Child Practice Review Report

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

Re: *CPR 03/2016*

Brief outline of circumstances resulting in the Review

Legal context from guidance in relation to which review is being undertaken

An Extended Child Practice Review was commissioned by Cardiff and Vale of Glamorgan Regional Safeguarding Children Board (CVRSCB) on the recommendation of the Child & Adult Practice Review Sub-group in accordance with Social Services and Well-Being Wales Act 2014 Part 7, Volume 2 Child Practice Reviews guidance. The criteria for this Review were met under section 3.12 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

- 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 6 months preceding

- the date of the event referred to 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 terms of Reference for this review are at Appendix 1.

Background information

The child who is the subject of this Extended Child Practice Review is now the subject of a Care Order to the Local Authority. The timeline of this review covers events between 1st January 2014 and 10th January 2016 when the Care Order was granted.

The child was born in 2009 and was the only child of a single mother who was living with her own parents at the time of the child's birth. The mother had longstanding substance misuse problems during her pregnancy and the first 6 years of her child's life. The child suffered exposure to the mother's substance misuse, her criminal activity and to domestic abuse. The child did not have a stable home, and suffered neglect of their health and developmental needs and of their education. The mother's boyfriend had a history of convictions for violence and substance misuse and he is alleged to have sexually abused the child. Services were involved with the family from the time of the child's birth and the child's name was on the child protection register from June 2014 to September 2015. The mother consistently refused to share the child's paternity with professionals and the father's identity was only ascertained during the care proceedings. The child had no knowledge of their father during the timeframe for this review.

The child is now in foster care and responding well to an improved and supported family environment however the decision to proceed with an extended child practice review was made on the basis of the impact of the sexual abuse the child had suffered and because of the likely consequences of the long term neglect and emotional abuse.

In January 2016, some five months after the child was removed from the mother's care, the grandfather died in a house fire. Mother was accused of murder but this was reduced to manslaughter and was ultimately found not guilty by reason of insanity. Despite the mother's mental state being a crucial evidential factor in the court case concerning the grandfather's death, throughout the timeline of this review there is no reference to mother having or having had a mental illness. A Domestic Homicide Review into the grandfather's death has been conducted in parallel with this review.

Significant Events Prior to the Period Under Review

There were 3 child protection referrals prior to the period covered by this review. The first was from the neonatal unit, where the child was admitted following birth for observation due to mother's substance misuse during the pregnancy and her agitation and threats to leave the unit with the baby, and also because of the aggression displayed by the grandfather on the ward.

The second referral occurred in September 2010 and came from the Community Addictions Unit (CAU) because of concerns about domestic abuse involving the grandparents and occurring in the mother and child's presence. There was also an acknowledgement that the mother's engagement with CAU and other services was poor. Within the referral by CAU it was noted that home visits were regularly refused by the mother and that the Health Visitor reported that she was not being allowed access to the property to see the child.

The third referral by a neighbour in August 2012 was because of concerns about poor home conditions, substance misuse and frequent callers to the address. The child was said to be often left alone in the front garden with only bags of crisps to eat.

Initial assessments were undertaken in response to the first two referrals and a core assessment was undertaken on the third occasion. Mother's explanation was that the first incident was due to mother's perception that ward staff were discriminating against her because of her addiction problems, that the concerns in the second referral were exaggerated and that the third referral was malicious.

All three referrals detailed above were investigated by Children's Services but no further concerns were identified and the child protection process was not progressed.

In 2013 a referral was received by Adult Services which alleged financial abuse by the mother and grandfather towards the grandmother. No further safeguarding action was taken as the grandmother did not wish to proceed with the matter. Mother continued to be known to CAU, and homelessness was identified as a matter of concern due to the mother, the grandfather and the child having vacated the grandmother's property. The grandfather was known to have resided with the mother and child for the duration of the period of the review although it was noted by professionals that he refused to engage in any assessment or discussion concerning his grandchild.

Significant Events During the Period Under Review

The Initial Assessment, completed at the beginning of the period under review, was initiated as a result of two PPD1 notifications received by social services from the police in December 2013; mother had been shoplifting whilst the child was in her care. The assessment was hampered by mother's lack of cooperation and refusal to consent to the social worker contacting other agencies to seek information about the child and family.

Enquiries made by social services with the child's school in December 2013 had identified concerns about the child's attendance, punctuality, presentation and poor dental health. The child's poor attendance was reflected in poor developmental and educational progress. The child's milk teeth were decayed and it was subsequently necessary for 10 of them to be extracted. The child also had a turn in the eye but wearing of prescribed spectacles was intermittent. The child had failed hearing and vision screening tests by the school nurse and was assessed as having mild/moderate difficulty in understanding spoken language. The mother did not acknowledge the concerns raised by social workers at the time and her engagement with

them remained unchanged and was considered to be poor. She was consistently confrontational and obstructive.

The outcome of the Initial Assessment was a recommendation to proceed to S.47 enquiries because of concerns about parental substance misuse, neglect of the child's basic care needs and instability of housing. The Core Assessment took 12 weeks to complete (according to the All Wales Child Protection Procedures (AWCPP) it should be completed in less than 35 working days) and between the referral that generated the Initial Assessment and the subsequent Initial Child Protection Conference almost 6 months elapsed. The social workers involved at the time were not available to attend the learning event, and the practitioners who did attend were unable to explain this delay as the reason was not recorded formally within the case notes.

In March 2014 police were called to a landlord tenant dispute. The mother had been served with an eviction notice from her private landlord for the two bedroomed flat she shared with the grandfather and the child. On attending the property police repeatedly asked mother, and grandmother who was present at the time, to remove the child from the room due to concern that the child had witnessed all parties shouting, was clearly distressed by events and was crying, but the mother refused to take the child out of the situation. A Police Protection Document or PPD1 (now known as a Public Protection Notification or PPN) was submitted at the time due to concerns about the child's distress and the police officer's view that the mother was not acting in the best interests of the child.

In May 2014 the S.47 assessment was completed and identified significant concerns around emotional harm, neglect, parental substance misuse and the mother's criminal activities. In June 2014 the child was placed on the Child Protection Register under the categories of neglect and emotional abuse. School's attendance at subsequent core groups was inconsistent. During this period the mother had poor engagement with CAU and regularly missed drugs tests. She often failed to attend appointments for her own health needs and for those of her child, and appeared unable to accept the impact this would have on her child's health and well-being.

In early October 2014 the grandmother mother contacted the police and expressed concern for her grandchild who was at home with the mother and her boyfriend who had allegedly caused damage to a door. Police attended and identified no concerns for the child and no damage to the property. The boyfriend was present and the police submitted a PPD1 (now a PPN) containing his details which was shared with partner agencies. Two days later the mother contacted police to make a Claire's Law disclosure request. The boyfriend had a history of domestic abuse. Attempts were made to contact the mother to advise her of this fact. Contact was not made until the following month, by which time the mother advised the police that she had changed her mind and did not want the disclosure. She gave no reasons as to why she had taken this decision. It was noted during the review that no PPD1 was submitted concerning this Claire's Law application and the boyfriend's history of domestic abuse.

In January 2015 at a Review Child Protection Conference there was mention of a short relationship with a man, and the mother informed conference that she had ended the relationship having been made aware of her boyfriend's background, which had included charges of battery, domestic violence and the possession of drugs. The conference report noted as an action that the child should only be introduced to new friends and partners of the mother once relationships were established and appropriate checks completed. The review panel questioned the appropriateness of the recommendation given that it was an unrealistic and unenforceable request.

In March 2015 the mother contacted South Wales Police to make a Claire's Law request about a new boyfriend of five months. She stated that she wanted to find out his history because of her 5 year old child. The boyfriend had 16 separate warning markers which included self-harm, violence, mental health issues, domestic abuse aggressor, the subject of restraining orders, and possession of weapons (bladed article). An occurrence was created and tasked in error to a dormant police inbox that was no longer monitored. When this mistake was discovered the mother was contacted by police, but declined the information being offered regarding the boyfriend. The Claire's Law application was not progressed and, whilst intelligence

was captured on police information systems concerning the association, no PPD1 (now a PPN) was created and the information was not shared with multi-agency partners.

In April 2015 on a statutory CP visit the social worker noticed that mother was wearing a wig to conceal the fact that clumps of her hair were missing, she also had a scald on her thigh and a burn on her arm. Mother gave implausible explanations for these injuries and the child subsequently disclosed having witnessed the boyfriend hurting the child's mother. It seems likely therefore that the injuries seen in April 2015 were inflicted by the boyfriend. In March 2016 The National Training Framework on Violence against women, domestic abuse and sexual violence (VAWDASV) was launched. Within this framework Group 2 training describes the group of professionals who will "Ask and Act". Ask and Act is defined as a process of targeted enquiry across the Welsh Public Service in relation to VAWDASV. As a result of this training participants will be skilled, able and confident to "Ask and Act", proactively identifying and offering support to victims of VAWDASV. Also during April 2015 mother was taken to court for a shoplifting offence and was given a 12 month community order. She was allocated a Community Resource Centre worker and given an appointment for the 15th of April 2015 which she failed to attend, citing having to care for her elderly parents.

At a Review Child Protection Conference held in July 2015 mother advised that she had ended the relationship a few days previously, adding that the boyfriend had never been physical towards her. However the Social Worker had recorded in July 2015 that the child had witnessed an argument between the mother and the boyfriend and the child said that they were frightened that he would hurt the mother. It is of concern that despite agencies being aware of mother's relationship with this man no action was taken to ascertain his role in the child's life.

The day after conference the social worker received a telephone call from grandmother informing her that the child had made a disclosure that mother's boyfriend had come into the child's bedroom with a knife and run it along the child's arm. This contradicted mother's assertion the day previously that the relationship was over. He had threatened that he would get rid of the child so that his own two children could live in the house instead. The boyfriend kept a knife in his sock and also on the bedside cabinet and the child had tried to hide it due to being scared for mother's safety. Police response officers attended and the child was removed from the address and placed with the maternal grandmother.

When the child was interviewed, the child repeated the disclosures and also reported having been placed in a shed for misbehaving and having witnessed several domestic violence incidents and the mother's self-harming behaviour. Disclosures of a sexual nature were later made to mother's aunt about the boyfriend, and the child was interviewed by police at the Cardiff Sexual Assault Referral Centre (SARC) where further disclosures of sexual touching and indecent exposure were made. The relationship between the child and mother's boyfriend was clearly having a considerable impact on the child. During this time a viability assessment of the maternal grandmother and grandfather was commenced, and this appears to be the first time throughout agencies' involvement with the child that the grandfather's background and relationship with the child had been formally explored.

By August 2015 the child was placed into foster care by the local authority, due to mother's imprisonment for shoplifting and breach of her probation order, and negative viability assessments in respect of both maternal grandparents. A full care order was granted by the family court in January 2016 and the child remains looked after. Throughout the period in foster care the child has continued to make more detailed disclosures of further sexual abuse which the boyfriend has denied to police. Following full investigation and consultation with the crown prosecution service the decision was made not to initiate criminal proceedings.

Practice and organisational learning

Identify each individual learning point arising in case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

As part of this Child Practice Review a Learning Event was held for practitioners involved with this child. The Reviewers would like to thank all those who attended the learning event for their contribution to the learning from this Review. Much of the practice and organisational learning considered below was raised at the Learning Event.

The Child Practice Review process

The panel expressed concern about the delay in initiating the child practice review process in this case. The referral was made by the police as a result of their involvement in the domestic homicide review; if there had been no death this child may never have come to the attention of the Safeguarding Board. The referral proved challenging for the child practice review sub group of the Cardiff and Vale Regional Safeguarding Children Board as the "sustained serious and permanent impairment of health or development" aspect of the case was debatable given that by the time of the referral the child was in foster care and responding well to an improved and supported family environment. The decision to proceed with the child practice review was made however, not only on the basis of the impact of the sexual abuse the child had suffered but also because of the impact of the long term neglect and emotional abuse. It was noted that the case would potentially highlight wider learning for multi-agency partners and proceeding to a CPR was agreed. The delay in initiating the review resulted in challenges for the process, in particular none of the social workers directly involved in the care of the child at the time were still in post and available to attend the learning event. Case notes for the child lack clarity and detail in some parts, and this has resulted in poor history and chronology. This means that some of the questions which arose from the discussion of the 2 year timeline remain unanswered.

At the Learning Event practitioners commented that the general practitioner for the child was not present and the GP was thought to have known the family well. Despite this, there was no record of the child having been seen by the GP during the period of the review. The GP's involvement may have been with the adult family members, which is where practitioner's focus too often lay and the child was often unseen. The Learning Event Practitioners also suggested that it would have been helpful to have representation from Legal Services at the Learning Event to aid understanding of the legal advice given in this case, whilst at the same time acknowledging that they are not the decision makers.

The Voice of the Child

It is accepted that in order that any child is fully supported then professionals must engage with the parents and wider family members. However, this must always be balanced with the need to ensure that all services involved have a clear line of sight to the child. Throughout the timeline of this review there was very little recorded about direct contact and discussion with the child. There is little evidence that the child's views, wishes and feelings were actively gathered and supported. Mother's behaviour meant that many professionals concentrated on her needs as opposed to those of the child. Throughout core group meetings, reviews and home visits, it was noted that much of the dialogue revolved around mother as opposed to her child, for example concerns about her wanting support for her housing situation and lengthy discussions about mother's relationship breaking down. The Signs of Safety model which has now been introduced in Cardiff Council supports professionals to ensure that children are seen and interviewed. The three houses exercise is undertaken which ensures that children are allowed to explore and demonstrate, either verbally, in writing or via drawings and play, what is working well, what they are worried about and what they want to see happen. This process expects workers to evidence that they have spoken to the child alone and in an appropriate environment to ascertain their true views, wishes, and feelings. It is pertinent that only when the child subject of this review felt safe and supported were they able to disclose the abuse which occurred in the home prior to them being placed in foster care.

Practitioners' Response to Mother and her Disruption of the Child Protection Process

The mother was variously described by practitioners as aggressive, confrontational and obstructive. Her behaviour was often manipulative and deflective in nature to ensure that professionals did not have open access to the child. At the Learning Event practitioners shared that child protection conferences and core groups and even some child protection statutory visits were 'all about mother', her concerns, her substance misuse and her relationships. They became diverted from their primary purpose by 'helping' mother in the belief that they were thereby promoting her engagement, even although this did not result in any sustained or meaningful progress. If challenged about her failure to engage with professionals and services or comply with the child protection plan, and when escalation was suggested, mother became upset and angry. The Learning Event participants observed that, when on occasion mother walked out of meetings, they believed that they then had to suspend any further discussion in her absence. She thus effectively disrupted the child protection process. The one Core Group at which there *was* effective information sharing and analysis, a clear action plan and an explicit statement of the consequences which would result if the plan was not adhered to, was the one Core Group which mother chose not to attend. Mother's response to this more assertive practice was to comply with services and the plan, just enough and for just long enough, to avert the planned consequences of her noncompliance i.e. she employed disguised compliance.

Practitioners should ensure that when parents' behaviours or actions prevent or compromise necessary safeguarding discussions and planning, the discussion or the meeting should continue in the parents' absence. Professionals can hold a meeting to share concerns, information and strategies and to draw up a plan without the parents being present, albeit there must always be a plan made to share what has been discussed with the family after the meeting. The RSCB has a multi-agency protocol in place for working with families who are not co-operating with safeguarding issues which aims to advise staff in understanding and responding to such issues. The protocol is now out of date (October 2011) and requires review and updating urgently.

Consent to Information Sharing

As noted above, the Initial Assessment at the beginning of the period under review was hampered by mother's lack of cooperation and refusal to consent to the social worker contacting other agencies to seek information about the child and family. Given the history of prior concerns and three previous child protection referrals in this case, consideration should have been given to over-riding mother's refusal to consent to information sharing for the purposes of the Initial Assessment, on the grounds that the child was at risk of significant harm.

Many previous reviews have identified that the failure by practitioners and agencies to share information appropriately about children and their families may have serious consequences for the children, through leaving them at risk of significant harm.

In his review following an inquiry into abuse in children's homes in North Wales in 2002 Lord Carlile stated:

> *'There is nothing within the Caldicott Report, the Data Protection Act 1998 or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children or prevention of serious crime.'*

In Lord Laming's report on 'The Victoria Climbie Inquiry' Recommendation 13 includes ' …*it must make clear in cases that fall short of an immediately identifiable section 47 label that the seeking or refusal of parental permission must not restrict the initial information gathering and sharing. This should, if necessary, include talking to the child'.*

Similarly the All Wales Child Protection Procedures 2008 state under section 1.4 'Sharing Information among Professionals' that '*effective sharing and exchange of relevant information between professionals is essential in order to safeguard children. The law is rarely a barrier to disclosure of information. There is no restriction in the Data Protection Act or any other legislation that prevents concerns regarding individuals being highlighted and shared between agencies for the purpose of protecting children. The Bichard and Carlile reports both confirm the need to be aware that concerns from a number of sources, which individually may not be of significance, can build up a picture which may suggest a child is suffering or is at*

risk of suffering significant harm and therefore requires professionals to act to protect them. Whenever possible, consent should be obtained before sharing personal information with third parties, but the public interest in child protection always overrides the public interest in maintaining confidentiality or obtaining consent from families. A child's safety is the paramount consideration in weighing these interests'.

The Code of Practice on the exercise of social services functions in relation to Part 3 (Assessing the needs of individuals) of the Social Services and Well-being (Wales) Act 2014 states that;

'*The willingness and ability to share appropriate and relevant personal information between practitioners and service providers is inherent to the delivery of effective integrated health and social care services*' and that '*when a child or adult is identified as being at risk of abuse or neglect the presumption should be that all information is shared among relevant partners' at an early stage provided it is lawful to do so….*' and that '*If anyone with parental responsibility for a child under 16 refuses an assessment for that child ……. The refusal of a parent must be overridden…where the local authority suspects the child is experiencing or is at risk of abuse, neglect or other kinds of harm.'*

Interface with Adult Services

As noted previously mother had involvement with the CAU throughout the child's life. It has also been acknowledged that practitioners allowed mother to prevent them having an open dialogue with the child and they did not always ensure that the child was at the centre of their interventions. It was evident to the reviewers on reading the timeline that whilst there was some communication with, and attendance at core group meetings by, the CAU service social worker this was often sporadic and limited. The inference throughout was that as CAU involvement was with the mother, then without her consent, much of the information they held could not be shared. It was clearly highlighted within the timeline that the interface between adult and children's services could be strengthened.

Decision-Making Within a Child's Timeframe

The mother in this case had, by her own admission in 2014, spent 7 years in and out of treatment for her drug addiction and during all that time she had not engaged positively or consistently with the CAU and had not made any sustained positive progress towards giving up or even stabilising her drug use. These 7 years included her pregnancy and the first six years of her child's life. During the first six years the child suffered exposure to the mother's substance misuse, to domestic abuse and to criminal activity. The child did not have a stable home, and suffered neglect of their health needs (notably including their dental health) and their education, whereby the child's school attendance and punctuality were poor, and neglected presentation at times isolated the child from their peers. The child was exposed to their mother's extended family members, associates and partners at least one of whom had a history of convictions for violence and substance misuse and who is alleged to have sexually abused the child. According to Brown and Ward in their 2013 report 'Decision-making within a child's timeframe' children who remain with parents who have not made substantial progress in overcoming adverse behaviour patterns and providing a nurturing home within a few months of their birth may continue to experience maltreatment for lengthy periods.

The principle that children are best brought up by their own families is enshrined in policy and legislation. Identifying the few children whose parents will not be able to meet their needs within an appropriate timeframe requires professionals to set these principles aside. Delayed decisions mean that children experience lengthy exposure to abuse and neglect, disruption of attachments with carers, unstable placements and prolonged uncertainty about their futures. International research has shown that such adverse (foetal and) childhood experiences or ACEs can lead to physical and chemical disruptions in the brain that can last a lifetime. The biological changes associated with these experiences can affect multiple organ systems and increase the risk, not only for impairments in future learning capacity and behaviour, but also for poor physical and mental health outcomes. This has been corroborated by recent studies of the Welsh population[1]. Adults in Wales who were physically or sexually abused as children or brought up in households where there was domestic violence, alcohol or drug abuse are more likely to adopt health-

[1]Welsh Adverse Childhood Experiences (ACE) Study, Public Health Wales NHS Trust 2015/16

harming and anti-social behaviours in adult life. They are also more likely to experience poor mental health and to be diagnosed with a chronic disease in later life.

Practitioners at the Learning Event recognised that this case had 'drifted' and suggested that it would be good practice for there to be mandated senior management review when children's names remain on the child protection register at the second review conference.

Re-victimisation, Poly-Victimisation and Disclosure

Children who have been abused or neglected in the past are more likely to experience further abuse than children who have never been abused or neglected (re-victimisation) and children who are being abused or neglected are also likely to be experiencing another form of abuse at the same time (poly-victimisation). [2] The child subject of this review suffered many forms of abuse some of which the child was only able to disclose in stages once they were removed from the care of the abusers. The child's experience of suffering multiple forms of abuse and the pattern of disclosure is not untypical and practitioners need to be aware of this in order that they may be alert to the increased vulnerability of the abused children they encounter, and take this into account giving it due weight when assessing risk.

Dental Neglect

One of the concerns identified during the S47 enquiries about this child at the beginning of the period under review was the pre-existing extensive dental decay which subsequently resulted in the child having ten teeth extracted under general anaesthetic. Poor oral health negatively impacts on the daily activities and quality of life of children. Untreated dental decay may cause pain, sleep deprivation, reduced nutrition, functional limitations, higher school absenteeism and reduced school performance.[3] This negative impact may include the need for general anaesthesia for dental extractions sometimes on more than one occasion. A representative from the C&V UHB Dental service attended the learning event and highlighted strongly for attendees the long term impact of poor dental health on an individual.

Dental neglect is defined as '*the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral or general health and development and includes a failure or delay in seeking treatment for significant dental caries or trauma, failure to complete a recommended course of treatment, or allowing a child's oral health to deteriorate avoidably*'.[4] It is rarely present in isolation, but instead forms part of the more general neglect of a child or may co-exist with other forms of abuse. Early identification of dental neglect by healthcare professionals and appropriate action, if necessary making a child protection referral, may help prevent children from experiencing further harm.

Record Keeping and Multi-agency Communication

In common with many other reviews, some issues with record keeping were identified during this review. In particular there was an incident in April 2015 when a social worker visited the home to find mother under the influence of substances and in sole charge of the child. The social worker was unable to find a safe person to leave the child with and, according to her records; she attempted to enlist the support of the police in dealing with this incident and also took advice from an emergency duty team social worker. However neither police nor EDT could find a corresponding record and the social worker did not record the names of the professionals she spoke to. This made it impossible to fully clarify the events of that evening. When it was discussed by the practitioners at the learning event it became apparent that there was a lack of understanding amongst some of those present about other professionals' roles, their powers and the limitations of their powers, which may have led to a breakdown in effective communication on the evening in question.

Practitioners at the learning event commented on the utility of the multi-agency timeline in helping them to see the whole picture and understand what had been happening for the child, as they had not been aware of all the multi-agency information at the time of their involvement. In particular the child's school were unaware of much of the multi-agency information, particularly about the agencies who were working to support mother. The learning event participants thought that it would be useful for the core group to have a

[2] Child Abuse & Neglect 31 (2007) 479–502

[3] **BRITISH DENTAL JOURNAL** VOLUME 220 NO. 9 MAY 13 2016

[4] journalofdentistry42(2014)229–239

shared multi-agency timeline which they could keep updated in order to monitor the progress made against the child protection plan. Such a timeline should include analysis, not merely record events, and could potentially be a good source of evidence for legal processes helping to minimise delays.

The involvement of Education in the Child Protection process is critical. School staff are the practitioners to whom school aged children are most likely to make a disclosure of abuse and who have more hours of contact with children than any other professional in most instances. However there is a challenge for schools around meaningful representation at core group meetings and child protection conferences which occur during school holidays. Where possible core groups and child protection conferences should be held during term time. When this is not possible the arrangements should be made so that the school's safeguarding lead can attend even outside of term time.

Public Protection Notices (PPN) Process

It was evident within the review that communication between the police and children's services could have been strengthened. There were occasions when PPNs (formerly PPD1s) were not completed when they could have been, or failed to identify potential risks to the child within the events reported, in particular on the numerous occasions when mother was arrested. Whilst this information was fully shared for consideration in the police report for the Review Child Protection Conference best practice would have been for it to have been shared at the time. In respect of those PPNs (formerly PPD1s) that were completed there was little follow up by children's services. When a child on the child protection register is identified by a warning marker within police intelligence systems, those children will be linked by association to their parents. If researched effectively by officers they should be able to identify when those arrested have responsibility for a child on the child protection register and undertake the necessary welfare checks, albeit this review has identified that this area needs to be strengthened.

Improving Systems and Practice

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

The reviewers have identified that many of the learning points in this case are far from unique and have been evidenced in other child practice reviews that have been undertaken here and elsewhere. As a result of these learning points being repeatedly identified, the C&V Regional Safeguarding Board has tasked its CPR/APR Sub-Group to develop and lead on regular learning workshops for all statutory and partner agencies across Cardiff and the Vale. The initial themes for the learning workshops have been identified as follows; the voice of the child, disguised compliance, difficult conversations with family members, sharing information, meeting attendance, and holistic approaches.

Recommendations:

1. When a care order is granted for a child or at the earliest opportunity in a case, the decision will be made and recorded by a relevant member of the multi-agency team as to whether or not a referral to the Safeguarding Board for consideration of a child practice review is indicated. This will mitigate against delays to the CPR process.
2. When Legal Services have given advice regarding a child who subsequently becomes the subject of a Child Practice Review they will be represented on the panel, provide a timeline of their involvement and be invited to attend the Learning Event if deemed appropriate by the panel. This will aid practitioners' understanding of their respective roles, evidential requirements and the legal advice given in the case.
3. Cardiff and Vale Safeguarding Children Board (C&VSCB) must be satisfied that
    a) at every statutory child protection visit practitioners have recorded that they have spoken to the child alone and in an appropriate environment, to ascertain their true views wishes and feelings, and to provide an opportunity for potential disclosures to be made, so that the voice of the child may be heard

b) internal case file audits should evidence that the process of senior managers in Children's Services recording their approval of the progress achieved against the child protection plan, before the second and any subsequent child protection review conference is undertaken, to ensure that decisions are made within the child's timeframe

4. C&VSCB will update and relaunch their 'Multi-Agency Protocol on Working with Families who are not Cooperating with Safeguarding Issues' and ensure that practitioners are aware of its contents. Managers and independent conference chairs should promote its use where appropriate, to help practitioners make an authoritative response to the resistant family, so that children are effectively safeguarded. This policy must clearly state that when parents' behaviour prevents or compromises necessary safeguarding discussions and planning, it is permissible to continue or hold a meeting of the professionals involved without the parents being present, albeit there must always be a plan made to inform the family after the meeting.

5. C&VSCB will be satisfied that training, support and advice around the need for effective inter and intra agency information sharing for the purposes of safeguarding children, including when parental consent is and is not required as well as enquiries and checks on wider family members, is available to staff working with children and families in all partner agencies. All agencies will ensure parents are informed at the start of their involvement that the welfare of the child is paramount, and that all relevant information will be shared and all necessary action will be taken.

6. C&VSCB will be assured that practitioners understand the relevance of ACEs and are aware of their potential long term impact and understand the concepts of poly-victimisation and re-victimisation. This knowledge should be applied and given due weight when assessing the risk to children and making decisions about their future care.

7. C&VSCB will require that all partner agencies ensure that members of their staff attend Group 2 training under the National Training Framework so that they are skilled, confident and able to ' Ask and Act' proactively identifying and offering support to victims of domestic abuse.

8.
   a) C&VSCB will ensure that all practitioners who work with children and families are aware of the concept of dental neglect. It is rarely present in isolation, may form part of the more general neglect of a child and may co-exist with other forms of abuse. Early identification and that taking appropriate action may help prevent children from experiencing further harm
   b) C&VUHB will ensure that all general dental practitioners know how to access appropriate safeguarding children training and advice, so that practitioners are confident in acting appropriately when they see dental neglect in a child.

9. C&VSCB will provide multi-agency training on a rolling basis to inform practitioners about their own and other professionals' roles and powers in the child protection process. This will enable better understanding and multi-agency communication.

10. C&VSCB will introduce a consistent standardised multi-agency timeline template that becomes the responsibility of each agency to complete when attending the initial child protection conference. The multi-agency timeline will be maintained and updated at each core group meeting and presented as part of the report to the review child protection conference. This will ensure effective information sharing between agencies.

11. C&VSCB will challenge and hold to account partner agencies whose practitioners consistently fail to prioritise attendance and participation at Child Protection Conferences and core group meetings.

12. C&VSCB will be satisfied that Education Departments across the region ensure that there is meaningful engagement from the child's school and attendance at child protection conferences and core group meetings, even when these have to be arranged during school holidays.

13. South Wales Police will review their procedure for linking parents with children on the child protection register in order to strengthen the process. All relevant agencies will review their arrangements regarding the action to be taken on receipt of a PPN (formerly PPD1) and ensure that practitioners are aware of the expected response to ensure appropriate actions are taken to safeguard children.

Statement by Reviewer(s)			
REVIEWER 1	Dr Lorna Price Designated Doctor National Safeguarding Team (NHS Wales)	**REVIEWER 2** ***(as appropriate)***	Alys Jones Operational Manager, Safeguarding, Cardiff Council
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)*	LORNA PRICE	**Name** *(Print)*	ALYS JONES
Date	11th October 2018	**Date**	11th October 2018

Chair of Review Panel *(Signature)*	
Name *(Print)*	DAVID DAVIES
Date	11th October 2018

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Child Practice Review process

To include here in brief:

- *The process followed by the SCB 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 had been provided to them.*

The Cardiff and Vale Regional Safeguarding Children Board (CVRSCB) Chair notified Welsh Government in November 2016 that it was commissioning a Child Practice review in respect of Case CPR 03/2016.

External Reviewer:	**Dr Lorna Price** Designated Doctor National Safeguarding Team (NHS Wales)
Internal Reviewer:	**Alys Jones** Operational Manager Safeguarding Social Services, Cardiff Council
Chair of Panel:	**David Davies** Head of Achievement for All Learning and Skills, Vale of Glamorgan Council

The services represented on the panel consisted of:

- Education, Vale of Glamorgan Council (Chairperson)
- South Wales Police
- Social Services Cardiff Children's Services (Reviewer)
- National Safeguarding Team, NHS Wales (Reviewer)
- Education, Cardiff Council
- Housing, Cardiff Council
- Cardiff & Vale University Health Board
- Community Rehabilitation Company, Wales
- Social Services Cardiff Adult Services
- Welsh Ambulance Service, NHS Trust
- Cardiff & Vale Integrated Family Support Team (IFST)

The Panel met between the period March 2017 and December 2017 in order to review the multi-agency information and provide analysis to support the development of the report.

A learning event was held on the 28th of September 2017 and was attended by representatives from the following agencies:

- **South Wales Police** – Detective Constables and Police Constable
- **C&V University Health Board** – Consultant Paediatric Dentist, School Nurse, Health Visitor
- **Social Services Cardiff Children's Services** – Team Manager, Social Worker, Operational Manager, IFST Worker
- **Education, Cardiff Council** – Head Teacher
- **Social Services Cardiff Adult Services** - Team Manager, Cardiff Alcohol and Drug Team, Cardiff and Vale UHB – Community Addictions Unit and Social Worker
- **Welsh Ambulance Service, NHS Trust** - Nurse Adviser, Call Handler Coordinator NHS Direct Wales, Call Handler NHS Direct Wales, Senior Nurse Adviser

☒ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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

Appendix 1: Terms of reference

C&V RSCB Child Practice Review 03/2016

Extended Review

Terms of Reference

Background

Children Services raised concerns in January 2014 that the child's basic care needs were not being met - the school has reported that the child appeared unkempt and their attendance was very poor. Concerns were also raised regarding the child's dental hygiene, progress and development. Professionals also raised concerns of the mother's engagement with agencies (CAU and missed tests). The child was placed on the Child Protection Register (Neglect and Emotional Abuse). There were concerns surrounding a relationship with the mother and a new male. The mother made a Claire's Law request for a male, the mother was contacted by police and declined the information being offered regarding the male and no Claire's Law disclosure report was prepared as a result.

The child had made disclosures about the male of a physical and sexual nature. The child was removed from the address. The child was placed into foster care.

There was a fire in the home address of the mother and grandfather. It was later established that the grandfather had been found passed away in the upstairs bathroom of the property and his death was being treated as suspicious. The mother was linked to the investigation as a murder suspect.

Timeframe for Review:

1st January 2014 – 10th January 2016

The review panel have decided that the incidents subsequent to the child being removed from the home did not need to be included in the timeframe however; the reviewers will still consider any significant events outside of the timeframe as party of the context.

Criteria for an extended review

The criteria for extended reviews are laid down in the Social Services and Well-being (Wales) Act 2014; Working Together to Safeguard People Vol. 2 – Child Practice Reviews are:

3.12 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 a looked after child (including a person who has turned 18 but was a looked after child) on any date during the 6 months preceding –

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

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.

- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

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

- Whether previous relevant information or history about the child and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances. How did that knowledge contribute to the outcome for the child?
- Whether the child protection plan (and/or the looked after child plan or pathway plan) was robust, and appropriate for that child, the family and their circumstances.
- Whether the plan was effectively implemented, monitored and reviewed. Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?
- What aspects of the plan worked well, what did not work well and why? The degree to which agencies challenged each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the child and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).
- There are ongoing criminal investigations however; these are unlikely to interfere as the trial date is **22nd March 2017**.

The Specific Tasks of the Review Panel

- Agree the timeframe for the review including any necessary reference to any significant background information or previous incident.
- Identify agencies, relevant services and professionals to contribute to the review not already requested by the Child Practice Review Sub Group, produce a timeline and an initial case summary and identify any immediate action already taken. The Panel has determined that the appropriate agencies to be engaged in this review and therefore participate as members of the review panel are:
  - Health: Cardiff and Vale University Health Board
  - Children Services: Cardiff Local Authority
  - Education Services: Cardiff Local Authority
  - South Wales Police
  - Housing, Cardiff Local Authority
  - Welsh Ambulance Service Team
  - Wales Community Rehabilitation Company

- Adult Services, Cardiff Local Authority

- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback. Based upon the timeframe within which the Panel will conclude the review the learning event will be scheduled for the **28th of September 2017**.
- Plan with the reviewers contact arrangements with the child and family members prior to the event. Advice will be sought about how to engage with the family/birth family subject to the review and any relevant family members.
- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Child Practice Review Sub Group and the RSCB for consideration and agreement. It is proposed that the report will be shared with the Child Practice Review Sub Group at its meeting scheduled for the **20th of March 2018** and at the RSCB meeting scheduled for the **17th of April 2018**. It is proposed that the final report will be signed off by the end of **April 2018** and submitted to Welsh Government by **May 2018**.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before ratification at RSCB. The Panel Chair and Reviewer will provide feedback to the family in advance of the RSCB meeting scheduled for **17th of April 2018**.
- Identify and commission a reviewer/s to work with the review panel in accordance with guidance for extended reviews.
- Agree the timeframe.
- Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis and hypotheses.
- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Confidentiality Statement

1. I have been told and I agree that under no circumstances (unless otherwise instructed by the panel Chair) will I discuss any aspect of the Practice Review with any person not directly involved in or appointed to the review.
2. I have been instructed and I agree, that should any person not appointed to the review enquire or otherwise attempt to discuss the review, I will provide no information whatsoever to them.
3. I agree to report any such attempted enquiry to the review Chair.

Signature:	**Date:**
Name (Print):	**Position/Role:**
Contact No :	
Parent Organisation:	
Witness Signature:	**Date:**
Name(Print):	**Rank/Status:**

Sharing Information

- There is also a DHR (Domestic Homicide Review) being undertaken by Cardiff Council into the death of the grandfather and it was agreed by both the CPR Panel and DHR Panel that because there will be many similarities and individuals involved in both cases, that the CPR Reviewers will meet with the family members on behalf of both the CPR and DHR.
- It has been agreed by the Panel that information/findings from this CPR may be shared with the DHR.

Tasks of the Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- *Review Pane*l complete the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and submission to Welsh Government.
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication on Board website.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Confidentiality Closure Statement

To be completed if there are any changes to the information provided since completion of the review.

Name:	
Position/Role:	
Parent Organisation:	
Signature:	**Date:**

Part 3: Agreement for persons leaving or ceasing activity with review.

1. I am aware of the confidentiality of the review and that this confidentiality is essential to its existence. I am also aware that any breach of this confidentiality could directly affect the responsibilities and capabilities of the review.
2. I agree that I will not discuss or otherwise divulge any information whatsoever relating to the review to any person or organisation without the express and written permission of the review Chair.
3. I agree that I will make no further enquiries on behalf of the review**,** and should any person or organisation contact me in the belief that I am still directly involved in the review; I will decline the communication and direct the person or organisation to the review Chair.
4. I agree that I will not discuss the review with any person, including any present or past member of the review, and that I will notify the review Chair of any such attempt at communication of information.

I undertake not to record or retain in my possession any material, whether written or otherwise recorded, which relates to the review, and that I will not, under any circumstances, publish or otherwise make public any aspect of the review or reveal the identity of persons subject of the review.

Date:	**Signature:**
Witnessed by (Print):	**Signature:**

APPENDIX 2

Cardiff and Vale of Glamorgan Regional Safeguarding Children Board
Summary Timeline
Re: *C&V RSCB CPR 03/2016*

Type of activity	2014											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
University Health Board							Child admitted as a day case to the Dental Hospital. Extensive dental extractions under general anaesthetic for dental caries.		Core Group meeting. It was explained that continuation of poor engagement with Community Addictions Unit would result in a reduction of her medication and discharge from treatment.			
Police	Strategy discussion between police and Children's Services. Decision to proceed to an Initial Child Protection Case Conference.											

Type of activity	2014											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Social Services	Initial Assessment completed by Children's Services. Concerns around parental substance misuse, evidence of neglect of child's basic care needs, instability of housing. S47 enquiries/Core assessment started.				S.47 enquiries/core assessment concluded. Significant concerns around emotional harm, neglect, parental substance misuse, criminal activities of mother. Family due to be evicted due to rent arrears.	Initial Child Protection Conference held. Child registered under the categories of Neglect and Emotional Abuse. Core Group identified. Outline Child Protection Plan formulated. Case transferred to long-term social work team.	Core Group held. Improvements noted to home conditions and child's general care, but concerns expressed re poor school attendance and punctuality and very poor engagement by mother with Community Addictions Unit.	First Review Child Protection Conference; Child's name retained on register under categories of Neglect & Emotional Abuse. Further concerns regarding care of child and mother's poor engagement with Community Addictions Unit. Core Group meeting held. Mother did not attend. The Chair recommended that a new Written Agreement be drawn up to include engagement with services, particularly Community Addictions Unit. The Written Agreement should be in place for three months and if broken Public Law Outline		Core Group held. Mother reported that she had been in relationship for several months. The Social Worker had completed checks; there was information held by the police in relation to previous convictions for battery, charges of domestic violence and possession of drugs. Mother informed the core group that since being made aware of this information she had ended the relationship.	Core Group held. Mother has attended CAU and provided supervised urine samples which were positive for illicit substances. Mother is now on Methadone which she collects daily.	

Type of activity	2014											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
								proceedings should begin due to the lengthy history of non-engagement.				

Detailed timelines were produced by the relevant services for the purposes of the review to assist the understanding of the complex interactions between events and services in this case.
This summary and partial timeline contains limited and anonymised details and is provided to supplement the outline of circumstances in the Child Practice Review report.

Type of activity	2015												2016
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
University Health Board	Core Group Meeting. Mother's engagement with Community Addictions Unit noted to be barely acceptable.		Mother was attending CAU for dispensing with a man. She stated they were not in a relationship and that he was just a friend.										
Police			SWP received a telephone call from Mother, wishing to make a Clare's Law application in respect of her new boyfriend of five months.				Mother received a prison sentence for shoplifting offences and breaching her bail conditions.		The child continued to make disclosures of abuse including sexual abuse and was interviewed by the police.				Further police interview completed and record closed.

Type of activity	2015												2016
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
CRC				Court Sentence for shoplifting offences. Mother received a 12 month Community Order. Probation officer was allocated. Mother failed to attend the initial appointment with Wales Community Rehabilitation Company. Mother committed several shoplifting offences that same day and the child was with her. Mother attended Community Rehabilitation Company for initial appointment under the influence of substances. Offender Manager									

Type of activity	2015												2016
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
				contacted social services and relayed her concerns that Mother was not fit to care for child that day. Arrangements were made for the child to be taken from school to grandmother's address.									
Social Services	Second Review Child Protection Conference. Positive improvements were noted but needed to be maintained. Child's name remained on the Child Protection Register under the categories of Emotional Abuse & Neglect			Statutory Child Protection visit to family home. Mother and child present. Boyfriend also arrived at the home whilst social worker was visiting. She had concerns about the presentation and behaviour of mother; that mother was misusing substances which were impacting on her self-care and the child was being exposed to		Legal Planning meeting held. Agreed PLO pre-proceedings.	During a home visit the child informed the Social Worker that the boyfriend hurts mummy and that the child is scared of him. The child was removed to the care of grandmother. Third Review Child Protection conference. The outcome of the conference was that the child's name remained on the Child	Interim Care Order Granted. Child placed in foster care. Once in foster care the child made disclosures about domestic violence perpetrated by the boyfriend on the child's mother and the dog. The child described witnessing drug use by the mother and the boyfriend.	Fourth review child protection conference. The child's name was removed from the register as the child was looked after by the local authority.			The child made further disclosures of sexual abuse to the foster carer.	Care order granted.

Type of activity	2015												2016
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
				parental substance misuse. CP statutory visit by social worker. Mother was under the influence of substances and the child was present at the home in her sole care. The social worker had significant concerns for mother's wellbeing and her capacity to care for the child. Other family members were not contactable. Mother refused consent for section 20 accommodation. The social worker phoned the police for assistance but they refused to attend the home. She then contacted			Protection Register under the categories of 'Neglect' and 'Emotional Abuse'. Grandmother reported to the social worker that the child had disclosed that mother's boyfriend threatens the child and the mother with a knife, he comes in to the child's room at night and they are scared of him. Legal Planning Meeting held. Viability assessment of extended family members was negative. Mother was not engaging with a parenting assessment or written						

Type of activity	2015												2016
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
				the Emergency Duty Team to seek guidance and report her concerns. It is unclear from the records how safeguards were put in place.			agreement and is still in a relationship with the boyfriend. Threshold met to initiate care proceedings.						
Housing						Anti-Social Behaviour Unit receives a complaint from Mother's neighbours regarding many visitors to and around the property at all hours. ASBU open an investigation.							