7 Minute Briefing **WG N60 2020 - Concise Child Practice Review**

The scope of the Review was from 1st October 2019 – 1st October 2020.

7. Learning Learning Opportunity

a) Assessment Skills To remind practitioners of the need for a holistic assessment and care planning of children to include both parents /carers.

b) Prevention. : Consideration of the impact of any restrictions such as those associated with a pandemic on care provided to a child.

c) Safeguarding:
Discharge meetings have to take place prior to discharge where there are safeguarding concerns.
Hospital staff to be reminded of the SBU Health Board Combined Safeguarding Children's Guidance including lead responsibility for reporting concerns and expectations around discharge planning.
Hospital staff will need to ensure they are providing health information with other agencies at a level that non health practitioners will understand to support risk analysis.

d) Joint working. Police and practitioners to be reminded of the need to undertake joint police investigations in a planned way to reduce the level of distress on the family and promote engagement. -

1. Background

The child subject to this Review was the second child to mother and father, referred to as child A. Father had previously been involved in an accident that had resulted in a brain injury and as a result suffered with memory issues, where he now required information to be provided in short periods to support his ability to retain information. Mother suffered with periods of depression and anxiety.

This Review was commissioned following a referral from the Local Authority identifying that child A suffered such severe malnourishment over a lengthy period of time, she required a blood transfusion. If this had continued this may have been fatal to A. A was reported to be significantly unwell and described as '*lethargic', 'floppy'* and '*pale'.* A's iron levels were so low that she required immediate medical care and had lost her ability to walk.

Key Learning Themes

Impact of Covid

This case took place during the course of the pandemic during which tight restrictions were in place for professionals and within the community. This further isolated the family and may have caused issues around feeding to escalate as previously the family may have sought support from grandparents during their weekend visits. Prior to the lockdown period there were no concerns in regards to A's health where she was described to be progressing well and gaining weight. During the learning event professionals advised that they were not aware of grandparents involvement or the impact of restrictions on the support available. When considering the importance of assessing families holistically and the impact of varying 'systems' in a child's life this may have been an opportunity to explore and understand how this may have created a further need that had not been there previously.

Hospital discharge/Safeguarding

A was discharged from hospital without any planning or strategy meetings. SBU Health Board Combined Safeguarding Children Guidance (2020) outlines the need to ensure no child admitted where there are safeguarding concerns should be discharged without not only the permission of the Paediatrician in charge but also a clear plan of future care.

Failure to have this meeting resulted in an immediate joint visit by police and the Local Authority at the home. Mother has described this as a traumatic event for her and her family resulting in her feeling she could no longer engage with the LA. Further to this, changes were made to the amount of police in attendance after having the strategy discussion. This impacted future engagement with the family and prevented the ability to collectively ensure A was safe before discharge home.

Engaging all primary carers.

Is it essential that professionals engage with both parents equally as potentially in this case this may have been an opportunity to better understand the issues at home and impact of this on the children's care. Father identified as part of his interview that he wanted to share concerns with the Health Visitor, however, did not feel he had the opportunity to do this alone without mother present and when he had tried this previously mum became very upset. Progress was made in respect of A's care when work was undertaken with father during hospitalization. It would also appear that later at the hospital progress was made with A's diet when hospital staff engaged with father and physically supported him with feeding techniques. Mother also advised that her first introduction to the Local Authority was with the police and very traumatic.

Professionals must be mindful and reflective of any gender cultures within society around mother's being the primary care giver to children. This could create barriers to involving fathers and engaging them equally.

Communication

On A's attendance at the hospital her presentation was reported as being a significantly unwell child. On receipt of the blood results the consultant confirmed that his concerns became nutritional rather than medical. SBU Health Board Combined Safeguarding Children Guidance (2020) indicates that a doctor of above grade ST7 would be responsible for making the referral. It was clear from the learning even that the consultant who had assessed A had concerns that were at a level of Safeguarding however did not make a direct referral.

Further confusion took place at this stage as health staff advised in the learning event that they were making a safeguarding referral yet the Local Authority did not identify that the referral had been made in respect of safeguarding. The person making the referral was an inexperienced member of staff who was unfamiliar with the process. Therefore, while it was evidenced that they were asked a number of questions from EDT as part of the referral, they were not able to fully share all the necessary risks and concerns to inform Social Care decision making at that time. Communication from the hospital and the Local Authority were crucial at this stage as there was a clear misunderstanding of the severity of A's condition, and concerns identified as a result of her care at the hospital. It was highlighted at the learning event that when reporting medical concerns and conditions, the significance of this are properly communicated to non-medical services to avoid misunderstanding the seriousness of concerns.

Consideration of sibling records.

During the learning event a GP advised that they were not aware of the previous concerns in relation to A's older sibling B, and that if they had been aware of this they may have responded differently to the concerns. The Health Visiting Service would have been aware of the previous involvement in respect of B and the outcome of Local Authority involvement. This would have been an opportunity for the GP to explore B's history and any concerns that may have supported a further analysis of the concerns around A's health as B had also experienced issued with feeding and nutrition previously.