Child Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Concise Child Practice Review

Re: *CTMSB 8/2020 - Child Q*

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. The criteria for Child Practice Reviews are laid down in The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. The criteria for this review are met under Volume 2, Chapter 6 of the statutory guidance Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).: 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.

2. A concise Child Practice Review was commissioned by the Cwm Taf Morgannwg Safeguarding Board (CTMSB) for Child Q, on the recommendation of the Board's Joint Review Sub-Group, in accordance with Section 139 of the Social Services and

Wellbeing (Wales) Act 2014 and accompanying guidance. The purpose of a Child Practice Review is to identify multi-agency learning for future practice.

Circumstances leading to the review

3. Early in the New Year in 2020, Children's Services received a phone call from Child Q's maternal grandmother advising that his father had fallen down the stairs with Child Q in his arms. The phone call was made because the grandmother wanted to explain that she could not attend a Child Protection meeting for her own child as a result of this incident. Child Q, who was 5 months old, was taken to hospital, where it was established that he had suffered a fractured skull. He was subsequently transferred to the regional specialist hospital. On the following day, a telephone call was received by the Safeguarding Nurse from that hospital, informing Children's Services that the skeletal survey results had shown a bleed on his brain and a fractured skull, as well as healing fractures to his ribs. She reported that these could be linked to the incident, but they could not rule out that the fractures had been sustained from a previous injury. Discussions with the treating Paediatrician also noted Child Q had swelling to both sides of his ribs and both sides of his wrists, which he said could also be due to the injury he sustained on the day of the incident. Additionally, the Paediatrician advised that Child Q had retinal haemorrhages (bleeding at the back of both eyes), which he said could have been caused by accidental or non-accidental injuries, such as shaking. Child Q's father was arrested the following day due to the nature of the injuries sustained by Child Q and was later bailed pending police investigation. To date, there have been no criminal charges brought.

4. A referral for a Child Practice Review was subsequently made to the Regional Safeguarding Board and was accepted. A Review Panel was convened, with two independent Reviewers and an independent Chair appointed. The Panel agreed that the timeframe for the Review would be the 12 months prior to the incident but would include the day after the incident because of the discrepancies that were found in agency recording of the Child Protection strategy discussion process. This timeframe would include the period since Child Q's birth and most of his mother's pregnancy. The Review proceeded but the learning event and contact with family were delayed because of the on-going criminal investigation and family court proceedings An interim report was completed that identified areas of learning for agencies.

5. A letter was sent to family members and Child Q's father responded. The Reviewer met with Child Q's father, together with a Panel member (as the second Reviewer had retired before the final Report had been completed) on 10th January 2023. Child Q's father stated that he was very much involved with caring for Child Q from when he was 4 weeks old and often had sole care of him. He also explained that he took him to hospital on two occasions and to the GP. Child Q's father maintained that he did not know that Children's Services were involved with Child Q and would have contacted them himself had he known, although he also said that Child Q's mother had told him to say he was Child Q's uncle and that he went along with that. Child Q's father's view is that Children's Services should have contacted him to inform him of their involvement, notwithstanding the fact that he did not have parental responsibility and that Child Q's case was not being managed as a Child Protection case. Child Q's father is now involved in lobbying for fathers' rights and said that, if he has another child, he will contact the relevant Children's Services himself.

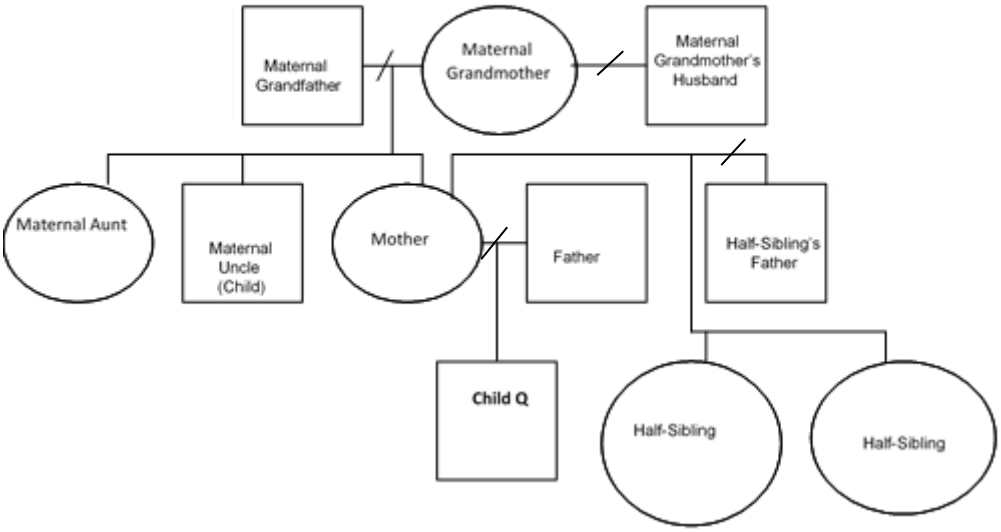
Family Structure

6. At the time of the incident the family members living at home address 1 were as follows;
    - Child Q's mother
    - Half-sibling 1, aged 3 years, 11 months at the time of the incident
    - Half-sibling 2, aged 1 year, 7 months at the time of the incident
    - Child Q

Living at home address 2 were:

- Maternal Grandmother
- Uncle of Child Q (child), aged 6 years, 4 months

The uncle of Child Q was living at home with his mother and his name was on the Child Protection Register under the category of Emotional Abuse.



Summary of Significant Events leading to the incident in the New Year, 2020.

7. At the beginning of the Review timeframe, the only agencies involved with Child Q's immediate family were the health visiting service for his 2 half-siblings and the GP. Both children had previously been subject to a Care & Support Protection Plan, until their names were removed from the Child Protection Register (CPR) some eighteen months earlier and their cases were subsequently closed by Children's Services.

8. During the first five months of 2019, there were 7 missed health visiting appointments for these children and Child Q's mother only presented for ante-natal care when she was 21 weeks pregnant with Child Q. The pregnancy was considered to be high-risk as Child Q's mother had had 2 previous Caesarean sections. When she had an ante-natal scan, an abnormality was detected in Child Q's kidneys, which meant that he would need continuing medical checks when he was born. Child Q's mother did not disclose his father's identity at the booking-in appointment, saying that they were separated and he would not be having any contact with Child Q.

9. There was an incident in late Spring of that year, when Child Q's maternal grandmother contacted police because she alleged that Child Q's father had appeared on her doorstep and was being threatening towards her. Child Q's mother also gave a statement to police alleging that she had been threatened on the telephone by a female, who she believed to be Child Q's father's new partner and disclosed historic domestic abuse by him. A Public Protection Notice (PPN) was generated that stated Child Q's mother was pregnant: she was subsequently assessed as a high-risk domestic abuse victim and her case was

discussed at a Multi-Agency Risk Assessment Conference (MARAC) daily domestic abuse meeting in the local Multi-Agency Safeguarding Hub (MASH). Although Children's Services had a representative in this discussion, the minutes of this discussion do not accurately represent the situation regarding Children's Services at that time. Whilst Children's Services had no involvement with Child Q's half-siblings, it was recorded in the minutes of that meeting that their cases were open on a Care and Support basis, which was not correct.

10. Nine days later, when Child Q's mother was 31 weeks pregnant, the Midwife made a referral to Children's Services. Co-incidentally, on the same day, Section 47 enquiries were initiated for Child Q's 6-year-old child uncle: his case was already open to Children's Services, managed as a Care and Support case.

11. The referral for unborn Child Q and his half-siblings was allocated to a Social Worker for assessment. The Social Worker attempted to visit the family 18 days post-referral. The visit did not take place because the family were not at home; the mother subsequently told the Social Worker that she and the children had been at her mother's house. The Social Worker made a case note of their intention to visit the following day: there is no record of a visit taking place. A further 12 days passed before the Social Worker recorded that they phoned the mother; she did not reply. The Social Worker made a case note that they would visit the next day; again, there is no record of this visit. During this time, Child Q's 6-year-old uncle's name was placed on the CPR. Despite the known enmeshed nature of the two families, unborn Child Q and his half-siblings were not considered as part of the strategy discussion, S47 enquiries or Initial Child Protection Conference (ICPC) for his uncle. Child Q's Social Worker struggled to see his mother and his half-siblings at their own home, but his uncle's Social Worker recorded that Child Q's mother and the children were present on each occasion they visited the maternal grandmother's home.

12. Six weeks after the referral from the Midwife was made, the Social Worker for Child Q told the Health Visitor that they had visited the family and that, in their view, there were no significant risks to unborn Child Q, or to his half-siblings. The recommendation of the Social Worker's assessment was that the children's needs could be met on a Care and Support basis: effective case recording would have provided evidence to support that decision. Child Q's pre-birth Care and Support assessment was completed within the required timescale at 42 working days post-referral. References were made in the assessment document about contacts by the Social Worker with Child Q's mother and his half-siblings, so it appears that

visits were made, but were not evidenced in the case notes, which forms the chronology of his case.

13. Child Q was born in hospital by Caesarean section at the beginning of August. He was commenced on medication immediately because of his congenital kidney abnormality. Four days later, and after their discharge home from hospital, Child Q's mother was asked by her Community Midwife to take him to be examined at the hospital because of jaundice. His mother did not do this, although he was seen at home by the Midwife the following day and his condition had improved. He was not seen again by a professional for another 17 days (he was 21 days old at this point) because he was not made available for his two health appointments. There were no arranged social work visits during this period. When he was 16 days old, the maternal grandmother reported to her child's Social Worker that she had not seen Child Q's mother for several days. Child Q or his half-siblings' whereabouts during this time were not present in health and Children's Services' records.

14. The Social Worker visited the family when Child Q was 22 days old, and it was noted on the case record that the children's cases might be closed after the 'next' Care & Support meeting, although there had not yet been any meeting recorded. About a month later, the team manager asked the Social Worker to hold a Care and Support Review meeting, but this did not take place. From the records there were no multi-agency meetings held and there was no Care and Support Plan produced. There is no record of a home visit for a further 3 months, although the children's cases remained open, and that visit took place because Child Q's uncle's Social Worker had informed Child Q's social worker that he had said that Child Q's father had been to their house. The conversation at that visit between Child Q's mother and his Social Worker was very limited because the mother was at a bus stop with the children and the Social Worker was in a car. There were no further documented attempted contacts or home visits recorded by the Social Worker until the day of the incident that resulted in Child Q's injuries.

15. There has been much work[1] undertaken in recent years on understanding how Adverse Childhood Experiences (ACEs) can affect individuals' health and behaviour in adulthood. Child Q was born to parents who had experienced abuse and neglect as children. His father was a child looked after by the Local Authority from the age of 10 years, having experienced multiple adverse childhood experiences. He was known by Children Services to have issues with anger and could be aggressive. He was also known to use substances and had many criminal convictions by the time of the incident. He was open and honest

[1] Home - ACE Hub Wales

about his past when he met with the Reviewer and Panel member. Child Q's mother and her siblings were known to Children's Services throughout their childhoods, having spent periods of time on the Child Protection Register. She had experienced homelessness, multiple accommodation moves, parental domestic abuse and her father's substance misuse. The maternal grandmother appeared to be in charge within the extended family unit, and, during the Review timeframe, Child Q's mother alleged that her mother was having her benefit payments being paid into her mother's account and that her mother was controlling her and her finances. Child Q's father described the maternal grandmother as 'controlling'.

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

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

It became evident during the learning event that Children's Services had been experiencing difficulties with sickness amongst supervisory and front-line managers in 2019 that meant the usual processes for management oversight were not always robust and that front-line practitioners were experiencing secondary pressures as a result of this. Likewise, local health professionals were in the midst of a Health Board re-organisation that resulted in them moving from being employed by one Health Board to another.

Key Theme 1: Understanding the Significance of Missed Healthcare Appointments

16. It was evident from the Health Board's summary of previous involvement and their chronology that there was a pattern of missed appointments with the Health Visitor in relation to Child Q's half-siblings. Whilst it is acknowledged that it is not mandatory to book into ante-natal care, Child Q's mother had booked in late into her pregnancy with Midwifery in 2018 when pregnant with Child Q's half-sibling 2 and had not attended for ante-natal care between being 16 and 30 weeks' pregnant. She did not book in until she was 21/40 weeks for ante-natal care when she was pregnant with Child Q. This was a month after she had informed her Health Visitor that she was pregnant. Information about the pregnancy does not appear to have been shared promptly with both the GP and the Midwifery service.

17. Repeated missed appointments and cancellations, resulting in children being late in receiving health checks and immunisations, can indicate Safeguarding concerns and should be followed up as part of a holistic assessment. There were 7 missed health visiting appointments for Child Q's half-siblings occurring during the first 5 months of 2019 and delays in accessing ante-natal care. Although the midwife and health visitor discussed these concerns, no action was taken, until the midwife made a referral to Children's Services was not made until the mother was 31/40 weeks pregnant and after the MARAC daily domestic abuse discussion in the MASH.

18. The Midwife liaised with the Health Visitor and shared information when the mother booked in for ante-natal care in March 2019. The Midwife recognised current risk factors, including the mother's late presentation for ante-natal care and reluctance to identify the father of her unborn child, but there was no triangulation of the risks resulting from her previous behaviour and current lack of engagement with health visiting for her other children. If there had been, it might have resulted in an earlier referral to Children's Services. It was noted on several occasions that a referral to Children's Services should be 'considered' without any rationale recorded for the decision not to make a referral. Whilst mothers are under no obligation to divulge their unborn child's father's identity, there can be underlying reasons for this that could include a desire to avoid the involvement of Children's Services because the father could be recognised as posing a risk to the child.

19. After Child Q's birth, there were missed or cancelled appointments, some of which were with the hospital paediatric service. Whilst there is evidence of some good communication between the hospital service and the Health Visitor, there is no evidence that there was onward reporting of the accumulation of missed or re-scheduled appointments to Children's Services. There is evidence of the Social Worker attempting to complete a chronology of these at the point of initial assessment, but there was no on-going mechanism for reporting further incidences, because there was no shared Care and Support Plan for Child Q (see below) and no multi-disciplinary meetings. The lack of completed chronologies rendered it more difficult to see the extent of the issues.

Key Theme 2: The Need for Comprehensive Case Recording and Compliance with Assessment/Care &Support Planning Processes.

20. When the Midwife made a referral to Children's Services, the Social Worker who was allocated to Child Q and his half-siblings' cases did not attempt to visit the family until 12 days post-referral. The visit did not take place because the family were not at home and no

further appointment was recorded as being made until 5 weeks later. There is no record on the Children's Services records of when an initial visit did take place.

21. There were gaps in documentation and recording: the pace of the assessment process was slow and visits in response to incidents were not timely. An example of this was when the maternal grandmother reported not seeing Child Q's mother for several days (the Reviewers have assumed this means the children's whereabouts were not known either, although there is no reference to this). The Social Worker did not see the children until 6 days later. The case recordings do not suggest that the mother was challenged about the inconsistencies in her account or asked to explain where the children were and who was caring for them during this time.

22. Care and Support Assessments that refer to direct contacts with Child Q, his half-siblings and mother were completed. The outcome of those assessments was that Child Q's and his half-siblings' needs could be met via a Care and Support Plan under Part 4 of the Social Services and Well-Being (Wales) Act, 2014. However, no Care and Support Plan was produced. The lack of a Plan meant that agencies' involvement was directionless and there was no escalation of the lack of a shared Care and Support Plan by the health professionals. No multi-agency Care and Support meetings were held, despite the Social Worker being asked by their line manager on two occasions to arrange a meeting. The Social Worker was in fact, at this point, recommending closure of Child Q and his half-siblings' cases, but the rationale for this recommendation is not apparent.

Key Theme 3: The Need for Robust Initial Risk Assessment & Re-assessment when Risks change

23. It is known that past behaviour is an important predictor of future behaviour [2]. All commonly used risk assessment tools include a chronology of historic behaviours and incidents for this reason. Current and future risk cannot be assessed in isolation from the past, although, equally, cannot be defined by it. It is, of course, possible for parents to change and the behaviours, relationships and environments that previously resulted in risk to their children to reduce or disappear. However, to take all factors into account and develop the most comprehensive risk assessment possible, an understanding of the past is critical. Consequently, health and social care professionals need to be curious about parents' individual life stories and the history of their parenting in all its aspects to understand fully the risks to their children.

[2] Munro, Eileen, 2011, Munro-Review.pdf (publishing.service.gov.uk)

24. The trans-generational impact of ACEs on parenting is well-known as a risk factor for the children of adults affected by ACEs. It was not apparent that any professional considered the mother's experience of trauma in her own childhood when undertaking assessments of her children, even though she had an extensive history with local Children's Services. In addition, her half-brother's name was placed on the Child Protection Register for the second time during the time that the pre-birth assessment for Child Q and assessments for his siblings were being undertaken.

25. It was decided that the maternal grandmother did not pose any risk to Child Q and his half-siblings, despite her significant involvement in their day-to-day care being acknowledged. More recently, for 8 months in 2018, both of Child Q's half-siblings' names had been placed on the Child Protection Register under the category of neglect. At that time, the mother had resumed her relationship with Child Q's half-siblings' father, despite a history of domestic abuse, and the mother having been abused again, became homeless. She moved to live with her parents despite her own history of childhood trauma and the fact that her half-brother was subject to a Child Protection Plan and care proceedings were being considered. Children's Services were aware of Child Q's father's identity and there was some reference to the mother's fear of him in the assessment: she was also identified as a high-risk domestic abuse victim by South Wales Police. Research of the father's history would have revealed the history of trauma in his own childhood and of his history of violence (this had been reported by criminal justice agencies at the MARAC daily discussion).

26. When a comprehensive risk assessment is completed at one point in time, previously assessed risks can change, and new risks can emerge. In this case, there were several incidents, each one of which suggested that any initial risk assessment should have been re-visited:

- Early June, mother reports she was in the process of moving in with her mother (Child Q's maternal grandmother)
- Late June: ICPC held in respect of mother's brother (Child Q's uncle), whose name was placed on the CPR under the category of emotional abuse. The family were now residing with the maternal grandmother, who was known to be controlling. She and Child Q's mother were reported by the Social Worker as 'co-parenting'
- Early August: Child Q was jaundiced, and his mother was requested by a midwife to take him to the Children's Assessment Unit. She did not do this and Child Q was seen at home by the Midwife the following day. It does not appear that this incident was reported to the Social Worker.

- Mid-August: The Health Visitor contacted the Social Worker to inform them that they were concerned because Child Q was now 16 days old and had not been seen by a professional since day 5 because the mother had not made herself available for any appointments. The maternal grandmother also told the Health Visitor that she had not seen the mother for a few days (it was not clear whether the children were with their mother or not). When the Health Visitor spoke to the mother, she told her she had been staying at the local homelessness hostel. The Health Visitor checked this and there was no evidence she had been staying there and she told the Social Worker. When the Social Worker saw the mother 5 days later, she denied staying with a man she had met in a coffee shop (as later alleged by maternal grandmother) and said she had been at her own home. There is no record of the Social Worker asking her about the hostel story.
- Late October: maternal grandmother and uncle moved into Child Q's family home on a temporary basis.
- Late November: a PPN was received following a verbal argument between the mother and maternal grandmother. The maternal grandmother told police that Child Q's father was staying at the mother's home. The mother denied this, saying he just helped her move to a new house. Child Q's mother alleged that maternal grandmother was controlling her and her finances. The Social Worker also noted that Child Q's father was reportedly initially very persistent in contacting her, requesting contact with his son, but more recently had stopped this. Having 'helped' Child Q's mother move to a new house, she was admitting that the couple were on more amicable terms at least and that the father was having contact with Child Q. The Social Worker made an unannounced visit that day due to her concerns but, on approach to the home, the mother was seen going to the bus stop with the children. A brief conversation took place but, as the Social Worker was in the car and the mother was at the bus stop, no meaningful discussion could take place. The Social Worker was clearly concerned, as they had made an unplanned visit that day because they felt the mother was being evasive. However, they did not arrange to visit again to discuss the concerns. There are no entries for the whole of December on the Children's Services chronology. If it was suspected that the father was in the family home, Christmas time would have been the ideal time to visit to ascertain if he was having contact with Child Q or was living there, but this did not happen. This was a significant missed opportunity to review the risks, as a Child Protection strategy discussion would likely have been initiated.

- 2 days later: it is recorded by Children's Services that Child Q's uncle told his social worker that Child Q's father had been at the house, the parents had been arguing and the father had been pushing for a relationship with Child Q's mother. The mother denied he had been there.

27. Professionals' view of risk needs to be flexible and dynamic. The degree of risk can change with a single or a series of events and professionals must be prepared to adjust their view. The nature and degree of risk being experienced by Child Q and his half-siblings was not re-evaluated. The recommendation that came forward was that Child Q and his siblings' cases should be closed, with no rationale and at a time when the risks appeared to be increasing.

Key Theme 4: The Need for Professional Curiosity and Awareness of Disguised Compliance

28. Professional curiosity and awareness of the possibility of disguised compliance are necessary when working to safeguard children's health and well-being; however, in this case, the mother's behaviour and statements were accepted largely at face value. Early on, an example of this was the acceptance of the mother's statement that she was involved with the local domestic abuse service and that she had a Restraining Order in place in relation to Child Q's father. The Reviewers found no evidence that Child Q's mother engaged with the domestic abuse service beyond one initial appointment, nor any evidence to suggest that a Restraining Order had been sought. There is no record of liaison with the domestic abuse service by Children Services at any point to seek confirmation of the mother's claims. When Child Q's mother allegedly disappeared for a few days, she was asked where she had been, but was not challenged when she said that that she had been at home, although she had told the Health Visitor that she had stayed at a homelessness hostel. There was one occasion at the end of November 2019 when the Social Worker became suspicious that Child Q's father might be having access to him, following receipt of a PPN from the Police and the involvement of the Emergency Duty Team: the Social Worker made an unannounced call, but this was unsuccessful and was not followed up on. Having rightly been suspicious, the Social Worker did not record further contact with Child Q's mother or the children until the day of the incident.

29. A similar incident, where there was acceptance of the mother's account, occurred in mid-September when the Health Visitor made a house call but there was no answer at the door. The Health Visitor could see the children alone downstairs. The Health Visitor telephoned the mother from her car and the mother explained that she was in the bathroom, but the Health Visitor did not return to the house to check that the mother was in

the home. Best practice would have been to return to the property immediately to establish that the mother was present and the children had supervision from an adult.

30. On two occasions (in early October and on Christmas Day 2019), a male person took Child Q to the Paediatric Assessment Unit for examination, as he was unwell. This person claimed to be Child Q's uncle, but no name or address for this person was obtained and the examination proceeded. It was not clear from the Health Board's chronology whether the mother was contacted to explain why she was not in attendance herself to give consent, but, from the information provided, it appears that the examination took place without obtaining the necessary consent from a person with parental responsibility. There was no evidence of curiosity about who this person was, and it does not seem that this information was made available to the Health Visitor. When the Reviewer met with Child Q's father, he confirmed that this was him, but he claimed that Child Q's mother had told him not to disclose who he was for fear of Children's Services' response. Child Q's father said he had had extensive involvement with Child Q from September on, regularly caring for him alone and having him with him at his flat overnight, including taking him to the GP 2 days before the incident. Child Q's father also told the Reviewer that he and the mother re-commenced their relationship.

Key Theme 5: The Need for Understanding of Complex Family Structures and Relationships.

31. Health and social care professionals should also be mindful of complex family structures and diverse care-giving arrangements for children. Whilst there were two parents with 3 children, ostensibly in 2 separate households, essentially Child Q's mother and his maternal grandmother could have been considered as a virtual (and, at times, actual) single household. There were descriptions of the arrangements as 'co-parenting', but no indication that this knowledge was applied in practice when considering the risks and needs for all the children in the family by the health and social care professionals involved. There was evidence of regular communication by the Social Worker allocated to Child Q's uncle whose name was on the Child Protection Register with the Social Worker for Child Q and his half-siblings, but there were no joint visits (there were also missed opportunities for Child Q's Social Worker to visit the family jointly with the Health Visitor).

32. It was known that the maternal grandmother was a regular caregiver for Child Q and his two half-siblings, but that knowledge did not appear to lead the Social Worker to question whether there was any risk to Child Q and his half-siblings because of this arrangement. Although the ICPC for Child Q's uncle produced a genogram, it was inaccurate, as it placed

the unborn Child Q and his half-siblings outside of the maternal grandmother's household, but the mother inside the household. Child Q's mother attended this ICPC, but there is no evidence that she was asked who was looking after her children at the time. The uncle's name was placed on the Child Protection Register. Robust consideration should have been given to the impact and risks to the unborn Child Q and his half-siblings, given that they were residing in the same household at that time. Even when they were not actually living together, they were so closely connected that they could still have been considered as a single extended household. It would have been beneficial if, at the strategy discussion that decided to initiate Section 47 enquiries in relation to his uncle, Child Q and his half-siblings had been identified as requiring strategy discussion too. Despite being a regular caregiver for the children, the maternal grandmother was not identified as such.

Key Theme 6: The Need for Continuous Information-Sharing and Constructing the Bigger Picture

33. There were several health-related incidents that, had they been reported to Children's Services, should have changed the risk analysis. The historic pattern of missed health care appointments continued for Child Q, but no one 'joined the dots'. There were several missed medical appointments for a young baby, but no evidence of advice being sought from the Health Board's Safeguarding Team or a shared Care and Support Plan that would have required multi-agency working and Care and Support meetings. In addition, the use of chronologies would also have supported a more systematic approach to identifying Child Q's risks and needs. Paediatric clinic appointments were missed on 3 occasions in October 2019 and a letter was sent to the General Practitioner in early November informing them about the missed appointments, but it is not clear whether the Health Visitor was informed. Child Q was a baby who needed paediatric follow up to manage his medical condition that could have long-term health implications.

34. Incidents were treated in isolation, so links were not made: important information was therefore lost and could not be utilised to give greater understanding of the risks to Child Q and his half-siblings. All incidents of non-attendance at health appointments should have been reported not only to the GP, but also to the Health Visitor. Had the hospital been aware of the wider concerns about Child Q and the involvement of Children's Services, staff might have reported directly to Children's Services. A shared Care and Support Plan might have identified the need for communication with Children's Services in such circumstances. An historic and live chronology of all missed, or repeatedly re-scheduled appointments would have been helpful for the Social Worker to form a picture of the extent of the issue. The Social Worker case recorded that they made attempts to obtain a historic chronology

during the initial assessment, but that was not provided. Whilst, on most occasions, Child Q and his half-siblings were eventually seen for their health appointments, a detailed on-going record would have revealed the degree of professional intervention that was necessary to achieve co-operation and how delayed the appointments were because of repeated re-scheduling. The scale of missed appointments amounted to disguised compliance but was not recognised as such.

Key Theme 7: The Importance of the Line Manager/ Practice Supervisor's Role

35. It is not known whether the Children's Services' line manager was aware that

- there was no Care and Support Plan.
- there were gaps in the case recordings.
- the Social Worker's successful contacts with Child Q and his half-siblings appear to have been minimal in the first seven months of their involvement.
- the line manager's requests on two occasions for a Care and Support meeting to be arranged had not been acted on.

Given that both families were known to the same team, there were missed opportunities to collaborate and make linkages between the children involved and the shared care arrangements between the two mothers. At the learning event, a Children's Services attendee explained that, at this time, the team manager had periods of sick leave and the team was under-resourced.

36. There was no analysis of the real challenges to engaging the mother that amounted to disguised compliance and persistent avoidance of professionals. There is no record on the system of discussions about risk or about the threshold for Child Protection procedures in relation to Child Q and his half-siblings. The Children's Services chronology demonstrates that the Social Worker for Child Q's uncle saw Child Q's mother at virtually every home visit and at almost every Core Group meeting, yet it seems that no connection was made between these facts and the risks that Child Q and his half-siblings might face as a result of their prolonged contact with their maternal grandmother. If unannounced visits or joint visits to the maternal grandmother's home had taken place, Child Q's Social Worker would have easily seen Child Q's mother and the children there.

Key Theme 8: The Need for Clarity and Shared Understanding between Agencies about the Decisions made in Child Protection Strategy Discussions

37. When the chronologies for Child Q's case were merged, it became apparent that there was a disparity in Children's Services and South Wales Police's understanding of what happened from a Child Protection procedural perspective, following the incident where Child Q was injured. There was confusion as to whether there had been a strategy discussion on the day of the incident and, if there had been, what the outcome was. South Wales Police recorded that there had been a strategy discussion between Police and Children's Services late afternoon on that day and, as there was no indication at that point that the incident was non-accidental, the outcome was that Children's Services would undertake a single agency investigation under Section 47, of the Children Act 1989. Police also noted that the strategy discussion took place without the full name of the child or the father being available, which limited the background research that could have been done by Police in advance of the discussion.

38. Children's Services had no record of this strategy discussion. According to the Children Services' record, the first strategy discussion was held on the day after the incident, when further medical evidence was reported that suggested Child Q's injuries could have been non-accidentally inflicted and there was no local Health representation at the strategy discussion. Health professionals from the out-of-county hospital where Child Q was a patient did attend. At this time, there was no shared system for sharing information and so each agency recorded the outcomes of strategy discussions on their own systems, which created the possibility of differing perceptions as to the decisions made during the conversations between the Police and Children Services on the day of the incident.

39. According to the police record, Child Q's Social Worker felt there were some concerning factors, such as the father's behaviour at the scene and the inconsistency of the explanation for how the injuries were sustained, compared with how the stairs were constructed. Despite these concerns, the Social Worker did not contact the police whilst at the scene. This was a missed opportunity to involve the police at an early stage. When any professionals have concerns that a child might have been injured non-accidentally and the situation is live, the police need to be contacted immediately so that they can attend, make their own assessment, and preserve evidence.

40. Good Practice

- The social worker requested a chronology of missed and re-scheduled health care appointments form the health visitor at an early stage in their assessment.

- The Health Visitor took the initiative to check the mother's account of where she had been when she was alleged to have disappeared for a few days, by contacting the homelessness hostel she claimed to have stayed at.
- Late September, the hospital Paediatric Renal Clinic contacted the Health Visitor to assist with securing Child Q's attendance for a planned renal scan, after repeated attempts to arrange an appointment with the mother. This strategy proved to be successful, as Child Q finally had the scan.
- Mid-September, the Registrar contacted the Health Visitor to inform them that Child Q's birth remained unregistered (he was nearly 7 weeks old at this point). This was good information-sharing between agencies.
- In late-November, police undertook a comprehensive search of Child Q's mother's home to check the father was not there before returning her and the children to the house following an argument with her mother.
- Police PPNs were detailed and contained information about all relevant parties.
- Time and date stamped Police recording of the strategy discussion process on the day of the incident, and on the following day, provided detailed records of developments in the case.

Improving Systems and Practice

To promote the learning from this case the review identified the following actions for the SAB 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)

The learning identified in the Review of Child Q's case is significant, but it is now from events that happened three years ago, prior to the Covid pandemic. It needs to be acknowledged that much has changed for both Children's Social Care and Health Services since that time. Many of the recommendations in the interim report have been actioned and practice has changed. In returning to this Review, it has been important to take account of the progress made. For clarity, the original recommendations have been retained with comments inserted to indicate where improvements have been made.

Key Theme 1: Understanding the Significance of Missed Healthcare Appointments

Recommendation to the University Health Board (UHB)

41. Health Visitors, midwives and hospital-based paediatric clinicians should be reminded of the significance of repeated missed healthcare appointments as part of their Safeguarding duties. This should include the following:

- The importance of sharing information with one another when both professionals are working with families. Midwives and Health Visitors should adopt a 'whole family' approach, working together to ensure that needs are being met for all the children in the family, including unborn children.
- The need for compliance with the All Wales 'Was not Brought' Policy and the Cwm Taf Morgannwg Safeguarding Board's Pre-Birth Policy. Where there is booking for ante-natal care late in pregnancy and a pattern of missed ante-natal appointments, midwives should take advice from their Safeguarding Lead and consider whether the Pre-Birth policy should be triggered.
- Lack of engagement with health visiting and ante-natal care should be assessed accordingly in terms of safeguarding concerns, and the risks of opting out of universal services should always be considered.
- The need to make timely referrals to Children's Services and of their 'duty to report' under the Wales Safeguarding Procedures.

Update from the Health Board: *a pathway has been developed between midwifery and health vising to support effective communication and Midwifery now keep an electronic file to record and support any safeguarding concerns that cannot be entered into the handheld records (2021). The 'Was not Brought' policy has been updated and ratified. Supportive Practice reviews for health visitors (SPR) are undertaken yearly to review practice, including review of documentation such as Chronologies. (started 2022). Safeguarding audits of documentation and actions are now undertaken six monthly for midwifes and Safeguarding documentation audits are completed yearly for health visitors (started 2022). A new Training strategy to support compliance in level 3 safeguarding with directorates accountable has been implemented.*

Key Theme 2: The Need for Comprehensive Case Recording and Compliance with Assessment/Care & Planning Processes.

Recommendation to Children's Services

42. Children's Services should ensure that case recordings are comprehensive & case management is compliant with Assessment/Care and Support Planning processes under the Social Services and Well-Being (Wales) Act 2014. This should include the following;

- As part of the Supervision and Quality Assurance framework, line managers should undertake regular audits to check compliance with expected standards.

Update from Children's Services: *Children's Services has introduced chronologies for every open case in Children's Services, has updated its Case Recording Policy and has launched a new Induction Programme which incorporates both.*

Key Theme 3: The Need for Robust Initial Risk Assessment & Re-assessment when Risks change

Recommendation to the UHB and Children's Services

43. Relevant assessments should be audited to ensure that the analysis of risk is robust and include;

- The identification of past, present, and future risk factors and an assessment of their impact
- Appropriate responses to incidents that suggest changes to the initial risk determination.
- The views of parents, caregivers, any children who are old enough to be able to contribute and other professionals.

Update from Children's Services: *Back to Basics, which is a mandatory training programme, has been introduced for all social work and social work assistant practitioners. This programme includes the importance of Professional Curiosity and the importance of unannounced visits to families.*

Update from the Health Board: *Use of the FRAIT tool to look at resilience is now embedded in health visitor practice. Health visitors have six monthly safeguarding supervision, work is currently ongoing with the clinical nurse specialist to build a model of supervision that allows practitioners to bring cases of concern. Safeguarding supervision is offered to midwives from the named midwife in a structured way, and they now have a point of contact.*

Key Theme 4: The Need for Professional Curiosity and Recognition of Disguised Compliance

Recommendations to the UHB and Children's Services

44. Agencies should be aware of the need for professional curiosity & the risks of disguised compliance

The UHB should ensure that;

- Health Visitors and other health care professionals should utilise chronologies to explore with the parent(s) the underlying reasons for partial or non-cooperation with health care appointments for their child(ren).
- An audit is undertaken to provide re-assurance of compliance with the Policy regarding obtaining consent for medical examination from a person with parental responsibility for all children.

Update from the Health Board: *Professional curiosity training has been offered to staff. Midwifery now has a Clinical nurse specialist for safeguarding, who has moved into the corporate safeguarding team to support with resilience and provide midwives with safeguarding advice.*

Children's Services should ensure that;

- Its practice-informed training for Social Workers on the importance of professional curiosity and working with disguised compliance when safeguarding children includes how to question and challenge and how to obtain corroborative information, using the learning from this case as an example.

Update from Children's Services: *professional curiosity training has been made available across the region.*

Key Theme 5: The Need for Understanding of Complex Family Structures and Relationships.

Recommendations to the UHB & Children's Services

45. Agencies should ensure that their staff recognise that family structures and care-giving arrangements can be complex and diverse.

Both the UHB and Children's Services should;

- Provide assurance that their practitioners apply Child Protection training in their practice, by recognising that family structures can be complex and diverse and do not always conform to the stereotype of the nuclear family. The needs of all children within a complex family structure should be assessed.
- Promote the value of joint visits between professionals working with different or the same family member. Both agencies should ensure that their training for professionals includes an understanding of how to work together in practice in Care and Support cases, and in cases where one child in the wider family might have a Protection Plan, but others do not.

Update from Children's Services: *A Genogram is now required for every for every open assessment in Children's Services.*

Key Theme 6: The Need for Appropriate Information-Sharing and to Construct the Bigger Picture

46. Agencies should ensure that processes and pathways are in place to support professionals to share information routinely with one another both within a single agency and between agencies.

Recommendation to the UHB

The UHB should

- ensure that all missed hospital appointments for children, including those arranged with caregivers directly by the paediatric ward, are routinely shared with the Health Visitor as well as the GP.
- remind Health Visitors of the need to share information about health care issues with Children's Services and proactively to seek to undertake joint visits to the family with the Social Worker when a child has a Care and Support Plan and escalating to their manager when no Plan has been produced or shared.

Update from the Health Board: *Safeguarding audits for health visitors have been introduced. The process for interagency challenge has been improved with the use of the Inter-agency Resolving Professional Disagreements process. The Clinical Nurse specialists for Safeguarding now link in regularly with the team managers to address unresolved issues, this includes ensuring that multi-agency documentation is available for all involved professionals. This would also form part of the safeguarding audit. Children who are identified as not attending clinic or the ward setting, are followed up by either the clinic nurse specialist for Safeguarding in Paediatrics or the Health visitor Liaison Nurse all relevant staff such as health visitors and GPs are informed.*

Recommendation to Children's Services

- Social Workers and their line managers should be reminded of the principles and practice of working together to safeguard children via appropriate training and consider the merits, not only of joint visits with other professionals, but also of 3-way supervision in cases where more than one social worker is involved with children in a complex family structure.

Key Theme 7: The Importance of the Line Manager/ Practice Supervisor's Role

Recommendations to Children's Services

47.Children's Services should undertake an audit of supervision records to be assured that there is compliance with the Quality Assurance Framework and should consider whether line managers should complete a summary of case discussion outcomes from supervision on individual children's case record.

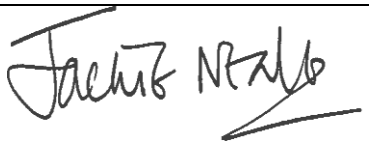
Update from Children's Services: *An audit of Supervision to identify any areas where Supervision could be improved has been completed. The Training and Development Team have also rolled out Supervision Training.*

Key Theme 8: The Need for Clarity and Shared Understanding between Agencies about the Decisions made in Child Protection Strategy Discussions

Recommendation to Children's Services, the UHB and South Wales Police

48.Since the date that Child Q was injured, a single shared strategy discussion record has been developed that is completed by Children's Services and is shared with partner agencies participating in the strategy discussion. An audit of the effectiveness of this process should be undertaken.

Statement by Reviewer(s)			
REVIEWER 1		**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 • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	I make the following statement that prior to my involvement with this learning review: - • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference
Reviewer 1 *(Signature)*  …… **Name** *(Print)* Jackie Neale ……. **Date** …03.04.2023…….	**Reviewer 2** *(Signature)* …… **Name** *(Print)* …… **Date** ……

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

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Adult/Child Practice Review process

To include here in brief:

- *The process followed by the SB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The Core Tasks of this Child Practice Review Panel were 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.

The agreed timeframe set for the Review was 10/01/2019 to 10/01/2020 and detailed chronologies and summary reports were completed by all the agencies involved. These were as follows;

- Local Authority Children's Services
- Local Authority Education Service
- Local Health Board
- Welsh Ambulance NHS Service Trust
- South Wales Police
- National Probation Service
- Domestic Abuse Services

Whilst the Review Panel wished to proceed with the Review quickly to be able to identify any early learning for agencies, a police investigation & family court were still in progress. After seeking legal advice, it was agreed that a preliminary report would be produced without a learning event or contact with the family in order not to risk compromising the police

investigation. Both parents were informed that the Review would be taking place and that they would be invited to participate at a later stage.

Unfortunately, the criminal investigation was slow to progress and by November 2022, it was decided that correspondence would be sent to Child Q's parents and maternal grandmother. Neither his mother nor grandmother responded, but the Reviewer did meet with Child Q's father. It was also agreed that a learning event would be organised and this took place on 8th February 2023.

The Learning Event was well-attended by all agencies. Unfortunately, neither the social worker nor the team manager still work within Children's Services. A current team manager did attend, but it would have been helpful to have had more representation from Children's Services. Notwithstanding this, the Learning Event was successful and evaluations were universally very positive. Participants were able to provide answers to any outstanding questions and the learning identified was consistent with the learning themes already identified by the Reviewers. In addition, practitioners also voiced familiar concerns about the multiplicity of agency systems (and, in the Health Board, within a single agency) which hinders good information-sharing and also wanted to highlight the vulnerability of lone workers attending addresses where there were potentially risks to their safety, but they were not aware of those risks.

☐ Family declined involvement

For Welsh Government use only

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	☐	☐	

TERMS OF REFERENCE – version 3 - 24th February 2021
CONCISE CHILD PRACTICE REVIEW PANEL CTMSB

Case Reference details
Child Q CTMSB 8/2020

Circumstances leading to the CPR

On the 9th January 2020 the Social Worker received a telephone call from Child Q 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 the Princess of Wales Hospital in Bridgend where it was established that he had suffered a fractured skull, he was subsequently transferred to the Heath hospital. On the 10th January a telephone call was received the safeguarding Nurse informing that the skeletal survey results had shown a bleed on the brain and the fractured skull. As well as, healing fractures in the ribs. She reported that these could be linked to the incident, but they could not rule out these fractures being sustained from a previous injury. Plan to re X-Ray again in 10-14 days. Discussion with the treating Paediatrician also noted Child Q had swelling to both sides of his ribs and both sides of his wrists, which he said was not normal, but could be due to the injury he sustained on the 9th January. The Paediatrician also informed that Child Q at that time had retinol haemorrhage – bleeding behind both eyes, which he said could be caused by other accidental or non-accidental injuries like shaking. Child Q father was subsequently arrested on the 10th January 2020 due to the level of injury sustained by Child Q.

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

- BCBC Children Services
- BCBC Family Support Services
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance NHS Service Trust
- South Wales Police
- National Probation Service
- Domestic Abuse Services

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
Julie Clark (Chair)	Head of Safeguarding	RCT Children Services
Jackie Neale (Reviewer)	Adult Safeguarding Service Manager	RCT Adult Services
Sarah Bowen (Reviewer)	Head of Inclusion	MT Education
Sue Hurley	Vulnerable Persons Manager	SWP
Elizabeth Walton-James	Safeguarding Group Manager	BCBC Children Services

Raeanna Grainger	Independent Reviewing Service Manager	BCBC Children Services
David Harris	Safeguarding Specialist	WAST
David Wright	Family Support Manager	BCBC Children Services
Nicola Jones	Public Protection Nurse	CTMUHB
Sara Evans	IDVA	Bridgend County Borough Council
Kate Fitzgerald	Senior Operational Support Manager	National Probation Service

Additional Areas of Focus
Whether previous relevant information or history about the child and/or family members was known and taken into account in professional's assessment, planning, and decision-making in respect of the child, the family, and their circumstances. How that knowledge contributed to the outcome for the child

Any Parallel Reviews or Other Such Activity to be Noted
None recorded.

Timeframe for the APR
The timeframe set for the Review is 10/01/2019 to 10/01/2020. 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.

The date of the Learning Event will be identified following the conclusion of criminal proceedings.

Completion Date
Considering the potential delays due to criminal proceedings the completion date for the Review will need to be established at a later date. In the interim, an early learning report will be prepared by the Reviewers and shared with the Panel on the 7th May 2021.

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.

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
June 2019	Initial Child Protection Conference for Child Q's uncle – no concerns raised with regards unborn Child Q and siblings
August 2019	Child Q born
September 2019	Review Child Protection Conference and Core Group held for Child Q's uncle. No information or concerns re Child Q shared.
November 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
December 2019	Father takes Child Q to hospital for an appointment and presents himself as an uncle
January 2020	Father takes Child Q to GP two days before the incident
January 2020	Child Q seriously injured