Adult/Child Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Concise Child Practice Review

Re: CTSMB 3/2019 (Child L)

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 Child L's family home on the 10th June 2019 and discovered that Child L was unresponsive. He was taken to hospital as a medical emergency. Tests revealed multiple bleeds to L's brain, two fractures to the skull and possible limb fractures. Both parents were arrested and were subsequently bailed. The Local Authority initiated care proceedings in respect of L. L's mother subsequently disclosed a more extensive history of domestic abuse than had previously been known to agencies and that she had been a cocaine user. L's father admitted to being a regular cannabis and cocaine user.

The Local Authority obtained a Care Order in respect of L, who is now placed with extended family members. After police investigation, no criminal charges were brought and the criminal

investigation has been closed. The Judge in the family court found that L's father was likely, on the balance of probability, to have caused his injuries.

The timeframe agreed by the Panel for this Review was from 10th June 2018 to 10th June 2019. This included the period of L's mother's pregnancy and the first 10 weeks of his life. 10th June 2019 was the date that L was taken to hospital by paramedics.

L was born at the end of March 2019, a healthy baby boy. His parents were aged 22 and 23 years, of white Welsh heritage and L was their first child. It was documented by both Health and Children's Services staff that they were in a relationship, but not living together, that L's father was a frequent visitor to the mother's home and that he was supportive. L was resident with his mother.

L's mother had no history of involvement with Children's Services or of offending behaviour. She engaged well with antenatal services, although she had several different mid-wives involved with her ante-natal care. Her pregnancy, L's birth and the neo-natal period were uneventful and they were discharged from midwifery 2 weeks post-birth. During the next 8 weeks prior to the incident, L had one brief hospital admission to the paediatric assessment unit with a rash ('red marks' on his face) and excessive crying. He was also referred for an Ultrasound when the health visitor noticed he had 'twitching legs'. L was seen by his own health visitor on two occasions and by a different health visitor for the 'birth home visit'. L was seen by the GP on 2 occasions.

L's father was well known to local Children's Services, having been a child looked after for much of his childhood. Prior to being accommodated with foster carers, L's father was known to have witnessed domestic abuse between his parents, who were prolific users of illegal substances. During this long-standing involvement with Children's Services, L's father was identified as having anger and anxiety issues and he was referred to the Primary Care Mental Health Services 3 times between 2015-2018. Children's Services closed L's father's case in March 2017, when he was 21 years old, because he no longer wanted any involvement with them.

L's father was also well-known to police, his home having been subject to 3 drugs-related search warrants (in May 2016, March 2017 and November 2017), resulting in a conviction for drugs-related offences.

During L's mother's pregnancy, there were 4 police contacts. 2 of these contacts were in response to calls from L's mother during (allegedly) verbal arguments with L's father. One was a report of youths in the area kicking the front door of the parents' home (although a female voice could be heard in the background and was documented by the call handler when police were contacted, but no female was found at the address when police attended) and the other was a complaint of a threatening Facebook message to L's mother from his paternal grandmother. Within this 'malicious communication', the paternal grandmother also referred to both L's mother and father being 'flat out on coke and weed'.

A Public Protection Notice (PPN) was initially completed for only one of these incidents (the verbal argument), although another was generated retrospectively for the threatening message incident at the request of the South Wales Police risk assessor in the Multi-Agency Safeguarding Hub (MASH). The role of the risk assessor was to screen domestic

abuse related PPNs being submitted by response officers and make decisions about the level of risk to the victim and whether information should be shared with partner agencies. Information about L's father's conviction and the police warning markers on his record highlighting mental health concerns was shared with Children's Services by the MASH risk assessor when the first PPN was shared.

Based on the first PPN, Children's Services undertook a proportionate assessment under the Social Services & Well-Being (Wales) Act 2014 with the purpose of establishing the current situation in light of the verbal arguments with L's father and threats from paternal grandmother. A 'What Matters' conversation with L's mother subsequently took place by telephone. L's mother said she was well-supported by her family and stated that she was in a relationship with L's father, but they were not co-habiting, and she was viewed by the social worker as taking appropriate action to protect herself and her unborn child. L's mother mentioned to the social worker that his father had been in care and that he might have had contact with police during this time, but there is no evidence that this information was researched any further by the social worker. The case was closed prior to the second PPN being received.

However, when the second PPN was received, the information was reviewed by the decision-maker in Children's Services, who found that there was no reason to re-open the case because L's mother had reported appropriately and the midwifery service were aware of the information shared by police. There was no mention of the concern of drug misuse contained within the message, either in the social worker's assessment or the decision-maker's rationale for case closure.

Three months after the last police contact, L was admitted to his local district general hospital as a medical emergency due to being unresponsive at his home address.

From the grandparents' perspective, they could not understand why agencies had not been more alert to L's father's history or questioned his parents' living arrangements. They both felt that it should have been obvious to any professionals visiting L's mother that a male was living there too. They also both said that there were obvious holes in the plaster on the walls in the home, where L's father had punched them in anger. They were aware of L's father's history of offending and as a child looked after, so they could not understand why this information was not taken into account by Children's Services when they were briefly involved. Consequently, they felt there were missed opportunities to provide additional support to the family when L was born.

L's mother met with one of the Reviewers and a Panel member (because of the second Reviewer's absence from work) late in the process and after the Learning Event (because she said that she did not receive the first letter sent out offering a meeting with the Reviewers). She said that she had experienced domestic abuse throughout her pregnancy and after L's birth but did not disclose to any professionals. She said she did not disclose because she was holding on to a 'fantasy' of being a happy family with a new baby. She was also scared that her baby would be removed from her if she did disclose because L's father had been removed from his parents' care by Children's Services when he was a child. She also said that she used cocaine throughout her pregnancy and after L's birth and claimed that she was never asked about illicit drug use by any health professional or by the social worker on the telephone.

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

1. **Professionals should consider information from all available sources, even if it appears that the information may have a malicious intent.**
   It is important for professionals to keep an open mind and not pre-judge situations or make assumptions. Although the reported threats against L's mother from the paternal grandmother included a concern that both parents were illicit drug-users, it appears that this was not addressed because all of the content of the message was viewed as malicious.

   Initially, no PPN was raised with regard to the 'malicious communication' incident despite the allegation contained within it & the police observation that the mother was heavily pregnant, because the incident was not viewed as 'domestic abuse' and L was unborn at that point. The allegation was perceived as purely malicious because L's paternal grandmother was well known to police herself. The Reviewers were assured that practice has changed since this incident and that a PPN would now be generated. The police officer explained at the learning event that he was cognisant of the concern in respect of drug use but, when he spoke to mother, he was satisfied that there was no concern. In addition, the paternal grandmother had not seen either parent for some time, so she could not know personally that they were misusing drugs. When the grandmother was spoken with by police, she made no further reference to the drug misuse.

   Children's Services closed unborn Child L's case prior to receiving the PPN regarding the threatening messages incident, based on what the social worker was told by L's mother. When Children's Services received the PPN, the decision-maker reviewed the original decision to close the case (incidentally, Children's Services had no mechanism for an alert to be raised should the second PPN not arrive). The proportionate assessment did not explore the concern of drug misuse by both parents and there was no mention of the information shared by police of L's father's offending history.

   In fact, police had shared information with Children's Services and with health professionals that corroborated the allegations of drug-misuse, at least by L's father (his flat having been subject to three drugs' search warrants in the past and him receiving a conviction for drugs-related offences).

   There needs to be an appropriate level of professional curiosity and scrutiny that utilises historical information available and information from other agencies to inform the assessment.

2. **There was little attention paid to L's father's involvement in his parenting by both health professionals and Children's Services.**
   At the booking-in appointment, the midwife noted that L's mother had reported L's father to be a care leaver, but that Children's Services' involvement with him had ceased. Although this might be assumed to be correct, given that he was now an adult, it is possible that leaving care services could still have been involved with him, and there was no further exploration of how his experience might affect him as a new parent.

   The social worker's proportionate assessment did not attach any significance to L's mother's reference to his father being care experienced or to his possible offending history. The father's history was, in fact, well-known to Children's Services, but his potential vulnerability because of the impact of adverse childhood experiences (ACEs) on him as a parent, was not considered. There is no evidence that the social worker considered L's father's role as being relevant to the assessment.

   It is not evident that midwives or health visitors actively tried to engage with L's father during their contacts, even when he was present.

   Even when professionals believe that a father or other parent is not resident with the child, if it appears that they are, or will be, involved in parenting, there should be active attempts to engage with them. In fact, it is now known that L's parents were living together and L's mother was not truthful with health professionals or the social worker. She successfully 'hoodwinked' the professionals about her relationship with L's father and about her drug-use, which she said she was involved in through her pregnancy and after L was born. There seems to have been a lack of professional curiosity regarding L's parents' relationship and their parenting arrangements and, as the perceived non-resident parent, L's father was marginalised and largely ignored by health and social care services. The Reviewers were told that practice has since changed in Children's Services and other family members are now involved even in proportionate assessments.

   Given the knowledge that professionals have about the impact of ACEs, additional support could have been considered for, and offered to, the family.

3. **Health professionals need to take every opportunity to make routine enquiries about domestic abuse.**
   Whilst there was evidence of regular antenatal care being given, there is only one record of the 'routine enquiry' regarding domestic abuse and, likewise, one record of 'routine enquiry' by the health visitor post-natally. Health Board policy is that the opportunity to ask about the parental relationship and any domestic abuse should be taken at every contact if it is safe to do so.

4. **There were gaps in the midwifery service's documentation.**
   L's maternal grandmother described an incident on the labour ward where L's father was verbally abusive to L's mother, whilst she was in labour. She described this as

being witnessed by a midwife, with the result that he was asked to leave the room, but this was not recorded or handed over to community midwifery.

Recordings made by the midwifery and health visiting service were not detailed: there were gaps and it seems that the PPN shared by police was not contained within their records. It has not been possible to ascertain whether it was not received at all or whether it was not retained on the records. There is also no record of any conversation with the social worker.

5. **The hand-over process between midwifery and health visiting was not comprehensive.**
   Midwifery records are not currently available to health visitors. It was apparent that the health visitor was not informed by the midwifery service that L's father was care experienced and had a number of ACEs.

   The allocated health visitor did not complete the initial birth visit because she was on leave when it was due. This is an important contact and there is no evidence of any liaison between the health visitor who undertook the visit in her place and the allocated health visitor.

6. **L's mother did not have a named midwife and saw a number of different midwives for her antenatal care.**
   It appears that there is no process for pregnant women to have a named midwife antenatally if their care is consultant-led, so there was no professional relationship developed with a single midwife that could have created the trust that L's mother might have needed to disclose domestic abuse.

7. **L's parents declined to view the video on 'shaken baby' syndrome.**
   This was noted on the record, but they were given no further opportunity to view it. It is not recorded whether they were given information in any other format.
   The Reviewers were told that this is not being offered at all Health Board sites and is, in fact, no longer available on the platform that was being used. It is vital that parents understand the catastrophic injuries that shaking a baby can cause and information should be offered routinely. There should be a range of formats for parents to have information about this issue.

Notable Effective Practice

1. There was evidence of some linkage between incidents by both response officers and the Multi-Agency Safeguarding Hub (MASH) Risk Assessor, who should be commended for recognising that the incident of threatening messages being received by L's mother from the paternal grandmother, needed to be recorded on a PPN and shared with Children's Services. The Risk Assessor also shared information with Children's Services about L's father's criminal history and the warning marker that police had on his Niche police record for mental health. The first PPN produced in relation to the domestic abuse incident was also detailed and made linkages with other incidents.

2. The health visitor was sufficiently concerned about L's 'twitching legs' that she asked L's mother to contact the GP and arrange an appointment in her presence.

Improving Systems and Practice

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

(what needs to be done differently in the future and how this will improve future practice and systems to support practice)

1. **Agencies should ensure that their staff are aware of the psychology of unconscious bias. In addition to stand-alone training, this should be included in training on assessment and Safeguarding. The concept of professional curiosity should also be included in all relevant training programmes.**

2. **Information about fathers should be actively sought by health and social work professionals in all assessments of pregnant women and children's well-being. Professionals should make every effort to involve and engage fathers in assessments and should seek collateral information when risks are identified. ACEs and their potential impact on both parents and their parenting should be identified.**

3. **Cwm Taf Morgannwg Safeguarding Board should ensure that its multi-agency pre-birth assessment guidance includes the above recommendation.**

4. **Children's Services should review their guidance for undertaking proportionate assessments to ensure that information is gathered from a variety of sources and not from just one individual. When an assessment for a child is being undertaken, the parents' records should be checked in order to establish whether there is relevant information that might indicate a potential risk to the child that has not been disclosed.**

5. **Midwives and health visitors should be updated about the Health Board's policy on 'routine enquiry'.**

6. **The Health Board should review its record-keeping in the midwifery and health visiting service and ensure that recording by these professionals is of the required standard.**

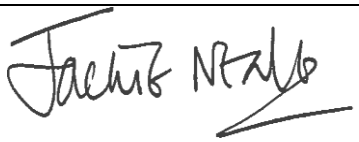
7. **The Health Board should ensure that the process for sharing PPNs with midwives and health visitors is robust.**

8. **The Health Board should review the process for the hand-over of cases from the community midwifery service to the health visiting service.**

9. **The Health Board should consider establishing a process by which pregnant women having consultant-led antenatal care can still have continuity of care by a named midwife.**

10. **There should be clarity as to whether it is UHB departmental policy still to offer the 'shaken baby' video (that was offered to L's parents to view in hospital and was declined). The UHB should ensure that all new parents are provided with information on this and that there is consistency across the Health Board area.**

Statement by Reviewer(s)			
REVIEWER 1	Jackie Neale	**REVIEWER 2** ***(as appropriate)***	Beverley Brooks
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 • The review was conducted appropriately and was rigorous in its analysis and evaluation of the		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	

	issues as set out in the Terms of Reference		
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	B Brooks
Name *(Print)*	Jackie Neale	**Name** *(Print)*	Beverley Brooks
Date	12.01.2021.	**Date**	16.03.21

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

Appendix 1: Terms of reference

Appendix 2: Summary timeline

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.*
A Panel Chair and two Reviewers were appointed and the CTMSB convened a Panel comprising all agencies who had some involvement with the family. The Panel had representation from; South Wales Police CTMUHB

RCTCBC Children's Services

There were five Panel Meetings on 23rd January 2020, 11th June 2020, 25th June 2020, 9th September 2020 and 5th October 2020.

L's mother, father, maternal grandmother and step-grandfather (who are separated) were contacted by the Reviewers to give them the opportunity to be involved in the Review. Neither L's mother nor his father responded to this invitation, but both his maternal step-grandfather and maternal grandmother expressed an interest in being involved. The Reviewers met with both family members individually, attending the step-grandfather's home (using Personal protective Equipment [PPE]) and meeting virtually with his grandmother. The Reviewers also met L and are pleased to report that he is developing well and, apart from some problems with his vision and some weakness on one side of his body, he is thriving in the care of his extended family.

When a further letter was sent to the parents and maternal grandparents to inform them that the Review had now been completed and offering to meet to share the learning and recommendations, L's mother responded and asked to meet with the Reviewers. This was arranged, although one Reviewers was unwell and unable to meet, so the other Reviewer met L's mother with another Panel member. Again, PPE was utilised for this meeting.

A Learning Event was held, with practitioners from all three agencies above who had had some involvement with the family: this was done virtually in order to comply with social distancing measures required during the COVID-19 pandemic. Whilst this method of delivering such an event was new to all parties involved, everyone engaged well and feedback from participants was positive. Participants identified learning that was consistent with the Reviewers' analysis.

☐ 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	☐	☐	

Appendix 1

TERMS OF REFERENCE

CONCISE CHILD PRACTICE REVIEW PANEL CTMSB 3/2019

Case Reference details
CTSMB 3/2019 (Child L)

Circumstances leading to the CPR

The child was admitted to PCH due to being unresponsive at his home address. Tests revealed multiple bleeds to the child's brain, two fractures to the skull and possible limb fractures. The child remains in a stable condition: however, his injuries may be life changing. Both parents have been arrested and both deny causing any of the injuries. They have been released on bail while the investigation continues.

Agencies Involved

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

- Children Services
- Health
- Police
- WAST

Tasks of the Child Practice Review Panel
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
Sue Hurley (Chair)	Independent Protecting Vulnerable Persons	South Wales Police
Lianne Rees	Detective Inspector	South Wales Police
Jackie Neale (Reviewer)	Safeguarding Service Manager	Adult Services RCT
Claire O'Keefe	Safeguarding Nurse Specialist	CTMUHB
Beverley Brooks (Reviewer)	Deputy Head of Safeguarding	CTMUHB
Julie Clark	Head of Safeguarding	Children Services RCT

Additional Areas of Focus

There were no additional areas identified to focus on, this will be a concise review.

Any Parallel Reviews or Other Such Activity to be Noted

There are no other parallel reviews underway, other than the family court hearing which has concluded and the outcome is imminent and the criminal investigation is currently ongoing and may impact further down the line but this will be considered at each panel. Family members will not be met until the conclusion of both of these investigations.

Timeframe for the CPR

The timeframe set for the Review is **10th June 2018** to **10th June 2019**. Summary reports of significant events to be completed prior to this time frame.

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 **29th July 2020**

Completion Date

The completion date set for the Review is **Monday 5th October 2020.**

Tasks of the CTM 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 CTMSB 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