Child Practice Review Report

Cwm Taf Safeguarding Children Board

Concise Child Practice Review

Re: CTSCB 02/2014

Concise Review	☒
Extended Review	☐

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

A Concise Child Practice Review was commissioned by Cwm Taf Safeguarding Children Board in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews (2012). The criteria for this Review were met under section 6.1 of the above guidance namely:

where abuse or neglect of a child is known or suspected and the child has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development

and

the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding

This review was commissioned following the serious injury of a child, aged 5 months. The child was one of twins and also had an older half sibling. Prior to the time of the incident the child and the family only had involvement with the usual universal services and the parents were viewed as being caring and having effective support from their wider family.

The child was taken to the GP who became concerned about the child's wellbeing and an emergency admission to hospital was arranged. When at the hospital, a medical examination and a scan revealed a serious non accidental head injury. The child protection procedures were immediately invoked.

The time period for this review is between 26th March 2013 and the 23rd January 2014. This covers the period before birth, from first ante-natal appointment, and up to the point of a multi-agency safeguarding meeting. The Terms of Reference for the Review are attached as ***Annex 1*** and the summary time line is attached as ***Annex 2***.

Practice and organisational learning

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

1. **Decision making and assessment or enquiries should be properly coordinated and recorded via strategy discussion or meeting. Several strategy meetings maybe required to achieve this. There should also be a common understanding across the agencies about the purpose and function of strategy discussions / meetings.** In this case there were examples of different records of strategy discussion / meeting in different agency records. Also, there was one meeting recorded as an 'information sharing meeting', and another as a 'meeting'. There were also examples of decisions being made outside of strategy discussion / meeting. There should have been one multi agency record of the decisions and actions that arise from strategy discussions / meetings.

2. **During child protection enquiries, the strategy meeting needs to coordinate enquiries / assessment in respect of each individual child in the household.** In this case, the focus was upon the child presented with the initial injuries. This distracted from the need to consider a medical assessment under child protection procedures for other children in the household.

3. **Professionals expressed concern that parents who are separated from their children during child protection enquiries; where there is a Police investigation, need support.** In this case, whilst one parent had reliable support another parent did not, despite stating that such support was available. Professionals were concerned but were unable to identify a service that could provide support.

4. **Where a person working or volunteering with children has been involved in the care of a child who has sustained unexplained or suspicious injuries, there should be a strategy meeting under the child protection procedures to coordinate information sharing, protect children, and support individuals.** In this case a strategy meeting did not take place under the child protection procedures to share information that was related to the work place, and thus, there was no opportunity to formally consider the issue of any risk or support to the employee or others.

5. **Professionals at Child Protection Conferences should be provided with all relevant information.** In this case, some professionals were not aware that an individual had admitted to harming the child. The Chair of the Conference should have ensured that this information was shared, if necessary via a closed session, to ensure professionals were making informed decisions.

6. **Decision making and care planning for children who are looked after must be dynamic, and responsive to new information, giving full attention to a child's right to be cared for by a parent / family member**. In this case, there was no effective challenge to the care plan in the light of significant new information that changed the assessment of risk at an early stage in the process.

7. **Practitioners should be aware of the impact of their actions and decisions upon individual family members, having regard to their personal circumstances.** In this case, one of the parents expressed concern about their treatment which they perceived as being different to what was viewed as a more positive and supportive approach afforded to the other parent. One parent expressed the view that there was insufficient consideration of the impact of frequent meetings for that parent's employment.

Effective practice

- Agencies acted effectively and promptly to safeguard the children.
- There was effective coordination communication of ante-natal, neo-natal, and post natal health care around the time of birth and discharge.
- The contribution of a Paediatrician at one of the strategy meetings was considered to be exceptionally useful
- The family recognised that, in the main, professionals made sound judgements and dealt with them in an appropriate way. One social worker in particular was viewed by them as having been especially helpful and supportive.

Improving Systems and Practice

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

1. The CTSCB guidance to practitioners in relation to strategy discussions and meetings should be improved to integrate the learning from this case. This must be shared with practitioners.

2. The Cwm Taf Multi-Agency Safeguarding Hub should include into its processes the learning in this case about the need to have a pathway that integrates the Professional Strategy Meeting process with the Child Protection Process for the child.

3. Learning from this review should be built into all levels of safeguarding training, in particular the support of individuals and families during the Child Protection Process.

4. Child Protection Conference Chairs should be made aware of the learning arising from this review in relation to information sharing at Child Protection Conference.

5. Whilst it is recognised that the Independent Reviewing Officer (IRO) role lies outside the scope of this Review, learning was identified about the importance of IROs and Conference Chairs liaising to ensure that the IRO has a fully informed position when reviewing and challenging the Care Plan. This should enhance the potential for looked after children to be cared for within the family and kinship network, wherever this is safe.

Statement by Reviewer(s)	
REVIEWER 1 Ann Batley	**REVIEWER 2** Annabel Lloyd
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)* A Batley	**Reviewer 2** *(Signature)* A Lloyd
Chair of Review Panel (Signature)	Eirian Evans
Name *(Print)*	Eirian Evans
Date	February 2015