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Child Practice Review Report

Western Bay Safeguarding Children Board

Historical Child Practice Review

WB S 6 2013

Brief outline of circumstances resulting in the Review

Legal Context:

A Historical 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:

In this Child Practice Review Report the parents are referred to as “mother” and “father” and the children of the family are referred to as “Child Z”, “Child Y” and “other children/baby/sibling”.

The circumstances involved:

1. The death of a baby (Child Z) and the subsequent very serious injury to the next baby born (Child Y) caused by physical abuse by the mother;

2. The responses by agencies and the courts to these events.

In 20O4, mother and father, who were born abroad and were nationals of that country, came to the United Kingdom with Other Children to claim asylum and lived in the Swansea area. On arrival they spoke no English. The application for asylum was rejected but in Autumn 2010 the Home Office granted the family indefinite leave to remain in the United Kingdom.

In 2006 Child Z was born in the UK and died just over a month later. Examination at the time of death did not identify any cause but post mortem examination findings included serious brain injuries caused on at least two occasions and bruising and bite marks to the left and right thighs.

The mother then claimed that one of her other children, 22 months old at that time, was responsible for the injuries. This explanation was supported by medical opinion at the time and accepted by the police and social services. No interagency child protection processes took place.

In 2007 Child Y was born and when aged 6 weeks was admitted to hospital with life threatening injuries. Fortunately this child survived.

The local authority commenced public law legal proceedings and Child Y was placed with foster parents under an interim care order. No interagency child protection processes took place.

In Winter 2008 a High Court Judge found that the mother had been responsible for the injuries to both children and the father had covered up for the mother.

The judge indicated that the police were not to be informed about the findings or admissions made in the proceedings by the mother. In Spring 2009 a judge directed that the police could be told about the findings, but that neither the police nor anyone else should be told that the mother had made admissions.

Lengthy and complicated legal proceedings continued with orders being made on an interim basis until Spring 2012. The proceedings were finally concluded in 2014.

Another child was born in Summer 2009. Interagency child protection procedures and processes were followed and this child was included in the proceedings relating to the other children in the family and initially placed with foster carers subject to an interim care order.

The local authority advised the court that the other children should be adopted but

during 2011 the court ordered that work be undertaken to rehabilitate the children in the family.

The parents separated and in Spring 2012 Child Y and a sibling were placed with their father under final care orders, and other children lived with their mother subject to supervision orders.

In Winter 2011 a police application to the court for disclosure of the case papers in order to consider criminal proceedings against the mother was reluctantly agreed by a judge. The police were criticised for the delay in making the application. In Spring 2014, a judge repeated the criticism of the police for the delay in applying for disclosure of case papers and in bringing a criminal prosecution.

In early 2013 the mother was charged with murder and grievous bodily harm with intent. In Winter 2013, after considering expert evidence concerning the mother's mental health when she inflicted the injuries, the mother's pleas of guilty to infanticide and wounding were accepted by the court and the Crown Prosecution Service. In early 2014 she was sentenced to a 3 year community order.

In Summer 2012 the Chair of the Swansea Safeguarding Children Board decided that a Serious Case Review should be carried out. The relevant agencies were identified and a Serious Case Review Panel was formed.

Considerable work was undertaken but the review was suspended due to criminal proceedings being taken. This issue was reviewed continuously by the Chair of Swansea Safeguarding Children Board and the delay kept to a minimum applying principles appropriate at the time.

In May 2014 the Association of Chief Police Officers and the Crown Prosecution Service published *A Guide for the Police, Crown Prosecution Service and Local Safeguarding Children Boards: Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews*. This is intended to assist the management of and encourage continuation of Reviews despite the likelihood of criminal proceedings.

The Guide includes "NOTE: In Wales the system is known as a Child Practice Review. For ease of reading, the term SCR is mainly used throughout this document but the guide is compatible with both processes."

The requirement in the Child Practice Review Process to arrange Learning Events does however present particular challenges if criminal investigations and proceedings are taking place or are contemplated.

We recommend that:

In the review of Child Practice Review processes the Welsh Government should consider including in any published guidance reference to the

application to Child Practice Review arrangements of the principles set out in the *2014 Guide for liaison and information exchange when criminal proceedings coincide with Reviews issued for England and Wales.*

From 1 April 2013 Western Bay Safeguarding Children Board became responsible for carrying out the Review, and a decision was taken that a Child Practice Review introduced under Welsh legislation and guidance with effect from January 2013 should be carried out.

It was confirmed that the scope of the Review should be from 23 July 2004, the date on which the family arrived in the United Kingdom, until 1 May 2012, when final orders were made by the High Court in relation to the children.

This has been the first Child Practice Review to be carried out that addresses historical issues over an extended period of time.

Following the decision to carry out a Child Practice Review a Child Practice Review Panel was formed chaired by Mrs Daphne Rose, Designated Nurse Safeguarding Children Service, Public Health Wales, and consisting of:

- Head of Child & Family Service, County and City of Swansea.
- Strategic Business Development Manager.
- Directorate Lawyer, Childcare Legal, County and City of Swansea.
- Manager, School Governor and Student Services, County and City of Swansea.
- Housing Options Manager, County and City of Swansea.
- Head of Operations, CAFCASS Cymru.
- Head of Safeguarding Children, Abertawe Bro Morgannwg University Health Board (ABMU).
- Detective Chief Inspector, South Wales Police.

A Writers' Panel was formed, chaired by Mrs Daphne Rose which included representatives from the following agencies;

- South Wales Police.
- Welsh Ambulance Service Trust.
- ABMU Health Board.
- Education Department, County and City of Swansea.
- CAFCASS Cymru.
- Housing Department, City and County of Swansea.
- Child and Family Services, City and County of Swansea.
- Legal Department, City and County of Swansea.

The Child Practice Review and Writers' Panels also included the Strategic Business Development Manager, Western Bay Safeguarding Children Board.

David Spicer was appointed as the Independent External Reviewer and Karen

Burrows, a senior manager with the NSPCC, as the Internal Reviewer. The Reviewers attended meetings of the Child Practice Review and Writers' Panels.

The Terms of Reference set out the purpose of the Review as to:

> "Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.
>
> 1. Identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result.
> 2. As a consequence, improve interagency working and better safeguard children."

Areas of particular focus to consider were identified as:

- The original accidental death diagnosis and whether it was appropriately addressed and tested.
- The information and communication between the family court and criminal justice processes and whether it had an impact on the safety and welfare of children.

Key issues also to be considered were:

- Ethnicity, culture, language and immigration status and its impact on practice.
- The testing of experts in court processes and its contribution to safeguarding children.
- Mental Ill Health and the impact on parenting.

The Terms of Reference for the Review required that:

> "Chronology timelines and analysis reports should be prepared and considered by the CPR Panel as the primary means of informing the learning event and fulfilling the review."

Members of the Writers' Panel were requested to produce Timeline Chronologies and provide an analysis of issues to contribute to the considerations and discussions with professional staff who were invited to attend Learning Events.

The Terms of Reference required that:

> "The CPR Panel will arrange and coordinate a facilitated learning event with the practitioners directly involved in the case where available. The learning event will be the main vehicle by which lessons are identified for learning and evidence of good practice are highlighted both of which will become the focus of the outcome report."

A Learning Event took place and despite the historical focus of this Review and length of time considered, 20 Practitioners who had been involved in the case attended. Two doctors, a Consultant Paediatrician and a Consultant Community Paediatrician and former Senior Paediatrician, were unable to attend and therefore the Reviewers met with them individually.

A Learning Event attended by 9 Managers involved in the case was also held.

The Terms of Reference required that:

> "The family will be contacted at the appropriate time by letter informing them of the Board's intention to undertake the review and make an appointment to visit to provide an opportunity to discuss the matter…."

The Reviewers met with the mother and father separately. The interviews with the parents by the Reviewers through an interpreter took place ten years after the family first arrived in the United Kingdom.

The Reviewers did not meet with the children as the Child Practice Review Panel concluded that this was not in the children's best interests.

The Terms of Reference required that:

> "The Child Practice Review Panel will consider the role of any experts or independent person in the review process including:
>
> The Judiciary;
> The Coroner."

At the conclusion of the Review Mr Spicer met with the Designated Family Judge at the Swansea Civil Justice Centre and the Coroner at his office in the Civic Centre in Swansea to make them aware of the conclusions of the Review and the proposed recommendations.

In accordance with the Terms of Reference legal advice was available on all matters relating to the review.

A Summary Timeline of Significant Events is annexed to this Report as Appendix 2.

Practice and organisational learning

The Child Practice Review has examined thoroughly the circumstances and issues that have arisen in this complex case. The events that led to the need to carry out a Review occurred in 2006 and 2007.

Unsurprisingly, many of the issues that have arisen have also been identified through other Reviews, inspections, and research and acted upon or have been

otherwise identified and addressed. Therefore, it has not been necessary to make recommendations that relate to those issues.

Circumstances Concerning the Death of Child Z

In 2014 the mother's plea of guilty to the infanticide of Child Z was accepted by the criminal court, which was satisfied on expert evidence that she wilfully killed Child Z but at the time of the act the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of Child Z.

This opinion was formed after retrospectively considering the mother's mental health in 2006 and the following years.

The Review did not find any evidence that prior to the death of Child Z any agency or professional in Wales was aware of any circumstances that suggested that the abuse and death of Child Z was predictable or that any interagency arrangements should have been in place to safeguard or promote Child Z's welfare.

Language and Cultural Issues

A primary practical issue for the workers in managing the case was language translation and interpretation.

Staff who attended the Learning Events commented on the difficulty of carrying out enquiries and addressing concerns with families who speak little or no English. Communication with the mother and father in the community and during court proceedings was carried out through interpreters.

Consistent attention to these issues is an example of good practice across all agencies, not only in matters regarding the safety and welfare of the children but with all engagements. There is evidence of planning in the selection and use of interpreters and the desire to get it right.

However, inevitably there were some problems with consistency of personnel; gender preference; availability for informal communications; one parent translating for the other and children in the family being used as translators. The case also raised cultural challenges of recognising the position of women.

It is important to confirm that there was no indication in the records of any agency that the family's immigration status adversely affected their access to services at any stage.

Research and experience indicates that the presence of these issues is not without impact. Professional staff and carers and children feel insecure about words, meanings, intentions and effects of their communication. There is also uncertainty about the extent of the understanding of English as time passes. Uncertainty about

how long the family are likely to be permitted to remain in the United Kingdom inhibits confident planning. Suggestions that different cultural attitudes might answer anxieties about culpability are difficult to investigate within a reasonable timescales.

Practitioners commented that the impact of these issues includes ensuring quality and availability of interpreters, complexities of immigration status and funding, delays in carrying out investigations and interviews, issues of conflict in a small community, lack of spontaneity and uncertainty about what if anything has been understood by the parents before questions are interpreted and answered.

They also felt that relying totally on the use of interpreters raised difficulties about dialects and whether agency terminology, technical, legal and medical terms were sufficiently understood to be translated accurately. Practitioners wondered what training interpreters receive in communicating sensitive and distressing information.

These issues make far more difficult subtle but important aspects of practice in assessing truthfulness by recognising evasiveness or pursuing contradictions or drawing inferences. Language becomes stilted and there is difficulty in pursuing issues. In court proceedings it has an impact on evidence in chief and on cross-examination.

A view put forward by practitioners, from which there was no dissent, was that it was difficult to understand the rationale for some decisions unless there had been an over-sensitivity to avoid discriminatory practice. This had been discussed privately within offices but not voiced elsewhere. Some spoke of the relief in having been able to voice and discuss these issues openly at the Learning Event.

Parents' religion and culture, and the additional complications of first generation immigration and asylum seeker status, are familiar features impacting on public service provision in Wales as in other parts of the United Kingdom as experience of working with these families is growing. The parents had links with their community but no immediate family support. They had little or no understanding of parenting thresholds and circumstances that drive the decision-making and actions of the public authorities.

We recommend that:

> **Western Bay Safeguarding Children Board should develop training and practice guidance on the issues that arise in child protection cases involving children and families from outside the United Kingdom drawing on experiences of staff involved in this case and experience in other cases and elsewhere.**

Interpreters

An Interpreter may be privy to information and knowledge about a family which is not more widely known.

They may hear exchanges between family members and may also become aware of deceits and other circumstances giving rise to risks to children's welfare, particularly if they are involved in a case for a lengthy period and have assisted a variety of professionals in different circumstances. They may also hear disclosures of abuse.

Practitioners felt that there should be clarity regarding the duties and responsibilities of interpreters acting in cases involving child protection.

We recommend that:

1. **Western Bay Safeguarding Children Board should develop guidance for staff on the issues to consider when selecting an interpreter to act in child protection cases.**

2. **The All Wales Child Protection Procedures Group should consider issuing guidance on the appointment of and duties and responsibilities and training needs of interpreters acting in child protection cases.**

Medical Examinations of Children Presented as Lifeless

When the examination was carried out by the treating paediatrician to ascertain a cause of death for Child Z, no concerns were identified and discussions with the parents took place on the basis that there was an absence of any explanation.

Subsequently the post-mortem examination identified two incidents of bleeding to the brain of different ages which could not be identified from a physical examination and bruising and bites marks.

The Reviewers' discussion with the paediatrician explored why the bruising and bite marks had not been observed during his examination.

The paediatrician could not explain why he had not observed the injuries, but suggested that bruises and marks not visible immediately after the time of death may become apparent sometime after death. The Consultant Community Paediatrician and former Senior Paediatrician commented that pathologists have given evidence in courts that bruises could possibly appear after death. Journal articles give some support for this.

The Overview Report of the Serious Case Review carried out by Coventry Safeguarding Children Board in relation to Daniel Pelka (Born 15th July 2007; Died 3rd March 2012) published in September 2013 recorded that serious injuries and gross neglect to Daniel were not identified when he was examined on presentation lifeless at hospital and were only recognised several days after his death.

Practitioners during the Learning Event for this Review suggested that two experienced paediatricians should be present at examinations immediately following

death.

The recommended practice for examinations carried out in cases involving unexpected deaths of children has received consideration since 2006. (See for example the Guidelines published by the Royal College of Paediatrics and Child Health in the Child Protection Companion in 2013 and the references therein.)

The Review has not been referred to any guidelines for examinations that take account of the possibility of bruises or other injuries inflicted before death becoming apparent sometime after death.

If there is any possibility that bruising and other injuries inflicted before death may not become visible or readily observable until sometime after death, there should be a second examination after a period of time has elapsed.

We recommend that:

> **The Royal College of Paediatrics and Child Health and the Royal College of Pathologists should publish guidance on the conduct of examinations of children who are presented at hospital lifeless but with no obvious cause of death and include a requirement that a second examination should be undertaken after an appropriate interval following presentation.**

In order to apply the learning from this Review locally while national guidance is being considered:

We recommend that:

> **Western Bay Safeguarding Children Board should establish a Working Group to develop protocols for the conduct of examinations of children who are presented at hospital lifeless but with no obvious cause of death which should include a requirement that a second examination should be undertaken after an appropriate interval following presentation.**

During the meeting with the Reviewers, the Consultant Paediatrician commented that it was not routine practice for post-mortem examination reports to be sent to the examining doctor. There is therefore no opportunity for reflection and learning and application of findings to future practice.

We recommend that:

> **The Royal College of Pathologists should issue guidance to pathologists to ensure that arrangements are made for copies of post mortem reports involving children to be routinely sent to the treating paediatrician who has previously examined the child.**

Safeguarding and Interagency Processes

Sudden Unexpected Death in Infancy (SUDI) Meeting

Two days after the death of Child Z an interagency SUDI meeting was held in accordance with Welsh Government procedural guidance. The minutes of the meeting include a conclusion that there were "no obvious CP issues."

Practitioners at the Learning Event questioned how this conclusion was reached as there was no explanation for the death, no post mortem report was available, very little was known about the family in the United Kingdom and nothing known about the family from their country of origin.

Arrangements were made for the attendees at the SUDI meeting to receive copies of the post mortem report, but no arrangements were made to meet again as required by the procedural document. It was the responsibility of every agency involved to ensure this occurred.

Practitioners at the Learning Event commented that a consequence of this early approach was that there were no safeguarding processes initiated that considered the safety and welfare of other children within the family pending the receipt of a post mortem report.

The SUDI procedures were replaced in March 2011 by the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) which set out the required multi-agency response to an unexpected death of a child or young person under the age of 18 years.

When the Guidance was launched it received considerable attention. Local Safeguarding Children Boards have arrangements in place to review the effectiveness of these procedures.

The PRUDiC Guidance was revised and re-issued in February 2014.

Appendix 9 of the 2014 Guidance sets out a Progress Review Document for use by those involved in PRUDiC meetings to ensure that relevant issues are considered. This document includes a prompt to record: "Was the child examined? If so, by whom?" There is no specific reference to any requirement for more than one examination of the child to have been carried out.

We recommend that:

Any Working Group established by Western Bay Safeguarding Children Board to develop protocols for the conduct of examinations of children who are presented at hospital lifeless but with no obvious cause of death should consider the development of a checklist of issues to be considered at PRUDiC

meetings and arrangements for it to be reviewed to take account of developing knowledge.

"Mind set"

Practitioners commented that there was an early determination to find "innocent" explanations. This has been identified as a persistent cause for concern in other Serious Case Reviews in Wales and England, and highlighted in the high profile Serious Case Review of the death of Hamzah Khan, the Overview Report for which was published by Bradford Safeguarding Children Board as recently as November 2013.

We recommend that:

Western Bay Safeguarding Children Board should review training provision and practice guidance to ensure that there is appropriate reference to the danger of early optimism inappropriately influencing the consideration of future events.

Reliance on Medical Opinion

At the Practitioners' Learning Event police officers made clear that on being notified about the death, it was treated as a suspicious death and conversations took place with the examining paediatrician.

An early indication of post-mortem examination findings indicated that Child Z had suffered serious injuries that caused the death and a police investigation commenced. The parents were formally interviewed by the police and the mother claimed that the injuries had been caused by the toddler pulling the baby from the bed.

The police wrote to the Consultant Community Paediatrician and Senior Paediatrician for Child Protection for an opinion about whether the suggested fall from the bed could explain the fatal injuries. She advised that there was likely to be an accidental explanation for the injuries and this led to the criminal investigation and child protection considerations ceasing.

Research available at the time indicated that serious injuries to babies can occur from falls from short height, but these circumstances are very rare and therefore possible but unlikely. In the subsequent legal proceedings no expert supported the view that a fall from a bed was a likely cause for Child Z's injuries and death.

In her interview with the Reviewers, the Consultant accepted that she had been misled by a family that presented as caring. She suggested that;

- Care should be exercised in distinguishing between what 'was likely' and what 'was possible'.

- When doctors are asked for opinions they need to have all the factual information in writing.

- There needed to be more communication and doctors need to know what the parents are saying not just what people think they have said.

Practitioners and the doctors commented that;

- Doctors are expected to provide a definite answer which determines whether action or no action should be taken and that their opinion is accepted without challenge.

- Other professionals should be prepared to challenge, inquire and seek explanation around the opinions expressed by doctors.

(See Report of the Victoria Climbié Inquiry published in 2003 in which Lord Laming in Recommendations 37 and 100 recommended that the training of social workers and police child protection officers must equip them with the confidence to question the opinion of professionals in other agencies including doctors, no matter how eminent those professionals appear to be.)

Cases will occur in which there cannot be a definitive opinion about causation and this should not lead to safeguarding considerations being abandoned. To defer to medical staff for the provision of the primary evidence to confirm or otherwise whether an injury to a child was the result of abuse or not, could be unhelpful. Even if a suggested explanation is plausible there may be other possibilities. (See the Overview Report of the Serious Case Review carried out by Coventry Safeguarding Children Board in relation to Daniel Pelka published in September 2013).

The Learning Events and discussions with the doctors emphasised that:

- Doctors should not rely on information they are given as being factually correct and it should be clear what is known to have happened and what is a suggested mechanism for injury; the source and status of information needs to be clear.

- Questions to medical staff need to be carefully framed.

- Doctors need to take a more forensic approach to giving an opinion. The use of language is important - for example the distinction between “likely” and “possible” being clear.

This issue has received attention. The Directorate Lawyer in the Childcare Legal Service for the County and City of Swansea has met with appropriate medical, social services and police staff and work is being undertaken to develop a protocol that will address the involvement of doctors in child protection processes and the issues that have arisen from this Review. When the work is completed a report will be made to

Western Bay Safeguarding Children Board.

These issues have importance beyond local arrangements.

We recommend that:

When the report addressing the involvement of doctors in child protection processes is made to Western Bay Safeguarding Children Board, the Board should consider how there might be wider dissemination of any arrangements put in place.

Discussions also highlighted the difficulty that social services staff have in obtaining a second opinion if uncertain about an opinion or judgment reached by a medical practitioner.

We recommend that:

Abertawe Bro Morgannwg University Health Board should ensure that arrangements are in place to enable the Local Authority to obtain a second opinion from a suitably qualified and experienced consultant paediatrician or other specialist health professional when:

1. **the paediatrician undertaking a child protection medical is uncertain as to whether injuries or other health concerns constitute evidence of non-accidental injury or other child protection concerns; or**

2. **when social services, the police or a parent, make a request for a second opinion in order to ensure that judgments concerning the safety of a child are soundly reached.**

Failure to follow child protection procedures
Lack of Interagency Processes

Practitioners highlighted that;

- No child protection referrals were made, no formal enquiries carried out under s47 Children Act 1989, or interagency procedures followed until a child protection conference was held in Winter 2010.

- Now the same circumstances would be expected to give rise to child protection processes.

- The practice was consistent with a widespread approach at the time, particularly if emergency court action was taken, that as court proceedings were being taken the welfare of the children would be addressed within that process and interagency safeguarding procedures did not take place.

- This failed to recognise that family court processes form part of the interagency framework for safeguarding children and are not a substitute for it.

- It failed to take account of the wider aspects of children's welfare and the need for professionals involved with the family to be aware of the circumstances and able to challenge the approach.

- Some practitioners were uneasy with the approach but had no forum in which to voice concerns.

- Professionals involved for a considerable time were unaware of events affecting and decisions made in relation to the children.

- There was uncertainty about what information secured for and from the court proceedings could be shared with other agencies by the Local Authority and there was no interagency forum for doing so.

Interagency procedures do not themselves protect children but they provide a framework, often developed in response to a tragedy or are based on good child protection practice research and theory.

These issues have been thoroughly considered within Serious Case Reviews carried out by the Swansea Safeguarding Children Board considering circumstances that arose at a similar time to these events and robust recommendations to address the issues were accepted and acted upon. Cases have been subject to audit and review. (See the Executive Summary of the Overview Report of the SCR concerning Child F published April 2014.)

No recommendations are therefore necessary concerning these issues.

Lack of background information

Practitioners commented that throughout the period of Review:

- Despite extensive court proceedings there was little or no information available concerning the family circumstances in the country in which they lived prior to arriving in the United Kingdom.

- There is no reliable way to discover details about backgrounds that in other circumstances would be available and essential in carrying out any assessment of risk of the safety of young children.

- Assessments that took place relied on the parents' accounts of their lives in their country of origin.

- No medical histories were available.
- That if something is not known there is a tendency "to assume it is ok".
- Professionals need to test the presentation and accounts given by parents.

The importance of information about background being accessed wherever it may be and not assuming it is positive if it is not available has been addressed in other Serious Case Reviews that have been carried out by Swansea Safeguarding Children Board and other Local Safeguarding Children Boards and further recommendations concerning this issue so far as it relates to cases the circumstances of which concern families from the United Kingdom are not necessary.

However, cases involving families or some members of a family who are from countries other than the United Kingdom give rise to additional issues. (See The Climbié Report 2003; the All Wales Child Protection Procedures 2008).

The importance of having arrangements in place will increase as the number of families from other countries grows.

We recommend that:

Any training, other learning provision and practice guidance developed by Western Bay Safeguarding Children Board concerning child protection cases involving children and families from outside the United Kingdom should include reference to:

1. **The need to secure as much information as possible regarding the background of a family or individual wherever it exists.**
2. **Guidance on how to access information held outside the United Kingdom.**
3. **The need to ensure that if information is not available there is not an assumption that the history is positive.**

Child Focus

Practitioners commented that;

- There is little evidence of direct work having been undertaken with the children in the period before and immediately following the commencement of the care proceedings concerning circumstances within the household.
- There was an apparent readiness to accept an explanation from the mother that one of her children was responsible for causing the death of Child Z.
- The family descriptions of one of her children's unruliness and difficult

behaviour continued but did not accord with the experience of the professionals in the community.

- There should have been consideration given to assessing the risk to the other children, and removing them from the household when Child Y was seriously abused.

- Community professionals and agencies remain unaware of what consideration this received in the court proceedings and made no contribution to any judgments relating to it.

- The oldest child appeared invisible in the processes.

Ensuring that children remain the focus of child protection work has continued to be a persistent feature in Serious Case Reviews nationally. Action has been taken locally to address this issue. For 3 years, Swansea Child and Family Services have been implementing the Signs of Safety Safeguarding Practice Framework. This places the voice of the child at the heart of practice, through the use of practice tools such as “three houses” and “words and pictures” safety plans, and is a strength’s based model of child protection practice.

The initiative has been acknowledged as leading development of practice in the United Kingdom and attracted positive references in The Munro Review of Child Protection (in England): A child-centred system (2011).

Monitoring that the focus on the child has been maintained is a feature of the programme of audit of child protection cases reviewing practice standards, significant findings from which are reported to Western Bay Safeguarding Children Board. Interagency training also addresses the need to retain this focus.

We recommend that:

Western Bay Safeguarding Children Board should consider the action taken by agencies across the Western Bay Region to ensure that safeguarding practice maintains a focus on children.

Obesity as a Safeguarding issue

One of the children was over-weight and this was identified as a serious health issue when a toddler in 2005 and continues to have life-long health implications.

When reviewing the whole period considered by the Review the Practitioners expressed significant concerns that the issue had not been adequately addressed. There had been health interventions which had limited impact and there were concerns about the parent’s management of the issue.

The issue was not given any significant consideration in the court proceedings.

The management of obesity and interagency responsibility to address the issue has been highlighted in recent years accompanied by controversy.

We recommend that:

1. **Western Bay Safeguarding Children Board should develop guidance for staff on the practice and management issues and assessment of significant harm that arise when considering the impact of obesity on a child's welfare.**

2. **Public Health Wales should consider issuing guidance on the health and inter-agency management of cases and the assessment of the impact of obesity in children.**

3. **When issuing safeguarding guidance the Welsh Government should consider including guidance on the appropriate approach to and relevant issues when considering the impact of obesity on a child's welfare.**

4. **The All Wales Child Protection Procedures Group should publish guidance on the practice issues that arise when considering obesity in children.**

Family Court Processes

Practitioners commented (confirmed by judicial commentary) that the history of the court proceedings was very complex and of exceedingly long duration with very high costs.

The parents also commented on the length of the proceedings. The mother pointed out that out that four different judges had been responsible for decisions.

Practitioners commented that;

- The case illustrates many of the concerns highlighted by the Family Justice Review chaired by Mr David Norgrove in his final report published in November 2011 which recommended reform.

- Seventeen experts were instructed, which reflected an approach in the courts at the time that commonly allowed each party to instruct their own experts.

- The management of the case in the community was undertaken and controlled by the court through a long series of interim orders.

- Experts and the Children's Guardian not only provided expertise to assist the court in reaching decisions but undertook direct work with the family to bring

about change.

- Work that was thought properly the responsibility of agency practitioners was carried out through appointed court agents, and the authority of community professionals and their ability to act was undermined.

- The case was dealt with, and decisions made, like no other with which they had experience.

- The court control created an environment in which there was nervousness about what could or could not be done by local authority staff.

- The impression was of a process continuing without reference to the responsibilities of community agencies that felt detached and uninvolved and made little contribution.

- There did not appear to be any consideration of the need for information to be known by agencies in the community so that the mother's contact with other families and their children could be considered.

- The implications of mother's mental health outside the court process were not considered. If serious mental illness had not been recognised practice in the community needed to be reviewed.

- During the lengthy processes the family circumstances inevitably changed and called for revised assessments which in turn led to repeated changes of approach, and a narrowing of the options for the children, by experts and the Children's Guardian.

- The court expected services to be provided by community agencies when they were unfamiliar with the reasoning, considered the family did not meet the criteria for services and without any agreement around priorities.

- Correspondence between heads of service did not resolve this, and the local authority paid for private health services for the mother.

- Despite pressure on the local authority to accept an outcome which it did not agree was in the best interests of the children, the authority refused to change its view.

Most of the Family Justice Review Recommendations are intended to be implemented with legislative support during 2014. It is therefore unnecessary for further recommendations relating to these issues to be made in this Report.

There have been a significant number of Serious Case Reviews involving consideration of the deaths or serious harm to children whose welfare has previously

been considered by a family court. However, the family courts have no arrangements in place to take part in or contribute to Child Practice Reviews or Serious Case Reviews or, so far as the Reviewers are aware, any process to review the circumstances of individual cases in order to learn lessons about the court process.

Shortly before the completion of this Report, Mr Spicer met with the Designated Family Judge at the Swansea Civil Justice Centre in order to make him aware of the contents of the Report and the recommendations.

We recommend that:

1. **The Family Justice Council should consider how the courts might contribute effectively to the review of a case in which circumstances require a Child Practice Review or a Serious Case Review to be carried out and there has been significant involvement of legal proceedings.**

2. **A copy of this Child Practice Review Report should be sent to the Family Justice Council so that consideration might be given to whether there should be any review to identify any further lessons for the family court jurisdiction.**

Coroner Services

In August 2007 the Coroner delivered a narrative verdict in relation to the death of Child Z.

The Practitioners at the Learning Event asked what responsibility a Coroner has in relation to the information that is collected to inform an Inquest and child protection processes.

Since the Inquest concerning Child Z was held, there have been significant legislative changes. Also the Coroner who conducted the Inquest has since retired. The Review therefore did not consider the detail of the circumstances of the Inquest held in relation to Child Z.

The Coroners (Amendment) Rules 2008 included provisions that addressed the relationship between Coroners and Local Safeguarding Children Boards in England but as a result a drafting error had no impact in Wales. The Coroners (Amendment) Rules 2010 corrected this omission.

The significant provisions of the Rules provided that:

1. The Coroner has a power to report circumstances to any person who may be able to prevent, eliminate or reduce the risk of death and require a report from them with details of action taken or proposed to be taken or an explanation as to why no action is proposed.

2. The coroner must, within 3 working days of deciding to hold an inquest into the death of a child, secure that the appropriate Local Safeguarding Children Board is notified of the death. Arrangements are in place to comply with this duty.

3. A coroner may supply information relating to an inquest or a post-mortem examination to a Local Safeguarding Children Board for use for the purposes of its functions.

The Coroner's Officer attends PRUDiC meetings.

It is important that there is a clear understanding of how these responsibilities and the exercise of discretion will impact on the business of the Western Bay Safeguarding Children Board and child protection functions within the revised regional structure.

Shortly before the completion of this Report Mr Spicer met with the Coroner in order to discuss the content of the Report and proposed recommendations. The Coroner agreed with the following recommendation being made.
We recommend that:

Western Bay Safeguarding Children Board should make arrangements for liaison to take place with the Coroner in order to discuss the relationship between the functions of the Coroner Service and Local Safeguarding Children Boards and other issues relevant to child protection and inquest processes.

Disclosure Issues

The sharing of information with the police was specifically addressed and prevented by the court.

If the opinion of the Community Paediatrician in 2006 had been consistent with that formed by the experts later involved in the proceedings, it is likely that a murder investigation would have taken place immediately.

When Child Y was injured, proceedings were commenced immediately and thereafter the court prevented the local authority firstly disclosing to the police findings made in the court and subsequently admissions by the mother and the material filed in the proceedings.

Practitioners at the Learning Event described the detrimental impact this had on working relationships with colleagues. Staff from agencies attended meetings (the underpinning purpose of which reflected the need to work together) when local authority staff knew that they were aware of serious issues concerning homicide and injuries to babies but could not disclose what they knew to the police.

Eventually the local authority was permitted to disclose information in a "cautious"

manner – to disclose the findings but not the admissions. In due course the police made an application for disclosure of the case papers and permission was reluctantly granted by a judge at a hearing at which the judge insisted on a Crown Prosecution Service Director attending court and explaining why he was required to consider the evidence before making a decision on prosecuting or not in the public interest.

The information concerning findings and admissions was communicated to the Police in Winter 2010. The Police application for disclosure of the case papers was made in early Autumn 2011.

A judge delivering a public judgment early in 2014 highlighted that this was already nearly three years after the finding of fact hearing before a previous judge and that the judge considering the application for disclosure could see "no reasonable justification" for the delay which appeared to be "inexcusable."

Practitioners commented that while there had been delay it would not have been surprising if even after disclosure, given the judges' previous directions, the police were uncertain about proceeding.

These issues have arisen in other Serious Case Reviews and been the subject of recommendations in Overview Reports accepted by Swansea Safeguarding Children Board which addressed circumstances that arose during a similar time period. (See the Executive Summary of the Overview Report of the SCR concerning Child F published April 2014).

The issues have also been the subject of national consideration and the publication in October 2013 of the *Protocol and Good Practice Model: Disclosure of Information in cases of alleged child abuse and linked criminal and care directions hearings*. With the exception of paragraphs listed in the document the signatories are the Senior Presiding Judge, the President of the Family Division, and the Director of Public Prosecutions on behalf of the Crown Prosecution Service.

The Protocol was issued with the support of the Association of Chief Police Officers, HM Courts & Tribunals Service and the Association of Independent Local Safeguarding Children Board Chairs in England. The Protocol indicates that:

"The Department for Education (DfE), the Welsh Government (WG), Local Government Association (LGA) and Association of Directors of Children Services (ADCS) are not signatories to the 2013 protocol and the content of this document is not, nor does it seek to be binding on Local Authorities."

"However, the DfE, WG, LGA and ADCS support the content of this document and consider it to be a Good Practice Model, offered by way of assistance, and therefore urge all Local Authorities to adopt the disclosure practices described within the document, observance of which will improve timeliness and therefore achieve better outcomes for children and young people who are subject to the relevant

proceedings."

Consideration of these matters locally has identified that disclosure of information issues also arise before proceedings have been commenced. The Directorate Lawyer in the Childcare Legal Service for the County and City of Swansea has been working with local agencies and raised the issues with senior judges. When the work has been completed a report will be made to Western Bay Safeguarding Children Board.

It will be important to monitor the impact of the national guidance and the local initiative.

We recommend that:

Western Bay Safeguarding Children Board should make arrangements to review the impact of the *Protocol and Good Practice Model: Disclosure of Information in cases of alleged child abuse and linked criminal and care directions hearings* published in October 2013 and any processes or procedures approved by the Board concerning disclosure of information during the pre-proceedings period.

Mental Ill-health Issues

The mother's mental health was the subject of consideration by mental health experts in the legal proceedings concerning the children in order to explore the link between her mental health and the death and serious harm that she caused to her children. In 2009 a psychiatrist appointed as an expert to consider the mother's mental state advised that she was a high risk to dependent demanding children.

When a criminal prosecution of the mother for murder took place acting on advice from psychiatric experts the court was satisfied that a plea of guilty to infanticide would be accepted. The criminal judge was satisfied that her actions were caused by severe post-natal depression, and difficult social and family circumstances.

The health contribution to the Child Practice Review examined carefully whether there was evidence in health records that should have alerted health professionals to the risk of possible serious harm being caused by the mother. The records indicate that at that time she was not thought to be suffering from a condition any more serious than depression commonly experienced by some mothers after giving birth.

For the purposes of the Review no records have been identified to indicate that copies of the experts' reports were seen by local practitioners for comment or discussion.

Practitioners attending the Learning Event commented that:

- They were surprised that the mother's mental ill health was sufficient to

significantly impact on culpability for serious criminal acts.

- There were difficulties in obtaining mental health monitoring and interventions that were thought by the court to be needed but were not a priority for health agencies.

- The impatience of the court and frustration of local authority staff led to the issue being escalated to formal exchanges of different opinions between the Local Authority's Chief Officers and their counterparts in the Health Board.

- In order to move forward with the court's plan the local authority paid for private psychiatric services.

- In the community practitioners' dealings with the mother at the time she did not appear to be suffering from serious mental ill health.

During her meeting with the Reviewers, the mother spoke briefly about the reasons why she committed the harmful acts and said that it happened because of her unhappiness caused by isolation, lack of family support, living in country with another culture and another language. She did not refer to her mental health or depression.

The father said he did not think the mother was depressed and that she did not tell him or he would have helped more.
The Practitioners commented that:

- They remain unaware of the reasoning of the experts who reported to courts.

- They think it is important that they should be aware in order to be familiar with the circumstances that lead to or suggest that the mother is at risk of deteriorating mental health.

- The mother may become pregnant and have other children and community staff will need to be alert to indicators.

- They need to consider whether their practice in relation to other patients should change the light of the experts' opinions.

Practice within the family courts now expects that there will be consideration given to what material filed in the proceedings should be disclosed to agencies uninvolved in the proceedings. It appears that no similar expectation applies in criminal court proceedings, in which arguably there may be stronger issues of public interest and safety.

We recommend that:

1. **An application should be made to the judge who presided at the Crown Court trial of the mother for disclosure of the expert's reports so that**

community staff may be made aware of the assessment of the mother's mental health and any procedural or practice or guidance implications.

2. **The Lord Chief Justice should issue guidance to Crown Courts on the need to consider what material created for the purposes of criminal justice needs to be considered by community agencies and professionals because of its relevance to the safety of vulnerable children and adults.**

Discussions during the course of the Review highlighted the difficulties that arise in obtaining psychiatric or psychological services to assist with forming judgments about the dangerousness of an individual, whether or not they have a diagnosable mental illness, when such an assessment is necessary to inform effective child protection planning.

We recommend that:

Abertawe Bro Morgannwg University Health Board should ensure that arrangements are in place for appropriate mental health services to be available when a multi-agency assessment of dangerousness of an adult or young person, whether or not they have a diagnosable mental illness, and subsequent multi-agency oversight of a safety plan are required and in order that judgments concerning risk can be soundly based and plans for children fully informed.

Removal of Other Children

In 2009 the mother disclosed that she was pregnant. A psychiatric expert reported to the court that he would be profoundly worried if another baby was to be left in the care of this mother.

A Strategy Meeting was held between the Local Authority social workers and the police to consider the safety of the unborn child. A child protection conference was not convened.

There was uncertainty about what information could be shared with the police. They were informed that in the last psychiatric report to the court the mother was described as being a danger to babies but were not informed about the court's findings or the mother's admissions.

It was decided that the mother was to be supervised constantly by social services while in hospital and that within 6 hours following the birth the baby would be placed in foster care.

The decision having been taken, the practical arrangements reflected good interagency working with arrangements being made for the police to take the baby into police protection to allow an application to be made to the court if the mother

attempted to remove the baby from hospital.

The baby was removed from the mother and placed with foster parents within a few hours of being born.

During her meeting with the Reviewers, the mother was critical of the removal and claimed that it had affected her ability to bond with the baby.

The difficult circumstances of removal of a baby from the mother at or close to birth had been considered critically by Munby J in 2008 in a public judgment in which he set out the statutory, common law and human rights principles that apply and should underpin practice. (R v Nottingham City Council (2008) EWHC 152 (Admin))

In 2012 Hedley J was also publicly critical of a similar removal. (Coventry City Council v C, B, CA, CH ([2012] EWHC 2190 (Fam)).

We recommend that:

Western Bay Safeguarding Children Board should:

1. **Consider whether current practice guidance addresses sufficiently the legal and practice issues concerning removal of child from a mother immediately following the birth.**

2. **Arrange for an audit of cases that have involved the removal of child from the mother immediately following the birth to ascertain whether the principles highlighted in court judgments have been reflected in the practice.**

Reporting Restrictions

Court orders have been made that restrict the details of this case that the press may publish. The restrictions also apply to any other publication including a Child Practice Review Report.

The circumstances in which orders are made imposing restrictions include those in which it is likely that a family will be identified or identifiable and it is necessary to protect surviving siblings from the impact of publicity concerning their family background and circumstances. (See also In the matter of X and Y (Children) [2012] EWCA Civ 1500, a case involving Swansea Safeguarding Children Board and publication of the Executive Summary of the Overview Report of the Serious Case Review concerning Child F.)

The purpose of a Child Practice Review is to identify any steps that can be taken by Board partners or other bodies to bring about improvements in multi-agency child protection practice.

The purposes of publication of the Child Practice Review Report includes making the circumstances of the case, the lessons and recommendations widely available for learning by practitioners and agencies who were not involved in the case or review.

Where an order restricting publication is in place, inevitably this has the potential to inhibit the ability to maximise learning. The Review concerned with Child F was exceptional but the Overview Report was accepted by Swansea Safeguarding Children Board in July 2012 and the Executive Summary was not published until April 2014.

Dissemination of Learning

We recommend that:

Western Bay Safeguarding Children Board should consider:

1. **How the learning from this Child Practice Review might be shared and the impact on improving practice maximised not withstanding any reporting restrictions.**

2. **Arranging a conference, seminar or other learning event to assist disseminating the learning from this Child Practice Review.**

3. **Including in any conference, seminar or learning event experiences from other cases and in other areas so far as language and cultural issues are concerned.**

4. **Including in any conference, seminar or learning event the need to guard against early optimism inappropriately influencing the consideration of future events.**

Review Process Issues

It has been accepted that the circumstances of this case should have given rise to carrying out a Serious Case Review, probably when in 2007 Child Y suffered serious injuries, and certainly following the court finding in 2008 that the mother had inflicted those injuries and had killed Child Z.

There was a collective and individual responsibility on Safeguarding Children Board partners to identify cases that required review.

The reasons for the review not taking place may have been linked to the impact of the court's jurisdiction on community processes. However, the issue has not been considered fully within this Review and no recommendations are made because during the period after these events occurred, arrangements of Swansea Safeguarding Children Board improved significantly and the Western Bay Safeguarding Children Board has robust arrangements in place to identify those

cases that require a Child Practice Reviews to be carried out.

Having regard to the circumstances of this case and the statutory responsibilities of Local Safeguarding Children Boards it was clearly appropriate for the Chair of Swansea Safeguarding Children Board and Western Bay Safeguarding Children Board to decide that the case should be the subject of review. The requirement to carry out a Child Practice Review in relation to events that occurred some years previously should be rare and will as the current guidance anticipates usually concern organised or institutional abuse. As this case illustrates, some cases will concern events within a family.

As the Child Practice Review Report presented to the Local Safeguarding Children Board will be published, it follows that, when there are reporting restrictions, the Report that the Board receives is likely to be less full than if there were no restrictions.

There is a danger that the Board will receive too little information to effectively challenge and test the Report unless additional information is provided other than within the Report. This is an issue relevant to the functioning of the Child Practice Review Process generally but is more starkly illustrated in cases in which reporting restrictions are made.

The experience of applying the guidance to this Review has led to the following recommendations.

We recommend that:

When reviewing the Child Practice Review guidance the Welsh Government should consider:

1. **Reviews involving historic circumstances and address more specifically historic cases arising in families.**

2. **The criteria for carrying out a Child Practice Review and include circumstances in which it appears that a child's name should have been on the child protection register and/or the child should have been a looked after child.**

The need for Local Safeguarding Children Boards to receive sufficient information to evaluate the quality of the Child Practice Review and the Report.

Improving Systems and Practice
1. In the review of Child Practice Review processes the Welsh Government should consider including in any published guidance reference to the application to Child Practice Review arrangements of the principles set out in

the 2014 Guide for liaison and information exchange when criminal proceedings coincide with Reviews issued for England and Wales.

2. Western Bay Safeguarding Children Board should develop training and practice guidance on the issues that arise in child protection cases involving children and families from outside the United Kingdom drawing on experiences of staff involved in this case and experience in other cases and elsewhere.

3. We recommend that:

    - Western Bay Safeguarding Children Board should develop guidance for staff on the issues to consider when selecting an interpreter to act in child protection cases.

    - The All Wales Child Protection Procedures Group should consider issuing guidance on the appointment of and duties and responsibilities and training needs of interpreters acting in child protection cases.

4. The Royal College of Paediatrics and Child Health and the Royal College of Pathologists should publish guidance on the conduct of examinations of children who are presented at hospital lifeless but with no obvious cause of death and include a requirement that a second examination should be undertaken after an appropriate interval following presentation.

5. Western Bay Safeguarding Children Board should establish a Working Group to develop protocols for the conduct of examinations of children who are presented at hospital lifeless but with no obvious cause of death which should include a requirement that a second examination should be undertaken after an appropriate interval following presentation.

6. The Royal College of Pathologists should issue guidance to pathologists to ensure that arrangements are made for copies of post mortem reports involving children to be routinely sent to the treating paediatrician who has previously examined the child.

7. Any Working Group established by Western Bay Safeguarding Children Board to develop protocols for the conduct of examinations of children who are presented at hospital lifeless but with no obvious cause of death should consider the development of a checklist of issues to be considered at PRUDiC meetings and arrangements for it to be reviewed to take account of developing knowledge.

8. Western Bay Safeguarding Children Board should review training provision and practice guidance to ensure that there is appropriate reference to the

danger of early optimism inappropriately influencing the consideration of future events.

9. When the report addressing the involvement of doctors in child protection processes is made to Western Bay Safeguarding Children Board, the Board should consider how there might be wider dissemination of any arrangements put in place.

10. *Abertawe Bro Morgannwg University* Health Board should ensure that arrangements are in place to enable the Local Authority to obtain a second opinion from a suitably qualified and experienced consultant paediatrician or other specialist health professional when:

    - the paediatrician undertaking a child protection medical is uncertain as to whether injuries or other health concerns constitute evidence of non-accidental injury or other child protection concerns; or

    - when social services, the police or a parent, make a request for a second opinion in order to ensure that judgments concerning the safety of a child are soundly reached.

11. Any training, other learning provision and practice guidance developed by Western Bay Safeguarding Children Board concerning child protection cases involving children and families from outside the United Kingdom should include reference to:

    - The need to secure as much information as possible regarding the background of a family or individual wherever it exists.

    - Guidance on how to access information held outside the United Kingdom.

    - The need to ensure that if information is not available there is not an assumption that the history is positive.

12. Western Bay Safeguarding Children Board should consider the action taken by agencies across the Western Bay Region to ensure that safeguarding practice maintains a focus on children.

13. Western Bay Safeguarding Children Board should develop guidance for staff on the practice and management issues and assessment of significant harm that arise when considering the impact of obesity on a child's welfare.

14. Public Health Wales should consider issuing guidance on the health and inter-agency management of cases and the assessment of the impact of obesity in children.

15. When issuing safeguarding guidance the Welsh Government should consider including guidance on the appropriate approach to and relevant issues when considering the impact of obesity on a child's welfare.

16. The All Wales Child Protection Procedures Group should publish guidance on the practice issues that arise when considering obesity in children.

17. The Family Justice Council should consider how the courts might contribute effectively to the review of a case in which circumstances require a Child Practice Review or a Serious Case Review to be carried out and there has been significant involvement of legal proceedings.

18. A copy of this Child Practice Review Report should be sent to the Family Justice Council so that consideration might be given to whether there should be any review to identify any further lessons for the family court jurisdiction.

19. Western Bay Safeguarding Children Board should make arrangements for liaison to take place with the Coroner in order to discuss the relationship between the functions of the Coroner Service and Local Safeguarding Children Boards and other issues relevant to child protection and inquest processes.

20. Western Bay Safeguarding Children Board should make arrangements to review the impact of the *Protocol and Good Practice Model: Disclosure of Information in cases of alleged child abuse and linked criminal and care directions hearings* published in October 2013 and any processes or procedures approved by the Board concerning disclosure of information during the pre-proceedings period.

21. An application should be made to the judge who presided at the Crown Court trial of the mother for disclosure of the expert's reports so that community staff may be made aware of the assessment of the mother's mental health and any procedural or practice or guidance implications.

22. The Lord Chief Justice should issue guidance to Crown Courts on the need to consider what material created for the purposes of criminal justice needs to be considered by community agencies and professionals because of its relevance to the safety of vulnerable children and adults.

23. *Abertawe Bro Morgannwg University* Health Board should ensure that arrangements are in place for appropriate mental health services to be available when a multi-agency assessment of dangerousness of an adult or young person, whether or not they have a diagnosable mental illness, and subsequent multi-agency oversight of a safety plan are required and in order that judgments concerning risk can be soundly based and plans for children fully informed.

24. Consider whether current practice guidance addresses sufficiently the legal and practice issues concerning removal of child from a mother immediately following the birth.

25. Arrange for an audit of cases that have involved the removal of child from the mother immediately following the birth to ascertain whether the principles highlighted in court judgments have been reflected in the practice.

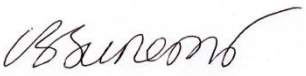
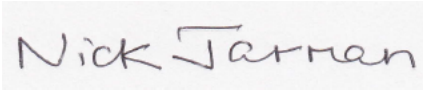
26. Western Bay Safeguarding Children Board should consider:

- How the learning from this Child Practice Review might be shared and the impact on improving practice maximised not withstanding any reporting restrictions.
- Arranging a conference, seminar or other learning event to assist disseminating the learning from this Child Practice Review.
- Including in any conference, seminar or learning event experiences from other cases and in other areas so far as language and cultural issues are concerned.
- Including in any conference, seminar or learning event the need to guard against early optimism inappropriately influencing the consideration of future events.

27. When reviewing the Child Practice Review guidance the Welsh Government should consider:

- Reviews involving historic circumstances and address more specifically historic cases arising in families.
- The criteria for carrying out a Child Practice Review and include circumstances in which it appears that a child's name should have been on the child protection register and/or the child should have been a looked after child.
- The need for Local Safeguarding Children Boards to receive sufficient information to evaluate the quality of the Child Practice Review and the Report.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the		**Statement of independence from the**	

case *Quality Assurance statement of qualification*		**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)*	David Spicer	**Name** *(Print)*	Karen Burrows
Date ……		**Date** ……	
Chair of WBSCB *Panel (Signature)* …  …… **Name** *(Print)* ……Nick Jarman……. **Date** ……18 December 2014…….			

Appendix 1:

Western Bay Safeguarding Children Board

Terms of Reference for Extended Child Practice Review

WB S 6/2013

SUBJECT FAMILY:

Mother
Father
Child Z (deceased)
Child Y
Other Children

1. This review is being commissioned by the Chair of Western Bay Safeguarding Children Board on the advice of the Chair CPRMG in accordance with Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews 2013 which has been adopted by WBSCB.

2. The review will be conducted by the appointed WBSCB CPR Panel.

External Reviewer - David Spicer
Internal Reviewer - Karen Burrows
Chair of Panel - Daphne Rose Safeguarding Children, Public Health Wales

Panel Members Included from the Following Agencies:

- ABMU HB
- City & County of Swansea Education
- City & County of Swansea Children's Services
- South Wales Police
- City & County of Swansea Legal Services
- City & County of Swansea Housing Department
- Western Bay Safeguarding Children Board
- CAFCASS Cymru*

*CAFCASS Cymru were invited to contribute to the work of the WBSCB in this review following identification of involvement with the family.

3. The purpose of the review is to:

4. Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.

5. Identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result.

6. As a consequence, improve interagency working and better safeguard children.

7. There are areas of particular focus which if appropriate each agency within their analysis should consider while undertaking this review. These are:

- The original accidental death diagnosis and whether it was appropriately addressed and tested.
- The information and communication between the family court and criminal justice processes and whether it had an impact on the safety and welfare of children.

8. Key issues also to be considered by this review are:

- Ethnicity, culture, language and immigration status and its impact on practice
- The testing of experts in court processes and its contribution to safeguarding children.
- Mental Ill Health and the impact on parenting

9. The scope of this review will be from 23rd July 2004 until 20th April 2012.

10. Chronology timelines and analysis reports will be undertaken by:

- Health
- CAFCASS Cymru
- Education
  (Including attendance dates from Further Education)
- Social Services
- South Wales Police
- Local Housing Department
- Children's legal services

11. The chronology timelines and analysis reports will be received as soon as possible and considered by the CPR Panel as the primary means of informing the learning event and fulfilling the review.

12. The CPR Panel may wish to ask questions of the chronology timeline and analysis report authors. If this arises the WBSCB will seek agencies' co-operation to do so.

13. The CPR Panel will arrange and coordinate a facilitated learning event with the practitioners directly involved in the case where available. The learning event will be the main vehicle by which lessons are identified for learning and evidence of good practice are highlighted both of which will become the focus of the outcome report.

14. The family will be contacted at the appropriate time by letter informing them of the Board's intention to undertake the review and make an appointment to visit to provide an opportunity to discuss the matter with the overview author.

15. The CPR Panel will be responsible for maintaining links with all relevant agencies and interests. The Chair of CPRMG and the Strategic Business Development Manager will facilitate regular meetings to update on progress.

16. The chair of WBSCB will be responsible for making all public comments and responses to media interest concerning the review until the process is complete. All contact from and responses to the media will be communicated to those responsible for undertaking this review.

17. The WBSCB will have access to legal advice on all matters relating to the review. In particular this will include advice on:

- Terms of reference
- Disclosure of Information
- Guidance to the panel on issues relating to interviewing individual members of staff
- Progress made within child and family court processes

18. The Child Practice Review Panel will consider the role of any experts of independent person in the review process including:

The Judiciary
The Coroner

19. The CPR will commence from the date of the first panel meeting namely 2nd August 2013. It should aim to be completed within six months of commencement.

20. The arrangements for commissioning the external review and undertaking the production of the outcome report have been completed and this role will be undertaken by David Spicer LLB. The identification of an Independent Reviewer to work with the external reviewer will be undertaken using the pool of trained reviewers available to WBSCB.

Note: There is a Reporting Restriction Order (RRO) in place in relation to the content of this report. For a copy of the RRO please contact: www.wbsb.co.uk

For Welsh Government use only

Date information received ……..

Date acknowledgement letter sent to LSCB chair ……

Date circulated to relevant inspectorates/Policy leads ……

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