Child Practice Review Report

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North Wales Safeguarding Children Board

Concise Child Practice Review CONWY 2019/1

Brief outline of circumstances resulting in the Review

To include here: -

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

A Concise Child Practice Review (CCPR) was commissioned by the North Wales Safeguarding Children's Board on 20th May 2018 on the recommendation of the Child Practice Review Sub-Group in accordance with statutory legislation set out in section 139 of the Social Services and Well-being (Wales) Act 2014 and accompanying guidance Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).

The criteria for this review was met under Chapter 6, Concise Child Practice Reviews:

A board must undertake a Concise Child Practice Review in any of the following cases where, within the board area, abuse or neglect of a child is known or suspected and the child has;

Died or;
Sustained potentially life threatening injury;
Sustained serious and permanent impairment to health and development or;

The child was neither on the child protection register nor looked after child in the 6 months preceding:

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

serious and permanent impairment of health and development.

The criteria for concise reviews are in The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

The purpose of the review is to identify learning for future practice. It involves agencies, practitioners and families in a collaborative undertaking to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability not culpability. The objective of the review is to generate professional and organisational learning and promote future interagency and child at risk practice. (Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016).

Child Practice Review Process

The Named Doctor for Safeguarding Children referred Child A for consideration at the Regional Child Practice Review Sub-group on 20th May 2018. The sub-group agreed the referral met the criteria for a Concise Child Practice Review.

Methodology

- A Review Panel convened with a Chair.
- Two Reviewers appointed.
- Terms of Reference agreed
- Timelines were developed by each agency
- Panel members produced a summary/analysis of each services' involvement.
- The child's parents interviewed.
- The child seen at the current placement.
- A Learning Event for practitioners.
- A Review Report produced with learning points and presented to the Review Panel.
- Review Panel met to finalise the report.
- Action plan developed from recommendations.
- Review Report presented by Reviewers and Chair of the Review Panel to the Regional Child Practice Review Subgroup and the North Wales Safeguarding Children's Board.
- Submission to Welsh Government.
- Feedback to Family.
- Publication of Report on NWCSB website.

The services represented on the Review Panel were as follows:

- Education
- Health
- Police
- Local Authority Children's Services

Timeframe Reviewed and Why

The timeframe agreed by the panel was a twelve month timeframe from 1st January 2017 to the 9th January 2018. This was agreed to capture the mother's pregnancy until the date that Child A sustained injuries.

The panel also agreed due to the limited information on the police file, the police would include some historical information which was deemed significant to this case. These incidents dated back to 2nd April 2006 to 9th January 2018.

The Terms of Reference were agreed at the first Panel Meeting held on 24th May 2019; agency timelines were then merged to produce an inter-agency timeline of the key events.

The review sought to understand how multi-agency systems affected this case and to identify any factors which influenced the actions of practitioners and agencies. The panel recognised good practice, opportunities for inter-agency learning and identified practice improvements.

Circumstances Resulting in the Review

Child A, aged 10 months attended the District General Hospital Emergency Department via ambulance at 10.38am on 9th January 2018 with evidence of a life threatening head injury. Child A was in a coma with unequal pupil reactions and stiffening of the left side of body, both of which are signs of severe head injury and brain damage.

Mother provided a history to staff that Child A had fallen from a cot. The history stepfather gave was that Child A fell from the baby bouncer. Staff were concerned regarding the inconsistencies of the history given for the injuries; neither were consistent with the severity of the injury seen. Child A received life support and was transferred to the paediatric intensive care unit for treatment and further investigation. Medical staff assessed the injuries as being consistent with an abusive head trauma and non-accidental injury.

Injuries included:

- Numerous unexplained bruising to the face and arm
- Abrasions inside the lower lip
- Bilateral subdural haemorrhages (Bleed on the brain)
- Hypoxic-ischaemic brain injury (brain damage)
- Bilateral extensive multi-layered retinal haemorrhages (bleeding at the back of the eye)
- Healing fracture of the left tibia (lower leg)

Child Health records indicated that prior to the incident Child A was in good physical health and her development was age appropriate. Due to the injury Child A sustained there is evidence of severe brain damage, severe visual impairment and severe developmental delays, which are likely to be lifelong. At the time of the referral to the Child Practice Review Group, the mother and her partner had been charged with Grievous Bodily Harm and attempting to pervert the course of justice. However, the charges were dismissed against the mother and her partner was charged with grievous bodily harm.

Children's Family History and Contextual Information

Child A was the youngest child in a sibling group of five living with their mother and father. All the children were in good physical health, there was a history of speech and language concerns regarding one sibling and behavioural issues displayed by another; none of the children had a diagnosis of any medical condition or disability. Professionals described the family as having a history of low-level neglect concerns.

The timeline notes home conditions seven times. Professionals and a young person visiting the home described it as 'cluttered, smelling of urine, untidy, smelling of cannabis, the kitchen not being fit for hygienic preparation of food/meals, and the bathroom had crockery in it indicating it was not used for bathing the children. Howarth (2007) identifies this as physical neglect. Parents demonstrated small improvements but the required change was not consistent.

The school had logged five Cause for Concerns within their own education system; these included concerns over the children having on-going head lice, wearing clothes that were too big and the children presenting as smelling and unkempt.

School noted during the Learning Event that things would improve for a short while and then

deteriorate. School highlighted positive communication by the father who was more responsive to their concerns and who would make contact with the school to discuss the concerns raised.

School reported the children had a good attendance percentage and the parents would usually attend the Christmas concerts.

The children had not been subject to a Child Protection Plan or a Child in Need/ Care and Support Plan. Agency analysis showed Children's Services had received eight referrals between 2010 and the commencement of the timeline on 01/01.2017. One referral resulted in a Section 47 enquiry.

Details of the response/ action relating to the other seven referrals was not shared with reviewers, however agency analysis shows the majority of the concerns were reports from neighbours, which on investigation, were not substantiated. These allegations and the reports were deemed malicious in nature.

Children's Services received a further four referrals/ contacts from professionals during the period of the timeline; two however were regarding the same incident which Children Services responded to by conducting three duty visits to the family. Children Services identified no safeguarding concerns during the duty visits.

The family had limited contact with the police during the timeframe of this review; police conducted five visits to the family during the timeline, with two further logs of intelligence recorded on police file.

The mother had significant involvement with Health professionals, historically with the older children and in the case of Child A. Mother presented to Midwifery Services at an estimated 13 weeks gestation, however the dating scan indicated she was 19 weeks gestation.

The Midwife or Health Visitor did not complete a Health Pre-birth Assessment (HPBA), as they did not consider there to be any risk factors indicating the need for a HPBA. However, the Guidance for Completion of HPBA by Midwife and Health Visitor in 2017 stipulated to consider a HPBA when late in booking the pregnancy (15-20 weeks).

Agency analysis identified there had been missed appointments and therefore delays in some aspects of care due to non-attendance. The midwife and health visitor did not consider this a risk factor at the time based on the information they had available.

The timeline shows that days prior to Child A sustaining the injuries the mother ended the relationship with the children's father and informed the Health Visitor she had left the family home taking all the children with her.

It is unclear whether the mother left the family home and returned, as the incident involving Child A occurred in the family home. It is also not known at what point the mother begun the relationship with the alleged perpetrator. The reviewers were unable to gain a clear understanding of this from the interview with the parents.

From the information shared by professionals during the Learning Event, the alleged perpetrator may have entered into a relationship with the mother some two months prior to the incident.

At the time of injury, the mother reported she was a single carer for her five children and described the father as being very involved with the children on a daily basis.

Engagement with Family, Child and Foster Carer

Parents Views

The Child Practice Review Chair wrote to parents individually to offer an appointment to meet the

reviewers. Mother contacted a reviewer by telephone to arrange a time and date to meet, as she was unable to attend on the date offered. A date was agreed and mother requested the reviewers meet both parents together.

Prior to meeting Child A's parents the reviewers prepared terms of reference and questions. Both parents of Child A attended and the purpose of the review was outlined to them.

The reviewers asked mother if she would like to tell them about her children. Mother spoke about Child A's siblings and shared what their hobbies were but did not refer to child A. Mother shared no information regarding her time with Child A.

Mother confirmed she is no longer in a relationship with the children's father, currently lives on her own but remains in a relationship with the alleged perpetrator of Child A's injuries. Mother shared she has been in a relationship with the alleged perpetrator for the past two – two and a half years.

Following her separation from the children's father, mother reported the children had continued to have regular contact with him as he remained involved with them as a family. Mother reported the alleged perpetrator would only visit the property once the children were in bed and the children did not have contact with him.

Parents were given the opportunity to share their views on the support they received from services:

When discussing the involvement of the police mother stated that neighbours would often contact the police to report that the family were arguing and shouting. Mother stated there was no further action taken by police following these reports.

Mother reported a good relationship with her Health Visitor and stated she was more helpful than Children Services in explaining the court process since the children have been in care. Mother reported the Health Visitor to be the supportive professional involved with the family.

Mother discussed she was unaware school had an assigned school nurse until the children were sent home due to head lice. Mother stated the school nurse had not shared any of the schools concerns with her.

Mother informed the reviewer's school had concerns over the children being late for school, presenting as dirty, with clothing, which was sometimes damp. Mother expressed she had not been made aware of these concerns until Child A was taken into Local Authority care. Mother felt school should have reported their concerns when they occurred. Mother informed she did not receive any letters inviting her into school to discuss these issues. Mother acknowledged the children's clothes were sometimes damp, as they had not dried in time for school. Mother commended the school for providing speech and language support to two of her children.

Mother shared information when social workers visited the home. She was not informed the reason for the visit and did not fully understand what the concerns were. Mother said social workers would check the children had bedding, mother stated no assessments were undertaken. A reviewer asked mother in her view what could have professionals done better, mother replied 'helped more', when asked how they could have helped more she replied 'with de-cluttering the home and helping with benefits'. Mother stated that professionals did not say what the problem was and so she was unaware of the reasons for their visits. Mother did not refer to substance misuse in the home or that any agencies had raised this as an issue. Mother described the home as a 'Wild House'.

Father was quiet during the meeting with the mother contributing most to the discussion. Father did however share that he could not recall any social worker involvement and stated he was often away from the family home working on an amusement park or working long hours. Father described mother as a single mother as he was often away from the home.

Foster Carer and Child

Social Worker facilitated Reviewers meeting Child 'A' in foster placement; both reviewers were delighted to meet Child A and her foster carer to see the progress made over the past two years. Foster carer shared how remarkably well Child A has developed; Child A has regained her ability to hold her head up without support, can sit up with a small amount of support and enjoys rolling around on the floor.

Child A had profound cerebral visual impairment when she first came into Local Authority foster care. With the dedication and commitment of her foster carers, she has regained some sight with the use of a colour tent and lights to stimulate her vision. Child A smiles and chatters in her own way and is starting to develop language skills by saying 'dadda, hiya, ta-ta, yes and no'. She enjoys playing with her toys and interacting with the whole family. Foster Carer said Child A is developmentally around an 8-10-month-old child and Child A was 2 years and 11 months when the reviewers met Child A at foster placement.

Child 'A' attends the Child Development Centre once a week receiving weekly physiotherapy and painting sessions with the other children. Child A also attends the local pre-school three mornings a week, and is a valued member of the class and loves her time there. The playgroup leaders ensure Child A has the same opportunities as the other children and social skills have improved since attending. Child 'A' is now able to eat a small amount of food orally and has now regained her suck, and can take a drink orally

Foster Carer said 'Child 'A' is a wonderful, happy, and much loved child who has a lot of determination and dare I say attitude. We have a fabulous support team who have worked with Child 'A' and supported us to ensure Child A's needs are met'.

Learning Event

The Learning Event took place on 24th January 2020. Panel Chair and two Independent Reviewers facilitated the day. Key Practitioners with direct case involvement were invited to the Learning Event, which supported practitioners to consider their involvement, practice, assessments and decision-making processes.

Representation from six professionals attended the learning event:

- Education
- Health
- Police
- Social Services

The Learning Event highlighted good practice, which included joint working between school and the school nurse, joint working between Children's Services, school nurse and the police. All professionals working with the family were experienced workers and good practice reported between the Health Visitor and Community Midwife, by informally meeting to discuss the case.

The Learning Event also recognised changes implemented to improve practice since the incident. Education reported they had implemented a change to practice in light of this case by introducing a robust recording system. This ensures all staff have access to documented safeguarding concerns, which provides the Safeguarding Lead with information to respond in a timely manner.

Health reported changes to their Health Pre-birth Assessment and information sharing documentation following recommendations from a previous Child Practice Review. Health shared how some changes in practice limited their ability to see families in their own home (Community Midwives). Community Midwife and Health Visitor provided insightful information at the Learning Event. They shared at no point did they identify any risks prior to the injuries sustained by Child A.

The Learning Event acknowledged the value of a multi-agency chronology, as some of the professionals who were involved with the family were not aware of some of the information within the chronology.

During the Learning Event, Children's Services and Police highlighted cannabis use from the timeline as a theme and discussed at what point does this becomes a safeguarding concern. Children Services did not consider this a significant concern in their involvement with the family.

The Learning Event enabled the reviewers to gain more insight into the family's life by linking the information shared by the parents and professionals. A balanced view from the parents and professionals perspective gave the reviewers an understanding of the challenges professionals had in assessing the risks.

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 identification of the practice and organisational learning has been obtained from the following:

- The production of a merged multi-agency timeline & agency analysis
- A Learning Event
- Parents perspective
- Discussions within Review Panel meetings
- Panel members discussions with practitioners involved in the review
- Chairs and Independent Reviewers Analysis
- Evidence based-practice

The review highlighted good practice as well as learning throughout the process. It is important to note that learning identified was with the benefit of reflection and hindsight.

What Worked Well

There was evidence within the timeline that Police responded to concerns raised in relation to the children, and conducted visits to the property when necessary. There was evidence of good communication between Police and Children Services, through sharing CID 16's with Children Services when involved with family. Agency analysis showed Police felt there was good joint working with partner agencies.

The timeline reflected school had logged all concerns within education internal Cause for Concern' log and liaised with the school nurse to provide support with on-going issues relating to children's hygiene. Positively, school had made contact with parents to invite them in to discuss these concerns, although the parents deny this, school report offering several meetings. The timeline-demonstrated school had also offered the mother a referral to Team Around the Family for further support, which mother declined. Positively school also provided extra support for two of the children to aid the development of their communication skills.

Within the timeline, there was evidence of good joint working between agencies, Children's Services conducted a joint visit with the school nurse, and updated the school nurse following a subsequent visit. Children Services had also contacted the Health Visitor to ascertain if health had any concerns over the family.

Children's Services identified in their agency analysis that social services or police assessed all referrals appropriately. Children Services responded to all referrals within statutory timescales and ensured trained experienced staff conducted Duty visits to the home.

The timeline highlighted good communication between the health visitor and school nurses when concerns identified and one safeguarding children referral submitted to Children's Services. There was evidence of Health liaising with Children Services, by forwarding concerns and requesting updates on referrals. Health accessed Safeguarding Supervision for professional support and learning in relation to this case. The Health Visitor and school nurse shared how they meet informally to discuss joint cases. Health agency analysis identified communication between professionals as an area of good practice and future learning. Highlighting the importance of sharing information with relevant colleagues/professionals working with the family. There are examples of positive multi-agency communication between health, education and local authority within the child health records.

The timeline showed that during the pregnancy health had offered mother support with smoking cessation. The agency analysis produced by the midwifery panel member concluded good practice in relation to Domestic Abuse Routine Enquiry (2018) completed in line with organisational guidance and documented appropriately in the midwifery records and mother did not disclose any concerns.

Mother took Child A for her routine childhood immunisations at the GP Practice. All Child A's immunisations were given at the right age, time and in the right number of doses to ensure Child A is fully protected. Vaccines are recommended at certain ages based on studies showing when children are at the highest risk of different diseases. There were no safeguarding concerns highlighted in the timeline from GP practice.

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:-

Emerging Themes and Learning

Voice of the Child

The timeline showed little evidence to suggest professionals had considered the voice of the child, nor did it provide assurance professionals documented the wishes and feelings of the children in practice. During the Learning Event, practitioners were able to provide the reviewers with some details of how the children presented within home visits, but there was little understanding of the children's lived experiences and the voice of the child was absent.

Failure to capture the voice of the child has been a reoccurring theme within inquiries and reviews and a failure to capture the narrative accounts of the children's experiences. A thematic report by Ofsted found children's needs were often overlooked because practitioners had focused too much on the parents. Amongst its key findings were, the child was not seen frequently by professionals, or was not asked about their views and feelings (Ofsted, 2011).

The timeline noted social workers observed the children to be happy and chatty; however, there is little evidence of practitioners speaking to the children individually, or details on their views. The National Society for Prevention of Cruelty to Children (NSPCC, 2015) emphasised that siblings of an at-risk child can give insight into family dynamics and important people in their lives. The timeline offered no insight to the children's views, but during the Learning Event school shared, the children raised no concerns over home life and made no disclosures.

Research by the National Independent Safeguarding Board found, through examining twenty Child Practice Reviews, children's voices or their perspective were sometimes missing and/or not always central to practice. Acknowledging discussions with children had taken place but their parents were present, which would not give them a safe place to disclose their experiences (Child

Practice Reviews in Wales, 2019).

Communication Between Agencies

Effective information sharing underpins integrated working and is a vital element of early intervention and safeguarding. Research has shown that keeping children safe from harm requires professionals and others to share information: about a child's health and development, any exposure to harm, a parent who may need help, or may not be able to care for a child adequately and safely, or those who may pose a risk of harm to a child. Often it is only when information shared from a number of sources and put together that it becomes clear a child is at risk of harm.

Although there was evidence of good communication between Police and Children's Services there was one instance where key information was missing from a police report. This report noted concerns over cannabis in the home and did not acknowledge Child 'A'. This raised issues around miscommunication between the Police and Children's Services in terms of the identified risks. The timeline showed a Police Community Support Officer (PCSO) had conducted a visit to the family due to one of the children throwing stones at a neighbour's house. The police logged a "concern for safety due to the smell of cannabis inside and outside the home". The timeline shows that Children Services, although acknowledging there was an extremely strong smell of cannabis at the property and that the father appeared under the influence of cannabis, Children's Services described the "main issue as being the child's anti-social behaviour".

Miscommunication and differing views on risks were evident again in the timeline when the school nurse contacted Children's Services to share concerns over the smell of cannabis in the home. Children's Services advised the school nurse, case closed to children's services and therefore no further action. It is unclear if the school nurse thought her contacting Children Services was a 'referral' to the department. Research shows that confusion about 'referrals' and 'contacts', and the misunderstanding of the referral process among some professionals can lead to referring agencies thinking they are making a referral or requesting action, but children's social care think they are only receiving information to be logged (SCIE, 2016). The school nurse did not follow up her phone call with a written referral, as is required with a formal referral from a professional. This was the fourth log of cannabis use in the home, the school nurse also raised concerns mother was allegedly selling cannabis from the home earlier on in the month.

Research also suggests that practitioners within universal services can be unsure about the point at which something has to be done, because of the lack of clarity on 'thresholds' for social care intervention and experience of referrals being 'knocked back' (Daniel *et al*, 2011). During the Learning Event the Health Visitor shared, she had previously made contact with Children's Services regarding the home conditions and informed not considered a safeguarding concern. This may have been a further incident of a professional believing they have made a referral, when in fact they have made contact and information logged.

Within the timeline, there was little evidence of communication between the school and Children Services, and on one occasion, Children's Services conducted a home visit the same day as school logged a Cause for Concern. School reported the eldest child continued to scratch her head and her general hygiene appeared particularly poor that day. Agency analysis from education-identified school should continue to refer to Children Services should neglect concerns persist.

Record Keeping

The NSPCC states accurate records of any concerns raised about a child and their family will help identify patterns of behaviour that may indicate a child is at risk of abuse or neglect.

During the Learning Event Health practitioners valued the multi-agency chronology and shared, they had not been aware of all the information within it. The Laming Report (2003) advocated the need for a comprehensive chronology of past events. Health agency analysis identified the need to develop a contact chronology to be in the front of the child health records to highlight the number of contacts, cancelled contacts, failure to attend health appointments in conjunction with the 'Was Not Brought' Policy.

It was also noted by health that for future learning it would be valuable to record who was attending appointments with mum e.g. was it boyfriend, husband or partner. All agencies agreed this information requires evidencing by all services providing appointments to parents.

The 'Midwifery to Health Visitor Confirmation of Pregnancy & Holistic Assessment form', the professional/ agency involved section had not been fully completed, therefore other professionals had not been consulted, or if they had there was no evidence of consultation taking place.

The child health records should identify the School Nurse and Health Visitor as allocated caseload holders for the family and contacted for further information. This additional information gathering would have made a more informed decision as to whether to proceed to HPBA. From the information available to the reviewers it was not recorded why a HPBA was not felt necessary. A review in 2019 of the guidance for completion of HPBA following recommendations from a previous Child Practice Review; now provides clarity in relation to the criteria for completing HPBA. There were concerns identified from the agency analysis regarding missed appointments and delays in some aspects of antenatal care due to non-attendance. The HPBA (2019) guidance does not make a specific reference to non-attendance but outlines the prospective parent(s) behaviour or circumstances during pregnancy indicate they will be unlikely to protect or care for their baby appropriately to consider a HPBA (2017). Women's Directorate have a Standard Operational Procedure: 'Follow up Arrangements for Women Who Do Not Attend Antenatal Appointments and for Women and/or New-borns where access is not established in the post-natal period', advises midwives and consultant led clinics to discuss with the Safeguarding Midwife any concerns in relation to non-attendance. The timeline identifies organisational learning in relation to sharing information about non-attendance and a need for professional curiosity in relation to non-attendance.

Disguised Compliance and Professional Curiosity

The Learning Event acknowledged professionals working with the family were experienced practitioners but the timeline shows there could have been opportunities for curiosity from professionals.

Educations chronology highlighted Child 'A's sibling had attended school with a bruise to the eye; mother stated the child walked into a lamppost. The child's account is not evidenced within the timeline but during the Learning Event education stated the child provided the same account as the mother. Although the child and mother provided the same explanation, further discussions with the child separately would have been good practice.

Four years previously, there had been concerns over another sibling observed with a bruise to the head, which the child disclosed "mummy throwing a bottle at me". A joint Section 47 investigation concluded the injury to be accidental. Prior to the visit the mother was made aware of the reason for the Section 47 visit by Children's Services. During the visit the child appeared happy and did not disclose any concerns, police and Children's Services closed the case. Research shows a large number of children will not disclose abuse or will retract a disclosure; this can be for a variety of reasons. If someone they know and trust is abusing a child, they may believe the abuse is normal and not recognise that anything is wrong. Family pressure can also be significant enough to encourage a child or young person to retract their disclosures (NSPCC, 2013).

The timeline shows that although mother may not have responded to the schools concerns, she did engage and respond to visits from Police, Children Services, and engaged to some extent with Health; although there was evidence of six 'Was Not Brought' clinic or home visits within the child health records. The timeline does not refer to mother requesting further support, as reported by the mother to the reviewers. Disguised compliance refers to parents that appear to be cooperating with child welfare agencies and not with other agencies. It entails parents cooperating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention (NSPCC, 2020).

Learning from Serious Case Reviews from 2014 onwards, the NSPCC found that within disguised compliance cases parents develop good relationships with some professionals whilst criticising or ignoring others, some parents may say the right things or engage 'just enough' to satisfy practitioners (NSPCC, 2019). The briefing highlighted practitioners should display professional curiosity when working with families and not accept information from parents at face value without investigating further. Practitioners should focus on the child's lived experience rather than the parents and carers' actions (NSPCC, 2019). The timeline and the Learning Event provided little evidence of the children's lived experiences and when parents were questioned over the cannabis use, their response was taken at face value with little evidence of further investigations being conducted.

Reder *et al* (1993) provides examples of disguised compliance as engaging with professionals for a limited period, or improving the home conditions for a short while for them to deteriorate again. Within the Learning Event school shared that the children's appearance and cleanliness would be "up and down" with parents responding to their concerns and the children's appearance improving, but parents could not sustain these changes and the children's appearance would deteriorate again. The timeline also demonstrated the parents could not maintain the home conditions as seven references were made to the poor home conditions. Parents would respond to professionals concerns and improve the home conditions for a while but it would soon deteriorate again.

Lord Laming (2003) in the Victoria Climbié inquiry suggested social workers needed to practice "respectful uncertainty", also known as professional curiosity, through applying critical evaluation to any information they receive and maintaining an open mind. Professionals should seek to understand what is happening within a family rather than making assumptions or accepting things at face value. The timeline showed no evidence of professionals having asked the parents why they were unable to maintain the home conditions. There was no evidence of asking parents why the children were repeatedly attending school with head lice and appearing unkempt. When a young person disclosed to Children's Services cannabis trading from the home, professionals accepted the parent's response rather than asking why a young person would allege this.

The Health Visitor and School Nurse provided universal health intervention as per the Healthy Child Wales Programme (2016). A Health Pre-birth Assessment was not completed between the Midwife and Health Visitor based on their professional judgement and considered interpretation of the guidance at that time. There is evidence of six 'Was Not Brought' clinic or home visits within the health records with, contacts cancelled by text and/or voicemail; Therefore, a discussion did not take place with the parents to ascertain the reasons for the cancellation. In relation to non-attendance to antenatal appointments, information sharing between professionals did not take place, record keeping was not of a good standard, in relation to completed documentation of Midwife to Health Visitor Notification of Pregnancy, which may have initiated professional curiosity in practitioners to undertake a HPBA.

Neglect

Neglect is the absence of provision for a child's basic needs (Gough, 2005). Within the timeline, there were a number of references indicating the children were experiencing some aspects of

neglect. Signs of physical neglect were evident in the schools on-going concerns over the children not having appropriate clothing, appearing smelly and unkempt and having on-going head lice. Howarth (2007) also identifies physical neglect in terms of cleanliness and living conditions; within the timeline there were seven references to the home conditions being poor, including issues with no lightbulbs in the rooms, the kitchen reportedly not fit for hygienic preparation of food, crockery in the bath, and animal urine/ faeces on the carpet. Neglect in terms of supervision was evident with concerns over the children being out in the evening unsupervised, and the children reportedly being home alone while mother visited a friend in prison.

Neglect is the most common form of child abuse in the United Kingdom, yet it sometimes can be the most difficult to identify (Action for children, 2017). It is the ongoing failure to meet a child's basic needs and a child may be hungry or dirty, or without proper clothing, shelter, supervision or health care (NSPCC, 2020). Positively the school identified the family were in need of support and referred to the School Nurse, however there was no evidence within the timeline of school referring their concerns to Children Services.

Action for children (2017) found that over 180,000 children referred to social services did not meet the threshold for support. The challenge for Children's Services where concerns are raised over neglect is that the threshold for state intervention is the child has to have suffered or is likely to suffer an ill treatment or the impairment of a child's health or development. The All Wales Child Protection Procedures 2008 defines neglect as the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Key to this definition is persistent and serious impairment; within this case, it was reported that the children's appearance, the home conditions, and parent's engagement with education would improve for a period, and then deteriorate. The Social Services and Wellbeing Act 2014 has more recently identified that more frequently significant harm occurs because of a long-standing compilation of events, which interrupt, change or damage a child's physical and psychological development.

Cannabis

The timeline made four references to cannabis use within the home, within a two-month period. The first concern raised by a PCSO who attended the home; a strong smell of cannabis was reported outside and inside the home, with father appearing heavily under the influence of cannabis. A month later, the school nurse made a referral to Children's Services regarding concerns over cannabis use in the home and mother allegedly selling cannabis from the home. A further concern was raised by a young person in Local Authority care, who reportedly had been to the family home to buy cannabis and used cannabis at the property. The final concern raised from the school nurse and Health Visitor conducting a joint visit to the property and reporting a smell of cannabis in the home. The timeline shows that all practitioner concerns regarding parental cannabis use and the supply of cannabis were shared with Children's Services. Parents denied cannabis use during Children's Services duty visits and no further action taken.

Substance misuse can result in money diverted to purchase drugs needed for food and clothing to satisfy parental needs (Department for Education, 2020). The timeline reflected concerns over the children's inadequate clothing and the lack of some necessities within the home, such as light bulbs, which could be linked to the alleged parental cannabis use.

During the Learning Event, the Health and Social Care Professionals were clear they personally observed no evidence of excessive cannabis use or any overpowering smell of cannabis within the home. Children's Services practitioners said cannabis use was common for many of the families with whom they had contact and cannabis use did not necessarily require Children's Services involvement. There was no evidence in the Child Health records of signposting parents to Substance Misuse Services in relation to cannabis use.

Children's Services did not deem cannabis use as a significant concern, which warranted further intervention, however with no assessment completed there was little evidence that consideration was given to the possible impact parental cannabis use had on the children. A Serious Case Review (SCR) conducted by Lancashire in 2017 explored the issue of parental cannabis use and identified that frequent exposure of practitioners to parents who use cannabis can at times result in the risks being overlooked (Connor, 2017). Cannabis use and its impact on parenting capacity was also identified by a previous SCR in Lancashire (Child K, 2013), which recommended the increase and more consistent use of relevant risk assessment tools and frameworks that include cannabis. In response to this recommendation, the LSCB found that there appeared to be inconsistent understanding amongst practitioners about the seriousness of cannabis use and the impact on children (Connor, 2017).

Hidden Men

The alleged perpetrator within this case was an unknown male. Agencies were not aware the mother was in a relationship with the male, therefore he was an unknown risk and professionals could not have foreseen the injuries sustained to Child 'A'.

The NSPCC (2015) briefing 'Hidden Men: Learning from Case Reviews' highlights key areas in identifying hidden men, the briefing identifies that lack of information sharing between adults' and children's services could be a risk factor. It is not known if the alleged perpetrator was working with any adult services, so it cannot be determined if there was a lack of information sharing in terms of the male, equally the reviewers did not know it if the mother had been open to any adult services.

The NSPCC (2015) also found professionals relied too much on mothers for essential information about men involved in their children's lives. It highlighted if mothers are putting their own needs first, they may not be honest about the risk these men pose to their children. During the Learning Event practitioners shared that other than asking the mother if she was having an affair there was no way to know she was in another relationship. Professionals said this question would have felt judgemental.

A common feature in case reviews and audit work nationally is the repeated finding that fathers and male figures are often absent in recordings. NSPCC (2015) notes learning for improved practice, suggests health, during pregnancy, and after birth, make active enquiries about the child's father, the mother's relationships and any adults in contact with the child. The health record did not show if the father was present during Child 'A's health appointments.

There is increased risk of abuse for children living in households where one parent, usually the father figure, is unrelated to the children has been well researched. In 2009 - Peter Connelly, 17-months old died of non-accidental injuries, the serious case review drew attention to the risk of an unrelated man joining the household; In 2014- Child J died of non-accidental injuries, the serious case review noted one of the concerns highlighted was 'Shadowy' unknown males in the background (Brighton & Hove LSCB).

During the Learning Event, all professionals said they had no knowledge of the alleged perpetrator and that had they had knowledge of the male, the injuries Child A sustained could not have been predicted as the alleged perpetrator had no previous convictions against a child and was not known to police for aggressive adult behaviour.

Although the reviewers share, the view the injuries Child A sustained could not have been predicted because they had no knowledge mother was in a relationship with the alleged perpetrator. Had professionals been aware of the male, a better understanding about his role within the home and his relationship with Child A assessed.

Coping with Crying

BCUHB adopted the Coping with Crying Guidance in 2016 and is currently under review by Women's Division. BCUHB Coping with Crying Guidance supports staff in advising new parents how to cope with a crying baby and the consequences of shaking an infant. It is a hospital-based intervention targeting parents and carers of all newborn infants. Parents/carers are invited by acute midwifery staff to watch a 10-minute DVD shortly before being discharged following the birth of their infant (or at home if a home birth, if delivered in an out of area hospital or if recently moved into the area). An information leaflet is given to parents/carers in the postnatal period before they view the DVD. The guidance clearly says if declined by parents/carers in an acute midwifery setting, the community midwife invites the parents to watch the DVD in the community and if not accepted at this point, the Health Visitor invites the parents to watch the DVD up to aged one year.

The reviewers requested clarity from the midwifery and health visiting panel members to ascertain if the parents had received this advice. Midwifery panel member clarified the box was ticked in the postnatal notes that the 'Coping with Crying' discussion was had prior to leaving the ward. However, it does not clarify if mother declined to watch the 10-minute DVD or if the information leaflet shared. The reviewers were unclear if Coping with Crying was documented in the handover to the community midwife. There is no evidence of discussion in relation to the Coping with Crying Programme in the Health Visitor records. However, the reviewers acknowledge the guidance refers to this intervention being for new parents and further on in the guidance refers to all parents and carers.

Conclusion

From the information presented to the reviewers it is evident there were periods when the parents did not meet the children's basic care needs, provide adequate supervision of the children and were unable to consistently maintain the home conditions. Short-term intervention to clean up the home led to signs of improvement resulting in no further interventions. The lack of assessment exploring these issues further to provide answers - as to why there were no light bulbs? Why were the home conditions so poor? - left the reviewers questioning whether there were any underlying mental health issues, were the family living in poverty, or were the parents prioritising their own needs and desire to use cannabis at the expense of meeting the children's needs. Most significant was the lack of any exploration of the children's experiences and how the poor home conditions, the parental substance misuse, and neglect they experienced, impacted on their safety, health and overall well-being.

The reviewers were sympathetic to the challenges practitioners faced, and with there being no evidence within the timeline of mother requesting or accepting support, the reviewers can only conclude the mother had not wanted assistance from professionals in addressing the difficulties the family were experiencing.

A key risk factor within this case was the unknown male. No professional who visited the home was aware of the male. The children had not shared any information with school regarding the male and the mother had not informed any professionals of him. From meeting the mother, the reviewers understood the difficulties professionals would have faced in obtaining any significant information.

The reviewers had assurance from the midwifery panel member there was evidence of 'Coping with Crying' discussion but no evidence if the parents declined to watch the DVD or given the information leaflet. The guidance needs to be clear if this intervention is for new parents/carers or all parents and carers. The reviewers recommend this intervention is offered to all parents and documented in midwifery and health visiting records.

Whilst identifying learning from this review, it is important to acknowledge professionals responded

to the needs of the family, as they understood them at the time. There was no evidence the information shared in this report could have foreseen the injuries suffered by Child A.

We would like to thank all professionals for their contribution to this review and willingness to reflect and explore learning for future practice.

Recommendations

1. **Coping with Crying:** BCUHB to review the Coping with Crying Guidance and training for Midwives and Health Visitors and will ensure documentation reflects accurate recording that the intervention has been offered to all parents and carers. This will be achieved by a 6 monthly audit of records

2. **Neglect:** North Wales Safeguarding Board to facilitate the development of a multi-agency neglect-training package. To include neglect of physical needs, poor home conditions, parental cannabis use, basic care needs and lack of supervision.

3. **Record Keeping and Communication:** All agencies to review their recording systems and information sharing protocols with partner agencies. This will be achieved by agencies undertaking a 6 monthly audit of records

4. **Voice of the Child:** All agencies to review internal policies and procedures and provide assurance the voice of the child is reflected in practice in line with the Social Services and Well-being (Wales) Act 2014.

5. **Professional Curiosity/Hidden Men:** All agencies to review their training packages and provide assurance training is developing workforce skills in professional curiosity in order to gain a clear picture of who the adults are in the child's life and this is clearly documented in agency records.

Statement by Reviewer(s)

REVIEWER 1:	**REVIEWER 2:**
Lisa Capper Independent Safeguarding & Reviewing Officer	Angela Roberts Safeguarding Practice Development Lead
Statement of independence from the case *Quality Assurance statement of qualification*	**Statement of independence from the case** *Quality Assurance statement of qualification*
I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	I make the following statement that prior to my involvement with this learning review: • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.

Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Lisa Capper	**Name** *(Print)*	Angela Roberts
Date	5th June 2020	**Date**	5th June 2020
Chair of Review Panel **(Signature)**			
Name (Print)	Jonathan Salisbury Jones		
Date	5th June 2020		

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Child 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 the services that attended* • *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
Family Declined Involvement.

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Date information received ……..
Date acknowledgment letter sent to Board Chair ……
Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			