Concise Child Practice Review Report

CYSUR 1/2017

Date report presented to the Board: 17th October 2019

Child Practice Review Report

CYSUR: Mid & West Wales Safeguarding Children Board

Concise Child Practice Review Re:
CYSUR 1 /2017

Brief outline of circumstances resulting in the Review

Legal Context

A Concise Child Practice Review was commissioned by CYSUR: The Mid and West Wales Safeguarding Children Board on the recommendation of the Child Practice Review Sub Group in accordance with the Social Services and Well-being (Wales) Act 2014[1] and accompanying guidance Working Together to Safeguard People - Volume 2 - Child Practice Reviews[2].

The criteria for this review are met under section 3.4 of the 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 of health or development; **and**

the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding -

- The date of the event referred to above; or
- The date on which a local authority or relevant partner[3] identifies that a child has sustained serious and permanent impairment of health and development.

The criteria for concise reviews are laid down in The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015[4].

The purpose of the review is to identify learning for future practice. It involves practitioners, managers and senior officers exploring the detail and context of agencies' work with a child and their family. The output of the review is intended to generate professional and organisational learning and promote improvement in future interagency child protection practice.

The Terms of Reference for this Concise Child Practice Review are at Annex 1.

[1] Social Services & Well-being (Wales) Act 2014
[2] Working Together to Safeguard People – V2 – CPRs (WG 2016)
[3] Local Authority or relevant partner means a person or body referred to in S.28 of the Children Act 2004 or body mentioned in s.175 of the Education Act 2002
[4] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. Regulation 4 (3)

Brief Outline of the circumstances resulting in the review

The CYSUR1/2017 Concise Practice Review was commissioned following the death of an infant who was 4 weeks old.

He died in the spring of 2017, following an episode of co-sleeping with his mother. His mother was reported to have consumed a large amount of alcohol both in licensed premises and in a caravan with acquaintances before falling asleep with her infant in bed. He was found in the early hours of the morning to be unresponsive whilst in bed with mother. The emergency services were called and life support was initiated, but tragically the infant died later in hospital.

Family History and Context

The mother and father were separated and the father was not aware of him until after the birth. This was the mother's first child and she received antenatal care and the child was born healthy. After their discharge from hospital, mother and baby received follow-up care from the Midwifery services, and both were seen once by the Health Visitor.

The mother was breast feeding and it was observed that mother's care and attachment was good at the Health Visitor's primary visit. This visit by the Health Visitor was when he was 12 days old and it was noted that the infant had gained weight. Mother then moved house and despite efforts, the new Health Visitor did not see mother and baby before the infant's death.

On the morning of his death, the infant was found to be unresponsive whilst in bed in a caravan with mother. The Emergency Services were called and life support was initiated at the scene by the Mid and West Wales Fire and Rescue Service (MWWFRS). This was further supported by the Welsh Ambulance Services NHS Trust (WAST) and continued in the ambulance and then at the District General Hospital.

Though there was a prompt response from the emergency services and the infant was promptly transferred to the Hospital, tragically he died.

The infant and mother had been asleep together in bed in a caravan. Mother had been consuming alcohol during the course of the evening in both licensed premises and privately with acquaintances in the caravan.

In accordance with procedures a Professional Response to Unexplained Death in Childhood (PRUDiC)[5] meeting was held.

The Police instigated a criminal investigation into the events.

[5] Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2010

Time period reviewed and why

The proposed outline for the Concise Child Practice Review was from the period of 1st June 2016 to 31st March 2017. The timeline reviewed was agreed by the Child Practice Review Sub Group, in order to include the time period from the identification of mother's pregnancy until his death.

It should be noted that at the commencement of the Child Practice Review process, there was an ongoing Police investigation. This did not delay the Child Practice Review process or in identifying and acting on the learning but did mean that the report could not be finalised until the Police investigation and criminal proceedings were completed.

Family involvement in the Child Practice Review Process.

The Independent Reviewer wrote to both parents at the start of the review and kept them updated during the course of the review. The parents did not respond therefore it is acknowledged that there are limitations to the review in that it does not have the views of the parents or family nor the personal stories about the infant involved in the review.

Practice and Organisational Learning

Key themes and learning arising from the review

Key theme 1. Effectiveness of inter- agency working and service provision

During the period of the review there were only two agencies who had contact with mother. These were Health and Housing and any decisions and actions taken complied with policies and procedures in place at the time. It was evident from the timelines and the Learning Event that there was no significant history to note which would have caused there to be any concerns regarding mother's parenting of baby.

There was a period of poor engagement in the early stages of pregnancy, but this was followed up appropriately by the Midwifery services. It was noted during the Learning Event that there was some confusion as to the status of the Health Board's Midwifery 'Failure to Attend Antenatal Care/ Follow up Non- Attendees' policy. During the Child Practice Review Process the policy[6] was reviewed.

Key theme 2. Safe care of children and the use of alcohol

There had been no evidence throughout pregnancy or in the post-natal period of any concerns regarding mother's alcohol use, and it was recorded during ante natal care that she was abstaining from drinking during her pregnancy.

During the course of the evening prior to baby's death, mother was reported to have been consuming alcohol with her sister in a number of licensed premises, and later in a caravan with some acquaintances. The baby was with them throughout the evening. The caravan was situated in a caravan park owned by a large company who have safeguarding policies and incident reporting mechanisms in place. The company's documentation states that staff are trained in child safeguarding and that there are designated key staff members with this responsibility. During the course of the evening, no concerns were recorded as being raised by the staff at the licensed premises or by members of the public.

Staff at all licensed premises and the public who access these premises need to feel empowered to raise safeguarding concerns regarding parental consumption of alcohol in the presence of their child/children.

A representative from the Local Authority's Licensing Department participated in the Learning Event and was able to contribute to the learning and recommendations.

[6] Hywel Dda University Health Board Failure to Attend Antenatal Care/ Follow up Non- Attendees policy 2009 (review date 2012)

Learning.

Training and advice given by the Local Authority's Licensing Department should reinforce the issue of selling alcohol to persons who appear under the influence of alcohol or substances. This may provide a further opportunity for children to be safeguarded.

Key theme 3. Co-sleeping whilst under the influence of alcohol

The infant's death occurred following an episode of co-sleeping with mother following her consuming alcohol. There is clear evidence from Child Death Review processes and Serious Case Reviews, of 'co-sleeping' being a contributory factor in child deaths, with alcohol being a significantly aggravating factor[7][8][9]. The mother had been advised on several occasions during the antenatal and postnatal period regarding the risks of co-sleeping under the influence of alcohol and was given the 'Bump, Baby & Beyond[10]' booklet which has a section on co-sleeping. During the Learning Event it was noted that the health professionals had felt confident in discussing with mother the risks of co-sleeping. The contributory risk factor in this case appears to be the use of alcohol.

Learning.

The importance of providing information relating to the risks of co-sleeping when under the influence of alcohol cannot be underestimated and parents/carers need to be aware of the increased risks involved when consuming alcohol.

Key theme 4. Record keeping

Health staff identified some areas of record keeping which could have been improved, but this was not identified as being a contributory factor in the death of the infant.

Learning.

The importance of robust record keeping in order to clarify information or events.

[7] https://learning.nspcc.org.uk/media/1348/learning-from-case-reviews_parents-who-misuse-substances.pdf

https://www.lullabytrust.org.uk/wp-content/uploads/Evidence-base-2019-1.pdf

https://www.bmj.com/content/339/bmj.b3666

[8] www.//child%20practice%20reviews /co%20sleeping/Overview-Report-Child-A-Final_Published-18-March-2016.pdf

http://southamptonlscb.co.uk/wp-content/uploads/2017/11/CDOPAR2016-17-Final.pdf

[9] www.//child%20review/co%20sleeping/Ages_of_concern_learning_lessons_from_serious_case_reviews.pdf

[10] Public Health Wales Bump Baby and Beyond

Effective Practice

There were many examples of effective practice identified in the care of the mother and baby.

1. There were a number of missed appointments in the early stages of pregnancy and the Midwifery services followed these up appropriately and mother's engagement improved towards the later stages of pregnancy.
2. There was clear evidence of good communication between the Midwife and Health Visitor. Key information regarding the change of address was communicated from the Midwife to the Health Visitor. This was important as the mother had not informed the Health Visitor of the change of address. The Health Visitor then communicated with the new Health Visitor and was able to provide a prompt handover.
3. Co-sleeping and risk factors including alcohol use were discussed with mother on several occasions both during the antenatal and postnatal care periods.
4. There was a prompt multi agency response to the incident and resuscitation was undertaken in a challenging environment and continued until and following his arrival at the District General hospital and handover to the hospital medical team.
5. There is clear evidence that the Child Protection process under the All Wales Child Protection Procedures 2008 and the PRUDiC procedures were initiated promptly.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:

There were no identifiable concerns regarding the mother's parenting or use of alcohol during the antenatal or postnatal period. These unfortunate circumstances came about after mother had been socialising and consuming alcohol whilst caring for him. It appears that the effects of the alcohol and the co-sleeping arrangements contributed to the tragic death of her infant who was only 4 weeks old. In this sense, none of the agencies had any information which would have indicated a risk of harm.

As previously noted, there was an ongoing Police investigation and although there was not a delay in the process or in identifying and acting on the learning, the report could not be finalised until the Police investigation was complete.

The Police investigation concluded in June 2019 when baby's mother appeared in Crown Court and pleaded Guilty to the indictment of Child Neglect.

The areas of improvement for agencies, as listed below, are the ones identified through the analyses and through the Learning Event, and were highlighted by the participants themselves, rather than issues which could have prevented his death.

Areas identified for improvement

Health

1. To review Hywel Dda University Health Board's 'Failure to Attend Antenatal Care/ Follow up Non- Attendees' policy.
2. To ensure Health Visiting staff are fully aware of the importance of accurate record keeping.

Licensing recommendations

1. The Local Authority Licensing Officers to request that the 'Personal License Holder' course training provider includes the subject of selling alcohol to persons in charge of children as part of the programme.
2. The Local Authority Licensing Officers to reinforce advice and guidance in relation to selling alcohol to persons who appear under the influence of alcohol or substances during routine licensing visits.
3. The Local Authority Licensing Officers to provide an input to local 'Pubwatch'/ 'Behave or be Banned' meetings on the subjects of serving alcohol to persons who are under the influence of alcohol or substances and those in charge of children.

Dyfed Powys Police

1. Dyfed Powys Police to consider local activities aligned to the national 'Drink Less Enjoy More' campaign.

CYSUR

1. To consider a multi-agency response to raise public and agency awareness about the risks associated with alcohol consumption and the safe care of children.

Public Health Wales

1. To consider a national campaign across Wales about the risk factors associated with co-sleeping and Sudden Infant Death Syndrome.

Improvements in practice noted to date

The final panel meeting members acknowledged that many of the areas for improvement that were identified during the Child Practice Review Process have since been actioned.

1. Hywel Dda University Health Board's Midwifery 'Failure to Attend Antenatal Care/ Follow up Non- Attendees' policy[11] has been reviewed.
2. The Senior Nurse Manager (Health Visiting) now regularly audits Health Visiting records to quality assure the standard of record keeping.
3. The Local Authority's Licencing Department has commenced working with staff in licenced premises regarding safeguarding awareness.
4. Dyfed Powys Police launched a summer campaign - #joiohdp/ enjoydpp which includes safe advice on a number of issues including safe alcohol use. https://www.facebook.com/DPPolice/posts/1405397719495529

[11] Hywel Dda University Health Board Failure to Attend Antenatal Care/ Follow up Non- Attendees policy 2009 (review date 2012)

Statement by Reviewer(s)			
Reviewer 1	Pauline Galluccio	**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 P Galluccio *(Signature)*		**Reviewer 2** …… *(Signature)*	
Name	Pauline Galluccio	**Name** …… *(Print)*	
Date	17.10.19	**Date** ……	
Chair of Review Panel *(Signature)*	Siân Howys		
Name *(Print)*	Siân Howys		
Date	17.10.19		

Child Practice Review Process

The Mid & West Wales Safeguarding Children Board (CYSUR) notified the Welsh Government in July 2017 that is was commissioning a Concise Child Practice Review in respect of CYSUR1/2017.
A Review Panel was established in accordance with the guidance and an Independent Reviewer was identified. The Independent Reviewer was in accordance with the guidance independent of the case management and who had the relevant experience, expertise, knowledge and skills as required to undertake the Review.

The Review Panel consisted of representatives from the following services:

- Hywel Dda University Health Board
- Dyfed Powys Police
- Local Authority Children's Services
- Welsh Ambulance Service NHS Trust (WAST)
- Mid and West Wales Fire and Rescue Service (MWWFRS)

The panel met regularly from October 2017. Individual agencies each provided a timeline of significant events together with a brief summary and analysis of their involvement. These were discussed by the panel and used to inform the Learning Event. During the course of the Child Practice Review process there was an ongoing Police investigation and although there was not a delay in the process or in identifying and acting on the learning, the report could not be finalised until the Police investigation was complete.
The Police investigation concluded in June 2019 when Child B's mother appeared in Crown Court and pleaded Guilty to the indictment of Child Neglect.

Learning Event

A Learning Event took place in February 2018. It was facilitated by the Independent Reviewer and was attended by practitioners from the following agencies.

- Hywel Dda University Health Board
- Dyfed Powys Police
- Local Authority Children's Services
- Welsh Ambulance Service NHS Trust (WAST)
- Mid and West Wales Fire and Rescue Service (MWWFRS)
- Licensing Lifestyle services, Local Authority

Family members informed

Relevant family members were informed that the Child Practice Review was taking place, and were offered opportunities to meet and/or contribute to the review or Learning Event. Unfortunately to date there has been no response. Even so they have been kept updated via a letter after each panel meeting and the Learning Event.

Family declined involvement: Yes

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Date information received:
…… *(date)*

Acknowledgement letter sent to Board Chair:
……*(date)*

Circulated to relevant inspectorates/Policy Leads:
……*(date)*

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Annex 1 Terms of Reference for CYSUR 1/2017 CCPR

Core tasks:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine effectiveness of inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were in the best interests of the child and outcome 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 multi-agency Learning Event for practitioners and identify required resources.

Specific tasks of the Review Panel:

- Identify and commission a reviewer to work with the *Review Panel* in accordance with guidance for concise 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.
- Complete the Proposed Initial Outline of Review document which includes information regarding the Independent Reviewer and Panel membership
- Produce a merged timeline, initial analysis and learning outcomes.
- Plan with the reviewer 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 contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft Child Practice Review (CPR) report to ensure that the terms of reference have been met 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 CPR Sub Group 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.
- *Review Panel* members will adhere to the principles of the Data Protection Act 1998 when handling personal information as part of the Child Practice Review process (see section on Information Sharing & Confidentiality).

Specific tasks of the CPR Sub Group:

- Agree and approve draft Terms of Reference and Proposed Initial Outline for Review for each case recommended for CPR.
- Agree conclusions from the draft report and an outline action plan, and make arrangements for presentation to the Exec Board for consideration and agreement.

- Monitor CPR action plans to ensure all recommendations are carried out on behalf of the Board

Tasks of the CYSUR Safeguarding Children Board:

- The Business Unit, on behalf of the Board, will inform Welsh Government of the undertaking of a CPR.
- Will adhere to timescales for completion, as per statutory guidelines.
- Receives and formally approves the final CPR report and action plan.
- Consider and agree any Board learning points to be incorporated into the final report or the 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 for a minimum of 12 weeks after completion.
- 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.

Information Sharing and Confidentiality

Ownership of all information and documentation must be clarified in order that the appropriate permission is obtained from the relevant organisation prior to sharing. Organisations can only share information that is owned or originated by them. Responsibility for requesting information from each organisation (including from independent providers) should be clarified and agreed by the Panel, as appropriate. A statement of confidentiality (as below) will be signed at each Panel meeting by all attendees to reaffirm the boundaries within which information is being shared.

In working with sensitive information in relation to a child practice review, all agencies have agreed boundaries of confidentiality. This process respects those boundaries of confidentiality and is held under a shared understanding that:

- The Panel meeting is called under the guidance of *'Working Together to Safeguard People: Volume 2 – Child Practice Reviews'* from the Social Services & Wellbeing [Wales] Act 2014.
- The disclosure of information outside of the Panel beyond that which is agreed at the meeting will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.
- If consent to disclose is felt essential, initial permission should be sought from the Chair of the Panel, and a decision will be made on the principle of 'need to know'.

However, the ultimate responsibility for the disclosure of information to a third party from the Multi-Agency Panel rests with the Mid & West Wales Safeguarding Board and must be referred to the Board Business Manager for authority to disclose.