Child B

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

Child B was born in 2009 and was the only child of a single mother who had a substance misuse problem. Child B witnessed the mother experiencing domestic abuse and the mother was also arrested for shoplifting. The mother was also accused of murdering Child B's grandfather but was subsequently cleared of manslaughter on the ground of insanity. Child B disclosed that they had been sexually abused by one of the mother's boyfriends.

Services were involved with the family from the child's birth. The child's name was on the child protection register from June 2014 to September 2015.

Circumstances of, and challenges faced by the individual

Child B did not have a stable home environment and Child B's health, developmental needs and education during the first six years of childhood were neglected. Child B's milk teeth were decaying, and 10 teeth had to be taken out. Child B also had a turned in eye which required correcting via glasses but was not seen wearing them regularly. Child B had failed both hearing and vision tests, which meant Child B was deemed to have mild/moderate difficulty in understanding spoken language.

What happened?

- There is no reference to the mother's mental illness in the timeline of this review despite it being crucial evidence in the murder case.
- Three referrals were investigated by children's services, but a child protection process was not progressed.
- Core assessment took 12 weeks to complete but should have taken less than 35 days.
- It took six months for an initial Child Protection Conference to be set up after the initial referral.
- Delays from the police in sharing information with the mother about her new partner (mother made request via Clare's Law (Domestic Abuse Disclosure Scheme) application).
- Core group meetings were not regularly attended by the family and child.
- The panel felt that if there had been no death (grandfather) then the safeguarding board wouldn't know about Child B (referral had been made by police as part of their domestic homicide review).

- The Care Order was granted on 10 January 2016. Child B is now in foster care and doing well in an improved and supportive family environment.

Why it happened?

- No reason was given as to why there was a delay of six months between referral and case conference (original social workers were not in post at the time of learning event).
- Delays with police disclosures (Clare's Law) were due to an inbox not being monitored.
- Police did not share all the PPD1 (now PPN Public Protection Notice – the police use these to share information about a child/children at risk, or witnesses of domestic violence or crime) with relevant multi-agency partners, which meant the potential risks were not identified.
- Lack of engagement from family (mother and grandfather).
- Agencies only formally explored the grandfather's background and relationship with Child B in 2015.
- Agencies were aware of the mother's relationship with one boyfriend and despite Child B disclosing that they were frightened that he would hurt the mother, no action was taken to assess his role in Child B's life.
- Mother refused consent for social workers to contact other agencies to gather information about Child B and family.
- Not enough conversations took place with Child B to obtain Child B's views, wishes and feelings. Conversations mostly focused on the mother's needs opposed to Child B's, i.e. Child B's child protection process was disrupted when the mother walked out of the meeting.
- Dental practice didn't make any child protection referrals during the identification of early dental neglect.
- Poor record keeping and communication between multi-agencies.

Report recommendations

The serious case review makes 13 recommendations:

1. When a care order is granted for a child the decision will be made whether or not a referral to the Safeguarding Board for consideration of a child practice review is indicated.
2. When legal services have given advice regarding a child who subsequently becomes the subject of a Child Practice Review they will be represented on the panel.
3. Regional Safeguarding Boards must be satisfied that at every statutory child protection visit practitioners have recorded that they have spoken to Child B alone and in an appropriate environment, and internal case file audits should evidence that the process of senior managers in

children's services recording their approval of the progress achieved against a child's protection plan.

4. Regional Safeguarding Board will relaunch their 'Multi-Agency Protocol on Working with Families who are not Cooperating with Safeguarding Issues' and ensure that practitioners are aware of its contents.

5. Regional Safeguarding Boards will be satisfied that training, support and advice around the need for effective inter- and intra-agency information sharing for the purposes of safeguarding children, including when parental consent is and is not required, as well as enquiries and checks on wider family members, is available to staff working with children and families in all partner agencies.

6. Regional Safeguarding Board will be assured that practitioners understand the relevance of Adverse Childhood Experiences and are aware of their potential long term impact and understand the concepts of poly-victimisation and re-victimisation.

7. Regional Safeguarding Board will require that all partner agencies ensure that members of their staff attend Level 2 Domestic Violence training under the National Training Framework so that they are skilled, confident and able to 'Ask and Act' proactively, identifying and offering support to victims of domestic abuse.

8. Regional Safeguarding Board will ensure that all practitioners who work with children and families are aware of the concept of dental neglect and all general dental practitioners know how to access appropriate safeguarding children training and advice, so that practitioners are confident in acting appropriately when they see dental neglect in a child.

9. Regional Safeguarding Board will provide multi-agency training on a rolling basis to inform practitioners about their own and other professionals' roles and powers in a child protection process. This will enable better understanding and multi-agency communication.

10. Regional Safeguarding Board will introduce a consistent standardised multi-agency timeline template that becomes the responsibility of each agency to complete when attending the initial child protection conference.

11. Regional Safeguarding Board will challenge and hold to account partner agencies whose practitioners consistently fail to prioritise attendance and participation at Child Protection Conferences and core group meetings.

12. Regional Safeguarding Board will be satisfied that education departments across the region ensure that there is meaningful engagement from schools and attendance at child protection conferences and core group meetings, even when these have to be arranged during school holidays.

13. South Wales Police will review their procedure for linking parents with children on the child protection register in order to strengthen the process.

Citation

Warlow A. and Baker A. (2018)
re:WesternBay, Concise Child Practice Review

www.safeguarding.wales/2018/11/29/western-bay-concise-child-practice-review-362017