had not in fact visited his GP recently. Staff note extreme concern as to the child's health and wellbeing and comment that he looked so unwell '*he may not last the weekend'.*
- 1st February 2018 – School nurse visits school and sees opportunistically in the playground. He is observed to be small with a red rash on his chin. His is also observed to have decayed and broken front teeth, wearing school uniform that looked quite clean.
- The school nurse subsequently contacts the mother, and they make arrangements to meet at the school on the 8th February 2018.
- 2nd February 2018 (which was a Friday) – School staff again note their extreme concerns and again note their fears that the child 'may not last the weekend'. Staff are upset and describe seeing his distended belly and an open, weeping sore to his chin. He is described as being listless and skinny, but with what is described as a 'pot belly'. A multi-agency referral form is submitted to Children's Services late that afternoon by email (subsequently confirmed to have been received at 4pm on the 2/2/18), but there is no follow up telephone call. The child is allowed to leave school and go home for the weekend. Children's services do not see/read the referral prior to the weekend and as such, are unaware of it at that juncture.
- 5th February 2018 (which was a Monday) – Duty manager at Children's Services reads the referral that had been submitted on Friday afternoon. It is

subsequently confirmed that there was no telephone call from the school to accompany the referral on the Friday afternoon.

- 5th February 2018 (continued) – Children's Services contact the school immediately upon becoming aware of the referral. They establish that the child was currently at the school premises. Children's Services contact police and hold a strategy discussion. The decision is made to conduct an immediate joint visit/investigation and Children's Services subsequently meet police at the school. Both parents also attend the school and provide consent for the child (and a sibling), to undergo emergency child protection medical examinations.
- 5th February 2018 (continued) – Police explain the requirement to attend the family home to carry out an assessment of the premises, however the parents are reluctant. Upon going to his car under the pretence of getting his house keys, the father makes off. Police pursue him and locate him at the family home. Police subsequently access the address.
- 5th February 2018 (continued) – The family home was in an extremely poor state of repair, filthy, with no electricity and no working toilet. There was no food in the cupboards and only inedible/spoiled food in the fridge, which was not working in any event. There was debris on the floor throughout the house and filthy mattresses on the beds.
- 5th February 2018 (continued) – Both parents were subsequently arrested for criminal neglect.
- The child was subsequently subject of an emergency child protection medical examination, as indeed was one of the siblings. One of the elder siblings was also medically examined. The result of this child protection was that the child had suffered neglect that met the threshold for significant harm. The child was described as being malnourished, with significant, advanced dental decay.

Practice and organisational learning

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

- **Professionals should be reminded to ensure that, where there is a requirement for an urgent safeguarding referral (child at risk of significant harm), this referral is made verbally, via telephone, in addition to an electronic submission.** In this case, the school staff were solely reliant upon a safeguarding referral, submitted by email at 4pm on a Friday afternoon, despite significant concerns as to the health and wellbeing of the child. This referral was not subsequently seen by Children's Services that afternoon and the child then spent the entire weekend 'at risk'.

Telephone contact should have been made with Children's Services duty team, emergency duty team, or even the police via a 999 call, in order to ensure that the significant safeguarding concerns apparent were attended to there and then.

- **Professionals should be reminded to ensure that, in cases where concerns are recorded, any decision not to complete/submit a safeguarding referral is accompanied by a documented rationale in relation to this decision.** In this case, there are several references to 'considering' safeguarding referral, however, this is not followed up and there is no documented rationale as to why these safeguarding referrals were not made. In considering whether to make safeguarding referrals, staff should refer to the Wales Safeguarding Procedures (2019).

- **Professionals should be reminded to ensure that information in relation to apparent safeguarding concerns is shared with other agencies.** In this case, there is a lack of appropriate information sharing, particularly between health and education (and vice versa). Had some/any information been shared with regard to their separate concerns, this would, in all likelihood, have subsequently led to a safeguarding referral. There was also evidence of poor communication internally within agencies. In the event that all safeguarding professionals used one, shared safeguarding IT system, this would ensure that all relevant, current information was available to all practitioners. The implications of the Soham murder investigation led to the formulation of the Police National Database (PND), for the improved sharing of information between police forces. The principles of this equally apply to the multi-agency safeguarding arena, where numerous reviews have highlighted poor information sharing as a contributory factor/learning. Despite this, effective information sharing remains an issue. Technology provides a number of potential options/solutions in relation to this aspect.

- **Professionals should be reminded to ensure that, where multi agency meetings or strategy discussions take place, these meetings/discussions are thoroughly and accurately documented.** In this case, reference is made to the child being discussed in a meeting between Flying Start and Children's Services. However, there is no record of these discussions, nor indeed of the outcome of these discussions.

- **Professionals should be reminded to ensure that where a fellow professional raises a possible safeguarding concern, that this concern is properly considered and decided upon.** In this case, a Paediatrician wrote to the health visitor, GP and the school, querying whether numerous missed health appointments raised a safeguarding concern. This was not followed up by any professional.

- **Professionals should be reminded to ensure that numerous missed health appointments (where the child was not brought) are considered a potential 'red flag', which requires appropriate consideration and follow up.** In this case, there were numerous occasions, where the child was not brought to pre-arranged medical appointments, or where there was no reply when medical professionals attended pre-arranged appointments at the family home. There was some evidence of disguised compliance by the mother of the child, who professionals described as doing 'just enough' to distract at the appropriate time and 'prevent' further action. However, there was insufficient professional curiosity shown by those concerned, with an overreliance on telephone conversation and written correspondence, as opposed to ensuring that the child was physically seen and confirmed to be fit and well.

- **Professionals should be reminded to ensure that dental neglect is considered a potential 'red flag', which requires appropriate consideration and follow up.** Dental neglect is defined by the British Society of Paediatric Dentistry as; 'Severe untreated dental disease, particularly that which is obvious to a layperson or other non-dental health professional, or dental disease resulting in a significant impact on the child'. Dental neglect is rarely present in isolation, may form part of the more general neglect of a child and may co-exist with other forms of abuse. Early identification and that taking appropriate action may help prevent children from experiencing further harm. In this case, the child concerned had obvious, visible, significant tooth decay, which should have raised greater concern in terms of possible long term neglect. Staff made reference that the child had been struggling to eat, such was the level of his dental discomfort.

- **Professionals should be reminded to ensure that they seek safeguarding advice from their agency safeguarding teams/children's services. This is particularly important in cases where there are escalating concerns, but uncertainty as to whether the threshold for a safeguarding referral is met.** In this case, there is reference to a 'neglect tool kit' as having been completed. On another occasion there is reference that this tool kit could not be completed, as they had 'insufficient information'. It is apparent that there was confusion as to how this neglect tool kit was to be completed and utilised, in order to make fully informed decision as to whether the threshold for a safeguarding referral had been reached. The RSCB no longer supports the use of any 'neglect tool kit' and there is no plan to either reinstate or relaunch this. When considering issues of neglect, professionals should refer to the 'All Wales Practice Guide – Safeguarding Children from Neglect'. There is an apparent lack of ownership in this case. The child was not invisible to professionals, but there is a lack of evidence of professionals being pro-active and taking responsibility to ensure that

safeguarding advice was sought, or that a safeguarding referral was submitted.

- **Professionals should be reminded to ensure a thorough hand over, which should be accurately documented.** In this case, there was a hand over between school staff, when the child changed schools, however, it does not appear that this was thoroughly documented. In addition, there was a lack of a thorough, documented hand over between the health visitor and school nurse when the child entered full time schooling. This is particularly important where there are concerns apparent in relation to a child, as there were in this case.

- **Professionals should be reminded to ensure that the 'voice of the child' is considered when dealing with apparent concerns in relation to a child.** In this case, evidence of the child's 'voice' was difficult to find. 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. It is acknowledged that throughout the period identified in the timeline the child was of a young age (4 to almost 5 years old) and known to have some speech and language issues - making it difficult for the child to express feelings in words. Yet, there is little evidence of practitioners using alternative approaches such to obtain the child's views, or indeed that the voice of the child was even considered. 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). This would have been an opportunity in this case.

EFFECTIVE PRACTICE

- At the point where the information in the safeguarding referral became known, agencies acted effectively and promptly to safeguard the child.

PRACTICE IMPROVEMENTS FROM EARLY LEARNING

The following section outlines the changes/improvements to organisational practice that have been implemented since the early learning from this child practice review became apparent. This in itself is positive, as agencies have not waited until the formal conclusion/publication of this child practice review in order to implement this learning.

RSCB to ensure that training/guidance is provided to staff in relation to process of urgent safeguarding referrals, in instances where a child is at risk of immediate harm. This training/guidance is to include the implications of a referral made just prior to a weekend/bank holiday and also the appropriate use of the emergency duty team and police, both of whom provide '24/7' functionality in order to address immediate safeguarding concerns.

- **VoG Education:** The processing of urgent safeguarding referrals now features as part of the Vale of Glamorgan's new Education Level 1 and Level 2 training, which will be rolled out fully in the Vale schools from September 2020. It also includes an emphasis on keeping a record of any contacts made.

- **C&VUHB**: Appropriate processes have been put into place within C&VUHB to ensure the appropriate and immediate response is in place. Additional slides have been included in all UHB safeguarding training packs to highlight to staff the need to phone through referrals prior to the weekend and Bank Holidays. In addition, the Safeguarding page on the UHB intranet has been changed to include advice to staff on the need to phone through referrals prior to the weekend or Bank Holidays. This is where most staff access the electronic form to make a referral.

RSCB to ensure that training/guidance is provided to staff in relation to instances where a child with known concerns is not brought to medical appointments and not present when medical professionals attend their home as a result of pre-arranged appointments. This training/guidance should focus upon what further action should be considered in such instances.

- **C&VUHB**: There is now an All Wales approach to Was Not Brought (WNB) appointments in the Health Visiting Service. This gives clear guidance to HVs that children in families where there are vulnerabilities and missed appointments, must be discussed with the UHB Safeguarding Team. In addition, it is now possible to place an alert on PARIS where children have missed health appointments with services such as SALT, Paediatrics and Audiology, to alert other staff involved with the family that appointments have been missed.

RSCB to ensure that training/guidance should be provided to staff in relation to the potential, broader implications and considerations around dental neglect.

- **C&VUHB:** The "Lift the Lip" initiative has been rolled out to families in the UHB area since July 2018. This programme encourages HV staff to teach parents to lift their children's top lip to check for signs of dental decay and take action. In addition, a slide to include the significance around dental

decay will be included (in July) in the UHB Safeguarding training on neglect at Level 2 and 3 of the Safeguarding training

- **VoG Education:** The child's school will be placing more emphasis on dental neglect training and will also be building in termly activities in reception to sight children's teeth.

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:-

In order to promote the learning from this case, the review identified the following recommendations/actions for the RSCB and its member agencies;

- **RSCB to ensure that all of the practice and organisational learning from this review is featured in all levels of safeguarding training. However, the following, specific training requirements are particularly relevant/important to this case;**

- **RSCB to ensure that training/guidance is provided to staff in relation to process of urgent safeguarding referrals, in instances where a child is at risk of immediate harm. This training/guidance is to include the implications of a referral made just prior to a weekend/bank holiday and also the appropriate use of the emergency duty team and police, both of whom provide '24/7' functionality in order to address immediate safeguarding concerns.**

- **RSCB to ensure that training/guidance is provided to staff in relation to instances where a child with known concerns is not brought to medical appointments and not present when medical professionals attend their home as a result of pre-arranged appointments. This training/guidance should focus upon what further action should be considered in such instances.**

- **RSCB to ensure that training/guidance is provided to staff in relation to the potential, broader implications and considerations around dental neglect.**

- **RSCB to ensure that training/guidance is provided to staff in relation to the effective use of the 'All Wales Practice Guide – Safeguarding Children from Neglect'.**

- **RSCB to ensure that training/guidance is provided to staff in relation to the importance of the voice of the child.**

- **RSCB to ensure that staff are reminded that the neglect tool kit is no longer supported by the RSCB.**

- **RSCB to explore with partner agencies, the possibility of having one, shared IT system/platform for safeguarding information.**

Statement by Reviewer(s)			
REVIEWER 1	Phil Sparrow Detective Superintendent South Wales Police	**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		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	issues as set out in the Terms of Reference

Reviewer 1 *(Signature)*	……	**Reviewer 2** *(Signature)*	……
Name *(Print)*	PHIL SPARROW	**Name** *(Print)*	……
Date	October 2020	**Date**	……

Chair of Review Panel (Signature)	……
Name *(Print)*	LINDA HUGHES-JONES
Date	October 2020

Appendix 1: Terms of reference
Appendix 2: Summary timeline

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 Board chair notified Welsh Government in June 2018 that it was commissioning a Concise Child Practice Review in respect of case CPR 2/2018.

The services represented on panel consisted of:

- South Wales Police
- Cardiff & Vale University Health Board
- Vale of Glamorgan Education
- Vale of Glamorgan Children & Young People's Services

A learning event was held on the 12th December 2019 and was attended by representation from the following agencies:

- South Wales Police
- Health Visiting, Cardiff & Vale University Health Board
- Paediatrics, Cardiff & Vale University Health Board
- Speech & Language Therapy, Cardiff & Vale University Health Board
- ENT Specialist, Cardiff & Vale University Health Board
- Primary School
- School Nurse, C&V University Health Board
- Flying Start, Vale of Glamorgan Children & Young People Services
- Early Years, Vale of Glamorgan Children & Young People Services

Several attempts were made to engage with the family and the family subsequently declined involvement.

☒ 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	☐	☐	

Cardiff & Vale of Glamorgan Regional Safeguarding Children Board

Terms of Reference for a Child Practice Review (Concise) Re: CPR 02/2018

Introduction

A concise child practice review will be commissioned by the Regional Safeguarding Children Board (RSCB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 2. A concise child practice review will be commissioned where an child who has not, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health.

Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be from February 2017 to February 2018

- Some information has been provided from before this period to provide background information about the family

- The following services will produce a timeline of significant events of its involvement with the child, for the timeframe above. A merged timeline will then be produced.

  - *South Wales Police*
  - *Cardiff & Vale University Health Board*
  - *Vale of Glamorgan Education*
  - *Vale of Glamorgan Children & Young People Services*

Core Tasks (for a concise child practice review*)*

- 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 individual 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. The Learning Event was delayed from early December 2018 to October 2019 due to the ongoing police investigation.

- Hold a learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.

- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review not already requested by the CPR/APR Sub Group, 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 RSCB 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.

- Produce a 7 minute briefing on the learning identified from the review.

Tasks of the Regional Safeguarding Children Board (RSCB)

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

- *Review panel* completes the report and action plan.

- RSCB send Report and Action Plan 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 CPR/APR Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on RSCB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the RSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.