**WEST GLAMORGAN SAFEGUARDING BOARD**

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| **Child Practice Review Report**  **West Glamorgan****Safeguarding Board**  **ConciseChild Practice Review**    **Re: WG N56 2020** |

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| **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 a concise Child Practice Review was commissioned by The West Glamorgan Safeguarding Children Board (WGSCB) on the recommendation of the Practice Review Management Group (PRMG) in accordance with the Guidance for Multi-Agency Child Practice Reviews.  The criteria for this Review were met under section 3.4 of the above guidance namely:  A board must undertake a Concise 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 neither on the Child Protection Register nor 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 resulting in the review:**  A Child Practice Review was commissioned by the West Glamorgan Safeguarding Board on the recommendation of the Practice Review Management Group in accordance with the Guidance for Multi-Agency Child Practice Reviews.  The panel was chaired by Damian Rees, Safeguarding Principal Officer, Child and Family Services City and County of Swansea. The reviewers are Jessica Myden, Team Manager of the Learning and Innovation Team, Child and Family Services Swansea and Wendy Sutherland - Evans, Jigso Lead Midwife. The following agencies are represented on the panel:   * Swansea Children’s Services * Neath Port Talbot Children Services * Swansea University Health Board * Education Neath Port Talbot * CALAN Domestic Abuse Service * South Wales Police. * CAFCASS * Probation   The panel met, constructed and analysed a multiagency timeline identifying some practice and organisational learning. Due to the ongoing criminal investigation, the practitioners’ Learning Event had to be postponed until this was concluded. Following conclusion of the court proceedings the Learning Event took place in September 2022.  **Scope of the Review:**  The scope of the Review was from 20th December 2018 to 9th December 2019 representing the 12 months leading up to Child X attending the hospital following identification of his injuries.  **Family Background**  **Genogram:**  **Mother**  **Father**  **Ex partner**  **Half sibling**  **Half sibling**  **Child X**  = Male  = Female  = Separation  Child X was born in June 2019 and in December 2019 was referred by the Health Visitor with a suspected squint to an outpatient Orthoptist Clinic. Child X was noted to have bilateral retinal haemorrhages that triggered safeguarding concerns as these injuries are usually caused by being shaken. At the hospital, parents were unable to provide an explanation. A number of tests were carried out including a skeletal survey, MRI, CT scan and blood tests confirming that Child X had sustained multiple subdural haemorrhages. A consultant neurologist noted three levels of bleeds indicating three separate injuries at differing times. In his expert opinion this was consistent with a car accident, diving, or having been shaken. He was clear that Child X had been shaken on three separate occasions.  Mother and her partner were arrested and released on court bail with strict conditions.  Child X has two half siblings with a different father to Child X. Both Child X’s half siblings lived between both mother and their father.  **Contact with Family:**  .  Prior to attending the Learning Event attempts were made to meet with both parents of Child X. The father to Child X unfortunately did not respond to attempts to make contact however mother was spoken to and shared her views:  **Meeting with Mother:**  The reviewers met with mother in July 2022 at her home. Mother was informed of the review process and asked to share anything she felt would support learning around the process. Mother identified the following:   * Impact of changes in worker on relationships.   Mother stated that she suffered with her mental health including self-reported Post Traumatic Stress Disorder (PTSD). Mother advised that building a relationship with those who supported her was very important in allowing her to feel she was able to open up and share her thoughts. Mother advised that every time there was a change of worker she had to repeat her story advising that each time this impacted her mental health and caused her to relive this trauma.  Positively mother identified that her Health Visitor and GP were of great support to her and felt that they listened to her.   * Need for a holistic assessment.   Mother advised during the meeting that she felt concerns centred around her only and her mental health. From mother’s perspective little consideration was given to father’s historical domestic violence and support she may need around this. Mother commented that she felt agencies did not communicate with one another. Further to this mother explained that on receiving information on Child X’s father through Claire’s Law she feels professionals should have challenged her more on remaining in the relationship and of their concerns about this. |

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| **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* |
| The following Practice and Organisational Learning Points were identified through analysis of the multiagency timeline at the Learning Event.  **Multi Agency working**  Mother and her ex-partner had a history of domestic violence, however were no longer in a relationship during the period leading up to Child X’s injuries. Mother became pregnant (Child X) with a new partner who also had a history of domestic violence with previous partners. Mother reported that she did not want her ex-partner to be aware of her pregnancy due to fear of repercussions. On reviewing the timeline, it was clear to see from very early on that different agencies were receiving different messages from mother around her relationship status. Each agency held this information in isolation and limited multi agency collaboration early on prevented this from being shared in order to fully assess and challenge the information. As the timeline proceeds, we can continue to see this pattern throughout as mother provides different information to different agencies around her relationship and engagement with services. Although at various times during the timeline concerns are expressed by Health Visiting and the GP service, this did not meet threshold for Child Protection and nor did it lead to a multi-agency meeting. On reflection this would have been an opportunity to pull all agencies together to share relevant information that may have supported the need for a single assessment of unborn X and siblings. Having a clear single multiagency plan may have supported further partnership work between all agencies around assessment of need and identified clear roles and responsibilities. There was a shortcoming of having no assessment or care support plan early on, which would have supported the understanding of historical and ongoing risk. This resulted in working with the assumption that because certain information was historical it had been dealt with.    Whilst mother was pregnant with Child X, health professionals raised concerns around the accumulation of Accident and Emergency (A & E) attendances for the older siblings and mother’s ability to manage all children’s needs collectively including her unborn child when born. This was shared not only at the time of the incidents, but also as a summary from the GP via a chronology in March 2019 of repeated A & E attendances where concern was raised about core supervision of the children at home. This summary included:   * 8 attendances in the previous four years for one sibling who was four years old which included head injuries, facial bruising and burns * 9 attendances for the other sibling who was three years old which included accidental ingestions i.e. insect repellent, mothers drugs, head injury and facial bruising.   This was recognised as good practice from health professionals in sharing and raising concerns. During the Learning Event it was recognised that the notification from Health raising concerns around the repeated number of attendances over time should have been the trigger to open all the children for an assessment given the shared care arrangement, the concerns for mother’s mental health, the injuries the children had sustained and ongoing reported domestic abuse. It appears that the decision not to proceed to a Section 47 Investigation was not challenged by the referring agency despite their ongoing concerns.  Multi agency work has since progressed as the Local Authority now have a multi-agency team at the front door including Health, Police and Education to promote inter agency sharing of information at the very start of involvement. Police advised that co- location has significantly improved sharing of information amongst agencies.  **Health**  In line with Health Board Policy, following the antenatal booking appointment the community midwife completed and emailed the electronic Sharing Information in Pregnancy Forms 1 and 2 to the Health Visitor and GP. This is a tool which shares safeguarding information and invites the Health Visitor and GP to share any safeguarding information with the community midwife. Mother was living in a Flying Start area so the family received an enhanced visiting programme from Health Visitors and Community Nursery Nurses. Given the mother’s challenging history and social background, this would have benefitted from two way communication between midwifery and health visiting services with the ongoing pregnancy to question how mother would cope with a third child.  A visit was undertaken to mother by a community nursery nurse during the course of the timeline where there was noted to be a smell of cannabis. There was no evidence to show that this was fed back to the case holding Health Visitor so this was not further explored during subsequent visits.  **The power of language**  This case has evidenced the importance of separating fact from opinion when recording. Throughout this case mother is identified as having Post Traumatic Stress Disorder (PTSD). This was repeated in a number of agency recordings and became fact despite mother never being diagnosed as having this. We have confirmed that mother was later assessed in the court process as not having PTSD. This identified the importance of clearly recording where someone has been diagnosed or is self-reporting this can influence how this person is then worked with.  Further to this, when reviewing the timeline there were a number of entries where mother was noted to attend health appointments with ‘partner’ however we could not identify who this individual was. This was of significance given the report that mother was stating to some agencies that she was not in a relationship with Child X’s father and was not having contact with him and yet identified him to another agency as her ‘new partner’. This again raised the importance of recording and identifying names of who is in attendance.  **Domestic Violence and the impact of this on our work with families**  Mother in this case reported significant domestic violence with her ex-partner, however there were no police reports to evidence this and mother did not want to pursue this later. Further to this, father of Child X also had a history of significant domestic violence in previous relationships. Discussion at the Learning Event questioned whether this impacted on professionals’ perception of siblings’ father (mother’s ex-partner). Child X’s siblings’ father repeatedly made contact with the Local Authority to express concerns around mother’s mental health, however professionals at the Learning Event questioned how much validity was given to this due to the report given by mother of his history. This does raise a query around how we work with perpetrators of domestic abuse and still ensure their voice is heard, despite the history. Agencies developed a shared bias of the ex-partner due to mother’s comments. The Learning Event participants questioned whether the reported domestic violence in this case clouded the concerns expressed by the ex-partner leading up to Child X’s injury.  Further to this, it was identified that there was also limited contact between professionals and Child X’s siblings’ father (ex-partner) to be able to fully understand and assess the needs of the child, parental capacity and undertake direct work with Child X’s siblings. The timeline did not evidence observations of parent child interaction and there was no evidence that the children had been presented with opportunities to have their views heard in respect of the emotional impact their parents’ relationship may have been having on them.  In addition to this the Health Visitor was only visiting the siblings at mother’s address. During the Learning Event, health acknowledged that this was a missed opportunity to fully explore the needs of the family that may have triggered further discussion. However Health did also feedback that this practice has now changed and Health Visiting would ensure children are seen in both care arrangements. The involvement of the father is emphasised in *An overview of the Healthy Child Wales Programme* (Welsh Government, 2022).  **Recognising risk when working with domestic violence**  The risk of experiencing domestic violence or abuse is increased in women who have a mental health problem (Trevillion et al 2012), around the time of separation (Smith et al. 2011), during pregnancy or who have recently given birth  (Richards 2004). Although mother was later confirmed as not having PTSD she was receiving support from the Perinatal Response and Management Service (PRAMS) for her mental health. During the pregnancy, the mother presented numerous times to maternity services, sometimes with vaginal bleeding or abdominal pain and was then discharged. Repeated attendances during pregnancy with these ailments are considered to be indicators for domestic abuse in the *Domestic violence and abuse: multiagency working guideline* (National Institute for Health and Care Excellence, 2014). This should prompt the midwife / obstetrician to ask the domestic abuse question ensuring the woman is alone. Although the maternity records did not evidence this during these hospital attendances, the maternity records make clear that when the mother presented alone to routine antenatal appointments, the midwife asked the Routine Enquiry (domestic abuse question) on a number of occasions and no disclosure was made.    **Professional curiosity**  Throughout the timeline Mother continued to deny the relationship with Child X’s father yet they were often noted in recordings as being together. Regardless of whether Mother was in a relationship with Child X’ father or not, as described above, recent separation can increase the risk of domestic violence. However professionals often, in domestic violence cases, see this as a positive move that reduces the level of risk. Mother was giving different information to different agencies in regards to her relationship status. Lack of communication and professional curiosity created a barrier to fully exploring this and the understanding of what the relationship really looked like. This also included fluctuating comments around engagement with services and mother’s mental health. Throughout the timeline there are minimal recordings or entries relating to the assessment of Child X’s father. It would appear that mother’s needs detracted the Local Authority and other agencies from reviewing this despite the historical concerns around Child X’s father. The Local Authority in the Learning Event reported positive observations of Child X’s father however there is no indication of this in the timeline.  Throughout the pre-birth assessment period Mother stated to the Local Authority that she was not in a relationship with Child X’s father and they lived separately. This would have formed part of the pre-birth assessment however after baby was born Mother and baby went to live with Child X’s father. This was an untested arrangement. The midwife during a postnatal visit made contact with the Local Authority to query this arrangement and was informed that this arrangement was satisfactory.  **Response to Safeguarding**  Some of the key health professionals who provided care to Child X were not invited to the Learning Event, although the Reviewers met with the health professionals afterwards. Important information was gained, but there was missed opportunity to enable a wider discussion amongst the multiagency professionals involved in this case. Panel members must be reminded of their responsibilities in the Child Practice Review process which includes that all key professionals involved in the case are invited to the Learning Event to maximise discussion and learning.  The following information was not shared at the Learning Event as the Orthoptist was not invited. The Reviewers arranged a meeting with the Orthoptist to review the timeline after the learning event.  The Orthoptist told the Reviewers that Child X’s injuries were identified whilst attending an outpatient eye clinic for a suspected squint. Child X was noted to have a bleed behind both eyes that triggered safeguarding concerns. The Orthoptist contacted the paediatric eye consultant and the Corporate Safeguarding Team. The paediatric eye consultant advised to send Child X to hospital for an appointment that day.  On the advice of the Corporate Safeguarding Team, the Orthoptist stated she made contact with the Local Authority to make a safeguarding referral, however, was passed through to the Duty Social Worker who did not answer the phone. Mother asked if they could go home to feed the baby before going to the hospital, the Orthoptist agreed to this as she felt unsure about how to proceed. The Orthoptist was advised by the Corporate Safeguarding Team not to mention the concerns at this stage but state that a follow up was required. The Health Board Corporate Safeguarding Team now provide safeguarding advice and support Monday to Friday from 8am to 8pm.  The Orthoptist shared that the re-design of the Local Authority multi-agency team at point of referral that has happened since these events now provides an immediate response.  **Use of Strategy Meeting**  After being identified as having a concerning bleed behind both eyes that required a Child Protection medical examination, an Initial Strategy Meeting took place on admission and initiated a Section 47 Investigation including a Child Protection Medical.  The Initial Strategy Meeting should have discussed the supervisory aspect of Child X’s care whilst in the hospital and involve all key agencies. This did not take place. This resulted in Child X being admitted to the paediatric ward and left unsupervised in the company of family. Further to this the timeline suggests that whilst on the ward unsupervised, Child X may have suffered a further bleed behind his eyes.  **Changes in Practice that have already taken place**  The following information was not shared at the Learning Event as the health staff from the paediatric ward were not invited. The Reviewers arranged a meeting with a paediatric senior nurse to review the timeline.  The Reviewers met with the Clinical Nurse Specialist for Safeguarding (CNSS) who recalled this case and shared that there had already been learning and positive practice change following this case:   * The Local Authority now provides a robust supervision plan /timetable for the paediatric ward where 24 hour supervision is required * There is direct contact between the Social Worker and the CNSS / or nursing staff to discuss the case and the plan * The CNSS is developing a group of staff to be champions in safeguarding to ensure in her absence, there are staff available who can advise/support staff in safeguarding * A named doctor for safeguarding has now been recruited who provides support/advice to medical staff with safeguarding * CNSS attends all safeguarding strategy meetings. Information/plans from strategy meetings are shared with the Health Board’s Corporate Safeguarding Team * The Paediatric Department have developed an information leaflet for parents which explains the process/ procedure when children are admitted with safeguarding concerns. |
| **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*: |
| **Recommendations**   1. The importance of identifying names of individuals in recordings and clearly recording diagnosis or self-reported illness has been identified as an area for improvement. To comply with General Data Protection Regulation, agencies need to strengthen their guidance and training provided in respect of recording information. This will ensure relevant individuals are identified clearly in recordings whilst also differentiating between self-reported information and diagnosed conditions. 2. Two way safeguarding communication in early pregnancy via the Sharing Information in Pregnancy process between Midwives, Health Visitors and GPs is embedded in practice. It is important that this two way communication between midwifery and health visiting services continue in the ongoing pregnancy to ensure a full assessment of mother. It is recommended that midwifery and health visiting services are reminded of the guidance and importance of effective communication and information sharing between their services. 3. When support staff are delegated a task, it is essential that any area of concern is communicated back to the case holder in a timely manner. 4. All agencies to be reminded of the importance of involving all key agencies at the Initial Strategy Meeting. 5. This case has highlighted learning around how we work with families who are experiencing domestic abuse. Not only how we assess risk depending on factors such as mental health, pregnancy and relationship status, but how we work with perpetrators in this process and ensure their voice is also heard. Agencies need to be reminded of duties to involve those who have parental responsibility. Training needs to include the importance of involving fathers and extended family to fully assess risk and maximise opportunities for better outcomes. 6. Agencies need to be reminded that if the referring agencies are not content with the proposed action they must challenge the decision and if necessary escalate their concerns by implementing the *Multi-Agency Protocol for the Resolution of Professional Differences (2020)*. Senior management to reiterate this to their staff and share with Multi-Agency partners*.* 7. Panel Members must be reminded of their responsibilities in the Child Practice Review process which includes that all key professionals involved in the case are invited to the Learning Event to maximise discussion and learning. |

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| **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 | | |
| **Reviewer 1**  *(Signature)* | …………………. | | **Reviewer 2**  *(Signature)* | | …………………… |
| **Name**  *(Print)* | …………………. | | **Name**  *(Print)* | | …………………… |
| **Date** | …………………. | | **Date** | | …………………… |

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| *Chair of Review Panel (Signature)* | …………………. |
| **Name**  *(Print)* | …………………. |
| **Date** | …………………. |

**Appendix 1**: Terms of reference

**Appendix 2:** Summary timeline

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| **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.* |
| Prior to attending the Learning Event attempts were made to meet with both parents of Child X. The father to Child X unfortunately did not respond to attempts to make contact however mother was spoken to and shared her views: |

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| **For Welsh Government use only**  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 |  |  |  | |

**Template 3. Summary Timeline**

**Safeguarding Children Board** *(insert SCB name)*

**Summary Timeline**

**Re: *insert numerical case identifier***

| **Type of activity** | **­­­­­­­Date** | | | | | | **Date** | | | | | | | | | | | | |
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| **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** | | **Dec** | **Jan** | **Feb** | **March** | **April** | **May** | **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** |
| **Midwife Services** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Health Visitor** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Hospital Services** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Police** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Youth/criminal Justice** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **WAST** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **GP** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Social Services** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Housing** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Education** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| **Contextual issues** |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |

*Detailed timelines were produced by the relevant services for the purposes of the review to assist the understanding of the complex interactions between events and services in this case.*

*This summary and partial timeline contains limited and anonymised details and is provided to supplement the outline of circumstances in the Child Practice Review report.*

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