Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board

CHILD PRACTICE REVIEW
CHILD T

7-MINUTE BRIEFING

BACKGROUND

On 31st July 2021 Child T died.

Prior to his death, Child T was residing with his biological mother and maternal half sibling. Whilst Child T's mother's partner (Adult A) had his own tenancy, in the week preceding Child T's death, Adult A, and his stepchild (Child Y), who he had recently acquired a Child Arrangements Order for, were also residing at the same address.

Child T's mother, Adult A and Child Y have subsequently been convicted of Child T's murder.

PRACTICE AND ORGANISATIONAL LEARNING

Impact of Covid 19 Restrictions on general working practices

Professionals' lack of confidence in challenging the family's potential use of Covid anxieties & symptoms as a barrier to engagement. The government restrictions resulted in changes in operating systems to protect both workers, families and individuals. This impacted on the ability of agencies to implement optimum child protection processes.

Systems and Processes

Health practitioners identified several significant injuries to Child T on 16th August 2020. Only initial concerns in respect of a delay in attending hospital were shared, with further injuries being observed later and not shared. Organisational barriers to sharing information, joint discussions and decision making. It is important that the public are supported to increase an awareness of how to share concerns

PRACTICE AND ORGANISATIONAL LEARNING

Multi-Agency Practice and Practice Knowledge

- There was an absence of one-to-one sessions undertaken with Child T outside of his family home, this was in part caused by the Covid 19 pandemic restrictions & pressures upon CP systems at that time
- Child T's voice was not heard; the complexities of the adult relationships overshadowed professionals' line of sight to him.
- Children's Services did not notify Child T's father of their involvement with him. There was a lack of understanding from professionals of their duty to inform any person who holds parental responsibility for a child.
- There were gaps in risk assessments & specialist skills around interrogating & analysing evidence. There were examples of risk management plans being stepped down without clear explanations.
- There were gaps in systemically considering the family's context within wider themes. There was a lack of curiosity concerning the presence and impact of Adult A within the two families and the risks he posed.
- Professionals did not fully explore the context of Child T's race and ethnicity on his lived experience.

PRACTICE AND ORGANISATIONAL LEARNING

Leadership and Culture

- Opportunities for a ‘safe space’ for practitioners to engage in meaningful supervision & learning was limited. There were limited processes outside of Strategy Discussions/Meetings that allowed for multi-agency reflections.
- Children’s Services information demonstrated an inconsistent approach to the quality assurance of assessments & planning.
- There appears to be a culture in which health staff are reluctant to challenge clinical assessments & decisions made by more qualified professionals.
- Within the Multi Agency Safeguarding Hub, the focus appeared at times to be maintained on agencies undertaking their agency’s role in ‘a silo’.
- There is a clear theme of working environments under pressure that does not enable and create organisational conditions that support such complex work.

LOCAL RECOMMENDATIONS

1. The Health Board should commission an Independent Review into its practice and management of identifying and investigating non-accidental injuries in children and adolescents.
2. The Health Board should ensure that practitioners who work directly with children and young people are aware of their roles in identifying safeguarding concerns and their duty to report.
3. The Safeguarding Board should review and relaunch their multi-agency training, ensuring that it explores the themes of managing Section 47 Child Protection Enquiries, identifying and managing suspected Non-Accidental Injury, identifying coercive control, and managing interagency professional challenge.
4. The Safeguarding Board should develop guidance for practitioners working to support individuals with Personality Disorders.
5. The Local Authority should develop, embed, and maintain a Quality Assurance Framework and an associated Framework of Management Oversight to ensure that there is high quality supervision, guidance and oversight of practice.

LOCAL RECOMMENDATIONS

6. The Local Authority needs to improve its approach to analysing and managing risk through adopting a clear model of practice.
7. The Local Authority needs to ensure that all safeguarding staff are clear on the rights of all persons with parental responsibility for a child to be informed of a safeguarding concern.
8. The Safeguarding Board should review their information sharing platforms with a particular focus on the Multi Agency Safeguarding Hub information sharing platforms.
9. The Safeguarding Board should consider the recommendations of the COVID-19 Public Inquiry and ensure that it informs future contingency planning
10. The Safeguarding Board should develop a regional campaign to raise public awareness on how to report safeguarding concerns.

NATIONAL RECOMMENDATIONS

1. Wales Safeguarding Procedures Project Board to include specific guidance to child protection practitioners about their duty to inform and include all persons with Parental Responsibility in child protection assessments and processes.
2. Welsh Government considers commissioning a pan Wales review of approaches to undertaking Child Protection Conferences to identify effective chairing/facilitation methods, ways of ensuring full multi-agency attendance and participation and to identify best practice.
3. Welsh Government considers commissioning an annual National Awareness Campaign to raise public awareness on how to report safeguarding concerns.
4. Welsh Government considers the commissioning of a full review of Health, Social Care, Education and Police recording, information gathering and sharing systems.
5. The President of The Family Division considers the imposition of a twelve-week minimum for any Social Work assessment within Public Law Proceedings.