Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

Child Practice Review Report

Cardiff & Vale of Glamorgan Safeguarding Board
Concise Child Practice Review

Re: *CPR 03/2019*[1]

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 *child practice* review was commissioned by Cardiff & Vale of Glamorgan Safeguarding Board on the recommendation of the Case Review Sub-Group in accordance with the Guidance for Multi Agency Adult/Child Practice Reviews. The criteria for this review are met under Working Together to Safeguard People, Volume 2 – Child Practice Reviews, issued under section 139 of the Social Services and Well-being (Wales) Act 2014 states that a Safeguarding Board must undertake a concise child practice review where 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.

The Cardiff and Vale Safeguarding Board commissioned a concise child practice review chaired by Clayton Richie, South Wales Police. The reviewer is Andrew Cole, Vale of Glamorgan Adult Services. The following agencies are represented on the panel;

- Vale of Glamorgan Children & Young People Services

- Cardiff and Vale University Health Board
- Vale of Glamorgan Legal Services
- South Wales Police

Administration and support to the panel is provided by Cardiff and Vale Safeguarding Board.

Representatives from Public Health Wales and Cardiff Council Children Services shadowed the panel as observers.

An Interim Report and Action plan was presented to the Cardiff and Vale Safeguarding Board in January 2021 to highlight early finding from the review while judicial proceedings involving the parents took place. On the completion of the judicial proceedings a learning event was convened on 12th July 2023 to inform the development of this final report and action plan.

Background

Child C was born on 18th October 2018. She lived with her parents until 2nd April 2019 when she was admitted to hospital with bruising to her neck and jaw area with an initial medical assessment of acute, severe hypoxic ischaemic brain injury, with CT imaging showing features of physical abuse including old fractures. Child C survived the injuries but is likely to live with the effects of lifelong brain damage as a result.

Father was known to the local authority as a looked after child, and as an adult received care and treatment for mental health issues. South Wales Police reports show a history of unstable behaviours including threats to harm himself and threats and acts of violence toward Child C's mother, prior to and following the birth of Child C and her older sibling.

Mother was known to the local authority as a child in need and has been in a relationship with Child C's father since 2016. South Wales Police records indicate that she was at high risk of domestic abuse.

It was not considered appropriate to seek the views of the parents during the development of this review due to the ongoing criminal proceedings.

Child C has one sibling who is 18 months older. Child C was born with a cleft palate and as such was under the care of the cleft palate team and the neonatal paediatric services in addition to the usual health visitor care from her local primary care medical practice.

The timeline of 01/02/2018 to 02/04/2019 was considered under this concise child practice review to enable the panel to take into account patterns of behaviour exhibited by the parents leading up to and following the birth of Child C.

2nd February 2018 to 18th October 2018

The panel considered events up to 8 months before Child C was born. During this time Child C's parents lived together with their first child, D. In February 2018, Child C's mother reported an allegation of physical assault and threat to herself and Child D to the police. Child C's father was arrested and bailed to his mother's address for the night but returned the next day as no further action was taken due to lack of evidence. Social services were informed. Further to the referral, mother advised Vale Children and Young People's Services that father had returned to the family home, and

disclosed his controlling behaviours and drug misuse by both parents, which was confirmed by father's Young Persons Advocate.

A further referral to Vale Children and Young People's Services from Tenancy Support in February 2018 reports poor engagement with tenancy support, concerns over the health of Child D, evidence of drug use and that mother and child were rarely seen and locked in the property when father was not at home. Father stated that he locked the house while he was out because there was only one set of keys.

Between February and April 2018, Vale Childrens Services completed a wellbeing assessment and found controlling behaviours by father, parental drug use, parental Adverse Childhood Experiences (ACE), father's mental health issues, financial problems and lack of external stimulation for older child, but noted that Child D as meeting milestones and that father showed good interactions with the Child D. The outcome of the assessment did not meet threshold for child protection and a referral for preventative services was made.

Health records indicate good engagement with Midwifery and Antenatal Services between March and 18th October 2018, when Child C was born.

20th October to 31st December 2018

Family engaged with Health Visitor home visits during early weeks. Health Visitor did notice that father has taken on main carer role and recommended enhanced Health Visitor service and high energy feed due to Child C's low weight. Home was described as stale and grubby.

Family did not attend Cleft Palate Team appointments at Hospital during this time despite offer of transport. It is noted that children born with cleft palate can pose additional challenges, due to difficulty feeding, for which the Cleft Palate team provide advice and support.

Health Visitor observed fluff stuck to Child C's body during routine vaccination appointment, which may indicate that she was not adequately washed.

9th January to 27th February 2019

Father responded to Health Visitor request to rearrange a missed appointment.

Mother attempted but failed to attend an appointment with the Cleft Palate Team in Swansea. She was seen in Bridgend in a distressed state, with Child C in grubby and inappropriate clothes for the season by a member of the public who reported the concerns to Vale Children Services.

On 30th January 2019, father attended for 2nd vaccination with Child C. She was reported to be hungry with nappy rash and with fluff and bits of soft plastic from the family sofa stuck to her body. A mark was observed on her arm which records indicate could have been a finger mark. The Health Visitor referred Child C to the GP for advice, who photographed the mark and assessed that the mark was caused by friction and therefore accidental. The Health Visitor made a referral to Children's Services.

Children's Services assessed the referral as not meeting child protection threshold and liaised with the health visitor who acknowledged the parent's ambivalence toward professionals possibly due to their own adverse childhood experiences. The Health Visitor planned to continue to work with the family regarding the importance of keeping appointments and to offer further support and a referral to Flying Start for additional community support – such as parenting programmes, childcare alongside the enhanced Health Visiting Service.

On 26th February, South Wales Police received a telephone call with a male shouting and swearing, identified as Child C's father and a baby crying in the background. A Police Community Support Officer (PCSO) visited the home address and spoke to father who stated he bumped his elbow causing him to shout. Mother was not seen face to face. PCSO advised father against swearing and shouting in front of the children. A PPN was made to Vale Children Services, who responded by leaving messages for the children's Health Visitor.

Family did not attend health appointment on 27th February 2019.

8th March to 2nd April 2019

Health visitor discussed her concerns about the family in safeguarding supervision, and agreed to continue to offer support, refer to Vale parenting support and to make a safeguarding referral if family do not engage in meaningful way.

Health Visitor received letter advising the family had missed three appointments with the Cleft Palate Team.

Health Visitor made home visit on 20th March 2019, but father declined entry stating the family had a cold but that he would make an appointment for the missed vaccination. Mother was seen wearing a grubby dressing gown and stale smell was sensed at the property.

Further Health Visitor visit on 27th March 2019, received no answer. Health Visitor completed a safeguarding referral detailing previous concerns: mark on Child C's arm, missed health appointments, concerns about children's cleanliness and general care, father heard shouting on call to South Wales Police, concerns regarding father's controlling behaviours. Vale Children's Services did not progress referral as no consent was given by parents and that previous concerns had already been addressed.

On 2nd April 2019, while parents were visiting family out of area, the parents attended Royal Glamorgan Hospital with Child C describing a 7-day history of Child C being lethargic and not feeding.

Child C presented as unresponsive to hospital staff with possible seizures, bulging fontanelle and bruising to jaw and was transferred to University Hospital Wales for immediate medical attention.

Referral made to Vale Children's Services who undertook strategy discussion with South Wales Police.

Learning Event

A Learning Event took place on 12th July 2023 with representatives of the Midwife and Health Visitor team, Vale Childrens Services and South Wales Police. Apologies were received from Vale Childrens Services Team Managers.

The main discussion points arising from the Learning Event were:

<u>Home conditions:</u>

The attendees acknowledged that the home conditions were often cluttered, stale and grubby, but that this is a matter of perspective. All attendees were able to identify other homes that were significantly more cluttered, stale and dirty, leading the group to wonder whether the experience of observing a range of homes of people living in cluttered, malodourous and squalid conditions affected their professional judgement about what should be an acceptable level of home conditions for very young children? The group acknowledged that while home conditions may not be a determinative factor, it

should be seen as an indicator of child neglect and should be considered alongside other elements of childcare.

Father's controlling behaviours:

The tenancy of the family home sat with father, which the group thought was due to his status as a care leaver. This gave him access to tenancy support but did not provide support to Child C's mother. The group questioned whether this empowered him to take a leading role in the parenting and encouraged his controlling behaviours.

The Midwife and Health Visiting attendees stated that prior to Child C being born, the parents relationship appeared positive and supportive, but changed to one where father become dominant and controlling and where mother's voice had become lost. This account does not appear to match the detail of the two referrals made before Child C was born.

Quality of information sharing, including PPNs (Police Protection Notice):

The group acknowledged that the presentation and discussion at the Learning Event enabled a holistic insight into the family, which in real time each agency does not have access to. The group acknowledged that agencies continue to work in silos, each with their own pressures of limited resources and increasing demands, which impacts on an analysis, reflection and sharing of information, which in turn impacts on the risk assessments and decision making. This was noted by the Domestic Abuse (DA) Risk Assessor of South Wales Police, who movingly stated that if historical and other agency information was known to her or documented on the PPN, this may have raised the domestic abuse risk assessment level which in turn would have led to further safeguarding enquiries.

A lack of access to shared contemporaneous and historical records will only perpetuate silo working and will continue to lead to gaps in decision making and therefore not reduce risks to children. This observation highlights the critical importance of multi-agency strategy discussions.

Side note: use of abbreviations when sharing information was noted as being unhelpful. Simple examples were provided such as NFA – some know it as No Further Action, others as No Fixed Abode which causes confusion.

Importance of handover.

The Health Visitor Team noted the importance of handover, as when she took over Child C's care the handover was minimal as previous HV had moved to Spain so there was no opportunity for face-to-face discussion. Since this time midwives and HVs utilise the same computer database (PARIS) which has improved communication and info sharing.

Impact of Adverse Childhood Experiences:

The group felt that both parents were affected by their own childhood experiences and their relationship with Children's Services while they were children. The group felt that the impact of adverse childhood experiences on parental wellbeing and childcare was not fully understood, but that it should be an indicator of family need. More training and research is needed to provide professionals a greater understanding of the impact of adverse childhood experiences on parental welfare and their ability to provide childcare, so professionals can be more informed of potential risks.

It is noted that Health Visitors working with families with parental Mental Health issues do not have access to adult mental health records, instead have to make a special request to the Mental Health Clinical Board to access the records which can act as a barrier to joint working.

Missed appointments with health professionals:

Child C's parents missed many appointments with health professionals, meaning that Child C did not get the healthcare that she needed in a timely manner, which is particularly important with a child with additional needs such as cleft palate. It was known that Child C was of low weight, which may indicate a problem with feeding (which is common in children with cleft palate) possibly leading to additional challenges such as restlessness, additional crying and susceptibility to infections such as glue ear. While all attendees agreed that missed appointments were not in Child C's best interests, it was not clear at what point missed appointments become a safeguarding concern.

The pressure on services mean that unannounced Health Visitor home visits are increasingly uncommon, police and social services welfare checks are only completed in exceptional circumstances, leaving the responsibility for child welfare with the parents even where there are concerns about the ability of the parents to ensure children's welfare. The group felt that this will lead to more children at risk of neglect or abuse.

Hazard notification.

It was noted that the Vale Childrens Services records identified Child C's home address as hazardous to professionals and advised that home visits should be completed in pairs. The group was not clear on the process for identifying such hazards but admitted that the process was staff focussed and did not lead to a child focussed assessment.

Professional Differences escalations process.

The group was unanimous in stating that where a mark on a very young or immobile child such as that found on Child C on 30th January 2019, a safeguarding enquiry should have followed, including a Child Protection medical examination. Despite the GP suggesting the mark was accidental, the Health Visitor made a referral to Children's Services who did not pursue an enquiry. The health professionals at the event stated that a medical examination might have picked up historical injuries and led to an earlier proactive multi-agency decision to safeguard Child C.

The group was not aware of any formal process for escalating professional differences.

Point of note: The Cardiff and Vale Safeguarding Board's escalating professional differences protocol has only been used once in the region since ratification in 2018, which may indicate a culture of acceptance between professionals, rather than a culture that is focussed on the child.

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

Parental engagement

It appears to be a well-established fact that the parents of Child C were difficult to connect with in a meaningful and child focused way. Their named Health Visitor postulated that the parents found it difficult to trust health and social care professionals due to their own adverse childhood experiences and involvement with children social services when they were children. This suspicion toward professionals appears to have been a barrier to a meaningful child focused relationship with professional but was not adequately addressed despite being well understood. The effect of this meant that the assistance of professionals was not sought by the family and indeed, the advice given by professionals was received with a level of distrust – this can be seen in the father's reluctance to accept advice regarding high energy feed.

The panel felt that the impact of parental non-engagement on the welfare of Child C was not adequately explored or understood across all professional groups. Children's Services did not develop a strategy for positive child focussed connection with the family, but instead accepted non-engagement as normal for the family without an analysis of the risks this presented.

Father's behaviours

It appears that several professionals who had worked with Child C's father found him to be aggressive and controlling. This behaviour was evident prior to Child C's birth. His Young Persons Advocate described him as aggressive and controlling and that they do not visit unaccompanied; he has a history of physical violence and threats to Baby C's mother and he has been recorded by South Wales police shouting and swearing in the presence of his young children. This dominant and controlling behaviour is further evidenced in his attendance at most of the health and social care appointments; his taking charge of the conversation at the appointments and through undertaking the main parenting role. While his behaviour at appointments should not necessarily be seen as coercive control on its own, it should have been considered alongside other dominant behaviours to gain a fuller picture.

Child C's father was also known to have mental health problems, which may have contributed to the presentation of some of these behaviours, but these needs do not seem to have been adequately addressed. His behaviours were highlighted as a risk factor, but there does not appear to have been a coherent management plan to address the risks.

Working Together to Safeguard People – Volume 5, is clear that children will suffer, directly or indirectly if they live in households where there is domestic abuse. The controlling behaviour described above is a sign of domestic abuse/coercive control and thus an indicator of potential harm to a child. This does not appear to have been adequately considered and explored.

It is important to note that the Domestic Abuse Bill recommends changes in practice with a stronger focus on the victim.

The panel questioned whether father's perceived dominance impacted on the professional's relationship with him and the family. This may have led professionals to accept his controlling behaviours as normal and exaggerated the perceived strength of his presentation as main care giver, which had the effect of producing an over optimistic and unbalanced assessment of the risks.

Mother's behaviours

The professionals involved in Child C's care do not appear to adequately address her mother's ability to provide a safe caring environment for her. They appear to be more focused on father's behaviours. Throughout the chronology, Child C's mother appears as a background character, often hidden away upstairs during home visits or locked in the house with the children when their father leaves the house. The one occasion, she attempted to attend an appointment on her own she failed to make, becoming distressed in the train station without adequately planning for the journey or the safety of Child C through the provision of clean, weather appropriate clothing. This incident shows mother to be in need of support or direction, but this was not proactively followed up by the relevant services, nor was the potential impact of mother's parenting skills on the children adequately considered.

The opportunity to see the mother on her own was not taken, which had the effect of dismissing or minimising her role as either a protective or indeed a risk to the children, which had the effect of producing an unbalanced assessment of the risks.

The impact of Adverse Childhood Experiences on parenting

Despite having a well-known effect on adult wellbeing, the impact of the parent's adverse childhood experiences on their ability to provide adequate and safe childcare was not clearly understood or questioned by relevant professionals, which may have compromised the quality of assessments and therefore safeguarding decisions.

Parent's relationship

The parent's relationship is characterised by the professionals involved in the care of Child C as being dominated by the father. This appears to have been accepted, despite the known history of his controlling and physically violent behaviours towards her, often in front of the children.

The impact of the parent's relationship appears to have been accepted as normal for this family, and was not adequately addressed with them, nor was the impact on the children considered as part of an assessment process. This had the effect of leaving the children to experience the impact of domestic abuse, which is known to have detrimental effects on child development and be a predictor of physical abuse and neglect.

Consent

The Health Visitor completed a safeguarding referral on 27th March 2019 detailing previous concerns: mark on Child C's arm, missed health appointments, concerns about children's cleanliness and general care, father heard shouting on call to South Wales Police, concerns regarding father's controlling behaviours. Vale Children's Services did not progress referral as no consent was given by parents and that previous concerns had already been addressed.

The panel is concerned that the lack of parental consent was seen as a barrier to child focused interventions. The panel was in no doubt that where there are clear safeguarding concerns, consent should never be seen as a barrier to further safeguarding enquiries as the welfare of the child is paramount. However, the panel acknowledged that when working with a family in need of care and support, a lack of parental consent could deter further work with the family. Indeed, the panel were of

the view that a lack of consent should give rise to suspicion and thus be considered as part of an assessment process.

Home conditions

During the many visits to the home of Child C, prior to and following her birth the home conditions were repeatedly described as grubby and stale, with some occasions noting clutter that caused a potential hazard to children – such as batteries left in reaching distance and a tile cutting tool left on the floor that were both potentially significantly harmful to the children. The parents were repeatedly advised to tidy up by visiting professionals, but there does not appear to have been an improvement in this area. An untidy home is not necessarily a safeguarding concern, it is an indication that the parents are not able to prioritise the safety of the children by providing a safe environment for them.

It is also worth noting that professionals were aware that Child C's clothes appeared grubby and not suitable for the weather conditions, which further indicates that the parents were not able to prioritise the safety of Child C.

The NCPCC highlights 'poor appearance and hygiene' and 'living in an unsuitable home environment' as potential signs of neglect.

The panel agrees that the presentation of home conditions is subjective but are clear that dangerous home conditions indicate an environment where a child is at risk, meaning that relevant professionals have a duty to report and the LA has a duty to consider a full child protection enquiry assessment. This appears to have been missed in this case.

Substance misuse

The parent's use of cannabis was known throughout the time the professionals were involved with the family and is known to distract parents from their role as care givers to their children. The use of drugs appears to have been accepted by the professionals, meaning that the impact of the drug use on the children was not addressed. The misuse of family income to purchase drugs instead of clean clothes, toys or activities for the children does not appear to have been considered. The impact of intoxication from drug use on a parent's ability to prioritise the health and wellbeing of a child does not appear to have been addressed with the family either, nor was the impact of drug use on the parent's ability to tolerate stress or manage feelings of aggression taken into account, thus leaving the children to feel the effects of drug use on the family.

The panel note that the Vale of Glamorgan hosts preventative services that work with parents who misuse drugs and alcohol, that may have assisted the family to gain control over their drug use and inform any assessment on the parent's ability to keep the children safe. This opportunity was not taken in this case.

Missed health appointments

The chronology considered for this Child Practice Review highlights repeated missed health appointments, indicating that the parents were not able to prioritise the health and wellbeing of Child C. This was regularly reiterated to the family but does not appear to have improved attendances, even when Child C was losing weight. Of particular note was the failure of the family to take Child C to a single appointment with the specialist Cleft Palate Team despite the offer of organised transport.

It is noted that the parents did take Child C to some appointments, which may have given professionals a sense of misplaced reassurance that the family were trying their best, removing the focus from Child C.

The impact of missed health and social care appointments was not fully understood by Children Services. Social care professionals need to be more curious about the impact of missed appointments and health professionals need to explain the potential risk caused by missed appointments on child health more clearly to ensure a more joined up approach.

The panel notes updated guidance since this incident. The All-Wales approach to 'Was Not Brought' (WNB) to appointments in the Health Visiting Service, provides clear guidance that missed appointments by children from families with vulnerabilities must be raised with the UHB Safeguarding Team. The health board PARIS system now includes an alert mechanism notifying staff/services who have involvement with the family, of a child's missed medical appointments.

The opportunity to fully understand the impact of the missed health appointments on Child C's welfare was not taken as part of a multi-agency discussion or assessment.

Potential injury

During a routine visit to the health centre for immunisation on 30th January 2019, a mark was observed on Child C left arm. The GP was asked to examine Child C and did not think it was a non-accidental injury.

The Health Visitor appropriately made a safeguarding referral to Vale Children Services, who followed up the referral with two phone calls: to the GP, who advised that the mark was an accidental injury and the Health Visitor who acknowledged that the family were difficult to engage and the older sibling was challenging. Vale Children Services did not investigate the referral any further.

The presentation of an immobile child with an injury (which includes marks/bruises) is a significant indicator of a child at risk as an immobile child is highly unlikely to have caused the mark/injury themselves. When set in the context of the multiple risk factors already outlined, this should have met the threshold for consideration of initiating child protection enquiries.

All Wales Safeguarding Procedures make it clear that where a non-mobile child presents to a GP with a mark/injury a referral to a specialist medical examiner must be made alongside a referral to Childrens Services Multi-Agency Safeguarding Hub.

The concerns at the time of Child C's presentation at the surgery that resulted in a Child Protection referral being made, were focused on the mark and the view of the GP that this did not appear to be non-accidental in nature without the advice of a specialise paediatrician and without taking into account the wider social context relating to Child C and the family.

Messages from Practice: Reviews and research highlight that bruising/marks in children who are not mobile are very unusual.

GPs are not specialists in child protection. The opportunity to seek the view of a paediatrician to consider the mark on Child C's arm and her overall health was not taken. The associated concerns around the child's presentation were also not considered or explored by the GP or Childrens Services.

SCIE (April 2016) in the document Practice issues from serious case reviews – learning into practice identified several occasions where the identification of an injury by a GP to non-mobile baby were not reported because:

- a lack of understanding of child protection procedures, particularly among those working in out of hours GP surgeries
- a lack of professional curiosity and 'respectful scepticism' about explanations for bruising

- second opinions not sought from more experienced clinicians.

In this case the mark was reported to Vale of Glamorgan Children Services, but the GP's view that the injury was accidental was given sufficient weight to stop any further enquiries without apparent consideration of the already known risk factors within the family. This was a missed opportunity to safeguard Child C.

Terminology

The panel acknowledged that in certain circumstances, the terminology and language used within safeguarding procedures has the power to influence decision making and therefore outcomes for children and that practitioners need to be mindful of this unintended influence.

The use of the terms 'accidental injury' and 'non-accidental injury' when used early in a safeguarding process or without specialist medical assessment has the ability to influence future decision making. This was clearly evidenced in Child C's case, where the bruise on her arm was described as accidental, which affected the safeguarding decisions.

The panel suggest that the use of the term 'injury' without an adjective remains neutral thus encourages further assessment.

The panel noted that the term 'accidental' should not be seen as 'without cause', as Child C's home environment was known to be untidy and potentially hazardous, raising the risk of injury through dangerous items (such as the tile cutting tool) in reach of the children.

The child protection referral process

During the course of the chronology, Vale of Glamorgan Children Services received 7 referrals; two prior to Child C's birth (One PPN and one referral from Tenancy Support) and five after Child C was born including one, from a member of the public, one PPN, two from the Health Visitor Team and the final referral after child C was taken to hospital.

The referrals appear to define Child C as a 'child at risk'; i.e. a child who is experiencing or is at risk of experiencing abuse, neglect or other kinds of harm and has needs for care and support. In this case the Social Services and Wellbeing (Wales) Act 2014 states that the local authority must consider whether there are grounds for carrying out an enquiry assessment under Section 47 of the Children Act 1989 by making such enquiries as it considers necessary to decide whether it should take action to safeguard or promote the child's welfare.

The All Wales Safeguarding Procedures state that following a report the relevant social services team must decide and record next actions within one working day and that the initial checks and decisions should focus on the safety and wellbeing of the child and should consist of:

- Checking information held in any existing social services records on the child, other children in the family and the carers, and past involvement by services.
- Checking the child protection register.
- Making enquiries with other agencies as appropriate.

It appears that each referral was examined in isolation of previously known information about the family, with limited consideration of the family context and the concerns of partner agencies. This led to incomplete information being considered by Children Services which therefore did not adequately safeguard Child C.

It is reasonable to expect safeguarding referrals are seen within the wider context of the family, which include previous support and identified risks. A full analysis of previous risk factors and the referral information should have led to a full Section 47 (CA89) safeguarding assessment rather than a section 21 (SSWA16) wellbeing assessment which has a different focus.

The panel strongly support the Social Services and Wellbeing Act (Wales) 2014 principles of wellbeing, voice and control, co-production and prevention when working with children with care and support needs and their carers, and welcomed the All-Wales Safeguarding Procedures advice (Section 3, Part 1) that states that in all cases (of initial enquiry), whilst the safety of the child must remain paramount:

- the least intrusive intervention should be used wherever possible.
- social services should aim to work with the family to safely protect the child.

However, the panel questioned whether the advice to provide a least restrictive option and to work with the family to safely protect the child, encourages an over optimistic approach to safeguarding in some circumstances.

There was no assessment of care and support and/or protection needs undertaken in relation to Child C until their presentation at hospital in April 2019.

Summary:

The family lived with multiple risk factors (financial problems, drug misuse, domestic abuse, parental mental health problems and the effect of their own adverse childhood experience) which indicate parental vulnerabilities which could place a 'child at risk'. These were not adequately considered in an assessment process.

The professionals involved in the care of Child C appear to have accepted the range of risk factors associated with this family, accepting it as normal, without due challenge or analysis of the potential harm to the children. In other words, the focus was over optimistic and, on the adults, not the children.

Parental non-engagement and missed appointments were shared with Childrens Services and followed up in coordinated manner by partner agencies. Health Visitor and Midwives made multiple referrals to Childrens Services alongside PPNs made by police officers detailing concerns around domestic abuse, missed health appointments, weight loss, grubby and unseasonal clothing of Child C and a non-accidental injury, but these were not given the opportunity of multi-agency oversight due to Children Services not initiating enquiries as part of a Section 47 safeguarding assessment. This represents a number of missed opportunities to safeguard Child C.

Improving Systems and Practice

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

Recommendations

1. The Board needs to be assured that practitioners and relevant partners, understand their duty to report children at risk, by confirmation that the referral documentation is fit for purpose by ensuring that all known relevant information regarding the child and the family is provided with sufficient detail to enable the receiving team to consider the impact on the child/ren and whether there are grounds for carrying out a safeguarding assessment under section 47 of the Children Act 1989.

2. The Board needs to be assured that practitioners reviewing a referral into Children Services should consider the current referral within the wider family context, including previous referrals/assessments and case notes as well as actuarial risk factors with a focus and understanding of the risk to the child, whomever the source of the referral.

3. The Board needs to be assured that practitioners are aware of their duty to request specialist medical examination of all injuries of a non-mobile child and that clear referral pathways are maintained to avoid delay.

4. The Board needs to be assured that practitioners understand the association between domestic abuse and child abuse and are aware of their organisation's policies and procedures in relation to domestic abuse. [This recommendation is similar to recommendations in previous CPRs, but remains an area of risk, particularly in understanding the implications of coercive control within families]

5. The Board needs to be assured that practitioners understand the association between parental non-engagement and unwarranted lack of consent and child abuse and review their organisation's policies and procedures in relation to working with families with such risk factors.

6. The Board needs to be assured that practitioners understand the association between the parent's vulnerabilities (such as adverse childhood experiences, mental health problems and/or drug use) and child abuse and review their organisation's policies to ensure such vulnerabilities are considered as part of the assessment process.

7. The Board should develop guidance for practitioners on describing and recording home conditions that pose a potential threat of harm to children, including the appropriate presentation of children (e.g.in clean clothes suitable for the weather, hygiene etc). This should include how to address the issue with parents or carers and when home conditions or the child's presentation cause a safeguarding threat to children.

Statement by Reviewer(s)	
REVIEWER 1	
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 individual 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)*	
Name *(Print)*	Andrew Cole
Date	12/12/23
Chair of Review Panel *(Signature)*	
Name *(Print)*	Clayton Ritchie
Date	12/12/23

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Appendix 1: Terms of Reference

Cardiff & Vale of Glamorgan Regional Safeguarding Board

Terms of Reference for a Concise Child Practice Review

Re: CPR 03/2019

Introduction

A concise child practice review will be commissioned by the Cardiff & Vale Safeguarding Children Board (CVSB) 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 undertaken where 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.

Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be **1st February 2018 – 2nd April 2019.**

- 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

- The sibling's chronology will be considered as part of the review.

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. The Senior Investigating Officer to be cited on any Interim Report.

- The Learning Event will be subject to a delay due to an ongoing criminal 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 Case Review 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 CVSB 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 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.

- CVSB 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 Case Review Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on CVSB website.

- Agree dissemination to agencies, relevant services and professionals.

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

Child Practice Review process
To include here in brief: • *The process followed by the SB 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 family were informed of the Child Practice Review at the start of the process.
☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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