Child Practice Review Report

Cardiff and Vale Safeguarding Board
Concise Practice Review

Re: CPR/072020[1]

Brief outline of circumstances resulting in the Review

To include here: -

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

A child practice review was commissioned by the Cardiff and Vale of Glamorgan Safeguarding Board on the recommendation of the Case Review Sub-Group in accordance with the Guidance for Multi-Agency Adult/Child Practice Reviews. The criteria for this review are met under Working Together to Safeguard People, Volume 2 – Child Practice Reviews, issued under section 139 of the Social Services and Well-being (Wales) Act 2014 states that a Safeguarding Board must undertake a concise child practice review 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; **and**

the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding –

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

The Cardiff and Vale Safeguarding Board commissioned a concise child practice review chaired by Linda Hughes-Jones, Cardiff and Vale University Health Board. The joint reviewers are Sarah Manley, Cardiff Council and Bryan Heard, South Wales Police. The following agencies are represented on the panel:

- Cardiff Children's Services
- Cardiff and Vale University Health Board
- South Wales Police
- Welsh Ambulance Services NHS Trust (WAST)
- Home Office
- Clearsprings Ready Homes Ltd.

Administration and support to the panel is provided by Cardiff and Vale Safeguarding Board.

[1] These are based on the year a CPR began. So, for example, the first CPR undertaken by CVSB next year will be (CPR 01/ 2025)

The review was paused in 2023 whilst there were ongoing judicial proceedings involving the child's parent. On completion of the judicial proceedings a learning event was convened on 27th February 2024 to inform the development of this final report and action plan.

Background

Child L was born in London in 2017. He was born with a medical condition which required ongoing medical review as he developed and grew.

Child L's mother, Adult A, had presented in Autumn 2016 at a London Hospital as being thirteen weeks pregnant, homeless, and living with friends from church. Medical records indicate that she was diagnosed as having Type 2 Diabetes during pregnancy.

Adult A is originally from Nigeria, and she came to the UK in 2011. She remained in London following the expiry of her visa as an undocumented Immigration Overstayer.

Following the birth of her child, Adult A made an asylum application to the Home Office. She was initially housed in London before being moved to Cardiff where she was provided housing by Clearsprings Ready Homes Ltd. who have a contract with the Home Office to provide housing to asylum seekers in the Cardiff area.

As result of Adult A's pregnancy related Type 2 Diabetes, she believed she was in a high-risk group in relation to the Coronavirus pandemic. She began isolating with her child at the start of the Coronavirus lockdown on 23rd March 2020.

On 29th June 2020 South Wales Police received a call from a friend who was supporting the family by doing the weekly food shopping and delivering the requested items to the house. The friend was concerned as he had been unable to contact Mother for several days. He had gone to their home and could not get a reply.

Police Officers attended and due to their concerns, forced entry into the bedroom. Child L was clearly deceased, whilst his mother was alive but severely dehydrated and malnourished.

It was later established that Child L had died of starvation as a result of neglect by Adult A.

Family Engagement

Adult A was diagnosed with a significant mental illness following child L's death and she is currently receiving in patient treatment. She has therefore been unable to participate in this review. The social worker supporting family members has however ensured that they are aware of the review and the report has been shared with them.

Review period

The review covered the period 1st June 2019 to 30th June 2020.

The family history was also considered by the panel to enable an understanding of the circumstances that led to the move to Cardiff and engagement with services prior to the start of the Coronavirus lockdown.

Chronology

Key events from the review period are summarised below. These were the focus of discussions at the Learning Event.

Date	Event
June 2019 to January 2020	
22nd July 2019	Child L attended clinic appointment, with mother for review by Consultant Paediatrician. A previous medical appointment was not attended as the family had been relocated to a new Cardiff address and the appointment letter had been sent to the original address that the family were placed in when they were dispersed to Cardiff.
8th August 2019	A developmental assessment was completed by Asylum Health Visitor at the home address. This showed that Child L was developing within normal limits and no concerns were identified at that time. A referral to the Community Nursery Nurse was made for support regarding diet and nutrition.
3rd September 2019	A property inspection was completed by a Housing Officer from Clearsprings Ready Homes Ltd. No concerns were noted or shared. Further inspections were conducted on 25th October and 26th November 2019 and again no concerns were noted or shared.
28th November 2019	A 999 call was received by the Welsh Ambulance Service NHS Trust. A female called stating that the lights were out in the property and was unsure who to call. She was advised to call the electricity provider. An ambulance was not dispatched.
17th January 2020	PARIS (patient electronic record in health) case note documented by Asylum Health Visitor. The family were seen in the waiting area of the Cardiff Heath Access Practice. Mother was advised there would be a long wait to be seen. She subsequently wrote a letter to the Health Visitor requesting a bed for her child as he was climbing out of his cot. Mother also reported that she was being attacked by another female tenant at 'Nass' accommodation. She felt that she had to tread very carefully around the accommodation due to the behaviour of the other tenant. Mother reported the tenant had mental health concerns and stated she was concerned for herself and her child.
22nd January 2020	A property inspection was completed by a Housing Officer from Clearsprings Ready Homes Ltd. No concerns were noted or shared.
February and March 2020	
6th February 2020	A female attended at the Police Station. She reported that she was residing in a downstairs room of a residence in Cardiff which is used by the Home Office and she stated was managed by Linc Housing Association to house refugees. She complained of banging and noise from an upstairs flat which was occupied by Child L, and his mother. She wanted the mother to be spoken to and be made aware of the noise but not to disclose who had reported the concern. At 00.10 on the 15th of February a Police Officer updated the occurrence stating that they had attend the address and spoke with the occupant. There was a three-year-old who appeared very healthy and energetic running and playing in the flat. The laminate flooring did not help the situation. The officer offered some

	suggestions to minimise the noise. It was accepted there was little she could do about the noise, and it was not intentional. No Anti-Social Behaviour referral was made because the officer did not feel it met the criteria. The officer did however send an email to Linc Housing Association suggesting that the family should change rooms with the reporting person. The premises were not managed by Linc Housing Association and this information was not passed on to Clearsprings Ready Homes Ltd, nor were Police advised that Linc Housing did not manage these premises.
24th February 2020	Incident described above reported to Clearsprings Ready Homes Ltd.
4th March 2020	Child L was not taken to four separate medical appointments between 2018 and 2020. Letter sent to the GP at Cardiff Health Access Practice to advice that Child L has been discharged from the service due to non-attendance at a hospital appointment
12th March 2020	Clearsprings Ready Homes Ltd. logged the incident reported to Police on 6th February 2020 following a property inspection. Housing Officers engaged with both Child L's mother and the other tenant. Resolved amicably.
23rd March 2020	Housing Officer hand delivered COVID-19 Symptom Advice Letter. Mother, Child L were present. Briefing provided on how to access support when isolating. Mother was also advised that all property inspections would be suspended, and a telephone number was requested to allow the Housing Officer to contact the family by phone to check on their welfare. This request was denied. The Housing Officer also offered access to a mobile phone handset, but this was declined by Mother. Mother was advised on how to contact Migrant Help, NHS and CRH if further support was required.
April to June 2020	
3rd June 2020	Mother was allocated a new GP at Cathays Surgery.
24th June 2020	Mother updated about allocation to new GP practice. It is not known how contact was made with Mother. Child L remained registered with Cardiff Health Access Practice. It is unknown why mother and Child L were not registered together as this would be usual practice.
27th June 2020	At 22.47 South Wales Police received a call from the other tenant at the property who appeared rambling and confused, alleging that the other female resident (Child L's mother) had deleted her phone data and taken a selfie on her phone. Police control room staff identified two calls from the same resident in May and early June and it was apparent that she had mental health issues.

	Mental health staff in the control room confirmed that the female is known to them and that the property is managed by Clearsprings Ready Homes Ltd. Officers attended and spoke to the tenant and confirmed that she appeared confused and kept changing her account about what happened. Her phone was checked and there were no issues. Clearsprings Ready Homes Ltd. were made aware of the incident and a PPN was shared with Adult Services who confirmed that a strategy meeting was not required.
29th June 2020	At 1750 South Wales Police were contacted by a family friend via 999 to report concerns that he had been unable to get a reply on the phone from Child L's mother and upon attending the address he could hear her screaming. At 1810 Officers attended the property and forced entry to the bedroom. Mother and Child L were both present. Child L was not breathing. Ambulance arrived and confirmed that Child L was deceased. Fire Service arrived and confirmed carbon monoxide reading as zero. Mother was examined at the hospital. She was described as being emaciated and dehydrated. There were no signs of any physical injuries.

Attendees at the Learning Event acknowledged that there have been changes and improvements in practice across all agencies since Child L's death in 2020. These have been made because of a general commitment to evolving and developing to meet the needs of the public and also in the context of lessons learnt because of the pandemic.

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.

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

Housing

Individuals seeking asylum or refugee status are by their very nature vulnerable, not only because of the events that have led them to the UK but also by the isolation associated with language and cultural barriers. Added to this, the challenges faced by authorities whose role it is to find suitable accommodation, means that families can be separated from established support networks.

Adult A had family and friends around her in the London area, who provided her with a close support network. However, the acute shortage of suitable housing in London led to her dispersal to Cardiff after the birth of her child. Dispersing individuals seeking asylum or refugee status to other areas of the UK where housing pressures are not as significant is not an uncommon practice.

For Adult A, the move led to her support network being diminished at a time when arguably she had become more vulnerable as the single parent to a small baby. She did however make good links to local church groups in the Cardiff area and made some new and supportive friendships.

Adult A and her child were housed in two different properties within the Cardiff area, both of which are managed by Clearsprings Ready Homes Ltd. The move from the initial property was at the request of the housing provider because of overcrowding. It is clear from this review that there is a challenge in respect of the availability of suitable properties to house families, and that it is constantly evolving situation in all areas of the UK. Shared accommodation presents a particular challenge in terms of differing cultures, ethnicities and individual living styles coexisting within the same space.

The second property that Adult A and her child were moved to was shared accommodation and classified as a House of Multiple Occupancy (HMO). There is no formal process for matching the needs of the residents of shared accommodation / HMOs and spaces are allocated according to availability. Although she had separate bedrooms for her and her child, the bathroom, living room and kitchen were all shared with a fellow resident of the same property. The other resident occupied the downstairs front bedroom and had equal access to the shared bathroom, living room and kitchen.

It is clear from this review that several agencies had recorded the other resident as being a neighbour or living in the downstairs flat and that the exact type and layout of the property was not clearly understood by all. Describing the other residents living arrangements in these terms failed to recognise the closeness of living in shared accommodation and the possible impact that this resident's poor mental health had on Adult A and her child.

There were reported incidents to Police and the Housing provider which were stated as being resolved amicably. A greater understanding of the reported incidents happening at the address would have highlighted that there were tensions between the residents, and action could have been taken to address this by the Housing provider and the agency responsible for placing people at that shared address.

The review evidenced regular and numerous checks being undertaken by the Housing provider as required in line with their contractual obligations. These were initially focussed on property maintenance/condition and give little or no indication of interaction with residents. It was highlighted at the learning event that these checks now also include a requirement to engage with the resident to check on their wellbeing. This includes physical and mental health, local issues which may be affecting the individual, difficulties within the accommodation and any concerns arising from issues outside of the UK which may cause the individual concern.

It should be noted that following Child L's death a multi-agency task and finish group was established in order to ensure that there was effective information sharing in relation to asylum seekers residing within the Cardiff area. The group undertook a mapping exercise to determine where everyone was living and whether they were in touch with services in the city. This exercise enabled there to be a focused effort on ensuring that the needs of individuals were being met and that appropriate safeguarding action was taken where needed.

Learning point

When individuals / families are placed into houses of multi-occupancy, an understanding is required of the property lay out and its other residents to identity the potential for vulnerability to the individual / family. Concerned curiosity is needed to understand the lived experience of the individual / family and reviewed regularly and at points where new information is received that indicates vulnerability. Multi agency information sharing is crucial in ensuring increased vulnerabilities are identified and responded to.

Engagement with Health services

Adult A and Child L had continuing health needs which required regular access to health services. The responsibility to ensure that services held up to date address details rested with Adult A. It is unclear whether Adult A understood her responsibility in this area. This resulted in medical appointments being missed as letters were sent to an incorrect address.

Adult A and her child were initially registered at the Cardiff Health Access Practice (CHAP). (Now called CAVIS Cardiff Vale health inclusion Service). At the learning event Health practitioners advised that the Red Cross now supports asylum seeking families and refugees registered at CHAP to complete any necessary paperwork and undertake a holistic well-being needs assessment to identify other support needs.

It was also highlighted at the learning event that there were several missed medical appointments relating to Child L. These were recorded as Did Not Attend (DNA). Health practitioners at the learning event explained that given his age this would not be the fault of Child L.
It was raised that there was a language barrier for Adult A and despite the letters for medical appointments being sent to a previous address, there was no exploration of whether translation of these was required or whether this was a factor in no responses being received.
The role of the health visitor in understanding the barriers that the families face and pro-actively supporting families to address issues they face in accessing medical services was highlighted as being a vital part of future process.

The policy for the recording of children's missed appointments has now changed and is now recorded as Was Not Brought. These missed appointments would also now trigger referrals to Children's Services.

The nature of Child L's medical condition meant that appointments were offered at specialist units across South Wales and London. These presented a challenge for Adult A to attend with Child L as they did not have access to transport. Although it is recognised that she had previously applied for funding to support transport costs to attend appointments this was refused by the Home Office. The subsequent non-attendance at these appointments led to Child L being discharged from those services.

Learning point
Where families do not have English as a first language, it is recognised that additional support and consideration may be required in ensuring their full understanding of processes. Where there are known continuing health needs, particularly in respect of children, any barriers to engagement need to be recognised and shared with relevant agencies and that these and any mitigating actions are fully documented.

<u>Mental Health</u>

Since the death of Child L, Adult A has been diagnosed with a significant mental health condition which has necessitated inpatient hospital treatment. Health records available as part of the review do not indicate previous mental health concerns. The environmental circumstances and isolation may have led to a decline in Adult A's mental health.

In addition, the other resident living in the shared accommodation with Adult A and her child was known to have ongoing mental health issues. This is documented by services such as the Police, Health and Clearsprings Ready Homes Ltd. Whilst there is limited evidence in relation to their interactions within the accommodation, it is clear from Police reports that the resident was experiencing paranoid thoughts in relation to Adult A and had reported that she had taken specific actions that were later disproved. This may have led to tensions within the property and an impact upon Adult A's mental health. There is no agency record of any wider consideration or information sharing in respect of these potential impacts on Child L

Learning point
As with earlier learning points, the impact of other residents within a house of multi-occupancy on those with vulnerabilities need to be understood and reviewed. Multi-agency information sharing and an inquisitiveness to understand the lived experience of the individual / family is crucial in identifying and responding to increased vulnerabilities such as the impact of declining mental health and the documenting of actions considered or taken.

COVID-19

At the onset of the pandemic there was a world societal concern and a lack of knowledge as to how best to protect the public from the coronavirus. Isolating oneself and family was generally advised, particularly for those with underlying medical conditions who were considered to be at a higher risk of complications if they contracted the virus. As Adult A believed she was a Type 2 Diabetic, Adult A believed she was within the high-risk group.

The COVID-19 lockdowns were highlighted within this review as significant as they clearly served to create an environment of isolation around Adult A and her child. There was less face-to-face contact with friends or at local church groups, and the opportunity for professionals to sight the family and make observations about their wellbeing were significantly reduced, both within the home environment and at professional premises. It is important to recognise the impact of all agencies and friends stopping face to face contact led to Adult A's total isolation and a lack of support.

It should also be noted that the onset of the coronavirus pandemic led to significant changes in service delivery for many agencies involved in this review process. The situation at the time was dynamic and evolving and the speed at which many agencies were required to review and adapt established practices was unprecedented. This was also against a backdrop of staff shortages for many agencies who were required to protect their own staff from contracting the virus.

Learning point
Whilst it is acknowledged that the Covid 19 pandemic presented considerable challenges for agencies, an accurate understanding of the lived experience of those with vulnerabilities, particularly where this inter-section, is pivotal in safeguarding them. Regular meetings and face to face contact are a necessity to ensure vulnerabilities and increased vulnerability are identified and responded to.

Religious Fasting

Adult A was a believer in the Christian religion and attended a local church where the practice of healthy adults fasting, was recognised as a way of committing yourself to God. Adult A is known to be devoted to her religion and followed the practice of fasting as a way of communicating with God.

At the church that Adult A attended fasting was voluntary and children would not be encouraged to fast.

There were no prior indications to agencies that Adult A's mental health was declining to the extent that what was previously seen as a positive influence on her life (being part of the Church community) could amplify risks from these practices.

Good Practice

There have been clear examples of good practice by professionals who came into contact with Adult A and her child during the review period. These include interactions with the Health Visitor who Adult A clearly had a positive relationship with. She appeared comfortable in approaching him for additional support and trusted that he would provide appropriate advice.

The Police Officer who responded to an anti-social behaviour report from 6th February 2020 was able to recognise the cause of potential friction between Adult A and the other resident and he made clear and helpful suggestions as to how resolve this situation. This included e-mailing who he believed was the housing provider with these suggestions.

In addition, the timely way information about COVID-19 was provided to residents by Clearsprings Ready Homes Ltd. has been noted. The Housing provider had offered to provide residents with a mobile phone link (Clear Voice) which provides service users with the opportunity for a 3-way conversation between them, the interpreter and a Housing officer. This would facilitate contact at a time when face to face contact was reduced, however Adult A declined this offer. This should be recognised as providing a good

means of contact and building a rapport and reassurance with the residents. Other options were also available to aid communication, namely Big Voice and Language Line.

Summary of learning

Child L and his parent experienced challenges in relation to housing and health, and at times struggled to understand systems within the UK. Sadly, isolation brought about by the coronavirus pandemic further complicated these challenges and led to the diminishment of a positive support network that Adult A had developed within the Cardiff area and a change in how support was delivered by key agencies. Whilst it is difficult to determine whether one specific issue or a combination of circumstances led to Child L's death, there are clear opportunities to learn from this tragic situation and to build on positive changes already made.

Improving Systems and Practice

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

Housing Learning point

When individuals / families are placed into houses of multi-occupancy, an understanding is required of the property lay out and its other residents to identity the potential for vulnerability to the individual / family. Concerned curiosity is needed to understand the lived experience of the individual / family and reviewed regularly and at points where new information is received that indicates vulnerability. Multi agency information sharing is crucial in ensuring increased vulnerabilities are identified and responded to.

Recommendations

1. Houses of Multiple Occupancy (HMO's) require a detailed assessment for each resident to identify any areas of incompatible lifestyles or cultures. Once assessed, if these potential conflict areas cannot be prevented this should evidence the need for placement in separate accommodation. There has already been some movement towards achieving this recommendation with the introduction of complex case discussions facilitated by the Home Office. This learning should be shared with providers within the region who have responsibility for the management of HMOs.

2. All Housing Providers of shared accommodation should be required to include within standard housing inspections a wellbeing check with a view to helping the early identification of support needs.

Engagement with Health services Learning point

Where families do not have English as a first language, it is recognised that additional support and consideration may be required in ensuring their full understanding of processes. Where there are known continuing health needs, particularly in respect of children, any barriers to engagement need to be recognised and shared with relevant agencies and that these and any mitigating actions are fully documented.

Recommendations

3. Agencies should take all reasonable steps to ensure that all communication is understood by the service user. This may require translation into different languages or the use of translation services. It is understood that agencies often have key information translated into the most common languages used by service users. It is recommended that agencies keep this under

review because of changes within the asylum cohort and the necessity to ensure that the use of local dialects is considered.

4. The Regional Safeguarding Board should develop best practice guidelines to support agencies to improve the quality of note taking and recording. These should encourage practitioners to describe the circumstance of the meeting/visit to ensure it removes any opportunity for assumption or beliefs and that checks and challenges are evidenced in their records. Staff need to be encouraged to record the details of what they have seen, heard, smelt and felt during their meeting/visit. These detailed recordings will allow colleagues to fully understand what the circumstances were at the time.

5. Allocated health professional to explore barriers to accessing health appointments and support to overcome to ensure health needs are met.

Covid 19 Learning point

Whilst it is acknowledged that the Covid 19 pandemic presented considerable challenges for agencies, an accurate understanding of the lived experience of those with vulnerabilities, particularly where these inter-section, is pivotal in safeguarding them. Regular meetings and face to face contact are a necessity to ensure vulnerabilities and increased vulnerability are identified and responded to.

Recommendation

6. Face to face contact with individuals and families is vital and cannot be replaced by virtually facilitated visits/meetings. The Regional Safeguarding Board should receive assurances from Board Agencies that their staff are undertaking regular in person meetings with service users and particularly with vulnerable individuals

Statement by Reviewer(s)

REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	

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

Reviewer 1 *(Signature)*	……	**Reviewer 2** *(Signature)*	……
Name *(Print)*	……	**Name** *(Print)*	……
Date	……	**Date**	……

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

Child Practice Review process

To include here in brief:

- *The process followed by the CVSB, 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.*

The first panel meeting took place on 8th September 2022. In total the panel met eight times.

All panel members were asked to provide a timeline of their agency's contacts within the agreed time frame. The timelines were then merged into a chronology for review and analysis by the panel. Relevant historic information provided by Children's Services, Health and Police was also considered as part of the review.

A learning event was held on 27th February 2024 which brought together 11 staff from agencies involved in the case. The attendees were identified by panel members for their respective agencies and were briefed by their panel member prior to the event. The agencies in attendance included:

- Cardiff Children's Services
- Cardiff and Vale University Health Board
- South Wales Police
- Home Office
- Clearsprings Ready Homes

The learning event was led by the Chair and Reviewers and provided professionals with an opportunity to reflect on their involvement with the family and identify any learning.

Involvement and contact with the family of Child L has been considered throughout the review and discussed in each panel meeting. The main contact considered was with Child L, so the reviewers contacted his social worker to establish if this was appropriate. The discussions determined that it would not be appropriate to have contact with Child L at this time, but it was established that he was in a stable foster placement and was doing well. This update was shared with the attendees of the learning event.

Consideration was given to contacting the mother of Child L as part of the review. Adult A was diagnosed with a significant mental illness following Child L's death and is currently receiving inpatient treatment. She has therefore been unable to participate in this review. The social worker supporting family members has however ensured that they are aware of the review and the report has been shared with them.

The Chair and Reviewers would like to thank all practitioners that attended the learning event and contributed to the identified learning.

☐ Family declined involvement

For Welsh Government use only

Date information received …….

Date acknowledgment letter sent to CVSB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

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

Appendix 1

Terms of Reference (Concise) Child Practice Review
CPR07/2020

Introduction

A concise child practice review will be commissioned by the Regional Safeguarding Children Board (RSCB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 2. A concise child practice review will be commissioned where a child who has not, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health.

Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be **1 June 2019 – 30 June 2020**
  [*which includes day after death]*

- The following services will produce a chronology/timeline of significant events of its involvement with the child (and family) for the agreed timeframe above. A merged chronology will then be produced.

    - South Wales Police
    - Cardiff Children's Services

- C&V University Health Board
- Home Office/Immigration Service
- Clearsprings Ready Homes
- Welsh Ambulance Services NHS Trust
- Cardiff Legal Services
- SWF&RS
- EMRTS

Core Tasks (for a concise practice review)

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were individual focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.
- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review not already requested by the Case Review Subgroup, produce a timeline and an initial case summary and identify any immediate action already taken.

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.

- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the Case Review Subgroup and the CVSB for consideration and agreement.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

- Produce a 7 minute briefing on the learning identified from the Child Practice Review.

Tasks of the Regional Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- *Review panel* completes the report and action plan.

- CVSB send Report and Action Plan to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the Monitoring Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on CVSB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Co-Chair of the CVSB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.