Child Practice Review Report

Western Bay Safeguarding Children Board

Extended Child Practice Review

WB N 25 2016

Brief outline of circumstances resulting in the Review

Legal Context:

The Social Services and Wellbeing (Wales) Act 2014, Working Together to Safeguard People Volume 2 – Child Practice Reviews sets out the requirements to undertake reviews in specific circumstances. Under these regulations an Extended 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 7.1 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:

(a) Died; or
(b) Sustained potentially life threatening injury; or
(c) Sustained serious and permanent impairment or health 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
- the date on which the local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development

Family Background

The child subject to this review is one of four siblings, all of whom were residing with their Mother at the time of the child's death. Within this family there was evidence of maternal family support. There are two Fathers relating to the children and Mother had on/off relationships with both of these men. More recently, Mother appeared to be in a new relationship with another man. All of the men were known to be substance misusers as was the Mother.

Circumstances Leading to the Review

This Review was commissioned following the tragic death of the subject of the Review in a house fire. All the children were on the Child Protection Register under the category of neglect at the time of this event. This was the second period of registration under the same category within the timeframe of the review.

Mother had a history of substance misuse and formed relationships with men who misused drugs; some of these men had been identified as being a risk to the children. This was the reason for the children being placed on the Child Protection Register on both occasions.

Following the death of the subject of this review all of the surviving children were removed from Mother and are now currently placed with extended family and are subject to Care Orders.

Scope of the Review

The scope of the Review was from 1st July 2014 – 31st July 2016.

Following the decision to carry out this Review a Child Practice Review Panel was formed;

Chair of Panel – Daphne Rose – Public Health Wales
Independent Reviewer – Virginia Hewitt – Abertawe Bro Morgannwg University Health Board (ABMUHB)
External Reviewer – Samantha Jones – Bridgend County Borough Council (BCBC)

Panel members

Agency

South Wales Police
Abertawe Bro Morgannwg University Health Board
Neath Port Talbot County Borough Council Children and Young People Services
Mid and West Wales Fire Service
Neath Port Talbot County Borough Council Education & Life Long Learning
Western Bay Safeguarding Boards Business Management Unit

Contact with the Family

The Child Practice Review guidance clearly outlines the requirement for family engagement in the process. In this case mother was written to twice offering her an opportunity to contribute to the review. Unfortunately the review panel did not receive a response from mother and so engagement has not been possible.

The Learning Events

This was a particularly emotive case and the Reviewers acknowledged this. Two Learning Events were held on separate occasions, one for practitioners and one for managers. Although both events were well attended it was noted that there were also significant absentees. The reviewers did arrange to meet some of the absentees separately to ensure a fuller and more accurate contribution was made to this Review.

Within the Practitioners Learning Event the reviewers spent time at the beginning of the day to ensure Practitioners understood the purpose of the event which is to learn and not to apportion blame.

A Managers Event can usually be very different from a Practitioners Event as managers may demonstrate a more strategic approach to the learning. This was evident on this occasion.

Some of the attendees only had limited involvement but were invited because they were involved with the family and their contribution was considered pertinent.

The Practitioners Event was attended by 19 professionals and the Managers Event was attended by 10 professionals from the following agencies:

Police
Education
Social Services
Health
Integrated Family Support Service
Fire Service

Practice and organisational learning

Management of Social Services professionals and caseloads

There was a perception from staff at the Practitioners Event that poor management of caseloads and poor supervision was evident in the social work team up to the time of the CP registration. It was suggested that the team was in a disrupted state: caseloads were described as unmanageable and professionals felt that there was insufficient management oversight and supervision. Although this was acknowledged at both Learning Events evidence has since been provided to

the reviewers which suggests that there was caseload management and staff supervision and there was some evidence of senior management oversight. Additionally since this time the reviewers were informed that the situation had changed significantly with new management structures and supervision arrangements in place since September 2015 and regular management oversight is now embedded.

It was also identified that when social workers covered for the allocated worker, who was on leave, they did not have time to access sufficient historical information on the family to undertake visits and tasks in an informed way. This was also apparent for workers undertaking the 'duty' role.

In mitigation, managers identified that one of the workers nominated to cover annual leave, had previously been involved with the family so it was considered that they knew the background.

Practitioners are expected to access sufficient information prior to visiting a family and managers have a responsibility to ensure that this happens so that informed judgements can be made.

Multi Agency Recording Keeping

It was identified in documentation that the terms 'good', 'acceptable' and 'unacceptable' were used when describing home circumstances. This does not tell the reader anything about the actual conditions being seen. In addition it is significant that there was a pattern whereby observations of home conditions were noted to be more positive at arranged or announced visits but were noted to be worse on unannounced or opportunistic visits.

The terms 'good', 'acceptable' and 'unacceptable' are unhelpful in respect of understanding the nature of the home conditions. In addition, it is also possible that what was 'good' or 'acceptable' may mean different things to different professionals. This was reinforced in the Managers Learning Event where it was agreed that professionals recordings, in all agencies, needed to be more descriptive in order to tell the story of what is seen and heard.

However, it was also noted that, at times, some professionals did use descriptive language and this was recognised as being expected practice. Professionals also identified that a universal assessment tool around neglect could be beneficial in that it would support the consistent use of language for professionals and families.

Furthermore, observations of the children within the family and any communication with them needed to be explicitly recorded. This would have given professionals the ability to assess the whole situation and any impact on each of the children as individuals.

The Panel considered that one of the children (not the child subject to the review) did not seem to have received the attention he required from the family with regard to his needs. However it was acknowledged at the Managers Learning Event that

there had been specific extended family support for this child. This was not evident from the documentation reviewed.

Effective Multi-agency Working

The family required numerous interventions with health professionals. Consequently the children needed to attend frequent health appointments. Within a chaotic, neglectful home the question was raised about whether expectations of the family were realistic. It was clear that many appointments were missed including health appointments for some of the children. Practitioners did, however, identify that action was taken to try to support Mother in this respect. For example, some health appointments were moved to a clinic nearer to the family home because of the difficulties with getting to hospital sites. The social worker and health visitor worked closely together to try to support Mother and text message reminders were sent to Mother to remind her of upcoming appointments.

It is apparent that different disciplines within health use different IT systems which can have an impact when booking appointments. For example, different children from the same family both having to attend appointments at different locations on the same day. In addition, there does not seem to be any alert that would identify other children in the family. Therefore it is imperative that all health professionals adopt a 'Think Family' approach.

It was identified, as part of the review, that the Mother and children were registered with one doctor's surgery and each of the Fathers were registered at different practices. However, this is not unusual. It is important that when treating adults, General Practitioners (GPs) use respectful curiosity and if they identify parental/caring roles of their patients that they consider the impact of the illness and its treatment on these children.

The relevant GPs from the practices involved with the family were invited to the Learning Event and two of these stated they would attend, although none did. GPs have a statutory role to safeguard children (along with other professionals) and it is vital that GPs share any relevant information with other relevant health professionals such as the Health Visitor and also multi agency partners. This is particularly so with regards to adults who have a caring role for children and present to the GP with mental ill health issues. Therefore it is imperative that GPs always consider the wider family impact when treating individuals.

This should allow GPs to "Think Family" in accordance with the Serious Case Review recommendation made in Bridgend regarding Child Q (June 2011):

'It is important that when GPs are treating patients for depression or other mental ill health issues [Including substance misuse] *and they are or will be involved in a child care role, consideration should be given to the possible impact this may have on their parenting capacity and in the first instance share the information with the health visitor and if necessary consider a referral to Safeguarding and Family Support.'*

It is recommended that each practice should have a Safeguarding Practice Lead (SPL) who must be a general practitioner. (A Guide for Safeguarding Children and

Adults at Risk in General Practice 2016, National Safeguarding Team, NHS Wales) The SPL is not expected to be an expert in safeguarding or deal with all safeguarding issues but a central person who will have oversight of safeguarding matters for the practice. The SPL will enable the other members of the practice to be aware of and access relevant guidance, recognise training needs and appropriate training events and be able to access appropriate support and advice on safeguarding matters.

As the GP was unable to attend the Learning Event , the reviewers met with the Safeguarding Lead GP from the surgery where Mother and the children were registered. The 'Think family' approach was discussed and it was acknowledged that whenever possible the wider family is considered by the GP and practice staff. However, it was also acknowledged, in relation to fathers, that unless a male patient made the GP aware of any associated children it is not always practicable to make further enquiries.

The GP stated that within the surgery there are regular, informal meetings with the Health Visitors because they are based there but that primary care meetings with HVs and midwives is something that they were aware of as good practice but needs to be further developed within her practice.

It was also identified that on the GP electronic systems there is a flag against a child in relation to the Child Protection Register but there is no link to the mother or father who may also be registered at the same practice.

The GP informed the reviewers that there is currently a 'clinical governance and information sharing consultation' which may have an impact on recording and information sharing in future. This needs to be clarified with regards to the sharing of safeguarding information.

It was established that there is no automatic information sharing process across GP practices. A GP may contact another practice if they were aware of any concerns that may affect someone in another practice but that would only be if they were aware of relevant others e.g. partners. The GP interviewed thought this was unlikely. In addition GPs may be reticent about sharing information inappropriately.

Safeguarding training delivered to GP practices was discussed in relation to its frequency and relevance. It was established, that training was offered but the GP considered that sometimes the content was not always relevant to their professional practice. The reviewers highlighted to the GP the importance of practice staff attending relevant and regular up to date training. The Health Board provide Level 3 training which many GPs do attend and it is important that the GP Safeguarding Practice Leads provide this information

During the timeframe of this review the mother gave birth to her 4th child, therefore it was appropriate to invite professionals from the Midwifery service. Although invited, there was no midwifery representation at the Practitioners Learning Event. It was noted, (particularly with regards to the substance misuse midwife) some questions were raised regarding Mother's drug use which could not be answered

at the Practitioners' Learning Event. The substance misuse midwife agreed to meet with the Reviewers but unfortunately she went on sick leave before they were able to meet.

In respect of the concern about the men that Mother associated with there seemed to be no relevant work with Mother around this for example work associated with healthy relationships. This would have been beneficial particularly as Mother began to engage with another male who posed a potential risk to the children shortly after the children were deregistered.

Both of the Fathers involved in this family were subject to probation interventions. Appropriate information sharing processes were evident in the timeline between probation and social workers. However, during the Practitioners' Learning Event, it became apparent that not all agencies were aware of the split within the Probation Service resulting in two services - The National Probation Service (NPS) and The Community Rehabilitation Company (CRC). In particular IROs/Conference Chairs stated that they were unaware of this. Although this didn't appear to affect this case this is an example of how information sharing processes are at risk of becoming inadequate. Therefore we recommend that any standard invitee lists for Child Protection Conferences should be updated to include both agencies..

At times, agencies considered that the family were working well and engaging appropriately. There was a clear consensus that improvements had been made when the children's names were removed from the Child Protection Register. It is impossible to state with any certainty how embedded any improvements were as the children's names were placed on the register again just 6 months later. Practitioners identified some level of 'disguised compliance' by the Mother and also that some maternal family members were potentially colluding with Mother. In addition, it appeared that there may have been a 'prevailing sense of optimism' by some practitioners involved with this family.

Professional Vulnerability

Consideration should be given to professionals who live and work in the same area as their clients. This can place the professional in a vulnerable position and can be professionally challenging. It could result in a blurring of boundaries where families can become over dependent on local professionals which can make the practitioner vulnerable. However, it is acknowledged that in some cases this is acceptable practice. Managers need to give consideration whether this will impact on practice and ensure practitioners are suitably supported. Managers need to be mindful that some cases are more demanding than others which may impact on the professional's remaining caseload. This needs to be considered by supervisors and managers and arrangements put in place to ensure practitioners are protected whilst also ensuring appropriate service provision.

Working with long-term neglect

At the Practitioners' Learning Event, Social Services acknowledged the difficulties experienced within cases whereby neglect is the overriding concern. However, it was identified that, at times, professionals felt overwhelmed and unsure of the best

way forward. During the Learning Event, Social Services identified that that there had been encouragement from management, with regards to children who had been on the Child Protection Register for over 2 years, to consider whether the threshold for care proceedings had been met or whether deregistration was appropriate. Managers at the Managers' Learning Event had a slightly different opinion whereby if, after two years of registration, there hadn't been any positive change or a reduction in the risk then proceedings under the legal framework should be considered. These long term cases of neglect are often referred to as 'stuck' cases. At the Practitioners' Learning Event it was identified that some, impartial, multi-agency supervision may be useful in dealing with these 'stuck' cases.

Home Safety

Following the house fire, Mid and West Wales Fire and Rescue Service (MAWWFRS) were alerted. Records were examined and it was identified that there had been no referrals made to the Fire Service for a Home Fire Safety Check (HFSC). A HFSC is a free service that involves a visit from the Fire Service to identify any fire hazards and providing solutions and advice to minimise those risks as well as fitting free smoke alarms and providing other safety equipment as required. MAWWFRS target the most vulnerable members of our community and rely heavily on partner- agencies providing that pathway.

As a result of this case it was identified, at the beginning of the review process, that all families, where children are registered under the category of neglect, should have a fire safety check as part of the protection plan. This was agreed by the WBSCB.

Integrated Family Support Services (IFSS)

IFSS had involvement with the family in supporting Mother around her substance misuse. Although a safety plan was in place, it did not appear to have been shared with all professionals working with the family. At that time, management oversight for IFSS was hosted by Bridgend County Borough Council. This meant that all IFSS records across the Western Bay Region were kept on Bridgend County Borough Council systems so were not always available to the appropriate practitioner. IFSS did, however, attend case conferences and share information within that forum.

During the panel meetings it was acknowledged that numerous attempts were made to engage IFSS management and identify an appropriate panel representative. These attempts were unsuccessful so interventions were unable to be explored further as part of the timeline and within panel meetings. It is of note that the IFSS worker did attend and actively contribute to the Practitioners Learning Event despite no longer working for IFSS.

Child Protection Conferences

'Parent/caregivers should always be actively encouraged to attend the child protection conference, unless there has been a decision to exclude them, because they should have a significant contribution to make.'

All Wales Child Protection Procedures 2008 p185

There was evidence of a Review Child Protection Conference taking place without Mother as she was unwell. The reason for going ahead with the conference was explored at the Practitioners Learning Event and practitioners suggested it would be because of the need for the review to take place in the required timeframe. However, it was accepted, in this case, that there was sufficient time to rearrange the meeting as the conference was held 3 months into the 6 month timescale. Therefore the Child Protection Conference should have been reconvened when Mother was able to attend.

Child Protection Plans

The All Wales Child Protection Procedures set out clear guidance on the requirement and use of multi- agency child protection plans. The plan should be a multi-agency, working document that is driven forward by all members of the core group, including family members and reviewed and updated at each core group meeting. The plan should be outcome focused but provide detail of actions to be taken to achieve all the planned outcomes. In this case there was evidence that the Child Protection Plan was not particularly robust and that desired outcomes did not have details of actions required. There seemed to be too much emphasis on the requirements and actions expected of the Mother. All Child Protection Plans should be centred on the needs of the child at risk and required to set specific actions to achieve appropriate outcomes for the child.

All systems and paperwork within the Local Authority are now 'Outcome Focused' in line with the Social Services and Well Being (Wales) Act 2014.

Organisational learning

Throughout the learning events it also became clear that several "process" learning points had been identified.

Western Bay Safeguarding Boards (WBSB) and the Practice Review Management group (PRMG – Formerly Child Practice Review Management Group) should ensure the following:

- PRMG need to ensure invite letters to professionals, who have left their previous employment, include information about where support and preparation for the Learning Event can be obtained.
- PRMG need to ensure that timelines for the Learning Events are appropriate without unnecessary annotations

- WBSCB need to reinforce the accepted recommendation from this review in relation to fire safety checks being requested as part of a child protection plan when children are placed on the Child Protection Register under the category of neglect.

- Panel members need to ensure that within their organisation, practitioners identified as needing to attend a Practice Review Learning Event are fully prepared and supported throughout the process.

- The PRMG needs to review its communication processes and ensure role profiles for panel members are signed and reinforced throughout the Review process.

  Due to the emotive nature of this Review the reviewers agreed that it would be beneficial for practitioners and managers to have a feedback session with the reviewers on the findings within this report prior to submission and publication.

Improving Systems and Practice

Reminders of systems already in place :

- Independent Reviewing Officers/Child Protection Conference Chairs can refer direct into legal surgery when assessed as necessary as part of the review process

- Children's services systems have been improved to make it easier to access all of the information relating to children

- Principal Officer Consultations are available for complex/difficult, long standing cases that might be in need of escalation.

- **These systems are in place locally and there are similar arrangements across the region.**

Learning Points:

1. Systems listed above should be considered across the wider region and embedded into practice if need be.

2. It is important to ensure, particularly during times of disruption and change, that adequate support is in place for professionals. Therefore professionals who take on cases for periods of cover should be given sufficient time to acquaint themselves with the detail of the case and handover/briefing sessions should be undertaken.

3. Professionals should ensure that when completing any assessments and/or recordings that clear descriptive language is always used. This is particularly important during cases of neglect.

4. Consideration should be given to the use of a multi-agency Universal Neglect Assessment Tool that would assist professionals in providing baselines when describing circumstances of home environment and contact with families and language.

5. Professionals identified that multi-agency, independent supervision would be beneficial with long standing, 'stuck' cases.

6. Any plan to protect and support a child including risk assessment, protection and safety plans must be tailored to individual need and shared with all practitioners who are working within the family.

7. When parental relationships are identified as presenting a risk to children professionals should consider ways to empower parents to make the right decisions e.g. Healthy Relationship work.

8. Statutory agencies need to be aware of what IFSS provide and how they can access this service if required. This needs to be a two-way process with IFSS and therefore IFSS needs to engage with any child protection process so that all agencies are updated with their work with the families.

9. IRO/Conference Chairs are reminded of their responsibilities to quality assure Child Protection/Looked After Children plans and escalate when progress and positive change is not evident.

10. All agencies are reminded of the statutory requirements set out in *Working Together to Safeguard People (Volumes 2&3)* to attend Practice Review Learning Events.

11. GPs and Practice staff need to give consideration to extended family when they are seeing patients who have a parent/caring role for children and share information with other agencies if appropriate.

12. Managers and Supervisors need to be aware of their practitioners who work in areas where they reside. In particular managers should consider any potential vulnerabilities for example: families becoming too familiar and the impact this may have on the professional.

13. The importance of individual agencies maintaining a live chronology on case files. This would be particularly useful when professionals are asked to cover cases.

14. Any professional that worked with a child who has died needs to have access to a support and debrief session within a short timeframe following the event.

15. Any child who is re-registered on the child protection register within a twelve month period should be reviewed by senior management within Children's Services.

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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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<tr><td>Reviewer 1
(Signature)</td><td>[signature]</td><td>Reviewer 2
(Signature)</td><td>[signature]</td></tr>
<tr><td>Name
(Print)</td><td>Virginia Hewitt</td><td>Name
(Print)</td><td>Samantha Jones</td></tr>
<tr><td colspan="2">Date 19.04.2015…………………………</td><td colspan="2">Date 19.04.2018……………………………</td></tr>
<tr><td colspan="4">Chair of Review

Panel
(Signature) [signature]
Name
(Print ……Daphne Rose……….

Date 19.04.2018</td></tr>
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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	☐	☐	