# CHILD PRACTICE REVIEW REPORT CTMSB 04/2021

## Cwm Taf Morgannwg Safeguarding Board
## Extended Child Practice Review

## CHILD T

## Circumstances resulting in the Review

An Extended Child Practice Review was commissioned by the Cwm Taf Morgannwg Safeguarding Board in accordance with Section 139 of the Social Services and Wellbeing (Wales) Act 2014 and accompanying guidance, Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).

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 Chapter 6, Extended Child Practice Reviews:

> A Board must undertake an Extended 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:
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> - died; or
> - sustained potentially life-threatening injury; or
> - sustained serious and permanent impairment of health or development; and
>
> the child was on the child protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) on any date during the 6 months preceding –
>
> - the date of the event referred to above; or
> - the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

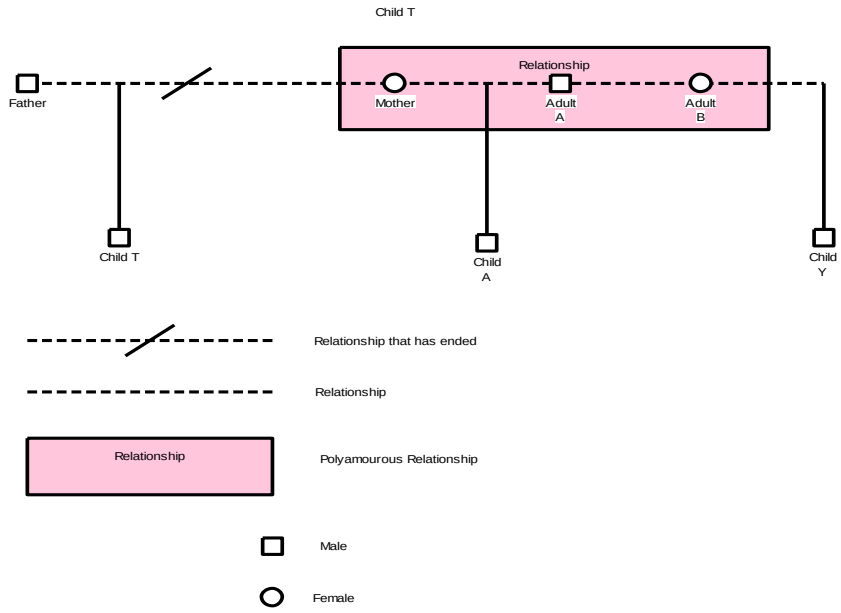
The purpose of a Child Practice Review is to identify learning to improve and support future safeguarding practice. The Review involves engagement with the subject's family. It involves practitioners, managers and senior officers exploring the detail and context of agencies' work with the child and their family. The learning identified within the Review is intended to generate professional and organisational learning and to promote improvements in future interagency and safeguarding practice.

This report gives consideration to the circumstances which led to the Review, including highlighting effective practice and what needs to be done differently to improve future practice.

**The Event that instigated the Extended Child Practice Review:**

For the purpose of this report the following anonymisation will be used:

Child T – Subject of Child Practice Review
Child A – Child T's maternal half sibling
Mother – Child T's biological mother
Father – Child T's biological father
Adult A – Child T's mother's partner
Adult B- Adult A's long-term partner and mother to Child Y
Child Y- Adult B's biological child




It was agreed at the Cwm Taf Morgannwg Safeguarding Board's Joint Review Group on 3rd September 2021 that the criteria were met for an Extended Child Practice Review. The circumstances are as follows:

On 31st July 2021 Child T died. He suffered blunt force abdominal injury and cerebral injury (including brain swelling, hypoxic/ischaemic neuronal injury, and traumatic brain injury).

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[1] 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.

There had been multi-agency involvement with Child T and his family prior to his death. Child T's name was on the Local Authority's Child Protection Register for the period between 4th March 2021 and 20th May 2021 under the dual categories of physical and emotional abuse.

## Timeline

The Panel, set up to oversee the Review, considered the involvement of agencies between 1st March 2020 and 31st July 2021, as well as relevant contextual information considered important from outside of this period. The rationale for this timeframe is that it includes the first referral made to preventative services within the area the family lived and highlights the restrictions that came about as a result of the Covid 19 Pandemic.

The Review Panel has sought to be timely in their reporting of the Child Practice Review for Child T. However, given the criminal circumstances around Child T's death, elements have been appropriately timed to ensure that there were no barriers to gathering robust information to inform learning and future practice.

Timelines, chronologies and analysis submitted by all agencies were reviewed and discussed in detail during the Review Panel meetings. Two multi-agency Learning Events were held, one for practitioners and one for managers. Child T's family and significant adults have been engaged within the Review. All these elements have informed the learning included in this report.

Family and Significant Adult Engagement:

| Relation Offered Interview | Engaged | Declined |
|---|---|---|
| Child T's Father | √ | |
| Child T's Mother | √ | |
| Child T's Paternal Grandmother | √ | |
| Child T's Maternal Grandmother | √ | |
| Adult A | | √ |
| Adult B | √ | |

## Background

Child T was five years old at the time of his death. Those who knew him have shared he was a bright and bubbly child. He liked playing with superheroes, Spiderman being his favourite.

[1] A Child Arrangements Order is an order that regulates with whom a child is to live, spend time or otherwise have contact, and when a child is to live, spend time or otherwise have contact with any person

Child T enjoyed spending time with other children when he was at school and had several friends he enjoyed playing with.

Child T's parents were in a relationship for approximately four years. They both resided within a Local Authority in England prior to Child T's birth. Child T was born in 2016 in South Wales. Child T's father was present at his birth, he is named on Child T's birth certificate and held parental responsibility. Child T's father is of Kenyan and British heritage, and his mother is of White British heritage.

Following Child T's birth, he and his mother spent increasing amounts of time in the South Wales area, residing with his maternal grandmother. Child T and his mother soon permanently relocated to the South Wales area. Child T's parents separated the year he was born. The month of separation is not known.

Child T's mother entered a new relationship in August 2017. Child T's mother married her new partner, but this relationship ended in 2019. The couple were legally divorced in 2020.

In the Easter of 2019, Child T's mother began a relationship with Adult A. They remained in this relationship until Child T's death. Child T's mother and Adult A had a child together (Child A). Following the birth, Child T's mother was diagnosed with post-natal depression.

Child T last had face to face contact with his father in 2019. Child T and his mother visited Child T's father in England, after that time contact was via telephone and facilitated by Child T's maternal grandmother. Following a breakdown in the relationship between Child T's mother and his maternal grandmother, Child T's contact with his maternal grandmother is reported to have become increasingly sporadic with periods of contact ceasing entirely. This meant that Child T's father no longer had any means of contacting him.

Prior to the relationship between Child T's mother and Adult A, Adult A had been in a relationship with Adult B since 2008. When they met, Adult B had a one-year-old son (Child Y) from a previous relationship who Adult A was reported to have subsequently raised. As a family, they had resided in England, and had received support from Social Services within the area between 2014 and 2017. Through a house exchange they moved from England to Wales in 2017, although neither adult had any links with the area they moved to.

There are points from 2019 until Child T's death during which Child T's mother, Adult A, Adult B and their children cohabited. All three adults have given varying versions of their relationship statuses to professionals throughout the period they were all known to one another. However, all reported that at points in time, all three adults were in a polyamorous sexual relationship. The nature of the adults' relationships, along with all three adults and their children cohabiting, meant that Child T had frequent close contact with Adult A, Adult B and Child Y. Child T's mother had a tenancy in her own right. Adult A and Adult B had a joint tenancy until 2021, when Adult A took over their tenancy as a sole tenant.

Information shared by agencies shows that Adult A had a pattern of sharing with his partners a history, some of it fabricated, that he had been a member of the armed forces, had an extensive knowledge of and ability in martial arts, and that he had pro-criminal connections. Following the criminal investigation into Child T's death, there is information that Adult A was

reportedly a former member of the 'National Front' and that he would call Child T racially derogatory names in front of family associates. There is no information within multi agency chronologies or assessments that were undertaken that confirms this information was known to agencies during their involvement with Child T.

Adult A had an extensive criminal history. This included convictions for assault including a common assault on a child, possession of an offensive weapon, domestic abuse, theft and illegal drug possession. His last conviction had been in 2007, when he served a custodial sentence for burglary. These convictions had been known to the previous Local Authority within England Adult A, Adult B and Child Y had resided in and Child Y had remained within their care.

**Key Events and Agency Involvement.**

On 1st March 2020, Child T's mother informed his school that she was struggling with his behaviour. An 'Early Help' Referral was made by the school for preventative support.

On 23rd March 2020, a national lockdown was triggered due to the Covid 19 Pandemic. Child T then became part of an extended household. Child T, his maternal half sibling (Child A) and their mother resided at Adult A's property that he shared with Adult B and her child (Child Y). During this time, the three adults and three children, including Child T, occupied a two-bedroom property. Child T shared a bedroom with Child Y. Information provided by the school consistently highlighted Child T's mother's anxieties about the pandemic from this period onwards.

The impact of national and local Covid 19 restrictions should be considered throughout the timeline of this review, as there were significant changes in statutory services throughout this period.

On 16th August 2020, the local Accident and Emergency Unit submitted a referral to the Children's Services Emergency Duty Team reporting that Child T had an injury to his arm, bruises on his right cheek and a fractured humerus (upper arm bone). The Child Protection referral made by Health Services raised concerns in relation to the delay in Child T's mother taking him to receive medical attention for his injuries.

On 16th August 2020, a Strategy Discussion was held between the Social Services Emergency Duty Team and Police. The purpose of a Strategy Discussion is to determine whether Child Protection Enquiries (Section 47) should be initiated, and how these enquiries should be undertaken. At this meeting, agencies agreed that the threshold to undertake Child Protection Enquiries (Section 47) had not been met at that stage, on the basis that there was limited medical information. There is no information recorded to confirm why a Health representative was not part of the discussion. Case file records stated that the Paediatric Consultant was reviewing Child T's case further.

Police checks identified concerns in respect of Adult A's historic convictions, and it was agreed at that time he was not an appropriate person to solely care for Child T or Child A. It is unclear how safeguarding concerns in respect of Adult A warranted safe care for Child A but did not meet threshold for Child Protection Enquiries (Section 47). On 16th August

2020, Police attended the hospital where Child T had presented and visited his family home. Child T's mother and Adult A were spoken to and were reported to be open in the information they provided to them. All parties reported the incident to have been an unwitnessed fall down the stairs at Adult A and Adult B's property. Police Officers reported no concerns in relation to the home conditions and the explanations provided were consistent with a fall down the stairs. The health records relating to this visit state that Child T's mother had said that she had called him for food and when running down the stairs he had slipped and fallen. She had observed an injury to his arm which she believed was dislocated. His mother stated she had 'clicked it back'.

A further health assessment undertaken by a Paediatric Doctor on 16th August 2020 documents that Child T had wider bruising and injuries. As part of the examination, thirty-one images were taken of the injuries. Records that document the images described the injuries as follows:

- 1cm blue mark above penis
- Superficial erythema to ankle 2x 2cm bruises
- 2 bruises to forehead
- Bruising to the top of both ears, bruising behind one of the ears
- Bruises to both cheeks
- Carpet bruise to chin
- Bruising to left arm and generalised bruising around fractured shoulder.

There is no evidence that information about these injuries was shared with agencies outside of the Health Board. The injuries noted were discussed by Health with mother who reported Child T would bang his head, pinch himself and that the mark to his ears was from a mask. Child T was present and stated he had fallen down the stairs, he also agreed when his mother gave the cause of the bruising to his ears as being from a mask worn due to the pandemic. Child T stated he bangs his head and pinches himself when he gets angry. Child T's mother did not know how the blue mark above his penis occurred. Neither the Health Board nor Children's Services have any records of Health submitting a Child Protection referral in relation to the injuries observed by the Paediatric Doctor or for any wider concerns for Child T's welfare, if he was reported to be presenting with such behaviours that were causing him injury. This information only became known to partner agencies during the process of the Child Practice Review. Child T was seen by several health professionals at that time.

On 17th August 2020, Health records document that they had contacted Children's Services to discuss the family's social situation. Their records documented Children's Services as being aware of the Paediatric Consultant's view that they did not consider Child T as a child who had sustained a non-accidental injury. Health records document that Children's Services requested the Consultant send confirmation of their position via email, there are no records of this action being undertaken.

Later that day on 17th August 2020, a discussion was held between the Police and Children's Services to share information and an update from Health was provided which stated that they did not consider Child T had sustained a non-accidental injury. The Police

and Children's Services agreed to Child T being discharged from hospital into his mother's care. Children's Services and MASH[2] Health held a further discussion confirming discharge. The decision was reviewed by a Children Services Team Manager, and it was agreed that the referral would be closed as they deemed appropriate enquiries had been made.

Throughout the Pandemic period, there were clear and consistent efforts made by Child T's school to keep in touch with Child T and his family. This included messages, phone calls, a visit to the family home, learning packs and the use of the class teddy bear (used as a motivational and engaging tool in the class). Information from the school highlighted Child T's mother's reported anxieties throughout the Covid 19 pandemic, and specifically about Child T attending school.

On 1st November 2020, the Local Authority Adults' Services department contacted Child T's mother to follow up on a referral received from her General Practitioner. Child T's mother told them that she had a diagnosis of epilepsy, she was struggling with her mobility and had a loss of feeling in her hands and feet. Medical records document she had a history of epilepsy, depression, asthma and borderline personality disorder. She was referred to the Community Resource Team, which provides support to adults in a person's own home. Over the period of the timeline, there are frequent reports by Child T's mother that she was unwell and had mobility issues. There are no records of any professional observing mobility difficulties, or Child T's mother having difficulties undertaking tasks around the family home, including providing basic care to the children.

On 22nd January 2021, two 999 calls were made from Adult A and Adult B's address. The first 999 call was from Child Y, reporting that Adult A had collapsed and was not breathing. There is no clear information from professional enquiries as to why the first 999 call was made. The second call was from Adult A, reporting that Adult B had taken an overdose and that she had assaulted her son, Child Y. Adult B had a history of reporting physical ailments, including fabricating a cancer diagnosis. Adult A identified himself in various discussions with professionals as Adult B's carer. When interviewed by Police, Adult A reported Adult B to be physically violent towards him and that she 'used his previous convictions against him'.

On the same day, Child T's mother contacted the Police and reported concerns for Adult A's mental health. She stated that she had been contacted and was told that Child Y had pushed Child T down the stairs in August 2020 which caused the fracture to his arm that he presented to Accident and Emergency with on 16th August 2020. A Police Protection Notice was shared with Children's Services. Child T's Social Worker explored the matter with Child T's mother, she shared that Child Y was downstairs in the living room at the time of the incident. It is unclear why Child T's mother contacted the Police to later confirm she knew Child Y to be in the living room. This information was consistent with the information shared with the Police on 16th August 2020.

The Accident and Emergency Unit submitted a Child Protection referral when Adult B was admitted to hospital due to concerns for Child Y. A Strategy Discussion was held, which

[2] The Multi-Agency Safeguarding Hub

included representatives from Children's Services, Police and Health and it was agreed that Child Y required a Child Protection Medical and Child Protection Enquiries (Section 47) were commenced. Adult B was then arrested for assaulting Child Y. Adult A and Child Y both stated that Adult B had assaulted Child Y. During Adult B's interview, reference was made to an assault on Adult A, Adult B's response was 'if he said it then it must be true'. Adult B reports no clear recollection of the incidents and later uses the same wording with regards to the allegation of her assaulting Child Y, i.e. 'If he (Adult A) said it then it must be true'. Adult B received inpatient treatment for her emotional wellbeing following the incident. Following this point Adult B's contact with Child Y was supervised and she had no contact with Child T.

Initially it had been agreed that Child Y would be cared for by the person he called 'Dad', (Adult A). Adult A had been asked to support Child Y in attending the Child Protection Medical but had refused to take him, citing concerns around Covid 19. This resulted in the Child Protection Medical, that was planned for 23rd January 2021, taking place on 25th January 2021. Child Y was taken by a Social Worker to the Child Protection Medical. Adult A attended and Child Y was seen alone. However, during periods when Adult A was in the room he was observed to interject into the conversation.

On 25th January 2021, Children's Services, Health, Education and the Police held a Strategy Discussion for Child T, Child A and Child Y. The Strategy Discussion reviewed the information gathered since Child Protection Enquiries (Section 47) had commenced on 23rd January 2021. For Child T and Child A, the Strategy Discussion considered the information gathered during Child Protection Enquiries for Child Y and transferable risks. The transferable risks were identified as Adult A's criminal history, him not safeguarding Child Y when he was allegedly assaulted by his mother and concerns in relation to coercive control between Adult A and Child T's mother. It was agreed that Child Protection enquiries would commence for Child T and Child A and that Child Protection Enquiries would continue for Child Y.

The suitability of Child Y being cared for by Adult A was reviewed by Children's Services during the Strategy Discussion on 25th January 2021 and the decision was taken that it was not appropriate that this arrangement continued. This decision considered that Adult A had been present on 22nd January 2021, when Child Y had clearly stated Adult B had assaulted him, therefore Adult A was in the pool of potential perpetrators. The Social Worker also had concerns that Adult A demonstrated coercive controlling behaviours. Child Y was subsequently cared for by Child T's mother, within Child T and Child A's family home, as a temporary measure whilst a placement was sought. Adult A reported he was Child T's mother's carer and he reported that she required supervision as her seizures could be triggered by stress. During a home visit by Children's Services, Child T's mother was observed for four hours. Child T's mother discussed her gratitude to Adult A for 'taking on' her and Child T. During the visit, Adult A attended the property and raised concerns that he believed Child Y would be returned to his mother's care, threatening that he would contact the media if this occurred. During the visit he showed a video to the Social Worker, reportedly showing footage of him restraining Adult B. It was not clear, due to the poor quality of the video footage, what was actually happening.

As part of the Child Protection Enquiries, Children's Services contacted the previous Local Authority in England involved with Adult A, Adult B and Child Y. Information was shared with them that Child Y had been violent towards Adult B and that there had been significant problems concerning him, both at home and at school, including bullying and 'sexualised' behaviour towards other children. In a home visit, Adult A highlighted his frustration that he was unable to care for Child Y. He disclosed that he had Adult B's bank cards and was reluctant to give them to her, advising he would end their relationship if the cards were returned. Adult A also disclosed that he, Adult B and Child T's mother had been in a polyamorous relationship which they had named 'Banshee'. Recordings throughout the January 2021 period document conflicting information from Adult A about the relationships between him, Adult B and the role Child T's mother played in those relationships. Adult B is not known to have had any relationship with Adult A or Child T's mother following this time. Adult A disclosed significant adverse childhood experiences within his own life.

Given the child protection concerns identified in respect of Child Y, the Local Authority made an urgent application to the Court, requesting an Interim Care Order and that Child Y be placed within the care of the Local Authority. The Interim Care Order was granted for Child Y on 28th January 2021.

In February 2021, Child T's mother again raised concerns around her mobility and lack of sensation in her hands, advising that she wished to access direct payments for a family member to care for her. Adults' Services and Children's Services discussed the case and subsequently undertook a joint visit. During the visit, Child T's mother discussed feeling that she had low confidence, she added that she had always had a husband or boyfriend to support her. During the visit, Children's Services discussed their concerns with Child T's mother, including the risks associated with Adult A and his offending history.

On 11th February 2021, Children's Services made separate MARAC[3] referrals for Child T's mother and Adult B due to concerns relating to coercive control perpetrated by Adult A. Adult B was assessed as being at high risk of harm. Child T's mother reported that she was not a victim of coercive control and that agencies may be confused by information that relates to her previous relationships.

On 4th March 2021, Child T and Child A were the subjects of an Initial Child Protection Conference. The Child Protection Conference was held remotely via Teams, in line with Welsh Government Covid 19 Guidelines at that time. It was the unanimous decision of multiagency professionals at the Initial Child Protection Conference that Child T and Child A's names should be included on the Local Authority's Child Protection Register under the dual categories of Physical Harm and Emotional Abuse.

Children's Services shared their concerns at the Child Protection Conference in relation to Adult A's criminal history, Adult A demonstrating coercive control behaviours and concerns for his mental health. Child T's mother reported that there had been information that she was unaware of until the point of the Initial Child Protection Conference, however, she maintained that she wished to continue the relationship. Adult A stated that that Police

[3] Multi Agency Risk Assessment Conference – this is a meeting where information is shared on the highest risk domestic abuse cases

reports were inaccurate. The Chair of the Conference raised that Child T's father had not been invited to the conference. The Chair documented that the Local Authority needed to make a decision on whether to share information with Child T's father and recorded that decision.

Between the Initial Child Protection Conference and the Review Child Protection Conference, Child Protection Core Groups[4] were held virtually, at timescales in line with safeguarding procedures. Core Group minutes reflect that Adult A viewed himself as a victim of Adult B and he was resistant to engaging with a Perpetrator Programme. Child T's mother advised that she would engage in the Freedom Programme (a programme for designed primarily for women who have been victims of domestic abuse).

During the Child Protection Registration period, child protection visits were undertaken both face to face and virtually, virtual visits being triggered due to the family reporting periods of illness, including reporting Covid 19 symptoms. There is an example of Child T being spoken with alone on a face-to-face visit, however, there is an absence of a clear understanding of Child T's lived experience within his family unit, evidenced in recordings and reports, to help professionals understand how he felt about his daily life. School reported an incident of Child T wetting himself in school and on one separate occasion Child T's mother reported he had returned home with urine on his clothing.

On 4th May 2021, Child T's mother shared with his school that his behaviour was difficult at home, the school reported that these observations were not reflected within his behaviour at school. Child T's mother disclosed to the school that due to the financial circumstances of the family she was unable to provide Child T with a snack for school, so school made arrangements for extra helpings of food to be offered at lunch time. The school also made a referral to Early Help Services. The following day school contacted Child T's mother, during the call she advised Child T was not to be given any 'extra helpings' as he had put on half a stone in the last three weeks. This information was recorded on the school system that they used to log concerns.

On 7th May 2021 Child T's General Practitioner records that a telephone consultation was undertaken with Child T's mother. Child T's mother reported that Child T on the evening of 6th May 2021, had got into the bath and lent backwards against a hot water tap causing a burn to his skin at back of his neck. Child T's mother disclosed that Child T was on the Child Protection Register. She reported that she had informed Child T's Social Worker and showed them photos of the injury. The Social Worker is said to have been satisfied but advised her to send a photo of the injury to the General Practitioner. The General Practitioner received an image via email which they reviewed. Health records do not document that the General Practitioner confirmed if Children's Services were aware of the injury or whether a Child Protection Referral was made.

On 12th May 2021, during a child protection visit, Child T voluntarily showed the visiting Social Worker a mark on his neck. He stated that he had hurt his neck on the bathroom tap as it was 'very hot'. The Social Worker viewed the tap, the Social Worker spoke with

[4] A Core Group is a group of practitioners and family members who work together to create, implement and review a Care and Support Protection Plan

Child T alone who stated that the tap had got very hot, and that Adult A had fixed it. The mark is noted to be a small triangular mark the same shape as the end of the tap. No further action was taken by the Social Worker. The information was shared at the Review Child Protection Conference.

On 13th May 2021, Adult A and Child T's mother advised the Court that they wished to permanently care for Child Y. Child Y at that time remained in the care of the Local Authority. The Local Authority was given a four-week timescale for a Parenting Assessment to be completed within Court proceedings. This was much shorter than the normal time allowed for this type of assessment. A Parenting Assessment was undertaken by Children's Services of Adult A and Child T's mother to consider their ability to care for Child Y. The assessment concluded that Adult A should be Child Y's primary care giver, the report acknowledges that in the future, it is Child T's mother and Adult A's intention to reside together with the three children. The Local Authority's position was strongly supported by Child Y's CAFCASS Guardian[5].

On 20th May 2021, in line with Wales Safeguarding Procedures, Child T and Child A were the subjects of a Review Child Protection Conference. The conference was held virtually due to working practices linked with the Covid 19 pandemic. It was the unanimous decision of multiagency professionals at the Child Protection Conference that both Child T's and Child A's names were removed from the Child Protection Register as multiagency professionals no longer deemed them to be at risk of 'significant harm'. It was recommended at the Child Protection Conference that Child T's and Child A's family continued to be supported on a Care and Support basis.

Professionals had identified no ongoing child protection concerns and there had been no Child Protection Referrals made to Children's Services during the period of child protection registration. However, it is important to note that this was not a family unit where frequent referrals had historically been made to Children's Services. The minutes of the Review Child Protection Conference document that consideration had been given to contacting Child T's father. The minutes note the following rationale that 'given the domestic violence and there having been no contact with Child T for a very long time the decision was made not to make contact with him'. This Review has seen no information that evidences Child T's father was a perpetrator of domestic abuse against Child T's mother. However, if there are concerns in respect of a person with parental responsibility this should be risk-managed to support their engagement, not be a rationale for not seeking to engage them.

At the time of the Review Child Protection Conference, Child T's mother had not yet engaged with the Freedom Programme. Additionally, Adult A stated he did not believe he was a perpetrator of domestic abuse and would not engage in a programme of work around this but would engage with a service that supported fathers. The deterioration of Child T's stammer had triggered a Speech and Language referral. Within the Review Child Protection Conference, Child T was described as a delightful, polite little boy who had lots of friends. He was reported to be meeting his educational milestones.

[5] The guardian's role is to make sure that local authority arrangements and decisions for and about children protect them, promote their welfare and are in their best interests

On 22nd July 2021, Adult A advised Children's Services that Child T had tested positive for Covid 19. A positive test was confirmed by Child T's health records.

On 26th July 2021, a Child Arrangements Order[6] was granted to Adult A for Child Y. A Supervision Order[7] was made concurrently. Subsequently, Child Y's Social Worker undertook a home visit. Child Y had been with Adult A at Child T's family home. The visit was not to see Child T, he was not seen as part of the visit, as he was reported to be isolating with Covid 19. There was no legal duty on the Social Worker to see Child T at that time and Covid 19 guidance in that period meant that the Social Worker would only knowingly come into contact with Covid positive persons if there was an immediate safeguarding concern.

On 30th July 2021, the South Wales Police Occurrence relating to MARAC for Child T's mother's case was finalised. She had been contacted on several occasions and had denied concerns in respect of coercive control within her and Adult A's relationship. Child T's mother has since shared that at the time she was contacted by services she did not consider herself as a victim of coercive control.

On 31st July 2021, Child T was initially reported missing by his mother, he was subsequently found unresponsive on the bank of a local river and conveyed to hospital where he was later pronounced deceased.

## Practice and organisational learning

**Learning**

Practice and organisational learning can be drawn from the following key elements of the Review:

- The production of a multi-agency timeline and agency analysis
- Discussions within the Review Panel meetings
- A review of key documents, including the legal bundle, MARAC minutes and Local Authority records
- Two separate Learning events for professionals, one for practitioners and managers
- Independent Chair and Reviewers analysis
- Interviews with Child T's family and Adult B
- The Rapid Review commissioned by the Cwm Taf Morgannwg Safeguarding Board

The Cwm Taf Morgannwg Safeguarding Board was proactive and took immediate action via the Rapid Review and developed an immediate action plan following the death of Child T.

[6] A Child Arrangements Order is an order that regulates with whom a child is to live, spend time or otherwise have contact, and when a child is to live, spend time or otherwise have contact with any person

[7] A Supervision Order imposes a duty on the local authority to 'advise, assist and befriend'the child

**Learning Events**

A Learning Event for practitioners was held on 5th September 2022. A Learning Event for Managers and those with supervisory responsibilities was held on 6th September 2022. Both Learning Events were well attended by agencies involved with Child T and his family. Practitioners who were unable to attend the Learning Events were offered opportunities to meet with the Chair and Reviewers.

The following agencies were represented at the learning events.

- South Wales Police
- Health Board
- Local Authority Children's Services
- Social Services Emergency Duty Team
- Local Authority Education Services including Early Help
- Registered Social Landlord
- CAFCASS Cymru
- Domestic Abuse Services
- Probation Services

Within the Learning Events, practitioners across all agencies demonstrated an openness to learn, they were reflective about how they, as individuals and as part of a wider agency, could improve practice. Attendees reviewed the full multiagency timeline and engaged in group activities to support the Chair and Reviewers in understanding the context in which practice occurred to consider learning for future practice.

Practitioners across all agencies identified clear themes and challenges around ensuring the right environment for effective child protection practice. Barriers included:

- Immediate changes to Local Authority, Health and wider agencies' working practices due to the Covid 19 pandemic. Changes included, at points, ceasing face to face meetings and agencies needing time to adapt to technological changes required in practice during the Covid 19 pandemic. Several agencies delivering intervention work did not undertake this work for significant periods during the pandemic.
- Organisational culture within areas of the Cwm Taf Morgannwg Health Board. Some practitioners reported feeling their value and voice being heard is dependent upon the status of their role, with examples of safeguarding concerns not being reported to external agencies due to the views of more senior practitioners. Staff shared a culture of not challenging colleagues in a more senior role.
- Judicial process taking priority over assessment timescales. Children's Services, CAFCASS practitioners and managers who participated in the Review shared that it is not uncommon for the Court to direct those assessments be undertaken within condensed timescales, if a family a member comes forward to care for a child within care proceedings. This was an extended family unit with complex dynamics. Child T's mother and Adult A had a number of changes in position in respect of them caring for Child Y. In order to robustly understand the family dynamics, practitioners need to

have sufficient time to undertake assessment sessions, opportunity to undertake observational sessions and sufficient time to reflect and analyse the information gathered. The Panel were concerned that this was a multi-faceted assessment that was given four weeks for completion.

- Absence of consistent experienced staffing across agencies; this was raised as a high-level concern within Health and Social Care.
- Information sharing platforms that support multiagency information sharing being absent or not compatible.
- The lack of 'soft' information sharing ability, such us incidents of a child wetting themselves in school and a child's involvement with preventative services. Agencies shared that there is often information that would assist decision making not known to Children's Services decision makers, as it is held on other agencies systems and has not met the threshold for a Child Protection referral.

**Learning Themes.**

As a result of this Extended Child Practice Review, key learning has been identified. The Review Panel believes that these issues may be systemic, and not isolated instances of individual error or poor practice.

The Panel has identified the following learning themes:

- The impact of Covid 19 restrictions on general working practices.
- Multi-Agency Practice and Practice Knowledge amongst agencies
- Systems and Processes
- Leadership, Culture and Context

**Impact of Covid 19 Restrictions on general working practices**

The impact of Covid 19 has affected all organisations, both statutory and non-statutory, in their ability to deliver and maintain services and respond to needs. In terms of this case, the following areas were significantly affected by the impact of the pandemic:

- Professionals' lack of confidence in challenging the family's potential use of Covid 19 anxieties and Covid 19 symptoms as a barrier to engagement with services. This highlights how Covid 19 was a further barrier to identifying potential disguised compliance, i.e. the family appearing to co-operate with professionals in order to allay any concerns and stop professional engagement. This is particularly apparent within the family's engagement in child protection interventions, the children within the home's lack of school attendance and delays in seeking medical assistance for Child T and Child Y.
- 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. Many of the activities normally carried out face to face, which are so vital to accurate assessments and decision making, had to be completed remotely. Differences in how universal services (services available to everybody) operated during the Covid 19 pandemic period, limited the level of

contact that the family had with agencies. For example, virtual Child Protection Conferences, Core Groups and General Health Practitioner visits.

**Systems and Processes**

- Health practitioners identified several significant injuries to Child T over the course of his hospital attendance which commenced on 16th August 2020. Only initial concerns in respect of a delay in attending hospital were shared in relation to Child T allegedly falling down the stairs, with further injuries being observed later and not shared. As a result, injuries observed on Child T were not shared with services that could have taken appropriate action to safeguard him. If a Strategy Discussion is held and new information follows that highlights a safeguarding concern, the agency who has concerns has a duty to make a child protection referral. Several of the injuries, even in isolation, should have triggered a referral. If the injuries were considered by Health Professionals to be non-accidental there should have been clear considerations to the number of injuries and site on the body, parental supervision being afforded to Child T and if wider agencies' support was required. This again should have triggered a child protection referral. The Core info leaflet series is based on a collaborative project by the NSPCC, Cardiff University and the Royal College of Paediatrics and Child Health (RCPCH). It tells practitioners:

  *'There are some patterns of bruising that may mean physical abuse has taken place. Abusive bruises often occur on soft parts of the body – such as the abdomen, back and buttocks.*
  *The head is by far the commonest site of bruising in child abuse. Other common sites include the ear and the neck.*
  *As a result of defending themselves, abused children may have bruising on the forearm, upper arm, back of the leg, hands or feet.*
  *……..*
  *Non-accidental head injury or fractures can occur without bruising.*
  *……*
  *A bruise should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given. Any child who has unexplained signs of pain or illness should*
  *be seen promptly by a doctor. Bruising that suggests the possibility of physical child abuse includes:*
  *……..*
  *bruises that are seen away from bony prominences*
  *bruises to the face, back, abdomen, arms, buttocks, ears and hands*

- 'In relation to the Multi-Agency Safeguarding Hub (MASH), which is a co-located multi-agency team, this case has highlighted that there remain organisational barriers to the sharing of information, joint discussion and decision making. The lack of a shared information sharing system critically affected the ability to respond to this case, in terms of achieving a shared understanding of the risks and the appropriate action that was needed.
- It is evident that current information sharing systems do not support and enable multiagency information sharing and are a barrier to agencies being systemic in their decision making.
- It is important that the general public are supported to increase their awareness of how to share concerns that they may have for a child potentially at risk of harm. The

criminal investigation following Child T's death identified a number of adults who had contact with Child T and had concerns for his welfare and how he was treated within his family home. However, there were no reported concerns raised by the wider public to professionals prior to Child T's death.

**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 and resulting pressures upon child protection systems at that time, such as high levels of staff absences due to the Covid 19 pandemic.
- Child T's voice was not heard; the complexities of the adult relationships involved in the care of Child T overshadowed professionals' line of sight to him. There was no knowledge of the reality of his lived experience.
- 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, of child protection concerns.
- There were gaps in risk assessments and specialist skills around interrogating and analysing evidence; family reported different versions of events and family relationship histories. There were examples of risk management plans being stepped down without clear explanations as to how the risk had changed or could be managed in the longer term, for example Adult A's convictions triggering safe care arrangements and this then being stepped down.
- There were gaps in systemically considering the family's context within wider themes; relationships that Adult A engaged in had a number of replicating themes that were not robustly considered. There was a lack of curiosity concerning the presence and impact of Adult A within the two families and the risks he posed within them. It seems that he was able to effectively manipulate his partners and some professionals he came into contact with.
- Professionals did not fully explore the context of Child T's race and ethnicity on his lived experience. With the value of hindsight, we know that both Adult A and Child Y held and expressed racist and discriminatory views that one would expect to have made life very hard for Child T within the family.

**Leadership and Culture**

- Opportunities for a 'safe space' for multiagency practitioners to engage in meaningful supervision and learning was limited across partnerships. Apart from the Core Groups, where family members were present, there were no set multi-agency meetings that supported practitioners to reflect upon the case, there were limited processes outside Strategy Discussions/Meetings that allowed for multi-agency reflections where patterns of behaviour and working hypothesis could be discussed. Furthermore, this case highlights the importance of Discharge Planning Meetings being undertaken for babies, children and young people, where safeguarding concerns have been identified. In addition, the importance of robust Outcome Strategy Meetings being held should be noted, so that multi-agency professionals are

all reflecting upon the information gathered during Child Protection Enquiries (Section 47) at the same time.

- Children's Services information demonstrated an inconsistent approach to the quality assurance of assessments and planning across several areas of case management. There was limited evidence that Child Protection Conference Reports and Care and Support Plans were consistently reviewed by supervisors.
- Within the Health Board, there appears to be a culture in which health staff are reluctant to challenge the clinical assessments and decisions made by more qualified professionals. With reference to the August 2020 Accident and Emergency attendance, some health staff were uncomfortable about the management of Child T during his assessment at the hospital but felt unable to express their concerns, either to the clinician or afterwards to others. Significantly, there was no use of the Health Board's 'Whistleblowing' or escalation policies which would have been available as an alternative to a 'face to face' challenge.
- Within the Multi Agency Safeguarding Hub, the focus appeared at times to be maintained on agencies undertaking their agency's role in 'a silo', as opposed to consistently operating as a Child Protection Enquiries team.
- Across the agencies that were involved with Child T and his family, there is a clear theme of working environments under pressure that does not enable and create organisational conditions that support such complex work.

**Areas of notable Positive Practice.**

Within the timeline, positive practice was identified:

- Police responded to all requests for help, concerns from agencies involved and members of the public in a sensitive and timely manner.
- When Child T was in hospital in August 2020, a prompt alert was shared by the hospital with Health Visiting Services to make them aware of his attendance.
- There were some examples of good practice when information provided to workers by the family appeared to be inconsistent and practitioners returned to the family to clarify and ask questions to seek to establish the truth, this included joint visits between agencies such as Adult's Services and Children's Services.
- The Initial Child Protection Report was an accurate and concise assessment of the risks, needs and resources of Child T's family. This was, as described above, a complicated and complex task to achieve.
- The Child Protection Enquires that led to the Initial Child Protection Conference identified coercive control concerns for Child T's mother and Adult B. Separate referrals were made to MARAC.
- Child T's school were consistent and persistent in efforts to maintain contact with Child T.
- Child T's school responded promptly to the practical and emotional needs shared by Child T's mother and referred on to appropriate services.

## Improving Systems and Practice

**Recommendations:**

Whilst there have been areas of good practice identified within this Review timeframe, there is significant core learning that this case has identified. Within the context of this Review there are recurring areas of learning that have been identified in reviews throughout Wales and England, which has led this Review to make both Local and National Recommendations.

**Local Recommendations**

1. Cwm Taf Morgannwg Health Board should commission an Independent Review into its practice and management of identifying and investigating non-accidental injuries in children and adolescents. The Independent Review should make recommendations as to how the Health Board develops escalation and quality assurance systems that embed and maintain any practice learning.

***At the point of concluding this review, Panel are aware that an Independent Review is being commissioned by the Cwm Taf Morgannwg Safeguarding Board. It is recommended that the remit of that review is reflective of recommendation 1***

2. The Cwm Taf Morgannwg 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. There needs to be a system in place to ensure compliance, including safeguarding training programmes across all health practice roles. Compliance should be reported on an annual basis to the Cwm Taf Morgannwg Safeguarding Board.

3. The Cwm Taf Morgannwg 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 Cwm Taf Morgannwg 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. This should ensure there is a focus on addressing the inconsistencies in the quality of practice and variable quality assurance systems for assessment oversight, that have been identified within this Review.

6. The Local Authority needs to improve its approach to analysing and managing risk through adopting a clear model of practice. This should include a clear framework for management oversight of safeguarding decisions and risk management plans.

***The Review Panel are aware that the Local Authority are implementing the signs of safety model[8]***

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. Cwm Taf Morgannwg Safeguarding Board should review their information sharing platforms with a particular focus on the Multi Agency Safeguarding Hub information sharing platforms, to ensure clarity of the information shared by agencies to inform decisions and records subsequent decisions made.

9. Cwm Taf Morgannwg Safeguarding Board should consider the recommendations of the COVID-19 Public Inquiry and ensure that it informs future contingency planning

10. Cwm Taf Morgannwg Safeguarding Board should develop a regional campaign to raise public awareness on how to report safeguarding concerns. Materials should be informed by learning identified in this and other Child and Adult Practice Reviews. This report recommends that in the first instance the importance of reporting child protection concerns by the general public and recognising signs of coercive control are part of the campaign.

**National Recommendations**

1. The Wales Safeguarding Procedures Project Board is requested 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. There should be a focus on how progress is measured to inform multi-agency decision making with a clear resetting of the process following the lifting of Covid 19 restrictions.

3. Welsh Government considers commissioning an annual National Awareness Campaign to raise public awareness on how to report safeguarding concerns. Materials should be informed by learning identified in Child and Adult Practice Reviews. This report recommends that in the first instance the importance of reporting child protection concerns by the general public and recognizing the signs of coercive control are part of the campaign.

[8] Signs of Safety is a strengths-based, safety-organised approach to child protection work

4. The Review recommends that Welsh Government considers the commissioning of a full review of Health, Social Care, Education and Police recording, information gathering and sharing systems. There should be a clear focus on reducing the number of information systems, streamlining information sharing and enabling key agencies to have greater information at key points of decision making.

5. That the President of The Family Division considers the imposition of a twelve-week minimum for any Social Work assessment within Public Law Proceedings. With clear guidance on any circumstances where there might be a case specific variation.

| **Statement by Reviewers** | | | |
|---|---|---|---|
| **REVIEWER 1** | Taryn Stephens | **REVIEWER 2** | Steph Webber |
| **Statement of independence from the case**<br>*Quality Assurance statement of qualification* | | **Statement of independence from the case**<br>*Quality Assurance statement of qualification* | |
| I make the following statement that<br>prior to my involvement with this learning review:-<br>▪ I have not been directly concerned with the individual or family, or have given professional advice on the case<br>▪ I have had no immediate line management of the practitioner(s) involved.<br>▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review<br>▪ 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<br>prior to my involvement with this learning review:-<br>▪ I have not been directly concerned with the individual or family, or have given professional advice on the case<br>▪ I have had no immediate line management of the practitioner(s) involved.<br>▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review<br>▪ 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)* | S Webber |
| **Name** | Taryn Stephens | **Name** | Steph Webber |
| **Date** | 18/10/2022 | **Date** | 18/10/2022 |

| | |
|---|---|
| **Chair of Review Panel** *(Signature)* |  …….....…. |
| **Name** *(Print)* | Jan Pickles …….....……. |
| **Date** | 18/10/2022 …….....……. |

**Appendix 1**: Terms of reference

**Appendix 2:** Summary timeline

## Child Practice Review process

The circumstances of this case were considered by the Cwm Taf Safeguarding Board's Joint Review Sub Group on 3rd September 2021 when it was decided that an Extended Child Practice Review would be undertaken.

The Review was carried out in accordance with Section 139 of the Social Services and Wellbeing (Wales) Act 2014 and accompanying guidance and a Panel was convened attended by senior representatives of the following services/agencies:

- Children Services
- Adult Services
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance Services NHS Trust
- South Wales Police
- Education
- VAWDASV Services
- CAFCASS
- Emergency Duty Team
- Valley 2 Coast Housing

An Independent Chair and two Independent Reviewers were identified to oversee the Panel process and complete the Review.

Learning Events were held on 5th & 6th September 2022, attended by professionals involved in the case, representing the services/agencies as mentioned above.

Family and Significant Adult Engagement:

| **Relation Offered Interview** | **Engaged** | **Declined** |
|---|---|---|
| Child T's Father | √ | |
| Child T's Mother | √ | |
| Child T's Paternal Grandmother | √ | |
| Child T's Maternal Grandmother | √ | |
| Adult A | | √ |
| Adult B | √ | |

☐ 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 | ☐ | ☐ | |

# APPENDIX 1 – TERMS OF REFERENCE

# EXTENDED CHILD PRACTICE REVIEW PANEL CTMSB 04/2021

**Case Reference details**
Child T CTMSB 04/2021

**Circumstances leading to the CPR**

Child T was reported missing by his mother in the early hours of the morning. Police were immediately deployed to the scene and commenced a search. Shortly afterwards, Child T was located within the river, and was found to be unresponsive. Child T was retrieved from the river and taken to hospital where he was pronounced deceased.

A Post Mortem was commenced during which it was identified that Child T had both internal and external injures the cause of which was unexplained.

3 persons were arrested and later found guilty of the murder of Child T.

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

- Children Services
- Adult Services
- Cwm Taf Morgannwg University Health Board
- Welsh Ambulance NHS Service Trust
- South Wales Police
- Education
- VAWDASV Services
- CAFCASS
- Emergency Duty Team
- Valley 2 Coast Housing

**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

For extended reviews, in addition to the standard review process, to have particular regard to the following:

- 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)
- To what extend the impact of the Covid Pandemic influenced decisions, actions and outcomes

Specific tasks of the Review Panel:

- Identify and commission two independent reviewers to work with the Review Panel in accordance with the child practice review 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 reviewers 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 reviewers contact arrangements with the family members prior to the event
- Receive and consider the draft 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

**Any Parallel Reviews or Other Such Activity to be Noted**
An Independent Rapid Review, commissioned by the Cwm Taf Morgannwg Safeguarding Board in November 2021, identified some initial/immediate learning in relation to this case. This will inform this Child Practice Review.

**Timeframe for the CPR**

The timeframe set for the Review is 1st March 2020 and 31st July 2021. 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.

It is anticipated that the Learning Event will be held on 5th & 6th September 2022.

**Completion Date**
The target completion date set for the Review is October 2022.

**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 Board's Monitoring Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and
  responses to media interest concerning the review until the process is completed.

## APPENDIX 2 – SUMMARY TIMELINE

| | |
|---|---|
| 1/3/2020 | Referral for Early Help in respect of Child T made by school |
| 23/3/2020 | National lockdown |
| 16/8/2020 | Child T taken to A&E with broken shoulder and other injuries – decision made not to initiate CP enquiries |
| 22/1/2021 | 999 call reporting assault on Child Y by Adult B, resulting in a CP referral. CP enquiries begin |
| 28/1/2021 | Interim Care Order made for Child Y to be placed in the care of the Local Authority |
| 4/3/2021 | Child T and Child A names placed on the Child Protection Register under the categories of Physical Harm and Emotional Abuse |
| 4/5/2021 | Referral for Early Help in respect of Child T made by school |
| 7/5/2021 | Mother reports to GP that Child T burned his neck on a hot tap on the previous day. No CP referral recorded. |
| 20/5/2021 | Child T and Child A names removed from the child protection register |
| 26/7/2021 | Child Arrangements Order granted to Adult A for Child Y |
| 31/7/2021 | Child T pronounced deceased |