WEST GLAMORGAN SAFEGUARDING BOARD

Child Practice Review Report

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West Glamorgan Safeguarding Children Board
Extended Child Practice Review

Re: WG S58 2020

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 Extended Child Practice Review was commissioned by the West Glamorgan Safeguarding Board (WGSB) on the recommendation of the Practice Review Management Group (PRMG). The criteria for this Review were met under section 7 of the above guidance namely:

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:

(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.

Circumstances leading to this Review

A referral was received by the Practice Review Management Group (PRMG) a sub group of the West Glamorgan Safeguarding Board 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 who resided with both parents and in Summer 2019 the children had all been placed on the Child Protection register under the category of neglect.

At the time of the referral to the practice review management group from the police the circumstances of the death were subject of a police investigation, however, it was quickly established and subsequently ascertained by the Coroner that child D had died of natural causes relating to their complex underlying health needs.

Following child D's death, the remaining children were removed from the family and Family Court proceedings were instigated. As a consequence of Family Court proceedings the safeguarding Board was requested by the District Judge to also undertake a review of this case. The focus of this review was to identify good practice and establish whether agencies could have worked better together with particular attention on the agencies planning to support child D, the child's siblings and their family prior to and during these tragic events.

Historical Context and Background information

Child D was a twin who had been born prematurely via an emergency caesarean section. As a result of their premature birth they had a number of complex health conditions, had several ventilated Intensive Care Unit (ICU) admissions and child D had mobility issues resulting in the use of an adapted wheelchair.

On the morning of the death, dad reported that he had checked upon Child D at 6am and mum added she had changed child D's nappy at around 6.05am when the child was awake and smiling and appeared happy. Child D was then placed back in the cot and next checked at 10.00am after the other siblings had been taken to school.

It was at this time that child D was found to be unresponsive and emergency services were contacted by parents. Following attendance at the house emergency service staff continued Cardio Pulmonary Resuscitation that parents had begun but found child D still unresponsive.

Both child D and mother were taken to the local general hospital, and they were joined by father later.

During the summer of 2019 following an Initial Child Protection Conference all four siblings in the family were placed on the Child Protection register for neglect.

There was concern about the parents' behaviour towards each other and their parenting of the sibling group. Their skills around establishing and maintaining routines and ability to prioritise the children's needs in what appeared to be a chaotic household was brought under scrutiny. All four children had some form of complex health needs, and this added to the difficulties faced by the family.

The home conditions were considered to be of a poor standard with lots of mess throughout the home including discarded food and rubbish. The children's bedrooms were deemed unsafe due to the level of clutter in them and some of the children did not have adequate bedding.

Support was provided to the family by social services to establish routines and tackle some of the concerns around home conditions. Limited improvements were noted by professionals especially when direct work on cleaning and clearing was completed. However, it appeared that these improvements were not maintained for any length of time and home conditions deteriorated when support was cut back. It was also noted that parents found it far more difficult to maintain routines without direct support, which resulted in the children often being late for school.

As a result of these continuing problems and the subsequent death of child D there followed an application for care orders in the family court. The children were made subject to care orders and remain in the care of children's services.

Scope of the Review

The scope of the review was from the 14th November 2018 to 14th November 2019 Following the decision to carry out this review a Child Practice Review Panel was formed:

Chair of Panel – Sue Hurley – South Wales Police

Independent Reviewer – Melanie Roach – Independent Reviewer

External Reviewer –Ali Davies – Neath Port Talbot County Borough Council

Panel members

Swansea Bay University Health Board

South Wales Police

NSPCC

Education Swansea

Swansea Council

The Practitioners Event was attended by 28 practitioners from the following agencies:

Police

School's

Social Services

Primary and Secondary Health

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

Key Learning Points

The optimistic view of some professionals appeared to allow disguised compliance by the parents.

- There was too much emphasis on small improvements to home conditions which could not be maintained in the longer term.
- It was also felt that professionals lost sight of the wider safeguarding concerns due to over emphasis on improving home conditions
- Parents reported lots of illness in all siblings. They may have used these bouts of illness when they had not completed specific tasks. This enabled them to avoid or postpone some professional meetings and visits on a number of occasions.
- They missed many health appointments but always had a reason to do so by suggesting clashing appointments on same days. Professionals struggled to get a holistic picture of life for the sibling group often due to the amount of appointments they needed to attend to meet the needs of all the children
- On planned visits parents engaged well with professionals and showed a willingness to change and prioritise their children's needs. However, for

unplanned work they were less able to be flexible and attempted to avoid meetings or visits if not pre-planned.

Parents used complaints and conflict to achieve changes in services they received.

- There were complaints made about several professionals from different agencies. Usually, the response was to change the professionals tasked with working with the family. This led to lack of continuity of workers and lack of consistency of approach to specific problems within the family
- Some professionals had difficulty in engaging with the family who were perceived as difficult, made vexatious complaints, and were often considered to be manipulative. Therefore, it was difficult to discuss progress or the lack of it.
- There were a number of complaints made about workers or the type of support that was offered and parents 'demands' were escalated within agencies. This resulted in delayed action whilst trying to accommodate parent's needs.
- There was a difference of opinion between professionals and the family about the support which should have been provided. The family were keen to receive financial support to help them care for the whole sibling group, but the support offered by professionals continued to be practical. Parents continued to voice their concerns about their perceived lack of support.

Use of Assessments and Care, Support and Protection Plans and hearing the voice of the child.

- The assessment processes that were used to establish facts and support provision of services should have been used to find out about Child D's daily lived experience.
- Child D was non-verbal in their communication. In this case the professionals would not have been able to gain the voice of the child when they were unable to give their own views, however the unspoken voice is just as important.
- When in school the older siblings were able to share their experience of life at home which contributed to the care and support plan (CASP)
- When one of the reviewers spoke with the sibling group as part of the review process they were very honest about what it was like for them at home. They were also able to explain what Child D's experience had been and how they all related to each of their parents.
- The voices of the children should have been specifically recorded, to enable the information to be used in the assessment process to provide clarity about the CASP plan that was in place.

Professional ability to analyse information from differing perspectives

- Emphasis was put upon home conditions and efforts to improve these. It was something tangible that professionals felt they could work alongside the family with.

- Practitioners need to understand parenting capacity given the complexity of the children's needs, and the impact upon the parents.
- From talking to mum, she felt that it became a hindrance to the family that 'there were people in the house not helping but just watching and being critical of everything we did'.
- Parents were not themselves able to see and understand the concerns, because they either weren't explained to them well or when they were the family couldn't hear them and would use the complaints process to undermine and avoid them.
- Parents stated that they asked for help during the summer school holidays as life felt very chaotic with the sibling group being at home constantly. Emails from parents, usually dad, to professionals increased at this point and there were clear signs that parents were requesting further help.
- This culminated in an incident when two of the sibling group went to the local supermarket unaccompanied to 'find some food'. They had to cross a busy road and large car park to get to the supermarket. They were returned home safely when parents came to find them stating they were playing outside and had wandered off.
- Staff at the supermarket stated that they ate the food offered as if "they had not eaten for a while" and commented about their unkempt appearance. There was a police community officer at the shop at the time and he requested the attendance of the Police. Subsequently a Public Protection Notice about the incident of the children being missing from home for a short while was completed. The parents' explanation about them playing outside and wandering off was accepted at face value and no broader safeguarding enquiries about how and why they went to the shop were made at this time.

Understanding Multi Agency working and the benefits of sharing information

- During the learning event it became apparent that there were differing views from several professionals about their understanding of the whole family and their complex needs. The family were viewed differently by a number of agencies, all of whom had different experiences of their presentation to professionals.
- All agencies who worked alongside the family had all put a considerable amount of time and effort into helping them and attempting to meet their individual needs.

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

- Each agency had their own unique 'piece of the puzzle' that was the true home situation for the children. Not enough of the information from some of the agencies were shared across all to achieve a good vision of the true picture.

- It became apparent that there was little understanding of the constraints faced by some agencies due to demand, staffing levels and pressure of work by all who were involved with the family. This led to some professional differences of opinion.

- Agencies had differing opinions of the support that was needed by or offered to the family, with not all being able to agree on what constituted significant risks. If they had been seen as at more significant risk, with that view fully agreed and shared, the level or type of support offered may have been different.

- Many professionals stated their frustration at thinking that the case was 'stuck' despite requests to escalate concerns via their own agencies.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SCB and its member agencies and anticipated improvement outcomes:

Improving Systems and practice

Participants at the learning event and discussion within the panel identified the following areas that would develop systems and practice in future:

Practitioners need to be aware of disguised compliance and have strategies and methods for working with family's where this is a factor.

- 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 supported in dealing with conflict and complaints from families that has potential to impact on the safeguarding of children

- Working relationships should not be severed due to complaints received from families
- Professionals working as conference chairs should help support professional relationships
- Promotion of the Regional Safeguarding Board protocol of working with un-cooperative families
- Consistency of workers and approaches is vital to effecting change

- Professionals should be supported to work at building relationships and trust through difficulties through regular reflective supervision

Use of Care and Support Plans and assessments and listening to children

- Practitioners should use the assessment framework and associated processes to build a clear picture of the situation that families face
- When Care and Support and Plans are in place they should be used as a tool for improvement. Multi-agency input to the plans via core groups has provided a benchmark for measuring improvement, though there was still disagreement on behalf of parents.
- It was identified that the Voice of the child was absent on many occasions for child D and their siblings. All Practitioners should be confident to work directly with and listen to children and young people to establish their voice. This has been done very effectively as part of this review and the children have stated that they got on well with their Social Worker and had a very strong relationship with them.
- Children's needs should be prioritised however difficult working and personal relationships are within the family group.

Thinking Safeguarding

- There was an opportunity for professionals to think about safeguarding in the broader context rather than providing a single level response when responding to the supermarket incident.
- The message about safeguarding being everybody's responsibility and Duty to Report should be re-enforced at every training opportunity including induction sessions and corporate safeguarding initiatives, especially those who do not work directly with children on a day to day basis

Multi Agency Working and sharing of Information

- Knowledge of the resolution of professional differences protocol to be promoted within agencies. This will highlight the ability 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 training on safeguarding should be offered to professionals from differing staff groups to ensure an understanding of each other's roles, responsibilities and constraints to practice which would improve communication between agencies in the future.

Good Practice

Several examples of good practice have been highlighted during the course of the review. These include:

- Excellent collaboration between education and health professionals

- Sharing of information about the children between specific schools
- The Police Community Support Officer calling his Police colleagues to deal with the supermarket incident as he recognised a safeguarding concern
- All agencies trying to do their utmost to support the sibling group despite difficult working relationships with the whole family
- Schools were extremely flexible around attendance and lateness; this was to enable as much attendance as possible by all children
- School staff had good relationship with each child and used this to provide support to meet their individual needs.

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 family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Name *(Print)*	Mel Roach	**Name** *(Print)*	Ali Davies
Date	12.10.22	**Date**	12.10.22

Name *(Print)*	Sue Hurley
Date	12.10.22

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Child Practice Review Process

To include here in brief:

- *The process followed by the SCB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The Process of the Review

A review panel was convened and met regularly. It was chaired by the supporting vulnerable persons review manager from South Wales Police. The panel Membership was made up of representatives of :

- Swansea children's services
- Swansea Bay University Health Board
- Swansea Education safeguarding
- South Wales Police (Chair)
- Neath Port Talbot (Reviewer)
- Independent consultant (Reviewer)

At the heart of the review was a full day virtual learning event attended by participants from a broad range of services that had worked with child D and their family. It was designed to be a safe learning space where participants could talk about their interactions with the family. It provided an opportunity for constructive professional challenge and discussions about constraints and difficulties faced by agencies.

It was acknowledged that this was evidently very emotive for participants who contributed well but needed support at various stages to manage both their anxiety and frustrations.

In addition to facilitating the learning event the reviewers contacted family members to discuss the process of the review and their experiences of services received.

The three siblings from the family were also consulted as part of this review and were able to provide great insight into their family life which clarified their story for the reviewers.

The material generated by the learning event, the discussions with family members and the discussions and challenges raised by the review panel form the basis of this report.
☐ Family involvement – The chair of the review panel and reviewers had a face-to-face meeting with the father prior to publication. The reviewers had telephone contact with Mum on two occasions, at the start of the review process and again prior to publication.

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Date information received ……..

Date acknowledgment letter sent to SCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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