**Child Practice Review Report**

**Western Bay Safeguarding Children Board**
**Concise Child Practice Review**

**Re: WB S 9/2013**

**Brief outline of circumstances resulting in the Review:**

**Legal Context:**

A Concise 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 6.1 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:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development;

**And**

the child was neither on the child protection register nor 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[8] identifies that a child has sustained serious and permanent impairment of health and development.

*The criteria for concise reviews are laid down in the Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.*

**Circumstances Resulting in the Review**

Following notification of the serious physical abuse of an 11 year old child, and agreement by the Chair of Western Bay Safeguarding Board to undertake a Child Practice Review, a Review Panel was established in accordance with guidance. The panel was chaired by a member of Western Bay Safeguarding Board, Laura Kinsey Principal Officer - Safeguarding, Quality Assurance & Independent Reviewing and included representation from relevant organisations from Health, Police, Probation, Education and Social Care. Kathy Ellaway Designated Nurse, Safeguarding Children Service, Public Health Wales was asked to work with the panel and to undertake the review. The time period for the review is from August 2012 to August 2013, a period of 12 months leading up to the incident. Historical

information was also considered, taking into account the services provided prior to this 12 month timeline.

The Terms of Reference are included in Appendix 1.

The Chair of the Panel and the Reviewer met with the child's mother and biological father to gain an understanding of their experiences of the services offered. An invitation to meet was also given to the step father who did not respond. Consideration was given to meet with the child, and the child's social worker was approached to raise this possibility with the child, who declined a meeting. The outcome of the meetings were shared with the practitioners at the learning event held on 10th March 2014, facilitated by the Reviewer and the Strategic Business Manager of WBSCB and attended by the Chair of the Panel. A record of the learning event was made.

The Reviewer and the Chair of the panel met with family members again to share the report with them prior to publication.

This review was undertaken following the serious assault of a child. The child lived with his mother and step father and three younger half siblings. Prior to the time of the incident the child and family had historical involvement with the police, due to a number of domestic abuse incidents, and with Child and Adolescent Mental Health Services (CAMHS), Children's Services and an early intervention service, as a result of behavioural issues as perceived by the mother and step father.

In the summer of 2013, a member of the public contacted the police via a 999 call saying they "could hear a child being beaten and crying". On attendance the police found an 11 year old child with marks to the face. Child protection procedures were immediately invoked and a child protection medical that day found the child to have numerous injuries, including a characteristic slap mark to the left side of the face and bruising on parts of the body which strongly indicated physical abuse. The examining doctor concluded the child's attitude and demeanour during the medical assessment suggested the child was well used to being emotionally and probably physically abused.
At the time of this report the circumstances in which the injuries occurred is still under investigation however we now know through assessment that the child had suffered previous incidents of physical and emotional abuse.

**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*

This review identified key learning points and some areas of effective practice.

**The importance of historical information in contributing to an assessment of current situations**

The family presented to services over a number of years requesting help with the child's behaviour.

The General Practitioner (GP) referred to CAMHS service on five separate occasions, the first referral when the child was 5 years of age, the second when the child was 6 years of age, two separate referrals when the child was aged 7 years and a referral when aged 10 years. Each referral was treated as a separate one, but if previous referrals had also been considered it may have helped build a better picture of the family. Unfortunately the GP was unable to attend the learning event. The Board should ensure that the child practice review process has been fully implemented across all agencies. Within health this is relevant to both primary and secondary care services.

- During the process of preparing a timeline one agency highlighted the difficulty of finding the information as the child had a number of records which were not in a central place.

- The police held information about incidents over a number of years involving the step father. Four of these were verbal domestic incidents with his previous partner and one relating to an alleged assault against his 18 month old child (subsequently finalised as no further action). All incidents concerning the family that met the appropriate criteria were shared with Children's Services, albeit recipient agencies records did not reflect that they had received them. In the year prior to the incident that triggered this review, there had been one occasion which required a Public Protection Department referral (PPD1) that was shared with Children's Services. This incident did not meet the criteria for a referral to Multi Agency Risk Assessment Conference (MARAC).

- Education professionals in the school the child attended were not aware of the domestic abuse experienced in the family.

- At the learning event, the issue of sharing information with agencies other than social services in relation to domestic abuse incidents which do not meet the criteria for a MARAC referral was considered. Practitioners voiced confusion with regard to sharing information about domestic abuse incidents which do not meet the threshold for intervention.

- Information shared at MARAC meetings regarding school age children was not routinely being shared in the school at the time of the learning event, though there are plans to do so.

**The need for greater emphasis on issues affecting parenting capacity**

- The Initial Assessment undertaken by Children's Services focused on the child's behaviour, with the action being a referral to the early intervention service for support for parents to look at routines and behaviour management. The school said the child's behaviour was not an issue. However this continued to be the focus for the intervention. There was no updating of the assessment by Children's Services following the closure of the case by the early intervention service. Wider factors were not considered.

- The early intervention service provided a separate worker for both mother and step father. However work was done with both parents together at the insistence of stepfather. The early intervention service was unaware of any domestic abuse history or of further anonymous referrals to Children's Services. When the family disengaged from the service the early intervention service closed the case and did not refer back to Children's Services even though there were concerns remaining around parenting. This was a missed opportunity to further assess and consider any safeguarding issues.

- The use of supervision in understanding families was recognised as an important tool by the early intervention workers at the learning event. On reflection they realised that the controlling behaviour of the step father throughout their interventions should have alerted them to consider the possibility of domestic abuse within the family.

- Mother commented to the reviewer that she would have preferred the opportunity for individual work to have been done with her, as well as together as a couple. This highlights the need to give the opportunity for women to disclose domestic abuse in a situation where they can be spoken to alone when feeling safe.

- The step father's health issues were not known to other agencies, yet did impact on his parenting capacity. It is important to seek information from involved adult services to contribute to the wider analysis of the impact on the child of any parental issues.

**The importance of listening and acting on the concerns of the community**

- Two years prior to the incident that triggered this review an anonymous referral resulted in an initial assessment being undertaken. Three months after the initial assessment there were two further calls to Children's Services from members of the public over a five day period expressing concern regarding the children. Community referrals should be taken seriously by all agencies and the value of the information they give should form part of any assessment.
- This review demonstrates the crucial involvement members of the community play in safeguarding children. It was in response to a member of the public calling 999 that resulted in the child being safeguarded the day of the incident.

**The importance of interagency working**

In this case there were examples of effective practice across agencies on the day of the incident that triggered this review:

- There was good work done by the early years' service in working with both parents however, the early years' service appeared to work separately from Children's Services.
- Child protection procedures were followed and all four children were safeguarded.

- The child had a timely medical examination and all agencies communicated effectively with one another.
- In particular the police officer attending the home used great skill in gaining the consent of the child to a medical examination which resulted in a detailed description of the abuse the child had suffered.
- The tenacity of the social worker in securing a foster care placement for a four sibling group is to be commended.

**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*:-

1. WBSCB should ensure that this report is made available to practitioners to inform practice and widen learning.

2. WBSCB should continue to raise awareness regarding safeguarding children with the general public and community via its website and other means of communication. This review highlights the role the wider community play in safeguarding children.

3. The Western Bay Safeguarding Children Board must ensure that agencies take anonymous referrals seriously and act on information provided.

4. WBSCB should ensure consistent arrangements are in place across the region for information sharing of domestic abuse incidents following submission of PPD1 from Police.

5. WBSCB should feed into the All Wales Child Protection Procedures Review Groups review of the All Wales Domestic Abuse Protocol to ensure it has sufficient focus on information sharing.

6. WBSCB should promote the expectation of a robust interface between early intervention services and Children's Services when dealing with child in need cases to ensure consideration of any safeguarding concerns.

7. CAMHS should ensure that all interventions with children and young people are recorded and maintained and easily identifiable.

| **Statement by Reviewer(s)** | | | |
|---|---|---|---|
| **REVIEWER 1** | | **REVIEWER 2 *(as appropriate)*** | |
| **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 prior to my involvement with this learning review:-<br><br>• I have not been directly concerned with the child 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 prior to my involvement with this learning review:-<br><br>• I have not been directly concerned with the child 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)* | K.D. Graway ……. | **Reviewer 2** *(Signature)* | …… |
| **Name** *(Print)* | Kathy Ellaway ……. | **Name** *(Print)* | …… |
| **Date** | 05/09/14 ……. | **Date** | …… |

| | |
|---|---|
| *Chair of Review Panel (Signature)* | Nick Jarman |
| **Name** *(Print)* | Nick Jarman |
| **Date** | 18 December 2014 |

**Appendix 1**: Terms of reference

**Western Bay Safeguarding Children Board**

**Terms of reference for Concise Review WB S 9/2013**

**A case of a child being physically and emotionally abused.**

Index Child: Child 1 D.O.B 02

**Scope of Review:** August 2012 – August 2013

Internal Reviewer - Kathy Ellaway
Chair of Panel - Laura Kinsey

**Panel Members Included from the Following Agencies:**

South Wales Police

City & County of Swansea Housing

Western Bay Safeguarding Boards

City & County of Swansea Social Services

City & County of Swansea Education

ABMU HB

**Core tasks**

• Determine whether decisions and actions in the case comply with the policy and procedures of named services and LSCB.
• Examine inter-agency working and service provision for the child and family.
• Determine the extent to which decisions and actions were child 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.

**In addition to the review process, to have particular regard to the following**:

• Were referrals/incidents/observations appropriately reported to in line with intra/interagency procedures?
• Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances? How did that knowledge contribute to the outcome for the child?
• Which interactions worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child? Was the protocol for professional

disagreement invoked? Were the respective statutory duties of agencies working with the child and family fulfilled?
• Were there 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?
• Were the statutory duties of all agencies fulfilled?

**Specific tasks of the Review Panel**

• Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and extended reviews.
• 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 reviewer/s 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 reviewer/s contact arrangements with the child and 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 LSCB 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.

**Tasks of the Local Safeguarding Children Board**

• Consider and agree any Board learning points to be incorporated into the final report or the action plan.
• Review Panel complete the report and action plan.
• LSCB send 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 Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
• Plan publication on LSCB website.
• Agree dissemination to agencies, relevant services and professionals.
• The Chair of the LSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

## Appendix 2

| CPR Timeline Including Historical Involvement | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summer 2002** | **Summer 2008** | **Winter 2009/10** | **Autumn 2010** | **Summer 2012** | **Autumn 2012** | **Winter 2012** | **Spring 2013** | **Summer 2013** |
| Health Appointment | CP Medical assessment for sibling | Poor school attendance | Anonymous referral to Social Services | GP Referral to CAHMS | Request to housing for maintenance works at the home | PPD1 referral following domestic abuse incident | Attended A&E | Anonymous 999 call re hearing a child being harmed. PPD1 Referral |
| Neighbour dispute | 13 x health appointments at eneuretic clinic | Anonymous referral to Social Services | Early Years Development Team undertake intervention | Referral not accepted; CAHMS advised GP did not follow correct procedure. | Mum asked school to make a referral re ADHD | Annual Gas Service at the home | Attended follow up hospital appointment | CP processes initiated |
| Behaviour Assessment by CAMHS | PPD1 Referral | IA undertaken and referral to Sure Start | Early Years Development Team withdrew as parents did not engage | | School gave CAHMS telephone number to Mum | | | Medical Assessment |
| Poor School attendance | CAHMS referral | Anonymous referral to Social Services | Housing contacted SS regarding concerns of neighbourhood disputes | | | | | |
| CAHMS referral | CAHMS referral | | Barnardos work undertaken in school with child | | | | | |
| PPD1 | Mother called NHS direct re behaviour | | Referred Housing Tenancy Support Unit, no engagement with service | | | | | |
| Sure Start referral | IEP Review in school | | Housing inspection undertaken | | | | | |
| CP medical | | | | | | | | |
| **Summer 2008** | **Autumn 2009** | **Autumn 2010** | **Winter 2010** | **Autumn 2012** | **Winter 2012** | **Spring 2012** | **Summer 2013** | **Summer 2013** |

**For Welsh Government use only**

Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

| **Agencies** | **Yes** | **No** | **Reason** |
|---|---|---|---|
| CSSIW | ☐ | ☐ | |
| Estyn | ☐ | ☐ | |
| HIW | ☐ | ☐ | |
| HMI Constabulary | ☐ | ☐ | |
| HMI Probation | ☐ | ☐ | |