Concise Child Practice Review Report

West Glamorgan Safeguarding Children Board

Concise Child Practice Review

Re: WG N60 2020

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

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 a concise Child Practice Review was commissioned by The West Glamorgan 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 3.4 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 or health or development

and

the child was neither on the Child Protection Register nor 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.

1. Family Background

The child subject to this review was the second child to mother (M) and father (F) referred to as child A. A was the youngest of two siblings and lived at home with her mother, father and sibling. Mother and father made the decision to home school their first child referred to as B. 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.

Mother and father both live in Wales and have regular contact with maternal grandparents visiting on weekends with A and B.

Mother and father first came to the attention of child and family services in June 2016. When mother was pregnant with her first child B midwifery sought support from preventative service Team Around the Family (TAF) as mother was using cannabis to manage her anxiety. The referral was passed back to midwifery for ongoing support. No role for statutory services or TAF identified.

A further referral was made to the Local Authority following B's birth in November 2016, with concerns that mother and father required support with nutrition and feeding, play, stimulation and home safety. An assessment was undertaken and identified care and support needs. Despite this the case was stepped down to TAF following the conclusion of the assessment. TAF provided support and the case closed as a result of the positive progress made by B and parents.

Six months later A was born and lived at home with her family. In March 2020, A did not engage in her 15-month development review therefore a further assessment was planned for 18 months. During this visit mother informed the Health Visitor that she did not want A to attend flying start nursery as she intended to home school A as she has done with her older brother.

Following this the Coronavirus Pandemic escalated resulting in restrictions around face-to-face contact. Government guidance at this time was to 'stay at home' if possible, with visits moved to phone calls or virtual visits. Guidance at this time also identified vulnerable individuals to 'shield' preventing mother and father seeking support from maternal family as they report they would usually.

2. Circumstances Leading to the Review

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.

3. Scope of the Review

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

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

Chair of Panel – Sue Hurley – South Wales Police

Independent Reviewer – Jessica Myden – Swansea Council (Children's Services)

External Reviewer –Damian Rees – Swansea Council (Children's Services)

Panel members were involved from the following agencies-

South Wales Police
Swansea Bay University Health Board
Children and Young People Services
Flying Start

Contact with the Family

Prior to the learning event mother, father and grandmother were interviewed as summarised below:

Meeting with Father (F)

On 19th April 2021, the reviewer spoke with F over the phone. F felt that the lock down restrictions had impacted greatly on the support available to his family and felt that the issues with A's feeding deteriorated during this time. Lockdown restrictions not only impacted on his ability to seek professionals support but also family support. F also advised that there were times when he wanted to seek support and share his concerns with the Health Visitor, however, he did not get an opportunity to speak alone. F also expressed fear that sharing his concerns would also be a sign of weakness and result in the children being taken from him.

F advised that he was not spoken to.

F advised that he did receive support from a hospital worker at one stage who visually showed him ways to support A with eating and advised that he felt this was a huge help to him.

Meeting with mother (M)

The reviewer met with M on 29th April 2021, virtually as a result of the Coronavirus pandemic restrictions. M's best hopes from this process were for changes to be made to the Health Visiting Service as she felt that if she had received support at an earlier time, A wouldn't have become so unwell that her 'life was at risk'. M stated that she could have received 'parenting help'.

M also requested changes to Local Authority involvement as she did not feel she had a good introduction resulting in her no longer feeling confident to work with the Local Authority.

M advised that between the period of January and September 2020, she did not have any visits from the Health Visitor and reports that this was when feeding started to become difficult with A. M could not remember receiving any calls during this time.

M stated that prior to the pandemic she would see the Health Visitor every 3 months.

Meeting with Maternal Grandmother (MG)

The reviewer spoke with MG on the 29th April 2021, over a telephone call as a result of the Coronavirus pandemic restrictions.

MG's best hopes from this process would be for more help and support to be provided by the Health Visitor as she felt parents were on their own without support. MG stated that there were no Health Visitor visits at all during the lockdown period and felt this was something that could have made a difference.

The Learning Event

The multiagency learning event took place on the 21st September 2021.

Within the 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.

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

those who attended were willing and open to the process engaging well with discussion and reflection.

The Practitioners Event was attended by 28 practitioners from the following agencies:

Police

Education

Social Services

Primary and Secondary Health

Practice and organisational learning

*Identify each individual **learning point** arising in this case (including highlighting **effective practice)** accompanied by a brief outline of the **relevant circumstances***

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

1. **<u>Involving both parents</u>**

The participants at the learning event highlighted the need for services to be working with both parents where possible and recognise fathers as an equal primary care giver that can promote change. 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 hospitalisation. During the learning event the Health practitioner shared that at an earlier visit father was observed with the children positively with no concerns. 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.

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 when there are concerns in regards their children's care. Research undertaken in 2015, by Swann specifically around the inclusion of fathers in children's social care concluded that *'children and family social work is one of the few institutions to confront the perversities and abuses of traditional gender and power relations and this confrontation has led to 'paternal*

alienation'. (p.3) [Chapter 2: A Summary Chronology of the Research Implementation (york.ac.uk)]

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.

Participants at the learning event identified that working with cases of neglect can be challenging and cause professional anxiety as it is not always as easy to identify. This makes it more important than ever to ensure we are exploring and asking questions, being professionally curious and engaging and exploring all areas with all carers.

2. Communication

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.

Further confusion took place at this stage, as highlighted at the learning event, as health staff advised 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. At the point of referral, A had already suffered significant harm. This should have resulted in a safeguarding referral being made and consideration of an initial strategy discussion in line with the Wales Safeguarding Procedures 2019.

We became aware during the learning event that 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 however the referral to the Local Authority was not made until after this time by another staff member. The SBU Health Board Combined Safeguarding Children Guidance state that '*All Doctors have a responsibility to refer cases of suspected child abuse to Social Services promptly. This should not be delegated to other colleagues. All medical staff receive Safeguarding training as part of their Induction Programme. Advice in the management of suspected abuse should be sought from the Named Doctor or Associate Named Doctor for the Health Board or the Paediatrician on duty. Children who may have been sexually abused should be referred to Social Services and the Police, who will refer for a Child Protection Medical examination*.' (page 14, 2020). In this case, A should have been referred the moment her presentation became a safeguarding concern and not later left to

another member of staff.

3. 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.

4. Child Protection Process/Approach to intervention

Mother described to the reviewer that the Police and Social Work initial contact with her was a very traumatic event as she was of the understanding that the Local Authority would be calling to talk to them about support, and how they can help the family. Mother did not feel that the Local Authority involvement had been made clear to her and therefore felt that there had been an element of dishonesty. This is within a context of a family who appeared reluctant and wary of services at times. Mother advised that this has impacted on her ability to work and trust the Local Authority. Police have advised that four Police Officers attended with the Social Worker. The Social Workers were unable to go in and speak to the family. This was the first direct introduction of Local Authority involvement with the family in relation to A. Whilst a joint visit was agreed, the number of police that did attend was not. At the learning event it was clear that the police support was proportionate, however, it was agreed at the learning event that the full details of the police response should have been clearly communicated and properly considered at the initial strategy discussion with the local authority. This could have ensured a more supportive and collaborative approach to safeguarding the children. This would have been an opportunity to explore all concerns including consideration to B, and would have supported all professionals to review the best plan to support the family and reduce the likelihood of ongoing significant harm to either child whilst in their parents care.

Participants at the learning event identified a clear need to have convened a strategy meeting prior to A being discharged from hospital. Further to this the 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 as outlined below:

'No child admitted with child protection concerns should be discharged from hospital without the permission of the Paediatrician in charge of the child's care, or a doctor

above the grade of ST7, and a clearly documented plan in place for future care and follow up arrangements. If the parents / carers refuse to agree to admission for the child or seek to remove of the child whilst child protection inquiries are taking place, Social Services and / or the Police should be contacted immediately. No attempt should be made to physically restrain the child or carer or put any member of staff in any danger.'(page 12).

It was clear from the learning event that the consultant who had assessed A had concerns that were at a level of Safeguarding however in this case a pre discharge planning meeting was not convened.

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 therefore available to the family. 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, and may have resulted in referrals for preventative support.

Good Practice

Visits during the Coronavirus Pandemic:

Within their interview parents felt that they were without support as a result of covid restrictions. Family support also reduced as outlined above. Despite the family feeling this way what was shared in the learning event was that the Health Visitor in this case made contact more than would usually be expected at the time. Further to this a follow up development check was arranged on the basis that A was asleep for the initial check.

During the learning event the Health Visitor also advised that she was aware from conversation that parents intended to home school and therefore she was the only professional visiting. As a result of home conditions issues, engagement issues and previous concerns she felt it was important to undertake further visits and to check in that the family were doing ok. The Health Visitor was mindful and aware that she was the only professional visiting and felt the need therefore to engage more than usual. This was an example of good practice in supporting families.

Communication within Health:

During the learning event a GP advised that there is now a regular weekly meeting in place at the surgery where any updates or concerns would be shared and discussed. This was not in place at the time of A's involvement however is now in place every week where safeguarding is a permanent topic on the agenda.

Dietetic Consultation line:

As a result of the difficulties with Covid restrictions there is now a dietetics consultation line to support families in place to ensure they are still able to receive support despite visit restrictions. This has been implemented during the course of the pandemic and would support families such as A where there are difficulties with feeding. This is a good example of identifying alternative ways to support families.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the LSCB and its member agencies and anticipated improvement outcomes:-

(what needs to be done differently in the future and how this will improve future practice and systems to support practice)

Engaging all care givers:

1. Both parents/carers are to be engaged and included where possible in relation to their children. This will allow all agencies to have a better understanding of the needs of the child and will enhance the opportunity for change and progress. Health Visitors, Hospital staff and Social Workers need to be engaging all carers when exploring the child's needs and identifying the best support. Training should be undertaken with Health Visitors, Hospital staff and Social Workers to outline the importance of engaging all carers including fathers and using reflective practice to continually challenge this in practice.

Changes in Care Planning:

2. A previous assessment undertaken in 2016, identified the need for the family to receive care and support services from the Local Authority and yet this decision was changed with a step down to Team Around the Family. Any changes to a care plan requires an explanation and rationale for decision making that is recorded clearly on file. This needs to be recorded clearly by the Social Worker or Supervisor.

Working with Covid:

3. Undertaking holistic assessments with consideration of different systems in a family's life are important in understanding the child's needs, and any impact of changes such as the coronavirus pandemic. Professionals are to be mindful of the impact of such restrictions if experienced in the future through exploring support and any changes. Health Visitors and Social Workers will need to explore this with the family to see if this has any impact on the needs of the child at a level that would require support.

Hospital Safeguarding measures:

4. Hospital staff need to ensure that they are requesting a hospital pre-discharge planning meeting with the Local Authority before a child is discharged home if there are ongoing safeguarding concerns. The Local Authority will determine if this meeting should take place as a Child Protection Strategy meeting in line with the Wales Safeguarding Procedures 2019, to ensure information is shared across agencies and that any follow on investigatory work is planned out as a multi-agency team.

5. When there is a significant health impact as a result of possible parental neglect of that child's care need, hospital staff must ensure they are providing health information with other agencies at a level that non health practitioners will understand to support risk analysis. This will need to form part of hospital safeguarding training.

6. In this particular case practitioners should have considered the needs of the child who remained at home as soon as safeguarding concerns were highlighted. Current safeguarding training for hospital staff includes the need to consider the risk to others when reporting safeguarding concerns. Staff need learning opportunities to revisit and remind themselves of this training to ensure this continues to remain a sustainable response in their practice.

Planning approach to families:

7. Where joint police and Local Authority visits are to take place this should, wherever possible, be planned to consider the best way to approach the

family to encourage engagement, and prevent further trauma for the family. This should be discussed between the Social Worker and the Police at the point of the Initial Strategy Discussion/Strategy meeting. This will also give an opportunity to gather all the relevant information and plan as a multi agency how to undertake the S.47 investigation. Swann.G , 2015, *Developing an approach to including fathers in Social Care,* p3 & 9. Chapter 2: A Summary Chronology of the Research Implementation (york.ac.uk)

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of Qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
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.		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.	
Reviewer 1		**Reviewer 2**	

(Signature)		*(Signature)*	
Name *(Print)*		**Name** *(Print)*	
Date ……..……. **Date** ……..……..……			
Chair of Review Panel ……. *(Signature)* **Name** *(Print)* ……. **Date** …….			

Appendix 1: Terms of Reference
Appendix 2: Summary Timeline

Child Practice Review process
To include here in brief:: *• The process followed by the LSCB and the services represented on the Review Panel.* *• A learning event was held and the services that attended.* *• Family members' had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

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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	☐	☐	