Concise Child Practice Review Report

CYSUR 1/2021

Date report presented to the Board:

14th June 2024

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Practice Review Re:
CYSUR 1/2021

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*

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

A concise practice review was commissioned by Mid & West Wales Safeguarding Children Board ("CYSUR") on the recommendation of the Child Practice Review Sub Group in accordance with statutory legislation set out in the *Social Services and Wellbeing (Wales) Act 2014*[1] and accompanying guidance *Working Together to Safeguard People – Volume 2 – Child Practice Reviews* (Welsh Government, 2016)[2].

The criteria for this review are met under section 3.4 of the guidance, namely:

*A Board must undertake a **concise** 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 neither on the Child Protection Register nor a Looked After Child 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*[3] *identifies that a child has sustained serious and permanent impairment of health and development.*

The criteria for concise reviews are laid down in The Safeguarding Boards (Functions & Procedures) (Wales) Regulations 2015[4].

The purpose of the review is to identify learning for future practice. It involves practitioners, managers and senior officers exploring the detail and context of agencies working with a child and their family.

[1] Social Services & Well-being (Wales) Act 2014.
[2] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016).
[3] Local Authority or relevant partner means a person or body referred to in S.28 of the Children Act 2004 or body referred to in s.175 of the Education Act 2002.
[4] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and child protection practice. It should include the circumstances which led to the review, including highlighting effective practice and considerations on what needs to be done differently to improve future practice (Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016)[5].

Circumstances resulting in the review

This is a tragic case which culminated in an unprovoked and violent attack on a young child ("child A") by their mother's partner ("Male B") on the evening of 16 July 2020 and the morning of 17 July 2020. Child A was pronounced dead on 21 July 2020, age 2 years and 10 months old. Child A had lived with her mother, Male B, and her younger and older sibling in the mother's home.

The first official record of the mother's connection to Male B is seen in a police report dated 19 June 2020. On that date, Male B reported to the police that a threatening letter had been hand delivered to the mother's home by a third party. This was less than a month before Male B went on to kill child A, however the relationship between Male B and the mother is understood to have begun around 4 months earlier in late February 2020.

Shortly before the incident which commenced on the evening of 16 July 2020, the mother was in contact with an Independent Domestic Violence Advisor ("IDVA") due to concerns of domestic abuse involving a previous partner. They spoke at around 11am on 16 July 2020 by telephone. The mother informed the IDVA that she had not been in a relationship with her previous partner since January 2020, but reported that she was in a new relationship. She did not provide any detail regarding Male B to the IDVA, nor was she invited to do so. The mother declined support and stated that she was "turning things around". She was, however, encouraged by the IDVA to request a Clare's Law disclosure regarding Male B; in order to understand whether Male B had a prior history of violence or abuse. This was important as the mother had previously been involved in a number of abusive relationships. The sentencing remarks of the judge following the criminal trial in this case highlighted that the mother had asked Male B for his date of birth on 16 July 2020, but that he refused to give it. It was further remarked by the judge that the mother realised that this was suspicious, but that she did not press it.

Shortly thereafter, during the morning of 17 July 2020, an ambulance was called to the mother's home, initially via a 999 call made by Male B's mother. The caller said that child A had fallen down the stairs and was unconscious. On attendance at the mother's home, ambulance staff raised concern that the injuries sustained by child A were inconsistent in number (there were over 100 injuries) and location with a fall down the stairs. Ambulance staff found child A with a large haematoma to the forehead and swelling to her left cheek and lips. She was urine incontinent and her pupils were dilating at different levels and in different directions. She also had old bruising to her face.

Child A was taken to a local hospital and concerns were again raised by treating clinicians regarding how she was said to have sustained her multiple injuries. Child A was intubated, ventilated and thereafter transferred to a larger hospital for further assessment. Following such assessment, child A was confirmed to be brain stem dead and ventilation and other life sustaining treatment was, as a consequence, withdrawn.

[5] Working Together to Safeguard People – V2 – CPRs (Welsh Government, 2016).

The mother and Male B were subsequently arrested by the police, however both denied the offences put to them. Male B claimed that child A had fallen down the stairs after tripping over the family dog. Her two siblings were also found to have unexplained bruises and were removed from their mother's care and placed with family members, where they have remained to date. This is now regularised by orders made by the family court.

Time period reviewed and why

The emotions which this case has understandably generated are fully recognised. This review has been robust in considering whether more could have been done to protect child A and what lessons can be learnt to support future multi-agency safeguarding practice. Such robustness necessitated extending the time period beyond the usual period of 12 months (by 5 months) to cover a 17 month period between February 2019 – July 2020.

The independent reviewer, panel chair, and review panel, all felt that there were exceptional circumstances in this case due, in particular, to the significant interagency involvement with child A's mother and Male B from February 2019. For example, in February 2019, Male B was referred to the community drug and alcohol team for assessment. The assessment was prioritised as he was homeless and presenting at his mother's property, who was reporting (including to the police) being fearful for her safety. Male B had a history of failed tenancies and poly drug misuse.

The overall timeline reflects the work undertaken with child A, the mother, Male B, and child A's two siblings over this 17 month period. The birth father had limited involvement in child A's life during this time. He did, however, fully engage with the review and provided helpful contextual information to assist the independent reviewer and panel chair understand the complex family dynamics. The timeline, chronologies and analysis submitted by all agencies were discussed in detail during panel meetings and at the learning event and have informed the learning included within this report. Additionally, the independent reviewer requested, and was given access, to the core records from the relevant agencies for the agreed period. It was considered proportionate and appropriate on the facts of this specific case for the independent reviewer to have access to all relevant material and not be limited to the summaries (albeit, very helpful) prepared by the agencies. The independent reviewer is very grateful for the full cooperation by all agencies in this regard.

A learning event was held on 4 and 5 July 2023, facilitated by the independent reviewer and panel chair. It was well attended by practitioners, managers and senior managers of all relevant agencies involved with the family. Whilst some professionals were not directly involved, they were nonetheless able to thoroughly contribute. The following agencies were represented at the learning event:

- Health board (midwifery and health visiting)
- Regional police force
- Local authority children's services
- Local authority adult services
- Education (Flying Start)
- Local authority housing
- Independent housing association

Finally, prior to the completion of this report, the independent reviewer was provided with further information from children's services regarding the context in which child A was assessed between January – March 2020. Supplementary information was also provided by the Welsh Government and the local authority regarding funding allocation at the relevant time, and to date. The additional information has been fully considered and incorporated, as appropriate, within this report.

Family history and relevant contextual information

The family were first known to the police and children's services one month after child A's older sibling was born due to referrals regarding domestic abuse. Records show that domestic abuse was present in a number of the mother's relationships. Notably, on 17 July 2020 (the same day as the fatal incident took place), the mother was discussed at a Multi-Agency Risk Assessment Conference ("MARAC") following a domestic incident involving the father of her youngest child. At that meeting, professionals became aware that an IDVA had been allocated.

Although children's services and education services did not identify the older sibling as a vulnerable child to be put forward for an educational placement during the Covid-19 pandemic, the emotional literacy support assistant kept in touch with the mother via phone calls, and the teacher kept in touch via an educational platform used by the school. Additionally, the mother saw her GP on 9 July 2020 and reported that her medication was no longer working. She had been prescribed antidepressants earlier that year, but reported that the symptoms had reoccurred the previous week. The mother reported feeling low and said she could not sleep. She was prescribed medication to assist. The GP also agreed to make contact with the health visitor to request advice as the mother reported that child A was only sleeping for 3-4 hours per night instead of the expected 10-12 hours for a child of her age.

Male B was open to the children with disabilities team within the local authority when he was a teenager. He has a diagnosis of ADHD and reports to also have Asperger's. Male B has one child from a previous relationship. Children's services became involved with that child in June 2014 following concerns regarding Male B's drug misuse and domestic abuse, and he received input from the community drug and alcohol team within the local authority. One reported incident involved Male B "smashing up" furniture in the presence of his child.

This review was undertaken concurrently with the police investigation and subsequent criminal proceedings to avoid delay. It was, however, necessary for those processes to conclude prior to this review being finalised. In October 2021 the panel convened and the chair was appointed. In December 2021 the independent reviewer was appointed and the time period and terms of reference were agreed. In July 2022 the initial timeline review took place, and in September 2022, at a full panel, an analysis of the timeline was considered and the panel agreed to suspend the review pending the conclusion of the criminal trial.

The criminal proceedings concluded on 25 April 2023. The mother was convicted of causing or allowing child A 's death and Male B was convicted of child A's murder. The mother was sentenced to 6 years imprisonment and Male B was sentenced to 28 years imprisonment. The sentencing judge commented that child A's death was a culmination of several months of physical child abuse by Male B. The judge also stated that the mother had been a victim of domestic abuse in the past and had prioritised her relationship with Male B over concerns for child A.

The judge further remarked that the mother did not disclose the presence of Male B, or the injuries to child A, to professionals. It is noted by the independent reviewer that the mother had ample opportunity to do so as there were a number of professionals involved in her life during the relevant time period (addressed further below).

Parents' involvement in the review

The family's views are an important element of the review to enable professionals to learn from their experience throughout the time period and to glean any learning to inform future practice. In this case, both parents fully contributed to the review.

The independent reviewer and panel chair met with the mother in prison to provide the opportunity for her to contribute. Notwithstanding her involvement in causing or allowing child A's death, the mother explained, in some detail, the steps that she considered could have been taken to prevent child A from suffering harm. The reviewer and panel chair also met with child A's father in his home. The independent reviewer and panel chair are grateful to both parents for their input.

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.

The individual learning points which arise in this case have been identified via the production of a composite multi-agency timeline and agency analysis, a learning event for professionals, engagement with both parents, discussions within the review panel meetings, consideration of core documentation and relevant polices from the agencies involved, and from supplementary information provided by the local authority and the Welsh Government; the latter regarding funding allocation.

It should be emphasised from the outset that although the impact of the Covid-19 pandemic inevitably affected how services operated during the relevant period, there is no direct evidence that the impact in the 4 month period between March 2020 and child A's death in July 2020 prevented direct access to child A within the home environment by professionals who had identified a need to see child A, which is positive.

Additionally, whilst child A did not attend playgroup from 24 March 2020 onwards (the provision having closed due the pandemic), telephone calls were made by the Flying Start leader to the mother on 20 April 2020 and 20 May 2020. Additionally, regular telephone contact was made to the mother by professionals at the school attended by the older sibling on 9 occasions between March – June 2020, prior to the older sibling returning to school on 30 June 2020 (31 March 2020, 7 April 2020, 16 April 2020, 20 April 2020, 29 April 2020, 4 May 2020, 11 May 2020, 20 May 2020 and 10 June 2020).

Furthermore, and importantly, health visitor provision for child A continued (in the 4 month period between March – July 2020), and attempts were made to contact the mother (set out further below). Attempts were also made by the speech and language therapist and nursery nurse to contact the mother. Consequently, although a global pandemic is inevitably "in the background", there are no individual learning points which arise directly from this. Instead, having carefully considered the multifactorial issues in this complex case, the 7 learning points are as follows.

Learning point 1

To ensure that relevant professionals are consulted during an adult needs assessment

In the knowledge of how child A died, it is important to understand, what, if anything, could have been done to address the various concerns known to services about Male B before he entered the family home, which appears (from evidence obtained within the criminal trial) to have happened in late February 2020 – 5 months before he killed child A.

Having considered a substantial amount of core material from the agencies involved, it is clear that Male B was known to the police from at least March 2019. The police logs include domestic related incidents between Male B and his own mother on 15 March 2019 and 9 October 2019, and he was arrested for breach of the peace on 25 May 2019. Additionally, Male B was assessed by adult services on 13 March 2019 in relation to the support that could be provided regarding his accommodation and substance misuse.

Save for when he was under the influence of substances, Male B was assumed to have capacity to make decisions regarding his accommodation and support needs in accordance with section 1(2) of the Mental Capacity Act 2005[6]. Although it was properly highlighted in the adult social services records that Male B would need help (as he had not acquired the necessary skills to live independently), this did not rebut the presumption of capacity.

Additionally, whilst mental health concerns were properly raised (including by his mother), this did not reach the threshold for compulsory detention under the Mental Health Act 1983[7]. Consequently, although Male B was encouraged and supported on a number of occasions to engage with primary health services, housing services, and the community drug and alcohol team (in particular), he could not, as a capacitous adult, be *compelled* to engage. His chaotic lifestyle could be considered unwise, but it was not behaviour that could, during the relevant time, reasonably lead to interventions against his will. Due to a lack of engagement, Male B was discharged from adult social services in May 2019, but was made aware of how to access support in the future, should he wish to engage.

There are a lot of positives regarding how adult services dealt with Male B from March – May 2019. Effective practice can be summarised as follows:

(1) There was joined up thinking and effective inter-agency working between the community drug and alcohol team and housing team, and there was a significant amount of contact with Male B by professionals (within these teams) in an attempt to encourage and persuade him to attend appointments and take up offers of support;

(2) There was a significant amount of contact by professionals (within the above teams) with Male B's own mother, who provided him with emotional and practical support when she felt able;

(3) Based on the information known at the time of assessment (undertaken by adult social services[8]) in March 2019, and without the benefit of hindsight, it was reasonable to conclude that Male B was not a risk to children at that time. He acknowledged that his lifestyle was

[6] Mental Capacity Act 2005

[7] Mental Health Act 1983

[8] Undertaken in accordance with s.19 of the Social Services & Well-being (Wales) Act 2014.

unsuitable (such that he could not have contact with his own child), and there was nothing to suggest he would enter a new relationship in the immediate future.

Having carefully considered whether anything more could have reasonably been done to obtain Male B's engagement with relevant services between March – May 2019, and having regard to his known mental health history and ADHD diagnosis (and potentially other neurodiverse conditions), it would, on balance, have been reasonable for the assessor (within adult social services) to have consulted Male B's GP.

Male B had consented to information being requested from health care professionals for the purpose of assessment. Although the GP records were properly considered by the assessor, consultation with the GP regarding Male B's mental health/emotional well-being and substance misuse (including a discussion of whether medication or other types of therapy were available), could have provided further advice and detail of wider support. Although Male B may not have engaged with wider support identified by his GP (due to his resistance to other forms of intervention), this may, in other/future cases, give rise to positive engagement. Ensuring that relevant professionals are directly consulted during an adult needs assessment is the first learning point.

Learning point 2

To ensure that an assessment regarding the needs of a child is undertaken and finalised in accordance with the relevant timescale by children's services prior to a case being closed in an appropriate way, and to ensure that robust systems are in place within children's services to attend to periods of absence by an allocated assessor

During the relevant period, verbal arguments took place in the family home where child A and her two siblings lived between the mother and a previous partner on (i) 17 June 2019 (ii) 19 July 2019 (iii) 24 September 2019 and (iv) 4 January 2020; all of which necessitated police involvement. Not all incidents were reported by the mother. The police emailed the child care assessment team on 4 January 2020, detailing the domestic violence call out, and on 5 January 2020, a referral was promptly made by the police. This was the first Multiagency Referral Form ("MARF") submitted during the relevant period[9].

The information provided was that the mother's previous partner had attended the family home and was being violent towards others, had caused damage to the property, and that her children were at the address (which included child A). The mother disclosed that she had also been assaulted by her previous partner a few weeks earlier. She stated that he had bitten her nose and pushed his thumb into her eye, causing bruising. Allegations were also made by a third party that the child's older sibling had said she had been assaulted by the mother and the mother's previous partner[10].

In addition to a referral having been made by the police, on 16 January 2020, the health visitor also completed a MARF. Concerns were similarly raised by the health visitor regarding domestic abuse, but also that the mother was finding child A demanding. Concerns were also raised by the

[9] The police stated that automatic notifications would have been sent by email to children's services regarding the first 3 incidents (via a Domestic Incident Notification). It was explained that this was automatic when a DASH assessment was completed. There is, however, no record of those notifications on the system used by children's services.

[10] It is noted (from the information provided by the police) that despite a lack of support by the mother to a police investigation regarding this incident, that this was (in fact) pursued by the police, which led to the previous partner being charged with assault and criminal damage.

health visitor regarding home conditions and the fact that child A was unwashed when last seen (which appears to be in November 2019), and that her feet were black with dirt. An assessment was opened by children's services on 7 January 2020. It is that assessment process that this learning point relates to.

The assessment

The framework for assessing the needs of a child is included in the Code of Practice prepared by the Welsh Government titled "Part 3 Code of Practice (assessing the needs of individuals)", which relates to the duties contained in the Social Services & Well-being (Wales) Act 2014 and the Care and Support (Assessment) (Wales) Regulations 2015[11]. Local authorities, when exercising their social services functions, must act in accordance with the requirements contained in the Code of Practice. Within the Code of Practice, it is emphasised that (i) the central duty (when assessing) is to safeguard a child and promote their well-being, (ii) that a key part of the assessment is to establish whether there is reasonable cause to suspect that a child is at risk, and (iii) that the timescale for the completion of the assessment is a maximum of 42 working days from the point of referral[12]. In child A's case, the assessment should have been completed by either 16 February 2020 or 27 February 2020, depending on whether the police or health visitor referral date is the start date used. Within the Regulations, it is emphasised that the local authority must make a written record of the results of the assessment and the matters to which the authority has had regard in carrying out the assessment[13].

The assessment of child A by children's services is titled *"integrated assessment – child comprehensive"* and was purportedly signed by the social worker and authorised by their team manager on 10 February 2020. That assessment was lacking in detail and analysis and concerns were raised by the independent reviewer regarding its content (or lack thereof) during the course of this review. During the latter part of this review, however, it became apparent that the assessment had not, in fact, been completed by the named social worker, and had instead been created on 18 March 2020 and closed on 30 March 2020 by their team manager. The rationale provided by the team manager during the latter part of this review was that they were engaging in a practice of closing down assessments for staff who were on sick leave in order to manage the team's workload, and that *"a very basic assessment"* would be written up from the presenting issues within a referral, but that *"to anyone looking at the system, these assessments would appear as if they had virtually no information in them"*. The team manager also explained that the assessment team were *"struggling under the pressure of the relentless workload and the fact that we also had a lack of staff".*

The social worker explained that she was on sick leave from 16 March 2020, that the assessment had been created by her team manager two days later on 18 March 2020, and that she was informed that her assessment would be closed via a text message sent to her by her supervisor when she was absent from work. The social worker explained that they had not anticipated this, that it was not usual practice, and they had thought they would complete the assessment on their return, whilst recognising this would be outside the usual timescales.

It also became apparent during the latter part of this review, due to further information provided, that the social worker not only had a significant workload, but also the responsibility for providing supervision to two newly qualified members of staff, and at the time of their involvement with child

[11] https://www.gov.wales/sites/default/files/publications/2019-05/part-3-code-of-practice-assessing-the-needs-of-individuals.pdf.
[12] For example, see paragraphs 76, 78 and 85 of the Code of Practice.
[13] Regulation 5(1).

A's family, they were the only senior practitioner in the team, with others being absent for different reasons (there would usually be four senior practitioners).

Although not documented in the records provided (addressed further below), the independent reviewer was informed that the social worker did visit child A at the family home on 23 January 2020, and that they also had discussions with various family members, including the alleged perpetrator of domestic abuse. As a result of those discussions, the social worker considered that voluntary engagement with the Team Around the Family ("TAF") service would assist. This was not progressed by the mother, however, following a referral being posted through her door on 6 March 2020 by the social worker[14].

Impact/learning from the above

The completion of child A's assessment and subsequent closure of the case by a team manager (i) when the social worker (the actual assessor) was absent from work, (ii) without the team manager seeking full information from the social worker before doing so (in order to obtain relevant information), and (iii) where the social worker did not document the steps they had taken on the electronic system (for the team manager to see/consider), was not appropriate. It is also inappropriate for an assessment to give the impression of being drafted by a particular practitioner, when this was not, in fact, the case. This is not a practice that was endorsed by children's services at the time, or to date. Although it is readily accepted that there should be a proportionate application to an assessment (to enable children to receive the help they need, whilst minimising the administrative burden), the consequence of what happened in this case is that an assessment of child A's needs was not properly undertaken by children's services, as required, and the only identified service to support the family (TAF), was not actioned.

It is impossible to say what the content of a properly undertaken assessment would have included or what would have happened if TAF had become involved. Even if children's services remained actively involved (with an open case) post March 2020, it cannot be said that the subsequent events of July 2020 would have been avoided, and this review must be astute to guard against the benefit of hindsight. It is reasonable to conclude, however, that if an assessment had been properly undertaken, that the views of child A's father (identified on the assessment as having parental responsibility) and the views of other professionals should have been included. Information was available, for example, from the police, the health visitor and flying start. Additionally, if the assessment had been properly undertaken, the mother's ability to protect child A from harm and/or her apparent prioritisation and need for a relationship (with at least one previous partner who she knew to be violent) over the safety of her children could have been more fully considered. It may very well be the case that the social worker had these considerations in mind, however as the assessment was "closed down" prior to their return, it is impossible to know.

An important point for practitioners, therefore, is to ensure that an assessment regarding the needs of a child is undertaken and finalised, in accordance with the relevant timescale, prior to a case being *appropriately* closed. The following learning points also arise:

[14] During the learning event, it was explained that social workers no longer leave TAF referrals with parents, and instead, a TAF referral is entered onto the computer system by a social worker, with the expectation that TAF will then consider this, and make contact with a parent. Whether that parent chooses to engage, however, is a different matter, as the TAF service is voluntary and a parent cannot be compelled to receive support.

(1) Supervision of team managers. It is of concern that the process employed by the team manager in child A's case was not identified (i) after child A's death as part of the local authority's immediate review process or (ii) until late into this review. It is unclear how many other assessments were finalised and cases closed in this unorthodox way and what (if any) impact this has had on the children being assessed. Consideration of how team managers are supported and supervised in their role is needed by senior management.

(2) Greater focus on supporting experienced staff before reaching crisis point is needed, and when extended leave is required, for consideration to be given regarding how their workload is managed in their absence. It was apparent that the workload of child A's social worker prevented her from being able to undertake her role as effectively as she ordinarily would, or how she would wish.

Learning point 3

To ensure that opportunities are not missed by health visitors to arrange home visits or escalate concerns (to management) if there is a failure by a parent/carer to engage, particularly where there is a history of child protection concerns within the family

The health visitor role is to deliver an All Wales Healthy Child Programme ("HCWP")[15]. HCWP sets out what planned contacts children and their families can expect from their health boards from maternity service handover to the first years of schooling (0-7 years). These universal contacts cover three areas of intervention: screening; immunisation; and monitoring and supporting child development (surveillance). A health visitor's professional assessment not only looks at the development of the child, but considers the whole setting and wider influences such as social, economic and environmental factors, and whether the child and family need additional support to address areas of concern.

The family were known to the local health visiting team from May 2019. Domestic abuse was noted in the initial assessment and the level of intervention considered necessary for child A, having regard to the 3 HCWP levels, was the "intensive" level. As the name suggests, this was the highest level of the HCWP surveillance programme. This level builds upon the "universal" and "enhanced" core programmes and can include intensive structured home visiting programmes, however there are no set timeframes for this, and it is ultimately a matter of professional judgement.

On 19 November 2019, the health visitor, having attended the family home, documented that child A's feet were dirty. The mother reported concerns regarding child A's behaviour, but declined nursery nurse support. On 16 January 2020, a MARF was completed by the health visitor which raised concerns regarding increasing incidents of domestic violence with a previous partner of the mother (such incidents having occurred on 17 June 2019, 19 July 2019, 24 September 2019 and 4 January 2020). It is clear to the independent reviewer that concerns were incrementally increasing, and the further domestic incident in early January 2020 appears to have tipped the balance, leading the health visitor to appropriately make a referral.

Thereafter, during a home visit on 5 February 2020, the health visitor was kept on the doorstep as the mother reported that child A and her younger sibling were unwell. She was not challenged by the health visitor about this, and it was not further explored. This was despite the health visitor knowing the family history, and knowing there was no access at a prior planned home appointment on 27 January 2020. The health visitor did observe child A, albeit on the doorstep. Child A was

[15] https://www.gov.wales/sites/default/files/publications/2022-03/an-overview-of-the-healthy-child-wales-programme.pdf.

appropriately dressed and advice was given regarding child A's "pink eye". The mother reported that a former partner was "going to prison" for hitting the children, but said that she did not believe he did this, and that it had been fabricated by her mother.

It was good practice, during a subsequent home visit on 15 February 2020 (for child A's 27 month developmental assessment), for the health visitor to refer the mother to the perinatal mental health team (as the mother stated she was in a low mood)[16], and for nursery nurse support. Significantly, the home visit on 15 February 2020 was the last health visitor home visit prior to child A's death almost 5 ½ months later on 21 July 2020.

A further visit was offered on 5 March 2020, but was declined by the mother, who cited a family bereavement. Thereafter, telephone calls were made on 23 March 2020 and 6 April 2020 by the health visitor, however there was either no answer or the line was engaged. Messages were left. As child A's playgroup had closed, and as her case was not open to children's services at this time, the health visitor remained an important professional to retain "eyes and ears" on child A. Although the health visitor did send a supportive letter on 20 April 2020 to arrange an appointment (in light of the failed telephone attempts), this "light touch" approach was insufficient. Child A should have been regarded as vulnerable based on what was known, and a more robust approach should have been adopted[17]. Due to the continued pattern of non-engagement, it is clear that there were a number of missed opportunities by the health visiting service to (for example) undertake unscheduled home visits to see child A after 15 February 2020, liaise with other professionals, or complete a further MARF due to the lack of engagement.

The mother did not respond to the letter sent on 20 April 2020, and the health visitor took no further action for a further 7 weeks until a telephone call was latterly made on 8 June 2020. During this call, the mother said that a female friend was staying. The health visitor did not probe regarding who this was. As noted by the sentencing judge in the criminal trial, this was a lie told by the mother and a "cover up" (the female person sleeping in her house was Male B). It is positive that the health visitor subsequently shared this information with children's services (regarding the "friend"), however the case was closed to children's services at that time, and nothing further was done. It is fully accepted that the mother *chose* not to disclose to the health visitor that Male B was living at the property, or even that she was in a new relationship (at this time). It is now known, however, from information provided in the criminal trial, that the mother began a relationship with Male B at some point in February 2020, and that he began living with her (and her children) shortly thereafter.

It is also known from the evidence in the criminal trial that on 14 May 2020, the mother said that Male B used a hammer to smash up parts of the house, had tried to headbutt her, and that she fled with the children to a friend's house[18]. None of that significant information was disclosed by the mother to the health visitor during the 8 June 2020 telephone call. The mother did inform the

[16] Although it latterly transpired that this was not the appropriate service due to the age of the younger sibling.

[17] Whilst a letter from the health visitor would usually be appropriate following two missed scheduled appointments, in the case of children on the child protection register, children in receipt of child in need care and support, **or considered vulnerable**, a more robust approach must be adopted (emphasis added) (§7.1 and §8.1: *"Guidance for Management of No Access Visits, Was Not Brought and Families who Decline the Health Visiting Service",* 13 July 2018). https://hduhb.nhs.wales/about-us/governance-arrangements/freedom-of-information/disclosure-log/disclosure-log-appendices/3-policies-pdf-1-023kb/#:~:text=1.-,Guidance%20for%20the%20Management%20of%20No%20Access%20Visits%2C%20Was%20Not,Decline%20the%20Health%20Visiting%20Service.&text=This%20right%20to%20good%20health,surveillance%20and%20immunisation%20programmes%20offered.

[18] This information was disclosed at the criminal trial. The police were not contacted of the time of the incident and there is no record of this on their system.

health visitor on 8 June 2020 that the *"stepdad"* visited daily, however the health visitor did not record (in the handwritten notes) who the stepdad (being referred to) was.

The health visitor records also refer to child A not sleeping well (sometimes up until 11pm) and that the mother was taking antidepressants. At this time, in June 2020, the Guidance from the Welsh Government was for health visitors to prioritise face to face contact for vulnerable families and families with safeguarding concerns. Child A clearly fell within that threshold. In the knowledge of what the mother disclosed during the telephone call on 8 June 2020, and the wider knowledge of this family, it is reasonable to conclude that the health visitor could and should have made arrangements for a home visit. This, again, was a missed opportunity.

The independent reviewer also questioned why the health visitor did not consider a video-enabled conversation with the mother, particularly as this was highlighted as a relevant option (to achieve family contact) within the aforesaid Welsh Government guidance. The response provided by the health board was that although this was a relevant option within the guidance, they could not (in fact) "action it" as the necessary technology (including smartphones and access to virtual platforms) was not available for health visitors at the time, despite requests being made. Devices were first made available in approximately August-September 2020. All health visitors now have access to a digital device and platforms.

No further contact was made by the health visitor after 8 June 2020 for a period of 5 weeks until a telephone call on 14 July 2020 – this was 2 days before the incident which ultimately caused child A's death. This was the last contact that any professional had with the family prior to child A's death. During this call, the mother said she was continuing to struggle with child A's behaviour. She also said that she had a new mobile phone number as she was having unwanted texts from a previous partner, and that she had seen that previous partner outside the family home at midnight in a car, watching her house. A home visit was offered by the heath visitor on 14 July 2020, however this was declined as the mother reported she was staying with her grandmother. This was not challenged or probed by the health visitor.

The health visitor was, quite properly, concerned by the information provided during the telephone call on 14 July 2020, such that she completed a MARAC referral. However, in light of the information provided by the mother during this call, and the knowledge regarding this family, it is reasonable to conclude that the health visitor could have taken further steps to seek agreement for a home visit. This was a further missed opportunity. Although a health visitor does not have a legal right of entry into a property, context is key, and if there are concerns regarding a family, questions (as to why entry is being refused/frustrated, etc) need to be asked, and proactivity (in an attempt to secure engagement) is crucial. There is also no evidence that the health visitor discussed any concerns with the specialist nurse for safeguarding or their line manager.

Considering the evidence disclosed within the criminal trial, had the health visitor attended the family home before the incident on 16 July 2020 which led to child A's death:

(1) The concerning home conditions (as at July 2020), which were made publicly available during the criminal trial (the photographs having been released by the Crown Prosecution Service) could have been seen, and would (on its own) have raised child protection concerns;

(2) Attendance at the family home could have provided an opportunity to see if Male B was at the property, and if not physically present, there may have been evidence that a male was living

there. Either way, this would have likely led to questions being raised. As set out above, Male B began living in the mother's home with child A and her siblings in late February 2020;

(3) It would have provided an opportunity for child A's wellbeing to be ascertained, and an opportunity to see any injuries sustained. The evidence provided in the criminal trial included Male B disclosing to the mother (via Facebook messages) that child A sustained a "bloodied nose" (19 April 2020), a grazed chin (26 April 2020) and a cut lip (4 May 2020) whilst in his care. Additionally, there was further evidence that a friend of the mother had observed child A to have bruising to her legs (5 July 2020) and that child A had an injury to the bridge of her nose which caused her eyes to appear bruised, which Male B said was a result of child A falling from the sofa onto a coffee table (9 July 2020). Had child A been seen by the health visitor after 19 April 2020 and before 16 July 2020, it is reasonable to conclude that these injuries would have been observed, and questions rightly asked about how they were caused.

During this review, the health board confirmed that on average, a health visitor has a caseload of 250 children, and that between January – June 2020, there were significant staff shortages and/or sickness within the service; the latter as regards sickness of health visitors and within the management team. Also, the service, from March 2020 onwards, was operating within the context of Covid-19, and whilst there is no evidence that this *directly* impacted on the care provided to child A by the health visiting service, guidance for practice was changing and the service were advised to use professional judgement.

The conclusions reached on the evidence provided within this review is that there were a number of missed opportunities by the health visiting service to arrange additional home visits, or escalate concerns to management/for management to thereafter address such concerns, including the failure of the mother to agree to any home visits in the 5 month period between 15 February 2020 – 16 July 2020. Practitioners should have access to strategic leadership which supports them to achieve the desired outcomes for a child. There is no evidence in this case that advice from management was sought regarding child A, or that management were asking questions (themselves) regarding the apparent non-engagement.

Safeguarding supervision is available for all health visiting staff in the health board. Prior to the pandemic, this was available face to face. In March 2020, with the introduction of restrictions due to the pandemic, the corporate safeguarding team contacted all health visitors and midwives to offer them supervision ad hoc by telephone. Supervision was also available via Skype. This was in addition to maintaining a daily single point of contact within the corporate safeguarding team for advice and support for all health board employees and independent contractors. That process, however, relied upon a health visitor seeking advice. In terms of supervision of health visitors during the period from January 2020 – July 2020, all staff had access to a team leader if they needed to discuss professional or caseload issues, however a formal supervision structure was not in place.

A senior nurse with responsibility for quality assurance was in post at the time, who implemented group supervision, however uptake varied on a regional level and was voluntary. This person also had 1:1 sessions with team leaders, but not individual health visitors. During the pandemic, a weekly supportive online session was implemented, however this was informal and simply a "check in" regarding staff wellbeing.
It is impossible to say whether there would have been a different outcome had more active steps been taken by the health visiting service. In future cases, far more probing and challenge is needed by health visitors (in the face of persistent opposition to home visits); particularly in circumstances

where there are known child protection concerns. Additionally, where there is persistent opposition, health visitors should be supported by their managers regarding how to address the impasse, and they should be given guidance as to the steps that could be taken to secure engagement. It is acknowledged that since 26 April 2022, a policy has been in place titled *"Guidance on Working with People who are Difficult to Engage"*[19], which provides assistance to professionals operating within the Mid and West Wales Safeguarding Board area, which is clearly positive.

Child A's mother suggested, when the independent reviewer and panel chair met with her in prison on 1 June 2023, that it would have helped to have a consistent health visitor and for her to be given the option of seeing the health visitor away from the family home. She also described how a more empathetic and respectful approach would have been beneficial as she said that she felt "judged". Such factors, she said, would have allowed her to "open up" about the reality of what was actually going on in the family home to a health visitor. Whilst continuity of health visitor, an empathetic approach, and venue choice are reasonable points to make, it is not accepted on the facts of this particular case that such concerns are legitimate, and (even if legitimate) would have made a difference. It was clear to the independent reviewer that the mother prioritised her relationship with Male B over the safety and welfare of child A, and having the same health visitor throughout the time period reviewed[20], and discussing matters at a different location, would not have realistically changed that.

In summary, ensuring that opportunities are not missed by health visitors to arrange home visits or escalate concerns (to management) if there is a failure to engage, particularly where there is a history of child protection concerns within the family, is a key learning point to take away from this review.

Learning point 4

To ensure there is professional curiosity when suggested negative behaviours of a child is limited to parental report only

A thorough understanding of child development is critical when working with children and their families. Each child's development is significantly shaped by their particular experiences and the interaction between a series of factors. Some factors relate to the physical and emotional environment in which a child is living. It is therefore crucial to understand the basis of any behavioural concerns identified.

From at least 21 June 2019, a health visitor has recorded that the mother was concerned about child A's behaviour. Child A was 1 year, 8 months old at that time. The health visitor had attended to discuss a domestic incident which had necessitated police involvement on 17 June 2019. It was good practice for the health visitor to attend and discuss matters fully with the mother. It was also good practice for the health visitor to thereafter make a referral on 4 July 2019 for a Flying Start nursery placement for child A. This was accepted on 21 October 2019, with provision for child A to start in January 2020.

During the visits to the family home by a health visitor from 21 June 2019 onwards, child A's extreme behaviour as described by the mother (angry/violent behaviour including headbutting, pulling her hair, hitting, biting, screaming, shaking, pinching others, and going red to the face)

[19] https://cysur.wales/media/bumbk3dp/working-with-people-who-are-difficult-to-engage.pdf.
[20] The health board have confirmed that there were two health visitors for child A during the review period.

were not observed. Such extreme behaviour was also not observed by Flying Start. Although child A was only at playgroup between January – March 2020 (it closing due to the pandemic), what was noted was that her attendance was poor (42.55%), staff rarely saw the mother (as she had arranged for a friend to often collect child A), and child A was often hungry on arrival. Such extreme behaviour was also not observed by the father when he cared for child A, albeit this was sporadic. The father's sister corroborated this during discussions with the independent reviewer and panel chair at the father's home on 21 June 2023. She described child A as a *"bubbly little girl, not naughty".*

Child A was first seen on 31 January 2020 at the child health department of the local hospital due to the behavioural concerns raised by the mother. The mother described significant sleep difficulties, stating that child A was only sleeping 3-4 hours per night, that she had difficulty going to sleep until gone midnight, that she would then wake during the night, and was usually fully awake by 5am. The mother also described the extreme behaviours outlined above.

Due to the significant difference in child A's stated behaviour at home compared to other environments between June 2019 – March 2020, a period of some 9 months (which was particularly significant in light of her young age), exacerbated by the circumstances of her attendance (or lack thereof) at playgroup, professional curiosity should have been raised and questions asked as to why there was such a difference. A child-centred approach was lacking. Had questions been asked, it may have become apparent (which is now clear from records up until July 2020) that the "behavioural" issues were, in all likelihood:

(1) Evidence of the mother's inability to cope (she was a single mother of three young children with a history of domestic abuse and her own mental health issues);

(2) A result of child A's exposure to being brought up in a household where domestic violence was prevalent;

(3) *(latterly)* Child A's attempt to vocalise the abuse she was suffering from Male B. During the criminal trial, there was evidence of child A spitting and crying when Male B was near her.

Had the health visitor, the social worker or professionals within the Flying Start provision asked why there was such an extreme difference between how the mother described child A, compared to what they were actually observing (a typical infant), it would, in all likelihood, have become apparent that the behaviour was a consequence of environmental factors and the harm and neglect child A was experiencing at home.

Probing may also have led to greater involvement with child A's GP or a paediatrician, but at the very least, far more questions should have been asked due to the length of time that this was being raised as a concern by the mother, and the increasing severity of the stated behavioural issues. In conclusion, an important learning point is for practitioners to ensure that there is professional curiosity when suggested negative behaviours of a child is limited to parental report only.

Learning point 5

To ensure that information is shared between agencies, that agencies understand when they are able to do so, and for agencies to "join the dots" when they have relevant information

It is disappointing that information sharing continues to feature as a theme in reports such as this, that there continues to be a lack of understanding regarding *when* information can be shared, and also, that when agencies are in receipt of relevant information, that the "dots" are often not joined. Such matters give rise to the risk of a child being harmed, or the risk of harm increasing. This learning point is wider than the repeated (known) issue that agencies have different systems and that the disconnected systems can limit information sharing. The following are five examples of problems with information sharing which became apparent during this review.

(1) From March 2019 until child A's death, her older sister would, on occasion, disclose information on a piecemeal basis to her teachers regarding home circumstances. The disclosures made caused the class teacher to, quite properly, make contemporaneous file notes of what was said. This included the older sibling being repeatedly tired (she said that she would often be unable to sleep due to various noises at night in her home) and cutting her foot on glass on the carpet at home. As child A was in a playgroup (early years setting) and not of compulsory school age, it became apparent during this review that there was no ability to share sibling information between the respective educational settings. Consequently, until the composite chronology was prepared for the purpose of this review, child A's playgroup were unaware of the increasing concerns regarding child A's older sibling.

(2) On 15 February 2020 the health visitor attended the mother's property. Part of the discussions related to child A's father wanting contact. As an example of good practice, the health visitor immediately contacted social services (whilst at the mother's property) to discuss the issue of parental contact, particularly as the mother had raised some concerns which needed to be properly considered. The health visitor was told, however, by a professional within the child assessment team, that information could not be shared *"due to confidentiality"*. There is no record of what was meant by that or that this was escalated by the health visitor to their team manager.

(3) On 8 June 2020 a professional within the assessment team (children's services) was contacted by the health visitor as the mother had disclosed that a "friend" was staying. The health visitor was informed by children's services that the family was *"closed to social care".* Although the mother had disclosed that it was a female friend, in light of the known history, and the vulnerability of the children within the household, a review of child A's circumstances should have at least been considered by children's services (for the purpose of review). Additionally, no log was made of this call by the professional within the assessment team, as would be expected.

(4) Child A's father had parental responsibility. He was not contacted by the social worker during the assessment process between January – March 2020, despite calls being made to other family members. The father was clear when he met with the independent reviewer and chair to contribute to this review, that he could have provided helpful information, including that consideration should have been given to continued home visits by social services. The father was also concerned that he was not provided with information by the police regarding incidents at the family home where child A was living (including incidents recorded by the police on 11 March 2020 and 18 and 19 June 2020). He explained that had he known of the things that were happening, he may have asked that child A move to his "bubble" during the pandemic. He also stated that he would have been able to explain to the health visitor (if contacted) that the behavioural issues raised by the mother were not seen by him/his family.

He felt that it was entirely inappropriate that he was first made aware of the above concerns during the criminal trial.

(5) On 19 June 2020 Male B reported that a threatening letter had been hand delivered to the mother's address by a third party. Male B was known to the police, including domestic related incidents between him and his mother on 15 March 2019 and 9 October 2019, and he was arrested for breach of the peace on 25 May 2019. The address was also known to the police following a number of callouts involving the mother and a previous partner on 17 June 2019, 19 July 2019, 4 January 2020, 11 March 2020 and 17 June 2020. The police were also aware that three young children lived at the address. The dots were not joined by the police at the time, and a referral was not made to social services regarding (i) the threatening letter or (ii) the fact that Male B was now living with the mother. Additionally, on 11 July 2020, 5 days before the violent assault began on 16 July 2020, the police were informed that Male B was said to have had contact with his biological child "secretly", despite safety concerns. A DASH risk assessment was completed, but was given the standard risk grading as the evidence did not indicate a likelihood of serious harm. Social services were not informed by the police, despite the police being aware that a month earlier (on 19 June 2020), that Male B was at child A's property (with child A's mother), and that there were 3 young children (in total) living there.

It is impossible to say what would have happened had the above information been shared between the police, social services and the health visitor or had the dots been joined at the relevant times. However, sharing information and acting upon such information is an intrinsic part of any frontline practitioners' job when working with children. The decisions about how much information to share, with whom and when, can have a profound impact on the lives of those needing protection. Additionally, information sharing helps to ensure that an individual receives the right services at the right time and prevents a need from becoming more acute and difficult to meet. It is an obvious learning point that practitioners must ensure that information is shared between agencies, that agencies very clearly understand when they are able to legally do so, and for agencies to "join the dots" when they have relevant information.

Learning point 6

To ensure that language used by professionals within documentation is not vague, and that there is, instead, specificity to appropriately assess risk

On 4 July 2019, a referral was made by the health visitor to the early intervention prevention service (education), and a joint assessment family framework was also completed by the health visitor. This was an example of good practice as the mother had raised concerns regarding child A's behaviour and it was properly recognised (by the health visitor) that extra support, including socialisation and routine setting, was necessary.

Within this paperwork (handwritten records), however, there were references to the involvement of a *"stepdad*" and also a *"dad"* (the terminology being used interchangeably). It is unclear who was being referred to, and as the mother had 3 children from 3 different fathers, references to such person(s) needed to be clear. This was particularly important as a query was properly raised by the health visitor regarding one of the referenced persons being "*controlling"* and *"making light"* of a domestic incident on 16 June 2019. The name(s) of the person(s) being referred to, and further detail of the nature of their relationship with the mother and the children, was clearly needed so that the reader of the referral/the assessment could immediately understand the family dynamics. This is basic information that was omitted.

A similar issue can be seen from an email sent on 3 October 2019 from a member of staff within the school where the older sibling attended. The email, addressed to the headteacher, stated that the mother had informed the school that only the *"stepfather"* could collect the older sibling. For the reasons set out above, the name of the *"stepfather"* was needed. Again, this was basic information that was omitted.

As a learning point therefore, practitioners should ensure that language used by professionals within documentation is not vague, and that there is, instead, specificity which will allow an appropriate assessment of risk to be undertaken, both at the time and thereafter (as appropriate).

Learning point 7

To ensure that written documentation is sufficiently detailed and entered onto the electronic system[21] **as soon as practicable after an event**

The contemporaneous observation reports regarding Male B completed by adult social services (particularly within the community drug and alcohol team and housing team) for the relevant time period are detailed (regarding the steps taken) and clearly set out the assistance on offer. This is an example of good practice.

As regards the assessment of child A by children's services, case notes (of actions taken) were not entered onto the electronic system by the allocated social worker, either prior to their period of extended leave, or on their return. In particular, there was a period of about 8 weeks between the social worker visiting the family home on 23 January 2020 and their sick leave commencing on 16 March 2020. This provided a reasonable opportunity for handwritten notes to be written up on the electronic system, however they were not. Additionally, there is no record of any notes being entered onto the system following the social worker's return to work on or around 16 April 2020, or at any time thereafter. Equally, the team manager has accepted they did not record the actions that they took on the electronic system.

As regards the health visiting service, the chronology of events was not completely clear and did not reflect the true complexity of the case, including the number of house moves, changes of health visitor, engagement/non-engagement with services and no access visits. There were also no growth charts for child A, and a genogram was not completed fully to illustrate the family relationships.

As a learning point, it is imperative that practitioners ensure that written documentation is sufficiently detailed, and is drafted as contemporaneously as possible, and entered onto the electronic system as soon as practicable, to ensure the accuracy of the account(s) and to also ensure transparency if (for example) there is a period of leave and a need for a different professional to ascertain what steps have been taken on the case.

[21] If applicable. For example, the health visitor service, in some areas, still operate using handwritten notes only.

Improving Systems and Practice

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

Looking to the future, it is trite to reiterate the key message that *"safeguarding is everyone's business".* Merely stating that, as many reports of this nature do, is insufficient. If safeguarding is to be considered with any degree of seriousness, effective resources must be in place, training and "checks" regarding knowledge gained must be effective, and multi-agency working between organisations is essential. As a result of this review, which includes the discussions during the learning event and the additional information provided by the relevant agencies and the Welsh Government, the following eleven action points are made in order to promote the learning from this case.

Action point 1: Local Authority

To ensure that guidance for heads of service regarding additional funding requests is readily available and understood, and to consider how internal funding decisions can be reviewed

As a basic point, there must be adequate staffing levels and resources across all local authority departments in order for such departments to run effectively, and having regard to the specific facts of this case, it is essential that professionals within the assessment team within children's services are able to respond to and fulfil safeguarding responsibilities. It was apparent from the information provided during the learning event in July 2023 that the assessment team were passionate and care enormously about the important work that they do for some of the most vulnerable in society. What was equally clear however, is that the service was overstretched and morale was low. It was also of concern that the updating information provided by the local authority highlighted how an experienced social worker was required to take extended leave as a consequence of an unmanageable workload. Such pressures (within the assessment team) were not specifically highlighted in the annual report of the statutory director of social services for 2019-2020 (the period of this review), or within subsequent annual reports leading up to the learning event in 2023.

The Welsh Government asked Care Inspectorate Wales ("CIW") to lead on a multi-agency rapid review of decision making regarding child protection in response to a number of tragic child deaths, and in September 2023, CIW produced a report[22]. As that report properly recognises, *"fragility across the workforce and limited resources across all sectors have inevitably led to delay in support for children and families. These challenges also impact on how well the current child protection structures and processes work in practice".* The latter part of this conclusion is particularly relevant to this case. Although practitioners involved in safeguarding work incredibly hard, and are committed to ensuring the safety of children, it is impossible for the system to work without sufficient numbers of staff.

There is a very real and obvious capacity issue in this case, having regard to the volume of referrals received by the assessment team, and it is unlikely that the issues identified regarding the incorrect assessment process for child A (between January – March 2020) were unique. To contextualise the issue further, in 2019-2020 (the period when the local authority were involved

[22] https://www.careinspectorate.wales/sites/default/files/2023-09/230928-Rapid-review-of-child-protection-arangements-en.pdf.

with child A's family), the number of contacts and referrals received by the assessment team was 5,092. At the end of 2023, it was over 10,000. Within the assessment team, there is currently one duty worker, four senior social workers and eight social workers. Having more professionals to undertake the crucial assessment role will likely improve future practice, and if the assessment team is to have any real chance of providing quality assessments, consideration is needed regarding greater resources being made available.

Careful consideration has been given to the issue of the funding of children's services, on both a national and local level within this review, and the independent reviewer is extremely grateful for the supplementary written documentation provided by the Welsh Government and the local authority in this regard.

The Welsh Government explained that in 2020 (when the tragic incident occurred), the local authority received a 4.9% increase in the Revenue Support Grant ("RSG") from the Welsh Government, which was above the overall Welsh average of 4.3%. Once given, the apportioning of the RSG is a local decision. In addition to that, the Welsh Government stated that a Social Care Workforce Grant has been provided to the local authority on an annual basis since 2017, and further funding has been made available through the Eliminating Profit and Radical Reform Grant since 2022.

The local authority explained that the budget in children's services has increased at a greater rate than any other department in the local authority, but this appears to relate (primarily) to significant increases in the cost of external residential care as opposed to staffing costs. The independent reviewer was informed of internal requests being made by the head of children's services (to the local authority) for more resources to be allocated for several years, including for the recruitment and retention of social workers.

It is important to emphasise, however, that the situation as of June 2024 appears to be far more positive; both in terms of staff morale and funding. In relation to the latter, shortly before the finalisation of this report, the local authority confirmed agreement to an injection of £611,640 into the assessment team for further members of staff. The head of children's services has reported that during June and July 2024, the service will start welcoming seven additional support workers, three additional social workers, one additional senior practitioner and an additional administrative worker, and has further stated that this has *"significantly and positively impacted on morale which will undoubtedly increase further as all new staff are inducted and fully operational in role"*.

It did become apparent, however, when reviewing resource allocation, that there was a lack of internal clarity within the local authority regarding the *process* for heads of service, including children's services, to request staffing uplifts to guard against potential service failure. The consequence of such uncertainty was that the concerns of heads of service had not been reflected in budget consideration discussions until very recently. Positively, the director of resources has recently clarified, with *all* senior managers *across* the local authority, the process that needs be followed when seeking to secure additional funding above the base budget for the individual department.

Whilst a welcome development, the local authority are invited to consider whether this could be improved upon to (i) ensure that the guidance regarding the rationale/evidence base that heads of service need to include when making additional funding requests is readily available and understood and (ii) what review mechanism (of any decision made by the corporate senior leadership team) could be, if (for example) there is concern about a decision to reject a request.

This is particularly important due to the statutory nature of social services and the need to maintain an effective operating level in line with statutory duties.

Action point 2: Children and Adult Services within the local authority
Training (for practitioners and managers) regarding the assessment/sign off process, and for there to be a robust process for the auditing of assessments

Children's services have a duty to assess whether a child is experiencing or is at risk of abuse, neglect or other kinds of harm. An appropriate assessment was not undertaken in this case and further training is needed as soon as practicable.

Practitioners
Training for practitioners within children's services regarding the completion of assessments is needed, and the following should be embedded into practice:
(1) Action points identified within an assessment must be capable of timely implementation;
(2) A case must not be closed until an assessment has been finalised and the identified action(s) implemented;
(3) Detailed case recordings documenting actions taken (including home visits, etc) must be made as soon as practicable after the event.

Practitioners within *adult* services should be reminded to consider, as part of their assessment process, consulting wider professionals, including the relevant GP if mental health/substance misuse issues are relevant, in order to ascertain whether medication or other types of therapy could be offered. This will improve future practice as an understanding of what is "on offer" from health services, in addition to that which could be provided by adult social care, may have a positive outcome for some service users. It would be proportionate to raise this action point in supervision meetings.

Management
Effective supervision of social workers and team managers within the assessment team is essential. The local authority are asked to review whether the current supervision arrangements for social workers and team managers are appropriate.

Quality assurance
For the local authority to ensure that a robust audit process is in place regarding assessments, but also, importantly, for the local authority to urgently arrange an audit regarding whether other assessments within children's services have been completed and closed by a practitioner other than the allocated assessor in isolation (ie, without at least speaking to the allocated assessor or relevant family members/professionals, etc) when the allocated assessor has been unable to complete the assessment due to a period of extended leave. This is needed to determine whether other children were/are at risk as a result of this practice. Consideration must be given to whether this audit should be undertaken on an independent basis.

Action point 3: Children's Services within the local authority
To ensure that a policy is in place regarding how staff are supported when sickness issues arise and how cases are managed when staff are on sick leave

Greater focus is needed on how to support experienced staff before reaching crisis point (where extended leave is needed). During supervision meetings on 21 January 2020 and 28 February 2020, it was documented that child A's social worker was not to be given any more cases, and

that reallocation of their current case load needed to be looked at by their supervisor. It is unclear if this was done. Senior management, as part of this review, have described the workload of child A's social worker as *"excessive"* due to the volume and complexity of cases. Due to pressures of work, from 16 March 2020 until around 16 April 2020, the social worker was on sick leave. During a supervision meeting on 16 April 2020 upon their return to work, it was noted that their caseload had been *"vastly reduced",* which is positive, however, that should have been addressed prior to 16 March 2020.

It also became clear during this review that children's services (and potentially the local authority as a whole) do not have a process to manage record keeping when staff are on periods of sick leave. This is problematic if other members of staff are allocated their work and there is an absence of a clear "paper trail" of work undertaken to date. Without such a process, the identified risks may not be fully understood and addressed.

Where staff are on extended leave (for example, for a period longer than two weeks), managers and/or supervisors must understand what stage the record keeping is at, in order to inform how that issue is addressed, both whilst the member of staff is off work and when they return to work. Children's services should develop a policy regarding this, in conjunction with HR (as part of the return to work and sickness absence review processes) as soon as possible. As a caveat, if a member of staff goes on leave and they are aware of a significant issue on any of their cases, it is incumbent on them to inform a manager without delay unless there are exceptional circumstances. This issue must be looked at within the development of the policy.

Action point 4: Children's Services within the local authority
For rapid reviews to be undertaken effectively/timely following a child's death or serious incident

For children's services to finalise a template to allow formal recording of an immediate case review by senior managers/head of service where an unexpected child death or serious incident has occurred on an open or recently closed case. This will allow immediate internal consideration of, and response to, practice issues in relation to serious incidents, outside of and preceding the child practice review process. Positively, the head of children's services has started to develop a template in conjunction with their senior team, which has been shared with the Regional Safeguarding Board. In addition to finalising the template as soon as practicable, consideration should also be given to how that rapid review process can (itself) be reviewed to ensure its effectiveness. It is unclear how the immediate internal review following child A's death was undertaken, but however it was undertaken, it did not identify a number of issues regarding the assessment process (highlighted above), and a more formalised approached, using an agreed template, is likely to assist uniformity and improve future practice.

Action point 5: All agencies
Multi-agency training regarding (i) when a MARF is needed, and if needed (ii) how it should be completed

The learning event discussed the fact that there is often a lack of clarity regarding when a MARF is actually needed. Clearly if a practitioner believes a child may be at immediate risk of harm, they must contact the police on 999. If there is no immediate risk, relevant partners[23] have a duty to

[23] Relevant partners are defined by s.162(4) of the Social Services & Well-being (Wales) Act 2014 and include the police and a local health board.

report a child at risk, which includes a child who is (a) experiencing or is at risk of abuse, neglect or other kinds of harm *and* (b) has needs for care and support (whether or not the local authority is meeting any of those needs)[24]. That is the threshold which must be considered when professionals are considering whether or not to submit a MARF.

The learning event also discussed the fact that the way in which MARFs are completed varies enormously, which makes an already difficult process even harder for the assessment team (within children's services). The current format used (from March 2023) is helpful. Clearly a lot of work has gone into identifying the correct questions to ask, however there appears to be a disconnect (thereafter) regarding how the form is actually completed, despite a two page "supporting information" guidance document being available (from CYSUR) for professionals to consider.

There were also questions raised at the learning event that those making a referral often do not receive any response once the form is submitted. It was commented that the onus is on the *referrer* to ring children's services and ask for an update. However, the "supporting information" document says the opposite, in bold, namely that "**Referrers should receive written feedback of the progress of their referral".** This is in line with the Wales Safeguarding Procedures which explains that children's services should communicate the outcome and reasons for the decision to the person making the referral[25]. Such communication is important as it ensures, for example, that any disagreement regarding the appropriate outcomes can be discussed between practitioners. If such disagreement cannot be resolved, the disagreement should be addressed using CYSUR's Multi-agency Protocol for the Resolution of Professional Differences[26].

By reason of the above, regular multi-agency training (which would assist collaborative working) is needed to ensure that there is a consistent approach and shared vision on safeguarding procedures and that the threshold for completion, and the actual completion of the MARF thereafter, is fully understood. Any training should take place face to face wherever possible. Such training will improve future practice as fewer MARFs may result (thus freeing up space within the assessment team), but, additionally, a well completed MARF will allow those picking it up to immediately understand what the issues are and triage the referral thereafter (having regard to other urgent and complex cases that need to be dealt with).

It is acknowledged that the National Safeguarding Training, Learning and Development Framework should be imminently available. A key objective of that framework will be to ensure a consistent national approach to training, learning and development and CYSUR is already engaged in developing this new framework, which launched as part of National Safeguarding Week on 13 November 2023.

Quality assurance

There must be a robust quality assurance process in place within the relevant agencies to evidence that the MARF process is being utilised by practitioners effectively and correctly, and that any learning is embedded.

Action point 6: All agencies

Multi-agency safeguarding hubs (or equivalent) or co-location to support multiagency decision making (for cases which do not meet the threshold of "significant harm")

[24] S.130(4) of the Social Services & Well-being (Wales) Act 2014.
[25] https://safeguarding.wales/en/chi-i/chi-i-c3pt1/c3pt1-p6/.
[26] https://cysur.wales/media/bjpprbqn/resolution-of-professional-differences-protocol-approved-20230124.pdf.

The learning event made it clear that for cases where there was no reasonable cause to suspect that a child was suffering, or was likely to suffer, *significant harm* (which would lead to enquiries pursuant to section 47 of the Children Act 1989[27]), multi-agency working was difficult as there was no formal structure in place. There appeared to be an appetite for more integration, which is positive.

Such integration will improve future practice as decisions would not be limited to a single agency. The nature of high risk decision making and the consequences of "bad decisions" have resulted in a high blame and accountability culture. No decision should ever be on one person in silo, and for cases where there is no acute incident (but rather a gradual increase of concerns), an ability to discuss patterns of emerging risk, even if within a virtual roundtable type meeting, is extremely important. The benefits of such an approach have been highlighted previously[28], and there are various models that could be used to take this forward. It was also recognised, however, that despite the agreement on the benefits of multi-agency approaches, the implementation of such models can be problematic – including governance, funding, information sharing and determining which agencies should be involved.

As was obvious from this case, it was only when agencies came together to look at the composite chronology as a whole (for the purpose of this review), that patterns and themes were identified that could have led to greater intervention at the relevant time. Having those discussions early on, and pooling knowledge early on, will clearly be of benefit to the child(ren) involved. At the very least, consideration should be given to specific working groups being set up between the relevant agencies (determined on a case by case basis) to enable effective relationships to be established for cases where the concern is short of the threshold of significant harm. This could be undertaken on a remote basis (ie, by video conferencing), which is currently being used to good effect for other multi-agency meetings (for example, MAPPA meetings).

The learning event and panel meetings also discussed the pros and cons of a Multi-Agency Safeguarding Hub ("MASH"), and the fact that a MASH pilot scheme was previously attempted in the region without success. Now that video conferencing is far more prevalent and is working with some success, consideration should again be given by the relevant agencies to whether a further "MASH pilot" could be attempted, via video, with the aim of identifying and managing risk at the earliest opportunity. It is accepted that "MASH" is simply a term, and that the development of an effective multi-agency relationship with a different name (to consider cases that fall below the threshold of significant harm) may be just as effective.

Action point 7: All agencies
Updated policies/practice guides and further training on information sharing

There are a number of examples in this case of a lack of understanding of when information can be shared between agencies. Practitioners need to be aware that they are able to share information, including without consent, if the purpose of sharing the information is to protect the child from neglect or physical, mental or emotional harm, or to protect their physical, mental or emotional well-being. Such decisions are based on the individual facts of the case and practitioners should have the confidence to exercise their professional judgement. The General

[27] Section 47 of the Children Act 1989
[28] *"Shaping the Future of Multi-Agency Safeguarding Arrangements in Wales: What does good look like?"* (November 2022).

Data Protection Regulation (GDPR)[29] and the Data Protection Act 2018[30], referred to as the UK's data protection legislation, allows for the sharing of information for the purposes of keeping children safe, and "data protection issues" should not automatically be used as a reason for not sharing. Moreover, if in any doubt (in a particular case), practitioners should seek advice from their information governance lead, as opposed to withholding potentially important information from others.

It is recommended that all agencies ensure that sharing policies and practice guides are up to date in line with current legislation, policy and procedures. Guidance has been provided by the Welsh Government for practitioners regarding information sharing to safeguard children, however it appears that despite its publication in 2019[31], it is still not fully understood by those on the ground. Further training is therefore required.

It is also recommended that an audit on staff training is undertaken. This relates to information sharing between practitioners and information between professionals and a non-resident parent. It is also recommended that any data protection training is in person to encourage discourse. Such training will improve future practice as it will ensure that information is (i) shared lawfully, and (ii) shared without delay.

Action point 8: Local Authority Education Services & the Welsh Government
Information sharing between compulsory education and early years settings involving siblings

There is no central information sharing platform within education services and there are further problems with information sharing between schools and playgroups, which creates obvious issues where sibling groups are in both provisions. Everyone in education services, whether employed by the local authority or otherwise, who comes into contact with children and their families, has a role to play in safeguarding children. This includes early years settings. Early years staff and school staff are in a position to identify concerns promptly, and provide help for children to prevent issues escalating.

The fact that "sibling" information cannot currently be coordinated (if one child is pre-compulsory school age) must be urgently reviewed. The sharing of "sibling information" will improve future practice and systems as there would be an understanding of the family "as a whole", which would allow professionals to more accurately assess risk. Otherwise, only a partial family picture and limited knowledge of the functioning of the family is known.

One of the recommendations made within the recent CIW report is for the Welsh Government to work with local authority education services to commission a suitable national IT-based system for education that enhances monitoring and information sharing. The rationale for such a system is to *"enable consistent recording of pupil-level data, encompass various factors affecting their well-being, and to facilitate seamless and timely exchange of sensitive information".* This is a very positive step which is directly relevant to this action point. However, the timescale for such commissioning is unknown, and this should not delay the issue of "sibling sharing" information being considered urgently on a local level by local authority education services.

[29] General Data Protection Regulation (GDPR)
[30] Data Protection Act 2018
[31] *Working Together to Safeguard People: Information sharing to safeguard children – Non-statutory guide for practitioners*

Action point 9: All agencies

Training/managerial support to be given to professionals when faced with parents who do not engage, and for professionals to be supported to ask difficult questions

This applies, in particular, to the local health board and local authority, but should be considered by all agencies. Addressing emerging concerns is key, and professionals should be supported to have the confidence to ask probing questions of families and not simply accept what is being said (in this case, by the mother) as being accurate. In addition to pressing the matter with the individual parent, professionals should try and ascertain why a parent is not engaging from other sources. Additionally, there should be an escalation to managers in the face of repeated non-engagement (as was prevalent in this case); particularly where numerous reasons are given to prevent attendance at the family home. Also, in this case, there was a significant difference in child A's stated behaviour at home compared to other environments over a prolonged period between June 2019 – March 2020 (some 9 months).

Asking probing questions (not only of the parent, but wider family and other professionals) and escalating to management will improve future practice, as such probing will likely establish a number of important points, including (i) whether the parent is struggling to cope (as opposed to being directly obstructive) and (ii) whether the parent is being open and honest about what is going on in the family home. The answers to such questions will, thereafter, provide good evidence for greater intervention (where appropriate).

Multi-agency training and greater managerial support for dealing with complex cases, in particular, non-engagement, and having creative ways to secure engagement, is likely to be extremely beneficial. This can build upon the regional "professional curiosity" training piloted on 8 April 2022 to multi-agency safeguarding professionals, the implementation of which is currently being monitored by CYSUR's training sub-group. Any training should include professionals from housing, to the extent they were not otherwise included. Additionally, professionals need to be aware of/utilise the policy which has been operative since 26 April 2022 titled *"Guidance on Working with People who are Difficult to Engage"*[32].

Quality assurance

There must be a robust quality assurance process in place within the relevant agencies to evidence that training/greater managerial support (regarding the issue of difficulties with parental engagement/engagement with other relevant persons, etc) is being addressed.

During this review, the health board confirmed that since the incident, it has commissioned professional curiosity training (regionally and now more widely within the health board), most recently for all practitioners in October 2023. The health board also confirmed that plans to embed the training commenced in February 2024. Children's services also confirmed that professional curiosity training was commissioned for all qualified social workers in December 2023. This is all positive, however whether such training is thereafter implemented into professional practice needs to be ascertained via an appropriate quality assurance process. This is relevant for all agencies.

Action point 10: The police

Flags/alerts to be placed on the police system if incidents are logged (not as a domestic incident) regarding an address where it is known that children reside

[32] https://cysur.wales/media/bumbk3dp/working-with-people-who-are-difficult-to-engage.pdf.

The police were aware that (i) Male B was involved in a number of domestic related incidents involving his own mother, (ii) child A's address was known following a number of police callouts involving the mother and a previous partner, (iii) Male B contacted the police regarding a threatening letter being hand delivered to the mother's address by a third party, (iv) 3 young children lived at the address, and (v) there were concerns regarding Male B having contact with his biological child.

The police currently use the Niche system as the operational database. This system has the functionality to record warning markers against individuals considered vulnerable or who may pose a risk to others, however this proposed action point relates to a Niche Flag or other alert warning being attached to *an address*. It is understood that there is an ability to place markers on an address, but via a different system[33].

During the learning event, the police agreed that a "flag" or "alert" should be placed on an address to improve future practice and systems, as there would be an immediate understanding by anyone using the system regarding the history of a particular address. It was properly raised, however, that a challenge will be in determining the specific criteria to place a marker on an address, particularly if there are no other obvious issues, such as child protection registration/risk of exploitation (etc), and that this will also come down to professional judgement by the relevant officer at the time.

The police are asked to consider the appropriate criteria, and update their procedures, as necessary, to incorporate the above. The criteria could include repeated attendances at the same address over a period of time, involving a parent/parents/partners/others, and where it is known that a child/children reside, and where it is reasonable to conclude that the child/children are being exposed to inappropriate adult behaviour (as was the case here).

<u>Action point 11</u>: All agencies
Importance of using specific terminology when completing records/reports (etc) and the importance of providing sufficiently detailed records

Professionals must be reminded of the need to clearly specify who a *"step dad", "step father*" and even *"dad"* (etc) is (and vice versa regarding *"step mother"* etc), by reference to their actual name when completing reports (etc). It is essential to understand who is actually being referred to, in order to appropriately assess risk. This should similarly be the case when referring to other members of the child's family/friends (etc). Additionally, professionals should be reminded of the need to provide detailed contemporaneous records.

Whilst time constraints are fully recognised, unless records are available and sufficiently detailed, it is impossible to follow the trail of information, and when there are changes in staff, it makes a difficult task even harder. It is suggested that this action point can be proportionately dealt with via supervision sessions with the relevant practitioners within the respective agencies who were part of this review.

[33] Via "Storm Command and Control".

Summary Recommendations

The above action points can be summarised within the following recommendations.

1. For the corporate management team within the local authority to ensure that guidance for heads of service regarding additional funding requests is readily available and understood, and to consider how internal funding decisions can be reviewed if a request for additional funding is rejected. This is particularly important within social services due to the statutory nature of this service, and the need to maintain an effective operating level in line with statutory duties. Where these pressures are not able to be met or statutory duties are compromised, this should be highlighted clearly in the director of social services' annual report for the attention of elected members and the public.

2. For training to be arranged for practitioners and managers within children's services regarding the assessment/sign off process, and for senior officials within children's services to ensure there is a robust process in place for auditing assessments. For senior officials to also review whether the current supervision arrangements for both social workers and team managers is appropriate, and to urgently review whether other assessments within children's services have been completed and closed in a similar way to child A, and to consider whether this review should be undertaken independently. Practitioners within adult services to be reminded in supervision meetings of the need for wider consultation with relevant professionals when undertaking adult needs assessments.

3. For senior officials within children's services, in conjunction with HR, to ensure that a policy is in place regarding how staff are supported when sickness issues arise to avoid crisis/ prolonged staff leave, and to address how cases are managed when staff are on sick leave. The latter point to include consideration of how records are managed when staff are on sick leave, and for such issues to be considered as part of the return to work and sickness absence review processes.

4. For senior officials within children's services to finalise a template for rapid reviews to be undertaken effectively and timely following a child's death or serious incident in an open or recently closed case. Consideration should also be given to how that rapid review process can (itself) be reviewed to ensure its effectiveness.

5. Agencies to review and provide assurance that training and guidance is available to multi-agency practitioners in respect of completing and understanding thresholds for completing Multi-Agency Referral Forms ("MARFs"), and for a robust quality assurance process to be put in place to ensure that the MARF process is correctly and effectively utilised by practitioners.

6. Agencies to consider mechanisms which would facilitate multi-agency decision making and collaborative practice in respect of children and families where concerns fall below the threshold of significant harm, including the formation of multi-agency safeguarding hubs, and for consideration for such hubs to meet "virtually" having regard to the wide geographical area.

7. Agencies to ensure that sharing policies and practice guides are up to date in line with current legislation, policy and procedures, for further training to be undertaken on information sharing, and for an audit on staff training to be undertaken. This relates to

information sharing between practitioners and information between professionals and a non-resident parent.

8. Information sharing between compulsory education and early years settings to be explored by local education services to facilitate sharing of sibling information, alongside national consideration of this issue (see CIW report commissioned by the Welsh Government, September 2023).

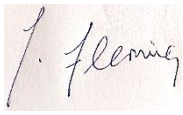
9. Multi-agency training to be undertaken and greater managerial support for complex cases where there are difficulties engaging with parents or carers, and for a robust quality assurance process to be put in place to evidence that training/greater managerial support (regarding the issue of difficulties with parental engagement/engagement with other relevant persons, etc) is being addressed.

10. Regional police force to pursue implementation of a flagging mechanism of a specific address (within the operational database) where there is a wider history of safeguarding concerns linked to that address (absent an incident being logged as a “domestic” incident).

11. For supervision sessions with relevant practitioners within the respective agencies to address the importance of using specific terminology when completing records/reports, and for professionals to be reminded of the importance of providing sufficiently detailed/ contemporaneous records. This is to include making it clear which individual(s) in or around a family are being referred to.

<table>
<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>Reviewer 1</td><td>Emma Sutton KC</td><td>Reviewer 2
(as appropriate)</td><td>N/a</td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td></tr>
<tr><td colspan="2">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.</td><td colspan="2">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.</td></tr>
<tr><td colspan="2">Reviewer 1
(Signature)  </td><td colspan="2">Reviewer 2 N/a
(Signature)</td></tr>
<tr><td colspan="2">Name EMMA SUTTON KC
(Print)</td><td colspan="2">Name N/a
(Print)</td></tr>
<tr><td colspan="2">Date 25 June 2024</td><td colspan="2">Date N/a</td></tr>
<tr><td colspan="4">Chair of Review Panel
(Signature)  </td></tr>
<tr><td colspan="4">Name John Fleming
(Print)</td></tr>
<tr><td colspan="4">Date 8 July 2024</td></tr>
</table>

Child/Adult Practice Review Process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel*
- *A learning event was held and 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 process followed by the Board and the services represented on the Review Panel

A referral for a child practice review was considered at a child practice review sub-group on 24 March 2021. The sub-group unanimously agreed that the referral met the criteria for a concise child practice review. The CYSUR chair approved the sub group's recommendation and the review process commenced. In October 2021, the panel convened and the chair was appointed. In December 2021 the independent reviewer was appointed, and the time period and terms of reference were agreed. In July 2022 the initial timeline review took place, and in September 2022, at a full panel, an analysis of the timeline was considered, and the panel agreed to suspend the review pending the conclusion of the criminal trial. The criminal proceedings concluded on 25 April 2023, and in late April 2023 the review recommenced. The agencies represented on the review panel are set out above.

Learning event held and services that attended

A learning event was held on 4 and 5 July 2023. The first day was attended by practitioners, and the second day was attended by managers. All agencies involved in this review were represented at the learning event.

Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them

Both parents accepted the invitation to contribute to the review and each met the independent reviewer and panel chair to provide their views and reflections. Feedback was provided to child A's parents prior to publication of this review.

Family declined involvement:	N/a. The mother and father engaged and participated as set out above.

For Welsh Government use only

Date information received: …… *(date)*

Acknowledgement letter sent to Board Chair: ……*(date)*

Circulated to relevant inspectorates/Policy Leads: ……..*(date)*

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Appendix 1: Terms of Reference

Terms of Reference for Concise Child Practice Review (CPR)
CYSUR 1/2021 (Pembrokeshire Concise CPR)

- **Nominated Safeguarding Lead** – Elliw Wilyman
- **Review Panel Chair** – John Fleming
- **Independent Reviewer(s)** – Emma Sutton

Core Tasks:

- Determine whether decisions and actions in the case comply with the policy & procedures of named services and the Safeguarding Board.
- Examine the effectiveness of inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were in the best interests of the child and were outcome-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 multi-agency learning event for practitioners, and identify required resources.
- Whether previous relevant information or history about the child and family members were known and taken into account in professionals' assessment, planning and decision-making regarding the child, the family and their circumstances, and how that knowledge contributed to the outcomes for the child.
- Whether the respective statutory duties of agencies working with the child and family were fulfilled.
- To include any relevant information, for the purposes and within the scope of the CPR, pertaining to individual(s) who had direct contact with the child or family.
- 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).

Specific tasks of the Review Panel:

- Identify and commission an independent reviewer to work with the *Review Panel* in accordance with guidance for concise reviews.
- Agree the time frame for the CPR.
- 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.
- Agree the appropriate and independent agency Panel membership.
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan, with the reviewer, 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 contact arrangements with family members prior to the event.
- Receive and consider the draft CPR report to ensure that the terms of reference are met and any additional learning is identified and included in the final report.
- Agree conclusions from the draft CPR report and an outline action-plan, and make arrangements for presentation to the CPR sub-group for consideration & 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.
- *Review Panel* members will adhere to the principles of the Data Protection Act 2018 when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the Practice Review Sub-Group:

- Agree & approve draft Terms of Reference for each case recommended for CPR.
- Agree conclusions from the draft CPR report and an outline action-plan, and make arrangements for presentation to the Safeguarding Board for consideration and agreement.
- Monitor CPR action-plans to ensure all recommendations are carried out on behalf of the Safeguarding Board.

Tasks of the CYSUR Mid and West Wales Safeguarding Board:

- The Business Unit, on behalf of the Safeguarding Board, will inform Welsh Government of the undertaking of a CPR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR report and action-plan.
- Consider and agree any Safeguarding Board learning points to be incorporated into the final report or the action plan.
- 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 the Safeguarding Board website for a minimum of 12 weeks after completion.
- Agree dissemination to agencies, relevant services and professionals.
- The Chair of the Safeguarding Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Information Sharing and Confidentiality:

- Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned or originated by them.
- Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel, as appropriate.
- A statement of confidentiality (as below) will be signed at each Panel meeting by all attendees to reaffirm the boundaries within which information is being shared:
- In working with sensitive information in relation to a Child Practice Review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:
    - The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 2 – Child Practice Reviews / Volume 3 – Adult Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
    - The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
    - If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.
    - However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.