## 7) Learning points.

- Practitioners need to be aware of disguised compliance
- Practitioners should use the assessment framework and associated processes to build a clear and holistic picture of the situation that families face
- Professionals working as conference chairs should help support professional relationships
- Promotion of the Regional Safeguarding Board protocol of working with un- cooperative families
- Professionals should be supported to work at building relationships and trust through difficulties through regular reflective supervision

## 1) Background

The West Glamorgan Safeguarding Children Board commissioned extended Child Practice Review July 2020 recommendation of the Practice Review Management Group (PRMG) in accordance with part 7 of the Social Services and Wellbeing (Wales) Act 2014 and the underpinning Practice Guidance for Multi-Agency Child Practice Reviews. The PRMG felt that this review could generate multi-agency learning around neglect, disguised compliance and multiagency involvement. A referral was initially received by the PRMG to consider commissioning a review following the tragic death of 3-year-old child D during the autumn of 2019.There had been historic concerns around the family of four siblings and in summer 2019 the children had all been placed on the Child Protection register under the category of neglect. It was subsequently ascertained by the Coroner that child D had died of natural causes relating to their complex underlying health needs.

## 2) Context

- Child D was a twin who had been born prematurely via an emergency caesarean section she had complex health needs and mobility issues, and a diagnosis of complex cerebral palsy.
- There was a protracted history of ICU and general hospital admissions, where she often needed ventilation.
- On the morning of her death child D was found by parents to be unresponsive in her cot having been checked on a few hrs earlier.
- The coroner's court found at inquest that Child D had died from natural causes.
- Summer 2019: The four siblings in the family were placed on the Child Protection register for neglect.

## 6) Improving Systems & Practice

- Multi agency training on disguised compliance should be commissioned by West Glamorgan Safeguarding Board and made available to a broad range of professionals.
- Practitioners should be better supported in dealing with conflict and complaints from families
- The resolution of the professional differences protocol to be promoted within agencies, to escalate concerns in cases of professional disagreement
- Consideration should be given to production of a multi-agency threshold document which gives clarity about points of intervention
- Multi agency safeguarding training should be offered to professionals to ensure understanding of roles and responsibilities and differing

- The message about safeguarding being everybody's responsibility and Duty to Report should be re-enforced at every training opportunity

**7 Minute Briefing Child Practice Review: WGS58 2020 - Extended Child Practice Review**

**The scope of the Review: 14/11/2018- 14/11/ 2019**


## 3) Context continued

- **Concerns:** parents' behaviour towards each other and their parenting of the sibling group.
- **Parenting skills;** establishing and maintaining routines
- prioritising the children's needs
- **A chaotic and dysfunctional household** : poor and unhygienic home conditions
- All four children had some form of complex health needs, compounding family's difficulties
- The children's bedrooms were deemed unsafe, and there was a lack of adequate bedding.
- **School routines;** were poor children often late or absent
- Despite support parents could not maintain improvements and directed numerous complaints against professionals
- Health appointments were often missed
- **Application to court**
- Following the death of child D The children were made subject of care orders and remain in the care of the local authority

## 5) Key Themes & Discussions continued: Thresholds.

- There was concern about agreement regarding the thresholds for intervention with some individual agencies stating that their requests to investigate the difficulties faced at home by the children were not actioned.

- There was collective multi-agency frustration around thinking that the case was 'stuck' despite requests to escalate concerns further.

- **The Child's voice:**
  All Practitioners should be confident to work directly with and listen to children and young people to establish their voices wishes and feelings.
- **Good Practice;** Excellent collaboration between education and health professionals
- Sharing of information about the children between specific schools
- The Police Community Support Officer recognising an immediate safeguarding concern
- All agencies trying to do their utmost to support the sibling group despite difficult working relationships with the whole family.

## 4) Key Themes/Discussions Neglect

- The optimistic view of some professionals appeared to allow disguised compliance by the parents.
- Parents used complaints and conflict to achieve changes in services they received.

- It became evident at the learning event that there were differing views from several multiagency professionals regarding the holistic view of the complex needs of whole family.

- Each agency had their own unique 'piece of the puzzle' that was the true home situation for the children. Not enough of the information was shared across all agencies to achieve the holistic and accurate picture of each child's individual set of circumstances
- Agencies had differing opinions of the support needed by the family, with not all being able to agree on what constituted significant risks.