**NWSCB 2022/1 Extended Child Practice Review**

## Brief outline of circumstances resulting in the Review

To include here:

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*

An extended review was commissioned by the North Wales Safeguarding Board on the recommendation of the Child Practice Review Sub-Group in accordance with the Guidance for Multi Agency Child Practice Reviews.

The criteria for this review are met under Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 which are that within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- died; or
- sustained potentially life-threatening injury; or
- sustained serious and permanent impairment of health or development.
- and the child was on the child protection register or a looked after child on any date during the 12 months preceding the date of the event

Child E, who was two years old, was subjected to extreme violence, starvation, dehydration and degradation. On the 13th and 14th of August 2021 he was subjected to violent and brutal assaults, including several blows to the head. He was violently shaken, which caused retinal bleeding, and sub dural bleedings in his brain and spine. This was not the first time that he had been violently beaten, leaving him exceptionally weak and vulnerable. Child E died of his injuries on 16/8/21.

He was subjected to violent assaults from 4/8/21 onwards. The full extent of the details of his injuries need not be listed in this review, suffice to say he was badly hurt and let down by those who should have loved and cared for him.

His grandparents were found guilty of subjecting Child E to extreme cruelty between 24/6/21 and 14/8/21, and of his murder. His grandfather was sentenced to a minimum of 23 years in prison, and his grandmother was sentenced to a minimum of 17 years. Neither of his grandparents showed any remorse throughout the court case.

Child E's mother was found guilty of allowing the death of her son and that of child cruelty in that she neglected her son and failed to give him food and drink. She failed to protect him from the violence and humiliation directed towards him by his grandparents; and deliberately disregarded his welfare. She chose not to seek help or to alert Local Authority Childrens Services to the way he was being treated. She was sentenced to 12 years in prison.

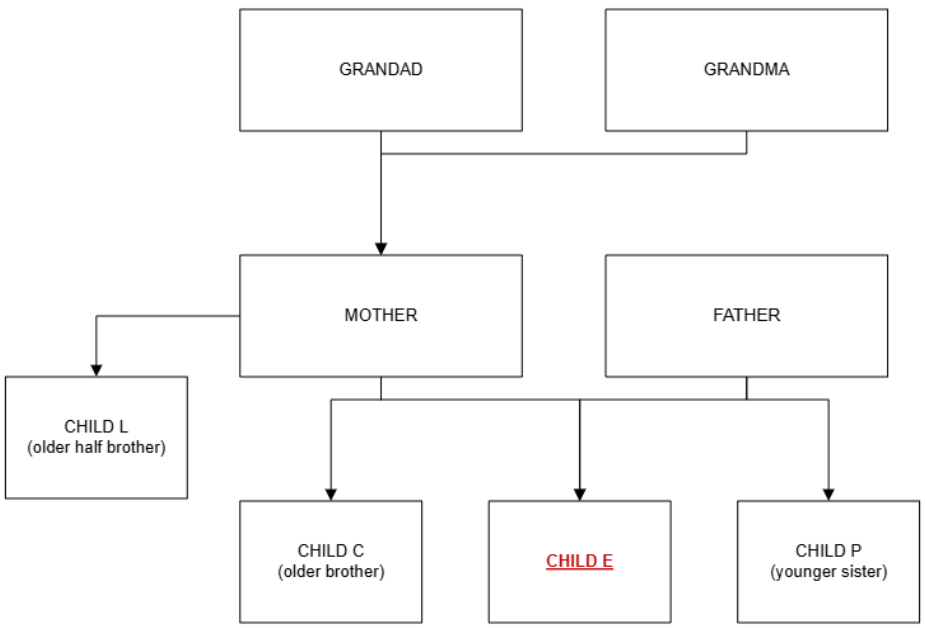
Child E's mother and maternal grandparents deliberately thwarted any attempts by Health Visitors and Social Workers to see Child E. They also deliberately kept Child E away from his father and his paternal family, who last saw Child E on 9/6/21.

Both grandparents and Child E's parents had long standing involvement with Local Authority Childrens Services.

Child E's name, along with his siblings had been placed on the Child Protection Register on 6/7/21.

In his sentencing report Mr Justice Griffiths summed up by describing Child E as "A two-year old with an independent spirit. His mother and his grandparents hit him, but when they did, he was defiant, and even laughed, even though he was only a toddler. He was a brave and resilient boy with a strong character. He already had qualities which could in an adult make for greatness. But the people hitting him didn't like the little boy standing up for himself. They decided to break him".

A Health Visitor's report to the Initial Child Protection Case Conference described Child E as "A very sensitive little boy, who relies on his mother for reassurance and comfort".



## 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 Review Panel have conducted an extended analysis of practice which has proven to be multifaceted and spanning several years.

Child E, his immediate family and his extended family were well known to Health, Local Authority Children's Services, Education, and the North Wales Police. Over the years there were significant concerns raised and there has been consideration of how these concerns were dealt with.

Organisational practice has been reviewed, and consideration given to the effect of the Covid 19 Pandemic on the provision of services.

Towards the end of Child E's life there had been Child Protection Enquiries which raised concerns regarding the children's safety in the care of their parents, however the real danger to Child E was when his mother left him in the care of his grandparents, whom she knew could be abusive as this was her experience of growing up in their care.

Once the children's names were on the Child Protection Register, the ability of the statutory agencies to monitor the children's care was significantly diminished by staffing issues, high volume of referrals to Local Authority Children's Services, lack of adherence with procedures, access to information and I.T. systems and the maternal family's determination to deny access especially to Child E.

Whilst not denying the impact of Child E's parents' toxic relationship; the presence of domestic abuse, and drug and alcohol issue, Child E's father and his family's attempts to alert Local Authority Children's Services and North Wales Police to their concerns about Child E being in the care of his grandparents were not acted upon.

On the day Child E was admitted to hospital, tremendous pressure was put on the working relationship between the two hospitals, The Countess of Chester and Alder Hey, Social Services and the North Wales Police. Lessons have been learnt regarding the importance of these agencies working together at times of stress to ensure the welfare of all children in the family, which included Child E, his siblings and the grandparents' own children, two of whom were under 18 at the time of Child E's death.

**Areas of learning**

1. **Background Knowledge**

The chronology put together for the purpose of this review has focused on the information available on file in relation to:

- The maternal grandparents and their own children. The grandparents had 8 children of their own, Child E's mother being the eldest at 24 years of age.

- Child E's immediate family, which included his parents, his two sibling's child C and Child P and his older half-brother Child L.

The chronology begins in 2016 with the birth of Child L, Child E's half-brother, however, there is historical information on file regarding the grandparents and concerns regarding their parenting which goes back to 2006 when the family lived in England. Whilst the other children of the grandparents do not feature in this Review, there are consistent references to concerns regarding their care of the children, including non-school attendance and attempts to avoid disclosures of physical abuse.

The records show that the mother had consented to a Health Pre Birth Assessment during her four pregnancies. The Health Pre Birth Assessment is a health assessment tool, designed to support Health Visitors and Midwives in identifying health needs and highlighting potential safeguarding concerns. The assessment includes questions relating to parental functioning, family circumstances, and support networks, and whilst it is not intended to provide the level of exploration associated with a statutory assessment, it was found that the Health Pre Birth assessments held important information regarding the mothers own parenting and the relationship between the parents.

Information regarding her own parenting especially physical abuse had been regularly reported by Child E's mother and recorded in the Pre Birth Health Assessments undertaken during her four pregnancies. It was noted that despite the concerns the Health Pre Birth Assessments were not shared with Local Authority Children's Services.

During this review Local Authority Children's Services noted that there had been 36 referrals/ concerns and CID 16 reports from the police in relation to Child E and his immediate family since 2016. The referrals included reports of significant domestic violence, issues of homelessness, parental substance misuse and parental mental health issues.

A high proportion of these referrals were closed with no further action.

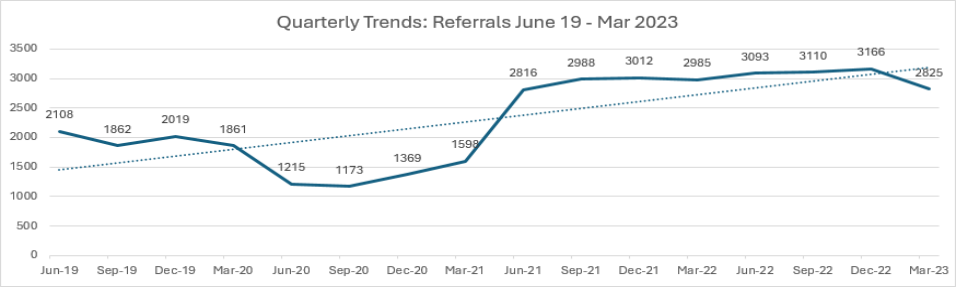
At the Learning Event, it became apparent that each agency reported a difficulty in accessing information on I.T. systems, which led to agencies not having access to all

the historical information held on file regarding previous referrals. Some agencies e.g. Education had access to the I.T systems but needed to request permission to access information on Child Protection cases.

Towards the end of the timeline two of the Local Authority Children's Services teams held the family's case, the Children's First Contact Team, and the Family Intervention Team. Prior to April 2021 there had been previous input by the Early Help Hub and the Targeted Support Team.

The family were initially allocated in April 2021 to the Children's First Contact Team; their role was to undertake the initial screening and to and make decisions about the most appropriate pathway for each referral. It was noted at the Learning Event that the capacity of the Children's First Contact Team to deal with referrals was limited due to an unprecedented increase in referrals.

The data demonstrates a significant and sustained increase in demand for local authority services. Referrals increased from 1,598 in March 2021 to 2,816 in June 2021, equating to a 76% increase within a three-month period. This represents the most rapid increase in referral activity experienced by the service, with monthly referrals rising by over 400 cases. Referral volumes rose from approximately 27 referrals per day to 47 referrals per day, placing significant additional pressure on services. Notably, demand did not return to pre-pandemic levels; instead, referral volumes remained consistently elevated until December 2022, indicating a sustained period of heightened service pressure and increased complexity in the aftermath of the COVID-19 pandemic.




It was also noted that managerial overview was affected by the wide range of services included in the managers remit and that this meant insufficient time could be given to monitoring the agencies response to referrals.

The Local Authority Children's Services report that given the significant increase in referrals there was limited capacity within the Children's First Contact Team to ensure consistent checks on previous referrals, and incidents were often reviewed in isolation.

**It was agreed that there was a missed opportunity to understand and consider significant historical information which could have supported assessment, analysis, risk managements and case planning.**

**It was also agreed that it would have been beneficial if information gathered during the Health Pre Birth Assessments would have been shared with the Local Authority Childrens Services, either as part of the safeguarding referrals or as information during ongoing enquiries and should all have triggered Pre Birth Risk Assessments by the Local Authority Children's Services, this was a missed opportunity to consider the parents ability to raise the children within a safe environment, free of domestic abuse and violence**.

2. **Professional Curiosity**

As noted above 36 referrals had been received since 2016, the majority of these being closed with no further action. Some support was offered via the Early Help Hub and the Targeted Support Team. The Early Help Hub was established in 2016 to ensure referrals were not turned away because they did not reach the threshold of child protection and hopefully this would avoid future escalation.

It was noted during the Learning Event that the Children's First Contact Team would screen referrals and signpost if appropriate to the Early Help Hub if there were no Child Protection concerns.

However, there was a well-established pattern of non-engagement by this family, leading to the cases being closed each time. Previous non-engagement was not considered when further referrals were being received and directed once again to the Early Help Hub.

All health visits were undertaken in line with Healthy Child Wales Programme Universal Scheduled Contacts for 0-7 years.

There was a pattern of the mother having good engagement with Health Services around the birth of the children however this diminished once the babies were born.

When concerns were being expressed by Health Professionals regarding not being able to establish contact with the family and to arrange to see the children the response from Local Authority Children's Services was to send letters to Child E's mother. When the mother did not respond to the letters the case was closed. No letters were sent out to the father. There did not appear to be any escalation of concern following repeated referrals and repeated non engagement. There appeared very little consideration to why these parents were not engaging with services. The parents were also aware that if they did not contact Local Authority Children's Services, they closed the case, which suited them.

Despite repeated non-attendance at scheduled appointments, the Health Visitor remained persistent in trying to engage with the family through opportunistic home visits, there were numerous attempts by Health Services to contact the family, the Health Visitors would call by, leave notes through the letter box, text and phone. It was noted that many of these visits were opportunistic visits as opposed to pre-planned visits. During the Learning Event it was discussed that as these visits were

not pre planned, they did not feature as failed visits with Betsi Cadwalader University Health Board (BCUHB)'s Was Not Brought Standard Operating Procedure and therefore were not escalated as part of the safeguarding procedures.

**There were missed opportunities to engage with the parents and the children, and a missed opportunity to consider the impact of the parents' non engagement on the children.**

Many of the concerns within referrals were in relation to Child E's parents' relationship.

Information has come to light during the Review regarding Child E's mother's vulnerability and especially her cognitive ability; her literary skills and her capacity to safeguard herself and her children. Routine means of assessing her vulnerability were not carried out on a regular basis and her lack of capacity to protect herself and her children was not assessed. There were missed opportunities to carry out the FRAIT (Family Resilience Assessment Information Tool) and the Routine Domestic Abuse Enquiries. It was thought that the routine enquiries were not undertaken as Health Professionals were aware of the domestic abuse and therefore the questions were not asked. However, as there were changes of Health Visitors as the family moved around the Routine Enquiries could have ensured the information was known by all and at the forefront of people's minds.

**There were missed opportunities to assess the parents' resilience, the effect of domestic abuse on the family and the parents' ability to protect the children from the effects of witnessing domestic abuse.**

Most of the references within the timeline and analysis has considered engagement with Child E's mother. However there appears to have been very little engagement with Child E's father. Child E's father was described as someone who could be volatile and aggressive, and this has featured in numerous referrals and CID 16's. Child E's father was interviewed as part of this review, and he shared that in his view the different agencies engaged with Child E's mother and not with him. He felt excluded and could not fully take part as he felt no one listened to him. Records show that all contact was made with the mother and not the father. Child E's father did explain that due to his early experiences he was suspicious of Local Authority Children's Services and that he would often panic and get wound up when dealing with Children's Services. He recognised this and asked for his stepmother to be able to support him in meetings, but this was not encouraged.

**There were missed opportunities to engage with the parents, especially the father who was attempting to voice his concerns about the children and their mother.**

Whilst the Review found that there were missed opportunities to hear the voice of the parents, there was also a lack of opportunity to hear the voice of the children.

The North Wales Police have noted that many of the CID 16's presented did not include any information regarding the children, whether they were present in incidents, what the children were witnessing and what the Police Officers observations were of the impact of the parents' behaviour on the children. On one occasion several Police Officers attended the family home, however the opportunity was not taken to speak to the children. The police have also reflected that there were opportunities to provide further CID16's but these were not presented.

It was also noted during the learning event that North Wales Police do not have the systems in place to note and record previous CID 16's sent in relation to children.

**There were missed opportunities to consider the voice of the children.**

3. **Safeguarding Procedures**

Up until April 2021 the Safeguarding reports and CID 16s as noted previously were mainly deemed as not requiring any further action or were closed due to non-engagement.

In April 2021 the Health Visitor made a safeguarding report which instigated Local Authority Children's Services involvement once again. This report was in relation to an injury sustained by Child L whilst in the care of his father during a visit to his home. Whilst not related to the death of Child E, the incident raised concerns about the mother's ability to protect her children.

Following the report initial checks were made, the mother was spoken to and consent to offer support was requested, suggesting the threshold of significant harm was not met, and that care and support was to be offered. This decision was reviewed by a manager a few days later and further information was requested by the manager. There is no record of a response from the mother to the offer of care and support. There is no record of the further information requested by the manager being provided and the case was closed on 6/5/21.

**There was a missed opportunity to gain a better understanding of whether the mother could or would protect her child.**

On the 11/5/21 the Health Visitor makes another safeguarding report again expressing concern about the mother's ability to protect her child L.

This time the report triggered a Strategy Meeting in accordance with the Wales Safeguarding Procedures, the meeting was attended by the Police and Local Authority Children's Services. Despite submitting two safeguarding reports in 12 days, the Health Visitor was not invited to the Strategy Meeting.

A single agency enquiry under Section 47 of the 1989 Children Act was instigated on 11/5/21 and an agency Social Worker allocated on 12/5/21. Within the Wales

Safeguarding Procedures, the Section 47 Enquiry should have been completed within 10 working days which would have been 25/5/21.

The social worker saw child L in school on 18/5/21 and conducted a home visit on 20/5/21.

There is no record of the conclusion of the Section 47 Enquiry on 25/5/21 or any record to explain the delay.

A meeting was scheduled with the mother at the school on 26/5/21 which was cancelled by the social worker, but when the social worker tried to rearrange the mother refused to rearrange another meeting that week. The social worker contacted the mother the following week 2/6/21 and the mother refused to arrange a meeting that week.

There is no record of the agency worker having any supervision to plan or review the section 47 enquiry process. There is no record of any discussion regarding the progress of the section 47 enquiry and especially the mother's lack of cooperation, essentially the mother was able to delay the Section 47 enquiry process for at least two weeks by refusing to arrange to meet the social worker.

On 8/6/21 the Health Visitor submitted a further Safeguarding Report, this time following a home visit where the Health Visitor was concerned regarding the relationship between the parents and the impact on the children.

This information was recorded as information on an open case and the record confirmed that Section 47 enquiry instigated on 11/5/21 was still ongoing, which was now 20 working days.

The Social Worker scheduled a meeting at the school with the mother on 9/6/21, as she had shared that she wanted to leave the father and she was not able to speak freely in his presence. When the mother contacted to say she could not attend the meeting at school, the Social Worker went to the family home. Whilst at the home the Social Worker saw that one of the children Child C has an injury to his lip. The Social Worker was concerned about the child's injury and suggested taking a picture of the injury to send to Health for advice. At this point the father became angry and asked the Social Worker to leave.

As the Social Worker was leaving the mother said that she wanted to leave the father and asked the Social Worker to help her.

The Social Worker sought advice from a Senior Practitioner and was told by the Senior Practitioner that the mother had to leave of her own volition, and that the mother would need to take the child to see a doctor regarding the injury to his lip. The mother agreed to take the child to the local Accident and Emergency Department so someone could look at this lip. The mother later said that she had gone to Accident

and Emergency Department but did not stay as the wait was too long. There is no record that Mother attended Accident and Emergency Department that day.

**This was a missed opportunity to reconvene a strategy meeting to consider the fact that during an ongoing section 47 enquiry there was another safeguarding report; a mother stating she felt unsafe and an injury to a young child. There should also have been a clearly recorded discussion around the need for a Child Protection medical.**

The Social Worker met with school staff as planned that afternoon and during this meeting the mother phoned the Social Worker to say that the father was "kicking off "and she needed help to leave".

The Social Worker and two members of the school staff went to the house.

When the mother asked for help to leave the Social Worker phoned the Police for assistance. The father became increasingly agitated and went into the garden with one of the children and refused to let him go. Several Police Officers promptly arrived at the scene, including a Police Sargeant who was a trained negotiator. The Sargeant manged to calm the father down within minutes and reported that he posed little resistance to step down and release the child.

The Social Worker phoned the office for advice and was told by a Senior Practitioner that the Social Worker was not to do anything to support the mother and the children to leave, and especially not to do anything that could be considered as "placing" the children in the care of the Local Authority.

This conversation was overheard by a Police Sargeant and the school staff. The Police Sargeant spoke to the Senior Practitioner, and they agreed the Police would take the children to the Police Station and then they could go on to mother's sister's house from there. The school gave the mother money for a taxi fare.

At the time, the School Staff, the Social Worker and the Police Officer thought they were instrumental in sending the children to safety, little did they know this was the first step in Child E's demise. The impact of this knowledge continues to be felt by these staff, who have noted the lack of support they have felt from their respective agencies since this time.

**The focus of the Senior Practitioner appeared to be making sure the children were not placed "in the Care of the Local Authority" and this appears to have taken precedence at the time over the need to ensure the children were safe. This was a missed opportunity to focus on the parenting the children were experiencing.**

A strategy meeting was held the following day, attended by the Police and Senior Practitioner only and a decision was made for the ongoing Section 47 to continue but that it should be a joint Section 47 enquiry between Local Authority Children's

Services and the Police. The allocated social worker was not invited. There is no record of whether a Child Protection Medical was required or requested.

From the records shared with this review, it has become apparent that the decision at the Strategy Meeting to undertake a Joint Section 47 Enquiry was reviewed later in the day by a Police Inspector and a decision made that a Joint Enquiry was not needed and the Police involvement was to end. The reasoning for this was that no child was hurt during the events of the previous day, this is despite what the children were experiencing and witnessing in terms of domestic abuse, heightened aggressive behaviour, and the number of police officers arriving at the home.

The Detective Sargeant who was dealing with the case felt that a Joint Enquiry was appropriate but could not question the decision made by a higher-ranking officer. This was not brought back to Strategy Meeting as would have been expected. It was also found that the child's injury was not seen by a health professional, there was no photographs taken and child protection medical was not undertaken.

The children were seen the following day, 10/6/21 at their aunt's house, however a few days later the family moved to another aunt's house. Apart from one phone call on 14/6/21 there was no contact between the parents, the children and the Social Worker before she left the Department on 24/6/21.

Information has since become available that Child E moved to live with his grandparents on 24/6/21. At the time the Local Authority Children's Services were unaware of this.

The Health Visitor also reported that she had been unable to contact the parents during this time.

A case summary was provided by the Social Worker to a Senior Practitioner when she left the department, outlining her concerns regarding the historical context of both the immediate family and the extended family; the level of domestic violence the children were witnessing, and experience and the noncompliance from the parents. The case transfer summary records that the mother was currently staying at her sisters address with the children. Before leaving the Social Worker concludes the Section 47 enquiry and completes the necessary report for Initial Child Protection Case Conference to be held on 6/7/21.

The Health Visitor who knew the family well completed a report that was shared at the Case Conference, but did not attend, no mention was made of the concerns regarding the mother's experience of parenting by the grandparents despite this having been known for some time, however at the time it was not known that Child E was living with his grandparents.

The children's names were placed on the Child Protection Register under the category of emotional abuse on 6/7/21.

After the Case Conference on 6/7/21 the case appears to have been held by the Senior Practitioner, no visits were undertaken and correspondence appears to be via email or text message. During this time the father contacted the Senior Practitioner to express his concerns about the situation. The IT system had the children as being allocated to the agency worker, despite her leaving the Local Authority on 24/6/21.

On 7/6/21, the day after the Case Conference the mother informs Local Authority Childrens Services that Child E is no longer in her care and that he has been living with her parents and gave their address. There is no record of any checks being made regarding the welfare of Child E now that the Local Authority Children's Services are aware that Child E has moved to live with his grandparents. Child E's address was not changed on the I.T. system.

Child E's mother and sibling Child C and Child P, all moved in to live with the grandparents on 19/7/21.

**Once Local Authority Childrens Services became aware that Child E was living with his grandparents, there was a missed opportunity to gain valuable information. It is now known the concerns regarding the grandparents' parenting was well documented.**

Between 10/6/21 and 22/7/21 the children were not seen by anyone from Health or the Local Authority Children's Services despite there being an ongoing S 47 enquiry regarding the children and the subsequent registration on the child protection register on 6/7/21.

The Wales Safeguarding Procedures say that a child on the child protection register should be seen at a minimum of every 10 working days. **These children were on the child protection register for 12 working days without being seen and had not been seen at all for a total of 42 days**. There is no indication that the fact that the children had not been seen was escalated in accordance with the Wales Safeguarding Procedures.

Following registration on the Child Protection Register, the Part 3 Care and Support Plan on each child should be reviewed and a Part 7 Care and Support Protection Plan put in place for each child, recognising the necessary steps that needed to be carried out in order to safeguard the children.

This Part 7 Care and Support Protection Plan is then reviewed at Core Group. There is no evidence that robust Part 3 and Part 7 Care and Support Plans were developed after Case Conference and the children's individual needs were not recorded.

The case was transferred to the Family Intervention Team on 14/7/21, however the allocated Social Worker could not take the case due to covid restrictions and the case remained unallocated until 22/7/21 and another Social Worker was allocated.

The date of the first core group was set at the Initial Case Conference and the core group members identified as the parents, Child L's father, the allocated Social Worker, School Nurse, Education Welfare Officer and Head Teacher.

An online Core Group meeting was held on 15/7/21, the mother attended but the father was not invited. There was no allocated Social Worker at the time, the case was managed within the Family Intervention Team's duty rota. A duty Social Worker did attend, but she had no knowledge of the family. The Head Teacher who knew Child L attended. The School Nurse and the Education Welfare Officer did not attend. The core group record confirms there was no discussion around the risks, and the care and support protection plan was not referred to.

The newly allocated Agency Social Worker was tasked on 22/7/21 to see the children, there is no record of a transfer meeting. After spending time looking for the family, he was able to conduct a statutory visit at the grandparents' house. This was the last time Child E was seen. Child P and Child C were also present.

This was the first contact between the Social Worker and the family. There had been very limited opportunity for the Social Worker to read any background information before he made the initial visit to see the children. Child L was seen the next day in the care of his father where he remained.

There were several attempts to see the children by the Social Worker and Health Visitor after this, however, access was denied each time. On 5/8/21 the Social worker visited the house, but both the mother and grandmother stopped the social worker from going inside the house or seeing Child E telling him that Child E was having a nap. That was a lie. Both the mother and the grandmother kept the social worker outside the house for a total of three quarters of an hour, until he finally left.

CCTV footage subsequently captured on 4/8/21 as part of the criminal investigation showed that by this time Child E had suffered significant harm, visible by his demeanour, the mother claimed Child E was too ill to be seen. We now know that during this time the grandparents and the mother were concealing the fact that Child E was seriously unwell, following physical attacks by the grandparents.

Child E's mother was aware of the treatment of her son by his grandparents.
The sentencing remarks of the judge Mr Justice Griffiths highlighted the mother's neglect and states that she did not alert Social Services "or doing anything else to protect Child E, or to get him to a place of safety"

Child P and Child E were not seen between 22/7/21 and when Child E was rushed to hospital on 4/8/21 which was 16 working days.

It is acknowledged that the mother and the grandparents were concealing Child E from statutory agencies. Child E's father and paternal family had contacted the Local Authority Children's Services to express their concerns and about the mother's

mental health and the fact that Child E was at his grandparents and his father was being prevented from seeing him by the mother and her parents.

The records show the attempts of the Social Worker and the Health Visitor to contact the mother. Visits were being made to various previous addresses. During the Learning Event the Social Worker shared that he was not aware that there were any immediate concerns regarding the family and compared with some of his other cases he was not overly worried about not seeing the children.

There is no record of a transfer meeting being held when the family were allocated to the social worker on 22/7/21.

There is no record of the Social Worker having received supervision whilst holding the case between 22/7/21 and the day that Child E died.

**There was a missed opportunity to escalate the fact that key agencies could not see the children. With hindsight we now know that consideration could have been given to taking steps to insist on seeing the children.**

A second Core Group Meeting was held on 9/8/21, 5 days before Child E was rushed to hospital. Local Authority Children's Services have no formal record of this meeting which was chaired by the Social Worker. The Health Visitor attended this core group meeting had taken her own summary record of the meeting. The record of the meeting confirmed that the family were living with the grandparents and that the Health Visitor was concerned as the mother has previously disclosed that her father can be volatile and was physically abusive toward her when she was younger. The mother was invited to the meeting but did not attend claiming she was ill. There is no record of the father being invited.

**There was a missed opportunity to explore the previous and ongoing concerns regarding the grandparents' care of their own children.**

4. **Local Authority Childrens Services**

The review has been told that the Local Authority Children's Services structure at the time, was that the initial contact was the Children's First Contact Team who took the calls and initial reports and undertake statutory checks. If there were child protection concerns, then the case would remain allocated to the First Contact Team. They would undertake strategy meetings and allocate for Section 47 enquiries.

Any further referrals once allocated were recorded as contact on open cases. Section 47 enquiries were undertaken by the Children's First Contact Team and screened by managers as to whether there was a need to proceed to Case Conference. The Emergency Duty Team (EDT) noted that when they became involved on a case out of office hours it was not always clear that a case was open and that there was an ongoing section 47 enquiries, as the section 47 enquiries were not inputted on the system until it had been signed off by the manager doing the

screening. During the time frame in question there was significant delay in signing the Section 47 enquiries off and inputting the outcome of the Section 47 enquiries on the system.

This resulted in two areas of concern;

- Additional referrals being received and EDT or Children's First Contact Team not knowing that there was a Section 47 ongoing. When the Health Visitor phoned EDT for advice one evening, the EDT worker could not see any indicator on the system that there was an ongoing section 47 enquiry and advised the Health Visitor to trust the mother's judgement and if she was concerned to make a safeguarding report which she did. It is now known that there was an ongoing Section 47 Enquiry at the time, but this was not known by EDT.

- Referrals being recorded as information on open cases when in fact the case had been already closed.

Once the Section 47 enquiry had been completed and screened by a manager, the ICPCC was booked in as was the case with this family.

Once children's names are placed on the Child Protection Register the case should then be transferred to the Family Intervention Team and a new Social Worker allocated to establish and monitor the Care and Support Protection Plan. The Local Authority's policy was that a case transfer meeting would be held on point of transfer. There is no record that a transfer meeting was held.

During the Learning Event, staff's recollection of the working environment at the time was not positive. The Children's First Contact Team were described as overwhelmed with the number of referrals; managers were screening referrals, chairing meetings and undertaking S 47 enquiries themselves.

In relation to child E and his family, the agency Social Worker had left the department 5 working days before the case conference on 6/7/21 and the case remained unallocated until 22/7/21. Any work to be done was held by the duty rota, which included attendance at the core groups.

The case should have in theory been transferred to the Family Intervention Team after the case conference, however according to the staff at the Learning Event the Service Manager with responsibility for the Family Intervention Team was voicing concerns about the capacity of the Family Intervention Team to be able to be allocate cases transferring from the Children's First Contact Team. This appeared to be due to staff vacancies within the team that limited the team's ability to provide the service. This led to some tensions within the service.

Records show that Child E and his siblings were transferred on 14/7/21 but remained unallocated to a Social Worker.

Some staff at the Learning Event shared that the service felt very disjointed at the time, and that there was a very awkward atmosphere within the service, with evident tensions between teams. There were vacancies within the social work teams as Local Authority Children's Services permanent staff had left. Agency staff were appointed to social work posts and this caused delay as agency staff came and went. Staff said that managers were aware of the issues but were not listening.

During the Learning Event process we also heard from an Agency Social Worker who noted dissatisfaction with the support received whilst working for the Local Authority. An Agency Social Worker told the review that as agency staff she was not seen to be part of the Local Authority Children's Services team; very little induction to the Local Authority was given; according to the worker Agency Social Workers were allocated cases and told to get on with it. Formal Supervision was provided every six weeks, which considering the family's Social Worker was newly appointed and working during the COVID pandemic gave limited opportunity for structured support. During the Agency Social Workers' nine weeks with the Local Authority, only one supervision session was achieved and despite being the case holder for Child E and his siblings, the family was not discussed during the supervision.

The lack of induction, case transfer meetings, co working and supervision meant there was a risk that agency staff were not supported to understand the culture and practice of the Local Authority Children's Services and there was a risk that their practice could differ from local practice. One example of this was when the Agency Social Worker asked the parents' permission to take a photograph of the child's injured lip. This caused the father concern, and he fiercely objected and forcibly asked the Social Worker to leave. Local Authority Children's Services staff at the Learning Event all agreed that they would not have tried to take a picture of the injury as it was not something in their practice to do so. The Agency Social Worker who often worked outside North Wales believed it was normal practice,

It has been noted that one incident in particular, the event of 9/6/21 when the social worker visited the family home and was faced with hostility from the father and the police were called, resulting in several police cars and officers attending including a hostage negotiator, appeared to be one where the support to the Social Worker was insufficient.

The worker had called the office for advice, when faced with knowing that she had seen a child with a potential injury and knowing that the mother was reporting that she felt unsafe and wanted support to leave. The Social Worker had arranged for the mother to come to the school, however when she was told that the mother was not going to come to the school then the Social Worker returned to the family home alone, despite facing aggression from the father earlier in the day.

The Social Worker rang the office for advice and was told by the Senior Practitioner on duty that day that the mother had to leave the home on her own volition and that she the Social Worker should not support her to leave as it could be construed as "placing the children in the care of the Local Authority" and under no circumstance

should she do anything what could be placing the children. The case records at the time did not seem to acknowledge the intensity of the situation and the need to support the Social Worker. There did not appear to be any attempt by the Senior Practitioner to send someone out to support the Social Worker. It was noted that the office was busy, and the Senior Practitioner said she was overwhelmed with the volume of work. The Agency Social Worker shared that she felt the Senior Practitioner was angry with her, but essentially, she did as she was told.

The Police Sargeant attending the scene was not happy with the instruction given to the Social Worker and asked to speak to the Senior Practitioner herself, the Senior Practitioner eventually agreed that the Social Worker could be present to support the police to take the family to safety, but not to take action herself. The school staff were concerned for the Social Worker and the lack of support and went to the house with the Social Worker.

The Police helped transport the mother and the children to a place where they could get a taxi from to go to her sister's house. The school gave the mother the taxi fare.

**Workforce challenges within the Local Authority Children's Service impacted on the ability to protect the children in accordance with the Wales Safeguarding Procedures.**

**Whilst recognising the commitment of the social worker and the school staff to ensuring the children's welfare by returning to the family home to support the mother and children to leave, there was a missed opportunity to support the Social Worker and ensure the safety of the staff attending at the time.**

**Whilst recognising the need to keep children with families, the instruction to the social worker not to do anything that would look like placing the children was not based on the children's best interest. There was a missed opportunity to support the family to move to a place of safety.**

**5. I.T. Systems and Information**

<u>Family's address</u>
Information held on the Local Authorities I.T. systems, especially the child's address and whereabouts has been raised as a significant issue.

The family, the mother, father and 4 children lived together until the mother and 3 children moved to her sister's house as a place of safety on 9/6/21. Child L was with his father.

It was noted that all of the CID's 16, referrals and case records viewed at this time referred to the fact that the mother had moved to her "sister's address". The fact that the mother had in fact 3 sisters was a confusing matter as the records did not specify which sister. The situation was further confounded by the mother moving to a second sister's house a few days later.

There is evidence that the Social Worker was trying to contact the family to undertake his statutory visit and that he visited both the address of the first sister they had moved to and the original family home before being told that the family were now living with the maternal grandparents. It was initially shared with this Review that the Local Authority Children's Services did not really know the whereabouts of the family.

However, the Local Authority Children's Services have confirmed that the mother had informed them that she had moved to the other sister's house and that Child E was now living with his grandparents. None of these movements were recorded on the relevant I.T. system. During the Learning Event, Local Authority Children's Services staff shared this this was not unusual, and that during COVID there was considerable delay in inputting data onto the I.T. system.

It was also noted that when Child E was admitted to hospital on 14/8/21, his address was still wrongly recorded on the system and this caused considerable confusion for the Emergency Duty Team (EDT).

<u>Information on children's files</u>
During this Review, it has been noted that there was a lack of consistency regarding record keeping about the children within Local Authority Children's Services files. The Local Authority Children's Services shared that at the time when a family was referred, there should have been a file opened on each of the children and information cloned across all files.

Whilst there was a case file opened on all four children, the information on these files was not always cloned.

There was relevant information recorded; however, some was recorded on Child L's file, some on child C and some on Child P. There was very little information on child E's file.

The Social Worker, allocated post Case Conference and the EDT staff reported that in order to piece together information, they had to trawl through each individual child's record to get a comprehensive picture of what was going on.

There were no links made between Child E or any of the other children and the other children of the grandparents.

## 6. The Events around Child E's death

CCTV footage captured on 12/8/21 saw Child E being maltreated by his grandfather and this was not challenged by his mother and grandmother. On the 12/8/21 the Social Worker was prevented from seeing the children by the mother.

On the 13/8/21 child E suffered a serious collapse, more than likely due to a brain injury inflicted whilst he was in the care of his grandparents. No medical attention was sought for him.

The following day 14/8/21 his mother was summoned from upstairs where she was talking to a friend on the phone to say that Child E had collapsed again. It took the family 20 minutes before they phoned 999 to summon help.

The postmortem confirmed that Child E had been hit with blunt force that caused multiple injuries. As a result, he suffered a catastrophic collapse from which he never recovered and which led to his death.

North Wales Ambulance Service alerted North Wales Police to the 999 call and Child E was admitted to the Countess of Chester Hospital around 22.05 pm. The Countess of Chester A and E and the Welsh Ambulance Service contacted Flintshire and Wrexham EDT to notify them that Child E had been admitted to hospital with serious injuries, the cause of which were unknown at the time.

The EDT service started checking their system and was faced with confusion stemming from earlier reported issues in that the address for Child E was not recorded correctly on file. The whereabouts of the mother and the children was not clear and the information on file was not cloned or linked between siblings.

The Countess of Chester was aware that Child E was from Wales. As Welsh children do not appear on the English Child Protection Information System (CP-IS), there was no mechanism for the hospital to determine from this system whether Child E was subject to a Child Protection Plan. The hospital therefore took appropriate action by contacting the Emergency Duty Team (EDT) in a timely manner to establish the child's safeguarding status.

The EDT worker informed the hospital that Child E was on the Child Protection Register once Child E had transferred to Alder Hey.

As the night progressed the medical staff were becoming increasingly concerned for Child E and were recognising that his injuries were non accidental. The hospital staff were worried about the safety of the three other children. There was also notification that there were other children, the grandparents' children in the home. Again, the records made it hard to ascertain which children were where.

A strategy meeting was held between EDT and the police. Hospital staff were not included in the meeting. EDT requested police assistance to go to the house to check the welfare of the 5 children in the house. The police refused to attend on the basis that they had already been to the property and ascertained that the children were unhurt and in the care of family. The family caring for the children would probably have been the grandparents.

The EDT service has since reflected that the decisions made by the Police meant they were not working within the Wales Safeguarding Procedures which would have been in partnership with the Local Authority EDT team. This caused considerable tension that night. The situation was serious and Police Officers needed to travel to the hospital however as lead agency within the Safeguarding Procedures there should have been better communication with EDT.

It was a particularly busy shift on the Saturday night and at one point there was only one member of staff in the office with the remaining team members attending to other duties. An on-call manager was available but was not contacted. Staff also had access to an out-of-hours contact list for senior managers but during the unfolding incident did not utilise it. The on-call manager was subsequently contacted the following morning and made aware of the events

The EDT staff member was having difficulties contacting North Wales Police and when the EDT worker finally managed to talk to the Force Incident Manager at around 5.00am, he was told that the officers involved in the case had gone home.

On the 15/8/21 Child E was transferred to Alder Hey Children's hospital.

Further strategy meetings were held on the 15/8/21 attended by EDT and the Police. All the remaining 5 children in the home were removed to a place of safety using Police Protection Orders and subsequently placed in the care of the Local Authority Children's Services.

Child E sadly passed away as a result of his injures on the 16/8/21.

**The Voice of the Child**

There is very little information about Child E throughout the files, reports and discussions. The information on the file does not capture his needs, his character, his likes or dislikes. There were case files opened on all 4 siblings, but there was very little information on Child E's file. His name was barely mentioned in reports and case recordings.

During CID 16s, the whereabouts of Child L, C and P are mentioned, e.g. during the events of 9/6/21 when the family were moved to safety, however there is no mention of Child E despite him being present.

From the information shared it is safe to say that Child E's voice was not heard.

Whilst the focus of this report has been Child E, the report cannot be concluded without reference to the other children who will have been affected by the violence and trauma they have witnessed.

Seven children were found to have suffered significant harm. These children will grow up with the memory of what happened to Child E and undoubtedly the impact this will have had on them.

**The Voice of the Parents**

Both parents were interviewed as part of the Child Practice Review.

The mother, now in prison shared with the reviewers that she was coerced by her parents not to talk to the Local Authority Children's Services. When asked what she would like to say to the Review Panel, her only response was that whilst she was living with her parents she hoped someone was going to insist on seeing the children, but nobody did. It was however noted that the mother had full access to her phone during the time they were living with her parents and she had a good relationship with the Health Visitor, yet she made no attempt to ask for help.

The father felt excluded by Local Authority Children's Services, who did not include him in meetings or let him know what was happening. He said that over the years help had been directed towards the children's mother and not him. Case records reflect attempt to contact the mother and there is no reference to trying to contact the father.

The father told the reviewers that he had contacted the Local Authority Children's Services to express his concerns about the children's mother and her parents, but no one listened. On 9/6/21 North Wales Police said that the father was "begging the social worker not to take Child E to his maternal grandparents", which at the time was not the plan, but the concern was noted. There is no record that this information was shared with the Local Authority Children's Service.

**The Learning Event**

This Child Practice Review highlighted the importance of agencies supporting staff not only during and after significant events like the death of child E, but also in the following months and years when there is significant media coverage of court cases.

There were numerous examples of staff being re traumatised when there was mention of Child Es murder in the media, and many staff across all agencies said that they received little or no support from their agencies to deal with the trauma especially with the ongoing media attention.

The Learning Event was held when the chair and the reviewers were satisfied that all staff members attending the learning event were properly briefed, prepared and supported to attend. Some staff members were interviewed separately.

14 staff members attended the learning event, representing BCUHB, North Wales Police; EDT, Social Services and Education.

## 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*:

The CPR review panel have considered the circumstances within the review timeline which comes to an end in August 2021 with the death of Child E.

The review panel have also been informed that the Local Authority's Children and Adults Social Services Department have also been subjected to a Performance Evaluation Inspection by the Care Inspectorate Wales (CIW) in 2023 with further Improvement Check visit in July 2025.

As the findings of the Review panel correspond with many of the findings of the CIW findings, the information within the CIW reports have been considered alongside the CPR review panel report.

When the recommendations of the CIW and the Child Practice Review recommendations are similar the wording of the CIW inspection has been used to streamline recommendations.

**Areas of learning**

1. Background Knowledge

**There was a missed opportunity to understand and consider significant historical information which could have supported assessment, analysis, risk management and case planning.**

**Information gathered during the Health Pre Birth Assessments should have been shared with the Local Authority Childrens Services, either as part of the safeguarding referrals or as information during ongoing enquiries and should all have triggered Pre Birth Risk Assessments by the Local Authority Children's Services, this was a missed opportunity to consider the parents ability to raise the children within a safe environment, free of domestic abuse and violence**.

There was considerable historical information available in relation to the parenting of the grandparents and the children's parents. This information was not accessed when referrals were received, and decisions were made in isolation. Concerns about domestic violence and the mother's own parenting were captured in Health Pre Birth Assessments however these assessments were not shared with Local Authority Children's Services.

**Changes already made:**

Since Child E's death, Local Authority Children's Services have reviewed their practice regarding the creation of chronologies to assist Social Workers in assessing

risk. A new practice directive around the use of chronologies was devised and shared amongst staff at the time it was created. This will highlight previous referrals and non-engagement. The practice directive indicates that no child can transfer from one team to another without the completion of the chronology. This is now being quality assured on a regular basis by a service manager.

There is now a stronger protocol between Health and Local Authority Children's Services regarding the sharing of Health Pre Birth Assessments. There are now regular partnership meetings between Local Authority Children's Services and Health to manage cases and share intelligence.

Education now have access to the Child Protection module on PARIS, the Local Authority's case recording system. In addition, there is now a finalised direct link Via CPOMS engage to request safeguarding information from school in Children's First Contact via the education worker.

**Areas for further development:**

The Local Authority Children's Services is developing a revised Newborn Baby Protocol to strengthen the use of Health Pre Birth assessments and the working relationship between Local Authority Children's Services and Health staff.

2. Professional Curiosity

**There were missed opportunities to engage with the parents and the children, and a missed opportunity to consider the impact of the parents non engagement on the children.**

**There were missed opportunities to assess the parents' resilience, the effect of domestic abuse on the family and the parents' ability to protect the children from the effects of witnessing domestic abuse.**

**There were missed opportunities to engage with the parents, especially the father who was attempting to voice his concerns about the children and their mother.**

**There were missed opportunities to consider the voice of the children.**

Many of the referrals received from Health and Police resulted in no action. Some referrals were dealt with by offering Early Help, however there was no checks made on whether the help was taken up. Invariably when the family were referred for Early Help, they did not engage and the case was closed, there was no process to reconsider the needs of the children when there was no engagement.

There was no professional curiosity around why the parents were not engaging and no attempts made to try and help the family to engage.

CIW inspection in 2023 found that in a few cases responses to initial concerns were delayed and lacked sufficient rigour. This includes instances of children not being seen promptly and insufficient information gathering to explore wider potential risks. When Health Staff reported concerns about not being able to gain access to see the children the parents were sent a letter by the Local Authority's Children's Services, but there was no redress if they failed to respond to the letter. BCUHB's Was Not Brought procedure was often not followed as the procedure only considers pre planned visits and not the many opportunistic attempts to see the children.

Domestic abuse was a common occurrence in the family's life, however FRAIT (Family Resilience Assessment Instrument and Tool) was not undertaken as part of routine enquiries by health to assess the impact of domestic abuse and the family's resilience.

The police failed to recognise the impact of witnessing domestic abuse on the children, and failed to capture the voice of the child in CID 16's.

North Wales Police have identified that officers should have considered evidence led prosecution when the mother was saying she was the victim of domestic abuse and there could have been positive action taken with the use of Domestic Violence Prevention Notices.

Most of the support from agencies was directed towards the mother, there were no services offered to the father and no attempts made to engage with him. The Local Authority Children's Services wrote letters to the mother; no letters were sent to the father.

**Changes already made**

Since Child E's death, Local Authority Children's Services have invested on training the childcare workforce in Collaborative Communication to support professional curiosity and engagement with parents.

A Safeguarding Hub has been developed which allows for daily scrutiny with partner agencies of cases of particular concern. The Safeguarding Hub also allows for the monitoring of non-engagement.

BCUHB have launched a new Maternity Service led Domestic Abuse Screening Tool and have introduced a new more thorough maternity led audit.

The Police have developed the AWARE mnemonic to help capture the voice of the child, additional AWARE training was delivered to frontline officers during 2025 and completed in early 2026.

Domestic Abuse and Child Protection cases are subject to annual Protection of Vulnerable People Unit (PVPU) quality assurance reviews, which include assessment of the quality of information submitted within CID 16s.

AWARE is also included in the latest continued professional development (CPD) programme for frontline Police Officers.

Domestic abuse remains a North Wales Police Force priority, and work in this area continues to develop. Since 2022, several internal initiatives have been introduced to support officers in their response to domestic abuse incidents.

These include Operation Chrysalis, which delivered a new investigation template designed to guide officers through domestic abuse investigations and ensure that all evidential opportunities are considered. In addition, a Pocket Notebook Guide has been developed for frontline officers, providing practical guidance to support a consistent and effective approach to all domestic abuse investigations.

Operation Protect was also introduced to provide clear guidance on the responsibilities of the various policing roles involved in responding to domestic incidents. The initiative focuses on improving the identification of risk, enhancing the prevention and detection of domestic abuse offences, and reinforcing a proactive, multi-agency approach to preventing and reducing domestic abuse.

The Force Domestic Abuse Practice Guide, updated in July 2025, emphasises a clear commitment to pursuing offenders and maximising opportunities through evidence-led prosecutions, alongside the use of civil orders and interventions to deter offending. It also highlights the need to identify and progress evidence-led prosecution opportunities from the outset, particularly where a victim may feel unable to support a case—demonstrating the strong focus and importance placed on evidence-led approaches.

To strengthen safeguarding measures and further disrupt offenders, the force has participated in the national Domestic Abuse Prevention Orders (DAPO) pilot since May 2025. Additionally, DAPO training has been incorporated into the latest CPD programme for frontline officers, with delivery scheduled between May and October 2026. Use of civil orders is also reviewed monthly within the force's investigation standards meeting chaired by the head of crime.

Monthly performance meetings continue to be held with senior officers from across the force to review the force's response to domestic abuse incidents. These meetings ensure robust performance oversight, with accountability for arrests, investigative outcomes, and the effective use of safeguarding measures to protect victims and manage offenders.

Domestic abuse (DA) training remains a key priority. It is embedded across all levels, including initial training, probationers, police leadership programmes, crime

investigators, and specialist units, covering areas such as evidence-led prosecutions and the use of civil orders.

Additional inputs include DA Matters training delivered by Safe Lives to all frontline officers, alongside continued professional development (CPD) sessions such as the Domestic Homicide Timeline training delivered by Professor Jane Monckton-Smith and police briefings focused on golden hour principles and evidence led prosecutions.

Domestic Abuse cases are subject to annual PVPU quality assurance reviews, which include assessment of the quality of information submitted within CID 16s as well as quarterly multi agency NFA scrutiny meetings.

Additional Voice of the Child training provided to front line Police officers in 2025 and completed in early 2026.

A Voice of the Child input also features within the latest CPD training with front line officers – officers will receive this training between May – Oct 2026. The training focuses on the following areas: the importance of capturing the voice of the child using case studies, barriers to capturing the Voice of the child, when to capture, the importance of the CID 16, including input from MASH manager, how to talk to the child, ACE's, what to record, where to record, Op Encompass, and utilising the AWARE framework. A Protecting Vulnerable People (PVP) specialist also provides examples of local case studies and requirements to document within the CID 16 using the AWARE framework.

The voice of the child is monitored through the monthly PVP performance report, informed by CRU researchers' review of CID16's received.

Voice of the Child is included within several PVPU quality assurance reviews scheduled annually, with results and any potential areas for improvement shared with the PVPU Senior Management team.

Whilst instances of professional disagreement regarding whether a joint visit or single-agency visit should take place are rare, a revised governance process has been implemented during 2026 to provide greater oversight and consistency in decision-making. Under this process, any future professional disagreement between a Detective Sargeant and Detective Inspector regarding joint visits to a single agency will be escalated to the Divisional PVP Detective Chief Inspector for review and resolution.

**Areas for further development**

Review BCUHB's Was not Brought Standard Operating Procedure to include management of risk including non-engagement and or restricted access, to include a clearly defined escalation pathway and expectations for timely action.

Local Authority Children's Services to review and strengthen the screening of cases within the Early Help Hub and the Safeguarding Hub where there is ongoing domestic abuse and evaluate the impact of witnessing domestic abuse on children.

The Early Help Pathway has been reviewed to include informing referrers when the families they have referred have not engaged with the service.

Review and strengthen attempts to engage with fathers, ensuring letters are sent to both parents and not just mothers.

North Wales Police to ensure the quality and appropriateness of CID 16's is to the required standard; this includes the continued use of the AWARE mnemonic to encourage professional curiosity when dealing with vulnerable victims. When the quality of a submitted CID 16 falls below the expected standard, the matter should be escalated to the relevant supervisor for review and appropriate action

North Wales Police to introduce measures to strengthen oversight of safeguarding activity. These include the monitoring of Section 47 joint visits and single agency visit decisions, with outcomes being tracked to ensure decision-making is appropriately recorded, proportionate to the presenting risks, and subject to effective supervisory scrutiny.

3. Safeguarding Procedures

**There were missed opportunities to gain a better understanding of whether the mother could or would protect her child.**

**There was a missed opportunity to reconvene a strategy meeting to consider the fact that during an ongoing section 47 enquiry there was another safeguarding referral; a mother stating she felt unsafe and an injury to a young child. There should also have been a clearly recorded discussion around the need for a Child Protection medical.**

**Once Local Authority Children's Services became aware that Child E was living with his grandparents, there was a missed opportunity to undertake welfare checks and gain valuable information.**

**There was a missed opportunity to escalate the fact that key agencies were not able to see the children. With hindsight we now know that consideration could have been given to taking steps to insist on seeing the children.**

Referrals were often closed with no action or non-engagement however this was not shared with referrers.

When safeguarding enquiries were undertaken there was no clear outcome to the enquiries and the outcome was not shared with referrers.

Timescales within the Welsh Safeguarding Procedures were not adhered to.

The mother was allowed to delay the safeguarding enquiries by refusing to arrange to meet with the social worker.

Referrers especially health were not routinely invited to strategy meetings despite repeated referrals in a short period of time.

There should have been more timely strategy meetings and a clear record of action to be taken especially to undertake a Child Protection Medical on Child C's lip.

The Police should not have downgraded an agreed S47 Joint enquiry to a single agency enquiry without returning to a strategy discussion.

Local Authority Children's Services Senior Practitioner should have been more proactive in supporting the mother and children to leave the property for a place of safety.

The children should have been seen on a more regular basis and there should have been escalation when no one was able to see the children.

Child E should have been seen and welfare checks undertaken when Local Authority Children's Services were informed, he was living with his grandparents. Information regarding Child E living with his grandparents was not shared when the case was transferred from the Children's First Contact Team to the Family Intervention Team. There was no clear transfer plan, and the outstanding tasks were not clearly recorded.

Once on the Child Protection Register, the children's Care and Support Protection Plan should have been monitored by the Core Group. The children should have had an allocated Social Worker and not held by a Senior Practitioner and the core group not undertaken by a duty social worker who had no knowledge of the case.

**Changes already made**

Since Child E's death, there have been new practice directives developed around:

- Pre-birth assessments
- Chronologies
- Case conferences and Core group
- Management and oversight
- Outcome focused care and support plans
- Positive risk taking
- Professional Curiosity
- Section 47
- Statutory visits
- Understanding the Child's lived experiences.

It has been acknowledged that accessing these practice directives can be confusing as they are held in different parts of the Local Authorities' recording systems. The new policies are not currently consistently shared as part of the induction process for new Social Workers.

Two managed agency teams were commissioned to strengthen performance in section 47 enquiries and to enhance Core Group practice. The team's remit evolved to support and stabilise Local Authority Children's Services front door and implemented a RAG system for referrals to support risk management. The team also focused on robust safety planning particularly between the conclusion of the S47 and the Initial Child Protection Case Conference.

An additional Service Manager post with dedicated oversight for safeguarding has been introduced within Local Authority Children's Services. Weekly performance data is reviewed which includes any unallocated cases.

The Safeguarding Hub has been developed to provide improved opportunity for multi-agency collaboration.

The Local Authority Children's Services has introduced close monitoring of when a child on the child protection register is spending time away from the family home and DBS checks are undertaken on all carers.

The Local Authority Children's Services have developed a transfer policy, to ensure robust transfer arrangements between social work teams, with weekly transfer meetings between managers.

Between 2020 – 2023, 98 licenses were issued to practitioners who completed Domestic Homicide Timeline Training which was delivered by Professor Jane Monckton Smith and designed to give users a thorough understanding of the 8 Stage Homicide Timeline and the way risk and threat can progress in a controlling relationship and potentially end in homicide.

In order to support practitioners with families resistant to engaging with Social Services, in 2024 and 2025, training on engaging hostile, reluctant and resistant families took place, together with Communicating with hostile and evasive families.

Training on Professional Curiosity was offered via the North Wales Safeguarding Board in 2025 which covered Domestic Abuse and professional curiosity, why it is important, disguised compliance and how to develop skills in this area.

Training on Domestic abuse and the Impact on Children training via Safe Lives was commissioned in 2025 and in 2026, to help practitioners understand the dynamics of domestic abuse and importance involving children in the safety planning process and adapting plans to ensure the child's safety and wellbeing.

**Areas for further development**

The Local Authority Children's Services should continue efforts embedding understanding and application of thresholds within its children's services workforce as well as with external partners. CIW 2025.

The Local Authority Children's Services to ensure all practice directives are easily accessible to all staff and shared within the induction process for new social workers including agency workers.

Further training is being offered from September 2026 on Understanding Domestic abuse and the use of DASH (Domestic Abuse, Stalking and Harassment) risk assessment checklist which provides practitioners with a structured evidence-based framework for identifying risk indicators that may escalate harm to victims and their children

The Local Authority Children's Services to review their practice in line with the Wales Safeguarding Procedures.

- Managers must ensure that following the timely conclusion of a child protection enquiry, and that next steps are explicitly recorded with clarity and rationale in relation to the determinations under the Wales Safeguarding Procedures/ CIW 2025.

- The Local Authority should ensure that when it has been determined that a child is experiencing or is at risk of experiencing harm, abuse or neglect that a child protection conference is convened within 15 working days of the strategy discussion or the last strategy discussion if more than one has occurred, which initiated the section 47 enquiry. CIW 2025

- Leaders should ensure practitioners have clear systems and standards for developing Child protection plan which are child centred and outcome focused. CIW 2025

- The Local Authority must ensure that Core group meetings consistently monitor progress against the children's Care and Support Protection plans and that the plan is updated as necessary to reflect the child/s current needs and risks in accordance with the Wales Safeguarding Procedures. CIW 2025

- There needs to be better sharing of core group meeting minutes and clearer recording of actions and outcomes.

- The Local Authority should ensure that all relevant agencies and consistently invited to strategy discussions. CIW 2025.

- The Local Authority should review processes with regards to informing safeguarding report makers of the initial decision in line with the Wales Safeguarding Procedures. CIW 2025

- Local Authority to ensure that all strategy discussions record whether a child protection medical is required or not. CIW 2025

4. Local Authority Childrens Services

**Workforce challenges within the Local Authority Children's Service impacted on the ability to protect the children in accordance with the Wales Safeguarding Procedures.**

**There was a missed opportunity to support the family to move to a place of safety.**

**Whilst recognising the commitment of the Social Worker and the school staff to ensuring the children's welfare by returning to the family home to support the mother and children to leave, there was a missed opportunity to support the Social Worker and ensure the safety of the staff attending at the time.**

**The Local Authority Children's Services were experiencing significant staffing issues, as a result these four children on the child protection register were unallocated.**

**There was a reliance on Agency Staff, who by nature of their employment often left with little or no notice.**

**Due to the lack of Social Workers, statutory requirements under the Wales Safeguarding procedures were delayed.**

The inability to allocate children to Social Workers meant statutory duties were being undertaken by duty Social Workers with limited case information.

Staffing issues resulted in delays in completing Section 47 enquiries and inputting the information on the IT system.

Due to delays in inputting up to date information on the IT system, the EDT are unable to see if there are ongoing S47 enquiries on children.

Delay in updating the IT systems meant new information received was recorded as information on an open case, when the case was either unallocated or when a Social Worker had left or the case had already been closed.

Staffing issues meant the system was under pressure and there were difficulties in transferring cases from the Children's First Contact Team and the Family Intervention Team. This led to tensions within the workforce.

The supervision of both agency and permanent staff was found in both the 2023 and

2025 CIW inspections to be inconsistent, required more reflection, consideration of professional curiosity and more focused on outcomes.

Whilst the majority of staff interviewed by CIW (78%) said they had manageable caseloads by 2023 and 86% of staff said they were well supported by managers, the review found that some staff remained concerned about the leadership and culture of the organisation. Some staff reported that there continued to be an over reliance on agency staff and that agency staff were valued more than permanent staff.

As reported to the CPR learning event and to CIW there was some feeling reported amongst staff that changes were being introduced without consultation with permanent staff and that some staff were not sufficiently briefed regarding the changes.

**Changes already made**

At the time of Child E's death, the Local Authority Children's Services was aware of the risks in relation to the staffing difficulties and the impact of the deficiencies were noted in the Local Authority's Corporate Risk Register. Resources were provided to try and resolve the issues and mitigate the risk.

There have also been attempts to make working for the Local Authority Children's Services more attractive financially as the Local Authority boarders on England and many Local Authority Children's Services in England pay their Social Workers more.

There have also been initiatives to retain experienced Social Workers but developing Level 4 social work posts, which increased capacity to mentor and support less experienced staff.

The All-Wales Pledge has also helped to provide consistency in the use and renumeration of agency staff.

Following Child E's death, the Local Authority Children's Services commissioned an agency to provide two Social Work teams, supported by two managers to relieve the pressure on both the front door services and section 47 enquiries. These teams reviewed practice and made changes to improve the services.

An internal system to quality assure and audit files is in place, and all unallocated children are monitored on a weekly basis.

The I.T. System has been changed to include a marker for unallocated cases which is monitored to make sure there are no unallocated children on the Child Protection Register.

The Local Authority Children's Service have strengthened their provision of structured supervision of social work staff. Structured supervision is now every 4 weeks and there are provisions in place to record and monitor supervision. Work is

also being introduced on Reflective Supervision practices and part of the Collaborative Communications model

Local Authority Children's Services have commissioned leadership training for key members in the workforce to help them manage change effectively and support their leadership styles. This included manging some tensions with the managed agency teams who were supporting the development of change and learning.

**Areas for further development:**

Review Local Authority Children's Services lone working policy.

Local Authority Children's Services to implement Monthly Reflective Supervision as part of the Collaborative Communications Framework.

5. I.T Systems

**Accurate recording of the family's details on the Local Authority Children's Services' I.T. system led to delay in establishing and often confusion regarding where the family were living.**

**Inconsistent recording practice saw vital information being recorded randomly on one of the children's files and not cloned onto the other sibling's files.**

Social Work case notes record attempts to try and see the children, but time was being wasted as records were not up to date.

**Changes already made**

Since Child E's death, the Local Authority Children's Services' recording policy has been updated to ensure each child has his or her own file and the information is adequately cloned and shared between across all files.

The Local Authority Children's Services are in the process of procuring a new I.T. system.

**Areas for further development**

The Local Authority Children's Services must ensure data can be recorded and accessed to support effective decision making, monitoring and service performance. CIW 2025

6. Events around Child E's death

**As the events of the night Child E was admitted to hospital unfolded there were several areas that caused concern.**

Inaccurate and incomplete recording on Child E's file.

Difficulties in the EDT gaining control of the safeguarding enquiries as lead agency.

Lack of communication between Local Authority Children's Services, North Wales Police and Hospital Staff both at the Countess of Chester and Alder Hey.

Lack of clarity regarding Child E's name being on the Child Protection Register and the limitation that English systems do not provide visibility of Welsh child protection information.

Lack of hospital staff's attendance at the strategy meeting.

Police's refusal to undertake a welfare visit to the other children once the nature of Child E's injuries was ascertained.

Lack of contact with senior managers out of hours.

**Changes already made**

Since Child E's death the EDT service has undertaken a comprehensive review of the service, including updated training, safeguarding practice development sessions and reflective group and one to one session.

EDT systems and processes have been reviewed.

A new escalation pathway has been developed between EDT and North Wales Police to deal with any disagreement over joint agency responses.

The process for EDT staff to contact on-call managers has been reviewed and made more robust.

EDT staff can now access the Duty Superintendent within North Wales Police to escalate any concerns.

An established escalation process was already in place at the time should EDT disagree with, or wish to challenge, a policing decision. However, the Force is confident that communication and partnership working have strengthened significantly since this incident. Senior leaders within PVP, including the Superintendent and Detective Chief Inspectors, are in regular contact with Children's Services senior leaders, supporting effective information sharing and joint decision-making.

Internally within North Wales Police, enhanced daily briefings and handover processes are now in place, providing greater oversight of safeguarding concerns and ensuring that discussions take place promptly where risk levels change. The Force is therefore confident that, in similar circumstances, immediate multi-agency conversations would occur to review risk and agree appropriate safeguarding actions.

**Areas for further developments**

Strengthen cross border safeguarding arrangements when children are admitted with physical injuries to hospitals outside their local authority area, ensuring timely, effective information sharing and coordinated multiple agency support.

Review and update Force guidance relating to the consideration, authorisation and implementation of Police Protection Orders (PPOs), ensuring clear roles, responsibilities and communication pathways are established where PVP-led investigations require coordinated support from frontline policing teams. The revised guidance should strengthen joint decision-making, improve operational understanding, and ensure timely safeguarding action where children are assessed as being at risk of significant harm.

There are significant concerns around Welsh children visiting Emergency Departments in England and it would be beneficial for Welsh Authorities to consider investing in the Child Protection Information System, "CP-IS" function allowing Health Authorities to access information about children on the Welsh Child Protection Registers.

**Voice of the child**

The voice of the four children was not reflected in the reports presented by agencies.

There were missed opportunities to speak to the children.

The daily lived experience of the children, especially witnessing arguments and domestic abuse was not consistently considered.

Despite the insufficient information with the reports regarding the voice of all the children, the voice of Child E was particularly missing. Even when the reports provided were meant to be on all four children, Child E's name was barely mentioned.

**Impact of covid**

Local authority Children's Services have noted the impact of the lack of Social Workers available in order to carry out their statutory functions under the Welsh Safeguarding Procedures.

The impact of COVID Lockdown and the need for some Social Workers to isolate and not visit families further reduced the services' capacity. E.G. a Social Worker allocated to the family after registration on the Child Protection Register was pregnant and could not undertake the role as she could not go out to visit the family and therefore the case was returned to the unallocated status.

Some Social Workers were agency workers and lived outside the Local Authority area, travelling restrictions during covid lockdown would have further limited the services' ability to undertake statutory assessments and visits.

BCUHB have reflected on the importance that Health Visiting Staff should not be redeployed from safeguarding roles should there be a similar pandemic in the future, recognising their critical role in maintaining oversight, early identification of risk and direct contact with vulnerable children and families.

**Recommendations**

1. NWSB to undertake a regional review and update Multi Agency Practice Guide: Responding to Risk & Need for Unborn Babies, including Concealed Pregnancies and then for each agency to consider and ensure compliance.

2. Review BCUHB's Was Not Brought Standard Operating Procedure to include management of risk including non-engagement, disguised compliance and restricted access during planned or opportunistic visits to include a clearly defined escalation pathway and expectations for timely action.

3. Review and strengthen the screening of cases and the need for risk assessments within the Early Help Hub and the Safeguarding Hub where there is ongoing domestic abuse and evaluate the impact of witnessing domestic abuse on children.

4. North Wales Police to ensure the quality and appropriateness of CID 16's is to the required standard; this includes the continued use of the AWARE mnemonic to encourage professional curiosity when dealing with vulnerable victims. When the quality of a submitted CID 16 falls below the expected standard, the matter should be escalated to the relevant supervisor for review and appropriate action including feedback to the officers completing the CID 16.

5. North Wales Police to introduce measures to strengthen oversight and quality assurance of safeguarding activity. These include the monitoring of Section 47 joint visits and single agency visit decisions, with outcomes being tracked to ensure decision-making is appropriately recorded, proportionate to the presenting risks, and subject to effective supervisory scrutiny.

6. NWSB to develop a framework on how to engage with fathers and male carers across all interventions and support.

7. The Local Authority should continue to strengthen the understanding and consistent application of threshold criteria across Children's services workforce as well as with partner agencies.

8. The Local Authority to implement arrangements to ensure all practice directives and operational guidance are readily accessible to staff and form a mandatory component of induction for all newly appointed social workers, including agency workers, and reinforce understanding through supervision, training and quality assurance activity shared within the induction process for new social workers including agency workers.

9. Agencies to strengthen their approach to Domestic Abuse ensuring that the impact on children, young people and family functioning is consistently recognised, and reflected in assessment, planning and interventions.

10. The Local Authority conduct a review of Children's Services practice against the Wales Safeguarding Procedures and implement a targeted improvement programme to address identified gaps.

11. Agencies to review and strengthen Lone Working Policies to establish risk assessment processes, management oversight arrangements and escalation procedures for staff undertaking lone working activities.

12. Local Authority Children's Services to implement monthly reflective supervision as a core component of the Collaborative Communications Framework.

13. The Local Authority must ensure that Children's Services information systems and recording practices enable the accurate capture, timely retrieval and effective use of data to support operational decision-making, quality assurance, performance management and strategic planning.

14. North Wales Safeguarding Board to strengthen cross border safeguarding arrangements when children are admitted to hospitals outside their local authority area, ensuring timely, effective information sharing and coordinated multiple agency support.

15. Through Welsh Local Government Association, Welsh Authorities should undertake a strategic review of the benefits, costs and implementation requirements of adopting the Child Protection Information Sharing (CP-IS) system to enable to access real-time information relating to children subject to Child Protection Plans or on Child Protection Registers.

16. Review and update North Wales Police guidance relating to the consideration, authorisation and implementation of Police Protection Orders (PPOs), ensuring clear roles, responsibilities and communication pathways are

established where PVP-led investigations require coordinated support from frontline policing teams. The revised guidance should strengthen joint decision-making, improve operational understanding, and ensure timely safeguarding action where children are assessed as being at risk of significant harm.

| Statement by Reviewer(s) | |
|---|---|
| **Reviewer 1** | **Reviewer 2** |
| **Statement of independence from the case**<br>*Quality Assurance statement of qualification* | **Statement of independence from the case**<br>*Quality Assurance statement of qualification* |
| I make the following statement that prior to my involvement with this learning review:<br><br>• I have not been directly concerned with the child or family or have given professional advice on the case.<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.<br><br>The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.<br><br>**Reviewer 1** *(Signature):*<br><br>H. Rylance.<br><br>**Name** *(Print):* Heidi Rylance<br>**Date:** 13/07/2026 | I make the following statement that prior to my involvement with this learning review:<br><br>• I have not been directly concerned with the child or family or have given professional advice on the case.<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.<br><br>The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.<br><br>**Reviewer 2** *(Signature):*<br><br>Valerie Ann Owen.<br><br>**Name** *(Print):* Val Owen<br>**Date:** 13/07/2026 |
| **Chair of the Review Panel** (Signature):<br>**Name** *(Print):* Fon Roberts<br>**Date:** 17/07/2026 | |

**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 ☐

**For Welsh Government use only**

Date information received:
Date acknowledgement letter sent to Board Chair:
Date circulated to relevant inspectorates/ Policy Leads:

**Agencies (yes/no – if no please state reason)**
CIW
Estyn
HIW
HMI Constabulary
HMI Probation