Diogelu Gwent
Gwent Safeguarding

Child Practice Review Report

South East Wales Safeguarding Board
Concise Child Practice Review

RE: SEWSCB 1/ 2020

Brief outline of circumstances resulting in the Review

A concise Child Practice Review was commissioned by the Chair of the South East Wales Safeguarding Children's Board on the recommendation of the Joint Case Review Group. 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 2 year old child, who will be known hereafter as Child C in accordance with her family's wishes.

Circumstances Resulting in the Review

This Review considers the circumstances of 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 (Adult B's) house. Her mother woke at 07:15hrs and found Child C was not breathing. An ambulance was called and resuscitation commenced. Child C was taken to the Children's Assessment Unit, but was unable to be resuscitated and was pronounced dead.

Child C had a diagnosis of hypoxic ischaemic encephalopathy and as a consequence had significant complex health needs requiring nasal gastric (NG) feeding and a sleep system for the nights. Child C had developed moderate to severe obstructive sleep apnoea in the months preceding her death, for which she had been admitted briefly to Hospital for 2 nights the month before her death, where a significant weight loss had been noted.

At the Procedural Response to Unexpected Death in Children (PRUDiC) meeting, concerns were raised around the number of missed health appointments and the number of referrals submitted to Children's Services regarding alleged undesirable adults who appeared to be under the influence of substances, frequenting Adult B's house.

When the ambulance and police arrived on scene there was no sight 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.

Background

Child C was born abroad where Child C's 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.

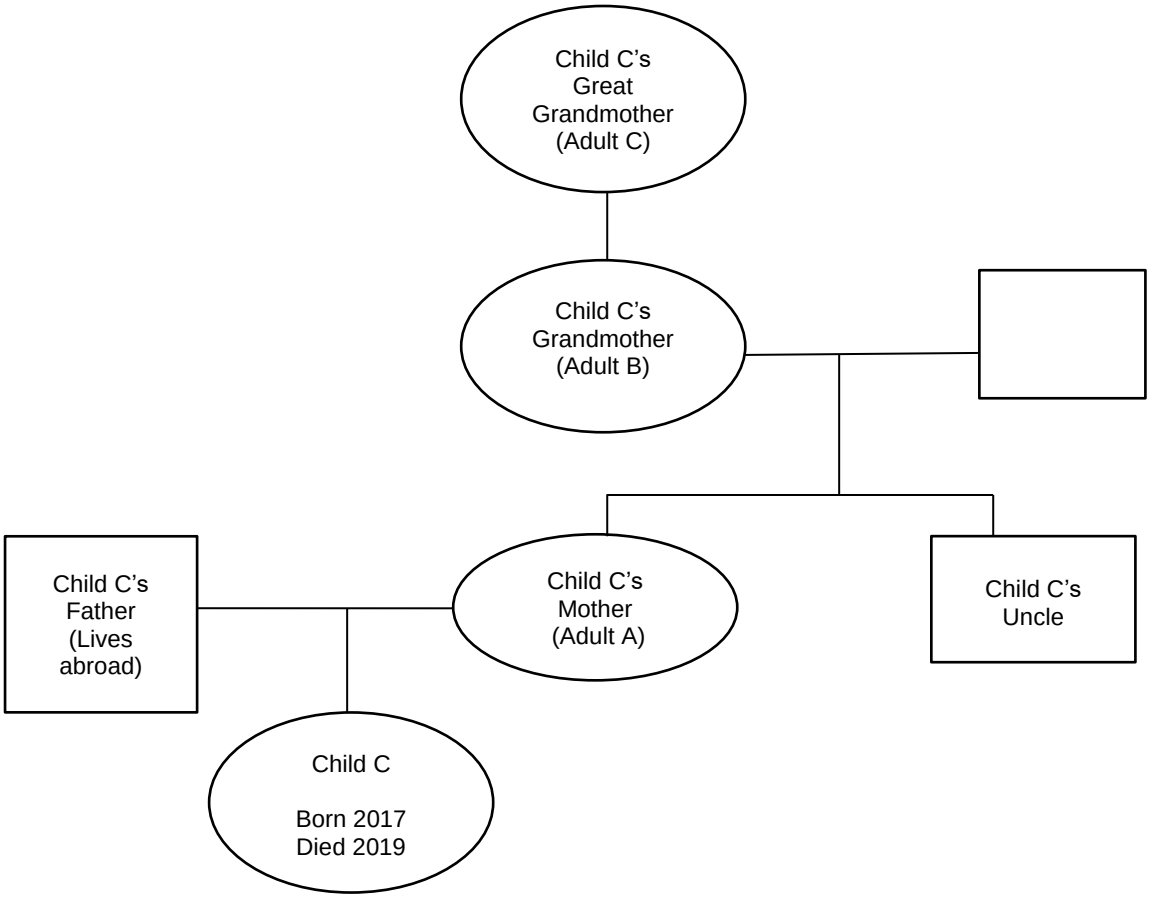
On returning to Wales, Adult A moved in with her own elderly Grandmother (Adult C). The home conditions here, were reported to be acceptable and this was the main address where Health professionals saw Child C and the address to which all specialist equipment was delivered.

It is believed that over the months, Adult C found having Child C and Adult A living with her challenging, given her age and own health needs. Adult A had applied for housing but over a gradual period of time she started spending more time at Adult B's house, which was at the end of the same street. Adult A continued to tell professionals that she was living with Adult C.

Child C had specialist equipment for sitting, sleeping and feeding and this would not have easily been transported between homes.

In August 2019, Child C spent 2 days in hospital and was noted to have weight loss. She was reviewed by a Dietician who prescribed a higher calorie diet. Child C was monitored by the feeding team at home.

Genogram



Time Period Reviewed.

The time period for the review was agreed as from 9th August 2017 when Child C returned to Wales and first made contact with Health services, up until her death on the 14th September 2019.

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.

Themes and Learning Points

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

- Ensuring the needs of the child are given priority
- Supporting families to fulfil their role as carers
- Communication

Theme 1 – Ensuring the needs of the child are given priority

Throughout her short life Child C had many Health appointments with a variety of different Health professionals. For the period of the review, it is recorded that she had 136 appointments, of which she attended 69. 16 were cancelled by the hospital, 23 were recorded as did not attend (DNA) and 28 recorded as could not attend (CNA). The timeline showed that some of these appointments were on the same day at different venues, in short timeframes. Child C also attended a neighbouring Health Board for her Neurological problems (epilepsy).

The Health Board does not have a single patient record. For example Hospital admissions and Emergency Department attendances are recorded on an electronic system, Health Visitors maintain paper records, some therapy services use the electronic system and others have their own or paper systems. For Child C this would mean that professionals may not know about missed appointments as they would not have access to that information.

Learning Points

- Professionals would not have known about the missed appointments.
- No single professional had oversight to be able to risk assess the implications of these missed appointments, to Child C's health, as they were seen in isolation by the departments for whom the appointment was held.
- Care co-ordination was with the Families First Team who were not aware of the missed appointments.
- Professionals supporting children with complex health care needs need to have an overview of the services providing support and ensure that there is effective multi-disciplinary communication.

Good Practice Example: Health staff recorded 'Could not attend' so it was clear when Child C was unable to attend, as opposed to not attending.

Recommendation

- The Regional Safeguarding Board should consider a 'Was Not Brought' Policy for adults at risk and children who fail to attend appointments with any agency.

The family reported they were struggling to attend medical or community based appointments for Child C due to the distress that Child C experienced during transportation. This can practically be attributed to the position that she was in when

she was placed in her car seat which increased the level of dystonic movements and distress which can lead to seizure activity or the need to administer emergency epilepsy medication. A specialist car seat was ordered by the Occupational Therapist who applied to a charity for the funding for this seat, however this took over 6 months.

Learning Point

- The impact the availability of specialist equipment had on ensuring Child C was able to attend appointments, for example waiting for the specialist car seat.

Good Practice Example: Where possible therapies would attend the home to support Adult A with transport issues.

In April 2018, a Multi-Agency Team (MAT) Meeting was arranged by the Care Coordinator but due to the number of professionals unable to attend, the meeting was cancelled. In June 2018, the MAT was reconvened. The Paediatrician at this meeting suggested that Child C would benefit from having a gastrostomy as opposed to her NG tube. There was only one further MAT held which again was not well attended.

Learning Point

- Where professionals are unable to attend MATs, a written update should be provided in advance to the Chair of the meeting.

The timeline does not record if the gastrostomy recommendation was reviewed or why it was not pursued. Subsequent checks have confirmed that Adult A unfortunately missed an appointment and this delayed the action being progressed. The records show that her weight plateaued and fell from her centiles from 13 months of age, to her death.

Good Practice Example: Although Child C missed the appointment, the paediatrician did not discharge her from the service and offered a further appointment.

In August 2019, on Child C's last admission to hospital, she was noted to have had a significant weight loss. Adult A asked to be discharged after 2 nights without a discharge planning meeting or a follow up medical review being arranged.

Learning Points

- If a child with complex disability / medical needs experiences significant weight loss / potential failure to thrive, a medical cause should be explored and consideration also given to whether there are any underlying safeguarding concerns which may require a Multi-Agency Referral Form (MARF), particularly if there are any other red flags, as this may be a feature of neglect to meet the child's basic needs. If the child is admitted they should not be discharged without these issues having been addressed and only when it has been established that dietary modification itself can achieve

weight gain or whether there are other factors.

- Health professionals involved in the community, if weighing the child, should be able to access and record on the Growth Chart on the Aneurin Bevan University Health Board (ABUHB) Clinical Work Station.
- If a child with complex needs is admitted to hospital, a discharge plan should be in place with clear follow up arrangements being documented and the concerns raised by any involved professional to be addressed.

Theme 2 – Supporting families to fulfil their role as carers

In January 2018, when Child C was 8 months old a Care Coordinator* was assigned who would then have regular contact with Child C and Adult A. The Care Coordinator's role and her involvement was to support Adult A but also to help her manage multiple appointments. In February 2018, the Care Coordinator visited Adult A at home and identified that the following support was required:

- Provide a letter of support for Child C's father to obtain a Visa so he can visit to see his daughter
- Apply for DLA/carer's allowance
- Register with Home Seekers and apply for appropriate housing
- Easier access to Child C's prescriptions.

Adult A was offered support however, she did not provide the Care Coordinator with timely information which led to delays in processing the relevant applications. At the learning event the Care Coordinator advised that they had not been aware of the volume of hospital appointments or when or where these were.

The Care Coordinator role is a Social Services position and the post holder had access to some of the Health Board systems. Some appointments are recorded within that system. However in this case the Care Coordinator had not accessed the system and so was not aware of the appointments.

Good Practice Example: Appropriate support was identified and offered to Adult A

Learning Points

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

Recommendation

- 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.

* It is important to note, that not every Local Authority in the Safeguarding Board region has Care Coordinator roles.

Theme 3 – Communication

A Multi-Agency Referral Form (MARF) was made in October 2017 during an admission into hospital where staff identified that Adult A was struggling both emotionally and practically. Social Services attempted to contact Adult A but were unsuccessful so they contacted the Health Visitor and there was an agreement that Families First would be more appropriate to offer the required support. This was on the basis that the Health Visitor had already made a referral to Integrated Services for Children with Additional Needs (ISCAN).

Good Practice Example: A MARF was submitted by the Hospital Nursing staff

Learning Points

- 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 to be made. The timeline identified that Adult A would often become aggressive or highly anxious which could deflect the concerns raised by agencies. If this is evident, 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.

In early July 2019, the first of several MARFs were submitted to Social Services regarding concerns that Child C was now predominately living at Adult B's house and that undesirable people were frequenting that address. Although not anonymous, these were made by someone in the neighbourhood who was known to have an ongoing dispute with Adult A. The neighbour raised concerns that whilst these people were at the property, they were misusing substances. They also highlighted that they were known to Agencies for misusing substances and they should not be having contact with children.

On the 3rd July 19, a "concern for a child's safety" was received by Police. This concern clearly outlined that a child with disabilities was being cared for by many different adults with a history of social services involvement and that they shouldn't be caring for any child. No liaison with other agencies or action was taken.

It is evident that decision making on these referrals was influenced by an over reliance on parental self-reporting and involvement of other agencies. A further complicating factor was professional confusion over roles and responsibilities of each agency which led to little or no co-ordination. There needs to be a better understanding of the roles and responsibilities of agencies supporting the family in order for the right information to be shared.

When parents appear to be struggling emotionally, communication between professionals to agree who is best placed to offer support and take the lead role at that time is critical.

Learning Points

- 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.

Recommendations

- 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.

Improving Systems and Practice

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

Recommendation 1

- The Regional Safeguarding Board should consider a 'Was Not Brought' Policy for adults at risk and children who fail to attend appointments with any agency.

Recommendation 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.

Recommendation 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.

Recommendation 4

- 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.

References:

The Social Service and Well-being (Wales) Act 2014 Https://www.legislation.gov.uk/anaw/2014/4/contents

Statement by Reviewer(s)			
REVIEWER 1	Liz Hiscocks	**REVIEWER 2**	Natalie Poyner
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**	
Name	Liz Hiscocks	**Name**	Natalie Poyner
Date	08.09.2021	**Date**	08.09.2021
Chair of Review			
Name	Gareth Jenkins		
Date	08.09.2021		

Appendix 1: Terms of reference

Child Practice Review process
The South East Wales Safeguarding Children Board (SEWSCB) Chair notified Welsh Government on 4th March 2020 that it was commissioning a Concise Child Practice Review in respect of a child. Reviewer: Liz Hiscocks, Deputy Head of Safeguarding, Aneurin Bevan University Health Board Reviewer: Natalie Poyner, Service Manager, Newport Children's Social Services Chair of Panel: Gareth Jenkins, Head of Children's Services, Caerphilly County Borough Council The services represented on the panel consisted of: • Gwent Police • Social Services • Aneurin Bevan University Health Board The Panel met regularly from June 2020 in order to review the multi-agency information and provide analysis to support the development of the report. <u>Learning Event</u> A Learning Event took place in April 2021 and was attended by the following agencies: • Aneurin Bevan University Health Board • Gwent Police • Children's Services

Family Members

Relevant family members were informed that the review was taking place and meetings were held with Reviewers where requested.

☐ Family declined involvement

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Appendix 1

Terms of Reference

CONCISE CHILD PRACTICE REVIEW IN RESPECT OF SEWSCB 1/2020

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 3rd August 2017 to 14th September 2019)
- 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.