Child Practice Review Report

Western Bay Safeguarding Children Board

Concise Child Practice Review

WB B 7/2013

Brief outline of circumstances resulting in the Review:

Legal Context:

A Concise Child Practice Review was commissioned by The Western Bay Safeguarding Children Board (WBSCB) on the recommendation of the Child Practice Review Management Group (CPRMG) 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 a concise 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 health or development;

And

the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding:

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

The criteria for concise reviews are laid down in the Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.

Circumstances Resulting in the Review

A concise review was commissioned by the chair of the Western Bay LSCB, on the advice of the Child Practice Review Sub-Group, the purpose of which was to:

- Establish whether there were lessons to be learned about the way in which local professionals and agencies work together to safeguard children;

- Identify clearly what those lessons were, how they can be acted upon and what changes could be expected as a result;
- Improve inter-agency working and better safeguard children;
- Identify examples of effective practice.

This review covers a period of 12 months – 6 months pre birth and 6 months following the birth.

The review was undertaken following a baby's emergency admission to hospital. The baby presented with unexplained bi-lateral bruising to the face and a subdural haematoma (bleed in the head between the brain and the skull). The baby made a full recovery and permanence plans outside of the family have now been secured.

The baby lived in the family home with mother, older sibling and mother's new partner. During the period of the review, the baby was known to the midwifery and Flying Start Health Visiting Service.

During this time, following a referral to Social Services, via South Wales Police, an Initial Assessment was completed and a child in need intervention commenced. The aim of this intervention was to assist the family with parenting advice and support. The baby's presentation in hospital occurred 8 weeks after the referral was received.

Birth Family Involvement

Birth mother did not respond to an invitation to contribute to the review, however this coincided with the final contacts and plans of permanence for the baby and it is recognised that this would have been an extremely difficult time for her.

Birth father on the other hand was keen to discuss his views. The role of the Western Bay Safeguarding Children Board (WBSCB) and the purpose of the review was explained to the birth father. He stated that he felt that before the incident he had not been listened to by professionals. He stated that he had rung social services anonymously on several occasions and in his opinion nothing was done. He also said he had spoken to the Heath Visitor who had advised him that "everything was ok". He stated that although he knew Social Services were involved with the family he was not clear about what they were doing and he hadn't met the Social Worker.

Practice and organisational learning

The Learning Event was attended by professionals who had been involved with the family during the review period. Those present at the Learning Event considered that it would have been beneficial for the GP to have been present at the Learning Event or for the views of the GP to have been ascertained to feed into the learning. A discussion took place with the GP following the Learning Event.

This review identified some key learning points and areas of effective practice which focused on the following areas:

1. **Joint Screening Process**

A Public Protection Referral Form (PPD1) is completed by the Police when an incident they deal with involves issues of domestic abuse (child abuse or POVA concerns). At the time of the first referral to Social Services, the PPD1 was considered by the joint screening process. The review heard how, the Police telephoned the duty senior Social Worker, to discuss the issues/concerns and the decisions are recorded on a secure file and not on the DRAIG system (the computer system used by the Local Authority). If the concerns warrant intervention then they proceed to a referral. It was evident that staff would not necessarily have access to this earlier screening information when considering any new information received in respect of the family in the future.

2. **Public Protection Referral Form (PPD1s) and how they are shared with agencies**

Files indicate that the Public Protection Referral Forms (PPD1s) were forwarded to Health; however, the health visitor did not receive it. Staff raised the following points at the learning event;

- whether there was a central point where all PPD1s were initially sent within Health
- how the PPD1's are then disseminated?
- whether checks are made in relation to whether PPD1s are actually received by the intended recipient.

3. **Challenges for staff involved**

It was noted that the post natal wards in maternity units were very busy. There were frequent changes in members of staff and this impacted on the continuity of care. Staff recognised that co-location of midwives with Health Visitors and GPs (as was common previously) aided more effective communication.

Currently, midwives and health visitors use different IT systems. Sharing a common system would assist working practices. For those professionals with no fixed base, access to technology and devices which allow easy recording of information was considered as invaluable. This is particularly critical when there is more than one practitioner involved with a family.

4. **The role of the family**

It was not evident that family members had been included in Child in Need planning during the Children In Need (CIN) processes. It is not documented how much information was gathered during the CIN process and it would be expected that such information would be gathered and documented.

5. **Parental health issues**

The Perinatal Response and Management Service (PRAMS) is a specialist team within ABMU Health Board working with women with significant stress and other mental health problems around pregnancy and up to a year after birth. Mother missed the appointment with PRAMS and was therefore discharged.

It was noted that Mother had previously been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). However it was not clear whether the GP was aware of concerns and any interventions in place.

6. **Evidence of effective collaborative working and communication between professionals**

It was identified that the sharing of information was appropriate and practitioners were seeking and giving advice to one another.

Improving Systems and Practice

Joint Screening Process

Since this review changes have taken place within the Local Authority's safeguarding screening and allocation processes. The screening out of possible Domestic Abuse cases in the police station no longer takes place and the book that was previously kept by the Social Services duty desk where enquiries/concerns were being logged no longer exists.

All referrals and contacts are put onto the electronic system and not printed and filed as was previous practice. If they are received on paper they are scanned on to the computer system. All referrals and contacts are electronically screened and actions and outcomes are recorded electronically.

Public Protection Referral Forms (PPD1s)

The process undertaken to pass the Public Protection Referral Forms (PPD1s) from the Police requires a mechanism within receiving agencies to ensure that PPD1s sent, are received by the central information points within key agencies and passed to relevant staff.

Challenges for staff involved

Adherence to the All Wales Child Protection Procedures should be used to strengthen and develop structures and forums to promote and facilitate inter-agency working. If a practitioner is unable to attend Child Practice Review Learning Events it would be advantageous for the guidance to be amended to allow for individual interviews to take place with the reviewer before the learning event to enable their views to be shared and explored.

Location of staff and IT systems are, beyond the remit of this review, however, issues remain which need to be addressed when considering reviews or their structures. It is recognised that a single health IT system would be advantageous however unlikely to be developed in the near future.

Role of the family

During the Child Practice Review process the evidence of any active role of the extended family was not present in records or through the practitioners attending the learning event.

Parental health issues

Following the Learning Event the GP confirmed that the Practice now has weekly meetings where the GP's and Health Visitors (and Midwifes when relevant) meet to discuss families they have safeguarding concerns about.

However, at the time of the review, when a Pregnancy Information Sharing Form was received by the GP it was unclear how this information informed GPs' contact with parent(s) and partner.

It was identified the communication between the Health Visitor and Midwife, in this case was proactive and appropriate.

Statement by Reviewer(s)			
REVIEWER 1 **Nichola Rogers** **Principle Officer** **Child & Family Services** **City & County of Swansea**		**REVIEWER 2** ***(as appropriate)***	N/A
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	

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<td colspan="2">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.</td>
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<td>Name
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<td>NICHOLA ROGERS</td>
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<td colspan="4">Chairman of the Board ……………….
(Signature)
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(Print) Nick Jarman
Date 8.12.14</td>
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Appendix 1: Terms of Reference

Western Bay Safeguarding Children Board

Terms of reference for concise practice review WB B 7/2013

Scope of Review 21st May 2012 – 21st of May 2013.

Internal Reviewer - Nichola Rogers, Principal Officer

Chair of Panel - Andrea Warlow, Named Doctor Andrea Warlow, ABMU Health Board

South Wales Police

Bridgend CBC, Safeguarding and Family Support

Abertawe Bro Morgannwg University Health Board-Health Visiting

Abertawe Bro Morgannwg University Health Board – Midwifery

Following the first Panel meeting timelines were produced by agencies and merged. The Learning Event included key professionals however it was not possible to have the lead social worker who is no longer working in the local area. The family were offered the opportunity to meet with the Reviewers before the Learning Events so their thoughts and feelings about the way agencies worked with them could be fed into the events. Birth mother did not take this opportunity up however discussions took place with birth father by telephone.

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and WSCB.
- Was the Child in Need plan effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of the multi-agency plan?
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

In addition to the review process, to have particular regard to the following:

- Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances? How did that knowledge contribute to the outcome for the child?

• Was the Child in Need Plan effectively implemented, monitored and reviewed? Did all agencies contribute to the development and delivery of the multi-agency plan?

• What aspects of the plan worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked? Were the respective statutory duties of agencies working with the child and family fulfilled?

• Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues?

• Were the statutory duties of all agencies fulfilled?

Specific tasks of the Review Panel

• Identify and commission a reviewer/s to work with the review panel in accordance with guidance for concise and extended reviews.

• Agree the time frame.

• Identify agencies, relevant services and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.

• Produce a merged timeline, initial analysis and hypotheses.

• Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.

• Plan with the reviewer/s contact arrangements with the child and family members prior to the event.

• Receive and consider the draft child practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

• Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the WSCB for consideration and agreement.

• Panel members to carry out own analysis to contribute to review.

• Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Western Bay Safeguarding Children Board

• Consider and agree any Board learning points to be incorporated into the final report or the action plan.

• Review Panel to complete the report and action plan.

• WSCB send to relevant agencies for final comment before sign-off and submission to Welsh Government.

• Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

• Plan publication on WSCB website.

• Agree dissemination to agencies, relevant services and professionals.

• The Chair of the WSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Appendix 2: Child Practice Review process

This family were considered by the CPMRG where it was agreed the criteria for a concise Child Practice Review was met.

Internal Reviewer	-	Nichola Rogers, Principal Officer
Chair of Panel	-	Andrea Warlow, Named Doctor ABMU Health Board

Panel Members Included From the Following Agencies:

South Wales Police

Bridgend CBC, Safeguarding and Family Support

Abertawe Bro Morgannwg University Health Board-Health Visiting

Abertawe Bro Morgannwg University Health Board – Midwifery

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Date information received ………………………………………………………………..

Date acknowledgement letter sent to LSCB chair …………………………………….

Date circulated to relevant inspectorates/Policy leads ……………………………….

Agencies	**Yes**	**No**	**Reason**
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	