CONCISE CHILD PRACTICE REVIEW CTMSB 8/2020 CHILD Q

Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

1 Background

In January 2020, Children's Services received a call from Child Q's grandmother, stating that she was not able to attend a Child Protection meeting in respect of her own child, due to Child Q father having fallen down the stairs with Child Q in his arms. Child Q was taken to hospital where it was established that Child Q had established that Child Q had suffered a fractured skull. He also had a bleed on his brain and retinal haemorrhages, as well as healing fractures in the ribs. Child Q's father was subsequently arrested on suspicion of having caused the injuries and was bailed. The matter remains with the CPS for a final decision on charging.

2 Summary Timeline

- **March 2019** – Midwifery booking at 21 weeks.
- **May 2019** - Discussed at MARAC following father making threats to Mother.
- **May 2019** – Referral to Children Services by midwife. Referral is accepted by Children's Services and Child Q's case is allocated to a social worker for assessment. Child Q's case remains open on a Care & Support basis.
- **June 2019** – Initial Child Protection Conference for Child Q's uncle – no concerns raised with regards to unborn Child Q and siblings.
- **August 2019** – Child Q born

3 Summary Timeline

- **Sept 2019** – Review Child Protection Conference and Core Group held for Child Q's uncle. No information or concerns re Child Q shared.
- **Nov 2019** - Police called following verbal argument between mother and maternal grandmother. Father was said to be present but advised that he was helping the family to move house
- **Dec 2019 -** Father takes Child Q to hospital for an appointment and presents himself as an uncle
- **Jan 2020** - Father takes Child Q to GP the day before the incident
- **Jan 2020** – Child Q seriously injured

4 Practice & organisational learning

1. Understanding the Significance of Missed Healthcare Appointments: a pattern of repeated missed and cancelled appointments can be an indicator of neglect and disguised compliance
2. The Need for Comprehensive Case Recording and Compliance with Assessment/Care and Support Planning Processes
3. The Need for Robust Initial Risk Assessment and Re-assessment when risks change risk is dynamic and needs constant review
4. The Need for Professional Curiosity and Awareness of Disguised Compliance

5 Practice & organisational learning

5. The Need for Understanding of Complex Family Structures and Relationships: the 2 families in Child Q's case functioned as a single unit but were treated as separate.
6. The Need for Continuous Information-Sharing and Constructing the Bigger Picture: chronologies can be a useful practice tool
7. The Importance of the Line Manager/ Practice Supervisor's Role in providing oversight and quality assurance.
8. The Need for Clarity and Shared Understanding between agencies about the decisions made in Child Protection Strategy Discussions

6 Improving Systems and Practice

- Health Visitors, midwives and hospital-based paediatric clinicians should be reminded that repeated missed healthcare appointments can indicate safeguarding concerns
- Children's Services should ensure that its staff work in accordance with Assessment/Care and Support Planning under the Social Services and Well-Being (Wales) Act 2014.
- Children's Services and the Health Board should ensure that their staff's analysis of risk is robust and includes past, present and future risk factors, the views of all relevant parties and is responsive to changing situations
- Agencies should be aware of the need for professional curiosity & the risks of disguised compliance. The use of chronologies should be promoted.

7 Improving Systems and Practice

- Agencies should ensure that their staff recognise that family structures and care-giving arrangements can be complex and diverse. The use of joint visits by staff involved with different children and staff from different agencies working with the same child should be encouraged.
- Agencies should ensure that processes and pathways are in place to support professionals to share information routinely with one another, both within an agency and between agencies.
- Children's Services should ensure that there is compliance with their QA Framework and should consider whether line managers should complete a summary of case discussion outcomes from supervision on individual children's case record
- Since the date that Child Q was injured, a single shared strategy discussion record developed that is completed by Children's Services and shared with partner agencies participating in the strategy discussion. An audit of the effectiveness of this process should be undertaken.

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