BWRDD Diogelu Gogledd cymru / north wales Safeguarding BOARD	**CASE REFERENCE** **ECPR DENBIGHSHIRE 2**

Concise Review	
Extended Review	x
MAPF	

Review Process

Legal Context

An Extended Child Practice Review was commissioned by the Chair of the North Wales Safeguarding Children Board on the recommendations of the Regional Child Practice Review Group in accordance with the All Wales Child Protection Procedures 2006, which have been adopted by the North Wales Regional Safeguarding Children Board; also in accordance with the Guidance for Multi-Agency Child Practice Reviews. The criteria for this review were met under section 6.1 of the above guidance, namely:

A Board must undertake an extended child practice Review in any of the following cases where, within the area of the Board, 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 heath or development;

and

The child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –

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

The criteria for Extended Child Practice Reviews are lain down in the revised regulations, *The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.* The purpose of the review was to:

- Establish whether there are lessons to be about the way in which local professionals and agencies work together to learned safeguard children.
- Identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result.
- As a consequence, improve inter-agency working and better safeguard children.
- Identify areas of good practice.

Methodology:

- A Review panel was convened with a chair:
- 2 Reviewers were appointed
- Timelines were developed for each agency identified
- A summary/analysis of each service involvement were produced
- A Learning Event was held for practitioners
- Review panel met and contributed to report
- Review Report produced with learning points/good practice and presented to panel
- Review panel met to finalise report
- Action plan developed from recommendations
- Review Report presented by the reviewers and chair of the Review Panel to the Regional CPR Sub Group and North Wales Safeguarding Children's Board
- Submission to Welsh Government
- Feedback to family
- Publication of report on NWCSB

Circumstances resulting in the Review

This review was undertaken following the tragic death of an 11 year old child following a severe asthma attack. On the 12/06/15 the child was admitted to a District General Hospital (DGH) via ambulance in cardiac arrest due to severe exacerbation of asthma. There were concerns that there had been a delay in presentation for medical assistance and that the child had not been given the appropriate medicine in the preceding days. School had raised concerns on the morning of the 12/06/15 that the child was presenting with a slight, chesty cough. The child was encouraged to use their inhaler throughout the morning, but as the child's cough did not improve school contacted parents to collect the child. The child was collected by step-father and taken home at 12.15. The child then presented at the GP surgery at 17.00 hours, exhausted and unable to complete sentences. An ambulance was called and the child arrested on the way to hospital. The child was then transferred to a Tertiary hospital and was cared for in intensive care. Sadly, on the 21/06/15 ventilation was withdrawn and the child passed away. The cause of death was recorded as hypoxic brain injury following an acute severe asthma attack resulting in cardiac arrest.

The child and his siblings names had been on the child protection register from the 15th May 2014 to the 4th June 2015 under the category of neglect. Part of the neglect concerns, was the persistent failure of parents to meet the health needs of the children, particularly in relation to the index child and management of their asthma.

Given the complexity of the case and the intensive ongoing professional involvement with the family, the Child Practice Review Panel agreed a 3 year timescale preceding the child's death. It was also agreed that historic incidents would be included for contextual purposes. The timeline considered for the review is focussed on events and agency involvement between the 16.05.12 (the first reference to a referral to children's services) through to the child's death on the 21/06/15.

Background Information:

The index child was the eldest of five children. The parents were separated but the mother was cohabiting with a new partner who was the father to the fifth child.

Together with the child's siblings, the child had been on the Child Protection Register on two separate occasions, during 2012-13 and 2014 -15. The latter period of registration spanned from the 15th May 2014 until the 4th June 2015 under the category of neglect, due to the mother's misuse of alcohol and failure to meet the health needs of the child. The initial period of registration spanned from 28th June 2012 until 6th June 2013 under the category of emotional harm, where domestic abuse was identified as a significant risk factor.

On the child's admission to the District General Hospital on the 12/06/15, there were inconsistent accounts provided by the child's mother and the medical staff had to rely on the younger siblings to provide an account of the child's condition. Three members of staff were concerned that the mother appeared unkempt and smelled of alcohol. A child protection referral was made to local authority social care. There were also concerns raised by staff in relation to the unkempt appearance of the child. The tertiary hospital also completed a child protection referral due to concerns that the mother was unkempt and smelling of alcohol and appeared unsteady on her feet. The child was noted to be unkempt with dirt engrained within skin creases and nail beds and was treated for a head lice infestation. The child had reportedly been unwell for the previous six days, but no medical advice had been sought.

Prior to this admission, the child had been admitted to the high dependency unit of the local DGH on two previous occasions due to exacerbation of asthma – December 2010 and February 2014. A referral was made to social services in February 2014 due to concerns regarding poor compliance with medication and delayed presentation. Following this admission to the HDU, the child was not brought to three review appointments in respiratory clinic and was referred back to the GP for follow up. On the 8th April 2015 the child was admitted to the local DGH for exacerbation of asthma.

Throughout their short life, the child had witnessed domestic violence, inconsistent and neglectful parenting and a lack of appropriate nurture and care. Parents were often resistant to help and support and there was a notable history of parent's failing to ensure that their children attended school regularly or attended health appointments appropriately. Maternal alcohol misuse was also a prevalent factor. This was most apparent in the poor management of the child's asthma, where there was continued concern that parents failed to manage the condition appropriately, despite endless exhortations by professionals for them to do so. Throughout the period considered within this review, there are notable periods of high concern, causing a PLO process to be initiated and court proceedings to be considered, followed by periods where there was deemed to be progress made, where the parents engaged and the care of the children improved. Health needs were met to a greater extent, and school attendance and home conditions improved. However, these improvements were not sustained resulting in a recurrent cyclical pattern of concern, improvement and case closure.

Family Views

Despite initial reluctance from the family to meet, the two reviewers finally met with the family on 13th June 2016. At the meeting the mother, step-father of the index child and the youngest sibling were present. The child's father had declined the opportunity to meet with the reviewers.

Understandably, the mother appeared emotional at times but was very engaging. The reviewers explained the process of the child practice review and informed the family that a learning event would be held and a final report would be written and shared with them prior to wider circulation.

When discussing involvement with agencies the mother was very positive and stated clearly that she had nothing negative to say in relation to this. She stated that she felt professionals had listened to her and she had felt supported. She did however comment that she felt 'Social services treated her like a kid sometimes'. She stated that she didn't understand why people had so many concerns about her children.

In relation to the child's asthma, the mother acknowledged that she understood that the condition could be fatal. She informed the reviewers that they got to most asthma appointments but things often cropped up due to a busy family life. The mother stated that the child always had appropriate medication and felt that the child was able to manage their own medication.

During the meeting it was evident to the reviewers that there was a lack of understanding from the perspective of the mother and step-father in relation to the concerns expressed by professionals regarding both the management of the child's asthma and the wider issues of neglect.

The mother talked frequently of how proud she was of her child. She described her child as one in a million, bright, brilliant and artistic. She talked of the years shared with her child as the best 11 years of her life and stated that she was proud to be the child's mum.

The learning event

The learning event took place on 16th June 2016. The event was well attended and all of the relevant practitioners and agencies were represented. During the first part of the morning, practitioners had the opportunity to review the combined chronologies of each agency, which was represented as a 'whole system' timeline. Each agency then talked through their involvement with the child and family. Questions were asked and comments and reflections were made by other participants. The results of this chronology based exercise informed the second part of the Learning event which focussed on identifying some key themes and learning outcomes for key agencies working together to safeguard children. The views obtained from the family during the home visit were shared with those practitioners in attendance.

It was very apparent that the circumstances leading to the death of the child were deeply distressing for those practitioners involved. Practitioners found it an extremely difficult and emotional day. Whilst it was acknowledged that there were many areas of good practice across agencies, some key learning points were identified. Great sadness and regret was expressed throughout the day at such a tragic loss of a young life.

Practice and Organisational Issues Identified

Narrative:

The review focussed on key learning points and areas of effective practice for each agency

Practice and organisational learning identified under the following themes:

Medical Neglect

Asthma is a common long term condition that can cause coughing, wheezing, chest tightening and breathlessness. The severity of these symptoms varies from person to person. Asthma can be well controlled in the majority of individuals most of the time, although some people may have more persistent problems. Occasionally, asthma symptoms can become gradually or suddenly worse, known as an asthma attack or 'exacerbation'. Severe attacks may require hospital treatment and can be life threatening in some instances. It is widely recognised that childhood deaths from asthma are largely preventable and in the majority of cases sub-optimal asthma control and poor adherence to recommended asthma medication and asthma action plans were identified as the cause.

The child was known to have 'fragile asthma'. This terminology suggests that the asthma can rapidly change from being apparently well-controlled to being poorly controlled and in a short space of time. Consequently the child was prone to deteriorating rapidly from feeling relatively well to having quite severe difficulty in breathing. The asthma was also considered severe in terms of the impact that it had on the child's education and other quality of life indicators.

In relation to the child's asthma, there is evidence of good practice from both health and social work staff throughout their involvement, demonstrating they worked tirelessly with parents in an attempt to engage them in the management of their child's asthma. There is significant evidence particularly from the child health records that appropriate advice and information was provided to parents and that attempts were made to engage the child in the management of their condition. The school nurse and the health visitor repeatedly reminded the family regarding health appointments. When the child was not taken to health appointments, the school nurse regularly responded to this, by contacting the family, re-arranging appointments and re-referring where necessary. There is also evidence that the GP was proactive in following up missed appointments.

Despite this however, the evidence contained within reports and risk assessments do not clearly and sufficiently identify the risks to the child's health and life from a significant asthma attack, despite two significant hospital admissions. It is not clear from any of the records, that there was a clear common agreement amongst professionals on the seriousness of the child not complying with health appointments or more importantly using their preventative medication. The strategy meeting that was convened following the child's final admission to hospital on 15/06/15 demonstrated this flaw:

i) A consultant from the DGH informed the meeting that the child may not have used his steroid inhaler since December 2014, when it was last prescribed by the GP. The Consultant stated that the inhaler should be used twice a day and would be expected to last 2 months. Concerns were also shared that the child had failed to attend 3 respiratory clinic appointments.

ii) During the child's admission to the DGH in April 2015, concerns were raised that the child had no spacer device home and the child's inhaler had run out.

iii) It was recorded in the GP records in May 2015 that the GP was concerned that the child's asthma was not under control and felt that that child was not taking their preventative medication enough. (This information was shared with the final review case conference via a report from the GP).

Concerns (i) and (ii) were not shared within the final review conference on the 04/06/15, issues that are clearly fundamental to understanding the true picture in relation to the child's medical needs. A health representative at the final review conference stated that the management of the child's asthma was not adequate and that something in respect of the medication needed to be tweaked. There was no suggestion or acknowledgement by any professional at conference, that the child's ongoing poor health was a direct result of poor compliance and failure to take medication as prescribed.

This is illustrative of a reoccurring theme whereby the implications of the child not having his asthma appropriately controlled is somewhat under estimated. The child protection plans and the analysis of risk on which they are based appear to have been flawed in relation to their understanding and promoting the child's significant health needs. It is not clear from any of the records that there was a common agreement on the seriousness of the child not taking their preventative medication as prescribed, and there was no evidence that this was been systematically checked or shared with other professionals. The learning event spent considerable time discussing the decision making that was made at the final case conference review on 4th June 2015 and whether the decision to deregister was the correct one. Concerns were raised about the child's health and whilst the conference had unanimously agreed that these concerns could be managed outside of the child protection conference environment, it is the view of the reviewers that that the significance of the child's medical condition was lost in the "plethora" of other issues of concern within the family.

In addition, physicians, scientists, and asthma sufferers have long believed that stress contributes to exacerbations of asthma. However, it has only been in the past two decades that convincing scientific evidence has accumulated to substantiate this hypothesis. For example, in an 18-month prospective study of children with asthma, the experience of an acute negative life event (eg death of a close family member)

increased the risk of a subsequent asthma attack by nearly 2-fold (Sandberg et al., 2000). The impact of an acute negative event was accentuated when it occurred in the context of chronic stress. Children exposed to high levels of acute and chronic stress showed a 3-fold increase in risk for an attack in the two weeks that followed the acute event.

There is no doubt that the child and siblings were suffering significant emotional distress within their home environment. Domestic abuse had been a significant feature and it is highly probable that they found it stressful to be around their mother when she was intoxicated. The child's asthma is likely to have been exacerbated by stress; however there was no indication that stress was even considered as a possible trigger for exacerbation of asthma.

Failures in safeguarding process relating to asthma management

There was no medical representation at the final child protection conference, which was also a feature of previous conferences. Although a report was provided to the conference by the GP, it would appear that the concerns raised in regards to prescribed asthma medication not being given were not given the consideration they required. The report was very minimal in content and did not expand on the concerns raised. It has been acknowledged by the GP that it would have been helpful if a copy of the medications were attached to have the report, which would have demonstrated that the child was not receiving the appropriate medication. Had a medical practitioner been in attendance at conference, with a specific focus on asthma compliance and outcomes, then this information may have initiated a more in-depth focus on the risks associated with poor medical compliance. Of note also, the information provided by the GP was not listed in the risks analysis in the chair's summary of the review conference.

In relation to the acute setting and the role of the DGH, some flaws in process have been identified. Following admission to the High Dependency Unit (HDU) on the 8th April 2015, a follow up appointment was requested for the respiratory clinic for within 2-4 weeks. However, the appointment given was for the 28th July 2015, ie some 3 months later. The reason for this requires further exploration. There is some suggestion that this may be an important resource issue that needs addressing.

In was considered important to examine the role of the DGH in relation to their position where a child fails to attend a medical appointment. The DGH uses a partial booking system whereby the parent/carer is sent a letter when an initial appointment is offered or a follow up appointment is due. The parent is asked to phone and make an appointment for their child. Failure to do this results in a 2nd request being sent. If this is not responded to, then the child is routinely discharged from the hospital with a letter informing the GP. The child then needs to be re-referred back into the system, before another appointment can be offered. This pattern of events happened on a number of occasions in relation to the child and this therefore placed the asthma management responsibility onto the GP. The hospital should have played a more active role in following up the failed appointments. In situations where the child's name is on or has been on the child protection register, any failure to either make an appointment as requested or failure to attend an appointment should receive a higher level of scrutiny.

BCUHB 'Standard Operational Procedure for monitoring children who were not brought (WNB) for appointments or surveillance in acute and community setting' states that where there is a refusal to engage with services and there are known safeguarding concerns, then the responsible health care professional should discuss their concerns with the safeguarding team and activate child protection procedures via a child protection referral. This procedure was not followed, which led to a re-occurring pattern of referral, discharge and re-referral with no individual practitioner taking overall responsibility in monitoring the child's well-being. Even during the two periods when the child's name was on the child protection register, when surveillance, monitoring and support should have been at the highest level, there were still entries in the health records evidencing poor compliance with treatment and failures to attend appointments, which were never challenged or raised as a significant stand alone concern.

Voice of the Child

The child's voice is a phrase used to describe the real involvement of children and young people. It means more than seeking their views, which could just mean the child saying what they want, rather than being really involved in what happens. Lord Laming said of Victoria Climbié that no-one could describe a day in her life. Children and young people should have the opportunity to describe things from their point of view. They should be continually involved, and have information fed back to them in a way that they can understand. There should always be evidence that their voice has influenced the decisions that professionals have made. Numerous previous reviews have highlighted the need for children to be seen on their own with practitioners away from parents and carers in an environment they feel safe, so that they can speak openly and honestly about any concerns that they may have.

In this case, the voice of the child and their siblings is represented in the social workers record keeping and within the conference process, but it has been difficult to see the full extent of this and how their views were used in relation to care planning. The child was articulate and talked about experiences at home, but there is no record within the social work files of any follow up to any of the concerns the child had expressed and no indication as to whether things had changed for the child and their siblings.

Conference recommendation lacked real direction in this area and there is little evidence to suggest that recommendations relating to the child's views were followed up and completed. Due to the ages of the children, the use of a 'conference buddy' would have ensured that the children's views were sought and shared within the conference. Of real significance in March 2015, the child was asked to complete a 'faces exercise' (a visual tool used for children to identify how they are feeling). The child ticked the 'I feel ill' box. There is no indication within the social work records to whether this was a general feeling articulated by the child or a specific response to him perhaps feeling unwell generally. No narrative or follow up to this consultation is evident. This was potentially a missed opportunity to explore how the child was feeling and to address issues around compliance with medication.

Information Sharing

It is well established that effective practice in safeguarding is built on efficient and effective information between internally within agencies and the wider multi-agency setting. Ofsted's evaluation of serious case reviews from 1 April 2009 to 31 March 2010 identifies that nationally, there are problems in how information is sought and shared. In relation to this case, the review highlighted evidence of some excellent communication both internally within individual agencies and externally between health, local authority social services and education: for example there is pleasing evidence of good liaison with the GP and asthma nurse and regular documented email communication between the Health Visitor and Social Services, providing updates on the case and sharing new information. There is good evidence that child protection referrals were made appropriately and that information was shared between agencies in a timely manner. There were instances however, where gaps in the sharing of some relevant information left some professionals without a complete picture and when episodic incidents occurred, they were not viewed as symptomatic of longer term historic patterns.

The learning event highlighted a concerning lack of communication between the DGH and the community health staff. It became apparent during the event that concerns raised by staff within the DGH during the child's admission in April 2015
relating to the child's inhaler having ran out and a lack of spacer advice had not been shared with wider health team or social services, despite the child being on the child protection register. Had this information been shared, then these significant concerns should have been an issue of concern at the review conference in June where the children were de-registered. The health agency timelines once again highlight the problems of health professionals not having common data sharing systems for patient recording; this is a national problem. There was no sense of a shared view that could identify patterns of missed appointments, inconsistencies and risk.

Assessment and Management of Risk

Several case conferences, core groups and other local authority records refer to the use of standardised assessment tools including the Graded Care Profile (GCP), Bruce Thornton Risk Assess and a risk 2 assessment. Within the minutes of the final review conference on the 4th June it is recorded that a Graded Care Profile and Aims 2 Assessment had been completed with the family, however the social work records fail to demonstrate that these documents were either completed or updated. Previous conferences had identified the need to complete these documents as a priority, but the process failed to question rigorously enough why these documents were not completed appropriately in their entirety. Whilst the learning event highlighted that staff were aware what a graded care profile/Bruce Thornton Risk assessment measured, the panel review identified that these assessments were not completed despite specific recommendations from Case conference.

In relation to these shortcomings, it is of note that the child was de registered on 4th June 2015 – however, when he was finally admitted to hospital eight days later on 12th June 2015 he was described as being in a very poor condition, with head lice and ingrained dirt, suggestive that neglect was still a significant issue. Whilst there had been an unannounced home visit on 11th June by social care due to concerns raised by school regarding his mother's drinking, the child was not at home as he was in school, so was not seen by the duty worker. At the learning event, school reported no

undue concerns about his condition when the child had attended school on 11th and 12th June, so there is some inconsistency about the standard of cleanliness reported by health professionals and other agencies. It is difficult to understand how the child's condition could have deteriorated so swiftly between these dates. It is the belief of the reviewers, that had the graded care profiles been appropriately completed as directed, then a more meaningful assessment around the neglect issues could have been ascertained at that final case conference.

Public Law Outline

It was identified that the Public Law Outline process (PLO) was not properly managed at the time. There is little clarity on the PLO process and it's relationship with the child protection activity, including conferences. This resulted in the process being somewhat peripheral to the child protection process, when it really should have produced a decisive set of requirements. The main purpose of the process is to discuss what can be done to help the family care for their children and what help the Local Authority can provide prior to legal proceedings being considered. An internal review accepted that the process was never followed through properly, it lacked teeth and was allowed to peter out. A crucial meeting was aborted and another postponed and the conclusion of the process appears to have been based on the decision of a single social worker, communicated via e-mail. There was evidence of a significant lack of parental engagement throughout the timeline, including non-attendance at case conference and core group, followed by brief periods of compliance. The non-compliance should have been subject of rigorous challenge and a trigger for further legal action. In order to safeguard children adequately, a lack of cooperation with core group/case conference must have consequences. It would appear that initially concerns regarding these issues were communicated via the process, but appeared to lose momentum. There is no evidence to suggest that the family were provided with clear communication that the local authority were seriously considering legal action.

Disguised Compliance

Throughout the timeline there is evidence of sporadic engagement by the parents followed by periods of resistance and unwillingness to deal with partnership agencies. Disguised compliance is an acknowledged method of diffusing professional intervention whereby a parent gives the appearance of cooperating with child welfare agencies to allay professional concerns then reverts to type. This can make it very difficult for all professionals who are involved with a family to maintain an objective view of progress in safeguarding the welfare of a child. In the Victoria Climbie inquiry, Lord Laming (2003) suggested that social workers needed to practice 'respectful uncertainty' applying critical evaluation to any information that they receive and maintaining an open mind.

Throughout this review, there are clear examples whereby the family engaged well, attending a run of health appointments and engaging with child conference processes followed by a period of disengagement. Local authority social services have acknowledged that at times discussions around the family led to staff being "over optimistic about changes in this family".

It was apparent from the documentation collated, that key staff involved with the family remained optimistic in regards to the family's continued engagement, despite a three year significant history demonstrating poor and sporadic engagement at best. From the privileged and independent vantage point of hindsight, there is some concern that professionals became readily over optimistic regarding minor improvements noted within the family setting, where mum partially engaged with services. Practitioners needed to have looked for evidence that demonstrated the change was both genuine and long-lasting.

Quality of supervision is one of the primary factors in encouraging practitioners to develop a critical mind set. The learning event identified that team leaders were carrying significant work-loads themselves and struggled at times to provide consistent supervision to their staff – the Chair highlighted that this was not good practice and was an issue that merited further review by the senior management team at social care to ensure that managers had sufficient time to oversee the more complex cases that their teams were faced with.

Good Practice Issues Identified

Local Authority Social Services

In the respect of the SSD, there was evidence of some good practice from the information and documentation provided and repeated efforts made encouraging parents to comply with health appointments and meet the needs of the child and their siblings. The documentation demonstrates a clear record of compliance with statutory visits and regular core groups. Case conferences were well minuted and discussions appropriately structured. Child protection plans were routinely reviewed highlighting areas of progress and provide a clear indication of improvement areas to be addressed.

BCUHB

There is strong evidence within the timeline and from discussions held within the learning event of good practice in management of the child's asthma from a health perspective. There is clear evidence of close communication between all health professionals involved including the General Practitioner, asthma specialist nurse, school nurse and health visitor. In addition, there is evidence of excellent communication between health staff and external agencies. The school nurse and GP were proactive in relation to arranging and re-arranging missed appointments for the child. An asthma management plan was in place in school and training had been delivered by the school nurse in relation key staff, the child and his parents. There is evidence within the child health records of the school nurse repeatedly trying to reinforce the importance of compliance with asthma medication to both child and parents and attempted to engage the child in their own asthma management.

There is evidence of very contemporaneous documentation within the child health records in line with the NMC code on record keeping and BCUHB information governance. Safeguarding Clinical supervision was provided as per BCUHB supervision policy. Concerns regarding lack of engagement with health appointments were appropriately shared with multi-agency colleagues via phone calls health reports for case conferences and core groups and meetings.

GP records also indicate appropriate discussions and referrals made to social services in light of poor presentation and poor compliance with health appointments.

The records also suggest that missed asthma appointments were regularly followed up and additional appointments made for the child.

Education

The child was reported to be an able and talented individual who appeared to enjoy school. School attendance was consistently low due to poor home routines. School struggled to engage the mother and the step-father was identified as the main point of contact in relation to the children. Education worked well with their multi-agency colleagues, demonstrated good attendance at child protection meetings and made appropriate referrals to local authority social services where there were concerns identified. Education recognised the difficulties in engaging parents, but ensured that the focus remained on the children accessing education regularly via regular discussion with the Education Social Worker and ensuring appropriate support was in place for the children whilst in school.

Conclusion:

This is undoubtedly a tragic and untimely death of a young child who had been subject to both neglect and emotional harm throughout their young life. The child had several health related needs and was reliant on his parents to ensure that he attended appointments with a range of health practitioners. There was clear evidence identified throughout the review process that for a variety of reasons, mainly due to the mother's own health and emotional needs, this was not managed adequately by parents, despite tireless efforts made by a number of key professionals.

There are lessons for practice improvement that can be identified. The child's death was triggered by a severe asthma attack. It is clear within the documentation, that risks associated with the child's condition were well known to all involved from the very first conference in 2012. From this initial involvement, it was clearly emphasised that the parent's primary responsibility was to ensure that the preventive medicine was taken as prescribed and any respiratory problems were to be responded to with medical intervention immediately. However, despite the consistent concerns raised in relation to delayed presentation, poor compliance with medication and medical appointments, the degree to which he did or did not take his asthma medication was never bottomed out, challenged appropriately or monitored robustly enough. There wasn't any systematic monitoring of whether prescriptions were collected, whether inhalers were used and what the true frequency of usage was. The child was consistently described by those who knew them, as a bright and able child with great potential; the department knew that. It is our view that there should have been a more proactive response by all professionals to encourage the child in recording their own usage and being more actively involved in the management of their condition.

The combination of neglect, historical domestic violence, resistant and minimising parents and complex health needs of the child made the management of this family's risks extremely challenging. The reviewers concluded that due to the complexity of the case and the plethora of concerns identified within the family, the child's serious medical condition became lost in the safeguarding process and not enough emphasis was given to the potential consequences of medical neglect.

We are extremely thankful that the mother and step–father eventually agreed to meet with us as the reviewers, as it enabled us to obtain a real sense of who the child was and what they meant to those who loved and missed them dearly. The mother engaged well with the reviewers and it was our understanding that she did not apportion blame to any individuals or agencies involved and on the contrary was grateful for the support that they had provided to her and her family.

It must be acknowledged that this has been a very difficult and emotional process for our professional colleagues who have supported and assisted in an extremely difficult review. Their involvement and co-operation has been very much appreciated.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the North Wales Safeguarding Children Board and it's member agencies:

It has been recognised by the reviewers that individual agencies have already reflected on their practices highlighted within the report and have instigated significant changes in relation to process and practice in order to address some of the concerns raised within the report.

1) We recommend that all agencies should review current practice in order to ensure that the wishes and feelings of children are addressed. Where appropriate children and young people should be given opportunities to contribute directly to decision making and to assessments of need and risk and this should be documented.

2) We recommend that local authority take a clear management stance on Public Law Outline activity with agreed standards for letters and decisions. All written statements of consequences to parents must be followed through and acted upon.

3) We recommend that a multi-agency Public Law Outline Protocol be developed to include a training programme.) We recommend that in order to ensure that consultation with children is at the forefront of all practitioners mindset, a signs of safety approach has been adopted by Local authority Social Services ensuring that the voice of the child is at the heart of all child proceedings.

4) We recommend that all conferences follow a Signs of safety approach to specifying risk, detailing protective factors and clarifying complicating factors and grey areas. A training plan should be developed in relation to this.

5) We recommend the BCUHB assure themselves that their staff apply their policies correctly particularly in relation to the 'Was not Brought' policy.

6) We recommend that where a child on the child protection register is known to have a specific chronic illness or complex health need, they should have an individual health plan that is integrated into the social work assessments and the child protection plan. The plan should record every service/ practitioner involved in the child's care. This health plan should be a standing agenda item for case conferences and core groups.

7) We recommend that where a child on the child protection register is known to have a specific chronic illness or complex health need, a medical practitioner must attend all initial case conferences and reviews. We recommend that some consideration be given to medical representation at core group, but recognise that this may be difficult for BCUHB to resource.

8) We recommend that where a child on the child protection register is known to have a specific chronic illness or complex health need, a named health professional should be identified at the earliest opportunity to take overall responsibility for ensuring that the health needs of the child are being met.

9) We recommend that all agencies re consider their position in relation to standing members only attending initial case conferences

10) We recommend that multi-agency training courses should be put in place to ensure that the importance of strict compliance with conference directives are understood and are fully monitored – this is work in progress.

11) We recommend that the recent good practice instigated by the child's GP surgery, whereby all children on the child protection register are electronically reviewed monthly by their GP to ensure compliance with medication, is disseminated across North Wales.

12) We recommend that all agencies review their staff support systems to ensure that staff are appropriately supported and fully briefed of the process, when they become involved in a Child Practice Review.

13) We recommend a comprehensive review of all team leaders workloads in Social Services to ensure that they have sufficient time set aside to provide consistent supervision to their staff when dealing with complex cases.

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Statement by Reviewer			
REVIEWER			
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.**			
Reviewer 1 (Signature)	S Scott	**Reviewer 2 (Signature)**	
Name (Print)	**Sara Scott**	**Name (Print)**	**Tim Green**
Date	**/2016**	**Date**	**/2016**

Chair of Review Panel (Signature)	
Name (Print)	**Marian Parry Hughes**
Date	**/2016**

Annex 1: Terms of Reference

TERMS OF REFERENCE

EXTENDED CHILD PRACTICE REVIEW

DENBIGHSHIRE 2 / 2015

INTRODUCTION

- This Extended Child Practice Review has been commissioned by the Chair of the North Wales Safeguarding Children Board on the recommendation of the CPR Group on 4th September 2015. In accordance with Safeguarding Children: Working Together under the Children Act 2004' guidance and AWCPP 2008 which have been adopted by the North Wales RSCB.
- A Multi – Agency review panel and review Panel chair has been identified by the Regional CPR Group and independent reviewers have been nominated to undertake the review; Sara Scott, Safeguarding Children Clinical Nurse Specialist BCUHB and DI Tim Green of North Wales Police. Marian Parry Hughes Head of Children and Family Services, Cyngor Gwynedd , BCUHB was appointed as the Chair of the Review panel. This review team will regularly report progress to the regional CPR Group
- Business Manager will be responsible for governance arrangements for the retaining of documentation.

PANEL

Marian Parry Hughes (Chair)	Head of Children and Family Services, Cyngor Gwynedd
Sara Scott, (Reviewer)	Safeguarding Children Clinical Nurse Specialist, **BCUHB**
Tim Green (Reviewer)	Detective Inspector , **North Wales Police**
Eryl Roberts	**North Wales Police**
Colin Tucker	Senior Manager for children services
Wayne Wheatley	Education
Lynda Collier	Clinical Nurse Specialist Safeguarding Children BCUHB
Dr Lindsay Groves	Named Doctor Safeguarding Children, BCUHB
Yvonne Harding	Head of Nursing, Children's Division BCUHB

PURPOSE

- To establish whether there are lessons to be learnt about the way in which local professionals and agencies work together to safeguard children.
- To identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result.
- As a consequence improves inter agency working and better safeguard children.
- Identify examples of good practice.

TERMS OF REFERENCE

The terms of reference agreed for this review are:-

1.	The following agencies will provide a timeline of actions taken by each agency during the 36 month preceding the event (20/6/12 – 20/6/2015) • Denbighshire children services • School Nurse • Paediatrics (Acute - BCUHB) • Paediatrics (Alderhey) • Education • Police • GP
2.	A summary/analysis of each agency's involvement will also be produced by the above services. This will include additional background information from outside the timescale for the review as well as initial analysis of the key issues involved, an indication of further issues for consideration by the Reviewer and any recommendation if appropriate.
3.	Other services may be asked to provide a timeline following review of the information provided.
4.	Determine whether decisions and action taken in the case comply with local and national policies and procedures.
5.	To examine inter-agency working and service provision for the child.
6.	To determine the extent to which decisions and actions were child focused
7.	To consider whether previous relevant information or history about the children and/or family members was known and taken into account in professionals' assessments,

	planning and decision making in respect of the child, the family and the circumstances. How did this knowledge contribute to the outcome for the children?
8.	To consider whether the Child Protection Plan and looked after child plan was robust and appropriate for that child, the family and the circumstances.
9.	To consider whether the plan was implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development of the multi-agency plan.
10.	To identify what aspects of the plan worked well and those that did not work well and why?
11.	To identify the degree to which agencies challenged each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child
12.	To determine whether the respective statutory duties of agencies working with the child were fulfilled?
13.	To identify any obstacles or difficulties in this case that prevented agencies from fulfilling their duties (organisational issues and other contextual issues)
14.	The Reviewer is to consider contact with the family, to apprise them of the review, ascertain the degree of involvement they want in the review and keep them informed of key aspects of progress.
15.	If any features of the case, indicates that any part of the review process should involve or be conducted by an independent party this should be referred immediately to the Review Chair and Regional CPR Chair.
16.	Identify any parallel investigations (for example, disciplinary, inspectorate investigations) of practice and determine if a co-ordinated approach will address all the relevant questions.
17.	To hold a learning event for practitioners and to liaise closely with North Wales Police and Crown Prosecution Service in relation to hosting the learning events and discussion points at the event.
18.	The Reviewer will produce a succinct Review Report with learning points and issues in accordance with 'Protecting Children in Wales 2012'.
19.	The Reviewer will share the findings of the review with the family.
20.	The Review Panel will identify the learning points and issues and will consider all actions if required
21.	The Review Report will be presented by the reviewer and Chair of the review panel to the Regional CPR Group and NWSCB.
22.	The Chair of the NWSCB will be responsible for making all public comment and response should there be any media interest concerning the review until the process is

	completed. Also consider whether there is a need for the public disclosure of information.
23.	The Regional CPR group and the Review Panel will seek legal advice on all matters relating to the review as necessary. In particular this will include advise on:- TOR DISCLOSURE TIMESCALES DATA MANAGEMENT Ceri Williams will be the Panel's legal advisor
24.	Panel Members will destroy all notes/paperwork relating to the review once the process has finished. All information relating the review will be stored by the Business Unit. Information will be stored securely and in accordance with their retention and data protection policies.
25.	All correspondence will be sent by e mail and will be password protected or sent via a secure e mail system. The use of initials or any other personal information that contravenes data protection guidance will not be used to identify the child or family outside of secure communication channels.
26.	Panel members will not share information with any third party without the permission of the Chair.
27	Is there evidence to support the decision making?..... To review whether the decision making of all agencies was robust and that the evidence is available to support this decision making