Diogelu Gwent
Gwent Safeguarding

Child Practice Review Report

Gwent Safeguarding Board
Concise Child Practice Review

RE: Elena

Brief outline of circumstances resulting in the Review

A Concise Child Practice Review was commissioned by Gwent Safeguarding Board following the recommendations of the Case Review Group convened on 13th November 2020. In accordance with the 'Working Together to Safeguard People' Guidance for Multi-Agency Child Practice Reviews, the criteria for this review are met under section 6. The Terms of Reference for the review are at Appendix 1.

Circumstances Resulting in the Review:

This review considers the circumstances of a female child aged 8 months, who will be known hereafter as Elena. Elena was born in December 2019 with a serious heart condition identified antenatally and for which she underwent surgery immediately following her birth. Elena was fitted with a naso-gastric tube for the feeding and medication routine.

In August 2020, Elena was taken to bed the evening before her death but when checked on the next morning, she was found unresponsive and was deceased when paramedics arrived. A Procedural Response to Unexpected Death in Children (PRUDIC) meeting was held in August 2020.

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

Prior to Elena'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.

Elena's parents themselves had complicated histories of Social Services involvement which included the removal of other children from their care and had experienced a still-birth the year prior to Elena's birth. Both parents also had vulnerabilities in terms of mental health related issues.

Engagement with the family for the purpose of the review

The family has communicated with the reviewers by telephone only.

Time Period Reviewed.

The time-period for the review is March 2019 until the child's death in August 2020.

Practice and Organisational Learning

The reviewers would like to thank panel members and the professionals who attended the Learning Event for their contribution to the review.

We would also like to thank the family for the information provided.

Key Learning Theme: Impact of the COVID-19 Pandemic on agency engagement with families

When Elena was almost 4 months old, the country went into lockdown due to the COVID-19 pandemic. The family was not open to Social Services but was open to Flying Start, which entails an enhanced Health Visiting service. Flying Start released a service recovery plan in June 2020 which supported a return to home visiting.

The onset of the pandemic presented all services with additional challenges especially in relation to conducting direct visits to families. Welsh Government issued guidance, with visits conducted remotely where possible. It remained the case, that all critical need or risk was to be met by face- to- face visits. It was globally recognised that reduced home visits increased risk of harm to some children. From the review, it is evident that agencies were not always aware of partner agency arrangements for conducting home visits.

Good Practice:
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.

Learning Point 1:

- Agency arrangements for responding to vulnerable families during the pandemic could have been better promoted across all partners.

Recommendation 1:

- In the event of significant service disruption, individual agency service delivery plans for responding to vulnerable families, are shared with partner agencies.

Key Learning Theme: **Adherence to Safeguarding Procedures under Social Services & Wellbeing (Wales) Act 2014: Identifying and Responding to Risk**

Agencies have a duty to report concerns which relate to vulnerable children and adults. The key to referral information being submitted is that it helps to build a picture of the current circumstances for families, and this assists risk assessment, management and decision making. Guidance on submitting Duty to Reports is documented in the Wales Safeguarding Procedures.

There are occasions when information sharing could have been more robust and warranted the submission of Duty to Reports to Social Services which, when set within the historical context of services involvement with this family, may have resulted in the case being re-opened on a multi-agency basis as opposed to the case being subject to a linear response. There are occasions when gaps in record keeping, information sharing and the low-level content of the Duty to Reports impacted on the consistency and quality of information sharing. The following highlight these issues.

In March 2020, incidents involving the family came to the attention of police, the nature of which were, a sexual abuse allegation from Elena's sibling perpetrated by another child outside of the family, domestic abuse between parents, threats to neighbours and assaults/threats from the parents toward the alleged child offender. These incidents should have resulted in Duty to Reports being submitted by police.

A Duty to Report was submitted by Midwifery to Social Services during the pregnancy, due to concerns regarding a chaotic household and lifestyle. Information submitted was in the context of the history, including this being the tenth pregnancy and the family experiencing a stillbirth. Whilst Midwifery records indicated the Duty to Report was submitted, Social Services records do not indicate a record of this.

Information submitted to Social Services by Education equally did not result in any need to escalate to more formal involvement.

Good Practice: Health Visitor service contact with the family, including home visits commenced well in advance of the pregnancy.

Learning Point 2:

- Agencies did not always respond to relevant information by submitting Duty to Reports in line with Wales Safeguarding Procedures under the Social Services & Well Being (Wales) Act 2014 and guidance for recognising and responding to concerns in relation to vulnerable individuals and families.

Recommendation 2:

- 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.

Key Learning Theme: **Communication, Information Sharing and Record Keeping**

The family was not being considered under multi-agency arrangements from the time of Elena's birth and up to her death. There is the possibility that submission of Duty to Reports from agencies, combined with the significant history of concerns about this family could have resulted in the case being open to Social Services and the potential for the case for it to be considered under Child Protection procedures. The arrival of a new baby with complex needs in itself, would not be a reason for Social Services involvement at a statutory level.

The cumulative effect of information known to individual agencies about the family, both prior to and following Elena's birth, for example, ongoing issues regarding parental mental health, self-reported use of street drugs and sexual abuse allegations could potentially have been to instigate a multi-agency response.

Elena received treatment for her heart condition from two hospitals outside and one inside the relevant Health Board area. This circumstance is not unusual due to these hospitals having the recognised expertise in complex heart conditions.

At the point of discharge, the criteria for a discharge planning meeting was not met. The review has found that with the added factor of cross–Health Board involvement, a meeting would have been advantageous in this case, as it would have provided a forum for coordination of the transition to community-based services.

From the hospital service perspective, no concerns had arisen to require the submission of a child protection referral and although Elena had some complex health needs, these were considered to be not beyond management within the community setting. The review has confirmed that position.

The system of care at home for children with complex needs relies on the commitment and competency of parents, who are provided with training to complete specific tasks. It is the view of the family that it would have been better if they had received nasogastric tube re-insertion training, prior to discharge instead of later at home which is when it was completed.

As a result of the information shared during this review, the relevant service is undertaking a service review with a view to implementing of a reviewed process. The service review will also look at the process of assessment on discharge with the aim

of standardising training and introducing a competency assessment at the initial home visit.

Midwifery departments managing the case are not routinely notified of a birth out-of-area but do receive discharge notifications. The expected date of delivery was later than the actual delivery date with post-natal care being undertaken by the hospital. Midwifery has identified that records were not updated on the system so there was an assumption that mother and baby were still in hospital and report that their information had disappeared off the system the day before the actual birth.

In line with expected practice, there were no post-natal visits undertaken by Midwifery because post-natal care was administered by the hospital for the required period post birth.

The obstetric history was well known to Midwifery and Health-Visting services and there was communication between these services regarding the birth.
Health Visiting services continued to offer support on a regular basis pre-birth. Records do not confirm the date in which the birth notification was received by the team. There was telephone communication from the hospital a month after the birth to alert them that Elena was being discharged home.

The Health Visitor undertook an unplanned home visit a week after Elena was discharged but there was no response so Elena was not seen. After another week, a planned visit was successful when information was shared regarding parenting mental health and use of street drugs that might have led to the submission of a Duty to Report, however, the overall picture was a positive one. Following subsequent visits, Duty to Reports were submitted requesting support for the family. These did not result in the case being opened to Social Services as it was deemed the appropriate services were in place. At this point, it was established by the Health Visiting service that there was no package of care in the community for Elena. This was followed up by referrals to the relevant Health services. A sleep environment assessment was not conducted during visits.

A month later Elena was taken to the GP by mother following an incident of sleep apnoea. There is no record of this information being shared with the Health Visitor and it is unclear how much the GP knew about the family history. This episode was followed up by an appointment with the cardiology clinic where positive progress in Elena's development was noted and no concerns highlighted.

As highlighted above, several Health departments were involved with the family, namely, General Practice, Health Visiting service, Community Mental Health, Perinatal Mental Health Paediatrics, Midwifery, and nursing teams. There is opportunity for improvement in communication and information sharing between departments. Record keeping arrangements are inconsistent across departments, which it is recognised, poses a significant challenge to the organisation. A comprehensive assessment of the impact of parental mental health on parenting capacity doesn't seem to have been considered. Parental mental health concerns continued to emerge throughout the months prior to and post Elena's birth. It became apparent at the Learning Event that there had been a good level of Community

Psychiatric Nurse support for mother, but this was not widely known amongst the other professionals.

The overarching picture of record keeping, is that it is fragmented across the Health service, with some records maintained electronically and others manually. This reduces the opportunity for efficient information sharing across departments.

Good Practice
Home visiting by the Enteral Feeding Team means that there is professional oversight of the capability of the carers to undertake the task within the home environment and nursing staff to establish rapport with parents which can be enabling.

Good Practice: 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. These are areas of improvement that has been initiated as a result of this review and is directly attributable to the constructive contribution to the Learning Event by those professionals.

Learning Point 3:

- A discharge planning meeting or a multi-disciplinary meeting (MDT) would have improved information sharing and coordination of the transition between community and hospital-based services.

Recommendation 3:

- There is promotion of the utilisation of multi-disciplinary meetings in cases of children with complex need requiring care in the community and where there has been cross Health Board involvement.

Learning Point 4:

- Health service record keeping is fragmented with some not being recorded and stored electronically. This reduces the opportunity for efficient information sharing across Health departments.

Recommendation 4:

- Consideration is given to improving the systems in which information is recorded, stored and shared between Health departments and partner agencies.

Learning Point 5:

- A sleep environment assessment was not undertaken.

Recommendation 5:

- There is awareness raising amongst Health Visiting services of the requirement to undertake sleep environment assessments in line with current practice guidance.

Key Learning Theme: Agency Responses to Complex Families

Historically, the family had been open to social services for periods of time, including periods of Child Protection registration. Examination of the family history identifies the presence of significant stress factors predominantly, poor parental mental health, use of prescribed and unprescribed drugs, violence and intimidation, a recent still birth and investigation into allegations of sexual abuse.

The combination of these key risk indicators in families can lead to multi-agency intervention. In this case, this did not happen because the family was instead, open to services which were considered relevant to the presenting need, 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.

The family was open to the Flying Start Health service element only, which entails an enhanced Health Visiting service. Flying Start submitted a notification of birth to social services in January 2020. Health Visiting services submitted a request for support from Disabled Children Team in March 2020. Neither of these warranted an escalation in Social Services involvement.

The COVID pandemic increased social isolation and led to an undermining of the continuity of support around the family. This, combined with a distrust/dislike of authority reinforced the barriers to effective engagement with the family. Continuity of social support is identified in research, as essential to effective engagement with complex families and support can only be effective if there is a good level of communication between all agencies.

At the Learning Event, 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 or multi-faceted families.

Learning Point 6:

- When working with complex families, there can be misconception about the roles and responsibilities of statutory and non-statutory services which includes lack of clarity regarding threshold criteria for access to each service.

Recommendation 6:

- There should be awareness-raising regarding the duties, roles, and responsibilities of statutory and non-statutory services.

Summary:

Elena was a baby with some complex health needs which had been identified antenatally. Despite this her death, at the time it occurred, was unexpected. The PRUDIC meeting and Coroner concluded that the death was not suspicious.

The focus of this review has been the level of inter-agency effectiveness in the case and what if anything could have made a difference to the way partner agencies engaged with the family.

In terms of health, wellbeing and safeguarding, children with complex health needs and/ or disabilities are known to be more vulnerable. Regular inter-agency communication, clear expectations and inter-agency trust are the core elements of inter-agency working in order to protect against such vulnerabilities. In this case, parents also had their own complex needs which required the involvement of agencies. There were many stress factors for the family which may have been compounded by the onset of the COVID-19 pandemic potentially compromising parenting capacity.

The review has found that there were areas of learning for agencies in terms of adherence to procedures, communication, information sharing and the approach to complex families. Learning points and recommendations contained in this review contribute to an action plan to address the areas of learning which will be implemented across the Gwent Safeguarding Board area.

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: -

Learning Point 1:

- Agency arrangements for responding to vulnerable families during the pandemic could have been better promoted across partners.

Learning Point 2:

- Agencies did not always respond to relevant information by submitting a Duty to Report in line with Wales Safeguarding Procedures under the Social Services &Well Being (Wales) Act, advice, and guidelines for recognising and responding to the protection of vulnerable individuals and families.

Learning Point 3:

- A discharge planning meeting or multi-agency disciplinary meeting could have improved better information sharing and coordination of community and hospital-based services

Learning Point 4:

- Health service records are fragmented with some not being recorded and stored electronically. This reduces the opportunity for efficient information sharing across Health departments

Learning Point 5:

A sleep environment assessment was not undertaken.

Learning Point 6:

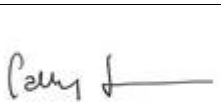
- When working with complex families, there can be misconception about the roles and responsibilities of statutory and non-statutory support, which includes, misconception about threshold criteria for access to each service.

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	Deborah Davies	**REVIEWER 2**	Elizabeth Hopkins
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)*	Deborah Davies		Elizabeth Hopkins
Date	11.10.2022	**Date**	11.10.2022

Chair of Review Panel (Signature)	
Name *(Print)*	Sally Jenkins
Date	11.10.2022

Child Practice Review process

The South East Wales Safeguarding Children Board (SEWSCB) Chair notified Welsh Government on 02.12.20 that it was commissioning a Concise Child Practice Review in respect of a young child.

Reviewer: Torfaen Children's Social Services

Reviewer: Newport Children's Social Services

Chair of Panel: Head of Children's Services, Newport CBC

The services represented on the panel consisted of:

- Gwent Police - Public Protection Unit
- Children's Services (Local Authority Areas 1 and 2)
- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust
- Education

The Panel met regularly in order to review the multi-agency information and provide analysis to support the development of the report.

A learning event was held on 16th July 2021 and was attended by the following agencies:

- Aneurin Bevan University Health Board
- Gwent Police
- Children's Services.

Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.

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**
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Appendix 1

Terms of Reference

CONCISE CHILD PRACTICE REVIEW IN RESPECT OF SEWSCB 2/2020

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.
- 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.