Child Practice Review Report

Western Bay Safeguarding Children Board

Concise Child Practice Review

WB B 15 2014

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 5.1 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:

(a) died; or
(b) sustained potentially life threatening injury; or
(c) 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 incident referred to above; or
- the date on which the Local Authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

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

Circumstances Leading to the Review

In the early hours of one morning over the Christmas and New year period of 2014 the child subject of this review died. This child was known to have special needs. At post mortem examination it was found the child had died of peritonitis. The onset of peritonitis can be rapid in young children and the conclusion of the pathologist was that it could not be concluded that the child had died due to neglect of the child's medical needs. However, subsequent to the child's death the other children in the family were removed from the family into local authority foster care.

Following lengthy debate by the Child Practice Review Management Group the recommendation was made to the Chair of the Western Bay Safeguarding Children Board the criteria for a Child Practice Review (CPR) had been met on the basis, not due to any neglect of the health needs of the child that had died, but that as a result of her death the long term neglect of the needs of all of the children living with mother was identified and resulted in their removal from her care. The family were well known to services, with two of the elder children being with maternal grandparents, one as kinship care and the other under a special guardianship order (SGO). At the time of the index child's death they were also responsible for supervising the mother's care of the four youngest children 24 hours a day albeit the children were living in their own home with mother. The mother's eldest child, who lives with her paternal family, is not subject to this review.

The scope for this review was 1st June 2013 – 17th July 2014.

Family Background.

The mother has seven children from four relationships. The mother is considered to have learning difficulties and struggled with the parenting of her children.

The Learning Events

Two learning events were held, one for practitioners and one for managers. Both were well attended

Practitioners' Event was attended by 22 staff members from the following agencies:

South Wales Police
Education
Social Services
Legal Bridgend County Borough Council(BCBC)
Flying Start
Health

Managers' Event was attended by 9 staff from the following agencies:

Flying Start
Health
Hafan Cymru – Housing
South Wales Police
Fostering
Action 4 Children

Some key managers were absent either due to having moved jobs or were on sick leave. This resulted in agencies identifying other professionals to attend in the absentee's place that had had no direct contact with the family.
The GP for the family was unable to attend the learning event but met with the reviewers for a professional discussion to inform the review. The reviewers also met

with the relevant local authority team manager who now works out of area.

The family were contacted and offered the opportunity to meet with the Reviewers to discuss their thoughts and feelings in relation to the services they had received from agencies. The family declined this invitation as they are still grieving for the loss of the child and considered the meeting would have been too difficult. The family were contacted again prior to publication of the report in order to share the findings of the learning with them.

Practice and organisational learning

Areas for improvement:

Communication /information sharing

Unfortunately it is not unusual for information sharing between agencies to be highlighted as an area of concern in Serious Case Reviews/Child Practice Reviews. This was evidenced at the learning event where there were a number of issues that fell into this category, including:

- Children's Services did not know of some other agencies' information.
- Schools were not aware of concerns and did not know other agencies' information in relation to the elder children.
- Police involvement was not known by some agencies.
- It would appear the Christmas period had a negative effect on information sharing.
- Fostering Service did not know any information relating to the recent concerns until just before Christmas
- Information known within health was not always shared appropriately and there was inconsistency in reporting.
- There could have been more involvement with disabilities teams

No individual agency had a full picture of what was going on within this family and in some cases information was not shared within their own agency

It was identified there needs to be a consistent approach to sharing Public Protection Notifications (PPNs) within schools with regards to domestic abuse. Participants at both events considered it was crucial that staff working with children where there have been PPNs should know about these so that they can be aware and sensitive to any behaviour changes in relation to the children. The process regarding PPNs within schools appeared to vary and relied on Head Teachers' discretion. PPNs were shared with schools but in some areas filed away and not always shared appropriately with teachers which could have a detrimental impact on the safeguarding of children.

Record Keeping

- Referrals to Children's Services should be recorded in the Records of every child within the family.

- There must be consistent processes for recording referrals within agencies.
- It was identified that Children's Services information systems do not allow for whole family information e.g. Status of children in LAC placement. This is considered to be a barrier to effective working with families.
- Referrers need to be reminded that any telephone referral should be followed up in writing within two working days.

Supervision

- There is a need for regular safeguarding supervision for practitioners in all agencies who work with families of concern. Both practitioners and managers identified the need for robust safeguarding supervision practices.
  The social worker for the family considered the supervision she received was not adequate for her needs and experience.

Flying Start

- There appeared to be a sense of complacency that because this family were in a Flying Start area this would act as a safety net and the children would be protected. Professionals working with children especially within Flying Start teams need to be mindful of this perception.

Good enough parenting including parents with a learning disability and children with global delay

What is good enough parenting?

- There was much discussion on this topic at both learning events and at panel meetings. It is important to remember there needs to be two parts to any assessments made, in order to conclude whether parenting is good enough; recording the history and analysis of the information.

- Some professionals knew the family and circumstances well. The mother was considered to be 'a nice woman' she and the family did not 'stand out' within the demographic area. It appeared any 'risks' were accepted as being the norm. Professionals saw the family as being of low to medium need based on the home conditions. Professionals involved, participated in a number of 'doing for' tasks such as folding clothes and tidying up and not actually assessing the risks to the children.

- The index child had special needs and the mother has learning difficulties and therefore although her parenting may have been deemed 'good enough' for some of her children this may not have been the case for the child with special needs. Participants at the learning events considered guidance is needed to help assess interventions with children with developmental delay. Also when a parent has learning difficulties, it is important to establish how these may impact on their ability to parent their child/ren. Therefore a formalised assessment such as Parenting Assessment Manual Software (PAMS) may be required. This mother had had an assessment in a mother and baby unit following the birth of

one of the older children. However it would appear there had been no consideration given to the need for a new assessment in respect of subsequent children.

Consent to share information

- The issue of consent to share information with other agencies and data protection issues needs to be clarified. There appeared to be a mis-held belief that information could not be shared with other agencies at 'Child in Need level' without the family's consent. Lord Laming made it very clear following the Climbie Inquiry (2003) that this is not the case but it is important to record the justification for sharing information.

Agencies understanding of kinship foster care

- During the learning events it became apparent that not all agencies were aware of the criteria/competencies required to be a registered foster carer and that they are at a higher threshold and therefore different than those required for kinship care. Placing a child with a family member may be preferable as it keeps the child within the family unit, however this should not be at the expense of ensuring the safeguarding of the child.

High risk v high need :Thresholds for concern especially re: neglect issues:

- Neglect is the most common reason children are made subject to child protection plans, albeit it could be argued that for a child's name to be made subject to a plan under this category it takes much longer than for a child to be made subject to a plan under the category of physical or sexual abuse, where one such incident could result in such a plan. This is often due to what is described as the failure to address the cumulativeness of neglect in reaching the threshold for a plan (Ayre (2010).)The understanding of 'what is good enough' is very subjective in that what is good enough for one group of professionals is not for another, as is the demography of an area, where the threshold for intervention can be higher than in other areas. Furthermore neglect is very complex; Howe (2006) identifies 4 forms of neglect: Emotional neglect, disorganised neglect, depressed and passive neglect and severe deprivation. The definition for neglect is usually referred to as the persistent and severe failure to meet a child's needs. This does not mean the neglect has to get progressively worse; the threshold can be met by the neglect concerns not getting any better despite professional intervention. It is noted, The Social Services and Wellbeing (Wales) Act 2014 has amended the definition and removed the word 'persistent' from the definition of neglect.
  The implementation of a formalised neglect assessment tool (such as The Graded Care Profile) with the commitment from all agencies to use it is needed across Wales. Alistair Davey (WG), identified in answer to a question posed at a Four Nations safeguarding conference in Cardiff in November 2015 that this should be in place by 2016.

Resolution of Professional Differences Protocol:

The Reviewers are mindful that this review has again highlighted a lack of awareness of this protocol as the following comments were made by participants:

1. Agencies requested 'a professionals' meeting" or strategy meeting and this was not granted by the Local Authority.
2. The same agencies did not consider their concerns were listened to when their level of concern was high.
3. A social services manager advised on two occasions that the requests did not warrant strategy meetings due to existing processes already in place.
4. Three months before the child's death, Health Visiting raised their assessment of need for professional intervention to high but considered their concerns were not listened to by partner agencies**.**
5. The social work manager for the social worker involved with this case did not recall that partner agencies raised concerns with her directly.

Unrealistic expectations of carers

- Participants noted their concern for the grandparents and that they were already under pressure with the kinship arrangements for the foster care of the eldest children. The grandparents were concerned about their ability to cope with the supervision arrangements required by them when mother returned to the family home with the younger children. These practicalities do not appear to have been addressed. For example it became clear through discussion after the death of the child, the grandfather did not fully understand what was meant by 'supervision'.
- There was a prevailing sense of optimism, potentially putting the children at risk and the expectation of mother's capabilities were not fully assessed.
- Midwife / Health Visitor / Flying Start knew most of the family information and felt reassured that there was a high level of family support and that supervision within the family would be adequate.

Perceived isolation of staff member under pressure

- One of the social workers was having difficulties within the team. It was noted the original plan for the social worker was to be office based and to catch up on paperwork and be relieved of front line work for a month but the social worker only completed two weeks of this plan preceding the child's death. The social worker considered that her caseload was unmanageable and that communication with management was poor. From the manager's perspective, she identified the social worker required additional support which she was given. She considered her decision to give the social worker space to catch up with her work was meant to be supportive and not punitive. However this was not how the social worker perceived it.

Structural Issues within the Local Authority

- The social work manager's recollection was that there was not enough staff to manage the caseloads. There was a significant level of staff sickness some of which the team manager identified as 'stress related'. Social workers were expected to carry caseloads which were significantly higher than the 18 cases which Lord Laming noted as being too high during the Victoria Climbie Inquiry. It is noted that another CPR undertaken in the same local authority also identified that social workers carried caseloads higher than recommended. It was also noted the team manager was under the impression the local authority's policy was not to employ agency staff. The local authority confirmed they have no such policy and agency staff were and continue to be employed when there is a demand on the service. The team manager also identified a high level of sickness across teams, not just in the assessment Team. This had an impact on the transfer of cases to other teams.

  With regards to the number of cases held by Social Workers within the Assessment Team, records show that the average caseload held at the time of the child's death was 20, with a number of workers having less than 10 cases. However, it is acknowledged that the Social Worker allocated to the child's case did have a higher caseload at this time. The Social Worker was allocated time to 'catch up' to enable her to close cases in order to reduce her caseload.

Areas where improvements have already been made

- Flying Start information can currently be recorded as a case note on DRAIG system (internal IT system) and this process will continue when Bridgend changes to the Welsh Community Care Information System (WCCIS) in April 2016.
- WCCIS: the business and technical design of the system will be citizen centred and will allow professionals to access and share information across organisational boundaries. The system has many benefits:
- Improve decision making – WCCIS will allow 24/7 access to records and information. Creating an information rich picture which can be reviewed at any time – supporting out of hours and other emergency services access to client data and processes.
- Improve coordination – WCCIS will enable health and social care services to work more closely and in a better coordinated way, where information is more easily shared and therefore better supports integrated working.
- Improve patient and service user safety – WCCIS will have the functionality to support a common referral process that will facilitate single point of entry across the whole system for initiating care and support referrals that will streamline and reduce complexity of current multiple referral processes.
- WCCIS will allow the use of suitable mobile devices to allow complete system access from all possible working locations.
- Reduce duplication in data capture and enable easier information sharing by the creation of a single citizen record for both health and social care.

Since this review commenced safeguarding social work teams have been relocated into multi-agency community hubs to improve locality working, joint working and assist in the sharing of information between agencies and professionals.

An internal audit of supervision has been added to BCBC's audit work plan.

The Resolution of Professional Differences Protocol has been redistributed to all Practitioners across Safeguarding within BCBC and ABMU Health Board.

Improving systems and practice

Recommendations

- **Flags/Alerts on GP systems**

  The GP practice associated with this case has a system which will alert the GP to the fact that a child is on the Child Protection Register and/or has been subject to a child protection conference. This is deemed as an example of expected practice and should exist within all GP practices.

- **PPNs in schools**

  A consistent approach should exist with regard to the dissemination of PPNs across all schools in the Western Bay Safeguarding Children Board area so that relevant information is shared with the children's teachers appropriately.

- **Initial referral being recorded on all children's records**

  Any referral recorded on a child needs to be linked to any other children in the family and recorded on their records too – 'Think child/ think family'. Since this case some changes have already been made but the continual need to be inquisitive is essential.

- **Global Delay/"Good enough Parenting"**

  Ensure there are guidelines on good enough parenting and how this may impact on developmental delay; and in addition, develop guidance in relation to the implications for parents with learning difficulties and whether they are able to achieve 'good enough parenting' for a child with developmental delay.

- **Manageable social work caseloads**

  There is a discrepancy in opinion between the team manager and the local authority in relation to caseload size albeit it is acknowledged there were issues regarding long term sickness and its impact on the service. The team manager

reported there was an expectation that they should be able to cope with high caseloads'. It is noted in the Local Authority report that it currently employs a number of agency staff and as noted previously did so at the time of this child's death. Caseloads can fluctuate but they are monitored regularly by senior managers and in regular performance meetings chaired by the Director and this should continue.

Reminders of existing practice

- **The need for regular safeguarding supervision across all agencies**

  To reinforce the importance of safeguarding supervision within all agencies and to be assured of implementation with regular auditing processes to support this.

- **Consent/information sharing/Data Protection**

  To reinforce principles of these issues not just across agencies but within disciplines as well. For example between community midwife and hospital midwife or between LAC social worker and child & family social worker.

- **Joint working arrangement**

  The need for a joint approach to practice across partner agencies when working with children and their families. When professional concerns are identified, clear structures need to be in place so that the best outcomes for the children are achieved.

- **Non-attendees at health appointments/DNA – Did Not Attend**

  A protocol has been developed within ABMU Health Board to address this and DNA has been changed for children not attending appointments to WNB – 'was not brought'. Although this is a positive step, this is relatively new and needs to be embedded into practice. A future audit of this would be useful to ensure implementation of this protocol.

- **Consistent processes for recording referrals**

  The WCCIS system when introduced in April 2016 will allow the creation of referrals on sibling files and enable greater oversight of the connections between relations and the involvement of different teams based within Social Services.

<u>Current situation and conclusions</u>

At the outset of this review it was identified that the index child's death was not considered to be due to neglect of her medical needs, however subsequent to her

death her siblings were taken into Local Authority care. Therefore this review does not suggest that the death of this child was preventable. However if she had not died appropriate protective action may not have been taken at the appropriate time for the wider sibling group and according to the views of the attendees at the learning event, the case may have continued to drift.

This review has identified a number of recurring learning issues and it is therefore essential these are addressed as soon as possible and should not wait for the publication of this report.

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<tr><th colspan="4">Statement by Reviewer(s)</th></tr>
<tr><td>REVIEWER 1</td><td></td><td>REVIEWER 2 (as appropriate)</td><td></td></tr>
<tr><td colspan="2">Statement of independence from the case
Quality Assurance statement of qualification</td><td colspan="2">Statement of independence from the case
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<tr><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><td colspan="2">I make the following statement that prior to my involvement with this learning review:-

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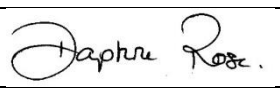
(Signature)</td><td>  </td><td>Reviewer 2
(Signature)</td><td></td></tr>
<tr><td>Name
(Print)</td><td>DAPHNE ROSE</td><td>Name
(Print)</td><td>VIRGINIA HEWITT</td></tr>
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Chair of Review Panel

(Signature)

Name
(Print ……LORNA PRICE…….

Date

Family members

Mother aged 35 years
Maternal Grandfather aged 57 years
Maternal Grandmother aged 55 years

Index child (5th child in family) aged 4 years at time of death

Sibling

Child 6 Sibling aged 2 years 9 months

Half siblings

Child 1 The eldest child of the family has not been included in this review due to her separate long term living status and lack of involvement with her maternal family

Child 2 aged 13 years
Child 3 aged 10 years
Child 4 aged 8 years
Child 7 aged18 months

Fathers

Father of children 1 and 2 aged 34 years
Father of children 3 and 4 aged 28 years
Father to index child and child 6 aged 36 years
Father of child 7 aged 26 years

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the Western Bay Safeguarding Children Board.

- Examine inter-agency working and service provision for the children and families.

- Determine the extent to which decisions and actions were child focused.

- 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.

- 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?

- Were plans effectively implemented, monitored and reviewed? Did all agencies contribute appropriately to the development and delivery of any multi-agency plans?

- What aspects of the plan(s) worked well, what did not work well and why? To what degree did agencies challenge each other regarding the effectiveness of the plan(s), 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?

Specific tasks of the Review Panel

- The Chair for this Panel is Dr Lorna Price Paediatrician and Designated Doctor for Safeguarding Children Service (Public Health Wales). Daphne Rose Designated Nurse for Safeguarding Children Service (Public Health Wales) will be the independent, internal reviewer for this case and will be shadowed for the purpose of professional development by Virginia Hewitt Head of Safeguarding Children (ABMU HB). All have declared independence from this case.

- The timeframe has been agreed to be a 12 month period with a brief synopsis of history prior to this if known within the agency. It was agreed the review needed to capture the birth of the youngest child as well as the subsequent care proceedings following the death of the index child and therefore dates are set for the scope to be: 1st June 2013 – 17th July 2014.

- The relevant agencies and services to be represented and required to contribute is as follows:

  BCBC – Children's Services
  BCBC – Education
  Abertawe Bro Morgannwg University Health Board (ABMUHB)
  Flying Start
  Welsh Ambulance Service NHS Trust (WAST)

  Action for Children

- 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's 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 WBSCB for consideration and agreement.

- 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 complete the report and action plan.

- WBSCB 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 CPRMG, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on WBSCB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Board will manage any media interest and enquires in accordance with its Media Management Protocol and relevant LA communications officer(s).

For Welsh Government use only

Date information received ……..

Date acknowledgement letter sent to LSCB chair ……

Date circulated to relevant inspectorates/Policy leads …….

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