Local Safeguarding Child Practice Review
Terms of Reference
Child: C101

March 2023

1. Reason and Context for Review

1.1 This review relates to a young child who has been given the pseudonym C101. C101 has a three year old sibling. C101, her sibling and both of their parents were living together at the time of the incident in question. On 4th December 2022 C101 was presented in a very distressed state at Torbay Hospital ED by her mother, with C101 being suspected to have an oblique midshaft fracture to her femur. The mother gave no adequate explanation for the nature of the injury. C101 was eight weeks old at this time. Hospital staff alerted Children's Services to request a strategy meeting and the subsequent Child Protection medical revealed that C101 had multiple fractures which had occurred over more than one occasion, with it being deemed conceivable that some of the fractures had occurred ten days or more before hospital presentation. This information was formally communicated to the Local Authority on 6th December 2022, both parents were arrested by the police and the children became cared for under S20 within the same foster placement. The children were made subject to Interim Care Orders on 15th December 2022.

1.2 Further concerns regarding C101 and her sibling's welfare were identified within the Rapid Review process, with examples of these being:

- The parents being reported to have a poor relationship.
- C101's older sibling exhibiting concerning behaviour and development.
- The mother experiencing low mood.
- The mother being concerned about the father's level of alcohol consumption.
- The concerns above leading to the GP making a referral to Early Help services in January 2021 but the parents declined support.
- The mother made a referral in October 2021 reporting concern about the father's drug and alcohol use.
- The father was reported to have cared for C101's sibling whilst under the influence of substance/s.
- In June 2022 the mother reported to the police that the father was driving under the influence of alcohol, adding that his place of work is concerning in respect of illegal drug supply.
- The father reportedly had a sexual relationship with another person whilst the mother was pregnant with C101's sibling.
- The parental relationship dynamics and self-reports of transactional sexual behaviour which leads to a potential hypothesis of coercive control by the father.

- The father accused the mother of having a sexual relationship with her own brother whilst she was pregnant with C101.
- The father's rough handling of C101 in the hospital.
- Child in Need planning was in process at the time of the injuries to C101.

1.3 The Serious Incident notification was submitted to National Panel by the TSCP on 12th December 2022 and the Rapid Review meeting was held on 22nd December 2022, with the associated report being submitted to National Panel on 4th January 2023. Although the Rapid Review meeting concluded that all learning had been identified the TSCP Executive recommended the undertaking of a local CSPR, with National Panel responding to the TSCP on 8th February 2023 and concurring with this view. National Panel agreed with the lines of enquiry identified by the TSCP and Siobhan Burns was confirmed as the Independent Reviewer on 23rd February 2023.

2. Purpose

2.1 This review will be based on the key lines of enquiry recorded in section four below. However, during the review, if further learning opportunities are identified these will be added at the discretion of the TSCP C101 Review Panel. The key purpose of the review is to prevent future similar harm and learn lessons where appropriate to further safeguard and promote the welfare of children. The review should aim to identify systematic learning, rather than holding individuals or organisations to account for their actions.

2.2 If concerns are identified within the review process that fall outside these terms of reference, such as those of a safeguarding or misconduct nature, the Independent Reviewer will refer to the TSCP who will then consult with the relevant body to consider appropriate responses and processes.

3. Period under Review

3.1 The period under review is from the confirmed date of the mother's pregnancy, 22/02/2022, until 12/12/2022 when the SIN was submitted by the Local Authority.

3.2 The Independent Reviewer may also request summary background and contextual information outside of this period and analyse as relevant.

4. Key Lines of Enquiry

4.1 The following key lines of enquiry have been established, based on the findings of the Rapid Review, and have been noted by National Panel. Further questions have been agreed by the TSCP C101 Review Panel and are recorded under their linked line of enquiry via bullet points.

A	**Analyse the effectiveness of communication and information sharing between agencies during the period under review and identify if this led to missed opportunities to support/safeguard C101.**
B	**Report on the quality of CIN and safety planning for C101.** • Did the delay in care planning post completion of the single assessment on 6th September 2022 elevate risk and/or prevent the family accessing services?

	• Do local agencies understand the purpose and legal limitations of written agreements?
C	**Comment on the effectiveness of existing local systems to protect children. Are these robust enough and/or being applied correctly?** • Were effective child protection procedures initiated in line with WT2018 and correctly applied following the identification of C101's injuries? • Was safety planning initiated after the strategy discussion/s SMART, robust and effective, including the timely identification of the pool of potential perpetrators? • Review and comment on the timeliness of arresting procedures for both parents. • Review the impact on safeguarding of the lack of professional curiosity following the assumption that the father was the perpetrator following his statement that he dangled C101 by her legs.
D	**Comment on the accessibility and quality of professional supervision for staff engaged in the safeguarding of children.** • Were all professionals able to access supervision, and if not, why not? • How could local supervision be better used to improve the safeguarding of children?
E	**Review local agencies understanding of the importance of awareness and knowledge around feeding difficulties and associated impact on infants' safety.**
F	**Comment on whether agencies fully understood the status and impact of the parent's relationship.** • Did this impact on risk management? • Was there evidence of coercive control and domestic abuse, and if so, what were agencies responses?
G	**Review local multi-agency practice in respect of 'hidden fathers' and identify potential learning for local agencies.** • Was the father visible to services and considered within recording processes and care planning? • Review the pathway from midwifery services to health visiting to ensure it is effective and being applied correctly, including the frequency and level of health visiting for children subject to child in need or early help planning. • Identify risk and potential learning regarding the transition processes between midwifery and health visiting teams. • Do health practitioners routinely record the presence of birth marks or similar marks on a child's file? • Identify why Universal Plus health visiting status did not elevate the level of visits to the family in line with agreed local process. • Was whole family care planning considered by health practitioners?

H	**Review and comment on the residual impact of Covid 19 on local safeguarding and support services and determine if this impacted on C101's safety and care planning.**

5. Methodology:

5.1 This review will be carried out according to statutory guidance and using best practice to ensure appropriate learning opportunities are identified and analysed. The final report should identify recommendations that can be converted into SMART actions to assist learning. It is anticipated that the review will be conducted remotely, however if 'face to face' meetings are required the need for these will be evaluated in advance by the TSCP C101 Review Panel.

5.2 The Independent Reviewer will feedback progress to the TSCP at regular planned intervals via the TSCP C101 Review Panel. In situations where urgent/unplanned feedback is necessary this will be undertaken via the TSCP Business Team.

5.3 The TSCP C101 Review Panel will meet monthly, however meetings can be held more frequently if required at the discretion of the Chair.

5.4 The TSCP C101 Review Panel will consist of:

- Divisional Director, Safeguarding (Chair)
- Children's Social Care
- Police
- Designated Health Professional (covering the health system)
- Early Years (if required)
- Independent Reviewer
- TSCP Business Team
- Additional members as deemed necessary

5.5 Legal advice will be provided by the Local Authority Legal Department.

5.6 Communications/PR support will be provided by the Local Authority communication lead for Children's Services.

5.7 The TSCP Executive have requested an interim report be completed at the midway point of the CSPR timescale.

5.8 Final learning from the review will be presented by the Independent Reviewer in the form of a full CSPR report that will be completed to timescale as far as is practicable. The final draft report will be agreed by the TSCP C101 Review Panel before being presented formally to TSCP Executive Group for review and sign off via partnership business channels. Any agreed amendments to the report will be required to be undertaken by the Independent Reviewer.

5.9 The timescale for submitting the final version of the report to National Panel is six months from the TSCP being notified of the need to complete the local CSPR. The last submission date to National Panel is therefore considered to be 8th August 2023.

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6. Review of Existing Materials and Papers

6.1 The Independent Reviewer will identify the information they require to undertake the review with the support of the TSCP C101 Review Panel. The information will be sourced and provided by the TSCP Business Team and partner agencies will be expected to comply with information requests (where legally permitted) in a timely manner.

7. Involvement of Practitioners and Staff

7.1 The Independent Reviewer will identify and engage with relevant practitioners, managers, and key workers to ensure any learning opportunities are fully incorporated into the reviewing process. It is anticipated that there will be at least one 'practitioner event', combined with the offer of 1:1 or small group sessions for workers to meet with the Independent Reviewer where this is deemed more conducive to the identification of learning. The TSCP Business Team will coordinate these events.

8. Involvement of Families/Other Parties

8.1 Parents, carers and family members of the siblings will be notified of the review by the TSCP and invited to participate at an appropriate time.

8.2 Involvement of other interested parties will be considered as appropriate by the TSCP C101 Review Panel.