BRIDGEND COUNTY BOROUGH COUNCIL

CABINET COMMITTEE CORPORATE PARENTING

REPORT OF THE CORPORATE DIRECTOR, SOCIAL SERVICES AND WELLBEING

19 OCTOBER 2016

CHILD PRACTICE REVIEW

1. Purpose of Report

1.1 To provide Corporate Parenting Cabinet Committee with information in respect of the most recent Child Practice Review (WB B 15 2014) published on 24th August 2016.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 The report links to the following priority in the Corporate Plan:

- Helping people to be more self-reliant.

3. Background

3.1 In 2013, Child Practice Reviews replaced what were known as Serious Case Reviews (SCR). This new process stems from the Care and Social Services Inspectorate Wales report published in October 2009 - *Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews.* This work was pivotal to where we are today, and concluded that action was required to replace the SCR process which had become ineffective in improving practice and inter-agency working.

3.2 A key element of the new framework is different types of review – known as 'concise' and 'extended' – depending on the circumstances of the child involved. Child Practice Reviews will be effective learning tools where it is more important to consider how agencies worked together. The formal review processes are underpinned by multi-agency professional forums that are critical to improving practice, and will allow practitioners to reflect on cases – and not only where things have gone wrong – in an informed and supported environment.

3.3 The guidance sets out arrangements for multi-agency Child Practice Reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected.

3.4 The overall purpose behind the reform of the review system is to promote a positive culture of multi-agency child protection learning and reviewing in local areas, for which the Western Bay Safeguarding Children's Board and partner agencies hold responsibility.

3.5 A Multi-Agency Professional Forum is a multi-professional event facilitated for practitioners and managers, primarily to examine case practice and provide opportunity for consultation, supervision and reflection, and to disseminate findings

from child protection audits, inspections and reviews, in order to improve local knowledge and practice and to inform the Board's future audit and training priorities.

3.6 Concise Reviews - a concise Child Practice Review is carried out in cases where abuse or neglect of a child is known or suspected and the child has:-
- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; *and* the child was neither on the child protection register or a looked after child on any date during the 6 months preceding the date of the event referred to above.

3.7 Extended Reviews - an extended Child Practice Review is carried out in cases where abuse or neglect of a child is known or suspected and the child has:-
- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; *and* the child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding the date of the event referred to.

3.8 Bridgend has published one report and is currently undertaking two Child Practice Reviews following the identification of concerns where the above criteria have been met. One of the reviews is a historical review relating to a young person who, now that she is in a safe care arrangement, has disclosed she was sexually abused by her biological father.

3.9 The two other reviews include a Concise Review which involves a child who sustained serious head injuries and a Historical Review where a young person has been sexually abused by her father.

3.10 The purpose of the reviews is to identify learning for future practice and involve practitioners, managers and senior officers in exploring the detail and context of agencies' work with the child(ren) and family. The review is intended to generate professional and organisational learning and promote improvement in future practice.

3.11 Recommendations from Child Practice Reviews are considered and any actions agreed are reported to and monitored by the Western Bay Safeguarding Children's Board. The lessons to be learnt are shared with senior managers and disseminated through learning events and training to Safeguarding practitioners.

4. Current Situation/Proposal

WB B 15 2014

4.1 This family has been known to BCBC since 2005 in relation to concerns about the quality of parenting and neglect issues.

4.2 The first child born to this mother resides with her paternal grandfather and is the subject of a Special Guardianship Order. The maternal grandparents care for the second and third children born. They are registered Foster Carers with BCBC in

respect of one child and they care for other child under the auspices of a Residence Order.

4.3 When the mother became pregnant with her fourth child she and this child spent 11 months in a mother and baby foster placement until such a time that she was able to reside independently but with continued support within the community. The mother was known to the Learning Disibility Adult Social Care Team in 2008.

4.4 Over the next few years the mother and her child were supported by Flying Start and this support continued during the years as the mother went on to have another three children. Throughout these pregnancies and the subsequent parenting of these children, no referral was submitted from any professional despite several agencies and professionals being involved.

4.5 In September 2013, there was a change in the Health Visitor who referred to Bridgend County Borough Council expressing concerns regarding the poor conditions within the home and with regard to the mother's ability to care for and manage all of her children. A referral to Early Help services was deemed appropriate but whilst waiting for transfer to this service the Health Visitor made a second referral in respect of a sibling who presented with a number of bruises to his face.

4.6 Child Protection Investigations were initiated and, to ensure safeguarding of the other children, the maternal grandparents entered into an agreement with the Assessment Team to supervise the mother with her children.

4.7 Whilst the investigation for the sibling was ongoing, the child subject to this review sadly died in the early hours of 1st January 2014. A post mortem was carried out on 7th January 2014 where it was confirmed that the Coroner had issued a Death certificate based upon Peritonitis.

4.8 The Paediatrician who examined the child noted she was a late developer with mobility problems, speech problems and was not potty trained. Various departments had been in touch with the family including speech therapy and physiotherapy but often appointments were not kept by the family.

4.9 The Section 47 Investigation in respect of the sibling who sustained facial bruises and had a Child Protection Medical examintion concluded that the causation of the bruising was non specific in terms of Non Accidental Injury.

4.10 The Local Authority issued care proceedings as a result of the combination of concerns and within the proceedings an independent Consultant Paediatric Surgeon was of the opinion that the combination of mother's learning difficulties and the child's delayed speech were contributing factors to her untimely death. Her death was not solely attributed to the neglect of her mother or other family members who were present at the time the child would have presented as being ill.

4.11 This mother has since had another child who is being cared for by the child's paternal family. The mother does not have any children in her care.

4.12 The Child Practice Review report was published on 24th August 2016 after the report was shared with the child's mother. It has also been presented at the Western Bay Safeguarding Children's Board. (attached at **appendix 1**)

4.13 The summary findings from this review are that professionals did not adequately consider historical concerns about the mother's ability to care for and parent her children and make the necessary referrals to the department. The extent of the mother's learning difficulties and her ability to therefore cope with her growing family were not assessed. Information sharing between professionals externally and internally was inadequate.

4.14 The implementation of actions recommended within the report will be overseen by the Western Bay Child Practice Review Management group. In addition Bridgend will convene team based learning events for practitioners between October and December 2016 and the findings will also be encorporated into core safeguarding training for employees.

5. Effect upon Policy Framework and Procedure Rules

5.1 There is no impact on the Policy Framework and Procedure Rules.

6. Equality Impact Assessment

6.1 There are no equality matters relevant to this report.

7. Financial Implications

7.1 There are no specific financial implications linked to this information report.

8. Recommendation.

8.1 The Cabinet Committee Corporate Parenting is asked to note and provide comment about this report.

Susan Cooper,
Corporate Director Social Services and Wellbeing
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9. Contact Officer: **Elizabeth Walton-James**
Group Manager Safeguarding & Quality Assurance
Telephone: (01656) 642073
Email: elizabeth.walton-james@bridgend.gov.uk

10. Background documents:

None