

Pembrokeshire Child Practice Review (CPR)

**Child and Youth Safeguarding: Unifying
the Region (CYSUR) 1 2021**

Death of Child A 21 July 2020

**Quality, Safety and Experience Committee
15 August 2024**

Situation

- The Concise CPR examines agency responses to Child A.
- The purpose of the review is to identify learning for future practice. It involves practitioners, managers and senior officers exploring the detail and context of agencies working with a child and their family.
- The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency and child protection practice. It should include the circumstances which led to the review, including highlighting effective practice and considerations on what needs to be done differently to improve future practice (Working Together to Safeguard People – Volume 2 – Child Practice Reviews (Welsh Government, 2016) .

Child A

- Child A had lived with her mother, Male B, and her younger and older sibling in the mother's home. She had limited contact with her father.
- During the morning of 17 July 2020, an ambulance was called to the mother's home, initially via a 999 call made by Male B's mother. The caller said that Child A had fallen down the stairs and was unconscious.
- On attendance at the mother's home, ambulance staff raised concern that the injuries sustained by Child A were inconsistent in number (there were over 100 injuries) and location with a fall down the stairs.
- Child A was taken to a local hospital and concerns were again raised by treating clinicians regarding how she was said to have sustained her multiple injuries. Child A was intubated, ventilated and thereafter transferred to a tertiary centre for further assessment. Following assessment, child A was confirmed to be brain stem dead and treatment was withdrawn. She was pronounced dead on 21 July 2020, age 2 years and 10 months old.
- The mother was convicted of causing or allowing child A's death and Male B was convicted of child A's murder. The mother was sentenced to 6 years imprisonment and Male B was sentenced to 28 years imprisonment.
- The sentencing judge commented that child A's death was a culmination of several months of physical child abuse by Male B. The judge also stated that the mother had been a victim of domestic abuse in the past and had prioritised her relationship with Male B over concerns for child A.



- The family were first known to the police and children's services one month after child A's older sibling was born due to referrals regarding domestic abuse.
- Records show that domestic abuse was present in a number of the mother's relationships.
- Male B was known to the police from at least March 2019. The police logs include domestic related incidents between Male B and his own mother on 15 March 2019 and 9 October 2019, and he was arrested for breach of the peace on 25 May 2019. Additionally, Male B was assessed by adult services on 13 March 2019 in relation to the support that could be provided regarding his accommodation and substance misuse.



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- During the visits to the family home by a health visitor from 21 June 2019 onwards, child A's extreme behaviour as described by the mother (angry/violent behaviour including headbutting, pulling her hair, hitting, biting, screaming, shaking, pinching others, and going red to the face) were not observed.
- Health visitor made a referral on 4 July 2019 for a Flying Start nursery placement for child A. This was accepted on 21 October 2019, with provision for child A to start in January 2020. Child A was only at playgroup between January – March 2020 due to closing due to the pandemic.
- From March 2019 until child A's death, her older sister would, on occasion, disclose information on a piecemeal basis to her teachers regarding home circumstances. The disclosures made caused the class teacher to, make contemporaneous file notes of what was said. This included the older sibling being repeatedly tired (she said that she would often be unable to sleep due to various noises at night in her home) and cutting her foot on glass on the carpet at home.
- During June 2019 and January 2020, verbal arguments took place in the family home where child A and her two siblings lived between the mother and a previous partner all of which necessitated police involvement.



- Not all incidents were reported by the mother.
- The police emailed the Child Care Assessment Team on 4 January 2020, detailing the domestic violence call out, and on 5 January 2020, a referral was promptly made by the police. This was the first Multiagency Referral Form (MARF) submitted during the relevant period.
- On 16 January 2020, the health visitor also completed a MARF. Concerns were similarly raised by the health visitor regarding domestic abuse, but also that the mother was finding child A demanding.
- An assessment was opened by children's services on 7 January 2020.
- Although child A was only at playgroup between January – March 2020 what was noted was that her attendance was poor, staff rarely saw the mother (as she had arranged for a friend to often collect child A), and child A was often hungry on arrival.
- Child A was first seen on 31 January 2020 at the child health department of the local hospital due to the behavioural concerns raised by the mother. The mother described significant sleep difficulties, stating that child A was only sleeping 3-4 hours per night, that she had difficulty going to sleep until gone midnight, that she would then wake during the night, and was usually fully awake by 5am.



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- Although not documented in the records provided, the social worker did visit child A at the family home on 23 January 2020, and they also had discussions with various family members, including the alleged perpetrator of domestic abuse.
- As a result of those discussions, the social worker considered that voluntary engagement with the Team Around the Family (TAF) service would assist.
- During a home visit on 5 February 2020, the health visitor was kept on the doorstep as the mother reported that child A and her younger sibling were unwell. The health visitor did observe child A, albeit on the doorstep. Child A was appropriately dressed and advice was given regarding child A's "pink eye". The mother reported that a former partner was "going to prison" for hitting the children, but said that she did not believe he did this, and that it had been fabricated by her mother.
- Home visit by Health Visitor on 15 February 2020 for child A's 27 month developmental assessment, mother referred to the perinatal mental health team as she stated she was in a low mood , and for Nursery Nurse support.
- Part of the discussions related to child A's father wanting contact. The health visitor immediately contacted social services (whilst at the mother's property) to discuss the issue of parental contact however she was told by a professional within the child assessment team, that information could not be shared "due to confidentiality".



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- A further visit was offered on 5 March 2020, but was declined by the mother, who cited a family bereavement.
- During the latter part of this review, it became apparent that the assessment by children services had not, in fact, been completed by the named social worker, and had instead been created on 18 March 2020 and closed on 30 March 2020 by their team manager.
- Thereafter, telephone calls were made on 23 March 2020 and 6 April 2020 by the health visitor, however there was either no answer or the line was engaged. Messages were left.
- Health Visitor sent a letter on 20 April 2020 to arrange an appointment – no response.
- A telephone call was made by the Health Visitor on 8 June 2020. During this call, the mother said that a female friend was staying (sentencing judge in the criminal trial stated this was a lie told by the mother and a “cover up”; the person sleeping in her house was Male B).
- Health visitor subsequently shared this information with children’s services regarding the “friend”, however the case was closed to children’s services at that time, and nothing further was done.



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- On 19 June 2020 Male B reported to Police that a threatening letter had been hand delivered to the mother's address by a third party. Police were aware Male B was living with Child A's mother.
- On 11 July 2020, the police were informed that Male B was said to have had contact with his biological child "secretly", despite safety concerns.
- The health visitor made a telephone call on 14 July 2020 to Child A's mother who said she was continuing to struggle with child A's behaviour. Also said that she had a new mobile phone number as she was having unwanted texts from a previous partner, and that she had seen that previous partner outside the family home at midnight in a car, watching her house.
- A home visit was offered by the health visitor on 14 July 2020, however this was declined as the mother reported she was staying with her grandmother.
- 14th July 2020, Health Visitor completed a Multi Agency Risk Assessment Conference (MARAC) referral. This was to be discussed at MARAC the same day emergency services were called for Child A.
- Mother did not disclose the presence of Male B, or the injuries to child A, to professionals.



1. To ensure that relevant professionals are consulted during an adult needs assessment.
2. To ensure that an assessment regarding the needs of a child is undertaken and finalised in accordance with the relevant timescale by **Children's Services** prior to a case being closed in an appropriate way, and to ensure that robust systems are in place within children's services to attend to periods of absence by an allocated assessor.
3. To ensure that opportunities are not missed by **health visitors** to arrange home visits or escalate concerns (to management) if there is a failure by a parent/carer to engage, particularly where there is a history of child protection concerns within the family.



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4. To ensure there is professional curiosity when suggested negative behaviours of a child is limited to parental report only.
5. To ensure that information is shared between agencies, that agencies understand when they are able to do so, and for agencies to “join the dots” when they have relevant information.
6. To ensure that language used by professionals within documentation is not vague, and that there is, instead, specificity to appropriately assess risk.
7. To ensure that written documentation is sufficiently detailed and entered onto the electronic system as soon as practicable after an event.

Review Recommendations

To ensure that guidance for heads of service regarding additional funding requests is readily available and understood, and to consider how internal funding decisions can be reviewed	Local Authorities
Training (for practitioners and managers) regarding the assessment/sign off process, and for there to be a robust process for the auditing of assessments	Local Authorities
To ensure that a policy is in place regarding how staff are supported when sickness issues arise and how cases are managed when staff are on sick leave	Local Authorities
For rapid reviews to be undertaken effectively/timely following a child's death or serious incident	Local Authorities
Multi-agency training regarding (i) when a MARF is needed, and if needed (ii) how it should be completed	All agencies
Multi-agency safeguarding hubs (or equivalent) or co-location to support multiagency decision making (for cases which do not meet the threshold of "significant harm")	All agencies



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Updated policies/practice guides and further training on information sharing	All agencies
Information sharing between compulsory education and early years settings involving siblings	Local Authority Education Services & the Welsh Government
Training/managerial support to be given to professionals when faced with parents who do not engage, and for professionals to be supported to ask difficult questions	All agencies
Flags/alerts to be placed on the police system if incidents are logged (not as a domestic incident) regarding an address where it is known that children reside	Police
Importance of using specific terminology when completing records/reports (etc) and the importance of providing sufficiently detailed records	All agencies

Actions taken by the Health Visiting service



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Immediate improvements to the Health Visiting Service after the death of Child A and this work is ongoing.

- Commissioned bespoke Professional Curiosity training which included identification and response to risk for the Health Visiting Teams in Hywel Dda University Health Board. We are continuing to build on this and have a rolling programme of training delivered in the Health Board.
- Continued with the rigorous recruitment campaign , ‘grow your own model’ and worked with workforce as a result of which there have been significant improvements in staffing levels. After a rigorous recruitment campaign, the Pembrokeshire service will be fully staffed by October 2024.
- Since the pandemic and in line with the Health Board guidelines, supervision within the teams has been formalised between team leaders and staff and in turn team leaders and Senior Nurses as well as yearly Supportive Practice Reviews are carried out with all staff.
- The capacity within the role of Senior Nurse Quality Assurance has been increased to eventually having one Senior Nurse per county to ensure a more robust system for supervision and support of staff.
- Every Health Visitor now has access to a smart phone or laptop so video meetings would be possible should we be in a pandemic situation in the future.

The Health Visiting Service are currently reflecting on this tragic case with the entire service to identify further learning and will further develop their action plan.



For the Quality, Safety and Experience Committee to:

- Note receipt of the published CYSUR 1 2021 and recommendations.
- Note that the Health Board will contribute to the regional action plan co-ordinated by the Corporate Safeguarding Team (to be developed).
- Take assurance that the Health Visiting Service have put in place immediate improvements and are further developing their improvement plan.



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