Child Practice Review Report

Western Bay Safeguarding Children Board

Concise Child Practice Review

Re: WB S36 2017

Brief outline of circumstances resulting in the Review

Legal Context:

A Concise Child Practice Review was commissioned by The Western Bay Safeguarding Children Board (WBSCB) on the recommendation of the Practice Review Management Group (PRMG) in accordance with the Guidance for Multi-Agency Child Practice Reviews. The criteria for this Review were met under section 6.1 of the above guidance namely:

A Board must undertake a concise 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:

(a) Died; or
(b) Sustained potentially life threatening injury; or
(c) Sustained serious and permanent impairment or health or development

and

the child was neither on the child protection register nor a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –

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

The criteria for concise child practice reviews are laid down in legislation – Part 7 of The Social Services and Wellbeing Act (Wales) 2014. Specifically Volume 2 Child Practice Review guidance.

Circumstances Leading to the Review

This review considers the circumstances of an 8 month old baby who died in the spring of 2017. An ambulance was called to the child's home and the baby was conveyed to the local hospital where he was pronounced deceased by the examining paediatrician. There were no injuries found on the baby and the paediatrician's opinion was that he had died prior to his arrival at hospital. The mother reported that she had found him blue/white in colour, stiff and not moving when she had awoken that morning. The baby and his elder sister were sharing Mother's bed. At the PRUDiC (Procedural Response to Unexpected Death in Children) meeting following the death there were concerns that the mother was continuing to bed share with her older child and that she was drinking alcohol. An Initial Child Protection Case Conference (ICPCC) was held in April at which it was disclosed that Mother had in fact been drinking regularly prior to the baby's death, including the night of his death.

A referral was made following the ICPCC to the Western Bay Child Practice Review management group who made the decision that a review should be undertaken.

Family Background. The Genogram for this family can be found at appendix 1

Throughout this Report there are 6 children mentioned, numbered 1 to 6 with the oldest being Child 1. Additionally there are 2 Local Authority areas namely LA1 and LA2.

The index child was the sixth child of this mother and the father's third child. Four older maternal siblings had been removed from their parents care in 2012 following Domestic Abuse incidents. The two youngest maternal half siblings were adopted and their adoption was finalised during the scope of this review. The elder two were Looked After by Local Authority (LA1) foster carers. The eldest child had actually left foster care and was, at times living with his mother and also living independently during the scope of this review. The fifth child of Mother was born in a neighbouring Local Authority area (LA2) after the Care Proceedings for the older children were completed. That child's name was placed on the Child Protection register at birth after Mother took an intentional overdose whilst pregnant. This child's father is not that of the older siblings.

During the care proceedings of the index child's older siblings a psychological assessment was undertaken in respect of Mother. This assessment showed that Mother had a personality profile with a number of impulsive sensation seeking and histrionic personality traits. Such a personality style features behaviours that may be erratic and/or unpredictable. It was not felt that her personality traits amounted to a personality disorder. At the end of the proceedings the judge gave permission for this report to be shared with professionals working with the family. It became apparent during the learning event that this report had not been shared with health and they stated they had no knowledge of Mother's personality traits. Although, the minutes of the Review Child Protection Conference held in October 2014 in LA2 clearly includes *"The psychologist report highlights Mother has a personality type*

which can include an egocentric personality where she could place her own needs above those of her children" Health are not recorded as being invited to attend the meeting or provide a report; although the list of those involved with the family does include a Flying Start Health Visitor. The minutes also do not indicate whether a copy was sent to any health representative; this box is blank.

The father of the index child did not live with the mother and she reported he had minimal involvement with the family; after the death of the index child Mother shared that the father was an 'alcoholic'. In addition Mother disclosed that since the removal from her care of the first 4 children, she had been consuming four cans of alcohol daily; further, since the death of the index child this had increased to eight cans. It is worth noting here, that at no point during agencies involvement with the family was alcohol use by Mother suspected or known.

During the period of the review there were several house moves for the family. Alongside this there were six changes of Health Visitor some of which were as a result of staff changes. In addition to transient housing, there were other known stressors for Mother during the scope of the review, the index child's older half sibling 2 was unsettled in their foster placement, seeking a legal return to Mother; this request was unsuccessful. Oldest half sibling 1 was reported by Mother to be 'angry' and at times aggression was displayed in the family home which was corroborated through Health Visitor recording of damage in the home.

Child 5 was the subject of a Child Protection Plan until early 2015 where at the Review Child Protection Case Conference the decision was reached that concern had been reduced and the child would now be subject to a Child in Need Plan. It is minuted that deregistration is recommended on the basis that the Public Law Outline (PLO) process would provide sufficient protection. At no point was this decision challenged by the Independent Reviewing Officer (IRO)/Conference Chair. This decision had a significant impact upon the PLO process, from which the Local Authority LA2 had to withdraw. The rationale being that if the threshold for a Child Protection Plan was not met, threshold for a Care Order no longer existed. All professionals involved at the Child Protection Case Conference appear to have viewed the fact that the PLO ongoing to have been a protective factor; they did not appear to appreciate that the removal of the child's name from the Child Protection Register (CP Register) would undermine the PLO process.

Current Situation

Child 5 is currently looked after by the Local Authority (LA2) and resides with maternal grandparents. The mother is currently pregnant with her seventh child; she reports that the pregnancy is the result of a "one night stand", a pre-birth Child Protection Conference has been held and the unborn child will become the subject of a Child Protection Plan at birth. Mother has stated to professionals that she plans to share a bed with this child; alcohol use and mental health continue to be a concern for her. Child 1 has returned to live with his mother and there have been incidents of aggression involving Child 1, Mother and neighbours.

The Learning Event

An interagency timeline of agencies interventions was produced to inform the learning event. A summary timeline can be found at appendix 2.

Learning Event Attendees included staff members from the following agencies:

ABMUHB Health staff x 6
Children's Social Care, Swansea x 5
Children's Social Care, Neath Port Talbot x1
Police x 2

Unfortunately the Principal Officer responsible for the PLO was unable to attend on the day however one of the Reviewers did meet with her following the Learning Event and a useful discussion around case related decision making rationale was held and incorporated into the report; however, this did not allow for the multi-agency discussion and analysis that the learning event would have provided.

Mother and father of the index child were written to prior to the learning event; there has been no response from the father but Mother's solicitor has provided a legal response. To date neither has sought to take up any opportunity to meet with the reviewers. Their comments would have been gratefully received and incorporated into the event and this report.

Practice and organisational learning

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

Cross boundary working:

During the scope of this review the index child was not known to either Children's Social Services (LA1 or LA2). The maternal sibling, Child 5, had been the subject of a Public Law Outline (PLO), a Child Protection Plan and was the subject of a Child In Need Plan. At the time of the index child's death there was no Local Authority involvement with Child 5. The case for Child 5 had been closed to LA2 for 18 months.

Throughout the scope of this review Child 2 remained open to a neighbouring Local Authority (LA1). Child 1 was also, at times, open to Children's Social Services or support agencies in the Local Authority area (LA2).

It was apparent from discussion at the learning event that not all relevant information had been shared across the two Local Authorities. Events involving

Child 1 and Child 2 were not routinely shared by LA1 with LA2. This resulted in the respective areas working parallel. At times decision making in respect of Child 5 was therefore not fully informed. Attendees at the learning event felt that the sharing of this information may have led to different discussions at key decision making points.

The psychological report which highlighted Mother's personality type provided detail that this mother was known to "use disguised compliance and her ability to work at any more than a superficial level would be in question". This was not shared by LA1 with partner agencies with the result that any impact upon her ability to work openly was not given due consideration.

The LA1 did not share information routinely with LA2 on the basis of 'significance'. If LA1 had considered there to be 'significant' information they would notify LA2. It was the view of event attendees that information should be shared and the onus be upon the receiving Local Authority to then consider action and/or disposal.

It was acknowledged that there is already Welsh Government legislation and guidance in place that informs cross boundary working, although this is in respect of children who are subject to a Child Protection Plan via the All Wales Child Protection Procedures 2008. Practitioners attending the learning event would welcome practice guidance aimed at those children with a Care and Support Plan to outline how Local Authorities should work together and share information particularly when sibling groups are split across Local Authority boundaries.

<u>Inter-agency Information sharing:</u>

At the learning event there was a lack of clarity regarding the outcome of Mother's psychological assessment that had been undertaken as part of a previous PLO in LA1. Some attendees believed Mother to have been diagnosed with a Personality Disorder and other attendees shared their professional anxiety at not knowing such significant information and considered whether this might have altered their decision making rationale at key points. The detail of the report was known to LA1 working with the index child's older maternal half siblings and it was reported by them that Mother would work on a very superficial level with agencies, telling them what they wished to hear and not providing a full account of events; she was further reported by some professionals to be 'plausible'.

Subsequent to the learning event this court report was shared with the reviewers and it is worth noting at this point that the psychological report states:

" [Mother] *has some moderate personality difficulties particularly in the presence of impulsive sensation seeking and histrionic personality traits"..." extremely impulsive who will often act without considering the effect of her actions upon herself or others"*

The report concludes:

"there is no psychological reason why the parents should not be able to work in an open, honest and constructive manner with professionals"

A further concern in respect of information sharing was identified and involves the process at the 'Information Access and Advice Service of LA2. At the learning event the Midwife shared that she had contacted the service, to share that Mother was pregnant with her sixth child and there had been a significant history of Local Authority involvement. The Midwife nor Local Authority staff had any current concerns. There is no written record in the Health notes of this communication and there is no record in the Local Authority information. However, it was explained during the learning event that only those contacts which lead to allocation or a service from Children's Social Care will have a record kept, therefore were this conversation to have taken place and there is no reason to doubt that it did, because the concern did not lead to an active referral, the information was not logged. There is no explanation why this information sharing was not recorded within Health records.

Terminology

It was apparent through the recordings contained in the timeline and from discussion at the learning event that some professionals did not understand terminology used regarding the status of the case at key points and felt it to be 'confusing'; therefore their statutory responsibility at key decision making points may not always have been fully understood.

Domestic abuse:

Prior to the scope of the review both Child 1 and Mother were arrested. Police attended at the grandparents' home because Child 1 was missing; upon arrival Child 1 had returned home and an incident took place which involved Child 1 and Mother. South Wales Police widely shared the incident however Child 5 was not identified and cross referencing was not robust enough across agencies.

Health had observed some damage in the home which Mother stated had been caused by Child 1; she further reported that he was depressed and angry and there had been times when he was using New Psychoactive Substances (NPS). Health consistently shared this information with subsequent Health Visitors and routine enquiries were undertaken; however, further incidents were not disclosed by Mother and there was no further Police involvement.

During the learning event Health professionals referred to their concern regarding Child 1 and their concern regarding domestic abuse however this concern was not shared with other agencies on the basis of assumption that it was already known; practitioners need to be reminded that concerns should be shared regardless of whether it may already be known. Throughout the scope of this review Child 1 was either living in the home or was a frequent visitor; however there appears to have been little consideration of the impact of his behaviour upon his younger, maternal siblings.

It is worth noting that there has been an increase in Risk Assessors within the Police, increasing capacity to task officers where information contained in Public Protection Notices (PPNs) is missing.

Consent issues:

During the learning event it became clear that practitioners had differing views and understanding on the need for consent to make enquiries with other agencies if a Child Protection threshold was not clear; this has been considered as part of a recent Child Practice Review (WB B 20/2015).

New partners involvement:

It appears minimal enquires were made about Mother's relationship with her new partner and little is known about the quality of this relationship or of the level, type and quality of contact with the children. This is especially concerning given Mother's vulnerability and previous abusive relationship.

Many times throughout the scope of this review Mother spoke about her 'partner' and due to the turbulent nature of the relationship it was difficult to establish whether she was referring to the father of the index child or another man. At key points she was not asked to provide a name, professional curiosity would have assisted in establishing the identity of the men in her life and the lives of her children.

Closing cases:

In respect of Child 5, an extensive piece of work around Mother's parenting was completed. However, it was identified at the learning event that upon closure of the Child In Need Plan no closure summary was provided to partner agencies. The records do confirm that a meeting was held with Mother that Health, although contributed to, did not attend where closure of the case was agreed. The minutes of this meeting were not distributed and therefore the closure summary was not shared; the outcome of parenting work was also not shared with partner agencies. Where a complex case is closed, Children's Services should ensure that all safety planning work that is still relevant should be shared with partner agencies. All agencies would then be clear about future trigger points for recognition and referral.

Co sleeping:

Advice about co-sleeping was given alongside other advice regarding the risk of "cot death", such as placing the infant on their back to sleep. Risk factors such as drug use (including prescribed drugs) and alcohol are discussed but should be emphasised particularly when discussing the issue of co-sleeping with parents. The Collaborative Thematic Review 2010-2012 of unexplained sudden infant death (uSID) (Child Death Review, Public Health Wales) recommended that:

Front line professionals should receive regular training so that they understand the key messages on the prevention of uSID, including research evidence on the interaction between co-sleeping and other risk factors such as smoking, low birth weight, very young infants and alcohol consumption, and are able to deliver these messages to parents.

The evidence review concluded that sleep position, co-sleeping, unsupervised sleep, pre and post-natal maternal smoking and being small at birth are risk factors for Sudden Infant Death (Price, et al. 2014). Whether or not co-sleeping in the absence of parental smoking or other factors was a risk factor remained unresolved. There was no evidence that planned co-sleeping in conjunction with breast feeding, in families with no other risk factors, was implicated in the deaths.

The Healthy Child Wales Programme has introduced a Birth Visit check by the Health visitor on where the infant will sleep.

Improving Systems and Practice

Cross boundary working

Guidance to be developed to help Children's Social Care staff to work better with their colleagues from other Local Authority areas, particularly in cases where members of the same family reside in more than one area.

Inter-agency Information sharing

Significant information about parents known to one agency should be shared with other agencies working with that family where there are historical or current Child Protection concerns so that all agencies are aware of any problems.

Where a family is subject to a complex history of concern significant changes e.g. – pregnancy, should be discussed with the relevant Children's Social Care agency.

All conversations held with Children's Services should be documented in the child's records – even if the outcome of the conversation is no further action.

Terminology

It appeared from the time line that some staff were confused about the exact legal status of the children during Children's Services involvement, and the case may not have been appropriately prioritised as a result of this. Detailed information about the different legislation should be included in Child Protection training.

Domestic abuse

The issue identified associated with an incomplete PPN is less likely to arise now that Police have an increased capacity of Risk Assessors. All PPNs should be completed in full, including details of children or vulnerable adults in the home and all efforts should be made to ensure full detail is recorded at the time of the

incident. All agencies continue to have a responsibility to cross reference details with their own records.

Consent issues

There were concerns expressed by professionals at the Learning Event about making enquiries without consent when the threshold for Child Protection was not clear. Similar concerns were raised in another recent Child Practice Review: WB B20/2015

"They were anxious that the Social Services and Well Being (Wales) Act 2014 would suggest this is not allowed, whereas what is important is that families are advised of the need to share information when practitioners consider it is justifiable. *(Laming, 2003 - Victoria Climbie Inquiry at 1.46 of his Report)"*

New partners involvement

Minimal information was obtained about the father of the index child and the child's mother changed the reported status of their relationship quite frequently. Practitioners need to be clear about family structure and seek information about all adults involved with a child and to consider the type, level and quality of contact and care.

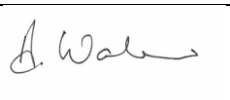
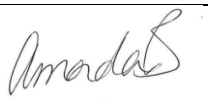
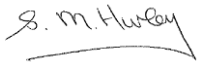
Closing cases

An "End of Pre-Proceedings Assessment Period" letter was sent to the mother on the closure of the PLO process. This highlighted what was expected of her going forward. No similar letter was sent to professionals who would be continuing to work with the family. A letter to professionals highlighting future changes which would be likely to raise further concerns would be helpful when cases are closed.

Co sleeping

Front line professionals should receive regular training so that they understand the key messages on the prevention of unexplained sudden infant death. The "other risk factors" should be emphasised when these messages are delivered to parents.

Co sleeping advice should be further reinforced after baby reaches 6 months, particularly with respect to risk factors.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
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)*	Andrea Warlow	**Name** *(Print)*	Amanda Baker
Date 07.08.18		**Date** 07.08.18	
Chair of Review Panel *(Signature)* **Name** *(Print)* **Date**	 Sue Hurley 07.08.18		

Appendix 1: Terms of Reference
Appendix 2: Summary Timeline

Child Practice Review process
ABMUHB Health staff x 6 Children's Social Care, Swansea x 5 Children's Social Care, Neath Port Talbot x1 Police x 2 Unfortunately the Principal Officer responsible for the PLO was unable to attend on the day however one of the Reviewers did meet with her following the Learning Event and a useful discussion around case related decision making rationale was held and incorporated into the report; however, this did not allow for the multi-agency discussion and analysis that the learning event would have provided. Mother and father of the index child were written to prior to the learning event; there has been no response from the father but Mother's solicitor has provided a legal response. To date neither has sought to take up any opportunity to meet with the reviewers. Their comments would have been gratefully received and incorporated into the event and this report.
X Family declined involvement

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Date information received ……..

Date acknowledgement letter sent to LSCB chair ……

Date circulated to relevant inspectorates/Policy leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	