Child Practice Review Report

South East Wales Safeguarding Board
Extended Child Practice Review

Re: SEWSCB 1/2021

Brief outline of circumstances resulting in the Review

Legal Context

An extended review was commissioned by the Chair of the South East Wales Safeguarding Board on the recommendation of the Joint Case Review Sub-Group, in accordance with the Guidance for Multi Agency Child Practice Reviews. This was in accordance with 'Working Together to Safeguard People: Volume 2, Child Practice Reviews, Social Services and Well-being (Wales) Act 2014, following the death of a 15-year-old child who will be known hereafter as child D.

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:

- died; or
- sustained potentially life-threatening injury; or
- sustained serious and permanent impairment of health or development; **and**

the child was on the child protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) on any date during the 6 months preceding –

- the date of the event referred to above; or
- the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

Circumstances resulting in the review

This review considers the circumstances of a male child who sadly died aged 15 years and 7 months.

Child D was born in January 2006. He was born at 24 weeks gestation, weighing 0.855kg, which is classed as extremely premature and he was given a 60% chance of survival with an elevated risk of disability. After birth, he spent a total of 19 weeks as an inpatient on a Neonatal Unit. During this time, child D suffered a cardiac arrest

and several bilateral brain haemorrhages. Child D's mother was 16 years old at the time of his birth.

Following his birth, child D was diagnosed with cerebral palsy and had needs associated with the diagnosis. Child D was first known to the Children's Services Disability Team when he was aged 1 year old for Occupational Therapy (OT) involvement due to his complex needs. Throughout the time that Children's Services were involved with child D and his family, they remained as part of the Disability Team within the Local Authority Structure.

Child D resided with his birth parents, however, in September 2007 a deterioration in home conditions were identified and from this point had Social Worker involvement in addition to his OT support. From this period until February 2008, it was also noted that his parents were not following medical advice regarding child D's care and poor home conditions remained a concern. In February 2008, his birth mother stated that she could no longer meet the needs of child D and after a section 47 investigation, child D was placed with Maternal Grandparents and became a Child Looked After (CLA). Following this event, his Maternal Grandparents were granted a Special Guardianship Order in December 2008 for child D. Shortly after this, child D's mother moved home and resided out of area. During this time, child D's mother had another two children who resided with her out of area.

From September 2015, the cluttered and poor home conditions were highlighted as a concern from the OT. In June 2016, child D was assessed for overnight respite care which was granted. At this time, the issues with home conditions became more evident. This precedes his mother and siblings return to reside in the home.

In July 2016, his mother and two siblings returned back to the area and resided at the grandparent's property with child D. Whilst residing out of area the siblings had Children's Services involvement with the family for poor home conditions and inconsistent and neglectful parenting. At this time, the grandparents refused to accept an agreement that his mother would not care for child D. However, they did accept concerns regarding his mother's mental health. During this time, there is little information regarding the siblings and the focus was on child D due to the additional needs and requirements that came with his health conditions.

In June 2016, child D's name was placed on the Child Protection Register under the category of neglect along with his siblings. His name was then removed from the register in November 2016 due to home conditions being acceptable. At this point, his Grandparents acknowledged that child D's mother sometimes struggled to care for him and agreed that they would support each other, and they fully trusted her. At this time, child D's siblings' names remained on the Child Protection Register due to ongoing issues related to their mother's parenting. They remained on the Child Protection Register until September 2017, under the Children's Disability Team, when their names were removed.

Child D continued to have input with OT and also received overnight respite care. Poor home conditions were again identified during 2017 but were improved in January 2018 which highlighted the fluctuation in home conditions.

Child D's health was continually reviewed by a Community Paediatrician and no issues were identified, he was noted to be doing well and progressing in the school environment.

In January 2021, concerns were raised by the respite setting regarding medication management for child D. On assessment, fluctuating home conditions were again noted and support was provided by Social Services. At this point it was noted that short term improvements were made, however, the family were unable to sustain these changes for any length of time. On 8th June 2021, child D and his siblings' names were again placed on the Child Protection Register under the category of neglect. Face to face support was given at this time to access core groups due to COVID-19. Home conditions were improved, and his grandparents stated that they were going on holiday and that child D's mother would be caring for him during this time. Extra Safeguards and support for mother at this time were arranged which included increased family support and school holiday club places were provided.

On the 5th August 2021, child D attended an x-ray for his hips, where it was discovered he was constipated. As a result of this, child D's General Practitioner (GP) was informed so that appropriate medication could be prescribed for the constipation. On the 13th August 2021, an e-consultation was carried out with the GP surgery for a laxative prescription. Prescription collection was arranged from the GP surgery; however, this was not collected.

The Social Worker conducted an unannounced home visit on 17th August 2021 whilst child D's Grandparents were on holidays. Child D was noted to be unwell and had been unsettled and vomiting throughout the previous night. It was reported that child D had had his bowels open normally in the few days before, however the stool that child D had passed the previous day had been small and harder than usual. Medication for constipation and pain relief had been given to child D and the GP had been contacted. It was also reported that a family member would be collecting a prescription from the GP. Consideration must be made that his Grandparents had previously stated that child D's mother struggled to care for him, yet no assessments were formally completed to assess this.

On the 18th August 2021, child D was found in bed unresponsive by his mother. Paramedics were called and poor home conditions were again noted. Unfortunately, paramedics called time of death at the home as there was nothing that could be done to help child D.

Time Period Reviewed

The panel agreed the time period for the review would be from 1st August 2020 to 18th August 2021.

Child D was described as a happy and popular young person who lit up a room with his smile. He was a larger-than-life character whose smile was described as contagious and loved by all that knew him. He was most happy when watching rugby and motor racing both in stadiums and on the television.

Practice and organisational learning

In undertaking this Review, we are grateful for the agency chronologies submitted and the information and time given by family members. We would particularly like to thank the professionals who attended the learning event.

There were four overarching themes identified which have informed the learning points from this review.

- Understanding of child D's lived experiences
- Recurrent poor home conditions and neglect
- Risk assessments for carers' understanding of child D's care needs
- Delay in the delivery of specialist equipment

The review completed considered systems and practice after March 2020, therefore there is a need to consider if there was any impact due to the COVID-19 pandemic. Therefore, we have sought to understand as much as possible how the circumstances of the global pandemic affected child D, his family, and the responses of professionals at that time.

Theme 1- Understanding of child D's lived experiences

At the centre of child protection is the need to comprehensively understand what life is like for the individual child. Any child experiencing abuse or neglect may be reluctant or unable to talk about their experiences. Practitioners need to actively hear what the child has to say or communicate, observe their behaviour in different contexts and hear what family members/significant adults/carers and professionals have said about the child. Practitioners require excellent skills and expertise to develop a trusting relationship with the child, ask the right questions and to critically reflect upon what the child is saying or expressing through their words, actions, or behaviours. Effective practice also necessitates understanding the impact that the histories of those involved in their life may have on the child's experiences.

Child D was predominantly non-verbal due to his complex needs. However, complexities with speech and language should not be a barrier to developing an understanding of a child's lived experience. The Children's Disability Team within the Local Authority currently sits within the Adult Services Structure. Physical needs relating to child D's disability were met with professional input from services such as Occupational Therapy. However, there is a lack of focus on child D's lived experiences as a child with disabilities living within a home where there was cumulative neglect over a number of years.

Learning point 1:
Multi-agency discussions should be bespoke for a child with disabilities and consideration made about how that affects individual children and their families.

Child D and his family had significant input from agencies due to the safeguarding process and there had been regular child protection conferences and core groups. However, during this process, no recognition was given to child D having complex needs. Within the relevant Local Authority, it is noted that the Children with Disabilities Team resides within Adult Services. Therefore, consideration should be given to assess if the care would have been different if the team was part of Children's Services. Within the home of child D, it is also noted that two siblings resided in the property and there is limited information regarding the lived experiences of any of these children.

Recommendation 1:
The Safeguarding Board should consider developing practice guidance on the lived experience of children with disabilities to assist practitioner insight, to ensure that the voice of the child is actively heard and to support effective action to safeguard children and young people.

Recommendation 2: Consideration should also be given for the Local Authority to review the strategic responsibility for the Children with Disabilities Team within the directorate of the authority. This consideration could include ensuring consistency across the region.

Good practice:
Child D's educational setting recognised and raised with his grandparents and mother when he appeared in pain and questioned the cause.

Learning point 2:
It was found that child D was in pain due to regular prescriptions not being collected from the pharmacy. The Pharmacist was not aware that child D's name was placed on the Child Protection Register to raise concerns appropriately.

In line with Wales Safeguarding Procedures, GPs and other relevant health professionals must be invited to Child Protection Conferences. A copy of the outline plan and a summary of the decisions made at the Child Protection Conference should be circulated to all those invited to the conference, irrespective of whether they attend. Pharmacists would come under the category of other relevant health professionals and as they have regular contact with children and their families they should not be excluded from these invitations.

Recommendation 3:
The Safeguarding Board to explore and consider if information from GP's regarding children who are subject to safeguarding procedures, should be shared with Pharmacists to monitor and share information as appropriate.

Theme 2 - Recurrent poor home conditions and neglect

Children who experience neglect can suffer short-term and long-term effects. These can include problems with brain development, risk taking behaviours, difficulty in forming relationships and have a higher chance of suffering with poor mental health. Although any child can suffer neglect, some may be more at risk than others. These

children include those who are born prematurely, have a disability, have complex health needs, those in care and those seeking asylum.

Throughout the time that professionals were involved with child D, there is a clear pattern of home improvements being made and then deteriorations noted within short periods of time. Improvements were seen by professionals when external pressure was aaplied and when mum and grandparents were working together. The cumulative effect of addressing a series of small things could have significantly improved child D's wellbeing.

Throughout the review, it was also noted that home conditions were a further concern for a child with additional needs as it is unclear how child D moved around the home in a wheelchair. The needs of a disabled child are increased, and additional items of equipment are required to enable adequate care to be given. However, this was not considered in any home assessments which were carried out.

The home conditions were noted to be extremely cluttered, and this was again exacerbated due to the amount of equipment that was needed for child D's care. During this time period, external services such as the fire service should have been asked to do a home risk assessment to highlight further risks associated with the clutter.

Learning Point 3:

Practitioners can encounter significant challenges when determining whether a child is suffering or likely to suffer significant harm, and one of these challenges includes organisational expectations regarding thresholds (Wales Safeguarding Procedure, 2019). In addition to these, personal thresholds can also differ. However, it is crucial that these differences are discussed in a multi-agency forum to ensure that expectations and boundaries are clearly defined for both professionals and the families involved.

Professionals should have recognised the cumulative effect of recurrent neglect witnessed by many professionals. If this had been identified and addressed this would have had a positive impact on child D's health and emotional wellbeing. This is particularly important as Child D was at more risk of neglect than some other children due to being born prematurely and having a disability and complex needs (NSPCC, 2023)

Recommendation 4:
The Safeguarding Board to consider the addition of a home conditions threshold to the existing regional neglect guidance. Photographs of home environments should be considered to enable professionals and families to identify and enable change, as appropriate. These could also be used to discuss acceptable standards. A multi-agency approach to a cluttered environment should be considered and agencies such as the fire service to be considered for education regarding risk.

Theme 3 - Risk assessments for carers understanding of child D's care needs

At the time of child D's death, grandparents who held over-riding parental responsibility for him were away on holiday. Child D's birth mother, who did have some form of parental responsibility was caring for him at the time of his death. Child D had complex care needs, used a wheelchair, and required 24-hour care. Medication was also required to be given to child D and tasks such as obtaining medication from a pharmacy required completion. In addition, child D's two siblings required caring for and parenting. The grandparents' judgement of the mother's ability to care for Child D should have been assessed, as well as the mother's capability to provide full care for all of Child D's needs.

Learning point 4:
Risk assessments were not undertaken to ascertain if child D's mother understood his needs fully and if she was able to provide appropriate and effective care to him. The Grandparents had previously raised concern regarding the mother's ability to meet child D's needs, but no formal assessments were completed by services to evidence this.

Good practice:

Professionals recognised that child D's mother may struggle to provide the level of care needed by him and his siblings whilst the grandparents were away. Extra support had been planned for this time with family members providing support, arranging additional sessions in the schools playscheme and the allocated Social Worker attending the home.

Recommendation 5:
When a child is residing with a parent/carer who no longer holds over-riding parental responsibility, Children Services should complete risk assessments for the parent/carer to prove competence related to the care needs of the individual child.

Theme 4 – Specialist equipment

As previously discussed, child D had care needs which required specialist equipment. This equipment needed regular assessment due to child D's growth and needs which were changing. The Grandparents were also aging and were finding it increasingly difficult to independently manage child D due to his growth. The updated equipment had been ordered. However, the delays in the delivery of the equipment were being experienced across all sectors due to the consequences of the COVID-19 pandemic.

Learning point 5:
The delay in equipment should have been risk assessed and escalated further if the risk to the care of child D was identified.

Additional specialist equipment had been identified and provided to the family such as shower slings and lifts. However, these were not being used at the time preceding child D's death as child D displayed distress when using them. These items also

reduced space as these remained in the home even though they were not in use and took a significant amount of space from an already cluttered environment.

Recommendation 6:
Risk assessments should be completed by the Local Authority in partnership with other relevant agencies to evidence and therefore enable escalation of poor service from outside companies when waiting times for equipment exceed expected timescales. The impact to the child or young person should be considered within this.

Learning point 6:
Regular assessments were not undertaken to clarify if equipment was being used by the family, and the reasons if not being used, and subsequent removal if appropriate.

Recommendation 7:
Regular assessments of equipment needed for individuals should be undertaken and equipment removed if appropriate by the Local Authority and partnership agencies. Escalation processes should be clear for all staff across all sectors to enhance the care needs for the child.

Impact of the COVID-19 pandemic

When the Covid 19 pandemic occurred in March 2020, organisations were having to constantly respond and adapt to changing government guidance to ensure continuity of service delivery. The safeguarding duties of statutory partner organisations remained unchanged during the Covid 19 outbreak. Local Authorities and safeguarding partners established clear processes for risk assessment, the prioritisation of cases and the implementation of covid-safe practice.

In Gwent, the Heads of Children's Services issued regional guidance setting out the operational arrangements, as informed by Welsh Government guidance. In practice, this meant that face-to-face visits were prioritised for children where there were safeguarding concerns or for those who required statutory visits as a result of their name being placed on the Child Protection Register or being a Child Looked After, subject to risk assessment. For Child D, this meant that there was a period prior to his name being placed on the Child Protection Register in 2021, when visits and meetings were largely conducted virtually.

Good practice:
School maintained regular contact with the family and child D was offered and attended a hub placement during school closure periods.

The Local Authority provided support at home to enable his grandparents to access virtual core groups.

Improving Systems and Practice

Recommendation 1:
The Safeguarding Board should consider developing practice guidance on the lived experience of children with disabilities to assist practitioner insight, to ensure that the voice of the child is actively heard and to support effective action to safeguard children and young people.

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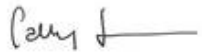
Statement by Reviewer(s)

REVIEWER 1		**REVIEWER 2**	
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 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Eleanor Edwards	**Name** *(Print)*	Susan Goodard
Date	26.02.2024	**Date**	26.02.2024

Chair of Review Panel (Signature)



Name
Sally Jenkins

Date 26.02.2024

Child Practice Review process

The South East Wales Safeguarding Children Board Chair notified Welsh Government on 10th January 2022 that it was commissioning an Extended Child Practice Review in respect of a child.

Reviewer: Susan Goddard, Group Manager, Social Services.

Reviewer: Eleanor Edwards, Senior Nurse for Safeguarding Education and Learning, ABUHB.

Chair of Panel: Sally Jenkins, Director of Social Services.

The services represented on the panel consisted of:

- Social Services
- Education Psychology
- Gwent Police
- Aneurin Bevan University Health Board
- Welsh Ambulance Service

The panel met to review the multi-agency information and to provide analysis to support the development of the report.

A Learning Event took place on 7th July 2023 and was attended by the following agencies:

- Social Services
- Aneurin Bevan University Health Board
- Welsh Ambulance Service
- Gwent Police
- Education

Relevant family members were informed that the review was taking place, and a meeting was held with the Reviewers prior to the event.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to LSCB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Appendix 1

Terms of Reference

EXTENDED CHILD PRACTICE REVIEW IN RESPECT OF SEWSCB 1/2021

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were individual 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.
  (scope 1st August 2020 to 18th August 2021)
- 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 individual 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 Board 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 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.

- Board sends 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 Review Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on Board website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the Board will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.