Historic Child Practice Review Report

Western Bay Safeguarding Children Board

Historical Child Practice Review

Re: WB N40/2017

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

Legal Context:

The Social Services and Wellbeing (Wales) Act 2014, Working Together to Safeguard People Volume 2 – Child Practice Reviews sets out the requirements to undertake reviews in specific circumstances. Under these regulations an Historic Child Practice Review was commissioned by The Western Bay Safeguarding Children Board (WBSCB) on the recommendation of the Child Practice Review Management Group (CPRMG) in accordance with the Guidance for Multi-Agency Child Practice Reviews. The criteria for this Review were met under section 7.1 of the above guidance namely:

A Board must undertake an Historic 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:

(a) Died; or

(b) Sustained potentially life threatening injury; or

(c) Sustained serious and permanent impairment or health or development

and

the child was on the Child Protection Register and/or was 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 has sustained serious and permanent impairment of health and development.

1. Family Background

The child subject to this Review was the fourth child to mother and father, referred to as child D within the report. The children's mother and father had a history of mental health issues as well as a history of non-engagement with professional services. There had also been concerns about father's involvement, both as a victim and alleged perpetrator of physical violence with members of the public. There were numerous moves of address in the eldest children's early lives within the local area.

Father moved between various locations during the time period of the review. He had family in Wales and England. Maternal grandparents lived close by and were frequently involved in caring for the children from late 2014.

Mother and father lived together for a number of years until 2014 when father left the home. There were concerns in respect of mother's parenting skills which resulted in them being placed on the child protection register. During this period around September 2014 child C moved to their father's address and remained in his care from that point.

Child A, B and C were subject to child protection from the Summer 2014 under the categories of neglect. Child D's name was put on the child protection register at birth under the category of physical abuse.At this time child C lived with father and children A and B lived with extended family (since January 2015).

2. Circumstances Leading to the Review

This Review was commissioned following a referral from Probation Services identifying Child D had suffered two separate fractures while in the mother's care which were considered to be non-accidental in nature. Having been victim to these injuries child D was removed from mother's care and placed in foster care. Child C now resides with father and children A and B reside with extended family and are subject to Care Orders.

3. Scope of the Review

The scope of the Review was from August 2013 – 27th August 2016.

Following the decision to carry out this Review a Child Practice Review Panel was formed:

Chair of Panel – Insp. Clive Bevan – South Wales Police

Independent Reviewer – Daphne Rose – Public Health Wales

External Reviewer –Damian Rees – Swansea Council (Children's Services)

Panel members -

Child and Family Services
Education
South Wales Police
Action For Children
ABMU Health Board
Western Bay Business Unit
Wales Probation Services

Contact with the Family

The Child Practice Review guidance clearly outlines the requirement for family engagement in the process. In this case mother was written to on three occasions offering her an opportunity to contribute to the review, but she has declined and therefore her views could not be ascertained.

Father was contacted on three occasions but after initially agreeing to meet with the reviewers, has subsequently declined and therefore his views could not be ascertained.

The grandparents were contacted and have declined to meet with the reviewers and therefore their views could not be ascertained.

The Learning Events

Two learning events were organised, the first on the 20th September 2018, for practitioners and the second on the 27th September 2018, for managers. In addition the GP surgery were met with separately on the 12th September 2018 due to their being unable to attend the learning events.

Within the Learning Event the reviewers spent time at the beginning of the day to ensure practitioners understood the purpose of the event which is to learn and not to apportion blame.

Some of the attendees only had limited involvement but were invited because they were involved with the family and their contribution was considered pertinent.

The Practitioners Event was attended by 19 practitioners from the following agencies:

Police

Education

Social Services

Primary and Secondary Health

Action for Children

Practice and organisational learning

*Identify each individual **learning point** arising in this case (including highlighting **effective practice)** accompanied by a brief outline of the **relevant circumstances***

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

1. **Communication and information sharing**

This case highlighted that in the early years of child A and B's lives the family moved frequently and accessed a number of different health visitors. During this time the family were evasive with professionals. Health practitioners held a number of important pieces of information in respect of the family that could have assisted with decision making. However, health visiting notes were not routinely shared each time this family moved. GP records were not used to form part of consideration by health visitors when meeting with the family and reviewing support. This meant the impact in respect of parents' mental ill health on their ability to parent was not fully considered.

The learning event identified that some of the barriers for sharing information was an overriding concern about confidentiality, specifically in respect of both parents' mental ill health and treatment. As a result the impact of both parents' mental ill health on their parenting was not fully considered by the practitioners working with the family at the initial point the Local Authority were contacted. In addition it appears that a number of practitioners in health did not share information both within health service as well as with social services. Health records were not complete due to the family moving which resulted in several changes of health visitor. The learning event highlighted that family records were not fully passed onto the next health visitor and it wasn't routine for the receiving health visitor to ensure that records had been fully shared.

In the timeline and learning event it became apparent that the baby's birth plan, while developed with mother and shared with midwifery, was not considered at formal meetings involving all practitioners and family members. Given that mother was not in agreement with all of the plan and there were concerns about compliance a core group meeting should have been convened to consider the plan, any contingencies and actions as necessary.

In the timeline and from the learning event there were a number of incidents of the older siblings having sustained various injuries. These had not all been reported by school staff as mother's explanations were accepted as accurate. Therefore the extent of these injuries were not fully considered by the Local Authority as they did not have the full information.

In respect to safe and appropriate information sharing, recent Government advice, "Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers", highlights that to effectively share information:

•*" all practitioners should be confident of the processing conditions, which allow them to store, and share, the information that they need to carry out their safeguarding role. Information which is relevant to safeguarding will often be data which is considered 'special category personal data' meaning it is sensitive and personal*

• *where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 includes 'safeguarding of children and individuals at risk' as a condition that allows practitioners to share information* ***without consent***

• *information* ***can be shared legally without consent****, if a practitioner is unable to, cannot be reasonably expected to gain consent from the individual, or if to gain consent could place a child at risk.*

• *relevant personal information can be shared lawfully if it is to keep a child or individual at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being."*

2. Postnatal Depression

The local health panel members noted that all mothers should have a postnatal depression assessment/ scoring. However, during the pregnancy and post birth of Child D there was no evidence that mother was ever considered as suffering from post-natal depression.

3. The neglect of neglect

During the time period that formed part of this review the home circumstances in respect of day to day life for the older siblings hadn't got any worse or any better which led to stasis. Concerns in neglect cases don't have to get worse to mean

that the impact on the children is increasing, rather the continuation of being neglected in itself can increase the harm to a child's welfare/wellbeing.

The language practitioners used in meetings and during visits suggested that they thought mother was doing well. For example, mother was offered positive affirmation when she attended a conference as an indication of her want to engage. However, the chronology evidenced that she was not engaging with practitioners, that changes to the risks and the concerns were not being seen and there was in fact no evidence of change. This was reflected in some of the meetings but not in the actual child protection plan.

During the learning events practitioners stated that while a large number of practitioners were trying to work with the family, mother was not engaging with services. Mother's capacity and motivation to change was considered during statutory intervention. However, this was not evidenced by setting clear expectations for mother of what practitioners needed to see to show progression for the children.

Once the family were open to children's services there was a very quick escalation from child in need, to child protection registration to entering the Public Law Outline (PLO) process. There was a pre-birth assessment and PLO assessment in respect of Child D pre and immediately post birth.

One reoccurring theme across the timeline were various agencies concerns about home conditions. However, there was no overall detailed view of the home conditions by any one practitioner. It wasn't clear whether the home conditions were safe, improving, worsening or staying the same and what this meant for the children in the home. Practitioners reflected in the learning event that with no clear agreed bench mark there could be no plan for how this was going to be monitored, reviewed and also shared with mother.

At the learning event practitioners reflected that mother's interaction with the children was of concern at times, this included how she spoke to them and managed their behaviour. However, this did not lead social workers to question what impact her care could have on all of her children, including Child D. The child protection plan created a narrative where practitioners may have been more focused on the older siblings' behaviour and not on how they were being parented by mother. This led to decisions being made for the older siblings to live with other family members. Child D returned home despite practitioners identifying that it was not appropriate for the siblings to be in mother's care. This was on the basis that mother would have opportunity to focus her attention on Child D.

4. Undertaking child protection enquiries

There were a number of issues relating to responding to child protection issues within the timeline. Firstly there was an incident where a health practitioner arrived at the family home and saw a child (who would have been a toddler at the time) in the window but no adult answered the door. Police were not called at the time and the incident was reported much later in the day to Social Services. Mother later explained that she was at home. Whilst Social Services responded promptly once

they were informed, no immediate actions were taken at the time of the event. At the learning event practitioners reflected that police should have been called and the practitioner should have remained until they had arrived to ensure that the children were safe.

In the early part of 2015 there were two separate child protection incidents that occurred almost at the same time. One was a scratch mark to child A's neck which mother stated was caused by paternal grandmother, and the second was an incident where school staff witnessed mother kicking child B in the thigh. There was a delay in school reporting this information to the local authority and by the point the referral was made the local authority child B had left the school and gone home. This alleged assault should have been referred immediately to the local authority to investigate and safeguard child B.

The first of these incidents led to a child protection investigation and a medical examination, and the injury was deemed by a paediatrician to be an unexplained injury that was not consistent with mother's explanation and that they could not rule out that it was a non-accidental injury. The second incident was an allegation of assault which had been witnessed by a professional. While investigated at the time and local safeguarding processes were followed by the Local Authority and police, it was recorded in Children Services' documentation that, due to capacity the police were not able to attend a joint visit on the day that the Local Authority had arranged. The social workers attended the home with the knowledge of there being a possible criminal offence having taken place.

Given that there were two separate safeguarding concerns in a short space of time, and the ongoing concerns about the welfare of child A and B and mother was pregnant with child D, better planning and information sharing between all key agencies could have been achieved through a Strategy Meeting. Instead this was dealt with at the review conference which was pre booked within the timescale of these events. The police, provided a written update to this conference in line with The All Wales Child Protection Procedures and local working practice. However, by not attending the review conference, they did not actively contribute to decisions nor provide opportunity to professionals to explore the police investigations that had taken place to further information decision making.

Given the circumstance a Child Protection Strategy meeting would have been an opportunity to bring together all the worries and concerns of practitioners and agree actions and any immediate safeguarding issues. The outcome of this enquiry was particularly important in this case as the Local Authority were in PLO and it may have raised and evidenced further safeguarding concerns. This may have led to a change in the plans around mother's contact or whether Child D should remain in her care.

The learning event highlighted that the above incidents occurred within a context where there were a significant number of injuries in respect child A and B over a 12 month period caused by one child hurting or biting the other. The frequency of these did not diminish whilst the older children were in mother's and later wider family's care, in fact there seemed to be little actual change following intervention.

In respect of the child D the focus at the child protection conference was the risks of physical harm from child A and B towards child D. The child protection plan did not highlight specifics around mother's parenting a new born or any risks she may pose through the concerns that had been raised about her neglectful parenting of the older siblings. The PLO assessment did not fully consider the issue of how safe the subject would be in mother's sole care post birth when she was unable to parent and protect her older children. Rather when mother returned to her own home, with just Child D, the PLO assessment was further extended as it had not previously considered how she would parent in this circumstance. Concerns had already been highlighted in the PLO assessment of her parenting, but despite this it was deemed appropriate for her to solely care for Child D subject to further assessment. Including the pre-birth assessment and the previous PLO assessment the Local Authority would have been assessing mother's parenting for almost 9 months.

Within the timeline at the end of March 2015, the managers of both the fostering and the locality team became aware of concerns that the kinship carers (at this point a kinship assessment was being undertaken), may have been smacking the older siblings in their care. At this point Child D was also living at the address. The Team Managers agreed to visit the family several weeks after it was reported that one of the children alleged being hit by their family carer. These concerns were not addressed immediately and there was about a month period before they met with the kinship carers to discuss these concerns. This potentially enabled this behaviour and any harm and risks to continue during this period without an assessment and consideration. It was unclear how that decision had been reached, both due to the time that had lapsed between the events and the learning event.

5. Perceptions of Parenting

During the timeline the focus of intervention with mother was in respect of her struggling to manage children's behaviour and her own parenting ability. There was however, very little observation of mother actually parenting, playing and managing the children. It was highlighted that no practitioners spent any time observing mother with the children during visits to understand how she was caring, playing and responding to them. It was clear that any observations that were done were only recorded when there were concerns. Practitioners need time to observe families as part of any intervention. Alongside this there is a need for more robust ways to ensure that observations are recorded and that these observations are reflected on in core groups, within any planning and decision making.

Observation of parents' and carers' interaction with their children should be an integral part of assessment and interventions. Social workers, and other practitioners, should take time to observe parents parenting their children as part of their role of working with the family. This will assist them with identifying what areas to support, but also to be able to observe any changes in parenting as a result of intervention.

6. Approach to intervention

While there were separate child protection plans for each of the children, these plans were often vague in respect of what they were trying to address. A child protection plan does not protect children, progressing a plan should. Plans were not specific, had no clear goals or outcomes and presented services and interventions as an ideal list rather than rationalising and prioritising services. At the learning event practitioners agreed that plans were difficult to interpret and hard to evidence and that they did not link concerns to behaviour – i.e. your children are biting each other because you are not supervising them properly, or that you are not responding. However, plans just stated the need for the children to stop biting each other.

It was unclear how these plans were used to review and drive interventions and decisions. There was no prioritising of what mother had to do first, rather a long list of people to work with. At various times it was clear mother was expected to attend and engage with a large number of agencies given that she was already not engaging in services, expecting her to meet with more people/services should have been better thought through. It required consideration of what this would have looked like for mother, and whether the expectations were realistic. Further, mother's views and voice were not captured in the plan, or her views in regards of how she was going to action any of the points in the plan, or any challenges, disagreements she had with the plan.

From the timeline and learning event it was evident that the PLO process had been undertaken in respect of child A, B and D. Senior management had oversight along with legal advice in respects of the threshold when this process was initiated. This process is considered where there are significant concerns and as a last step before a Local Authority commence legal proceedings to safeguard children. From the timeline these factors were considered. However, the PLO assessment plan was not reflected within the child protection plan. This meant that progress and expectations were not robustly reviewed in all the core groups.

To further highlight the above, the use of plans when working with families is an integral and essential part of communicating, coordinating and reviewing the impact of any intervention. In a previous Western Bay Child Practice Review (N25) the poor quality of plans was highlighted. In this case there were similar concerns identified. Through the learning event it was highlighted that a number of agencies did not have copies of the plans and that the plans themselves were not specific about what changes and outcomes were required. Further the child protection and PLO plan were separate and core groups, while they considered intervention and progress, did not evaluate and use the plan as a central document to inform decisions and reflect on progress.

There was a delay of a month in the social worker telling mother that the Local Authority were concerned enough that they would be seeking legal advice and the formal meeting. It is important that the timing and any impact of telling a parent of this process is considered beforehand to ensure that any safeguarding risks can be managed and the family supported appropriately. In this case the mother was told a few days before Christmas, at a time when the Local Authority, save for their out of office service, would be closed for a period of time. In this case mother had

a history of presenting to her GP as depressed and with low mood. Telling her at this time of year, in addition to their being limited opportunity for social workers or other staff to visit the family, should have been more fully considered. Further consideration should also be given to only informing families of PLO once it has been agreed in a formal meeting in the Local Authority and a PLO letter has been completed.

Following feedback from a current audit in the authroity it was positive to note that practice has now changed and plans are now child focused, specific and measurable and form a central part of case management. At the managers learning event we were informed that there has been significant changes to how plans are written and shared with families and practitioners since this period. The reviewers were told that this change had occurred through organisational change and recognition within the service to develop this area of practice.

It was also apparent through the learning event and timeline that when child C moved to live with their father the receiving Local Authority were informed of the child protection registrations and concerns promptly. Further the other Local Authority were contacted and updated, at various stages within this timeline, of the safeguarding concerns and requests were made to new home authority for child C to ensure that they were safe and well.

Appendix –
Additional general point in respect of Practice Reviews

Requests for Child Practice Reviews.

The learning events took place over 3 years from the time of the incidents. No agency had referred this child to a child practice review at the time of the events. This has created a significant gap between the events and practitioners' reflection, meaning that some of the learning and practice issues identified have in this time already been addressed. However, due to the time lapsed those who took part in the learning event were not always able to fully recall or reflect on their actions at the time.

During the time of this review there has been training to all agencies locally about referring for a practice review. In addition to this Safeguarding Board Members also seek reassurance from the Chair of the Practice Review Management Group during Board Meetings that agencies are making referrals into the group for discussion and decision irrespective of the outcome.

If the learning events had taken place sooner than practitioners may have been able to reflect on their practice in a more informed way which could have further assisted the learning.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the LSCB 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. Currently police only routinely attend initial child protection conferences. The current All Wales Child Protection Procedures (3.24.2) state that participants in the review should be both those who are part of the core group and other relevant agencies such as those that were present at the initial child protection conference. Police should attend review child protection conference when there is an active child protection police investigation or other significant police involvement with the family. This will ensure that they are actively involved in decision making and safeguarding children while they are on the child protection register.

2. Observation of parenting should be a central part of assessing and working with families. Practitioners need to have time within their assessments and interventions with families to spend time observing. To support this consideration of specific training in regards to child and family observation should be given.

3. When there is a PLO plan in place alongside any other plan these need to be combined into a single child focused plan that reflects the current concerns, actions, and any bottom lines. This will ensure that plans are robustly reviewed and the focus of intervention will be clearer as all the information will be contained in one document. Organisations need to ensure that their processes do not create unnecessary systems that rely on duplicating plans due to the multiple status a child.

4. Strategy meetings should be considered when there are multiple separate child protection issues in a short period of time, or where the child is already on the child protection register, or looked after.

5. School staff who witness children being assaulted must immediately report this to the Local Authority and police. In addition, school staff must always record in writing the concern, keep a record of this in the school and also share this with the Local Authority.

6. Any 3rd sector agency that is working with a family when a child is on the child protection register should only end their involvement and intervention via a core group meeting and not in isolation or outside of the child protection arena.

Reminders of expected Practice

The below are not new learning points, rather through this review a number of expected practice issues were noted that should be highlighted to remind practitioners –

a) Patient records need to follow the patient and be available to health practitioners. It should be the responsibility of the most recent health service to obtain these records.

b) Training for GP's and health visitors may be helpful so that there is a better understanding of safe and appropriate information sharing both internally and with other agencies.

c) Health practitioners to ensure that when treating a patient that they also consider what this means for that person in their role as a parent/ carer.

d) Post-natal depression should be assessed/ scored for all mothers by health visitors.

e) Assessments should refer to the framework for assessment and include a chronology, and consider adverse childhood experiences in respect of parents' lives to inform appropriate interventions. When assessing parental capacity social workers should consider the persons capacity and motivation to change, the impact on the child and the expected timescales for change in order to offer the most effective and child focused interventions. In addition to these the impact of any adverse childhood experiences that children are experiencing should be considered by practitioners and reflected in interventions and plans.

f) A Child Protection Plan is everyone's responsibility to oversee, contribute too and challenge where deemed necessary. Child Protection Plans must be shared with all members of the core group and the family. To support this Child Protection Plans should be clear and include any consequences and actions that would be considered in the event that there is no change, or where there are escalation of concerns.

g) There should be no significant delay, once a parent has been formally informed of PLO, of a meeting being set up with parents, their legal advisors and the Local Authority.

h) It is not any one sole agency that is responsible for making a Child Practice Review referral. Rather, all agencies can refer to the Local Safeguarding Board for a Child Practice Review and organisations need to ensure that any children who may meet the criteria for a Child Practice Review are referred through for consideration without delay.

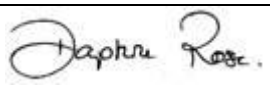
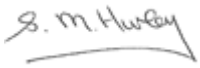
i) When children are not in parents' care there should be consideration of their looked after status. The rationale should be recorded for any decisions and parents and legal advisors informed and given opportunity to challenge decisions. This is especially important if those children live in other Local Authority areas and are needing to access services.

j) If siblings are placed, or not living with birth parents, then the remaining child's looked after status needs to be considered detailing the reasons why siblings are not with birth parent to inform any safety planning and intervention.

k) If anyone has a concern in respect of a child being home alone they must contact the police immediately.

l) When a S.47 investigation is being undertaken due to concerns where a child has been physically assaulted, police should always complete a joint visit with the Local Authority.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of Qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned	

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.		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)*	Damian Rees	**Name** *(Print)*	Daphne Rose
Date : 30.09.19		**Date:** 30.09.19	
Chair of Review *Panel* *(Signature)* **Name** *(Print)* **Date**	 Sue Hurley 30.09.19		

Appendix 1: Terms of Reference
Appendix 2: Summary Timeline
Appendix 3 : 7 minute Briefing

For Welsh Government use only

Date information received ……..

Date acknowledgement letter sent to LSCB chair ……

Date circulated to relevant inspectorates/Policy leads ……

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	