CHILD PRACTICE REVIEW REPORT – redacted for publication

Cwm Taf Morgannwg Safeguarding Board
Concise Child Practice Review

Re: CTSB3/2018 – Child J

Circumstances resulting in the Review

A concise Child Practice Review has been undertaken by the Cwm Taf Safeguarding Board in line with the Board's duties under Working Together to Safeguard People Volume 3) which is issued under the Social Services and Well-being (Wales) Act 2014.

The guidance states that :

> 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 identifies that a child has sustained serious and permanent impairment of health and development

During the period of the review, the Safeguarding Board boundary changed to incorporate the Bridgend locality and as a consequence, the Safeguarding Board's title has been changed to the Cwm Taf Morgannwg Safeguarding Board.

The purpose of a Child Practice Review is to identify multi-agency learning for future practice.

This report identifies the practice and organisational learning identified from a case where a child who resided in the Cwm Taf Morgannwg region sadly died.

In accordance with the Welsh Government's guidance on the publication of Child Practice Reviews and Adult Practice Reviews, released in August 2019, the Regional Safeguarding Board has redacted the parts of this Child Practice Review that describe the details of the case.

Practice and organisational learning

Learning Points:

Professionals carrying out mental health assessments of parents should make contact with other professionals known to the family in order to inform the assessment and decision making.

The Reviewers have been informed that clinic based 'triage' screening and assessment that was carried out in this case provides a 'snapshot' in time that is heavily influenced by patient self-reporting, professionals' skilled interviewing and observations of a patient's presentation.

The assessment tool did not facilitate engagement with the referrer and the social worker in a way that would have been appropriate given the circumstances of the case. There was no consideration of the advantages of a planned home visit with the health visitor and social worker. Liaison with involved professionals in this way would have facilitated a more robust and accurate assessment.

The assessment tool used by mental health professionals did not trigger any discussions with mother about the requirement to share safeguarding information. Assumptions were made without clarification that the arrangements for the children at home were safe and appropriate. The duty to make a safeguarding report in relation to a child at risk was not initiated as is required under the Social Services and Wellbeing (Wales) Act 2014.

At the time of the assessment there was additional information within the professional network, particularly with the school, that would have assisted in reaching a more informed view. The mental health practitioners were not in possession of key information when carrying out an assessment and in reaching a judgement about any risk and optimum response.

The circumstances of the case are unusual and there is no evidence or assumption that detention under the Mental Health Act would have been indicated. However, professional judgment based on self-reporting without further enquiry, home visit, or liaison with other professionals to verify facts, represents a missed opportunity.

Reviewers found a lack of professional curiosity about the children in the family on the part of the mental health professionals and an assumption that responsibility for the safety and well-being of the children lay with other services. The use of the mental health assessment tool failed to trigger key checks and conversations with other professionals before reaching a judgement about risk.

Where it is deemed appropriate to step down from statutory Children's Services to voluntary preventative services, case management should be informed by an analysis of the Children's Services chronology and the impact of this for the child and future work with the family.

Prior to closing the case, a referral was made by the social worker to the Resilient Families Service. This is a non-statutory commissioned preventative service.

Preventative interventions with vulnerable families where there is parental commitment to change is known to achieve positive results. In this case, there was over-optimism about the suitability of this approach. Best practice in this area allows for there to be a distinction between professional or agency outcomes for the child and parent led outcomes. This ensures that there is potential to avoid drift from the original objective of the work that may impact negatively upon child well-being.

The Reviewers have been informed that since the events of this review there have been service developments and improvements in pursuit of ensuring that there is an evidence-based match between the circumstances of a case, parental motivation to change and the suitability of preventative services to achieving positive outcomes for the child(ren).

Positive Practice

On the whole, there was robust safeguarding practice by the school and the Attendance and Well-being Service. Information was shared appropriately, effectively and promptly.

Family members praised the Family Liaison Service provided by South Wales Police who supported family members through harrowing times in an honest, clear and reliable way. It is acknowledged that this relates to service provision outside of the time frame of the review but has been included to reflect comments made by the family.

Improving Systems and Practice

- The University Health Board should review and improve the guidance and assessment tool for professionals carrying out Crisis Mental Health Assessments of parents and care givers responsible for children.
    - The new guidance and assessment tool must trigger consultation with other health services and partner agencies where there are children within the household.
    - The assessment tool must trigger consideration of a home-based assessment and joint visiting with child care professionals for patients with parenting responsibilities.
    - There should be appropriate and proportionate follow up of non-attendance prior to the discharge of patients with parenting responsibilities.
    - Safeguarding children and adults at risk must be a key element of the assessment tool. Any safeguarding concerns should be recognised and responded to in accordance with the duty to report.

- Principles for professionals should be developed about the types of cases that are suitable for step-down to preventative services, taking into consideration the parent(s) motivation to work towards change.

Statement by Reviewers			
REVIEWER 1	Louise Mann	**REVIEWER 2**	Annabel Lloyd
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- ▪ I have not been directly concerned with the individual or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved. ▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- ▪ I have not been directly concerned with the individual or family, or have given professional advice on the case ▪ I have had no immediate line management of the practitioner(s) involved. ▪ I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review ▪ The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*	……	**Reviewer 2** *(Signature)*	……
Name *(Print)*	……	**Name** *(Print)*	……
Date	……	**Date**	……

Chair of Review Panel *(Signature)*	…….....….
Name *(Print)*	…….....…….
Date	.....…….

Child Practice Review process

The circumstances of this case were considered by the Cwm Taf Safeguarding Board's Child Practice Review sub Group in July 2018 when it was decided that a concise Child Practice Review would take place.

The review was carried out in accordance with the Social Services and Well-being (Wales) Act 2014 "Working Together to Safeguard People Volume 3" guidance and a Panel was convened attended by senior representatives of the following services/agencies:

- RCT Children's Services
- South Wales Police
- School
- RCT Attendance and Well-being Service
- Welsh Ambulance Services NHS Trust
- Cwm Taf University Health Board (now Cwm Taf Morgannwg University Health Board)
- South Wales Fire and Rescue Service

An Independent Chair and two Independent Reviewers were identified to oversee the Panel process and complete the Review.

Given the circumstances of the case; an independent consultant psychiatrist advised the Reviewers and was present to contribute to the Learning Event.

The Learning Event was held on the 3rd April 2019 attended by professionals involved in the case, representing the services/agencies as mentioned above (with the exception of the South Wales Fire and Rescue Service who did not have direct involvement in the case prior to the event).

Family Involvement
Family members were provided with the opportunity to meet with the Reviewers or convey their views about the multi-agency practice in other ways. Those that did contribute informed the learning identified in this review and this was shared at the learning event. Family members were also offered an opportunity to view the final report before publication.

☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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