Diogelu Gwent
Gwent Safeguarding

7 Minute Briefing

Concise Child Practice Review

1 Background

A Concise Child Practice Review was commissioned by Gwent RSB in accordance with the Social Services and Wellbeing (Wales) Act 2014 guidance for Multi Agency Child Practice Reviews

The review considers the circumstances of a female child who died aged 8 months. The child had been diagnosed with a heart condition antenatally which required surgery post birth. A naso-gastric tube had been fitted for feeding and medication routine.

The child had been placed in her cot the night before and on the morning of her death, she was found unresponsive. She was deceased when paramedics arrived.

2 Context

The family has a significant history of involvement with agencies, the context of which was domestic abuse, violence and aggression in the community, poor parental mental health, use of illicit and prescribed drugs, ownership of weapons and exotic pets and poor home conditions.

Parents themselves had a complicated history of social services involvement, which included removal of other children and had experienced a still birth the year prior to this child's birth

Prior to this child's birth, agencies had been investigating an allegation of sexual abuse made by children within the family against an older child within the community and another child within the family.

3 Identified Themes

Impact of the COVID Pandemic on agencies engagement with families: When the child was almost 4 months old, the country went into lockdown. Which impacted on direct visits to families. It remained the case however, that all critical need or risk was to be met by face- to- face visits. It is evident that agencies were not always aware of partner agency arrangements for conducting home visits during the pandemic. **Adherence to Safeguarding Procedures under SSWA (2014):** There were occasions when information sharing could have been more robust and warranted the submission of Duty to Reports to Social Services which, set within the historical context of services involvement with this family, may have resulted in the case being opened on a multi-agency basis. **Communication, Information Sharing and Record Keeping:** Record keeping arrangements across the Health departments varies which reduces effective inter-departmental information sharing

4 Identified Themes

Agency Responses to Complex Families: Consideration should be given to a family's history of key risk indicators alongside presenting need. in this case namely, a child with complex Health needs. There was limited emphasis on the potential increased level of risk precipitated by the addition of a new baby into the family.

Roles and responsibilities: Professionals identified that the relationship between statutory services and support services and the roles and responsibilities of enhanced services like Flying Start, can lead to misconceptions about which service is the appropriate service and agency threshold criteria can be perceived to be a barrier to accessing services for complex families.

5 Positive Practice

Service delivery through COVID Pandemic: Service delivery continued by adjusting practice arrangements as a response to the complications imposed by the onset of the pandemic. Some services continued with no disruption to direct contact.

Enteral Feeding Team: Home visiting took place by the Enteral Feeding Team which allowed professional oversight of the capability of the carers to undertake the task within the home environment and nursing staff establish rapport with parents which can be enabling.

Competency assessment: Work has commenced to introduce a review process into practice and competency assessment at the initial home visit by the Enteral Feeding Team. The service is also reviewing the process of assessment upon discharge.

6 Learning and Actions

Agency arrangements for responding to vulnerable families during the pandemic could have been better promoted across all partners. In the event of significant service disruption, individual agency service delivery plans for responding to vulnerable families, are shared with partner agencies.

Submission of Duty to Report referrals: there is a renewed drive on multi-agency training in relation to recognising and responding to concerns in respect of vulnerable individuals and families **and** on the quality of the information submitted.

Sleep environment: A sleep environment assessment was not undertaken. Awareness raising should be promoted amongst Health Visiting services, of the requirement to undertake sleep environment assessments in line with current practice guidance.

7 Learning and Actions

Discharge or multi-agency planning meeting: This would have improved information sharing and coordination of the transition between community and hospital-based services. In cases of new- born babies with complex health needs, which require care in the community, the need for a multi-agency discharge planning meeting is to be considered and the decision recorded

Health service records: Consideration is given to improving how information is recorded, stored and shared between Health departments and partner agencies.

Roles and Responsibilities: There should be awareness raising of the roles and responsibilities of statutory and non -statutory services