Child Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Concise Child Practice Review

Re: CTMB 5/2020 (Child O)

Brief outline of circumstances resulting in the Review

A concise Child Practice Review has been undertaken by the Cwm Taf Morgannwg Safeguarding Board in line with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 2".

The guidance states that:

A Board must undertake a concise Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

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

the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding the date of the event referred to above; or the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

The purpose of a Child Practice Review is to identify multi-agency learning for future practice. The circumstances of this case are as follows:

Emergency services were called to the home after the mother found her three-month-old child face down in their cot and unresponsive. Cardio-Pulmonary Resuscitation (CPR) was administered by the mother with over the phone support until the arrival of the ambulance crew. On arrival, rigor mortis and hypostasis were noted to be present and resuscitation was unsuccessful.

It was reported by the parents that the child was put down to sleep, in their own room, at 7pm. The child slept in a travel cot with a pillow and blankets. Parents reported that the child was heard to be giggling in their sleep at around 10pm then settled. The child was not seen by either parent from the time they were put to sleep until the morning at 10am.

Police attended, relevant protocols were followed, and a coroner's file was submitted.

The Inquest report concluded that the child died suddenly and unexpectedly, without an identifiable, or established cause of death. Factors increasing the risk of sudden infant death syndrome were identified – they had been unwell, an adult pillow was within their sleeping environment, child was solitary sleeping, and had not been placed on a firm, flat mattress. The coroner concluded that these factors taken cumulatively were, at least, temporally associated with the child's death.

The family were known to several agencies, and both parents were involved with statutory services prior to the commencement of their relationship and birth of their child.

Family Structure

At the time of the incident the family members living at the home address were as follows:

- Child O's mother
- Child O's father
- Half-sibling 1, aged 3 years, age 2 at time of incident
- Child O (deceased)

The timeframe for the review is 12 months prior to the date of incident.

Background information

O's arrival was an unplanned home birth, O was delivered by the father. The mother and father had visited hospital the day before, they followed the advice given at the time, which was to return home. An ambulance crew and midwife attended, there were no concerns with the baby's condition and mother and child remained at their home.

The parents are of white Welsh heritage. They were aged 24 and 19 when O, their first child was born. The mother has another child who resides with them, the father has a child who lives with its mother.

The family live in a rented property situated within an established community, they both have relatives living in the area, whom the couple access for support.

O's mother was involved with Social Services and the Police during her adolescence as there were concerns about her vulnerabilities to abuse and risk of exploitation.

O's father was exposed to adverse and stressful experiences during his childhood. Social Services had been involved with O's father over a number of years, initially around him witnessing domestic violence within the home. Following O's father's birth parents' separation, he spent some time living with his birth father outside of Wales, until their relationship broke down and he returned to the home area to live with his birth mother and her partner. Due to tensions in this household, he left home and having no alternative place to live, was accommodated by the Local Authority.

He had several placements in both foster and residential homes during the period of time he was looked after. Whilst in foster care, there were a number of incidents of violence reported to the police, with him as a perpetrator but on a few occasions as a victim. When he reached 18 and ceased to be looked after, he continued to receive support from the Local Authority through 16+ provision.

O's father has a child with a previous partner, he had little contact with the child until they were temporarily placed with him at aged 3, following the mother's arrest for neglect. He was by this time in a relationship with O's mother and was living with her and her child.

During the time his child was living with him and O's mother, there were concerns raised around neglect and emotional abuse to both children and domestic abuse towards O's mother. Welfare checks were undertaken, and the couple provided with advice. Following a contact visit, the child's mother refused to let the child return to O's father, the police were involved, there were no formal grounds to return the child to the father and so the child remained with the mother.

During the year preceding O's death, the police responded to a number of domestic incidents, attendance by the police was prompt, with relevant parties spoken with and 9 Public Protection Notices (PPN) submitted. Initial PPNs were submitted for information only, it was only after several reported incidents that O's mother was noted on the PPNs submitted as being a 'repeat victim'. It is noted that where risk was assessed by the police as 'standard', the PPN would not have been routinely shared across agencies, practice has now changed and PPNs are shared with key agencies.

Alongside the domestic incidents, three reports were received via the NSPCC of alleged physical abuse to the children. Social Services undertook initial enquires with the parents, shortly after this and following a referral from the social worker for the father's first child, regarding allegations of physical abuse towards the children, the allegations were reviewed, and a strategy meeting took place. The case was allocated for assessment; however, it did not progress to Child Protection (Section 47) enquiries as the agencies present did not consider that the threshold was met.

Social Services historical records evidence concerns about the vulnerability of Child O's mother and her being a victim of domestic abuse. She did not have a stable lifestyle, there were multiple accommodation moves and she was also felt to have avoided contact with professionals. Her relationship with O's father was volatile with numerous reports of domestic violence, including self-reporting, and periods of separation. There were concerns that she was not being open about the status of their relationship and was minimising concerns. In addition, she was not felt to be looking after her own health needs, in particular her antenatal care. There were concerns that she was not providing a stable living environment for her child and that the child's health, care and wellbeing needs were not being met consistently.

An assessment was carried out by Social Services and needs for support were identified; the children were not found to be at risk of harm. In line with Children's Services duties and early prevention agenda, a referral was made to the Early Intervention Service with a view to supporting the couple's relationship and parenting, by addressing their identified needs. Intervention objectives were identified with the couple and after some initial hesitation, the couple did engage with support services and some progress against outcomes was achieved.

Within the health records it had been identified that there were several concerns raised and child protection referrals submitted in relation to concerns of O's mother's chaotic lifestyle, multiple moves, unstable environments, lack of family support and non-engagement with midwifery services.Historic information had previously listed these ongoing concerns in relation to the sibling, when the Health Visitor performed a joint visit with the Social Worker involved with the family at the time.

There were identified missed appointments with health professionals for both Child O's mother and sibling, multiple house moves, outstanding immunisations and concerns for the child not being registered with a GP were a recurrent theme on the child protection referrals submitted.

During a home visit the Health Visitor also advised Child O's father to attend his GP for his self-reported anxiety, following concerns having been identified regarding his mental health. There is no evidence that help was sought.

A primary birth home visit was undertaken by the Health Visitor when Child O was born. When it was identified that there was no steriliser being used, advice was given regarding the appropriate way to sterilise bottles and to make feeds. Some concern was also

highlighted regarding the baby's sleeping environment and the advice regarding safe sleeping was provided by both midwifery and health visiting professionals.

GOOD PRACTICE

Throughout the multi-agency timeline there is evidence of a good verbal handover between the Health Visitor and Social Worker. Child protection referrals were submitted at each point that Health raised concerns, and this remained consistent.

Both Midwifery and Health Visiting had reiterated advice regarding safe sleeping to the parents. This was also noted for the older sibling.

Professionals actively worked to engage with both parents and were persistent even when they received a negative response.

There was effective information sharing and interagency working between the Social Services Emergency Duty Team, the Police and British Transport Police in dealing with an incident when the mother and daughter were reported as missing persons.

Parents spoke positively about the support they received from agencies in the immediate period following their child's death.

Parent's perspective

In line with the Child Practice Review process, the family were visited at their home to discuss their wishes and feelings regarding the support, intervention, and information they had received before and following the death of their child. It was explained to both parents of Child O that this information would be shared with the Child Practice Review (CPR) Panel and that the purpose of this is to enhance the CPR process and ensure all professionals involved identify and share any learning within their agencies.

Father shared that their child was born at home following being discharged from the hospital, he stated it was 'scary' delivering the baby at home and felt his partner was not listened to and should have remained at the hospital. Mother shared that she felt a bit depressed after her baby was born, stating she would struggle to get up, feed and comfort her baby. This was the reason why her partner took on the lead parenting role.

Mother felt there was not much support given when she became a mum for the second time and that she felt everyone thought she would know what to do.

They were very positive about the Police Family Liaison Officers who supported them at the time of their loss and felt they really listened to what they had to say.

Practice and organisational learning

Key Theme 1- Understanding the relevance and importance of chronologies

* Chronologies are useful tools in assessment and practice, they are significant in that they are able to give a succinct family history and are useful in identifying themes and trends in order to identify previous and current vulnerabilities.

- Whilst chronologies were present across agency files, there were inconsistencies in the quality, with some significant events not present and not all records were up to date. When Child O was born, the chronology from the oldest sibling's Health Visiting records was not transferred into the youngest child's records.

Key Theme 2 – Explore if there were any missed opportunities for important intervention by agencies

- The timeline clearly indicates that there were missed opportunities for all agencies to review the support that was being provided to the family. There are clear themes of domestic abuse, multiple house moves and a lack of stability for the family. In addition, there were also missed health and social care appointments for the older sibling as well as missed antenatal care. Concerns regarding home conditions are also a consistent theme.

- The family made a number of accommodation moves, within and outside of the local authority area. A referral was made by Health with concerns, but these were not considered as a risk, subsequently no assessment of the impact on the child of the change in circumstances was undertaken.

- Working with parents and professional curiosity is key. Whilst the parents acknowledged the advice and guidance provided by professionals, they did not necessarily follow it, for example the use of a pillow in the cot. They used internet searches to source information, and they held some fixed views on how to parent. Professionals did not have a clear understanding of the ability of the couple to safely care for the children. There was insufficient professional curiosity around parental behaviour and identification of any patterns which may have posed a risk to the baby and the older sibling.

- Both parents reported that they were managing and were keeping in touch with relevant professionals. This self-reporting implied co-operation was an indicator of the presence of 'disguised compliance', however was taken at face value by professionals. Given the pertinent information and history of both parents, that were held by key agencies, such as both adults' adverse childhood experiences, there were missed opportunities to undertake a robust assessment of the needs of the children and of family members.

- Child O's mother experienced domestic abuse. There was evidence that O's father had been violent in previous relationships. Her personal sense of agency was impacted on by his influence and controlling behaviour. There were missed opportunities by professionals to appropriately target enquiries about domestic abuse. This may have been because it was not felt there were any immediate concerns or direct risk of harm present.

- An associated consequence of this was that there was insufficient consideration given to the potential impact of coercive control and domestic abuse on the mother's ability to parent and protect the children.

- Police responded to an incident of neighbour dispute. The initial response was effective. However, there was an 11-week delay in sharing the information of anti-social behaviour with the Housing Association, and no anti-social behaviour referral was made.

Key Theme 3 – The relevance of good communication and handover of care/information between professionals/agencies

* Within a 12-month period there was evidence of 3 child protection referrals made by multiple sources where services had no initial knowledge or oversight of each other's concerns.

* If information about the concerns leading to the referrals and the action taken had been shared between agencies, then questions around the decision to step down to the Early Intervention Service may have been raised. Agencies could have requested a strategy meeting to be convened to challenge the decision where the escalating concerns regarding multiple house moves, missed health and ante-natal appointments could have been discussed.

* Social Services viewed these referrals in isolation and not cumulatively, resulting in the safeguarding risk not being considered significant enough for further on-going assessment, with limited feedback regarding the outcomes of referrals given to the referrer.

* The Local Authority Early Help and Prevention Service supports families where their case has been either:

  i) referred to the IAA (Information, Advice and Assistance Service) but does not meet the threshold for statutory Children's Services intervention; or
  ii) 'Stepped down' from Children's Services intervention.

  The Service undertook a six-week programme of work with the family. There was some reluctance from the parents to engage, and when work commenced, attention was diverted towards the needs of the adults, losing some focus and understanding of the impact of their behaviours on the child's and the unborn's needs.

* Health Records indicate that the standard of communication between the family and healthcare staff, and inter-professional staff was insufficient; particularly in relation to the sharing of information regarding the family dynamic, and difficulties in maintaining family contact and engagement.

* During initial assessments within Health, it was recorded that there were no safeguarding concerns and there was no vulnerability identified. However, there were previous concerns regarding the older sibling around the stability of the family, house moves and Police Public Protection Notifications (PPNs).

* The family also had previous involvement with Children's Services. If health services had knowledge of this information, the outcome of the initial assessment at the booking appointment may have resulted in increased professional curiosity. This is an example of health agencies potentially working in isolation and not sharing relevant information in order to inform a more thorough assessment of the family circumstances.

* Social Services did not have access to the neighbouring authority's electronic data systems to access information on the family. This resulted in key information and possibly, historical concerns not being known. Digital records can now be

accessed between services and across regional boundaries, enabling sharing of relevant and appropriate information at the time it is required.

Key Theme 4 - Routine Enquiry and the opportunity to explore any concerns

* Midwifery and Health Visiting Services should make a Routine Enquiry into domestic abuse at every available opportunity. Health Services have highlighted that O's father was present at a number of the appointments and also answered mother's phone. Routine Enquiry was undertaken by both Midwifery and Health Visiting, however the fact that O's mother was difficult to access alone and the number of PPNs received, would have suggested that professionals should have considered alternative strategies to safely engage with her alone.

* All Public Protection Notices (PPNs) on vacant caseloads are allocated for assessment as per the Health Visiting Vacant Caseload Policy. Due to the child sitting under a vacant caseload (no allocated Health Visitor), another Health Visitor in the team was made aware of an incident at the home via a PPN. This Health Visitor attempted contact by telephone with no answer, and no further action was taken. Due to the number of previous PPNs received for the family this should have warranted a home visit as per Health Visitor PPN Guidance. An up-to-date chronology would have been key for this Health Visitor, who did not know the family, to identify the ongoing theme of domestic abuse.

Key Theme 5 - The impact of COVID restrictions and challenges for all agencies

* At the start of the Covid-19 Pandemic, restrictions were introduced very quickly and the allocated Health Visitor for this case had to shield. As this case was not deemed to be a vulnerable family, due to the documented assessment of "routine" they were not handed over to another Health Visitor as per the Vacant Caseload Policy. There was no documented handover of care in the records and no evidence of any ongoing concerns.

* Police attended the home during the initial lockdown period in response to reports of an altercation. Follow up contact was made by Social Services; support was offered to the family but was declined. The family was not considered to be vulnerable; this was based on presenting information without enough consideration being given to past multi-agency involvement.

Key Theme 6 - Thresholds

* Referrals to agencies were treated in isolation, and did not consider previous contacts, or historical information from other sources. It seems that individual referrals were not sufficient to meet thresholds for child protection. Screening and initial assessment focused on the content of the referrals; they were viewed in isolation and did not consider a case history.

* When a referral is received for a child who is an open case, the individual team take responsibility for assessing and decision-making regarding whether the referral should be escalated to child protection. Good practice would be a multi-agency assessment approach and a review of agency chronologies where there is a new concern on an open case, to ensure multi-agency decision making as to whether it should proceed to child protection.

Improving Systems and Practice

* Midwifery and Health Visiting services need to develop a regular, consistent information sharing process in order to share relevant information regarding families identified as vulnerable.

* All agencies should review and update their guidance in relation to Public Protection Notices (PPN) and the assessment of the impact / risks posed to children from Domestic Abuse.

* Health Visiting and Midwifery Services to complete an audit of Routine Enquiries to establish compliance.

* Use of chronologies: An effective chronology can help identify risks, patterns, and issues in a child's life. It can help in gaining a better understanding of the immediate or cumulative impact of events. It can assist practitioners to make links between the past and the present, in this case for example consideration of the impact of the parents' adverse childhood experiences on their relationship and their style of parenting. Chronologies should be present on all cases.

* Referrals to agencies were treated in isolation, and did not fully consider previous contacts, as individual referrals these were not sufficient to meet thresholds for child protection. Screening and initial assessment focused on the content of the referrals; they were viewed in isolation and did not consider a case history. Local Authority to review screening processes to ensure that safeguarding concerns are recognised and responded to appropriately.

* Practitioners should be alert to patterns of coercive or controlling behaviour, as well as incidents of abuse. Agencies should ensure that practitioners, when working with individuals who may be experiencing domestic abuse, know how to enquire safely about violence or abuse and to signpost to support services.

* Professionals should remain professionally curious when working with individuals and families. To explore and understand what is happening within a family rather than making assumptions or accepting things at face value. And to triangulate information that they receive, with independent confirmation from other professionals and / or other family members.

* Agencies should assist professionals to recognise when an individual(s) are resisting engagement with services and how this can manifest itself. And to support staff to understand the causes of uncooperative behaviour and consider strategies to effectively assess risk factors and address motivation to change.

* Police to ensure that information relating to anti-social behaviour (ASB) is submitted to relevant agencies in line with South Wales Police ASB process and without unreasonable delay. Where there is an identified Public Protection Notice for sharing, this should be completed in a timely manner to inform the appropriate key agencies.

<table>
<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>REVIEWER 1</td><td>Claire Holt</td><td>REVIEWER 2 (as appropriate)</td><td>Nadine Long</td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
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• I have not been directly concerned with the child or family, or have given professional advice on the case.

• I have had no immediate line management of the practitioner(s) involved.

• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.

• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.</td><td colspan="2">I make the following statement that prior to my involvement with this learning
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<tr><td>Reviewer 1</td><td>A C Holt</td><td>Reviewer 2</td><td>N Long</td></tr>
<tr><td>Name</td><td>Claire Holt
29/07/2022</td><td>Name</td><td>Nadine Long
29/07/2022</td></tr>
<tr><td colspan="4">Chair of Review Panel (Signature)

 

Terri Warrilow Date 29/07/2022</td></tr>
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Appendix 1: Terms of Reference

Appendix 2: Summary Timeline

For Welsh Government use only

Date information received ……..

Date acknowledgement letter sent to LSCB chair ……

Date circulated to relevant inspectorates/Policy leads ……

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

APPENDIX 1 – TERMS OF REFERENCE - CONCISE CHILD PRACTICE REVIEW PANEL CTMSB 5/2020

Case Reference details

Child O CTMSB 5/2020

Circumstances leading to the CPR

Concerns were raised at the Phase 1 PRUDIC meeting following the death of Child O. Child O was 3months old at the time of death, it was reported by parents that Child O was "put down to sleep at 7pm in an attic bedroom off the master bedroom, Child O was in a travel cot with a pillow and blankets present. Child O was heard to be "laughing" in their sleep at around 10pm then settled (not checked). The following morning Mum found Child O face down in the cot at 10am (13 hours later) and could not see any rise or fall of their chest. A 999 call was made to WAST.

Agencies Involved

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

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

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 decide 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

Additional Areas of Focus

Child O's Dad was a previous Child Looked After.

Any Parallel Reviews or Other Such Activity to be Noted

To run parallel to the Coroner's Inquiry.

Timeframe for the APR

The timeframe set for the Review is 27/04/2019 to 27/04/2020. 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.

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.

APPENDIX 2 - SUMMARY TIMELINE

April 2019	Several concerns reported to agencies with regards domestic abuse and neglect
May 2019	Further reports of DV and concerns for children. Father's child returns to mother (ex-partner)
June 2019	Further reports, strategy meeting held but threshold for S47 not met
July 2019	Case transferred to RF and assessment initiated
November 2019	Closed to RF with recommendations in place for further support
Jan 2020	Child O born
April 2020	Report of domestic incident, Police called and Children Services notified – no further action required
April 2020	Child O death