Child Practice Review Report

***North Wales* Safeguarding Children's Board**

Concise Child Practice Review

Re: NWSCB1 / 2021

Brief outline of circumstances resulting in the Review

To include here:

- *Legal context from guidance in relation to which review is being undertaken.*
- *Circumstances resulting in the review.*
- *Time period reviewed and why.*
- *Summary timeline of significant events to be added as an annex.*

Legal Framework

A Concise Child Practice Review was commissioned by the North Wales Safeguarding Children's Board on the recommendation of the Child Practice Review Sub-Group in accordance with the Guidance for Child Practice Reviews. The criteria for Child Practice Reviews are laid down within the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 and SSWB(W)A 2014 Code of Practice on Child Practice Reviews (CPR) and Learning Event Guidance.

Regional Safeguarding Boards have a statutory responsibility to undertake Multi - Agency CPRs in circumstances of a significant incident where abuse or neglect of a child is known or suspected.

A Concise CPR must be held 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 CP Register, nor a LAC on any date during the 6 months preceding;
    - The date of the event referred to above; or
    - The date on which the LA 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 or family. The output of a review is intended to generate professional and Organisational learning and promote improvement in future interagency child protection practice.

Methodology

- Child Practice Review Panel Meetings 10 June; 13 July; 11 August; 2 September; 21 September; December 2021; 24 March 2022; June 2022
- Merged individual agency timelines and analyses
- Family perspective sought
- Organisational early learning
- Independent Reviewer
- Evidence based practice/ legislative/ regulatory/ CP
- Panel members' discussions with practitioners
- Learning Event consideration
- Action Plan
- Presentation to CPR Sub - Group and NWSCB delayed and re-scheduled.
- Submission to Welsh Government
- Involvement of and Presentation of Report to Family
- Publication of report

Circumstances which required a review to be held by the Board - taken from the Referral to the Child Practice Review Panel

"[Child 3] was a sibling group of 4, she had one elder half sibling, age 6yrs, an older sister 4yrs and a younger sister age 1yrs with additional needs, requiring a period of time in hospital before discharge, with her sister continuing to require ongoing health intervention.

[Child 3] sadly died on the 20.1.20, age 21 months, with the cause of death being that of drowning. Within the investigations, it has come apparent that [Child 3] was left in the bath unattended; the length of time is uncertain with police continuing to investigate. [Child 3]'s mother has been advised of safe bathing with her older child, due to concerns that the health visitor noted that the mother had left her child unattended. Within initial enquiries, it was also noted that the mother has had a difficult time over the last few years, with her mainly parenting as a single carer due to the separation from the children's father. Whilst he remained involved in the children's lives, [Child 3]''s mother was the main carer for all four children.

There is also some concern that the mother was requesting support from the mental health service for a short period of time, although this does not appear to have been consistent. Support from the health visitor has continued, which fortunately remained the same professional for a period of time. Further to this the police have considered that the mother's negligence was so significant that the matter should be put to the CPS for possible neglect charges.

As such, the local authority] is of the opinion that a Multi-Agency Child Practice Review is considered. [Child 3] was neither on the child protection register nor a looked after child on any date during the 6 months preceding, therefore the criteria for an extended review is not met. A concise review could identify learning opportunities in supporting single parent families, particularly those which have children with additional needs within early support and where police reports are received in regard to families. This was a significant incident that resulted in the tragic death of [Child 3] at this stage we cannot exclude that neglect was a contributory factor to the death"

It is noted that the subsequent police investigation, supported by the view of the Crown Prosecution Service was that the death, whilst avoidable, did not constitute child neglect in accordance with the Children & Young Persons Act 1933 section 1 and the Inquest recorded a verdict of accidental death. The Children's Services' assessment concluded that there were no concerns about Child 3's siblings.

TERMS OF REFERENCE - SEE APPENDIX ONE.
TIMELINE OF INVOLVEMENT – SEE APPENDIX TWO.

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

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

Child's Direct Testimony and Lived Day to Day Experiences

The paramountcy of the child's welfare and the importance of his / her wishes and feelings are enshrined in the Children's Act 1989, reinforced in The Children Act 2004, the United Nations Convention on the Rights of the Child Article 12 and The Social Services and Well-Being (Wales) Act 2014 and related Codes Of Practice: Part 3 Assessing Needs; para 74; Part 7 Codes of Practice Safeguarding (Volume 2 6.31 – 6.36 (engagement with child) and Volume 5 para 9: 'have regard to the wishes and feelings of the individual; paras 40 – 41 'Child Centred Approach') and Section 10 Code of Practice Advocacy:

"Anyone working with a child must see them and, subject to a child's age, stage of cognitive development and level of verbal or non -verbal communication skills:

- speak to them; and
- listen to what they say;
- take their views, wishes and feelings seriously;
- work in partnership when determining how to meet their care and support needs; and
- feedback to the child"

From the information provided to the review, there was very little specific information recorded about the children and the impact of the circumstances and parental stressors on them, and on their experiences of being parented. The Child Development Team's later submission did provide an enlightening profile in respect of Child 4. From the Reviewer's perspective, it was difficult to establish the lived day to day experiences of Child 3 in the family during the timeline period.

The Family Wellbeing Profile Tool has nine sections, eight of them refer to the Family with the ninth entitled 'Child's Learning & Development' and it is not clear whether this section is informed by direct work with the child. There are excellent tools available to ensure that the child's experiences are captured and validated including Horwath (2016).

The Role of Housing
Local Authority Council Housing and Independent Housing Provider

The Housing Provider Analysis and subsequent responses to reviewer queries highlights a seemingly highly complex myriad of organisational and legislative arrangements through which those vulnerable to housing difficulties and homelessness need to navigate. The Housing Provider is a partnership between the Local Authority and another provider organisation and is made up of three teams: Homeless Prevention Team (LA staff); Home Finder Team (holds LA Register) and Other Provider organisation staff & Temporary Accommodation Team.

The family experienced housing difficulties necessitating formal intervention for a period of 18 months from early August 2018 onwards. The Housing Provider Analysis for the Review notes that the family were in established and secure accommodation for the eight months from May 2019 prior to a three bedroomed property became available in February 2020. During this eight month period the only direct involvement was a six-month property inspection check undertaken in September 2019 following which a pest control service was provided, indirect involvement comprised of regular reviews of the Housing Application and Banding.

The analysis acknowledges that the importance of early response to initial referral has been highlighted in this review (a delay from referral 8.8.2018 to assessment on 14.9.18, due to a combination of factors, did not have implications in this case) and further notes the following good practice points:

- Intervention prior to eligibility
- Good partnership working (e.g. appropriate referrals to Welfare Rights; Shelter Cymru for legal advice; NACRO for Homeless Prevention Support; attendance at Child 4 Discharge Planning Meeting 28.3.2019).
- Financial assistance towards rental payments during key transition times.
- Staff work to safeguarding principles and can access the Welsh Government supported Physiologically Informed Environment (PIE) training on Adverse Childhood Experiences.

Role and Status of CID16 Reports North Wales Police (NWP)

The NWP's only involvement with the family was the 11 September 2018 visit to an alleged verbal incident between the parents during which Mother referred to a previous alleged

domestic abuse incident. The NWP Analysis submitted to the CPR process viewed this incident primarily as a civil matter and noted that the service response had been appropriate and proportionate: “Good practice can be demonstrated in the recording of the potential assault and submission of the CID16 despite being outside prosecution timeframe”.

The CADA DASH risk assessment resulted in a score of 8 (referenced as 9 elsewhere), and a Z card was issued. Advice was given and safety measures were put in place with no indication that a child/ren had suffered any physical harm. The risk had been subsequently upgraded from a standard to a medium risk by PVPU which triggered the domestic abuse officer to review the circumstances. CID16 completed and submitted to Local Authority Social Care Children’s Services.

It is now known that Mother would have been approximately 9 weeks pregnant with Child 4 at the time of this incident, the earlier alleged domestic abuse incident had been referenced as happening at the beginning of her previous pregnancy (June – September 2017). Mother was described by partner as, ‘being bi-polar’ and as having ‘post -natal depression’.

This incident provides an opportunity to consider:

- The role and status of CID16 reports
- The interplay between criminal thresholds, formal complaint, and welfare /well-being thresholds (The Children Act s.47; Social Services & Well-Being (Wales) Act s.21 /s.130).
- The proactive stance on reports of domestic abuse in accordance with the Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015.

Continuum and Thresholds of Need – Identification and Assessment – Dovetailing Between Preventative Services and Assessment of Care and Support Needs – Within and Multi-Agency Shared Understanding

Betsi Cadwaladr University Health Board (BCUHB): Midwifery; Health Visiting (HV); Hospital Services; General Practitioner (GP); Child Development Team (CDT); Community Mental Health Team (CMHT); Perinatal Mental Health Service (PMHS).

Prior to the review timeline, on a home visit of the 8.5.2017 Mother had answered the door to the HV, with Child 2 unattended in the bath, safety issues had been discussed and advice given. The BCUHB Analysis notes that the Routine Domestic Abuse Enquiry had not been completed at Booking In appointment and further confirmed that it had not been appropriate to conduct a Pre-Birth assessment in respect of any of the pregnancies.

In summary BCUHB Agency analysis reports that safety and safe bathing information and advice had been given, via the ‘Bump, Baby & Beyond’ publication which was referenced in Home Visit records. Appropriate monitoring of well-being was evidenced in the Edinburgh Postnatal Depression Scale (EPDS) assessments and referrals to GP, TAF, Welfare Rights, CMHT & Perinatal Service and provision of 24 - hour mental health helpline details on one instance. The Neonatal Unit had followed Safeguarding procedures and submitted ‘Child Protection Referrals’ when concerns were identified in March 2019 and the Discharge Planning Meeting held in respect of Child 4’s discharge was attended by key personnel.

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Local Authority: Social Care Community Well-Being (CWB) – Family Centre, Team Around the Family (TAF), Flying Start (FS); Social / Children's Services Assessment & Support Team (AST).

Prior to the timeline period the family had received Community Well-Being services in the form of a childcare placement for Child 1 (September 2016 - March 2017) via the preventative Flying Start provision which covered their postcode area and a referral to the Team Around the Family (TAF) service which engaged across agencies to assist families in navigating support.

The Local Authority Children's Services Assessment & Support Team (AST) Analysis noted: 'None of the children were ever open for either [assessment or investigation]".

In respect of lessons to be learnt, the Assessment and Support Team analysis notes: "As the case was not open there were few issues that required agencies to work together" and references the involvement of police in relation to crime; housing in relation to eviction and neonatal services in relation to Child 4's needs.

After the timeline period: - On the 3 February 2020 the Housing Provider offered the family a permanent 3 bedroomed property which was accepted; the Local Authority undertook an Assessment of Care and Support Needs under s.21 of the Social Services and Well-Being Act (Wales) Act 2014 and Mother has been assessed by and diagnosed by CMHT with Anxiety, Depression & Post Traumatic Stress Disorder (June 2021).

Health and Social Care services provided during the review timeline period will be considered together in this section.

In August 2018 the family's move to alternative accommodation took them outside the Flying Start designated area. A referral was received by TAF from a Nursery Nurse (wrongly referenced as Health Visitor in the Merged Chronology) requesting housing, income and

parenting support with Mother being described as, ‘very stressed and low in mood. During the same month the GP diagnosed her with ‘generalised anxiety disorder, low mood and depression’ and went on to prescribe medication in October 2018.

This was the beginning of eighteen months of uncertainty regarding housing, significant debt (£2,000 and increasing) and of caring for the children as a single parent following the August 2018 parental separation, with Child 1 now aged 4 years 4 months, Child 2 aged 2 years 3 months and Child 3 now aged 4 ½ months.

During September 2018 there are five record entries from TAF to arrange a ‘pre-JAFF conversation to understand the issues as the family perceive them and how we might assist’ (Pre -JAFF being a semi structured conversation to understand the outcomes the family wished to achieve’). This took place during a joint visit of 5 September with the HV who was visiting following a request from Mother who wanted to discuss ‘relationship difficulties’, her partner having left 2 days earlier. A referral was made to the Welfare Rights service and ongoing liaison with the Housing Provider regarding the validity of the eviction process (due to take place 8.10.18) was established. The reviewer now understands that the use of the Pre- JAFF template has now been replaced with the Family Wellbeing Profile Tool which is more robust and structured and has a scoring mechanism which assists in quantifying needs.

The TAF assessment identified housing and finances as key concerns, “although the original referral referenced parenting support it was not sought when the discussion was held…it is possible that we should have … explored whether the original referral suggesting parenting support was a current issue…however, it had only been raised as part of the referral” (Analysis). TAF closed the case on 21 September 2018 and Welfare Rights closed the case on 24.11.18 after securing Housing Benefit and Income Support.

In reference to the direct approach from Father of 11 September 2018 and the subsequent NWP CID16, the AST analysis notes: “SSD concluded that the issues were part of a break-up and were either the responsibility of the police or did not meet our threshold criteria” and in respect of the reference to a previous incident of domestic abuse: “However, no complaint was made, and this went no further”.

Reference is also made to the involvement of Housing and TAF, a service whose involvement ended later that month on the 21 September 2018.

During September and November 2018, the Health Visitor conducted two Edinburgh Post Natal Depression Scale assessments (the second and third of four assessments within 10 months: May 2018 – score 8; 9 October 2018 – score 21; 5 November 2018 – score 15; and 6 March 2019 – score 14).

Child 4 was born at 27 weeks’ gestation on 28 January 2019 and due to Child 4’s needs was not discharged from hospital care until 1 May 2019. There is reference in the Merged Timeline to a 28 January 2019 ‘Child Protection Referral’ from hospital due to the imminent threat of eviction. However, this entry may be an error and may refer to the 6 March 2019 ‘Care and Support referral’ (Health terminology and indicated as such on the referral template) made by the Staff Nurse at the hospital to AST regarding the impending eviction, with a follow up contact on 25 March 2019 regarding the ‘Child at Risk Report’ (Health terminology) as there had been no response. There is a previous reference to an 18 February 2019 concern from a specialist hospital out of area that Mother was not visiting

Child 4 (who was subsequently transferred to Hospital 1 on 27 February 2019).
The AST analysis: “Team then made assumptions about the eviction not likely to be a day away and also concluded that this was a housing matter”. The analysis does acknowledge that the 6 March 2019 referral should have triggered an action and notes that the second 25 March 2019 approach does result in a telephone call to the Housing Department. The analysis states: “As while processes were in place to support [Mother] it is clear that she did not understand that and neither did the nurses supporting her”, it is not clear to the reviewer what these supporting processes were at that point, other than Housing and the Health Visitor.

The Health Visitor referral (informed by the EPDS assessments) to the Local Primary Mental Health Services of 12 March 2019 led to a 22 March 2019 appointment and follow up GP appointment of 9 April 2019.

On 9 April 2019 following liaison with the Primary Care Mental Health practitioner the Health Visitor made a referral to the Peri-Natal Mental Health Service which concluded (23.4.19) that the ‘stressors [were] caused by social situation’, and that there were no significant risk concerns to self or others, and /or severe or enduring mental health issues, with reference to TAF, Housing, HV & LPMHSS involvement and ‘multi agency support package’.

On the same date, 9 April 2019 a referral was sent from the Primary Care Mental Health practitioner to the Family Centre Team (FCT) (services having been realigned from TAF, FS & Rural Families First to a form a more accessible 5 site model), requesting support with finances and debt. The actual set wording on the referral template is potentially ambiguous in that, ‘What other additional support has been tried’ does not determine the status of the provision (counselling services, anxiety management workshop), whether current or accepted nor provides a prompt to state the intervention outcomes.

FCT (Business Support personnel) attempts to engage with Mother via telephone (15 April; 22 April & 29 May 2019) were unsuccessful and, “the decision not to continue to contact was in line with our processes at the time” (it is noted that LA practice has now been amended to include postcards and text messages).

The referrer was not advised that contact had not been made. The analysis notes: “we missed an opportunity to speak to the HV to confirm that there were no further concerns…equally HV in Flying Start (family now back in the catchment area) regularly raise concerns… communication could have been better between the service and professionals, it is difficult to link this to any later issues however”.

Mother failed to attend three further scheduled appointments with the Community Mental Health Team (2 May 2019; 30 May 2019 & 10 June 2019). There was no apparent contingency for non -attendance including when known risk factors, such as a newly discharged infant with additional care needs, are a feature. This period coincided with Child 4’s discharge home from hospital and the family’s move to alternative accommodation (1/3 May 2019) which took them back into the Flying Start catchment area.

Child 4 was discharged from the Neonatal Community Outreach Service on 15 November 2019 and remains, at the time of writing, under the Community Paediatric Service and Child Development Team multi-disciplinary team due to significant developmental delay including feeding difficulties, dysphagia and propensity to viral episodes resulting in numerous hospital admissions and requiring physiotherapy and Speech and Language Therapy.

Health Visiting services continued with a joint HV/Special Care Baby Unit visit of 14 May 2019; the 16 week contact of 23 May 2019 records –'no concerns of note at contact'; a 6 June 2019 visit; 28 June 2019 record when it is noted that the Consultant Paediatrician is happy with Child 4's progress; 7 August 2019 Child 4's 6 months review: 'slight developmental delay due to prematurity' – noting need for individualised feeding plan, dysphagia and SALT provision; 8 August 2019 home visit to undertake Child 3's 15 month review when home safety and accident prevention was discussed and 2 January 2020 home visit for Child 2's review at 3 ½ years of age.

It appears to the reviewer that there were four opportunities to assess the needs of this family: 15 August 2018 referral to TAF; 11 September 2018 (CID16); 6/25 March 2019 Child Protection / Care and Support referrals; and the 9 April 2019 referral from the CMHT to TAF. It is also relevant to note that the duty to trigger an assessment is a presumed one if a child is disabled (s.21(7) SSWBA 2014). In response to supplementary reviewer questions the Local Authority notes that the need for a Care and Support Needs Assessment combining the s.21 assessment and parenting capacity assessment was considered in response to each referral, however, was satisfied that all needs were being met by other services. On each of these occasions the family were viewed as meeting the threshold of General Information, Advice, Family Centre or universal services rather than requiring an assessment of care and support needs under s.21 of the SSWBA 2014.

The Pre-JAFF template completed does not constitute an assessment in accordance with the Code of Practice Part 3 para 63 and related Annex, with Para 33 noting the practitioner skills and proficiencies required to undertake a s.21 assessment. It is positive to note that the local authority has now adopted the Family Profile Tool which is more robust and better able to quantify needs.

It is evident to the reviewer that the child protection threshold would have been applied, if evident, on each of these contacts. Hindsight is a privileged vantage point. It appears to the reviewer that the family profile of need, which emerged and evolved particularly during the period August 2018 – April 2019, indicates that the s.21 threshold, 'assessment on appearance of need' would likely have been established. To the reviewer, and with the benefit of hindsight, it appears that there was a presumption of non- eligibility, in the absence of an assessment.

This family profile of need included four children under the age of 5 years, two previous GP diagnosed episodes of Post - natal depression (following the births of Child 1 and Child 2); four assessments of Edinburgh Post Natal Depression Scale in 10 months (May 2018 – 8; 9.10.18 – 21; 5.11.18 – 15; 6.3.19 - 14); an August 2018 GP diagnosis of 'generalised anxiety disorder, low mood and depression'; recent parental separation; ongoing threat of eviction and homelessness; significant and increasing debt; referrals expressing concerns from professionals (15 August 2018 – Nursery Nurse/HV; 12 September 2018 – Police CID16 following alleged domestic incident and reference to a previous incident; Father's 11 September approach expressing concern about Mother's mental health and questioning her ability to care for the children; 28 January 2019 (not properly established)/ 6 / 25 March 2019 referrals from hospital staff following birth of Child 4; and a 9 April 2019 referral to TAF from a Primary Care Mental Health practitioner.

This case provides an opportunity to consider the dovetailing, not only between the well – established 'reasonable cause to suspect' child protection (TCA s.47; SSWBA s.130) and care and support thresholds (s.21 SSWBA 2014), but also in this case, the more pertinent

dovetailing between the preventative and care and support thresholds. The primary focus of the preventative services appears to be on the family unit and adult perceptions. Code of Practice Part 3 Para 12 establishes the centrality of the person, the model of assessment and care planning starts with the person themselves, strengths and capabilities and what is important to them', whereas the care and support focus is on the assessed needs including the individual child. This apparent distinction may be a factor worthy of consideration.
The critique of the current review in England, 'The Independent Review of Children's Social Care. The Case for Change' warns against the proposed separation of preventative and child protection services:

"Family support, early help and safeguarding services do not operate in silos, rather they operate across a spectrum to support children and families according to their changing needs, locating these services together …avoids children and families falling through service gaps".

Steve Crocker Association of Directors of Children's Services' Vice President, as reported in Community Care 31.8.21 challenges the misconception that assessment duties are any less statutory than child protection duties.

It is positive to note that the local authority has now developed a mechanism of regular meetings between the Assessment and Support Team and Family Centre Teams as a forum to consider the fluidity and continuum of thresholds and further that Family Centre Standards now adopted have established a feedback system to referrers. This should minimise the potential for a lack of shared understanding vis a vis parallel service provision.

The first and only s.21 assessment of need was undertaken following the incident which triggered this review. In the reviewer's opinion conducting a s.21 assessment (and an assessment of parenting capacity as is the recognised local authority practice) would have:

- Ensured a child focused approach and provided an insight into the child's lived experiences (see above)
- Developed a shared multi agency understanding of one another's respective role and responsibilities
- Provided a mechanism to identify and assess 'on appearance of need' based on professional judgement rather than being process driven.

Evidence from the Housing, Health Authority and Social Care information (and with no further involvement with the Police) indicates that the period from May 2019 – January 2020 was a more settled period for the family and in the reviewer's opinion there is no causal link between the services provided or not provided with the sad incident which triggered this review. It is also reported that Father remained an active parent and that a great deal of support was provided by Mother's extended family. However, it appears to the reviewer that there are learning opportunities from this case to inform future practice.

This incident was an accident and the circumstances in this case are very different to NWSCB 1 2019. However, it appears to the reviewer that there are assessment related learning opportunities from this case to inform future practice.

At the time of writing this Review, Mother's views and perceptions were not

known to the Reviewer. This matter is addressed further in the Family Involvement section below.

The Role of Midwifery and Health Visiting Services in the Prevention of Drowning Incidents

Fortunately, incidents of drowning are extremely rare, with less than an average of 3 drownings involving individuals under 18 years of age annually in Wales (from a child 0-15 years population of 555,841).

However, they are undoubtedly an absolute tragedy for those affected.

Drowning constitutes the third highest cause of accidental related deaths in children aged 0 – 4 years, (England) following threats to breathing and car accidents, followed by crush/ strike injuries and

fire/inhalation of smoke (RoSPA Figure 13 'Deaths 0 – 4 years' /Graph p.24).

Kendrick et al (2012)'s large review of 98 studies (population 2.605,044) evidenced that safety interventions can be effective in some areas of safety, citing the examples of: safe hot tap water temperature; smoke alarms, fire escape plans, safe storage of chemicals and socket covers. However, in relation to incidents of drowning within the home, (where indeed it is difficult to evidence or quantify a reduction) the review concludes:

'there is some research evidence to suggest that multi-component home safety education is ineffective in preventing children from being left alone in the bath'.

Kendrick et al (2012) note that the familiarity of the home setting may give the carer / parent a false sense of reassurance (echoed in Roberts 1996). In addition, an established bathing practice with no previous adverse outcomes may be another relevant variable. Purnell & McNoe (2008) highlight the false reassurance that can arise by the use of aids such as bath seats, however, this was not a feature in this case).

In its thematic review (Public Health Wales 2016) highlighted the role of supervision: 'more active and appropriate adult support may have prevented some drownings' (Theme 8). This echoes the importance of active and close direct physical supervision, that is within actual physical reach (cf Australian safety campaign 8.4 'Be prepared, be within arms') and not supervision within earshot.

The literature concludes that one to one safety education approaches are likely to be the most successful in establishing safe bathing practices, thus highlighting the importance and agency of the Midwife / Health Visitor role in the relationship with the parent(s) as well as the role of ante-natal; post- natal and health visiting services.

The 'Bump, Baby & Beyond Pregnancy to 4 years' publication widely used by Health authorities including BCUHB contains the following caution:

"Water safety: Children can drown in even a couple of inches of water. Never leave your baby alone in the bath or near water, either inside or outside the house. Look out for things like a garden pond, or even a bucket that has collected rainwater. Don't leave the paddling pool filled with water overnight. When you are running a bath for your baby, keep an eye on him as he may try to get into the bath alone. Check the temperature using your elbow or the inside of your forearm. Your baby's skin is thinner than yours and he will scald more easily. Don't leave him alone in the bath, not even for a second. Not only will he be at risk of drowning, but he may play with the taps and scald himself (p.189)".

The advice is unequivocal: ‘never leave your baby alone, not even for a second’.

There is reference to a specific potential drowning safety concern (amongst other potential risks including Sudden Infant Death Syndrome, Safe Sleeping, Home Safety Accident Prevention) being highlighted during Health Visiting home visits (April 2018, October 2018, 5 May 2019, 7 August 2019). The Health Visitor was aware of the May 2017 incident when Child 2 (then aged 12 months) had been left unattended in the bath momentarily, to answer the door to the HV. Advice had been given at the time of that incident to either ignore the call at the door or to remove the baby.

This case provides an opportunity to consider what more, if anything, can be done by organisations and practitioners in this regard? What can reasonably be expected of them, when information is provided, and the parents / carers have capacity?

NICE recommends that Safeguarding Boards should have a professional with specific responsibility for Child & Young People Injury Prevention.

“Despite guidance related to the prevention of child injuries being issued by NICE and PHE a 2017 study found substantial variation in preventative activities in LAs in England and Health Boards in Wales” (October 2018)

Learning Event

The Child Practice Review Panel considered the convening of a Learning Event in accordance with the related Learning Event Guidance and Briefing Note (2017). These discussions were informed by direct consultation of their views between the review panel members and their related practitioners. The Panel concluded that this would not be advisable based on the following factors:

- Attempts to secure a suitable and ‘Covid compliant’ physical venue proved to be unsuccessful.
- No established causal link between the services provided or not provided with the sad incident which triggered this review.
- The known difficulties of managing a potentially heightened emotional environment remotely; addressing support needs and providing proper contingencies within the virtual meeting context.
- The review findings and arising lessons to be learnt were in respect of organisational processes and responsiveness/ inclusiveness rather than in respect of individual practitioner actions.

It was agreed that an alternative mechanism or forum would be offered to agencies and relevant practitioners, in that prior to the point of publication there would be an opportunity for them to meet the Child Practice Review Panel Chair and Reviewer for reflective discussions.

Family Involvement (Section completed November 2022)

Unfortunately, contact with relevant family members and involving them in the Child Practice Review process has remained an unresolved issue throughout the process of undertaking this Review. This is as a result of a combination of factors including some case -related and

others organisational-related which have led to the making of Process-Related Recommendations This has resulted in undue delay, and it is important that this focus does not detract from the opportunities to learn and implement lessons.

Fortunately, as can be seen from the Action Plan many of the lessons have already been implemented.

I am indebted to the birth Mother who, in response to a request for her to become involved, has written a letter (March 2022) which includes the statement, 'this is the best way to help you and I hope you can use this email in the Review'. The letter details the extreme stress caused by inadequate and inappropriate housing and the constant threat of eviction exacerbated by the trauma of the birth of a child requiring long term hospitalisation a significant distance from home. Birth Mother is saddened at the lack of formal agency support following the family's loss and praises the voluntary counselling provided by a Children's Hospice.

Birth Mother further notes, 'The point of me telling you all this is because families that are struggling or have had the worst day like mine…there's always a background. There's always a time when they are trying their hardest…a family shouldn't be put (in inappropriate housing and places). I got some help but I got dismissed because you just had to tick boxes instead of seeing what is important, the children.

Hearing one less 'Love you' is painful. I'd like to thank everyone who tried'.

Improving Systems and Practice

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

The review highlights evidence of Early Learning Points Identified and put into practice prior to the review.

Local Authority Children's Services

- The realignment of services to the Family Centre Team (FCT) model (from TAF, FS & Rural Families First) provides a more accessible 5 site model.
- The introduction of the more robust Family Wellbeing Profile Tool to replace the pre-JAFF template.
- The introduction of a postcard and telephone text communication system ensures a proactive approach when engagement proves difficult.
- Regular meeting system between the Family Centre Team and the Assessment & Support Team provides a forum to consider continuum of needs and develop a shared understanding.
- The Family Centre Standards adopted have established a feedback system to referrers, again ensuring a shared understanding.
- Development of a Multi - Agency Safeguarding Hub with closer collaboration with the Police (CID 16)

To further promote and learn from this case, the review identified the following recommendations for North Wales Safeguarding Children's Board and its member

agencies.

Recommendation One

Child's Direct Testimony and Lived Day to Day Experiences

- That agencies ensure that the child's lived day to day experiences are understood within the context of preventative services where the focus is on the 'family' and directed by adult parent led engagement

Recommendation Two

Continuum and Thresholds of Need – Identification and Assessment – Within-Agency and Multi- Agency Shared Understanding:

- To ensure that organisational processes recognise the fluidity of the continuum of need and the dovetail between preventative services and the duty to assess care and support needs.
- To ensure that practitioners have the confidence to utilise escalation processes.

Recommendation Three

The Role of Midwifery and Health Visiting Services in the Prevention of Drowning Incidents

- To consider what more, if anything, can be done by organisations and practitioners in this regard?
- To consider what can reasonably be expected, when information is provided, and the parents / carers have capacity?

Recommendation Four

Peri-Natal Mental Health Services.

- To ensure a shared agency and multi-agency understanding consideration should be given to the role and responsibilities of CMHT and Peri-Natal Mental Health Services (including eligibility thresholds) in respect of professional referrals at identified times of patient and family crisis.

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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 individual or family, nor have I 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 individual or family, nor have I 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)* .. Non Davies **Name** *(Print)* Non Davies…… **Date** 25 November 2022		**Reviewer 2** *(Signature)* …… **Name** *(Print)* ……	

First Draft 19 September 2021

Completed Draft and Merged Action Plan June 2022

Family involvement Section 25 November 2022

Chair of Review Panel

(Signature)	
Name *(Print)*	Jacqueline Downes
Date	30 November 2022

Appendix 1: Terms of reference

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.*

APPENDIX ONE

Terms of Reference (to be amended /updated 21.9.21)
Timeline: From Child 3 date of birth 28.03.2018 to 18 January 2020 (date of death)

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were individual 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 reviewer/s 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 individual 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 Board 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 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.
- 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.
- 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 complete.

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	☐	☐	

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Social Services & Well-Being (Wales) Act 2014 Working Together to Safeguard People Volume 5 Handling Individual Cases to Protect Children at Risk

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