Child Practice Review Report

Cwm Taf Morgannwg Safeguarding Board
Concise Child Practice Review

Re: CTSB02/2018

Brief outline of circumstances resulting in the Review

Legal Context:

A Concise Child Practice Review was commissioned by the Cwm Taf Safeguarding Board which, following re-organisation, is now named the Cwm Taf Morgannwg Safeguarding Board. This was on the recommendation of the Board's Review Group, in accordance with *Part 7 of The Social Services and Wellbeing Act (Wales) 2014,* specifically *Volume 2 Child Practice Review Guidance.*

The criteria for this Review were met under section 6.1 of the above guidance namely:

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 or health or development

and

the child was neither on the child protection register nor a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –

- the date of the event referred to above
- the date on which the Local Authority or relevant partner identifies that a child

Due to the delay between the commissioning and finalisation of this review, there was several changes in the appointment of Independent Reviewers and Panel Chair. At the time of commissioning, the panel was chaired by Jane Randall, Head of Safeguarding CTUHB, who was then succeeded by Sue Hurley, Independent Protecting Vulnerable Person Manager, South Wales Police. The Reviewers were Gareth Powell, Training Officer, Cwm Taf Social

Care Workforce Development Service and Dr. Lorna Price, Designated Doctor, National Safeguarding Team (NHS Wales) until her retirement in May 2020

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

The following Practice and Organisational Learning Points have been identified through an analysis of the multi-agency timeline and discussions in the Review Panel and the Learning Event held on the 8th July 2020. The Learning Event provided the Reviewer with an opportunity to explore these issues with practitioners from partner agencies involved with the family.

The child protection referral process:

Practitioners could have given more significance to a long history of domestic violence and abuse and this should have been a significant factor when considering the risks posed to the child and the siblings.

This was acknowledged by partners at the Learning Event, as it was felt that the threshold was met for a child protection strategy discussion, but this appeared not to have been acknowledged and acted upon at the time. Also, there was insufficient weight given to the additional concerns around disguised compliance and drug abuse which could have impacted on how the case progressed.

When a child protection referral was made by one agency, it was assessed as not meeting the threshold. The referrer had to contact Children Services for feedback on their referral when they had not received any update, in accordance with the All Wales Child Protection Procedures (AWCPP), which was in place at that time. The decision not to proceed to Section 47 (Child Protection) enquiries was not challenged by the referring agency, despite their ongoing concerns.

Discussions with assessing social workers advised of a lack of information and no sense of concern for risk being shared.

Assessments

Some important information, including a child protection referral, was not recorded by Children Services but was recorded by other agencies. Information held regarding an adult was not consistently shared or joined-up. There was a failure to make adequate enquiries with other agencies in response to expressed concerns and referrals. A lack of sound judgement in

making decisions regarding risk was evident on more than one occasion and by more than one practitioner.

We were advised of 3 Police Public Protection Notices (PPNs) on the Children Service's system which were NFA'd (no further action).These were shared with agencies, and we heard at the Learning Event that these PPNs alluded to the adult and his parents at their home address and resultant requirements in him to not have contact with them.

At this time, the Police were not aware that the adult was in a relationship with a person with children but would have shared the PPN stating that the adult had a child in another local authority area. Therefore, it was not felt that this information required Children Services involvement in the area where his parents resided.

Management and supervision of trainee social worker and their caseload

Initially, it was felt that practitioners appeared to have responded to a lack of engagement from a hostile and uncooperative parent by closing the case, (as after consideration, it was felt not to meet threshold for child protection enquiries). However, following discussions with some of the practitioners involved, this was not the case. This was a very complex family and many agencies held pieces of information but not all agencies had fully shared all the information and concerns held, to allow for effective and informed decisions.

The case was not deemed to be meeting threshold for child protection, due to a lack of shared and available information to use to inform the assessment and also, potentially a lack of professional confidence and judgement in the social worker undertaking the visit. This is not a criticism of the social worker involved, the assessing practitioner was very inexperienced, she advised that she was a third-year student social worker and that this was her first potential child protection case and she had visited alone. That social worker has been spoken to as part of this review and it is her perception that she was not provided with the supervision that was required, she felt unsupported and was made to feel that she was not part of the team. She felt isolated and as a third-year social work student, did not have the confidence to ask for advice or challenge.

It would appear that the social worker's inexperience contributed to there not being a fuller picture of the conditions within the home, a more experienced practitioner may have asked different questions and been more professionally curious, as well as making further enquiries with partner agencies, to inform any decisions. However, a lack of a robust supervision and management response also possibly contributed to the decision to close the case.

Following a visit to Mother's house by the social worker, a phone call was made to the Multi Agency Safeguarding Hub (MASH) colleagues to discuss significant concerns. Following this discussion with MASH, it was determined it did not meet threshold to consider child protection and an earlier visit by the social worker was cited in that decision to discount the concerns raised and not to consider escalation to child protection.

It has been disclosed to the Reviewer that practitioners involved with this case left the team after this time and one of the senior practitioners was subsequently allocated the case, which was on a Care and Support basis, at the time of closure.

Domestic Abuse and Child Protection.

Midwifery did not appear to follow their own policy in respect of routine enquiry regarding domestic abuse or show any further professional curiosity in respect of the relationship. There were several missed opportunities identified where health professionals may have undertaken a routine enquiry or had an "Ask and Act" conversation with Mother, (Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015). It remains unclear why this did not take place as we were told at the Learning Event that this is usually done at "booking in" stage.

The adult had a probation officer and was working with a service, which supports the delivery of a Domestic Abuse and a Perpetrator Programme for male perpetrators, with the aim of effecting behavioural change and reducing abusive behaviour towards victims. There was a lack of professional curiosity because had enquiries been made, it would have been established that the previous partner was a victim of domestic abuse from him.

MARAC Process.

There were missed opportunities when the individuals were discussed at the Multi Agency Risk Assessment Conference (MARAC). There appeared to be a lack of respectful curiosity in the practice of support agencies. There was no apparent effort to corroborate information given to them by the family. There appears to have been a failure by practitioners to give sufficient weight to a long history of domestic abuse, including violence, when considering the risks to the children. We were advised that "markers and flags" were put on the parents' property by the Police, which was the appropriate course of action, but there were limitations on the Police's ability to take positive action. We were advised at the Learning Event that following the MARAC discussion, information was not routinely shared with Police from neighbouring areas.

There was a sense that the responsibility to report breaches to the restraining order was placed largely with the adult's parents, who were likely to be the victims of his coercive and controlling behaviour. A significant amount of work was undertaken by the Independent Domestic Violence Advocate (IDVA), who explained to parents why they would need to report breaches, but this proved to be difficult for them.

Fabricated Illness and Consent

Health professionals advised that Education were asked to speak with the School Nurse with regards to accessing health records. At the Learning Event we heard of issues regarding Mother giving consent to obtain this information. However, it was agreed that if there was a

concern that this was in fact, Mother making claims of a possible fabricated illness, there would be no requirement for Mother's consent due to the potential child protection pathway.

Home conditions.

The assessment of home conditions can be subjective which can lead to conditions being overlooked or under-reported.

There was an apparent lack of professional curiosity on the part of the housing provider by not being able to access the premises.

RSPCA colleagues advised at the Learning Event that home conditions of this nature, where children were clearly living, would automatically trigger a referral to the NSPCC. This does not appear to have reached Children Services on this occasion. We were advised at the Learning Event that this decision can often lie with individual officers and is not necessarily shared with any senior officers. However, by this time Children Services were already aware and involved with the family.

Effective Practice

Use of IDVA

The involvement of the IDVA proved to be very positive and supported the mother of the adult into making a complaint.

Furthermore, there was an effective exchange of information between the IDVA and the Police and the adult's parents, which allowed for positive action to be taken against the adult to safeguard his parents.

Information sharing

Some aspects of information sharing were positive. Information was effectively shared with a neighbouring area via a PPN when incidents of domestic abuse were perpetrated.

Challenge between agencies.

Appropriate challenge was identified between the IDVA and the Police regarding the decision by the Police to take no action in regard to a restraining order. In addition, there was effective communication between the Police and IDVA around the advice to strengthen the information contained within the restraining order to prevent any dispute of a breach thereby enhancing protection and safety.

Engagement of RSPCA in the Learning Event.

Despite the initial difficulties experienced in obtaining information from the RSPCA by having to submit a data protection application, there was good, effective engagement from the organisation at the Learning Event with three individuals being in attendance.

Areas where improvements have already or should have been made

Children's Services- supervision and support in complex cases:

Following receipt of the Child Practice Review referral and information from the Safeguarding Board's Review Group, an audit was undertaken by Children Services on all of the Care and Support plans and Child Protection cases held by the team that was involved with the family. Colleagues from Children Services acknowledged several missed opportunities where the concerns should have been considered in a strategy discussion involving partners.

The allocation of potentially complex cases to an inexperienced practitioner, and a lack of perceived supervision and support, and in addition, how the visits to the home were carried out, appears to have had an impact on how the case was managed.

Areas for development have been identified and action has already been taken to improve practice within the team.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SCB 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. The Safeguarding Board needs to be assured by its partner agencies that practitioners understand the association between domestic abuse and child abuse and are aware of their organisations' policies and procedures in relation to domestic abuse.

A reminder of expected practice - Midwifery to ensure routine enquiry is implemented.

2. The Safeguarding Board needs to be assured by its partner agencies that practitioners are aware that when they have a child protection concern they should make a timely and accurate child protection referral, regardless of whether the child is already known to children's social care in another context.

3. The Safeguarding Board needs to be assured that when a child protection referral is made, that all relevant information is shared, particularly when a case enters Section 47

enquiries. Agencies need to be aware of and act in accordance with protocols regarding GDPR when sharing information for a Section 47 assessment.

4. The Safeguarding Board needs to be assured that when a case is discussed at MARAC, that information is shared, actions agreed are robustly followed up and any outcomes or difficulties are shared with all agencies.

5. The Safeguarding Board needs to be assured by its partner agencies that practitioners are aware that when they have made a child protection referral, they should expect a response from Children Services within 7 days. If they do not receive feedback within the 7 days, then there is a responsibility on them to follow this up. If they are not content with the proposed action, they should challenge the decision and if necessary, escalate their concerns by invoking the 'Protocol for Resolving Concerns about Inter-Agency Safeguarding Practice'.

6. The Safeguarding Board needs to be assured that when a restraining order is in place that there is a robust interface between each partner agency to ensure effective management.

7. The Safeguarding Board should develop guidance for practitioners on recognition, description and recording of home conditions where children are present, or when people are not able to take responsibility for the conditions of their own accommodation. This should include guidance on how to address the issue with parents or carers. Such guidance would help to safeguard children within their own homes and provide a safe environment for visiting professionals, in addition to a shared understanding of how concerns are identified.

8. The Chair of the Safeguarding Board should write to the Chief Executive of the RSPCA and request that, in view of the association between animal cruelty and child abuse, when staff visit a property where an animal has been maltreated and children are known to be residing or there are presenting immediate concerns regarding home conditions, a child protection referral is made to Children Services. This should be in addition to informing the NSPCC, which is the usual protocol.

9. The RSPCA should review their responsibilities around their duty to cooperate with Child Protection Procedures and reviews according to the Children Act 2004 and The Charity Commission's own guidance. At present, information will only be disclosed following a data protection application, which slows down the process.

10. The Safeguarding Board's Protocols and Procedures Sub Group should undertake a review of the Protocol on Working with People who are not Co-operating with Safeguarding Concerns, to ensure that it covers disguised compliance, professional curiosity and corroborating information.

11. Children Services has confirmed that following this case, they conducted an internal review of this case and made respective changes to ensure that complex cases are not given to trainee social workers and that trainee social workers are now given appropriate support and management. The Safeguarding Board needs to be satisfied that this piece of work is making a difference and the commissioning of an internal audit would confirm that effective changes have been made.

Statement by Reviewer(s)			
REVIEWER 1	Gareth Powell	**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 child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	……
Name *(Print)*	Gareth Powell	**Name** *(Print)*	……
Date	12.04.21	**Date**	……

Chair of Review Panel (Signature)	S.M.Hurley
Name *(Print)*	Sue Hurley
Date	12.04.21

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Child Practice Review process
To include here in brief: • *process followed by the SCB and the services represented on the Review Panel* • *The 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 circumstances of this case were considered by the Cwm Taf Safeguarding Board's Child Practice Review Sub Group in April 2018 when it was decided that a concise Child Practice Review would take place. The review was carried out in accordance with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3" guidance and a Panel was convened attended by senior representatives of the following services/agencies: ▪ RCTCBC Children Services ▪ Cwm Taf Morgannwg University Health Board ▪ Welsh Ambulance Service Trust ▪ Wales Community Rehabilitation Company ▪ South Wales Police ▪ Education ▪ Trivallis ▪ Substance Misuse Services An Independent Chair and two Independent Reviewers were identified to oversee the Panel process and complete the Review. Due to COVID-19 a virtual Learning Event was held on the 8th July 2020, attended by professionals involved in the case, representing the services/agencies as mentioned above.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SCB 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 CTSB 2/2018

Case Reference details

CTSB 2/2018

Agencies Involved

- RCTCBC Childrens Services
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance Service Trust
- Wales Community Rehabilitation Company
- South Wales Police
- Education
- Trivallis
- Substance Misuse 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 focused and robust
- 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

- 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
- Whether the actions identified to safeguard the child were robust, and appropriate for that child and their circumstances
- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of multi-agency actions
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the child. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the child and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

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 CTMSB 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 Person Manager	South Wales Police
Gareth Powell (Reviewer)	Training Officer	Cwm Taf Social Care Workforce Development Service
Hayley Jeans (Temporary Reviewer)	Principal Educational Psychologist	Cwm Taf Education Psychology Service
Tracy Prosser	Team Manager	Rhondda Cynon Taf Children's Services
Beverley Brooks	Deputy Head of Safeguarding	Cwm Taf Morgannwg University Health Board
Nicola Williams	Safeguarding Specialist	Welsh Ambulance Service NHS Trust
Natalie Bevan	Team Manager	Wales Community Rehabilitation Company
Trudy Hawkins	Corporate Director Neighbourhoods	Trivallis

Throughout the process the panel members have changed due to the retirement of Jane Randall, Chair and Dr Lorna Price Reviewer. Sue Hurley and Hayley Jeans kindly agreed to take over at the relevant stages.

Additional Areas of Focus
None identified.

Any Parallel Reviews or Other Such Activity to be noted

None recorded.

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 Learning Event will be held virtually on 08/07/2020.

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.