Child Practice Review Report

Western Bay Local Safeguarding Children Board

Concise Child Practice Review

WB N 13/2014

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 Child Practice Review Management Group (CPRMG) in accordance with the Guidance for Multi-Agency Child Practice Reviews. The criteria for this Review were met under section 5.1 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 was 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 extended/ concise reviews are laid down in revised regulations, The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012

Circumstances Resulting in the Review:

A concise review was commissioned by WBSCB on the recommendation of the CPRMG in accordance with the Guidance for Multi Agency Child Practice Reviews.

The scoping period for the review was agreed as the 12 month period from 14th January 2013 to 14th January 2014. This agreed time covered the antenatal period and the time leading to the baby being admitted to hospital. In the course of the review process it was noted that multi-agency information provided in the timeline

would not identify sufficient learning to warrant a learning event for the professionals involved. Therefore it was agreed that this concise review report would be completed without convening a specific learning event and the report would be shared with relevant staff to provide them with an opportunity to identify any learning, practice issues and good practice observations or share additional learning.

This review relates to one child, who at age 4 months was admitted to hospital in January 2014 presenting with a history of vomiting and being floppy. Medical examination and subsequent radiological investigations identified a number of serious injuries to the neck, thoracic and lumbar parts of her spinal cord, fractured ribs, fractures to both tibiae and numerous bruises and grazes over her body.

Parents and baby were living with extended family throughout the baby's life including the time of the hospital admission. The family were only involved with one agency in the preceding period; that being health professionals in relation to the pregnancy and post natal care. There was extensive contact with the family during this time and this was mostly unremarkable. There were no obvious signs of concerns in relation to abuse and neglect observed by professionals up to the hospital admission; although two potential "injuries" were noted and managed by relevant health staff (see following section).

The local authority issued care proceedings following the diagnosis of child maltreatment. Through the course of the proceedings the father provided a statement in which he gave his own account of circumstances at home and an admission to causing the injuries to the baby. The judge noted that the explanation given by father was completely at variance with any understanding of human nature. The father was convicted of the offence of causing Grievous Bodily Harm with Intent upon the child and received a custodial sentence.

Practice and organisational learning

The following learning points arose from a review of the timeline and information from agencies in contact with the family:

1. There was contrast in the presentation of the family to health professionals and that as described through father's statement and Family Proceedings judgement, father's behaviour being described as;

   'conduct so completely at variance with any understanding of human nature, conduct which has no basis rational or irrational....which violates the most basic and elemental taboos which govern our society'

   It is difficult to identify specific learning in such exceptional circumstances and aid the learning in how professionals can identify children at risk within this context. As a general note, practitioners should be aware that within a child protection context (this case identified no child protection concerns until the hospital admission) parents' behaviour can fall in to a number of categories of behaviour towards professional intervention such as disguised compliance.

Disguised compliance happens when parents or carers don't admit their lack of commitment to the process and work subversively to undermine it (Valios, 2012). Father described a stressful and erratic relationship at home and taking on much of the practical caring tasks, but he did not ask for help from professionals. Daniel (2013) describes why some parents do not respond to assistance; some are unable to use voluntary services for various reasons, some have difficulty accepting they need help, others don't recognise there is a problem and others avoid professionals.

2. The family's presentation to health services during pregnancy and the first 4 months of baby's life raised no significant concerns:

   The family appeared to engage well with health professionals. The family had many appointments which were well attended. The mother attended at least 12 antenatal appointments with health staff.

   The mother tried to breast feed her baby despite a number of factors that would have made this more difficult such as a preterm baby of 34 week gestation and prolonged jaundice, by bringing expressed breast milk to NICU, and attending the family unit to try and establish feeding.

   Both parents were at home for the initial weekly health visitor visits and were described as polite and welcoming. The family attended neonatal follow up appointments and blood tests at the hospital. Although at the time of the second minor injury presentation the father did not want to comply with the plan of waiting for eye drops to take effect and the family went home, they returned the same day following health request. However mother has stated that this is inaccurate. She stated that eye drops were administered and testing was done and they were told they could take the baby home. About an hour later the doctor rang and said the test hadn't been done and they needed to bring the baby back to hospital which they complied with.

3. Practice by health professionals identified:

   The Start Well Flying Start Midwife undertook a home visit at 31 weeks and identified a number of family issues including mother's disrupted upbringing, unplanned pregnancy, and sparse home environment.

   The routine enquiry was undertaken by the midwife and it was documented that mother did not disclose that she was a victim of domestic abuse. The Health Visitor documented that she was unable to ask the mother about the relationship as the father was always present at home visits. The NSPCC DVD 'I promise' was shown to both parents the day after the baby's birth.

   At the first birth visit at home, the Health Visitor did a Child And Family Needs Assessment (CAFNA) identifying multiple vulnerabilities (housing situation, young couple with troubled backgrounds, on benefits and preterm baby with slow weight gain). Due to the medium level of concern, the family accepted the more intensive weekly visiting programme until the baby was 6 weeks old. However the CAFNA score was still medium at 6 weeks which would indicate

the need for continued visiting and the review of the CAFNA score at a minimum of 3 months. The Health Visitor explained that prior to taking planned leave; in subsequent months her cases were reallocated to colleagues. This was carried out in order of priority and this case was not identified as one of highest level of need consistent with the empty case load guidance.

There were multiple documented observations of the parents' relationship and how the parents handled the baby, none of which raised concern.

4. Minor injuries:

   At three weeks old the Health Visitor identified a small graze on the back which the parents suggested was caused by the nappy being too big. A plan was made and followed up 8 days later with smaller nappies in use and healing of the graze. The Local Safeguarding Children Board (LSCB) 2010 Multiagency Policy for Bruising and other Minor Injuries to Babies recommends referral to paediatrician when a non-mobile baby has a visible injury which did not occur. However the policy does not have a clear definition of minor injuries, and only specifies bruising; bleeding from the nose or mouth, sub conjunctival haemorrhage but not 'grazes'. The WBSCB updated this policy in 2014 including a clear definition of minor injuries. The reviewers consider that although the practice did not fully comply with the policy that it was a reasonable response and referral to a paediatrician would not have changed the outcome for the baby.

   At two months, the paediatrician at a routine outpatient appointment identified a sub conjunctival haemorrhage and scratch near the eye. Child maltreatment was considered and a second paediatric opinion was requested consistent with LSCB policy, which was explained to the parents. The family were unable to wait for eyes to be dilated to complete the ophthalmology assessment and went home against medical advice. This increased concerns and the family were contacted and were seen that evening by the ophthalmologist who assessed the injury as consistent with father's explanation that the baby grabs her face when upset. Mother has disputed this version of events (see previous reference on page 3). The injury was considered to be accidental; therefore a referral to social services, nor further non accidental injury investigations were indicated. Reviewing the radiology results from the hospital admission in January, the rib and tibiae fractures were aged as not present at the time of this minor injury and it is unlikely that any fractures would have been identified at this time.

   The action taken by the paediatricians was consistent with the LSCB policy, and another Health organisation's guideline (2)

References:

Daniel, B. (2013), Action on Neglect – A Resource Pack

Local Safeguarding Children Board 2010, Multiagency Policy for Bruising and

other Minor Injuries to Babies

Western Bay Safeguarding Children Board 2014. Multi-agency policy for Minor Injuries in Babies

Valios, N. (2012) Community Care; http://www.communitycare.co.uk/blogs/childrens-services-blog/2012/06/disguised-compliance-tips-for-social-workers/

Guideline for assessment of Subconjunctival haemorrhage (SCH) in infants and recognition and response to safeguarding concerns. Nottingham University Hospitals NHS Trust 2014

Improving Systems and Practice

This child practice review has concluded that the serious injuries incurred by the baby were unpredictable. The court has noted it was the father who was responsible for the injuries sustained by the baby, and the father's behaviour was inexplicable. With the benefit of hindsight the quality of professional judgement and decision making was acceptable and proportionate to case circumstances as they presented at the time.

1. Updating of Minor Injuries Policy 2010 has been undertaken and replaced with Multi-Agency Policy for Minor Injuries in Babies 2014, to be reviewed September 2015

2. Health input significantly reduced when the baby was 6 weeks old despite medium concerns remaining. The panel would invite the Health Board to reinforce the guidance in relation to contact with families and the CAFNA assessment where families are categorised as a medium concern.

3. The panel noted that neither parent was seen on their own following birth. There were no opportunities on home visits as the parents were living in one bedroom in the home of paternal grandmother. Mother attended baby clinic but there were no known indicators in this setting to further explore any specific issues with her.

   Therefore the panel recommend the Health Board consider this in any review of the guidance in relation to communicating with parents about domestic abuse and other concerns.

Conclusion:

The review has identified that despite extensive and thorough direct contact with this family there were no indications for health professionals that abuse was occurring.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER2** ***(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)*	Alison Mott Designated Doctor, Safeguarding Children Service, Public Health Wales	**Name** *(Print)*	Michael Holding Principal Officer Safeguarding, Quality & Performance
Date ……..……. **Date** ……..……..……			

Appendix 1: Terms of Reference

Western Bay Safeguarding Children Board

Terms of Reference

Concise Child Practice Review WB N 13/2014

A case of a child who was physically abused and suffered serious permanent impairment of health and development.

Index Child: WB N 13
Other siblings: None

Scope of Review: 14th January 2013 to 14th January 2014

Co-reviewer	-	Alison Mott, Designated Doctor Safeguarding Children Service, Public Health Wales
Co-reviewer	-	Mike Holding, Principal Officer Child and Family Services, City & County of Swansea Council
Chair of Panel	-	Samantha Jones, Child Protection Coordinator for Education & Youth Service, Bridgend CBC

Panel Members Included From the Following Agencies:

South Wales Police
Neath Port Talbot CBC, Children and Young Peoples Services
Abertawe Bro Morgannwg University Health Board
Welsh Ambulance Services NHS Trust
Neath Port Talbot Youth Offending Team

Core Tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the WSCB.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child 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 reviewers 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 child 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 WSCB 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 Western Bay 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.

- WSCB send 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 WSCB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the WSCB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

Appendix 2: Summary Timeline

February and March 2013

Mother attends antenatal appointments, full antenatal booking interview undertaken by community midwife. The pregnancy information sharing process completed.

April and May 2013

13 week appointment for antenatal screening, expected date of delivery confirmed as 14th October 2013. 16 week routine antenatal appointment.

June and July 2013

20 weeks anomaly scan and appointment with Start Well Flying Start Midwife. 25 week routine antenatal appointment.

August and September 2013

Home visits from Sure Start midwife, both parents engaged with the antenatal programme. Plan agreed to return to extended family following delivery of baby. Family social history noted by midwife. 32 week antenatal follow up with consultant. Baby born at 34 weeks gestation. Baby admitted to Neo-Natal Intensive Care Unit due to gestational age and signs of respiratory distress. NSPCC DVD shown to both parents. Baby discharged home.

Health visitor birth visit at home. CAFNA score medium. CAFNA is Child and Family Needs Assessment – brought in to replace the CAFRA in 2013 and aims to ensure a consistent approach to health visitor assessments in the health board. Following the assessment families are given a low, medium or high priority. A number of vulnerabilities were identified by the health visitor - housing situation, young couple, on benefits, troubled backgrounds, and premature baby with slow weight gain. At this level families would be offered increased support – weekly visits would be conducted as enhanced health visiting offered to Flying start families. Positive observations of both parents.

Small graze noted on baby's back.

October and November 2013

Home visits by health visitor note both parents being tired. Interaction between parents and baby positive. Sub conjunctival haemorrhage noted by doctor at outpatient review. Full examination undertaken. Parent explanation is that baby scratched her eye. Second opinion sought from community paediatrician. Concern that parents left the hospital without full ophthalmologist tests being completed. They

returned later the same day and Ophthalmologist examination noted injury consistent with described mechanism.

January 2014

The Welsh Ambulance Service received a call to attend the home address, baby was admitted to hospital.

Appendix 3

Arrangements for the review

This family were considered by the CPMRG where it was agreed the criteria for a Concise Child Practice Review was met.

Co Reviewer - Alison Mott

Co Reviewer - Mike Holding

Chair of Panel - Samantha Jones

Panel Members Included From the Following Agencies:

South Wales Police

Bridgend CBC, Education

Neath Port Talbot CBC, Children and Young Peoples Services

Welsh Ambulance Service Trust

Abertawe Bro Morgannwg University Health Board

Neath Port Talbot Youth Offending Team

Following the first panel meeting timelines were produced by agencies and merged. It was agreed there would be no specific learning event, but that the report would be specifically shared with relevant staff who had worked with the family. The family were offered the opportunity to meet with the Reviewers so their thoughts and feelings about the way agencies worked with them could be fed into the process.

☐ 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	☐	☐	