AGENDA ITEM
6.8

QUALITY & SAFETY COMMITTEE

CHILD T – CHILD PRACTICE REVIEW

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Claire O'Keefe, Head of Safeguarding Louise Mann, Assistant Director. Quality Safety & Safeguarding.
Presented by	Greg Dix – Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Safeguarding Executive Group	(23/01/2023)	ENDORSED FOR APPROVAL

ACRONYMS	
MASH	Multi-Agency Safeguarding Hub
CTMUHB	Cwm Taf Morgannwg University Health Board
CTMSB	Cwm Taf Morgannwg Safeguarding Board
CPR	Child Practice Review

1. SITUATION/BACKGROUND

1.1 Following the tragic murder of a child from the Bridgend region, the Cwm Taf Morgannwg Safeguarding Board commissioned a Child

Practice Review to examine the involvement of various agencies across to inform learning and improvements required. The child is referred to as Child T within the report. This CPR was published by CTMSB on the 24th of November 2022.

1.2 As a result of this Child Practice Review, key learning for all agencies were identified. It was the Child Practice Review Panel perspective that these issues may be systemic, and not isolated instances of individual error or poor practice. The review identified learning for individual statutory agencies and for working together in partnership. For CTMUHB there were two specific recommendations. These included;

- Cwm Taf Morgannwg Health Board should commission an Independent Review into its practice and management of identifying and investigating non-accidental injuries in children and adolescents. The Independent Review should make recommendations as to how the Health Board develops escalation and quality assurance systems that embed and maintain any practice learning.

- The Cwm Taf Morgannwg Health Board should ensure that practitioners who work directly with children and young people are aware of their roles in identifying safeguarding concerns and their duty to report. There needs to be a system in place to ensure compliance, including safeguarding training programmes across all health practice roles. Compliance should be reported on an annual basis to the Cwm Taf Morgannwg Safeguarding Board

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 On the 16th of August 2020, Child T presented to the emergency department of the Princess of Wales Hospital, who subsequently submitted a referral to the Children's Services Emergency Duty Team, reporting that Child T had an injury to his arm, bruises on his right cheek and a fractured humerus. The Child Protection referral made by Health Services raised concerns in relation to the delay in the mother taking him to receive medical attention for his injuries.

During this admission a Strategy Discussion was held between the Social Services Emergency Duty Team and Police. The purpose of a Strategy Discussion is to determine whether Child Protection Enquiries (Section 47) should be initiated, and how these enquiries should be undertaken. At this meeting, these agencies agreed that the threshold to undertake Child Protection Enquiries (Section 47)

had not been met at that stage, on the basis that there was limited medical information. There is no information recorded to confirm why a Health representative was not part of the strategy discussion as would be expected practice. Case file records stated that the Paediatric Consultant was reviewing Child T's case further.

Examination of Child T by a Paediatric Registrar and Consultant Orthopaedic Surgeon were not carried out under the framework of a child protection medical examination. During examination, multiple bruises were documented on the child's head and body; those on the face were clearly visible. Mother reported that Child T self-harms pinches and hurts himself when he is being sanctioned for his aggressive behaviour, and that this had been happening since the birth of her new baby. There was no evidence of professional curiosity or concern that a four-year-old child would physically harm themselves for any reason.

Medical photography and blood tests were requested and completed. Orthopaedic Consultant examination documented that given the whole history there was a clear suspicion of Non-Accidental Injury (NAI). The decision documented by the Lead Consultant Paediatrician when reviewing the investigations, (there is no documented evidence of discussion between orthopaedic and paediatric colleagues of their opinions on the cause of the injuries), and visiting the child on the ward is that the injury is consistent with the history given by the mother and the view is that the presentation is not suspicious of a NAI. There is no documentation that the incidence of bruising was reported to children services or police as a concern in addition to the late presentation of the shoulder injury. The conclusion of the Lead Consultant Paediatrician was shared with the local authority via a telephone call from the ward nursing staff.

Child T's attendance to hospital in August 2020 was considered by the CPR that information regarding the extent of his presenting bruising and injuries were not appropriately shared with other agencies and that if this information had been shared with police and local authority, this may have led to a decision to commence child protection enquiries and action. The information that was not shared included 31 medical photographs of the documented bruising that was observed during a medical on the paediatric ward at Princess of Wales Hospital. It is important to note that there was no safeguarding platform in which to share this information other than a new child protection referral as agencies were working outside the section 47 process.

In addition, there were concerns raised by CTMUHB at the CPR practitioners Learning Event. Some colleagues reported feeling their

value and voice in relation to concerns about children are not heard, with examples of safeguarding concerns not being reported to external agencies due to the dominant views of more senior practitioners. Colleagues shared a culture of not challenging those in a more senior, 'expert' position and their voice being heard is dependent upon the status of their role.

2.2 A CTMSB and CTMUHB action plan was developed following the initial independent rapid review of multi-agency safeguarding practice in Bridgend, commissioned by the safeguarding board in December 2021. The CTMUHB action plan addressed several areas of practice including training compliance. This action plan has been shared with the Lead Doctor for Safeguarding and Clinical Nurse Specialists for Safeguarding. The monitoring and progress of the actions are overseen through the Children's Safeguarding Operational Group, upwardly reported to the Safeguarding Executive Group, through to Quality and Safety Committee.

The CTMUHB safeguarding team undertook an internal audit of safeguarding referrals, involving children presented to the Princess of Wales Hospital with injuries. Partner agencies also conducted internal audits prior to completion of the CPR to ensure early learning was identified and acted upon. Following this, a multi-agency audit reviewed the same cases. In total 16 cases were reviewed, the remit included referrals made by the Emergency Department for children attending with injuries. The learning from the multi-agency audit was incorporated into agency improvement plans.

A Lessons Learnt event was delivered face to face and via Teams to Bridgend medical and nursing staff on the 27th of October 2022. In addition, three bespoke level 3 safeguarding training sessions were delivered. These events provided an opportunity to share the learning identified within the Bridgend multi-agency audit and from the CPR, the forum was used to promote confidence in safeguarding processes, improve information sharing, to enable colleagues to professionally challenge when cases do not follow the Wales Safeguarding Procedures.

A 7 minute briefing and NAI pathway has been developed in partnership with CTMSB, this has been disseminated through the Operational Safeguarding Groups and shared with leads for emergency care, acute and community paediatric teams. The Clinical Director within POW has shared these with medical colleagues; posters of the pathway are displayed on the wards and departments and discussed with all Consultants and Registrars.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 In addition to the multi-agency recommendations and action plan from the Child Practice Review, a CTMUHB improvement plan has been developed in partnership with the Named Doctor for Safeguarding, Safeguarding leads and the Medical Director. The focus of this improvement plan is to ensure a robust system is in place to provide appropriate level 3 training to medical groups and monitor compliance of safeguarding training across all staff groups, including medical colleagues.

This plan will include the development of a CTMUHB training forum and strategy that will support a sustainable model of reviewing safeguarding training compliance.

3.2 Repeat audits will be required to evaluate the effectiveness of any changes to practice, implemented learning and subsequent training.

3.3 The learning from this review will be shared via the Operational and Safeguarding Executive Groups. In addition, the new organisational Listening and Learning Framework, Repository of Learning, and biannual Listening and Learning Event will support organisational values in using this learning to share knowledge, shape change and create opportunities to develop excellence in practice. The next Listening & Learning Event on the 28th March 2023 will focus on sharing the learning from the CPR and subsequent improvements to the quality and effectiveness of safeguarding services, as well as ensuring public trust and confidence.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The improvement plan is developed to improve safeguarding practice within the health board and amongst statutory partnerships in relation to safeguarding children.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	The duty to report safeguarding concerns applies equally across the health board and to all children and adults at risk.
Legal implications / impact	Yes (Include further detail below)
	There is a statutory duty to report safeguarding concerns in relation to children and adults at risk.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

5.1 **NOTE** the content of the report
5.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
5.3 **NOTE** the risks identified
5.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports