Diogelu Gwent
Gwent Safeguarding

SEWSCB 1 / 2020
Concise Child Practice Review

## 1) Learning Opportunity

**Reflect** on the case discussed & think of how this situation could have presented in your work with vulnerable individuals.
**Ask** are there any similarities in cases you have worked or situations you have encountered?
**What** would you have done in a similar situation when working with vulnerable individuals & what are the barriers to practice in your organisation?
**Identify** key support for yourself in your team.

## 7) Recommendations

**Theme 1**
The Safeguarding Board should consider a 'Was Not Brought' Policy for adults at risk and children who fail to attend appointments with any agency.
**Theme 2**
The Safeguarding Board should consider how the role of the Care Coordinator for children with complex needs can be strengthened to ensure coordination across multiagency bodies, ensuring the needs of the child are at the centre.
**Theme 3**
Thought should be given to how to strengthen partnership working together. Consideration to the benefits of co-location of all Agencies could be one option. Local Authorities should review their front door arrangements to ensure that all referrals have the initial screening by IAA and the Police including those where a child is known to have a disability.
Chronologies should be completed when making decisions on new referrals into the social work teams. Practitioners should not rely on self-reporting but use professional curiosity and evidence-based practice.

*Adapted from 7 minute briefing created by Hywel Dda University Health Board*

## 2) Reason for Review

This review considers the circumstances of Child C, a female child who sadly died aged 2 years and 4 months. On the day of her death in September 2019, Child C and her mother (Adult A) were staying at the maternal grandmother's house. Adult A woke at 07:15hrs and found that Child C was not breathing. An ambulance was called, and resuscitation commenced. Child C was taken to the hospital but was unable to be resuscitated and was pronounced dead. When the ambulance and police arrived on scene there was no sign of Child C's sleep system or of her NG tube. Both agencies were concerned regarding the poor home conditions and where Child C was found to be sleeping.


## 6) Key Learning Themes

### Communication

Regardless of whether referrals are considered to be potentially malicious they should still be treated as a potential concern and assessed or investigated accordingly. Sharing and gathering information at that initial stage needs to be paramount.

Adult A was clearly under an enormous amount of pressure but in no recordings does it mention that her emotional wellbeing had been considered.

Best practice would always be that the parent provides consent for any referrals to services. The timeline identified that Adult A would often become aggressive or highly anxious which could deflect the concerns raised. It would be prudent to consider why this could be. Had checks been undertaken at the point of referral, then it would have been established that Adult A had experienced trauma as a child, which could have impacted on her ability to parent and to engage with services.

## 3) Background

Child C was born abroad where her father lived. Adult A had a difficult labour and following a traumatic delivery Child C was left with significant complex health issues. Adult A returned to Wales due to what she described as poor Health care but Child C's father was denied a visa to enable him to support or care for their daughter here in Wales. There were a number of referrals made to Social Services, some of which were thought to be malicious which raised concerns in respect of Child C being exposed to inappropriate adults. Adult A was under a huge amount of pressure which often resulted in a breakdown in communication with agencies.

## 4) Key Learning Themes

### Ensuring the needs of the child are given priority

Due to her complex Health needs, Child C had a significant number of medical appointments. These appointments were sometimes on the same day or in different Health sites, which made it difficult for Adult A to attend. Although many of these appointments were attended, many were not. There appeared to be no one person or system that flagged this up. When appointments were missed, they were recorded as "did not attend". Adult A reported difficulty in transporting Child C without a specialist car seat which took over 6 months to arrive once ordered.

## 5) Key Learning Themes

### Supporting families to fulfil their role as carers

There needs to be a regional multi-agency agreement about expectations, roles and responsibilities regarding the Care Coordination role.