CWM TAF SAFEGUARDING CHILDREN BOARD

Child Practice Review Report

Cwm Taf Safeguarding Children Board

Concise Child Practice Review

Re: CTSCB 3/2014

Concise Review	☒
Extended Review	☐

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*

A Concise Child Practice Review was commissioned by Cwm Taf Safeguarding Children Board in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews (2012).

The criteria for this Review were met under section 5.1 of the above guidance namely where 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[4] identifies that a child has sustained serious and permanent impairment of health and development.

• The purpose of a review is to identify learning for future practice and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and family. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency child protection practice.

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This review was commissioned following the death of a child, aged 17 months; an only child. Prior to the death, the child and the family only had involvement with the normal health services and the mother was viewed as being competent, caring and having effective support from wider family.

An ambulance was called to the family home in September 2014 following a report that the child had fallen down the stairs. The child was admitted to hospital in emergency circumstances and later transferred to a specialist regional hospital where the child died the following day. When at the hospital, a medical examination and a scan revealed a serious non accidental head injury. The child protection procedures were immediately invoked.

The time period for this review is between September 2013 and September 2014. This covers the year prior to the child's death. The Terms of Reference for the Review are attached as ***Annex 1*** and the summary time line is attached as ***Annex 2***.

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

1. Following thorough examination of the timelines prepared by each agency no safeguarding issues were identified for multi agency practice, therefore it was agreed a learning event would not be held in respect of this Child Practice Review. The child and family only received normal health services; consequently there were no practitioners involved with the child on a multi agency basis to enable such an event to be held.

2. The investigative and legal processes have now been completed and the Child Practice Review has taken account of the findings. It has concluded that there is no additional information for the review to consider about professionals' involvement with the child.

3. Safeguarding Children Boards need to engage with the community to enhance the confidence in reporting safeguarding concerns and raise awareness of the arrangements that are in place to ensure safeguarding concerns about children are shared effectively. During the course of the legal proceedings concerning this child it became apparent that members of the community may have had safeguarding concerns for the child which professionals were not aware of.

Effective practice

- Welsh Ambulance Services NHS Trust arrived at the family home within 5 minutes of the 999 call.

- Although there were a number of incidents in relation to mother's partner, involving a range of different individuals, which were dealt with by police; on the single occasion when the child was linked to an incident, an appropriate notification was sent to other agencies, even though the matter did not fall within domestic abuse procedures.

- Health issues of mother's new partner were known to his GP. As the GP practice was different to the mother and child's GP practice, these health issues were not known to the Health Visitor and GP providing care for mother and her child. However, when mother's health visitor became aware of the new relationship at a home visit, she did contact the new partner's previous family health visitor to ask if there were any concerns.

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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. As part of the annual stakeholder event Cwm Taf Safeguarding Children Board should ensure there is a focus on how the Community and the Board work effectively together to safeguard children across the region.

2. As part of National Safeguarding week planned for November 2016 which is to include all Safeguarding Children Board across Wales consideration should be given to including a focus on the key role played by the Community in safeguarding children.

Statement by Reviewer(s)	
REVIEWER 1 Kathy Ellaway	**REVIEWER 2** Liz Pearce
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

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