Child Practice Review Report

Cardiff & Vale of Glamorgan
Regional Safeguarding Children Board
Extended Child Practice Review

Re: C&VRSCB 09/2014

This document is also available in Welsh.

Brief outline of circumstances resulting in the Review

Legal context from Welsh Government Guidance in relation to which review is being undertaken

An extended child practice review was commissioned by Cardiff & Vale Regional Safeguarding Children Board (RSCB) in accordance with Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews (Welsh Government 2013). The criteria for this review are met under section 6.1 of the above stated Guidance.

6.1 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-

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of 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 six months preceding-

- The date of the event referred to the above; or
- The date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

The purpose of a child practice review is to identify learning for future practice, and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and family. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency child protection practice, with a focus on accountability and not on culpability (Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government 2013).

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

Background information

This Extended Child Practice Review (ECPR) was commissioned following a recommendation from the Child Practice Review Subgroup of the Cardiff & Vale Safeguarding Children's Board on 6th January 2015. It considers the circumstances of a young child who is now the subject of a Care Order to the Local Authority.

The timeline of this extended child practice review looks at circumstances from 1st July 2012 to 1st July 2014 (Appendix 1 ToR).

During the timeline period the child had been living with her mother (and elder brother). From the age of 3 years 7 months to the child being made subject to a Care Order, at the age of 6 years 10 months; the child had exhibited concerning behaviour within the child's nursery placement and later the child's school, including soiling, sexualised behaviour and aggression toward other children. Medical examinations were undertaken on 3 occasions and whilst neither physical nor sexual abuse could be ruled out medical findings did not explicitly (forensically) prove the concerns expressed by education and health professionals.

The mother of the child was considered to have low mood and depression and parenting skills deficits. It later emerged she was working as an 'escort' from her home. She left the child in the care of an older male friend and other males who had overnight caring responsibilities, including bathing and collecting and delivering to and from nursery and later school.

Significant Events During the Period Under Review

From the beginning of 2012 Children's Services (CS) initially supported the mother on a 'child in need' basis following a number of concerns communicated by the nursery. Health professionals began to express significant concerns regarding the child's presentation and considered it was highly suggestive of sexual abuse in addition to all other categories. The child was then voluntarily accommodated under section 20 of the Children Act 1989 in August of that year. Subsequently she was later rehabilitated with her mother in February 2013. There was a package of support around the mother and the child had intensive support within the educational setting.

Throughout the remainder of 2013 the key agencies (Health, Children's Services and Education) record concerns around the child's sexualised, aggressive behaviour, physical and emotional development, health and wellbeing and the mothers ability to protect and nurture the child. The child remained 'child in need' status until the first Child Protection Conference was convened on 3rd December 2013. At this conference the child was registered under the category of emotional harm.

In late 2013 and up to July 2014 the child's sexualised and aggressive behaviour continued and escalated. She was soiling and suffering ongoing genital soreness and urinary tract infections. The child talked to professionals about being hit by mother's boyfriend and her ex-partner (September 2013 in school) describing what could be construed as explicit sexual abuse (November 2013 to Play Therapist and Head teacher separately a month later in January she repeated the same disclosure to school staff, July 2014 to her foster carer, in Local Authority care). She describes mother's boyfriends as "scary men" that come into her bedroom (December 2013), it

emerged that mother was working as an escort from home. The child's mother attributed the behaviour of her daughter to inherited paternal mental health issues. As a consequence a number of assessments were commissioned to eliminate any medical diagnosis. Mother was reported by health in 2013 as failing to meet child's health needs, e.g. Optician and Dentist.

In July 2014 CS successfully applied to the Court for an Interim Care Order under the 1989 Children Act and the child was placed in foster care aged 6 years and 10 months. The child's mother and her friend/boyfriend were later arrested and interviewed, however the Crown Prosecution Service advised that no further action should be taken against either party.

Practice and organisational learning

Voice of the child

Good practice informs us that children are likely to make disclosures of abuse when they meet on their own with professionals, away from parents and carers in an environment where they feel safe. In this case the child aged between 3 years 6 months at the beginning of the review to 6 years and 10 months at the end of the review timeline, made a number of disclosures although not always a verbalised disclosure. These included sexualised behaviour as discussed in the Strategy Discussion on the 4th November 2013, involving another child in her class in the sexualised behaviour.

The child displayed escalating highly concerning sexualised behaviour and increased aggressive behaviour towards her peers. This behaviour, although documented and shared amongst professionals involved with the child, did not in the early stages increase the level of concern enough to trigger an Initial Child Protection Conference. When this process was invoked on the 3rd December 2013 the category of Emotional Abuse did not reflect the high level of significant concerns around the sexual abuse expressed by practitioners during the review period. It should be noted that key agencies/ professionals were not represented at the Initial Child Protection Conference, i.e. the Lead Paediatrician and Police who both sent apologies.
The purpose of placing a child's name on the Child Protection Register is to alert all professionals working with a child to the risk of significant harm.

"The categories should reflect all the information obtained in the course of the child protection section 47 enquiries and subsequent analysis and should not just relate to one or more abusive incidents" (AWCPP 2008). The child was exhibiting signs of sexual abuse which is not adequately reflected in the category of registration.

Professionals need to be alert to parents that distract the focus away from the child by suggesting that the child may have a medical problem or behavioural difficulty that would explain the behaviour displayed by the child. During the early part of the review there were medical assessments to determine if the behaviour may be attributed to ADHD, later visits to the General Practitioner (GP) with genital soreness and soiling were investigated as a urinary tract infection. The investigations to eliminate a medical diagnosis are important however, when an accumulation of concerns arise over a number of months with a history of mother having multiple male partners, the child witnessing domestic abuse and disclosing physical abuse, this should alert

professionals to the concerning environment where the child resides.

It is the opinion of the Reviewers that the mother used what could be described as disguised compliance by attending a number of parenting programmes and appearing to engage with services, however this did not improve her relationship with the child or her ability to manage and supervise her child. The mother confirmed that she did not acknowledge that her child may be at risk of harm from the number of male partners and friends in her life. Professionals focus was also on mother's low mood and depression, her financial circumstances and possible learning difficulties.

Professionals' efforts were focused on maintaining the child at home with her mother and reducing risks by ensuring that mother engaged with services and maintained her own health and well-being. Whilst Mother did attend parenting courses there was little recorded change in her behaviour or awareness of the reasons for professionals concerns and the child's troubled behaviour continued. As there was little or no improvement between early 2012 and July 2014 (apart from the period of her placement in voluntary care) reviewers find it difficult to understand the decision making that allowed the child to remain under the care of her mother for as long as she did.

Professionals need to listen to what children say and make sense of the behaviour that they consistently display in order to protect them. It seems that in the absence of a verbal disclosure made by the child, CS did not feel that there was enough evidence to remove the child from mother's care to adequately safeguard the child. However, when legal advice was sought in May 2014 advice was given to initiate Care Proceedings. Albeit in this case the child's description of events were explicit and beyond the usual comprehension of a child of this age, her disclosures did not state who did what, when and where. She was 3 years of age when her behaviour attracted the attention and concern of professionals. It is unlikely that a child between the age of 3 and 6 years could formulate the language necessary to achieve "full disclosure" of this type, however on at least 3 occasions she describes penetrative sexual contact.

Meeting with mother

Both reviewers met with mother prior to the learning event to determine her experience of the involvement of services and what led to the child protection conference, the Interim Care Order and the subsequent removal of the child from her care. During the arranged meeting the child's 10 year old sibling was also present.

On reflection the mother recognises that she made mistakes and regrets her actions. She stated that she trusted her partner/ friend at the time, he did the majority of care due to her working, and he also helped her financially. In addition on one occasion he paid for cosmetic private surgery. The situation upsets her and she wishes that it had never happened.

Mother feels that she is blamed for everything by professionals. She did not feel that professionals were good at listening to her however she understands why the child was removed from her care and the actions taken to protect her from further harm. Mother spoke predominantly about her relationship with CS although recognised that other agencies were involved in communicating with CS and decision making. Mother does not feel that communication with the other agencies on the whole was good, she felt

criticised and too afraid to be open and honest, and she was particularly scared of CS. In conclusion mother indicated that she would like more contact for herself and other family members with the child. She is concerned that her bond with the child will be compromised.

Learning Event

Professionals directly involved with the case were invited to the Learning Event from across all agencies. Attendance included:

4 Police Officers
2 Operational Manager's Children's Services
1 Independent Reviewing Officer
2 Family Intensive Support Service
2 Paediatricians
1 Education
1 General Practitioner
Staff from the RSCB Business Unit supported the facilitation of the learning event presented by the Reviewers. During the Learning Event it became clear that information shared by professionals with CS were not documented as a referral, even though the professional believed this to be the case. This lead to constructive discussions in the workshop between agencies and how this may be resolved.

Issues discussed were:

- multi-agency training,
- management oversight,
- the importance of Children's Services collating all available information to ensure a full and holistic understanding of the child and their life
- professional documentation,
- confidence of professionals to challenge decisions and escalating professional concerns.

Professionals at the learning event acknowledged that, following workshop discussion and feedback from reviewers, they would feel confident to act as an advocate for the child, recognise indicators of abuse especially sexual abuse, challenge decisions and to consider recommendations made at the child protection conference to ensure that they are child focused. The learning event provided a forum for professionals to explore difficulties that they had experienced with the case and address some frustrations.

Inter Agency Information Sharing

It is recognised that effective practice in safeguarding is built on timely and effective information sharing between agencies. The review highlighted good examples of information sharing, for example the school in particular actively shared information about the child's behaviours, wellbeing and family dynamics. Health communicated their concerns about the child's wellbeing and the mothers parenting capacity. Despite frequent telephone calls and letters from both these agencies to CS (CAP Team) this information was not always acted upon in the way expected by the referrer, leaving the school to manage the child's difficult behaviours and both health and education professionals frustrated by the apparent lack of intervention to safeguard the child.

In summary there was some confusion within the agencies as to what constituted a "referral" where concerns were being expressed about the child. There was also some frustration that there was no explanation or feedback from CS around what action was taken, or planned to be taken following telephone calls and letters concerning the child's wellbeing. It should be noted that the AWCPP (2008) state that referrers should seek feedback where this has not been received within 10 working days.

Resolving Professional Differences

The management of the case was challenged on a number of occasions by the lead Paediatrician. Two letters expressing concern about the likely sexual, physical and emotional abuse of the child, and requesting a full multi agency assessment, were sent to CS. These letters are not recorded on CS case records. The school made a number of telephone calls to CS which appeared to result in no action. At the learning event these agencies highlighted their frustration at the lack of feedback or action to safeguard the child however neither agency invoked the "Resolving Professional Differences" guidance to challenge how the case was being managed.

Practitioners and managers in all agencies should ensure they understand and use this guidance.

Assessment and analysis

AWCPP 2008: good practice in assessment: "Serious case reviews (since 2013 referred to as Child Practice Review) frequently highlight the importance of assessment and analysis. Assessment is the process by which information is collected, collated and analysed. Effective assessment seeks overall patterns that explain what has happened to a child and provides a framework for understanding and analysing need, risk and the dangers individuals pose to children. Particular care needs to be taken that assessments do not become over optimistic or minimise risk to children. The focus needs to be on gathering evidence to make judgements about whether a child is safe from injury, neglect and emotional or sexual abuse."

The review highlighted that there were delays in recording, collating and analysing the concerns communicated to CS. Although there was a considerable amount of information provided by a range of agencies it does not appear information was used to develop an overall pattern that could have explained what was happening to the child. There is evidence in records and meeting notes that there was an over reliance, (by CS prior to the first child protection (CP) conference and later by all agencies who attended the CP conferences), on evidential medical diagnosis rather than use of professional judgements about probable cause of the child's behaviour and presentation, given the known context of the child's life.

Over the two year review period there were five social workers (SW) allocated and two recorded episodes of management supervision. There were a total of seven GPs involved and two family support workers. It may be that staffing changes in CS inhibited a holistic approach with each new social worker, rather than utilising the wealth of information communicated to and held by CS.
The delay in convening a formal multi agency review through a Child Protection Conference further reinforced the reactive, rather than proactive multi agency approach to the case.

Practitioners need to be mindful of the role and scope of each agency's involvement with the family, and the value of such information. At the learning event practitioners from one agency perceived that the validity of their information was not seen as important and was not informing decision making despite the fact that their exposure to and engagement with the child, her mother and other carers was more frequent and longer in duration than that of CS. Effective, complex casework requires a coordinated approach, valuing the contribution of all agencies involved.

Thresholds and Decision Making

Discussion in the learning event raised concerns from Education and Health professionals that they were not present at strategy meetings. This raised questions of which agencies were present and how decisions were made. Education professionals in particular voiced concern that they were not informed of the progress and activity around the time that the child became a "Child Looked After". The feedback from groups at the learning event suggests that information sharing between agencies had broken down at an early stage, numerous concerns had been raised by all agencies and in many instances there appears to have been no feedback by CS.

The AWCPP (2008) 3.5.2 p66 states that:
"Both police and social services staff, together with other professionals from education and health or other people who can assist in the planning process of the enquiries, should always attend the strategy meeting. A paediatrician should attend when a medical examination of the child has been undertaken or is likely to be required".

It must be acknowledged that gathering all agencies together for a strategy meeting is a challenge, however in complex, highly concerning cases every effort must be made to ensure representation from all agencies involved with the child, including use of up to date technology where physical attendance is not possible. This will draw upon all information surrounding the child, ensuring that the child's welfare is paramount, the child remains the focus and appropriate safeguarding measures are in place.

The initial Child Protection Conference took place almost 2 years after the first concerns about the child were communicated to CS. Agencies expressed some frustration that decisions to initiate a multi-agency forum for decision making and developing a child protection plan were significantly delayed. Key personnel were not in attendance at this initial conference, including police and the paediatrician, apologies were received. During this review key agencies questioned why the child was not registered under the category of sexual abuse.

The AWCPP 2008 defines sexual abuse as follows "sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include none contact activities, such as involving children in looking at, or in the production of pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways"

Historically the concerns regarding this child had been in relation to sexualised behaviour, towards herself and her peers, the child's disclosures and the number and type of carers to whom she was entrusted by her Mother. The lead paediatrician had

written a report for the conference explicitly expressing her view that on the basis of the child's behaviour the child could be experiencing sexual abuse.

The purpose of defining the category of abuse on registration is to indicate to those consulting the register, the primary presenting concerns at the time of registration and to inform the resulting child protection plan. Not including the category of sexual abuse is considered a missed opportunity to agree the risks, plan for monitoring and interventions and identify professionals' responsibilities in relation to risks.
One of the actions emerging from the child protection plan was for CS to seek a legal planning meeting. During this review process this has been referred to on a number of occasions during the year before the child was finally taken into Local Authority care (July 2013, Child in Need review meeting, November 2013, Strategy meeting, November 2013, Case work supervision, December 2013, Initial Child Protection Conference, January 2014, Core group meeting). This caused agencies some frustration that no progress had been made, or that no feedback had been given in regard to outcomes of any such legal planning meetings during the lengthy period of escalating concern.

Safeguarding Children- Medical Examinations

The first medical examination (08/08/12) followed a strategy discussion and strategy meeting. Information shared at this point focused on:

- the care provided to the child from mother's partner/ friend,
- lack of supervision of child late at night,
- presentation of sexualised and aggressive behaviour,
- inconsistent reports from mother and her blaming difficulties on the child's mental health,
- the child reporting that she has been hit by older sibling.

The medical report completed by the paediatrician concluded that the history was very concerning and warranted further investigation by CS.
The next medical examination (22/08/12) nineteen days later raised concerns of multiple unexplained bruises and injuries with the majority of bruises in relatively protected areas, and the overall pattern of bruising was reported to be highly suggestive of abuse. The paediatric medical report highlighted concerns around neglect, physical abuse, emotional abuse and sexual abuse due to her sexualised behaviour which was abnormal for her age. The child entered the looked after system at this point following mother's request for accommodation, Section 20 of the Children Act applied.

The third medical examination (13/03/13) seven months later had been instigated by school and the Family Intensive Support Service (FISS) following information shared by the child and the observation by staff of bruising. The conclusion of the examination states that the bruising could be accidental although the possibility of abuse could not be ruled out.

All medical examinations were followed up with further appointments with a paediatrician; information was shared with CS and the GP.

All medical examinations took place whilst the child was in mother's care. Whilst we have no record of who was present at the medical examination it is usual practice for CS

to accompany the child.

The first two medical examinations contributed to concerns raised by professionals and resulted in the child becoming a “Child Looked After”.

Effective Practice

At both the learning event and during the review it became clear that Education professionals were persistent and consistent in their efforts to raise concerns with CS and to further actions to safeguard the child. The school provided a package of support in order to assist the staff in managing the child’s difficult behaviour and support the child’s obvious distress; they viewed her as a “victim” rather than a management “difficulty” and maintained a focus on the child’s needs and wellbeing.

Health professionals offered good follow up appointments following referrals, GP visits and medical examinations (for example paediatric appointments, speech & language, CAMHS and ADHD assessment). The lead paediatrician in this case was assertive in her assessments of the possible causes of the child’s medical problems and problematic behaviour and the likely causes of these being social factors. She and her colleagues communicated these concerns in writing to CS, requesting a full multi-agency assessment.

There is evidence of good practice relating to the referral for a medical examination for the child when concerns are raised. The AWCPP (2008) advocates that a medical examination is considered in cases where concerns are raised. The purpose of the medical examination considers possible indicators of abuse, the child’s condition is medically assessed and treatment given as appropriate, to ensure signs of abuse are noted for evidential purposes and to secure forensic evidence.

Despite the reviewer’s concerns around delays in the process during the period of review, it would be true to say that CS explored a range of medical and psychological causes to try and explain the child’s behaviour and presentation during this time period. It is unclear if permission for legal advice was sought from a manager prior to May 2012. When permission was given to initiate Care Proceedings (12/05/14) an application was made to Court (09/07/14) and a guardian was appointed. Court date for the initial hearing set for 14/07/14 and the child was removed from mother’s care following this hearing.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the RSCB and its member agencies and anticipated improvement outcomes:-

Since the period under review there have been a number of local policy and practice changes that have impacted on all agencies involved in child safeguarding.

- Launch of Multi- Agency Safeguarding Hub in Cardiff, July 2016. This involves the co location of strategic agencies using a common platform for sharing information, risk assessments and decision making
- Children Services led quarterly Child Protection Forum that allows multi-agency open professional discussion around processes and challenges to effective safeguarding
- Introduction of the Public Law Outcome (PLO)
- Introduction of Legal Surgeries for Children's Services to obtain prompt legal advice

Recommendations:

1. The responsible Local Authority and partner agencies should ensure that they have an action plan in place to address the issues raised in this Child Practice Review, taking into account research and best practice regarding the voice of the child.

2. The Cardiff & Vale RSCB should consider introducing a consistent standardised multi-agency timeline template that becomes the responsibility of each agency to complete when attending the initial child protection conference. The agency timeline should be maintained and updated at each core group meeting by individual agencies and presented as part of the report to the review child protection conference.

3. Reminder to all agencies that their practitioners follow the AWCPP (2008) and to ensure the involvement of police as statutory partners and paediatricians (when a child protection medical has been undertaken) in strategy discussions/meetings. Paediatricians who have been involved with the child and police must be invited and attend all Initial Child Protection Conferences to ensure that all decisions are agreed and endorsed.

4. Cardiff and Vale RSCB to review its existing Resolving Professional Differences guidance. Key considerations in this review may be:

    - Whether it remains fit for purpose

    - Whether the guidance is sufficiently detailed

    - Whether the process is clear and widely known by staff from all respective agencies, including the responsibilities of each agency involved

    - Whether a formal re-launch of the guidance is necessary

5. Cardiff & Vale RSCB Protocols and Procedures Subgroup should ensure that its 'Working with Hostile and Uncooperative Parents' Protocol includes specific guidance on the following:

   a. The 'Working with Hostile and Uncooperative Parents' Protocol is also aimed at working with parents whose behaviours, whilst not overtly hostile or uncooperative, prevent the effective safeguarding of their children. This should include guidance on when practitioners may legitimately meet without parents present to reflect on progress and the child protection plan.

6. Risk Management of all cases requiring support from Children's Services for a period over two years should be considered by all individual agencies for internal audit. Learning from statutory agencies audit should be shared at the RSCB audit sub-group for extended learning.

7. The learning event highlighted the need to submit formal child protection referrals, rather than rely on communication by telephone or letter, where information regarding safeguarding of a child on an open case is being communicated. This will ensure it receives management oversight and will strengthen the level of supervision of the case.

8. Practitioners need to be mindful of the role and scope of each agency's involvement with the family, and the value of such information. Effective, complex casework requires a coordinated approach, valuing the contribution of all agencies involved.

9. The conference Chair (Independent Reviewing Officer) must ensure that the registration reflects the view of professional participants and the risks discussed at the meeting. This is in line with AWCPP (2008) and demonstrates robust decision making and confidence of practitioners.

10. Incorrect categorisation of registration is a missed opportunity to agree the risks, plan for monitoring and interventions and identify professional's responsibilities. Cardiff & Vale RSCB audit sub group to consider undertaking quality assurance of the category of registration for cases over a six month period 2016-17.

11. Medical evidence should form part of the information used in decision making, rather than being solely relied upon to determine whether abuse has taken place or not. Decision making should be informed by professional judgements about the probable cause(s) of a child's behaviour and presentation, and the absence of medical evidence providing irrefutable proof that the injuries could only have been caused by abuse should not be used to demonstrate that abuse did not take place.

12. Managers in all agencies need to consider the developing complexity of individual cases and provide regular supervision to involved practitioners.

13. All agencies must consider the seniority of staff participating in Child Practice Review panels and providing a chronology of significant events. All chronologies must be completed or overseen by managers to ensure accuracy and analysis and ensuring attendance at Learning Events.

14. Cardiff & Vale RSCB audit subgroup to consider an audit of cases where:

- sexual abuse is suspected
- a CP medical is undertaken
- the medical examination suggests that sexual abuse is possible or likely

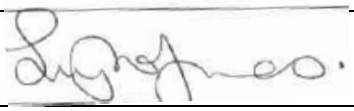
and map

a) Number of cases (total)
b) Number of cases resulting in registration
    i. by category of registration

15. In line with AWCPP guidelines Children's Services should ensure timely feedback to agencies in regard to outcomes of any referrals and recommendations to seek legal advice. (This to be addressed by Children's Services in their action plan).

16.

a. Every time resolution of professional differences policy is invoked the team manager or principle social worker in Children's Services should initiate "signs of safety/ risk assessment" model meeting with all partner agencies involved with the child. This will ensure that focus remains on the child.
b. Cardiff & Vale RSCB should consider arranging a further learning event for all practitioner's and managers to emphasise the importance of working together, endorse consistent clear communication and consolidate multi-agency learning from this case.

Statement by Reviewer			
Reviewer 1	Linda Hughes-Jones	**Reviewer 2** (as appropriate)	Gail Reed
Statement of independence from the case Quality Assurance statement of qualification		**Statement of independence from the case** Quality Assurance statement of qualification	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 (signature)		**Reviewer 2** (Signature)	
Name (Print)	Linda Hughes-Jones	**Name** (Print)	Gail Reed
Date	16/01/2018	**Date**	16/01/2018

Chair of Review Panel:

Signature: 

Name (print): Chris Fox

Date: 16/01/2018

Documents added as appendix
Appendix 1: Terms of Reference ☒

Child Practice Review Process

To include here in brief:

- The process followed by the RSCB and the services represented on the Review Panel.
- A Learning event was held and the services that attended.
- Family members' had been informed, their views sought and represented throughout the learning event and feedback has been provided to them.

The Cardiff and Vale Local Safeguarding Children Board (CVRSCB) Chair notified Welsh Government in 2015 that it was commissioning a Child Practice review in respect of Case CPR 09/2014.

The services represented on the panel consisted of:

- South Wales Police
- Cardiff Children's Services
- Cardiff & Vale University Health Board
- Cardiff Council Housing (Chair)
- Cardiff Council Education
- National Probation Service
- C&VRSCB Business Unit

A learning event was held on the 20th January 2016 and was attended by representatives from the following agencies:

- Cardiff Council Education
- South Wales Police
- University Health Board - GP Health Centre
- Cardiff Children's Services
- FISS

The mother of the subject of the Review was visited seek her views prior to the learning event and to guide and support the review outcomes.

The Reviewers and Chair have undertaken to share the learning from the report with the mother prior to publication.

☐ **Family Declined involvement**

For Welsh Government Use Only

Date information received:

Date acknowledgement letter sent to RSCB Chair:

Date circulated to relevant inspectorate /Policy Leads:

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

APPENDIX 1

Bwrdd Diogelu Plant Rhanbarthol Caerdydd a Bro Morgannwg
Cardiff and Vale of Glamorgan Regional Safeguarding Children Board

Child Practice Review C&V LSCB 09/2014

Terms of Reference

The 09/2014 Child Practice Review (CPR) referral was received by the Cardiff and Vale CPR Sub Group on 6th January 2015, where it was agreed that the case met the criteria for an extended Child Practice Review as the child was either known to services, or registered on the Child Protection register under the category of neglect at the time of the event leading to the referral. The CPR Sub Group considered the referral and *felt that the child may have sustained serious and permanent impairment of health or development.*

It was agreed by members of the Sub Group that the timeframe of the review should focus on the 12 month period prior to the most recent Looked After episode. Therefore the timeframe of the review will be:

14th July 2013 – 14th July 2014

Agencies Concerned in the review are:

Health: Cardiff and Vale University Health Board

Children Services : Cardiff Local Authority

Education Services: Cardiff Local Authority

South Wales Police

National Probation Service

The Chairperson of the review will be:

Chris Fox
City & County of Cardiff Council
Housing Services

The Reviewers

Gail Reed
National Probation Service

Linda Hughes-Jones
Cardiff & Vale UHB