Child Practice Review Report

Cardiff and Vale of Glamorgan Safeguarding Children Board
Concise Child Practice Review

Re: *C&V CPR04/2018*

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*

Legal Context

A Concise Child Practice Review was commissioned by *Cardiff and Vale Regional Safeguarding Board* on 04/09/2019 on the recommendation of the Child and Adult Practice Review Sub Group in accordance with the Guidance for Multi Agency Child Practice Reviews 'Working Together to Safeguard People (volume 2)'. The criteria for this Concise Child Practice Review are met under section 3.4 of the above guidance issued under the Social Services & Well Being (Wales) Act 2014:

'The criteria for child/adult practice reviews are set out in Regulation 4 of the Safeguarding Boards (Functions and procedures) Wales Regulations 2015, which states that child/adult practice reviews must be undertaken where abuse or neglect of a child or adult is known or suspected and the child/adult has;-

- Died, or
- Sustained potentially life threatening injury or,
- Sustained serious and permanent impairment of health or development

In accordance with the guidance, the criteria for a Concise Child Practice Review was met; there was evidence of child neglect that could have sustained serious or permanent impairment of health and development. A Concise Review rather than an Extended Review was commissioned as the child had not, for the six months preceding the discovery of the neglect, been on the Child Protection Register or been a looked after child.

Circumstances resulting in the review:,

An anonymous call was made to the RSPCA in August 2017, regarding concerns in relation to the welfare of the family's pet cats. The home was found to be in a poor state, contaminated with cat urine and faeces, no food and there was excessive rubbish and clutter throughout the house (in excess of 100 black bags of rubbish that were later removed from the home). Following this discovery, the NSPCC and Social Services were contacted and safeguarding procedures were initiated. The children were removed from their mother's care and placed in the temporary care of paternal grandmother, until their father moved back to their home area to take care of them.

One of the children had a life limiting condition. Prior to the above incident, a referral was made to Social Services on 10/08/2015 by a specialist Children's Nurse, as the mother had failed to collect the child's prescriptions for almost a year and had failed to engage with home visits. Indicators of neglect were identified which would have a more profound and potentially serious and sustained impairment on the health of the child with this particular life limiting condition; hence this review concentrating on that particular child.

A previous anonymous email had also been sent to the NSPCC helpline on 28/03/2015, raising concerns about the living conditions of the children. The children were reported to be eating out-of-date food, were unkempt and were attending school not appropriately dressed. The email stated that the house was unsuitable for the children to live in and that there were significant levels of rubbish both inside and outside of the home. The NSPCC helpline practitioner identified the children as being at risk of harm due to their basic needs not being met and a referral was made to Vale of Glamorgan Children's Social Care by the NSPCC on 30/03/2015.

The time period reviewed was from 1st August, 2015 to 31st August, 2017. The two year timeframe covers the initial referral made in August 2015 when indicators of neglect were identified, up until the incident which triggered safeguarding proceedings.

Background information was received from VOG Children Services detailing the previous referrals received about the children's welfare.

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

Representatives from South Wales Police, VoG Children & Young People's Services, VoG Housing Services, VoG Education Department, Cardiff and the Vale University Health Board, NSPCC and RSPCA attended the learning event. Contact was made with the children's family and interviews took place with two adult family members. A further interview also took place with the family GP.

Communication and information sharing.

Practitioners prior to and during the learning event had identified that they had, at times, worked in isolation from each other. They did not always liaise with other agencies appropriately at a time of concern.

A MARF referral made by a Health representative resulted in no tangible action being taken by social services as the parent, when contacted by social services, deflected concerns about the welfare of her child by alleging that she had a poor relationship with the professional that had made the referral. Social services did not speak to the referrer. Social services have since changed their procedures and guidelines regarding MARF referrals and efforts are now made to speak to the referrer prior to making any decision to curtail any involvement with the child.

Staff from all agencies to increase their confidence with the **Protocol for the Resolution of Professional Differences.** If professionals are not content with a decision made by another agency, they should be supported in challenging the decision to ensure that all efforts have been made to secure additional support for a child or vulnerable adult.

Child neglect and disguised compliance.

The Learning Event identified that significant progress had been subsequently made with regards to the recording of concerns about children at the school ('My Concern' electronic recording system implemented in September 2016) and a more robust approach would now be made were a child to be regularly attending school unclean and inadequately clothed. Education are very conscious to maintain a good working relationship with parents as they do not wish to alienate vulnerable parents and children and this needs to be balanced against the need to appropriately refer concerns of child neglect to social services to ensure that significant harm to a child does not occur. A parent can seem amenable to accessing support and it can be difficult to identify deliberate procrastination and assess how harmful the lack of progress is to the child.

Neglect can and does cause significant harm . The statutory safeguarding guidance for Wales Safeguarding Procedures states that, 'Neglect can in some cases be challenging to identify because of the need to look beyond individual parenting episodes and consider the persistence, frequency, extent and pervasiveness of parenting behaviour which may make them harmful and abusive.' It is also of note that the same guidance also states that, 'There is a reluctance to pass judgement on patterns of parental behaviour particularly when deemed to be culturally embedded or when associated with social disadvantages such as poverty.' All practitioners also need to be alert to the following concerns in this safeguarding guidance which states that 'in families where there is neglect because of impaired parenting capacity, practitioners may become focussed on the needs of the parent rather than the child. If support becomes focussed primarily on the parent in order to support their ability to parent there can be a failure to consider whether this is actually translating into better outcomes for the child.'

Disguised compliance of a parent can also be an issue where a parent gives the appearance of cooperating with services to avoid raising suspicions and allay concerns. Wales Safeguarding Procedure guidance also states that , 'It is important to establish the facts and

gather evidence about what is actually occurring or has been achieved, in order to not lose objective sight of what is happening.'

Housing services and safeguarding concerns.

The parent of the child had not complied with gas safety certificate procedures (there was no gas credit on the pre-payment meter for several appointments). Consequently, the gas meter was capped off due to the service anniversary date having expired, effectively stopping the gas supply to the child's home. This resulted in no gas central heating, limited hot water and no cooking facilities from November 2016. The children were removed in August 2017. The children were without gas amenities for that period from November 2016 until August 2017. No safeguarding referrals were made with regards to the children. VOG Housing department have since revised their procedures and are confident that any future such incidents would result in appropriate safeguarding referrals being made about either children or vulnerable adults left without access to heating, hot water or cooking appliances.

Unclaimed prescribed medication for children with life limiting conditions.

The parent had regularly not picked up repeat prescribed medication from the pharmacy for her child who had a life limiting condition. Discussions have been undertaken with the GP and will continue with safeguarding staff from the Cardiff and the Vale University Hospital Board and the Local Medical Committee to ensure that the GPs are made aware by pharmacy if any repeat prescribed medication is not collected for children with life limiting conditions. A safeguarding referral will then be generated. In addition C&VUHB Safeguarding Team will liaise with the Local Medical Committtee to ensure this is embedded throughout GP practices in Cardiff & Vale of Glamorgan.

Access to GP records by Medical teams supporting children with life limiting conditions

Further discussions to take place between Cardiff and the Vale University Health Board safeguarding representatives and Primary Care to ensure that there is easy access to a child's GP health records by specialist teams such as those supporting children with a life limiting condition. With regards to this child, this would have helped focus interventions on the child and would have prompted further safeguarding referrals.

Liaison between schools and medical teams supporting a child with a life limiting condition.

It was discussed in the Learning Event and evident from the Child Practice Review timeline that a meeting between the school and the specialist nursing team shortly after the child started at the school would have resulted in a stronger focus on the child's general wellbeing. The parent would sometimes allege that the child's poor attendance was due to health problems associated with their life limiting condition, however the school had been told by the Cystic Fibrosis Nurse, that the child's health would not negatively impact on his attendance. Whilst it's acknowledged that there are challenges to convening meetings between busy professionals it would have assisted all in supporting the child if a meeting could have taken place. The parent could have been more robustly challenged about poor attendance sooner and if the school had been reminded of previous safeguarding concerns, perhaps more prompt action could have been taken by the school.

Other Safeguarding Boards do have a separate Safeguarding Disabled Children policy. One such Board states the following about their Safeguarding Disabled Children's Policy. "This practice guidance makes clear that disabled children have exactly the same human rights to be safe from abuse and neglect, to be protected from harm and achieve the Social Services and Well Being Act 2014 (Wales) outcomes as none disabled children. Disabled children do however require additional action. This is because they experience greater vulnerability as a result of negative attitudes about disabled children and unequal access to services and resources, and because they may have additional needs relating to physical, sensory, cognitive and/ or communication impairments."

RSPCA and safeguarding arrangement with the NSPCC.

The RSPCA refer all child protection concerns to the NSPCC. It was noted at the Learning Event that this arrangement has helped increase appropriate safeguarding referrals. It was thought that the family were away on holiday hence the RSPCA referral did not prompt a same day response from the NSPCC. RSPCA did not alert the police for this same reason in that they did not feel that any child's safety was in imminent danger. The safeguarding arrangement between the RSPCA and NSPCC does seem robust but both agencies were reminded at the Learning Event that the police are happy to be called with any concerns that the RSPCA may have; it does not just need to be matters that require an urgent response.

Hoarding, self neglect and safeguarding.

The Learning Event did focus on the poor home conditions and the very negative impact they had on the children's wellbeing and safety. It was apparent that there is not a coherent multi agency approach to dealing with hoarding issues in the Vale of Glamorgan. A better understanding of hoarding would help improve the wellbeing of both children and adults in that area. Previous attempts had been made to assist with poor home conditions but the root of the problem was not addressed hence any good progress was shortlived. The North Wales Safeguarding Board does have a Hoarding Protocol which could be adopted.

"The Hoarding Protocol sets out a framework for social care and other relevant agencies to work in partnership using an outcome focused, solution based model. The protocol offers clear guidance to staff working with hoarders." It outlines that compulsive hoarding is a problem for several reasons. Because of the amount of clutter, the person may not be able to use the rooms in their house for their intended purpose, or even be able to sit in a chair without having to move things. In extreme cases the piles of clutter can become a fire risk and can result in the hoarder tripping and falling. And because the home is virtually impossible to clean, living conditions tend to be very unhygienic and can lead to rodent or insect infestations, blocked drains and other problems that may also affect neighbouring properties. The hoarder is usually reluctant or unable to have visitors, or even allow tradesmen in to carry out essential repairs. They quickly become isolated and lonely and are often prone to anxiety and depression. The hoarding probably brings them comfort, but deep down they are unhappy. They may ignore the pleas of family and friends to get help, as they do not see it as a problem or cannot bring themselves to tackle it. The hoarding literally takes over the person's life, causing their work performance, personal hygiene and social life to suffer. They may ignore the pleas of family and friends to get help, as they do not see it as a problem or cannot bring themselves to tackle it. The hoarding literally takes over the person's life, causing their work performance, personal hygiene and social life to suffer".

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:-

Agency Improvements in Practice

Agencies have already taken some action to improve practice during the time that has elapsed since the intervention of social services in August 2017. Those actions have been alluded to but are listed below:

1. Social services have since changed their procedures and guidelines regarding MARF referrals and efforts are now made to speak to the referrer prior to making any decision to curtail any involvement with the child.

2. Significant progress had been subsequently made with regards to the recording of concerns about children in schools in the Vale of Glamorgan on the electronic system called My Concern. and a more robust, child focused approach would now be made were a child to be regularly attending school unclean and inadequately clothed.

3. VOG Housing department have since revised their procedures and are confident that any future requests to sever gas supplies would result in appropriate safeguarding referrals being made about either children or vulnerable adults left without access to heating, hot water or cooking appliances.

Recommended Actions for the Regional Safeguarding Board.

The learning points identified through this review have resulted in further recommended actions for the Regional Safeguarding Board.

1. The Child Neglect – Practice Guidance and Protocol is currently under review in the Cardiff and Vale area. Once reviewed, it needs to be disseminated to all staff involved in safeguarding. A multi agency training strategy needs to be developed to refresh all staff with good practice principles and interventions for families with neglected children.

2. Social Services to ensure they speak with referrers as part of determining whether the referral meets a threshold.

3. To enhance awareness and encourage all agencies to use the Protocol for the Resolution of Professional Differences.

4. Cardiff and the Vale Regional Safeguarding Board to consider adopting and promoting a Safeguarding Disabled Children Policy.

5. Cardiff and the Vale Regional Safeguarding Board to consider adopting and promoting a Hoarding Protocol to complement the C&VRSB Self Neglect Messages for Practice.

6. C&V UHB to establish standardisation of health care planning for children with complex, life limiting conditions.

7. Cardiff and Vale Regional Safeguarding Board to engage with Digital Health Care Wales to establish if a system to notify GP when repeat prescriptions are not collected or dispensed from the pharmacy could be developed.

8. Cardiff and Vale Regional Safeguarding Board to further explore with Digital Heath Care Wales, improving the means by which health teams supporting children with life limiting conditions can access their GP records.

9. RSPCA staff to be reminded of the circumstances when they can also alert the police to safeguarding issues as well as making a referral to the NSPCC.

<table>
<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>REVIEWER 1
Jane Foulner</td><td></td><td>REVIEWER 2 (as appropriate)</td><td></td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
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<tr><td colspan="2">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</td><td colspan="2">I make the following statement that prior to my involvement with this learning review:-

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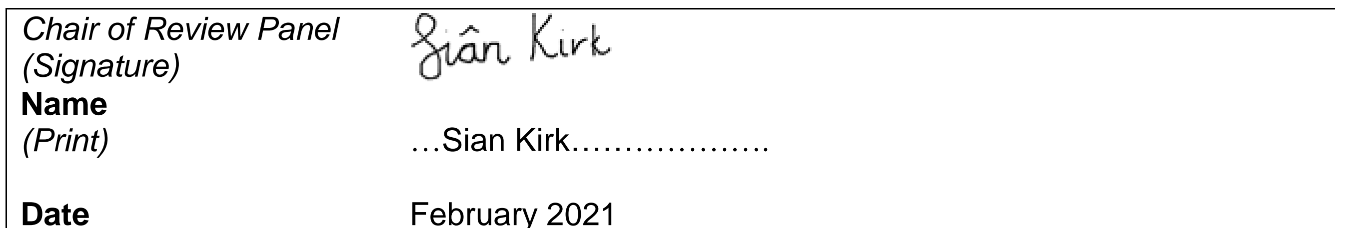
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	……………………
Name *(Print)*	Jane Foulner ………………….	**Name** *(Print)*	……………………
Date	February 2021	**Date**	……………………



Chair of Review Panel (Signature)	
Name *(Print)*	…Sian Kirk………………
Date	February 2021

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.*
A Child Practice Review Panel was established on 30/09/20, chaired by Sian Kirk, Safeguarding Lead, Wales and South West Asylum Safeguarding Hub, Resettlement, Asylum Support & Integration Directorate. The Reviewer was Jane Foulner, Senior Probation Officer, National Probation Service, Cardiff. Mandy Evans, Chief Executive of MIRUS was an observer reviewer. The Panel consisted of representatives from South Wales Police, VoG Children Services, VoG Housing Services, VoG Education Department and Cardiff and the Vale University Health Board. A Learning Event was held on 02/02/21. Representatives from South Wales Police, VoG Children & Young People's Services, VoG Housing Services, VoG Education Department, Cardiff and the Vale University Health Board, NSPCC and RSPCA attended the learning event.

Contact was made with the children's family and interviews took place with two adult family members. A further interview also took place with the family GP.

☐ 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	☐	☐	

Cardiff & Vale of Glamorgan Regional Safeguarding Board

Terms of Reference for a Concise Child Practice Review Re: CPR 04/2018

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 commisioned where a 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 **1st August 2015 – 31st August 2017.**

- The following services will produce a chronology/timeline of significant events of its involvement with the child (and family) for the agreed timeframe above. A merged chronology will then be produced.

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

Core Tasks (for a concise 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.

- 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 Child Practice Review.

Tasks of the Regional Safeguarding Children Board

- 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 **Vale of Glamorgan Co-Chair of RSB** will be responsible for making all public comment, and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the Final RSB Report.