	CASE REFERENCE **LSCB / RSCB**
Concise Review	☐
Extended Review	☐
MAPF	☐

Review Process

Circumstances Resulting in the Review

An Extended Child Practice Review was commissioned by the Chair of the Conwy & Denbighshire LSCB, on the recommendation of the Regional Child Practice Review Sub Group, in accordance with "Safeguarding Children: Working Together Under the Children Act 2004" Guidance and "All Wales Child Protection Procedures 2008". The purpose of the review was to:

- Establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children.
- Identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result.
- As a consequence, improve inter agency working and better safeguard children
- Identify examples of good practice

This review was undertaken following the death of a 5 week old baby. The baby had been placed on the Child Protection Register under the category of Likelihood of Physical Abuse due to the parent's history of Domestic Abuse. The parents had 3 previous children, the 2 eldest children had been adopted and the youngest child was in foster care.

During the mother's pregnancy, her relationship with the father of her children ended and she was accommodated in supported housing. During this time she engaged with Social Services and attended midwifery appointments. Unknowingly to all agencies, the mother had developed a friendship with another man which continued after the birth of the baby. Following the birth of her baby the mother suffered from postnatal depression and was prescribed anti-depressants by her GP but remained engaged with services.

The Child Protection Plan stated that the mother should notify the Social Worker regarding overnight stays away from her home. The night of the baby's death, the mother stayed at her new partner's flat without informing Social Services. The baby had been unsettled that night and was settled in bed with the mother and partner. In the morning the baby was found blue with blood around nose and mouth. An ambulance was called and resuscitation attempted. Baby was pronounced dead in hospital.

Methodology:

- A Review Panel was convened with a Chair
- 2 Independent Reviewers were appointed

- Timelines were developed from each agency identified and these were amalgamated into one timeline
- A summary/analysis of each service involvement was produced
- The 2 reviewers met with mother on 26 June 2014 to gain her views and give her an opportunity to contribute to the Learning Event
- A Learning Event held for practitioners facilitated by the 2 reviewers and attended by the chair was held on 4 July 2014
- A draft Review Report was produced with recommendations and presented to the Panel on the 24 July 2014
- A Panel Meeting held 12th August 2014
- Further Panel Meeting held on 24th September to accept Final Report
- Report presented to the Regional CPR Sub Group 17th October 2014
- Presentation to be delivered to Regional Safeguarding Children Board 13.3.15
- Feedback to family

Practice & Organisational Issues Identified

Narrative:

The review focussed on three key learning points and areas of effective practice for each agency

Child Protection Processes

Consideration to be given to the point at which staff withdraw their involvement with a family and the impact this might have

In this case the support worker ceased her involvement at the discharge meeting**.** The support worker had a positive relationship with the mother (as evidenced during discussions with both mother and support worker) and the discharge from hospital with the new baby was a critical time to change the support networks that were already established**.** The decision seems to have been based on organisational constraints/ processes rather than the needs of the family.

Information Sharing at Child Protection Conferences

There was no link made at the Child Protection Conferences about the MARAC meetings that had taken place in regard to this family. Previously there was also no Probation staff invited to Conference even though an ex offender was involved. The reviewers also queried the role of the chair who had commented that the only risk was the perpetrator of the domestic abuse. This could have prevented the conference from considering the wider potential risks posed by the mother.

The incident in March that the police were called to was recorded as criminal damage and not domestic abuse; however, given the history of the case, consideration should have been given to this being a domestic abuse incident and entered on a CID16 to ensure that information was shared appropriately with agencies.

Child Protection Planning

Whilst core group meetings were held regularly, it was not clear to reviewers why the plan

allowed mother to go to some places during the day, but not to stay overnight. Also there was no clear contingency if the Child Protection Plan did not progress.

Over Optimism/Disguised Compliance

As part of the Child Protection Plan the mother was asked not to stay at particular houses with the baby, however the social worker believed the mother when she said that she was staying with a friend and did not make any checks. There was an over optimism based on the positive relationship that had formed between the Social Worker and the mother.

Strategy Meetings

The Local Authorities timeline states that there had been a Strategy Meeting prior to the baby's birth in order to agree that a Child Protection Conference was required. In reality this was a discussion between the manager and the worker and as such could not be considered a Strategy Meeting as per the All Wales Child Protection Procedure's. It is not clear from the timeline or discussions in the Learning Event, when the referral was made, regarding the forthcoming baby, or what assessment processes were put in place at an early stage, given the history of this case.

Midwifery Services to Children on the Child Protection Register

At present the frequencies of visits are not increased when a baby is placed on the Child Protection Register and midwifery input is only increased if there are increased physical needs. Their role is not to do welfare checks however this was not the common understanding of partner agencies.

Transfer of Information

Handover between Community Midwives

In this case the second Community Midwife involved, in the latter part of the mother's care, was not aware of the mother's past history.

Handover between staff

There was a change of worker during the delivery of care to this family and Hafan Cymru felt that more information should have been shared between workers.

Case Transfer Process

This was highlighted as an area of good practice by the reviewers as the Social Worker had received a good handover from the Social Worker in the previous authority, when the family moved to the present authority. The previous Social Worker had relocated to the same office as the current Social Worker and this resulted in a smoother handover as background knowledge of the family was easily accessible, and provided the Social Worker with a point of reference, rather than just reading from a file. The Local Authority has confirmed that there is a Transfer Protocol which encourages face to face meetings at the point of handover.

Correct Storage of Midwifery Hand Held Notes

There was no postnatal information available to the Panel due to the hand held notes being missing.

Clarity re Externally Funded Services VS Universal Services

It was not clear to professionals and the mother what the differences were of having externally funded services rather than universal services. For example, Flying Start Services and Supporting People Services were involved.

Supervision/Support

Participants access to records

Some participants at the Learning Event said that they had not had access to their records so had been unable to refresh their memories

Good support required by staff prior to Learning Event

BCUHB provided very good support to staff who participated in the Learning Event however this was not replicated across all agencies and needs to be provided as a matter of routine, to ensure that staff are adequately supported throughout

During this case the Practice Leader was absent due to sickness. This was a difficult and complex case for the Social Worker who was also dealing with the mothers previous children via the court processes The Social Worker perceived she had received limited supervision during this period. However positive comments were made that she had received a high level of informal support from colleagues.

Bereavement Support/ Emergency Situations

Immediately following the admission of the baby to hospital the Social Worker felt she had not been given clear direction by her manager as to the purpose of her attendance at the hospital. However this was the perception of the Social Worker and not corroborated with further information. The use of Critical Debriefings would have been beneficial.

Improving Systems & Practice

In order to promote the learning from this case the review identified the following actions for the Regional Safeguarding Children Board and its member agencies:

Social Services

- Child Protection Plans must be outcome focused with realistic timescales and a clear contingency so that family members are aware of what will happen if the plan does not progress
- Validation by agencies should always be undertaken in order to verify the information given to safeguard the wellbeing of the child.
- Pre-birth assessments should be considered by Local Authorities as soon the pregnancy is confirmed by a referral, even if the case is already open to the department.
- Ceasing professional involvement with families should be planned and discussed with family members and if possible some flexibility shown. Decisions should not be based solely on funding streams.

Transfer Meetings should be facilitated between Social Workers from different Local Authorities rather than just case summaries/assessments being sent over.

BCUHB

- The system developed for the return of midwifery hand held notes needs regular audit/monitoring
- BCUHB to provide clarity to professional's and families as to the differing service provision provided by Universal Midwives/Health Visitors and Flying Start Midwives/Health Visitors and regarding roles/responsibilities

Hafan Cymru

- Review/standardise the transfer process within Hafan Cymru

North Wales Police

- Police Officers, attending Child Protection Conferences, need to ensure they are sharing **all** relevant information required, for example MARAC,. MAPPA previous domestic incidents.

All Agencies

- Frequency and quality of formal supervision to professionals in all agencies should be regularly audited by senior management, to identify any anomalies. At times of sickness, managers need to ensure levels of supervision, are maintained
- Child Protection Plans should be mindful of disguised compliance when measuring change.
- Consideration should be given as to how senior managers advise/inform staff when a child dies and ensure adequate support networks are available. All agencies to introduce a Critical Debrief Model.

Conclusion:

Whilst it was envisaged that mother would not want to engage with the Child Practice Review process, when approached she engaged well. Mother who was from a Welsh Caucasian background agreed to meet with the reviewers in her home. Mother stated that she was happy with the services provided during her pregnancy, she was clear that she did not want any professionals blamed for the death of her baby and believed that nothing could have been done to prevent it.

Whilst there is no evidence at this time to suggest that the death of this child was preventable there has been learning identified for agencies and actions recommended for the future to improve interagency working.

This case particularly highlighted for the reviewers the importance of support provided to staff following the death of a baby. Several staff members reported that files had been taken/locked down from them immediately following the death leaving them feeling vulnerable and "somehow to blame". The majority talked about their frustration at not having been told anything further feeling left in the dark and wondering about what would happen in the future. All professionals were asking if the death could have been prevented however without a final cause of death it is hard for anyone to say at this time.

There are several areas of good practice within this case which should be shared across North Wales such as the positive working relationships established both between agencies and with the family; however a consistent theme has been the problematic handover processes both in terms of information sharing but also timing of changes of personnel working directly with this family.

Finally the importance of supervision for staff during these complex cases needs to be highlighted to all agencies but particularly with Local Authorities. The reviewers feel that it is imperative that all agencies review their supervision policies and put a system in place to robustly monitor both the frequency and the quality of formal supervision.

Statement by Reviewer

REVIEWER

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.

Reviewer 1 (Signature)	Chris Weaver	**Reviewer 2 (Signature)**	Francine Salem.
Name (Print)	**Chris Weaver**	**Name (Print)**	**Francine Salem**
Date	**24.4.15**	**Date**	**27.4.15**

Chair of Review Panel (Signature)	R Shaw
Name (Print)	**R Shaw**
Date	**27.4.15**

Annex 1: Terms of Reference

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North Wales Regional Safeguarding Children Board Child Practice Review Panel

TERMS OF REFERENCE FOR HJ EXTENDED CHILD PRACTICE REVIEW

Introduction

- **This Child Practice Review has been commissioned by the Chair of Conwy and Denbighshire LSCB on the recommendation of the Regional CPR Group in accordance with 'Safeguarding Children: Working Together Under the Children Act 2004' guidance and AWCPP 2008, which have been adopted by Conwy and Denbighshire LSCB.**

- **A multi-agency Review Panel and review Panel Chair has been identified by the Regional CPR Group and 2 External Reviewers have been commissioned to undertake the review - Francine Salem, Head of Service for Safeguarding, Wrexham CBC, and Chris Weaver, Interim Safeguarding Lead, Mental Health and Learning Disability CPG, BCUHB. The Chair of the review Panel will regularly report progress to the Regional CPR Group.**

- **Review Panel Members:**
  - **Rachel Shaw, Designated Nurse Child Protection, Public Health Wales (Chair)**
  - **Francine Salem, Head of Service for Safeguarding, Wrexham CBC, Reviewer**
  - **Chris Weaver, Interim Safeguarding Lead, Mental Health and Learning Disability CPG, BCUHB,** Reviewer
  - **Dr Sue Roberts, Community Paediatrician, Betsi Cadwaladr University Local Health Board**
  - **Sue Trehearn, Service Manager - Safeguarding and Practice Quality, Children & Family Services, Denbighshire County Council**
  - **DCI Mark Chesters, North Wales Police**
  - **Christine Hinton, Safeguarding Children Specialist Paramedic, Welsh Ambulance Service NHS Trust (Observer)**
  - **Tricia Jones, Regional Business Manager, Hafan Cymru**
  - **Catherine Mason, Clinical Nurse Specialist, Safeguarding, BCUHB**
  - **Nia Grisdale, Legal Advisor – to provide support to the panel as and when required**
  - **Gabrielle Heeney, Business Manager, North Wales RSCB to be responsible for governance arrangements for the retaining of documentation**

Purpose

- **Establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children.**

- **Identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result.**

- **As a consequence, improve inter agency working and better safeguard children.**

- **Identify examples of good practice.**

Terms of Reference

The terms of reference agreed for this review are:

1. **The following services will produce a timeline of actions taken by each agency from 1st November 2012 to September 2013.**

    - **BCUHB Midwifery**
    - **BCUHB Health Visiting**
    - **BCUHB Acute and Community Paediatrics**
    - **BCUHB Emergency Dept**
    - **BCHUB General Practitioners**
    - **WAST**
    - **North Wales Police**
    - **Denbighshire SSD**
    - **Hafan Cymru**

2. **A summary/analysis of each services involvement will also be produced by the above services. This will include additional background information from outside the timescale for the review as well as initial analysis of the key issues involved, an indication of further issues for consideration by the Reviewer and any recommendations if appropriate. This should be brief (no more than 2 sides of A4)**

3. **Other services may be asked to provide a timeline following review of the information provided.**

4. **Determine whether decisions and action taken in the case comply with local and national policies and procedures**

5. **To examine inter-agency working and service provision for the Child**

6. **To determine the extent to which decisions and actions were child focussed.**

7. **The Reviewers to meet with the family to seek contributions to the review and keep them informed of key aspects of progress.**

8. **Identify any features of the case, which indicate that any part of the review process should involve, or be conducted by an independent party.**

9. **Identify any parallel investigations of practice and determine if a co-ordinated approach will address all the relevant questions.**

10. **To hold a learning event for practitioners.**

11. **The Reviewers will produce a succinct Review Report with recommendations which will constitute the Overview Report and Executive Summary under the current regulations in accordance with 'Safeguarding Children: Working Together under the Children Act 2004' Guidance**

12. **The Reviewer will share the Review Report with the family**

13. **The review panel will establish an RSCB/LSCB action plan from recommendations**

14. **The Review Report will be presented by the reviewer and Chair of the review Panel to the RCPR Group and RSCB and it will then be made available to the public on the RSCB/LSCB website.**

15. **The Chair of Conwy and Denbighshire LSCB/RSCB will be responsible for making all public comment, and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the Review Report. A media statement will be prepared by the Review Group and approved by the LSCB/RSCB Chair for use at publication of the Review Report, if required.**

16. **The LSCB/RSCB and Panel will seek legal advice on all matters relating to the review. In particular this will include advice on:**

    - **Terms of Reference**
    - **Disclosure of Information**

Appendix 2: Summary timeline

Conwy & Denbighshire Local Safeguarding Children Board
Summary Timeline

Type of activity	2013								
	Jan	Feb	March	April	May	June	July	Aug	Sept
Midwife Services		Booking Appt	18 wks pregnant CP Referral made	21 wk appt	25 wks appt. CP Conf held	HV meeting. Pre Birth Assessment completed. 33wk appt	36wk appt	Baby born 5.8.13	
Health Visitor/School Nursing Service						HV meeting with Flying Start midwife. Pre birth assessment completed	Meeting with midwife. Liaised with SS	Review CP Conf held. Pre Discharge meeting. Primary Birth Visit. Core Group. 2nd Home Visit	T/C to SS. Mother feeling low in mood. Appt to see GP. Reviewed by HV. 12.9.13 death of baby
Hospital Services									
Police			DA incident. Recorded as criminal damage		CP Conf held				12.9.13 Sudden/unexpected death of baby
WAST									999 call received on 12.9.13 2 ambulances dispatched. Police informed. CPR commenced. Baby handed over to ED
GP	12 wks pregnant Scan		Low mood. Prescribed anti depressants						Anti depressants changed. HV informed GP of death of baby
Social Services	SW informed of pregnancy. Report of assault by ex partner			Referred to Freedom Programme. Strategy Discussion	CP Conf held. Core Group meeting	Core Group meeting held	Core Group meeting held	Review CP Conf held Pre Discharge meeting. EDT inform SS re not staying at home. PLO Letter. Core Group. 2nd Home Visit. PLO Meeting. Aware of new male friend. PNC check	CP visit 12.9.13 informed of death of baby
Hafan Cymru				Moved to supporting housing	Concerns re male visitor. CP Conf held	Poor engagement. Liaised with SS	Requesting to move & to discontinue support	Review CP Conf held. Aware of new male friend	Feeling low in mood. Accompanied by male. SS informed of death of baby