

Child Practice Review Report

Western Bay Safeguarding Children Board

Concise Child Practice Review

WB B 20/2015

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.

Circumstances Leading to the Review

This review considers the circumstances of a 17 month old baby who was admitted to hospital in the summer of 2015 following a medical referral from her GP after a 3 week history of recurrent vomiting. The baby was found to have sustained a number of injuries, many of which were considered at the time to be non-accidental in origin. The baby's parents/ carers were unable to give a satisfactory explanation for the injuries at that time.

The injuries included :

- a fracture to the left occipital area of the skull

- a bulgy swelling measuring 5cm x 3.5 cm on the left corresponding to the area of the fracture
- Bruise 1cm in diameter on the right side of the forehead
- Two sets of bruises on the upper part of knee cap each measuring 0.5 cm in diameter.
- Two sets of bruises on the lower back either side of the spinal process
- Two other bruises 0.5cm to the left of the upper back below the shoulder blade
- A 0.5cm bruise lateral to the spinal process on the right below the shoulder blade
- A nail-bed haemorrhage on the ring and little fingers of her left hand
- Bilateral papilloedema with peri-papillary haemorrhage

The police instigated a criminal investigation into the injuries, during this time the Child Practice Review Learning Event was suspended. During the course of the criminal investigation and several months into that investigation the mother disclosed that the child had fallen down the stairs around the time the injuries were sustained. She said that it was “panic” on her part that prevented her from providing the explanation at the time. Medical opinion was sought, which concluded the injuries could be consistent with the history of such a fall. As a consequence no criminal proceedings were instituted. The Western Bay Safeguarding Children Boards’ Child Practice Review Management Group had concluded at the time of the referral, the case met the criteria for a Concise Child Practice Review.

Family Background.

The mother and father of the child are separated and their relationship was acrimonious involving some reported violent and aggressive behaviour. At the time of the child’s injuries mother was in a new relationship. There was a history of domestic abuse in her partner’s previous relationships. However the status of his relationship with mother and whether they were living together is unclear.

Mother had been attending the GP for her own health needs on a regular basis. She suffered with low mood and had been referred to Primary Mental Health Services and to the Perinatal Response and Management Service (PRAMS) service by her GP, but did not take up the PRAMS service. Professionals identified evidence of cannabis use within the family home. Mother and child attended the local Flying Start facilities. The child was seen by the health visiting service within the Clinic setting. She was not seen within the home setting due to being in an ‘empty health visiting caseload’ i.e. no assigned Health Visitor to that practice at that time.

Current Situation

The child now lives with her birth father.

Parents were seen as part of this review and their views regarding the services provided to them are included in the learning.

The Learning Event

An interagency timeline of agencies interventions was produced to inform the learning event. A summary timeline can be found at appendix 2.

Learning Event Attendees included staff members from the following agencies:

ABMUHB Health staff x 3
GP x1
Children's Social Care x 6
Police x 2
Flying Start x 2
Action for Children x 3

Practice and organisational learning

Areas for improvement:

Communication /information sharing

Mental ill health

- Mother had been prescribed medication for her mental health by her GP after the baby was born. Primary mental health services saw her twice and then referred her to the Perinatal Response and Management Service, with whom she did not engage and a copy of the discharge letter from PRAMS was sent to the HV. Practitioners across agencies identified they have an ongoing problem with liaison with mental health services.
- It was acknowledged that there are regular meetings within the GP Practice to discuss families, but these focus on child protection concerns rather than the wider concept of families in need and safeguarding. It was acknowledged that the Practice intends to address this and where there are parental concerns such as mental ill health issues, these will form part of the discussions with relevant staff such as Health Visitors, Midwives and or school nurses.
- Mum confirmed with the Reviewer she remains on medication for depression and anxiety

Removal into foster care:

- From the parent's perspective concerns were expressed about the manner in which their child was discharged from hospital into foster care. Neither of them considered it was necessary and they both expressed concerns that when they had independently of each other contacted the hospital to enquire after their

daughter's wellbeing they had not been informed she was to be discharged to foster care later that day

Parenting classes

- Father identified when attended parenting classes with Flying Start saying he had expected this to be 'a hands on' course where parents would learn by example and thought it would mean the opportunity to spend time with his child. However this was not the case as it was 'taught session' and the child was in a crèche. Mother said she found them useful and enjoyable, however it is noted the child was living with her so she did not need the contact with her child in the same way as the father had wanted it.

PPD1s

- It was noted that mother's new partner/friend had been involved in a number of incidents in previous relationships where the police were called and PPD1's (notifications from police) were completed. In the majority of cases these were appropriately shared with partner agencies. It is however pertinent to mention that since this time a PPD1 is now referred to as Public Protection Notification (PPN). The process has also changed and the police complete a PPN in every domestic abuse related incident, which are risk assessed to identify those that should be shared with other agencies. If the incident involved a concern for a child then the PPN would be shared on a Multi Agency basis.
- When parents were living apart (Cardiff and Bridgend respectively) and there were domestic abuse issues police appropriately sent PPD1s to both Cardiff and Bridgend.

Consent issues

- During the learning event it became clear that practitioners had differing views and understanding on the need for consent to share information with other agencies if a child protection threshold has not been met. They were anxious that the Social Services and Well Being (Wales) Act 2014 would suggest this is not allowed, whereas what is important is that families are advised of the need to share information when practitioners consider it is justifiable. (Laming 2003- Victoria Climbié Inquiry at 1.46 of his Report states "*However, I was told that the free exchange of information about children and families about whom there are concerns is inhibited by the legislation on data protection and human rights. It appears that, unless a child is deemed to be in need of protection, information cannot be shared between agencies without staff running the risk of contravening this legislation. This has two consequences: either it deters information sharing, or it artificially increases concerns in order that they can be expressed as the need for protection. This is a matter that the Government must address. It is not a matter that can be tackled satisfactorily at local level*".

Recommendation 13 *The Department of Health should amalgamate the current Working Together and the National Assessment Framework documents into one simplified document. The document should tackle the*

following six aspects in a clear and practical way:

- It must establish a 'common language' for use across all agencies to help those agencies to identify who they are concerned about, why they are concerned, who is best placed to respond to those concerns, and what outcome is being sought from any planned response.*
- It must disseminate a best practice approach by social services to receiving and managing information about children at the 'front door'.*
- **It must make clear in cases that fall short of an immediately identifiable section 47 label that the seeking or refusal of parental permission must not restrict the initial information gathering and sharing. This should, if necessary, include talking to the child.***
- It must prescribe a clear step-by-step guide on how to manage a case through either a section 17 or a section 47 track, with built-in systems for case monitoring and review.*
- It must replace the child protection register with a more effective system. Case conferences should remain, but the focus must no longer be on whether to register or not. Instead, the focus should be on establishing an agreed plan to safeguard and promote the welfare of the particular child.*
- The new guidance should include some consistency in the application of both section 17 and section 47. (Paragraph 17.111). This review considers this advice is still pertinent to current practice.*

Domestic Abuse

- Both parents confirmed the domestic violence issues between the child's mother and father (the child now lives with her father). These included mother accusing him of 'trashing her home' and threatening to damage her car if she didn't give the child back to him, (the child was present on this occasion). Mother also alleged that during an altercation she received bruising to her arms when father gripped her and on another occasion she was grabbed by the neck. Father's version of events was he was trying to prevent her from falling down steps. In relation to the grab around the neck he denied the allegation he stated it was a 'tit for tat' altercation. It is not clear from records where the child was because this incident was incorporated into a statement obtained sometime after an event which was not reported at the time. What is clear is that positive police action was taken in respect of the matter. Later on the father was attending Flying Start sessions with mother. Mother later stated she had elaborated on the severity of the altercations, and said this was a plan she had made with her mother to try and get custody of the child.
- It was noted in the initial assessment mother disclosed father was jealous of her new relationship, and father reported mother had 'been cheating on him'. It appears this was not considered further. Her new partner appears to have 'remained unknown' to services and his involvement with the child was not included in the assessment. Father identified from his perspective they were very much a couple and she was living with the new partner and father found the new partner antagonistic towards him.
- Mother admitted in discussion with the Reviewer violence between her and the child's father had taken place and considered as 'tit for tat'. Mother said she

did not want to press charges; her priority was to get her child home and settled.

Bruising in Toddlers

- When mother and child attended the Family Link Nurture Programme for the second time a number of bruises were noted and mother's explanation for those bruises were accepted and the health visitor was informed, however whilst this is positive in terms of sharing information it is not the role of the Health Visitor to investigate bruising to a child. The following week the child was reported to have hit herself with a toy which had caused bruising to her legs and had "aggravated a bruise to her ear". These explanations were accepted. (At the Learning Event it was identified that practitioners lacked knowledge in relation to the significance of bruising to the ears, especially in young children – such injuries can be indicative of abuse and should be referred for a child protection medical opinion). On one occasion when mother was leaving, the health visitor offered to weigh the child, this would have given the health visitor the opportunity to have undressed the child. Mother declined the offer and no further action was taken. The nature of the bruising should have led to an escalation of concern by professionals.

Frequency of GP attendance

- Mother attended the GP practice frequently and appropriately when the child was unwell in the spring of 2015.
- The child attended the Out of Hours Service on 23/05/2015 and 26/05/2015. It is unclear and probably unlikely that the child was undressed when examined. On 23/05/15 mother reported the child was vomiting and the child was prescribed dioralyte. The child appeared to be experiencing a 'tummy upset' which mother advised she had also had and it was reported the child was eating, drinking and having wet nappies and was not considered that unwell. On 26/05/15 mother said the child was still vomiting and had been unable to keep any medication down. Mother was advised to see her own GP the following day if child was "no better". Mother and "father" took her to see the GP the following day.
- 5 days later (01/06/15) she was reviewed by another GP as she was still vomiting. The GP considered that although she had lost weight there were no signs of dehydration and he considered an admission to hospital was not required. Blood tests were arranged, but these were not taken for a week.
- The following day the health visitor spoke to the GP and identified her weight had dropped from the 50th to 9th centile in three months. The health visitor advised she had also noted bruises on her back which she considered was consistent with mum's history of the child having fallen on her toys, and also reminded the GP of the history of domestic abuse between the parents. The GP advised the health visitor she was to be seen in paediatric assessment unit the following week.

- When mother returned to the GP a week later for the blood test results, she identified that the child had developed a squint over the last few days. The GP arranged hospital admission where the injuries were noted. At this time she had been backwards and forwards to the doctors for 3 weeks.
- In discussion with the Reviewer mother said she considered the GP did not take notice of her concerns when she described how the child was holding her head when they visited him about the child vomiting. She felt if he had she may have gone to the hospital earlier, however it is unlikely this would have altered the outcome in any way. During this time the child was seen by 3 different GPs in the surgery and 2 in Out of Hours.

New partners involvement

- It appeared little/no enquires were made about mother's relationship with her new partner as mother referred to him as 'just a friend'. This is especially concerning when it was clear from the timeline that domestic abuse was a feature in his previous relationships. There was no evidence of assessing the level of contact or caring responsibility this person was having with the child during the Initial Assessment.
- Mother told the Reviewer they are no longer in a relationship but remain friends. She referred to him positively and said he was great with children. It had been at his home that the child fell down the stairs. Her explanation of the fall given to the Reviewer was that the child was following mum upstairs and toppled backwards, which was consistent with the injury sustained.

Areas where improvements have already or should have been made

- The Health Visitor identified that since this child's injuries were sustained she has adopted a more proactive approach in discussing any cause for concerns with the Flying Start Staff.
- This is particularly important where there are identified concerns and she would encourage a joint referral.
- Other professional groups should consider similar improvements to their own practice.

Improving systems and practice

Recommendations

PRAMS

- When a patient is referred to PRAMS the invitation for the patient to contact the service to opt in should also be sent to the health visitor, GP and midwife if relevant so the patient can be actively encouraged to attend, whereas the current practice is that the health visitor is only contacted when the patient fails

to respond to the opt in letter.

Listening to fathers

- Fathers' voices are often absent from records as mothers are often seen as the principal carer. It is important to take information from fathers seriously, as father identified he expressed concerns for his daughter in regard to the mother's lifestyle and in his opinion these were not taken seriously.

Ensuring parents understand the decision making.

- The issue of domestic abuse between the parents has already been identified in this report. Although outside of the timeline for this review, it is clear the parents did not understand the decision making rationale for the child to be discharged into foster care. It is noteworthy that mother and father expressed their concerns as to why the child was taken into foster care They could not understand why there had been no consideration for the child to be discharged from hospital to his care. Mother considered that as father hadn't had any unsupervised contact with their child for some months he could not have been in the 'pool of perpetrators' when non accidental injury was suspected. She identified she felt pressured to allow her child to go abroad on holiday with the foster carers as it was stated she would have to go into respite care whereas mother considered she could have gone to father. They did not understand, and it had not been explained to them that the concerns in relation to domestic abuse was a factor in the decision making.

Sharing of PPD1s/Public Protection Notifications (PPNs)

- PPD1s (now known as PPNs) are currently shared with health visitors, midwives and school health nurses only where there is an under 5 in the family but not with GPs on a routine basis. Such information could be invaluable when GPs see clients. Currently Health Visitors will share this information with GPs where there are already known child protection concerns. It is recommended that a scoping exercise is undertaken to consider how PPNs can be shared in such a way that they can become part of the 'flagging systems' GPs have on parents/children's records to assist in their differential diagnoses when patients attend for consultations.

Reminders of existing practice

Bruising to ears

- All Practitioners in all agencies are reminded that any bruising to ears should be considered as suspicious unless proven otherwise. When such bruising is seen the information should be shared with partner agencies for investigation into the cause.

Respectful Uncertainty

Frequent attendees

- When a young child is attending primary care services on a frequent basis (in the case the child was seen on 7 occasions and had 4 telephone consultations within a three week period) with mild childhood illnesses and concerns, child in need/protection concerns should be considered as part of the differential diagnosis (in this case the mother was a single parent, with mental ill health issues for herself and a history of domestic abuse- these are known indicators of risk).

Being clear about 'family structure'

- The father of the child had disclosed that mother had been cheating on him in relation to the allegations of domestic abuse. Mother maintained this new man was just 'a friend'. It was never clear how much time or access this man had with the child and he was never assessed as part of the family structure. However this Review has clarified domestic abuse was a feature in his previous relationships




Current situation and conclusions

The child is now living with her biological father out of area, and appears to have made a full recovery.

The Reviewers were able to meet the child when they visited father. It is clear the relationship between father and child is close and nurturing.

Mothers living arrangements are of concern as she has no fixed abode. She told the Reviewer she is happy the child is living with her father and spoke positively about him, saying she has daily updates from him and frequent photographs. He supervises her contact with their child but she did identify she would like to see her daughter more often as she is only allowed to see her once every four weeks whereas when she was in foster care she was seeing her weekly. Mother does not understand this. Mother identified she is unhappy with the way the local authority have managed the case and that they have very little if anything to do with her now.

There were occasions when the concerns should have resulted in agencies making a fuller assessment of the mother and child's needs, including seeking more information about her 'friend/partner'. However, even if these issues had been addressed it cannot be concluded the injuries to the child would have been prevented.

Statement by Reviewer(s)			
REVIEWER 1		REVIEWER 2 (as appropriate)	
Statement of independence from the case <i>Quality Assurance statement of qualification</i>		Statement of independence from the case <i>Quality Assurance statement of qualification</i>	
<p>I make the following statement that prior to my involvement with this learning review:-</p> <ul style="list-style-type: none"> • 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. 		<p>I make the following statement that prior to my involvement with this learning review:-</p> <ul style="list-style-type: none"> • 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)		Reviewer 2 (Signature)	
Name (Print)	DAPHNE ROSE	Name (Print)	Dr. Andrea Warlow
Date		Date	
<i>Chair of Review</i>			
<i>Panel (Signature)</i> ... 			
Name (Print) Amanda Hinton		Date	

Terms of reference for Concise Child Practice Review WB B20/2015

WB B 20/2015

Index Child: D.O.B 21.01.14

Scope of Review: 1st June 2014 – 1st July 2015 when baby was removed.

External Reviewer – Daphne Rose – Public Health Wales

Internal Reviewer – Andrea Warlow – ABMU HB

Chair of Panel – Amanda Hinton – ELLLS, Neath Port Talbot

Panel Members:

South Wales Police

ABMU

Welsh Ambulance Service

Bridgend CBC

Action For Children

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and WBSCB.
- Examine inter-agency working and service provision for the child and family.
- 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.

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 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.
- Take cognisance of any on-going criminal investigations.

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	<input type="checkbox"/>	<input type="checkbox"/>	
Esteem	<input type="checkbox"/>	<input type="checkbox"/>	
HIW	<input type="checkbox"/>	<input type="checkbox"/>	
HMI Constabulary	<input type="checkbox"/>	<input type="checkbox"/>	
HMI Probation	<input type="checkbox"/>	<input type="checkbox"/>	