Child Practice Review Report

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North Wales Safeguarding Children Board

Concise Child Practice Review Re: *NWSCB 1/ 2017 FCC*

Brief outline of circumstances resulting in the Review

Legal Framework

A Concise Child Practice Review was commissioned by North Wales Safeguarding Children Board in January 2017. The criteria for child practice reviews are laid down within The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015, Regional Safeguarding Children Boards have a statutory responsibility to undertake multi-agency Child Practice Reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected.

A Safeguarding 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:

- died; or
- sustained potentially life threatening injury; or
- 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 agency identifies that a

child has sustained serious and permanent impairment of health and development.

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

Circumstances resulting in the review

An eight week old baby boy sadly died on the 13th June 2016. Ten days later his 21 year old mother disclosed that she had suffocated him. Post mortem results also showed that the baby had been poisoned. The Mother was subsequently convicted of his murder and sentenced to life imprisonment in February 2018. The mother had been in receipt of local services as a teenager and during the year prior to the baby's death.

The baby was the only child of a couple who resided together with the paternal grandmother. There were three episodes prior to the baby's death that resulted in emergency admissions to hospital and a similar episode during the second admission whilst he was in hospital. The final admission to hospital on 9th June 2016 led to the baby needing full life support due to a significant brain injury. The life support was withdrawn on 13th June 2016. The baby died peacefully in Alder Hey Children's Hospital that same day.

Timeline

The time line for the review was one year from June 2015 to June 2016, but agencies were also asked to consider their involvement prior to the time line, if relevant. The review was completed at the end of 2018 following agreement by the review panel to delay the learning event until after the mother's trial.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

Until the summer of 2014 the mother in this case had been engaged with several services as a teenager. These were in relation to her social situation and her mental health needs. She next came to attention in June 2015 when she started to access appropriate services in relation to her pregnancy. The scrutiny of this case gave no indication that additional services should have been offered, or that alternative actions should have been taken by practitioners.

Areas of good practice were noted by the reviewers, the review panel and also at the Learning Event. At the learning event, the process of detailed examination of interagency working and the facilitated learning provided the opportunity for reflection by practitioners and as a result, wider learning emerged about the ways in which services work together. These are summarised below:

Good Practice

There were areas of good practice noted throughout the review process and within in the single agency reviews. Specific examples that were expressly commented upon were:

- The clear and appropriate Section 47 referral made by the Health Visitor in May 2016 to Children's Social Services and the timely responses to that referral.
- The quality for the information shared by Child and Adolescent Mental Health Services (CAMHS) when the mother transferred to Adult Mental Health services in August 2013 and their helpful advice when contacted after the baby's death by the Health Visitor
- The mother specifically commented upon the 'lovely nurses' who were 'easy to talk to' when the baby was in hospital.

Communication and Information Sharing

As is common in any practice review the issue of communication and information sharing between services was a key discussion point. This was particularly the case when, at the learning event, practitioners first saw the combined timeline and the wealth of information available about the mother in particular. They wondered if they would have done things differently had they known the whole story.

There was discussion that Children's Social Services, given the nature of their previous involvement, had they known about the mother's pregnancy they would have undertaken a pre-birth assessment. While a pre-birth assessment could have been undertaken in respect of mother, it was understood and agreed by everyone that the outcome of the pre-birth assessment would have been unlikely to have altered the course of events.

In a similar vein, practitioners noted that due to changes in working practices, the patient's GP was not always informed about a women's pregnancy. It was recognised that this significantly reduces the opportunity for reciprocal information sharing and in obtaining a fuller picture. While there is nothing to suggest that there were any detriments caused by not sharing relevant information in this case, this process issue could and should be addressed, as it already has been at the mother's practice.

The other discussion point about information sharing was about the baby's admissions to and discharges from hospital. The three admissions were very close together and as a result there was some time lag in the GP and Children's Social Services being aware of them. It is likely that only an electronic discharge notification may have improved this situation. However despite these delays, once contact had been made there were no social worker concerns raised about the mother's presentation, her parenting ability, nor any identified safeguarding needs? There was a shared view by professionals that the baby presented as a healthy, happy and contented baby whose needs were being met.

In this case the family resided in Wales and received some healthcare services in England, particularly in relation to the emergency hospital treatment given to the baby. There is no evidence to suggest that this affected information sharing in a detrimental way, but practitioners felt that it probably did affect the timeliness on occasion.

Reviewing the case led to many discussions about the value of shared premises by integrated teams and how practitioners gain support and share concerns in complex cases, if they work together. The mother in this case was described to us as 'memorable' and 'attention seeking', but she did not raise many concerns for practitioners during the year prior to her baby's death.

The recommendations made are based upon these points, but it is acknowledged that these would only have enhanced the information sharing and care given.

Peri-natal Mental Health Services

In the postnatal period the baby's mother presented with some signs of mental ill health and was supported by the Health Visitor and GP. Practitioners working in the area commented upon the fact that in 2016 Peri-Natal Mental Health services were not available to mothers giving birth in Wales, but were available over the border. If the baby had been born at the local English hospital his mother would have received the service, which practitioners felt she would have benefited from. It is good to report that the service is now available in Wales for new mothers, but we must ensure it is fully embedded and accessible.

Fabricated or Induced Illness by Carers

In the reporting of this case there was speculation by the press that it was a case of Fabricated or Induced Illness by Carers (FIIC). This was also questioned by practitioners and members of the review panel. FIIC was previously called Munchausen Syndrome by Proxy (MSbP) and is the deliberate production or fabrication of physical or psychological symptoms in a child by a parent or carer. FIIC describes a pattern of behaviour rather than an underlying psychiatric disorder or syndrome. It was never formally identified in this case. It has to be acknowledged that in most cases the identification takes a considerable amount of time and requires a significant amount of analysis of information and evidence.

The 4 emergency episodes for this baby took place over a period of just 10 days, when he was less then 2 months old. It is not uncommon for babies of that age to have episodes when they stop breathing momentarily, which do not progress to on-going problems. Apart from the fourth and final episode, the baby recovered fully from the previous episodes.

Tests carried out after the baby died showed that there was evidence that the baby had been given a prescription medication. This was evident from tests taken at the post mortem examination and also from a re-examination of blood tests from a previous admission. Routine toxicology tests which were carried out, check for certain classes of drugs as well as commonly prescribed medications. A discussion with the parents regarding the availability of prescription medications in the household, could have led to the laboratory testing for specified substances.

The hospital staff involved in the baby's care agreed in hindsight, that a differential diagnosis of possible abuse could have been made and that in future, they should "think the unthinkable". This leaning has been embedded in their safeguarding training.

Learning Event Information Sharing and Preparation

It was clear at the learning event that the combined timeline had not been shared as agreed with all of the participants. Some had also not received their invite letters. The review panel had requested that panel members where the conduit for

preparing their practitioners for the learning event and for sharing relevant information. This clearly had happened for some, but it was a clear gap for others. This is an issue that needs addressing for future learning events. As a result the programme for the event had to be adjusted on the spot, which on this occasion worked well, but could have been very difficult in a more complex case. The event received excellent feedback with all participants giving positive feedback.

Support to Staff and Debriefing

There were key points highlighted in the service reports and at the learning event where staff acknowledged that support and debriefing were needed by practitioners. The three significant events that were specifically discussed were: the point of disclosure by the mother, the trial and in preparation for the learning event. Over the course of the full period that the services worked with the mother, there were undoubtedly also other points for individuals that were challenging and upsetting. There was evidence and acknowledgement that some staff had received good support, but this was not consistent and not formalised, except in Welsh Ambulance Service Trust (WAST). Colleagues in WAST felt that the debriefing and support processes available to them were extremely helpful and provided in non-judgemental ways for all staff involved. It was generally acknowledged that all the emergency have good access to supportive frameworks. We recommend that these are shared and considered by all agencies.

Conclusion

The findings of this review do not indicate that alternative actions should have been taken by practitioners or that inter-agency practice could have altered the outcome of this case. Areas of good practice were noted and the mother also had no contribution, other than the positive comment noted above, to make about any aspect of the services and support she received at any stage.

Scrutiny of practice always provides an opportunity to consider ways in which services may be improved and therefore the recommendations made are based on the reflection and learning from this case.

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:-

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

Recommendation 1 - Midwifery Division to review current processes in all GP practices across BCUHB to give assurance that midwives share the notification of pregnancy with GP's - Head of Women's Community and Inpatient Services BCUHB

Recommendation 2a - Guidance for Completion of Health Pre- Birth Assessment to be included in Level 3 Safeguarding Children training and supervision sessions for all midwives and health visitors - Safeguarding Specialist Midwife BCUHB

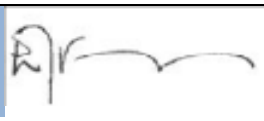
Recommendation 2b - A 6 monthly audit of the quality of Safeguarding related Health Pre-Birth Assessments to be conducted -Safeguarding Specialist Midwife BCUHB

Recommendation 2c- A Multi agency group to be developed to review the current Guidance for Completion of Health Pre-Birth Assessment. - Safeguarding Specialist Midwife BCUHB

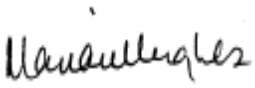
Recommendation 2d- Promote staff awareness of the 'Supporting Children, Supporting Parents: A North Wales Multi-agency Protocol. Parents with Severe Mental Health Problems and/or substances Misuse: A Framework for Safeguarding Children.' - Safeguarding Lead MHLD BCUHB

Recommendation 3- Remind all paediatricians within BCUHB to take a history of parental medication in cases of suspected Fabricated or Induced Illness and to request that the specific drug be tested for when requesting a toxicology screen- Named Dr Safeguarding Children BCUHB

Recommendation 4.- All agencies should develop a model of debriefing for staff members following child deaths - North Wales Safeguarding Board Business Manager / All Agencies

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)* Ian R Turner

Name *(Print)*	**LIZ FLETCHER**	**Name** *(Print)*	**IAN TURNER**
Date	**07.01.2019**	**Date**	**07.01.2019**

Chair of Review Panel *(Signature)*	
Name *(Print)*	MARIAN PARRY HUGHES
Date	07.01.2019

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Child Practice Review process

To include here in brief:

- *The process followed by the Board and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

Methodology

Following notification of the tragic death of the baby in this case an agreement was made by the North Wales Safeguarding Children Board to undertake a Child Practice Review. A Review Panel was established in accordance with guidance. This included representation from relevant organisations within Health, Police, Social Care and Welsh Ambulance Service Trust. Two reviewers where commissioned to undertake the review, but whist the review was at an early stage of the review process, due to changes in personal circumstances, a further two reviewers had to be appointed.

Full Terms of reference are included in Annex 1.

All agencies reviewed all their relevant records and provided timelines of significant events and a brief analysis of their involvement. These were considered by the panel and provided opportunity for panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the reviewers and the review panel and this informed the areas of interest that were thought to need further exploration and consideration. The process also allowed for the identification of the key practitioners who were required to attend a learning event, in order to fully understand the detail of the single and interagency practice in this case.

The key practitioners attended the learning event which was held on 20th June 2018. It was facilitated by the reviewers and attended by the Chair of the Review Panel and the Business Co-ordinator of the North Wales Safeguarding Children Board. The learning event was organised in line with Welsh Government guidance and a record of the event was made.

Following the learning event the Chair of the review panel and one of the reviewers

met with the mother to gain an understanding of her experiences of the services offered and taken up by her. Unfortunately it was not possible to meet with the baby's father.

Following the learning event, the reviewers collated and analysed the information for discussion with the panel. Practice issues originally identified by the panel were re-examined in the light of the findings of the review. In reviewing the findings consideration was given to what could be done to further improve future practice. A draft report was provided to the review panel on 17th September 2018. The finalised report was then be submitted to the North Wales Safeguarding Children Board for consideration in March 2019.

Family declined involvement ☐

For Welsh Government use only

Date information received ……..
Date acknowledgment letter sent to Board Chair ……
Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			

Annex 1

TERMS OF REFERENCE
CPR 1 - NWSCB 2017 / 1 (Flint)

Introduction

- A Concise Child Practice Review was commissioned by North Wales Safeguarding Children Board in January 2017. The criteria for child practice reviews are laid down in The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015

- A multi-agency Review Panel and review Panel Chair has been identified by the Regional CPR Group and an external reviewer has been commissioned to undertake the review. The Chair of the review Panel will regularly report progress to the Regional CPR Group.

- Review Panel Members:

  - ❖ Marian Parry Hughes, Children and Family Support Service, Gwynedd, Chair
  - ❖ Liz Fletcher, Betsi Cadwaladr University Health Board, Reviewer
  - ❖ Ian Turner, Conwy County Borough Council, Reviewer
  - ❖ Liz Fox, Betsi Cadwaladr University Health Board, Panel Member
  - ❖ Christine Hinton, Welsh Ambulance Services NHS Trust, Panel Member
  - ❖ Dr Lindsay Groves, Betsi Cadwaladr University Health Board, Panel Member
  - ❖ Howie Isaac, Countess of Chester Hospital, Panel Member
  - ❖ Karen Milne, Countess of Chester Hospital, Panel Member
  - ❖ Craig McLeod, Flintshire County Council, Panel Member
  - ❖ DCI Andrew Williams, North Wales Police, Panel Member
  - ❖ Ceri Williams, Legal Services, North Wales Safeguarding Board, Panel Member

Purpose

- ✓ To establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children.
- ✓ To 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 during the 12 months preceding the child's death, up to the time of the first PRUDIC meeting. ➢ BCUHB Clinical Nurse ➢ BCUHB Mental Health Chronology ➢ BCUHB Midwifery Services Chronology ➢ Community Mental Health Team Chronology ➢ Countess of Chester Hospital Chronology ➢ Flintshire Children Service Chronology ➢ GP Child Chronology ➢ GP Mother Chronology ➢ Health Visiting Team Chronology ➢ North Wales Police Chronology ➢ WAST Chronology ➢ Youth Justice Service Chronology Timelines are to be completed and returned to the reviewer by September 2017.
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 Reviewer is to consider contact with the family, to appraise them of the review, ascertain the degree of involvement they want in 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 (for example, disciplinaries, inspectorate investigations, NWAS etc) of practice and determine if a co-ordinated approach will address all the relevant questions.
10	To hold a learning event for practitioners on 20th June 2018
11	The Reviewer will produce a succinct Review Report with learning points and issues in accordance with National Guidance

12	The Reviewer will share the findings of the review with the family.
13	The review panel will identify the learning points and issues and will consider all actions if required.
14	The Review Report will be presented by the reviewer and Chair of the review Panel to the RCPR Group and the NWSCB
15	The Chair the NWSCB will be responsible for making all public comment, and responses, should there be any media interest concerning the review until the process is completed. Also consider whether there is a need for the public disclosure of information.
16	The Regional CPR group and the Review Panel will seek legal advice on all matters relating to the review, as necessary. In particular this will include advice on: ➢ Terms of Reference ➢ Disclosure of Information ➢ Timescale ➢ Data Management
17	Panel members will destroy all notes/ paperwork relating to the review once the process has finished. All information relating to the review will be stored by the relevant children's services authority (Flintshire County Council). Information will be stored securely and in accordance with their retention and data protection policies.
18	All correspondence will be sent by email and will be password protected or sent via a secure email system. The use of initials or any other personal information that contravenes data protection guidance will not be used to identify the child or family outside of secure communication channels.
19	Panel members will not share information with any third party without the permission of the Chair.