Child Practice Review Report

Child Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Concise Child Practice Review

Re: CTMSB 06/2021

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*

1.1 In accordance with the Social Services and Well Being (Wales) Act 2014, a Concise Child Practice Review was commissioned by Cwm Taf Morgannwg Safeguarding Board on the recommendation of the Adult/Child Practice Review Sub-Group in January 2022.

1.2 Legislation outlines that the Regional Safeguarding 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's name was on neither the Child Protection Register nor was a Child Looked After 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 purpose of a Child Practice Review is to identify multi-agency learning for future practice.

1.3 Background & Family Context

The circumstances in the case of Child C are as follows:

Child C was 9 years old when she died. She was found in the bath, submerged under water in September 2021, having been left unsupervised. Child C had global delay, epilepsy and learning disabilities, culminating in significant and complex needs. Practitioners involved with Child C described her as an energetic, entertaining child who was often determined and willful when deciding on what she wanted to do. It was suggested that Child C could communicate to a moderate degree, but that the success of this would depend on her mood and environment.

For the majority of the timeline, Child C was living with her older brother (Child D), her older sister (Adult F), her mother and her mother's partner who was not the biological father of Child C or her siblings. Child C's biological father had passed away in 2019, having remained married to her mother until this time. Child C's maternal grandmother would regularly take on caring responsibilities for the children to accommodate her mother's employment commitments.

Child C's mother was diagnosed with depression and records illustrate that she was in receipt of medication to manage this condition.

At the conclusion of the timeline, Adult F, who was also diagnosed with epilepsy and had moderate learning disabilities, was residing in a supported living provision following allegations of physical abuse being made against her mother's partner.

The family had been known to Social Services since 2010 with Child C and her siblings' names having been placed on the Child Protection Register on two separate occasions. The first period was April 2014 to December 2014 under the category of Physical Harm. The second period was November 2019 to January 2021, under the categories of Neglect and Sexual Abuse.

The period of time within which practice was reviewed is 1st September 2020 to 13th September 2021. This accounts for the 12 months prior to Child C's death.

1.4 Summary of agency involvement during the timeline

- Given her complex health needs, Child C was under the care of Paediatric Neurology for epilepsy and would also be routinely seen by an Epilepsy Specialist Nurse. She was in receipt of medications to help manage the epilepsy and records indicate that she hadn't had a seizure for approximately 2 years prior to her death. However, there are some indications which have become apparent during the course of this review, that this may not have been the case. It has come to light that she may have had a seizure more recently although there are no records of this disclosed to this review. During the timeline Child C had scheduled Paediatric, Radiology and Neurology appointments. Her sister, Adult F, was also diagnosed with epilepsy and was under the care of Learning Disabilities Psychiatry due to having moderate learning needs.

- In September 2020, Child C commenced admission to a local special school. She maintains a 95% attendance rate in 2020/21 and also engaged with the emergency vulnerable group hub provision during the Covid-19 lockdown in January 2021 – April 2021. Child C's sibling, Adult F, had been a former pupil at the school so the family had been well known.

- As alluded to above, the family had been known to Children's Social Care Services for over a decade. A Disabled Children's Team Social Worker had been involved with Child C prior to and during the timeline, in response to her assessed needs requiring multi-agency care and support. Prior to the timeline, Child C and Child D were added to the Child Protection Register in November 2019 under the categories of Neglect and Sexual Abuse. At this point, the responsibility of coordinating the Care and Support Plan effectively transferred to a Child Protection Social Worker although the Disabled Children's Team Social Worker remained involved with the family. The siblings were de-registered in January 2021, leading to the coordinator role again moving back to the Disabled Children's Team in June 2021. This was 6 months post de-registration safeguarding support as is common practice.
  It also notable that in January 2021, there was a change in the Disabled Children's Team Social Worker allocated to the family, at the request of Child C's mother.

- At the conclusion of the timeline, the Adult Safeguarding Team are involved with the family due to allegations of physical harm made by Adult F against her mother's partner. An Adult at Risk Enquiry was commenced on 10th June 2021 to explore the potential risks posed to Adult F.

  Subsequently, a strategy meeting was held on 14th June 2021 in relation to Child C and Child D in order to assess their welfare and decide whether they may be likely to suffer significant harm. Here, it was decided that s47 enquiries would be initiated to determine what action may be required to safeguard the children. In adherence with Wales Safeguarding Procedures, the outcome of these enquiries was finalised on 28th June 2021. The conclusion is that there is no evidence of significant harm to either sibling and this matter was closed.

- South Wales Police are involved in Child Protection Strategy Meetings and Conferences during registration, decision making in relation to the s47 enquiries described above and also the investigation into allegations made by Adult F.

  Significantly, there was a series of five incidents involving Child D being found unaccompanied outside of the family home or having been reported missing during the timeline. South Wales Police responded to these concerns, locating Child D, returning him home and, in almost all cases, submitting a Public Protection Notice. These notifications were made in recognition that Child D was subject to registration and would serve to summarise his vulnerabilities to Children's Social Care Services.

- A domiciliary care provider was a consistent source of support for the family throughout the timeline. This organisation was employed by Child C's mother

through Direct Payments to support Child C inside and outside of the family home.[1] This would involve activities such as playing, socialising and practical home support.

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

2.1 A learning event was held on 27th September 2022. This is a facilitated practitioner focused event which is led by reviewers and chair of the practice review. Practitioners are encouraged to share their understanding of events and identify key learning points for future practice. Professionals involved with the family of Child C went through the timeline of events, were able to share their experiences and identify thematic learning. This was understandably challenging for some, particularly those who knew and had worked directly with Child C. However, the group were focused on their task, professionally discussing challenging areas of practice and greatly supported the formulation of learning themes.

The family of Child C have been informed of this review and were given an opportunity to engage with the reviewers but to date there has been no response.

Having considered direct feedback from practitioners and the timeline of practice activity, the Reviewers identified the following learning themes:

- Multi-agency sharing of information to identify child protection concerns
- Quoracy and the quality of information being presented at Conference
- Management of multi-agency responsibilities for a disabled child outside of child protection process

2.2 Barriers to multi-agency sharing of information to identify child protection concerns

There were several agencies coming into regular contact with the family of Child C offering a broad range of services in order to meet the complex needs presented. This review has found that, although there was certainly breadth and value in terms of the expertise

[1] When a child is assessed as requiring care and support services, those with parental responsibility are able to receive direct payments funded by the Local Authority. The recipients of the direct payments are able to select the service provider and pay for the provision.

available, there were barriers in effectively co-ordinating this knowledge to inform collaborative risk assessment and management.

It must also be noted that there were also good examples of appropriate information sharing. These included Police providing a narrative of risk and vulnerabilities relating to Child D through the submission of Public Protection Notifications, school escort staff immediately reporting unusual behaviours of Child C's mother to teaching staff and the swift exchange between Adult Safeguarding and Children's Services when concerns related to Adult F were realised.

2.2.1 Changes in the Care and Support Plan Coordinator Role

Child C was a child with disabilities with assessed needs for care and support being provided across multiple agencies, in line with Part 3 of the Social Services and Wellbeing (Wales) Act 2014 (SSWBA Act). During a period where the child is not a child at risk, communication across agencies is still required under Part 4 of the SSBW Act to ensure proper co-ordination of services.

Section 145 of the SSWB Act states the local authority:

> *must ensure that there is a named individual to co-ordinate the preparation, completion, review, delivery and revision of the plan.*
>
> *The responsibilities of this role will include… [to] act as a focus for communication for different practitioners and the individual.*
> Details available here

As alluded to in the previous section, the lead in the role of Care and Support and Protection Plan Coordinator transferred between Social Workers in the Disabled Children's Team and Child Safeguarding Team during the timeline. Although this process seems to be established to promote specialist expertise within safeguarding procedures, the change in personnel did appear to create challenges.

Practitioner reflections in the learning event did highlight how retaining the original lead social worker, even after child protection protocols had commenced, would have helped ensure that other agencies, as well as the family, had one consistent line of communication. It is noted that records indicate that Child C's mother felt better able to engage with the Child Protection Social Worker.

Notably this follows a breakdown in the relationship with the Disabled Children's Team Social Worker which occurred after they had undertaken a section 47 enquiry in response to an allegation made by Child C about the mother's partner. Safeguarding processes would usually be dealt with by the safeguarding team involved with the family, however they were not available to respond at the time.

The Disabled Children's Team social worker had developed a good working relationship with the family during the three years prior to Child C being allocated

to the Safeguarding Team following child protection concerns. The Disabled Children's Team social worker retained the focus on disability specific needs and support.

The Review's conclusion is that the Disabled Children's Team Social Worker had acted appropriately in pursuing difficult conversations with Child C's mother within which parenting concerns were explicitly explored. This sense of professional curiosity and challenge is identified as good practice.

The Reviewers suggest that a vast knowledge base about the family and support networks would have been preserved by maintaining one Children Social Care professional, which may otherwise have been diluted by the introduction of a new lead social worker. These circumstances hindered effective multi agency co-ordination and information sharing and acted as a barrier to potential emerging risk being visible.

2.2.2 Understanding the importance of health expertise in building the bigger picture

As noted, there were several professionals actively contributing to Child C's health care including an Epilepsy Specialist Nurse, Epilepsy Consultant, Paediatric Clinician, GP, Neurologist and School Nurse. This reflects the complexity and breadth of Child C's needs but, in this case, also evolved into an obstacle for co-ordinating health expertise to inform critical child protection decisions and care and support plan activity.

Health representatives, although aware of important information and the potential impact this may have on Child C and her family, would have benefitted from a more robust information sharing process. This would have added clarity about what information to share with other agencies. Examples include informing Children's Services about missed medical appointments and the home bathing assessment and epilepsy safety information only being shared with school.

This information, which could have been critical to keeping Child C safe, was not shared amongst multiple agencies either as a standalone act or as part of more formal processes such as a multi-agency team meeting or strategy discussion and child protection conferences. As a result, it could inform neither the care and support plan or the child protection care and support plan and could not be used as information to inform multi agency risk analysis. This also meant it was not available to the child protection core group to develop and deliver the care and support, protection plan.

In terms of Review Child Protection Conferences, the reviewers have concluded that expecting one single point of contact for Health to provide qualitative, precise information on behalf of all of the specialist practitioners is a challenge. The alternative appears to be that representation from each field would be required to feed into assessments and decision-making forums directly which is unlikely to be a proportionate use of health resources. It appears most reasonable to expect the Health Board to identify the most suitable practitioner to be a conduit between active health professionals and present all relevant information to the conference. Equally, Independent Reviewing Officers and child social care lead practitioners should raise enquiries about agency attendance and

contribution at critical meetings in real time in order that relevant professionals are identified and invited as required.

2.2.3 Oversight of Adult at Risk concerns and Child Protection enquiries pertaining to the same family

In June 2021, an Adult at Risk enquiry relating to Adult F and a child protection investigation in relation to Child C and Child D were instigated. There is a sense that these could have been more closely aligned given the commonality of potential risk. It is evident that there was swift communication between Adult Safeguarding and Children's Social Services once a disclosure of concern was made by Adult F. Additionally, immediate actions were undertaken, including the provision of respite care, to mitigate against any potential risk posed to Adult F.

However, the two processes did not progress in parallel and delays to the Adult at Risk enquiries meant that the child protection investigation was concluded sooner. Although the latter was appropriate and in accordance with Wales Safeguarding Procedures, opportunities to fully understand the breadth of information being shared and its impact on all members of the family could have been lost. For example, following the closure of the child protection investigation, further disclosures were made by a third party that the mother's partner was hostile and aggressive. It is not clear whether this information was communicated to Children's Social Services.

The complex family structure in this case and the disconnection between the child and adult investigative safeguarding processes led to a missed opportunity for comprehensive, holistic risk assessment for the family unit. A single point of contact, from a social care perspective, maintaining oversight of information as it became available, risk dynamics and needs within the family would have been beneficial. Such an overview would have helped ensure that concerns and protective factors relating to Child C, Child D and Adult F were fully comprehended and responded to.

2.2.4 Identifying critical sources of information

Throughout the timeline, the domiciliary care provider was a critical contributor in supporting Child C and offering respite to the family. The domiciliary care worker assigned to Child C had very regular and intensive contact with her and most family members and would have been a rich source of information pertaining to behaviours, risk and protective factors. There appears to have been a barrier in their expertise and knowledge being routinely shared with social services, most likely due to the lack of a clear information sharing protocol being in place. Both the timeline and discussions during the practitioner learning event highlight that care and support plans and potentially the water safety plan, could have been made more robust and individualised had there been a clearly defined avenue for the care provider to contribute to dynamic assessments.

2.2.5 It is evident that a wide range of services and support were consistently provided to Child C and their family in order to meet a variety of needs. A theme identified through the review was the challenge that this subsequently presented in terms of practitioners understanding who was involved and to what extent. Additionally, information sharing practices and the knowledge of who to disclose critical information to became diluted and led to some risks not being fully visible. Finally, there could have been improved cohesion across agencies and safeguarding enquiry structures to support collaborative decisions being made about the same family. This review has identified how complex family units may require more effective support and management from a multi-disciplinary perspective.

2.3 Quoracy and quality of information at child protection conference

The third review child protection conference was held during the review timeline in January 2021. The role of the review conference is to discuss and analyse current risk and decide if children are at continued risk of significant harm.

A conference can only make safe decisions if informed professionals and family provide accurate information that stimulate a dynamic analysis leading to a clear picture of current risk. Three issues are relevant here. Professional attendance with reference to quoracy, co-ordinated comprehensive risk analysis and the risk of misplaced optimism.

2.3.1 Professional attendance and quoracy

The conference was attended by two agencies. Social Services and Education. This is despite Child C's disability resulting in significant input from Health and an agency providing direct support to Child C. A report was produced by the Police and there were Health updates. The Wales Safeguarding Procedures (WSP) say:

> *Members attending must have enough information and evidence to make informed decisions…*
>
> *A minimum of three agencies or practitioner groupings that have had direct contact with a child will normally need to be present before a conference can proceed.*
>
> *Situations may arise whereby only two agencies or practitioner groupings are present... In these circumstances, the chair of the conference has the discretion for the conference to proceed, if they are satisfied that essential information is available, particularly from the key agencies involved. The decision and rationale to proceed must be recorded within the record of the conference.*
>
> *The review conference requires as much preparation, commitment and management as the initial conference.*
>
> Ref. to WSP here & here

The records of the review conference do not contain a rationale for continuing with the review whilst not being quorate. This is despite key Health professionals not being present. Whilst it is acknowledged delaying conference can be unhelpful, it is questionable in these

circumstances if conference could fulfil its role to decide on continued risk of significant harm while limited to the information present.

2.3.2 Co-ordinated comprehensive information

A key point highlighted at the learning event was that a child protection conference is only able to analyse the information with which it is presented. The critical point here is that detailed information pertaining to risk was available to multi-agency partners but was absent at conference leaving conference in a weak position to fulfil its core role.

The roots of this issue are discussed above. It is evident that the review child protection conference may have benefitted from attendance from additional relevant professionals which may have led to more effective communication and risk identification. Determining significant harm requires the right information and analysis. The WSP state that if de-registration is to safely occur there needs to be:

> *Clear reasons for the decision, with the evidence in terms of quality changes to the lived experience of the child, should be given and recorded.*

Child protection conference members and the conference chair cannot be responsible for information that is not available to them about the child's lived experience. That said, the s47 enquiries preceding the initial conference should seek to identify key professionals involved with the child and family in order to promote the participation of those with critical information.

Information held by wider Health practitioners about Child C was crucial to the conference. As a result of the epilepsy nurse not being identified as having regular involvement and subsequently not being invited, no links between the missing Health information, parental capacity and their significance for Child C could be realised. Additionally, the domiciliary care provider was at no point invited to conference despite their significant engagement with Child C.

There is great value in achieving the right multi-agency attendance at the initial child protection conference. With multi-agency professionals who know the child and family in place, any subsequent core group membership is likely to be well informed and in a strong position to carefully review the child protection care and support plan. In turn this should lead to a review child protection conference being fully updated on progress against the personal outcomes in the plan. Conference would therefore be in a strong position to make informed decisions on whether continued registration is required to ensure safety of the child or children being discussed.

2.3.3 Risk of mis-placed optimism

There is no evidence known to the practice review panel that there is a direct link between Child C's epilepsy and the circumstances of her death. There is no documentation to indicate that she had a seizure for approximately 2 years prior to her death although a disclosure was made in the period of this review that suggested there may have been a more recent episode. However, this is a risk that may have warranted discussion. Of greater note is the point above about provision of safe bathing advice and no shower being

present in the home which may be more relevant to the circumstances of Child C's death. The appropriate Health attendance together with other agencies' knowledge of parental capacity and the ability to critically analyse this, could have made a material difference to the conference decision to remove Child C's name from the child protection register. Without this information being available, other more positive information available to conference about parental capacity seems possible to have led to mis-placed optimism about the current presenting risk resulting in deregistration.

Below are two additional but important points relating to Police reports and to child protection conferences and the multi-agency responsibility for the management of core groups.

Police reports

The WSP state that as well as providing relevant information about convictions and information about offences from Police records to inform conference reports provided by Police need to:

> *specify how the offences are likely to impact on the safety, care and support needs of the child*.
> Ref. to WSP here

The learning event was informed by Police Officers who had direct contact with Child C's brother Child D. It was noted that Child D's voice was not as clear to others due to him being the quieter child. We heard that Child D was driven to go missing from home as he was drawn to, "happier people and happier times," outside of the family home and that he shared this information with Police Officers. This is a good example of how the Police report can meet its responsibility to the WSP by informing conference not just of factual information about offences but by adding a narrative about the impact on the lived experience of the child, their safety and any potential care and support needs.

Chairing of and participation in core groups

During a discussion about core groups being a vehicle for change for risk reduction the learning event was informed by the chair of the review child protection conference. The WSP are clear that the core group (including all members) has direct ownership of the child protection care and support plan. The point for discussion was there is commonly and it seems in this case an over reliance on the Social Worker to both chair and take minutes for this critical meeting. Core groups need to be truly effective multi-agency meetings sighted on professional curiosity, stimulating discussion and properly informing the review child protection conference. To achieve this the role needs to be the responsibility of all core group members, owned and managed by the group thus avoiding an over reliance on the care and support protection co-ordinator (social worker) as detailed in the WSP:

> *Any practitioner member of the core group can chair- it is not the sole responsibility of the care and support protection co-ordinator (social worker)*
> *Ref. WSP here*

2.4 Multi-agency responsibilities for risk management for a disabled child or a child in need of care and support outside of the child protection process

As a child with a disability, Child C, prior to the timeline of this review, was assessed as having eligible needs for care and support. In these circumstances where the child's name is not on the child protection register the SSWB Act is clear that local authorities must hold multi-agency reviews of the care and support plan. SSWB Act Part 4 Code of Practice (meeting needs) is clear about the principles which should underpin the preparing and reviewing of care and support provided. Two of these principles prescribe that the practice should be:

> ***Integrated:*** *support for people and families will be based on a consistent and common framework across services, and jointly owned and operated by practitioners, in order to ensure that people receive timely and effective access to safe care and support*
>
> ***Safeguarding & Protecting:*** *all practitioners will be alert to any risk or harm to the individual or to others – including others in their care. Assessment and care and support planning will explore the possible responses to those risks and agree approaches to risk management and/or mitigation.*

2.4.1 Expectation of multi-agency communication following de-registration

We can see here how the important activity of multi-agency planning and communication is by no means restricted to child protection processes. We can see that safeguarding and protecting children should also be achieved through preventative risk management work integrated across services. Specifically joint work between the local authority and Health is highlighted in the Code of Practice as a "key part of effective health and social care".

Relating this point to the section in our timeline between the date Child C's name was removed from the child protection register on 5th January 2021 until her tragic death on 13th September 2021, we can see a contrast between the relevant legislative principles above and the multi-agency contributions to care and support planning meetings. This is at a point where Child C had very recently been seen as a child at risk from neglect.

2.4.2 Lack of participation from key agencies in care and support reviews

The practice review timeline shows a care and support review was held on 26th May 2021. This was four months after the date Child C's name was removed from the child protection register. The records show this meeting was held with no attendees. Another care and support review was arranged for 16th June 2021. Both relevant schools attended. It seems there were no representations from a Health provision nor the agency providing direct support to the family. In addition, the records provided to the panel do not include any detail of the care and support plan or measurable personal outcomes or actions designed to achieve those outcomes being discussed.

2.4.3 What a care and support plan must contain

The SSWB Act Part 3 Code of Practice sets out the foundations of how a child's personal outcomes are established through a proportionate assessment. This assessment should be "delivered as part of a coordinated multi-agency approach to address primary and underlying needs". It is these personal outcomes that are co-produced between professionals and the family that directly inform the care and support plan. The SSWB Act Part 4 Code of Practice differentiates between what care and support plans *may* set out and what they *must cover*. It is clear in this 2014 Act that the care and support plan *must* measure "How progress towards achieving those outcomes will be monitored and measured" and also that the care and support review is the vehicle for measuring how well these multi agency co-produced outcomes have been achieved.

2.4.4 What makes a care and support review effective

Although it is a necessary prerequisite, the effectiveness of a care and support review meeting should not be measured by the number of professions present. To be effective, those present need to be clear how the multi-agency care and support plan is meeting the assessed personal outcomes of children with needs for care and support while being alert to any potential risks in order to prevent or mitigate harm.

2.4.5 The care and support plan is owned by the multi-agency group

Following the final child protection conference, within six months there were two multi-agency care and support reviews convened. Both lacked key participants notably neither Health nor the agency providing direct support were represented. Additionally, it seems neither review was sighted on agency progress towards what was needed to keep her safe. Whilst it is the responsibility of the practitioner who has developed the plan to ensure there is clear and concise confirmation of the agreed actions, and who will undertake them, the review of the plan is a multi-agency responsibility. Additionally, following the local authority safeguarding team 'stepping down' their involvement in July 2021, with responsibility for Lead Practitioner now with the Disabled Children's Team, Education professionals reported not being made aware of the name of Child C's social worker.

2.4.6 Importance of escalation of concerns between agencies

Also, where duties are not carried out in a way that is prescribed by the relevant legislation and may expose children to preventable harm, any agency involved with Child C is able to and has a responsibility for escalating concerns. This is outlined clearly in section 4 of the Children and Young People at Risk of Harm section of the Wales Safeguarding Procedures titled *De-registration*. During this period no known professional challenge occurred, and we can see how the idea of multi-agency integrated support sighted on safeguarding and protecting children in these circumstances was not realised. It is possible that over optimism following Child C's name being removed from the child protection register encouraged an environment for risk to be present and for this to be unclear to the multi-agency group.

2.4.7 Barriers to better communication and inter agency challenges and a systemic issue

The challenging circumstances of the Covid 19 pandemic at this time was very real. Professionals at this time were presented with considerable additional complexities and this is fully acknowledged. Also acknowledged is at the practice review learning event that Child

C was known by various multi agency professionals who were passionate about their roles and possessed strong willingness to be part of a child focused system that kept children safe. It remains unclear what the barrier was to multi-agency attendance, proper discussion of the informed care and support plan and where necessary the constructive professional challenge.

We cannot say if Child C would not have suffered the harm she did if the care and support meetings had been held in line with the legislative expectations. It is though reasonable that where a group of professionals work together as a multi-agency system with a clear collective view of current circumstances and potential and emerging risk, this multi-agency group is then in the best position to prevent or mitigate harm.

2.4.8 Communication of water safety risks

During the learning event related to this practice review, an extensive discussion was held on the issue of water safety, Health information provided relating to this and the potential for epileptic seizures. Health records are clear that on 1st July 2020 an Epilepsy Care Plan with a safety precautions leaflet, which included water safety advice, were provided to Child's mother and the school. It was communicated in the Learning Event that water safety advice leaflets were annually provided to Child C's mother, alongside verbal instructions during every appointment with the Epilepsy Specialist Nurse. There could have been clear benefits if this was clearly reflected in health records, specifically with a narrative as to how Child C's mother's understanding of this guidance was gauged and secured. It is of note that the advice given for water safety is the same for all children with epilepsy as determined nationally by the Royal College Paediatric and Child Health Epilepsy Audit 12 document.

There was a sense, communicated within the learning event, that professionals outside of Health and Education did not fully understand the circumstances and parental expectations relating to bathing precautions. This in turn meant that this safety responsibility, held by those with parental responsibility, was not reflected in multi-agency care and support planning discussions. Additionally, no multi or a single agency risk assessment was discussed or completed in relation to safe bathing.

Acknowledging the presence of hindsight bias, it may also in this context have been beneficial for the advice of a Paediatric Occupational Therapist to inform decision making about domestic bathing arrangements.

Although the above is relevant to this multi-agency learning theme, the narrative here must be considered in the context that there is no documentation to indicate that she had a seizure for approximately 2 years prior to her death. The last documented seizure was June 2019 and there is no evidence to suggest a direct link between her epilepsy and the circumstances of her death. It is also important to note that Child C could have had an epileptic seizure at any point. Also, that it would have been reasonable during the eight months between Child C's name being removed from the child protection register under the category of neglect and her tragic death for the risks associated with bathing to have multi agency attention as part of post review conference care and support planning.

2.5 Effective Practice Themes

Consistent Service Provision during COVID-19

- Records reflect that Child C's parents were particularly anxious about COVID-19 which could have caused a significant barrier but agencies were pro-active in maintaining contact and meeting the family's needs.
- Emergency hub provision offered to Child C during lockdown period (18/12/20 – 18/03/20) and was attended. School responded swiftly to Child C's mother presenting in crisis and also increased this provision to twice weekly.
- In January 2021, the Disabled Children's Team Social Worker successfully requests that the ratio of personal assistant staff via the domiciliary care provider increases from 1:1 to 2:1. This is in response to increased risks identified in Child C's challenging behaviours and serves to promote the safety of staff and ensure the service provision remains feasible.
- Frequency of contact with the family was maintained according to Wales Safeguarding Procedures regardless of the impact of COVID-19. These involved a blended approach of home visits and telephone contacts with varying objectives.
- Covid-19 child safeguarding practices for Bridgend stipulated that deregistration could not be pursued during specific periods, although records indicate these considerations were still explicitly explored during supervision (October and December 2020).

<u>Professional relationships demonstrating responsivity and promoting family engagement</u>

- The Disabled Children's Team Social Worker is noted to have appropriately challenged Child C's mother in relation to allegations, despite being faced with a hostile response. This professional curiosity and ability to challenge is critical to ensuring that the child's needs and safety remain the focus of involvement.
- There appears to be a sense of transparency between Child C's mother, maternal grandmother and professionals. Deliberate disclosures are made by both, particularly to Children's Services, despite being likely to invite professional scrutiny or concern.
- Child C's mother is encouraged to seek assistance when in difficulty or reaching crisis and receives swift and effective reaction from professionals. Examples being from the Epilepsy Nurse responding to concerns about Child C's behaviours and prescription and immediately liaising with other health professionals to address the issue (February 2021, September 2021).
- Education representatives were solution focussed when issues arose. Examples relate to providing strategies and alternatives when Child C's behaviour became challenging when being transported to school.
- Education were consistent in providing clear advice and boundaries. When Child C's mother attempted to pass medication to transport escorts or to ask them to carry out actions outside of their remit, education representatives swiftly provided appropriate guidance and outlined expected behaviours.

Improving Systems and Practice

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

Whilst examples of good practice have been identified across agencies, there remains core learning in this case which has been translated to local recommendations for the Cwm Taf Morgannwg Safeguarding Board and its member agencies.

1. The Local Authority to ensure that, where quoracy is not observed, that Child Protection Conference Chairs fully consider and always record the option of postponing the meeting or alternatively the rationale for it still going ahead. Such a consideration would be to allow for full participation of relevant agencies.

2. All agencies under the safeguarding board to ensure that they identify the correct professionals to attend Child Protection Conferences who are able in a position to provide the relevant information that is bespoke to the child/children being considered. This includes the process of identifying all agencies and expertise involved with the child at the earliest opportunity.

3. All contributing agencies to ensure that Care and Support Reviews are sufficiently robust in terms of attendance and contribution. These should take into account the actions within the relevant Care and Support plans which identify measurable outcomes.

4. Cwm Taf Morgannwg Safeguarding Board to consider reviewing guidance for professionals for reporting to Child Protection Conferences to ensure that relevant critical information, including specialist expertise, is captured. The guidance needs to ensure that lived experience as well as factual information is recorded.

5. Cwm Taf Morgannwg Safeguarding Board to review the All Wales Safeguarding Procedures and their Core Group Guidance (April 2022) with a view to aligning both protocols and establishing a process for identifying the most appropriate chair, attendees and minute takers for Core Groups

6. The Local Authority to review their process for Social Worker allocation following the identification of child protection concerns, when a team is already involved in the family. An automatic allocation to a Child Safeguarding Social Worker may not be in the best interests of the child/children and may complicate information sharing routes. The rationale for this decision to be clearly recorded and communicated with the professionals involved.

7. Cwm Taf Morgannwg Safeguarding Board to consider reviewing how the adult at risk and child protection enquiries pertaining to the same family can be aligned under one point of contact to ensure a holistic sharing of information and risk assessment for the family unit as a whole.

8. All agencies must ensure that support is available to all professionals facing acutely challenging and/or hostile situations through their employment.

National Recommendation:

The following recommendation is made in the Child Practice Review Report CTMSB 04/2021 relating to Child T. The Reviewers in the case of Child C lend support to this recommendation:

The Review recommends that Welsh Government considers the commissioning of a full review of Health, Social Care, Education and Police recording, information gathering and sharing systems. There should be a clear focus on reducing the number of information systems, streamlining information sharing and enabling key agencies to have greater information at key points of decision making.

Statement by Reviewer(s)			
REVIEWER 1	Kate Fitzgerald	**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 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		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	• 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)* Kate Fitzgerald **Date**	**Reviewer 2** *(Signature)* …… **Name** *(Print)* …… **Date** ……

Chair of Review Panel (Signature) Eve Davis **Name** *(Print)* …… **Date**	

Appendix 1: Terms of reference

Appendix 2: Summary timeline

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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

CONCISE CHILD PRACTICE REVIEW PANEL CTMSB 06/2021

Case Reference details
Child C CTMSB 06/2021

Circumstances leading to the CPR
Child C had been found in the bath, submerged under water in September 2021. Accounts were taken from both parents at the address, and it is believed that Child C had been left in the bath alone.
Child C had global delay, epilepsy and learning disabilities and had significant needs and was operating at around 18 months old.
The family have been known to Social Services since 2010 with Child C and siblings names have been placed on the CPR on two separate occasions. April 2014 to Dec 2014 under the category of physical harm and Nov 2019 to Jan 2021 under the category of Neglect & Sexual Abuse.

Agencies Involved
The following agencies were involved with Child T and will be completing a timeline and analysis of their involvement:

- BCBC Childrens Services
- Cwm Taf Morgannwg University Health Board
- South Wales Police
- Education

Core Tasks

The Core Tasks of this Child Practice Review Panel are to:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the 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 the child practice guidance
- Agree the time frame
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken
- Produce a merged timeline, initial analysis and hypotheses

- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback
- Plan with the reviewer/s contact arrangements with the family members prior to the event
- Receive and consider the draft adult/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 CTSB 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

Panel Members

NAME	TITLE	ORGANISATION
Eve Davis (Chair)	Independent Chair	South Wales Police
Kate Fitzgerald (Reviewer)	Independent Reviewer	Probation
Jon Eyre (Reviewer)	Independent Reviewer	Merthyr Social Services
Claire Holt	Workforce Development Manager	Children Services BCBC
Sue Hurley	Protecting Vulnerable Persons Manager	South Wales Police
Emma Reed	Nurse Specialist	Cwm Taf Morgannwg Health Board
Gail Biggs	Education Engagement Team Manager	Education BCBC

Additional Areas of Focus
No additional areas of focus.

Any Parallel Reviews or Other Such Activity to be Noted
No parallel reviews ongoing, other than the criminal proceedings.

Timeframe for the APR

The timeframe set for the Review is 1st September 2020 to 13th September 2021. Summary reports to be completed prior to this.

Learning Event

The learning event will ensure that the voice of practitioners directly contributes to the review and that practitioners can hear the perspectives of the family. Practitioners and managers are expected to attend if asked. All practitioners will reflect on what happened and identify learning for future practice.

The Review Panel has responsibility for supporting the reviewers in carrying out an effective learning event.

It is anticipated that the Learning Event will be held on 27th September 2022.

Completion Date
The completion date set for the Review is January 2023.

Tasks of the Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Send the 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 Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.