Child Practice Review Report

Western Bay Safeguarding Children Board

Extended Child Practice Review

WB B 3/2013

Brief outline of circumstances resulting in the Review:

Legal Context:

An Extended 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 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

The criteria for extended reviews are laid down in revised regulations, *The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012*

Circumstances Resulting in the Review:

This Extended Child Practice Review (ECPR) was commissioned following a recommendation from the CPRMG of the WBSCB. It was noted the concerns for this family had been raised by The Children's Guardian during Court Processes. The

Guardian identified the situation for these children warranted a 'Serious Case Review' (SCR now CPR). The CPMRG noted this was not the appropriate manner for a case to be identified to meet the requirements for a Review in that this should have been referred to the CPMRG via the WBSCB. At the CPRMG meeting it was agreed that the criteria was met for an Extended Child Practice Review.

This review involved a family of 5 children with the index child for the Review being born with significant complex health needs in 2009. The child's siblings were born in 2010, two in 2011 and a half sibling was born in 1997. The family did not engage with health professionals in a consistent fashion to the benefit of the index child. The child was not taken to many of the necessary appointments and services appropriate and offered to the family for the child were not taken up. The family had been considered as a 'family in need' (as per health visiting assessment) since spring 2010 after the index child was born, due to 'poor home conditions'. The child's details were entered onto the Child Protection Register - along with those of its siblings - in the autumn of 2011 under the category of neglect. Despite intensive work by agencies the parents were not able/or motivated to sustain any small improvements made in the care of the children.

It was noted that Portage considered it impossible to undertake work within the family home due to the conditions, and their support was given in a clinical setting. The eldest child's details were removed from the Child Protection register at the first Review Conference.

In the spring of 2012 the eldest child was assaulted by his step father and at an Initial Child Protection Conference, the child's details were entered onto the child protection register under the categories of physical abuse and neglect. Professionals considered the child was a 'scape-goat' for the situation in the family. In the summer of 2012 the local authority issued proceedings for all children. Conditions in the family home remained poor, and in the autumn the parents agreed for the children to be accommodated under s.20 of the Children Act1989.

At the first meeting of the Child Practice Review Panel (CPRP) it was agreed that the scope for this ECPR would be 1 year before the index child was placed on the Child Protection Register up until the child was removed from the register i.e. autumn of 2010 to autumn 2012.

Practice and organisational learning

Two learning events were facilitated by the Reviewers, one for the Practitioners and one for Line Managers.

Practitioners' Learning Event

- Ensuring Practitioners are properly prepared for Learning Events:

It was clear to the reviewers at the beginning of this practitioners learning event that certain staff members had not received appropriate preparation to attend and were

anxious expecting it to be ‘about blame’.

There were a number of themes identified during the event.

Practitioners noted the following:

The Complexities of Neglect

- The need for a clear and defined definition of Neglect and a suggestion was made to use the definition of Neglect under UN Convention on the Rights of the Child.
- Neglect is not ‘specific’ and far too ‘loose’ and open to interpretation and asked, ‘How long does neglect have to be present in order for it to be ‘persistent’?
- There is a need for ‘professional challenge’ to the persistency and severity of neglect
- There needs to be an agreed understanding of the thresholds for neglect and what is good enough for all children, rather than accepting a perceived norm for a community/locality.
- The reviewers considered it very significant that a practitioner had stated it was impossible to undertake her work within the family home.

Chronologies

- It would be especially helpful for a multi-agency chronology to be developed, for all agencies to access and contribute to; this would allow the recognition of each agency’s perspective of the situation.

Assessments

- The need for ‘Holistic Assessment of the family’, as well as assessments for individuals within the family. It was noted the Framework for the Assessment of Children in Need and their Families addresses this.
- It was identified that Core Assessments are often understood to be the domain of the Social Services, and held by them whereas all agencies working with families should have a copy of the completed Core Assessments.
- Referrals made by other agencies into social care have often been assessed by a qualified member of staff in that agency and therefore it is inappropriate for an unqualified practitioner to make a decision of ‘no further action’.
- It was noted that Social Work Assistants had been completing initial assessments. This is inappropriate and has been identified as poor practice in previous Serious Case Reviews. Assessments must be undertaken by qualified Social Workers.

Escalating concerns

- Staff within all agencies, need to have attempted to address issues/differences of opinion before formally escalating concerns. It was explained during the training event that it is not necessary to gain ‘consent’ from the family to escalate professional concerns.

- It was identified there is a policy for resolving professional differences and that

practitioners need to invoke this policy in situations where there is a difference of opinion into the level of concern. There needs to be clear evidence of the rationale and decision making when concerns are escalated via supervision to Senior Managers.
- There is a need for better understanding of the legal processes open to professionals.

Legal Surgery

- Practitioners noted difficulties in taking cases to 'Legal Surgery' and having their concerns heard. Practitioners were of the opinion this case could not have been taken any earlier as it would not have met the criteria for 'Legal Surgery'. They considered the advice would have been that the threshold was not met. Practitioners said "*you need to have tried 'everything' before taking a case there".*

Work Load Pressures

- Unreasonable expectation of working levels of frontline staff.

  This included working many hours in excess of their contacted hours (with it being identified this could be up to 70hrs a week on occasions) and having caseloads well above those recognised as appropriate. There was an acknowledgment that this is considered to be unsafe practice both for the practitioners and their clients.

Record Keeping

- It was noted that the 'Primary' records of visit are those that are completed at the time of visit – but these records are not in an acceptable format for Court/Legal proceedings which causes a duplication of effort to suit both requirements.

Child Protection Conferences

- GP & Consultant Paediatricians attending Child Protection Conferences - it was acknowledged this can be a difficulty when conferences are convened during surgery hours etc. but that it is important to have information from them and for them to have the information from the Conference. It was noted the GP did not recognise the fact these children were at Risk.
- There is a need for engagement of all staff involved with a case at Child Protection Conferences and their opinions listened to.
- It was noted the quality of child protection conference minutes varies and that it can be several weeks before minutes are distributed, this delay is not acceptable.
- Due to the 'banding' of some health staff, these staff can visit a family but 'cannot' attend a Child Protection Conference. I.e. Flying Start and Early Years Advisors. Therefore it was considered, the appropriateness of relevant staff attending these case conferences needs to be addressed and should not be based on agency hierarchy but based on direct contact with child or family.
- Opinions of all staff are valuable and should be listened to and respected, especially those working directly with the family, for example, Family Support Staff.

Information Sharing

The sharing of information in a timely and effective manner is imperative to the safety and wellbeing of children. Practitioners noted the following:

- Health staff stated they are often unaware of the intervention of services and support to families.

- Difficulties for professionals accessing a variety of information about an individual or family. It was noted that 'Myrddyn' (Health IT system) is being rolled out to all departments across the Health Service over the next 12 to 18 months.

- Health Visitors experienced difficulties in accessing records from GP's as Health Visitors are not always based in GP Surgeries.

- Professionals said they don't have the 'time' to access the information (Social Services & Health).

- Education advised that It would be beneficial to be able to cascade/share/collate information in more timely way

- Professionals are unable to share information quickly and efficiently for the benefit of a child/family.

Being clear who you are talking to

- It was identified that some Social Work Assistants will refer to themselves as a Social Worker and this is clearly unacceptable and must be addressed. It is essential staff members identify themselves accurately and not relying on people's assumptions of their role. When sharing information over the phone it is essential people know who they are actually talking to.

Was not Brought v Did not Attend

It was recognised that the index child was in need of a number of services but due to the parents failure to take the child to appointments the child was therefore discharged from the service as 'did not attend'.

There was a lack of awareness of the provision of Child Assessment Orders under s.43 of the Children Act 1989 and whether consideration had ever been given to invoke such an order. It was discussed as to whether such consideration should have been explored for the index child.

Being clear in Reports

Practitioners felt there is a need for training in report writing and use of appropriate language. Language needs to be more descriptive...e.g. what does 'poor home conditions' really mean?

Timescales

- The view was expressed that the pressure of reaching Performance Indicators (PI) being met is detrimental to the quality of work and services offered to families.

Sharing information by secure Email

- When information is to be emailed use 'secure email' i.e. CJSM accounts.

The Motivation for families to 'Change'

- There was discussion about the difference between cooperation and compliance. Practitioners need to ensure families understand professional concerns in relation to the child protection processes in order for them to make changes. Questions were raised

    1. Did these parents understand professionals' concerns and the need to change?
    2. Did they believe they needed to change? Or were they too lazy or didn't consider they needed to change?

- For these parents, it appeared there was a level of compliance rather than cooperation and a lack of understanding of the need to change. Training in the '7 Steps to Determination' would be useful (Assessment of Parental Motivation to Change' by Jan Howath & Tony Morrison in: Jan Horwath (ed.) (2001) The Child's World. London: Jessica Kingsley.

Eldest Child Views

- The Reviewers met with the eldest child prior to the learning event and he was clear in his views that his parents knew what they needed to do, but just couldn't be bothered and were lazy. He felt visits should have been unannounced so staff could see it as it really was. He showed great insight into their behaviour.

Understanding the roles and responsibilities of other professionals

- During the learning event practitioners identified they did not always understand the roles and responsibilities of other professionals. In order to work effectively with others it is essential roles and responsibilities are clearly understood

<u>Managers Learning Event</u>

Managers identified the following:

Sharing Perspectives of Managing the Case

- It was noted that during the period of the review five health visitors had been involved with the family. The Clinical Nurse Specialist (CNS) noted she had 30 staff to supervise on a 4 monthly basis and the nature of the cases being brought to

supervision meant it was difficult to fit all they needed to discuss into the time allocated per session. On reflection it was considered the family should have been referred earlier ... as soon as the index child was born.

- The father was seen as hostile, and mother was seen as not taking on board information.

- The need to challenge male family members who are perceived as the decision makers in their family.

- Social Care managers noted that current practice would be for this family to be taken to 'Legal Surgery' at the time of the second Review. At that time practitioners were not sure about what the threshold was to take something to Legal Surgery. It was noted practitioners are nervous about referring cases into the Court arena and that neglect is always a difficult issue to combat in the Court arena.

- There was a perceived pressure from senior management to put priorities on to other cases and some cases were then closed as they were seen to be 'quiet cases'.

- When there are perceived issues with one child in a family the other children's care needs to be assessed as they are being parented by the same parents.

- There was a sense of optimism with this family as, at times they appeared to be working with professionals and there would be some improvement for a while (but yo-yo improvement).

- It was noted that it was following the physical assault of the eldest child that the level of concern escalated; this raised the question as to how long the neglect would have been allowed to continue if the physical assault had not occurred.

- It was noted that the birth of the two youngest children had a huge impact on the family, which 'tipped the balance' from being 'just good enough' to not coping.

- On reflection managers noted that there should have been focus on whether the family had the potential to change and whether the family could understand the advice and information given.

- There was a culture in the Local Authority of some staff working over and above contracted hours and taking work home.

- It was noted that some staff were carrying caseloads which were considered to be excessive. It is noted that currently case loads are more manageable.

- Meeting Performance Indicators was the priority for Senior Managers rather than the quality of interventions.

- There is a need for the recognition of complexity vs. numbers in caseload distribution.

- A need for support, mentoring and training for new and existing team managers.
- Making time to learn from successes rather than always having to learn from mistakes so we repeat what went well.

- Managers considered there was a lack of support for managers, including supervision.

Effective practice in inter-agency collaboration

- There was an agreement by agencies and practitioners working with this family that the threshold for neglectful care was met.

- There was a consistency in Social work intervention

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- Professionals did communicate with each other and there was a consistency in approach.

The children were seen regularly by professionals.

Improving Systems and Practice
• Adopting the Neglect Assessment Tool which is being used in other areas of Wales: *Staff need a tool across agencies to be able to help them 'measure' neglect and to identify which areas of parenting are neglectful so they are able to target these areas in plans to work with families.* • Did Not Attend (DNA) should be changed to 'Was Not Brought': *This has been identified in previous SCR's and has been recognised by the ABMUHB, compliance to the term 'Was not Brought' should be monitored, and children followed up as required to meet their identified health needs* • 'Child Assessment Orders' awareness training: *An understanding of the provisions of such an order needs to be understood and consideration be given to invoking such an order when the above is not successful.* • Training on Assessment of Motivation for Parental Change which should include practitioners being able to understand and respond to different types of parental behaviours (e.g. disguised compliance): *It was made clear during the learning event that such training would be advantageous and noted that this does not have to be a 'long' training session – could be provided*

within a Team Meeting and supported through staff supervision.

- Training on the Role of 'Fathers' in families:

Both Practitioners and Managers identified the father in this family was the 'gatekeeper' as to what would or would not be done yet he was difficult to engage in any meaningful way.

- Ensuring Practitioners understand how and when to use the Escalation of Professional Differences Policy:

This has been identified before in Serious Case Reviews (SCRs) and needs managers to ensure their staff are aware of and understand the provisions of this policy.

- Social Work Assistants (SWA) must not lead other professionals to believe they are qualified workers

- Initial assessments must be undertaken by qualified workers:

SWA's undertaking initial assessments has been identified as not being appropriate in previous SCRs across the WBSCB area. This was a recommendation of SCR WD which was presented to and accepted by the Western Bay Safeguarding Children Board in 2013. It should be noted social work assistants are not registered with a professional body.

In addition the importance of appropriately trained professionals undertaking Assessments was identified in 3 SCRs in the Western Bay region (M1 and M2, Child N and Child P).

- A balance need to be achieved between Performance Indicators v Quality of Interventions:

Practitioners are under constant pressure to meet time scales and they consider this impacts on the quality of their interventions with families.

- There is a need for support, mentoring and training for Line Managers:

It was identified newly appointed managers in Social Care have little support in adapting to their role.

- The Social Work Case Management System requires a balance between engagement and families and addressing child protection concerns:

(i)The Social Workers presented as working in a case management system that had focus on 'evidence' gathering, whereas this is an essential component of the child protection system, a balance needs to be found in intervention that best engages parents whilst also addressing child protection concerns.

(ii) The social worker case management system gave minimal opportunity for Social Workers to achieve 'critical thinking' and reflection on key child protection issues.

- Multi-agency thinking through risk:

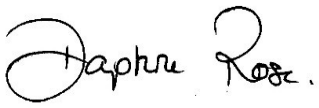
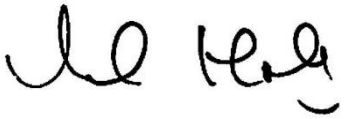
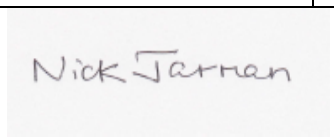
The lead child protection agency is Social Services; this does not mean that risk analysis should be deemed a single agency process and all agencies should contribute to the thinking about risk and the risk assessment process.

All Wales Child Protection Procedures must be followed so that the decision and recommendations of child protection conferences are disseminated within 48 hours of the conference. This will enable prompt and effective interventions with the family and for key information to be available for the first core group meeting.

- **Understanding each other's roles and responsibilities**

Single and multi-agency training should address the roles and responsibilities of all partners working to safeguard and protect children so professionals know what to expect of each other

Statement by Reviewer(s)		
REVIEWER 1 Daphne Rose Designated Nurse Safeguarding and Looked After Children Safeguarding Children Service Public Health Wales		**REVIEWER 2** Michael Holding Principal Officer Children's Services Swansea
Statement of independence from the case		Statement of independence from the case
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)		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.		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)*	
Chairman of the Board (Signature)			
Name *(Print)*	Nick Jarman		
Date	8.12.14		

Appendix 1:

Western Bay Safeguarding Children Board

Terms of Reference for Extended Child Practice Review

WB B 3/2013

A case of neglect of all children in the family which resulted in the index child, who had complex health needs, suffering from serious permanent impairment of health and development.

Index Child: Child 1 D.O.B. 09

Other siblings: Child 2 D.O.B. 11

Child 3 D.O.B. 11

Child 4 D.O.B. 10

Child 5 D.O.B. 97

1. Scope of Review

At the first Panel meeting it was agreed that the start date for the scope of the review would be 1 year before the birth of the index child was placed on the CP Register up until he was removed from the register i.e. 11th September 2010 to 11th September 2012

External Reviewer - Daphne Rose

Internal Reviewer - Mike Holding

Chair of Panel - Jayne MacKay replaced Amanda Hinton

Panel Members Included From the Following Agencies:

South Wales Police

Bridgend CBC, Education

Bridgend CBC, Safeguarding and Family Support

Welsh Ambulance Services NHS Trust

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:

• 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?

• Was the child protection plan (and/or the looked after child plan or pathway plan) robust, and appropriate for that child, the family and their circumstances?

• Was the plan effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?

• What aspects of the plan 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.

• SCB sends 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 SCB 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 Summary Timeline

September 2010

Family had been made CIN by Health Visitor (Since 12.03.10) due to 'home conditions' and DNA appointments. Health Visitor visits record home visits identifying poor state of home.

ChildA discharged from dietician due to DNA.

Parent's interaction with ChildA and ChildC described as 'appropriate and warm'.

Early November home visit by Health Visitor notes home conditions improved, but visits at end of November records concerns again about home conditions.

Mother cancels dietician's appointment as no money for bus.

November 2010

December 2010

Early December home conditions poor again, given a month to improve. Liaison with housing officer. No stoma bags for ChildA.

Parents don't seem to understand the importance of ChildA's investigations.

Referral made to Social Services by Doctor in relation to non-attendance.

Initial assessment completed by Day Care Support Worker.

The plan focussed on complying with health appointment, this was reflected in Health Visitor liaising with family.

'999' call recorded; neighbours describe fighting, reference to Father shouting, fighting and swearing. Explanation given (ChildC accidentally head butted father). No sign of a disturbance. (No previous history up to this point). Officers observe baby strapped in pushchair, 'children appeared well fed, albeit a little dirty and unkempt'. (Similar description for ChildB).

February 2011

March 2011

Home conditions not improved.

New Social Worker introduced.

Six health visits in March regarding missed appointments for ChildA and ChildC.

Child A in hospital for bowel operation.

CIN Review attended by parents. Focus on practical support. Childrens relationship with parents positive as was parents relationship.

New Health Visitor

Mother observed to be singing and reading books with ChildA.

Further visits in May by Health Visitor and Social Worker regarding state of house. Social Worker described house as acceptable

Mother in hospital with gall stones, father looked after children with help from paternal grandfather.

May 2011

June 2011

House clean and tidy. Slight improvements in home conditions. Joint Social Worker/ Health Visitor visit.

ChildD & ChildE born

Joint visit by Social Worker and Health Visitor in response to anonymous referral after Mother was taken into Hospital. Concerns regarding ChildA's health needs being met and general care.

Recommendation to complete another assessment.

ChildA has not attended Dietician Clinic, Dietician concerned about ChildA's appearance and poor weight gain.

Tasks set to improve home. Practical support provided.

Social Worker case transfer to new Social Workers

Reference to FST to undertake motivational interviewing with parents.

Slight improvement to home condition. Family Aid Visiting.

ChildD & ChildE reviewed in clinic, reported as well with no new problems. Development normal.

CIN Review. Regular profession contact. Plan discussed and agreed.

Reference to FST to undertake motivational interviewing with parents.

August 2011

September 2011

CIN Meeting at home.

Portage Worker concerned about home conditions ChildA described as dirty and smelly. Dad refusing any support (ChildA) and being very defensive. He says there are too many people visiting. Mother more accepting. Liaison with Health Visitor and Social Worker.

EWO talks to dad outside house about ChildB.

Dad aggressive and agitated.

ChildB not open to Social Services.

Portage meeting records high level of concern that the children are still at home, but the service will stop until home is cleaned up.

Agreed that CNS will contact Team Manager to re-visit strategy meeting.

Another neighbour referral Decision to open a new initial assessment. Strategy Meeting convened Sec 47 agreed. Initial Assessment on ChildB agreed.

ChildB interviewed and seems to be taking on a lot of caring responsibilities.

Initial Child Protection conference held. All children's names registered.

GP Report records, 'does not feel children are at risk'.

Nursery concerned about ChildA's bag being unclean and non-attendance.

November 2011

December 2011

Core assessment completed and ChildB assessed as unlikely to suffer significant harm.

Core groups held.

Home conditions worse. Health appointments continue to be problematic. Concern re ChildA's Stoma Bag.

Home conditions worse. Health appointments continue to be problematic. Concern re ChildA's Stoma Bag.

ChildA discharged from Portage due to non-attendance.

Neighbour reports concerns to support worker in relation to the children crying every night.

Review Child Protection Conference. Unanimous decision to remove ChildB name from CPR.

Social Services to take legal advice.

February 2012

March 2012

Father assaults ChildB.

ChildD & ChildE accommodated four days later.

Concerns regarding ChildA's stoma bag care remain but a core group notes significant improvement at home (although caution was noted re sustaining change).

Initial case conference on ChildB, re-registered under neglect and physical abuse.

ChildA did not attend playgroup.

Social Worker noted that family have four weeks to improve.

ChildA has operation.

Concern in relation to ChildD's head shape, abnormal due to lying in Moses basket too long when a small baby.

At the end of this period it is noted family have not attended a PLO meeting but have made progress, but unless improvement in four weeks, court proceeding will commence.

May 2012

June 2012

List of missed health appointments sent to Social Services.

Dieticians reports some improvement but ChildA still looking pale and tired.

Mother observed interacting well with ChildA.

ChildA seen with severe nappy rash. ChildC not going to nursery. Home conditions poor.

Core group reviews limited progress, contract of expectations not being adhered to.

Public Outline Meeting. Review Child Protection Conference.

ChildA has a head injury from falling; he was not taken for medical attention.

It is noted the family spend a lot of time at the home of the paternal grandmother.

It is felt that ChildB has been scapegoated for the situation by family. ChildB is doing well in school in spite of circumstances.

Local Authority decides to issue proceedings.

ChildA attends A & E with a small laceration to forehead having hit head on table.

Home conditions described as poor (Sept) ChildA grubby.
Parents agree Section 20 to accommodate, children taken into care. Foster mother reports ChildD is having great difficulty biting and chewing food.

September 2012

Appendix 3: Child Practice Review process

Arrangements for the review

This family were considered by the CPMRG where it was agreed the criteria for an Extended Child Practice Review was met.

External Reviewer - Daphne Rose

Internal Reviewer - Mike Holding

Chair of Panel - Jane Mackay replaced Amanda Hinton

Panel Members Included From the Following Agencies:

South Wales Police

Bridgend CBC, Education

Bridgend CBC, Safeguarding and Family Support

Welsh Ambulance Service Trust

Abertawe Bro Morgannwg University Health Board

Following the first Panel meeting timelines were produced by agencies and merged. It was agreed there would be two learning events; one for Practitioners and a separate on for the Managers. It was considered this would enable a full and open discussion for both groups of staff at their respective learning events.

The family were offered the opportunity to meet with the Reviewers before the Learning Events so their thoughts and feelings about the way agencies worked with them could be fed into the events. The parents did not take this opportunity. The eldest child did meet with the Reviewers in the foster carer's home. The young person's thoughts and opinions were insightful and mature, and showed an ability to reflect on the experiences of all the children. The thoughts, feelings and opinions of the eldest child were shared at appropriate points during the learning events.