



Child Practice Review Report

Child Practice Review Report

North Wales Safeguarding Children Board

Concise Child Practice Review

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.*

A concise Child Practice Review was commissioned by the North Wales Safeguarding Children Board on the recommendation of the Child Practice Review Sub-Group in accordance with the Guidance for Multi Agency Child Practice Reviews.

The criteria for this review are met under Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 which are that within the area of the Board, abuse or neglect of a child is known or suspected and the child has died. The child was neither on the child protection register nor a looked after child on any date during the 6 months preceding her death.

The child, a 14-month-old girl, lived with her parents and older brother in a coastal town in North Wales. She was described by her parents as a happy and content little girl.

The family were seen regularly in accordance with the Healthy Child Wales Programme and were in receipt of an enhanced service from both the generic and Flying Start Health Visitors. The parents had initially engaged well with ante-natal and post-natal appointments. The child was seen by the GP and was up to date with routine developmental checks and immunisations.

The family faced many challenges and there were references made to housing issues;

substance misuse; domestic violence; conflict with neighbours; the child's weight and sporadic concerns regarding the overall cleanliness of both the children and the family home. There were also concerns that the child missed ophthalmology appointments.

During the 14 months of her life the family were accommodated in a hotel for 4 months before moving to their own property. These moves involved moving in and out of designated Flying Start areas.

The family were consistently saying that they would engage with early preventative services, and this was seen as an appropriate protective factor.

The family were known to local agencies and there had been cooperation by the family when visited.

The family initially engaged well with midwifery and health visiting services and when they moved in and out of Flying Start areas there was a robust transfer process and the family continued to engage with the new Health Visitors.

The family cooperated with the housing officers who were involved with securing permanent housing and when there were issues with neighbours.

The family called the police when there were disputes with the neighbours. Neighbours also phoned the police and reported shouting and loud noise coming from the property.

On the morning of 4/12/22 the child was checked in her cot and was found to be cold and unresponsive. Emergency services were called and her parents administered CPR as instructed until paramedics arrived. She was taken to hospital and pronounced dead later that morning.

A postmortem examination concluded that the cause of death was 1a Invasive Group A Streptococcus (IGAS) Infection. The postmortem report noted that she also had Coronavirus and Respiratory Syncytial Virus (RSV).

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

Since the postmortem, Public Health Services have published the Four Nations Rapid Review into Invasive Group A Streptococcus (IGAS) Deaths in children in March 2024.

The report notes that there was an unusually high occurrence of IGAS in children between October 2022 - February 2023 which was when the child contracted IGAS. <https://phw.nhs.wales/services-and-teams/child-death-review/child-death-review-publications/4-nations-igas-report/>

The report concludes that "Clinical presentations, which were often initially mild and non-specific, combined with rapid deterioration meant that children were unable to access sufficiently timely emergency care to potentially prevent death, despite often best attempts by caregivers and health services. It also noted that co-infection was common amongst the children that had died.

Given the above it was felt that nothing more could have been done to prevent the child's death given her rapid deterioration.

However, the report also noted in its conclusion that "Children with health and social complexities may be particularly at risk of poor outcomes."

Given the opportunity to reflect during the Child Practice Review process there have been areas identified that could have contributed to the risk of a poor outcome for the child and this learning may benefit other children in the future.

The review panel considered the information held within the merged timeline; the agency analysis and the discussion during the learning event and found four areas of learning.

1. Safeguarding Reports and Responses
2. Feedback from Safeguarding Reports
3. Engagement with Early Preventative Services
4. Escalation of Concerns

1. Safeguarding Reports and Response

Between November 2021 and September 2022 five safeguarding reports were presented to the Local Authority, two by Housing Support and three by Health Visitors. The police also presented three CID 16's following concerns regarding disputes with neighbours.

These reports were responded to by the Local Authority and the threshold of significant harm was not met. None of the safeguarding reports from professionals triggered the need for a strategy meeting.

One strategy discussion was held following a referral from a member of the public regarding a dispute between the parents and neighbours; this concluded with a single agency visit from the Local Authority and further enquiries were not made.

Social Services have reflected that at the time, initial safeguarding reports were managed by the Local Authority Single Point of Entry (SPOA), known as the Gateway. It was noted that each safeguarding report up until September 2022 was responded to by the Gateway and at the time the manager did not feel that the reports warranted passing to the Social Services' Children's Intake and Intervention Team, and that an appropriate response was to instruct a worker from the Gateway to conduct a "Part 2 What Matters Conversation" with the family.

There was a clear period noted for the completion of the assessments which was adhered to. Each assessment was completed and the outcome stated. The threshold of significant harm was not met, and the case was closed with the family agreeing to engage with preventative support from Team Around the Family.

Following a Safeguarding Report from the Health Visitor on 28/9/22 a joint visit by a Social Care Practitioner from the Local Authority Gateway team and the Health Visitor was undertaken on 12/10/22. The case was discussed in the Social Services Intake and Intervention Team Transfer Meeting. A decision was made to transfer the case from Gateway to the Social Services Intake and Intervention Team, and a decision was made to undertake a Part 3 What Matters Conversation Assessment with the consent of the parents. This assessment was completed and as before the finding was that the threshold of significant harm was not met and that the family were agreeing to engage with

preventative support from Team Around the Family.

Reflection and changes already made

Social Services have noted that following an internal review of their services they no longer undertake the Part 2 What Matters conversations within the Gateway as was the practice during this time, as there was no managerial overview by a social work team manager. All reports are now passed directly to the Children's Assessment and Intervention Team and overseen by a social work manager. The previous Part 2 What Matters Conversation process was meant to be a light touch assessment akin to an initial assessment.

The Police have also reflected that whilst they did submit three safeguarding reports (CID 16s) The CID 16s presented gave details of the disputes with neighbours, but no information was shared regarding the condition of the house or any information about the children.

There were seven other occasions when the police were called out to disputes with neighbours. Even though the children were present at the time of the disputes, and there were reports of shouting and loud noise at the premises, some of which was alleged to be directed at the children, no CID16's were presented on these occasions.

Since this time, the Police have produced a framework called AWARE which is a mnemonic designed to assist the police to glean information from vulnerable children and adults at risk to share with partners via the central referral unit.

It is hoped that the AWARE mnemonic will prompt response officers to consider the whereabouts of children, the home conditions when children are present and the welfare of the child in the circumstance.

2. Feedback from Safeguarding reports

It appears that there was a lack of clarity regarding Local Authority's involvement following the receipt of safeguarding reports from agencies. Both Health and Housing said that they were not aware of the Local Authority's response following safeguarding reports. At the Learning Event held as part of the Children Practice Review it became apparent that following each submission of safeguarding reports the Health Visitors contacted the Local Authority via the Gateway and were informed that the case was open. This provided the Health Visitor with reassurance that matters were in hand.

However, it transpired that the case was closed after each Part 2 What Matters Conversation was held as the threshold for significant harm was not met and the family said they would engage with preventative support from Team around the Family. The Health Visitors were being told the case was open to the Local Authority when it was not.

Reflection and changes already made

Social Services have reflected that when the Health Visitors were contacting the Local Authority, they were speaking to Gateway administrators who would check their IT system and saw that the file was open. When this was investigated it was found that the case was closed however there had been a delay in actioning the closure on the IT system. This meant all messages from the Health Visitor were being filed on closed cases and not picked up.

This practice has now changed, and all cases are now opened and closed on Paris by the Social Services' Intake and Assessment Team Manager. All emails, phone calls and

messages during the assessment period are now sent to the allocated Social Care Practitioner/ Social Worker and not held in the Gateway IT system.

It remained however that health and housing were reporting that they were not aware of the outcome of the safeguarding reports that they had submitted.

It is imperative moving forward that all agencies are aware of the need to continue submitting reports when they are concerned, even if they believe the case to be open.

3. Engagement with early preventative services

Four Part 2 What Matters conversations held by the Local Authority Gateway and one Part 3 What Matters conversations held by the Social Services concluded that the threshold for significant harm was not met, however there was much reassurance placed within these assessments on the family saying that they were happy to engage with early preventative services.

Early preventative services mentioned included Team Around the Family, Parenting package of support provided by the Flying Start Health Visitor Team and Flying Start Support Services.

During this review it was established that the family had never been referred to Team around the Family and when the family said they were happy to engage with Team Around the Family no one checked that they were in fact receiving a service.

Reassurance was also placed on the family agreeing to a package of support from the Flying Start Health Visitor Team. This was to be requested on the 7th of February 2022 and was to be monitored by the Health Visitor in two weeks' time as part of the child's Six-Month Developmental review. However, the family moved house and there was a change of Health Visitor, and the package of support was not provided. The child was next seen on 6th April 2022 at 7+months.

When the family moved, they moved back into a Flying Start area. A referral was made to the Flying Start Support Services and this was again seen as reassurance within the assessments by Social Services. However, there was a delay of three months between the referral being made and start of the service. There were also several appointments cancelled by the family so that, even when Flying Start Support workers had been allocated, the service was not in fact being accessed by the parents.

No agency made any attempt to verify the family's engagement with Team around the Family or Flying Start support services. During this time health and housing representatives continued to express concern and further safeguarding reports were presented.

The review has found that there was a good level of engagement between the family and the midwifery service, GP and health visiting service. However, once the chronology was populated within the timeline it became apparent that the family consistently cancelled visits by the health visiting service; they did not accept phone calls from the GP and the child was not brought to Ophthalmology appointments.

Reflection and changes already made

During the Learning Event all agencies represented, i.e. Social Services, Health and Housing reflected on the importance of checking the uptake of preventative support services before assuming they are a protective factor.

Whilst reference was being made to the parents' engagement with preventative services, there does not appear to be any consideration to the impact of the perceived preventative service on the child and any improvements to the family's situation.

Whilst all unanswered phone calls, no access at premises and cancelled visits were recorded the number of instances were not captured across all health departments and therefore there was a missed opportunity to reflect on the family's ability to engage with key health services. It was suggested that the lack of digital health records across BCUHB meant that the extent of missed health appointments across different departments was not fully captured and therefore the opportunity to escalate concerns under BCUHB 'Was not Brought' Standard Operational Procedure was missed.

BCUHB is in the process of developing a strategic business case for an Electronic Healthcare Record (EHR) system. This system is intended to offer an interoperable solution, ensuring visibility of patient records across the health board. While there is currently no defined timeline for the implementation of an EHR, work on this initiative is actively progressing.

A Task & Finish Group within BCUHB to review the Was Not Brought Standard Operational Procedure has been operational since November 2024. The National Safeguarding Team are currently developing All-Wales NHS Was Not Brought Guidance.

4. Escalation of Concerns

As time went by Health and Housing representatives were becoming increasingly concerned about the condition of the child and the home environment. There were concerns about the child's weight and about the cleanliness of both the home and the children.

During unannounced or planned visits by Health and Housing the home was seen to be untidy and dirty, however equally there were times when both the children and the home were viewed by all agencies as acceptable. When Social Services undertook planned visits to undertake the What Matters Conversations the house had been cleaned and tidied.

There was increasing concern about the child's weight, and a referral was made to the paediatric dietician, and the parents were given advice sheets to follow, as is customary practice. The dietician service would not always need to see the child. It was also noted that it was only towards the end of her life that the child's weight became of more significant concern as up until then the child's weight was in proportion to her height. The child had also been referred to the Community Paediatric Service however died before the appointment could be offered.

There were concerns expressed regarding the child's skin being dirty, but when Social Services visited the child appeared to be clean and wearing clean clothes.

The child's care was assessed after each safeguarding report; a decision was made by the Local Authority Gateway on all but one occasion not to hold a strategy discussion as the threshold to hold such a meeting was not met. As there was no evidence to suggest the likelihood of significant harm which would warrant enquiries under section 47 of the 1989 Children Act, Social Services could not make further enquiries or make unannounced visits.

A Joint visit was undertaken by Social Services and the Health Visitor as part of one of the What Matters 2 Conversation Meeting. Health and Social Services representatives at the

learning event reflected on the value of being able to do joint visits by Social Services and Health, especially as the child would have been stripped to be weighed naked, giving an opportunity to observe the condition of the child's skin, however it was raised at the learning event that should the social services representative visit at the same time as the health visitor that this could jeopardise the take up of health services which was historically good.

When Health and Housing continued to be concerned about the situation. Health Staff sought safeguarding supervision, and the health visitor was advised to call a Professionals Meeting in accordance with BCUHB standard operational procedures. Social Services were invited to the meeting but did not attend as the case was closed. Social Services had recently undertaken a Part Two What Matters Conversation assessment following a recent safeguarding report from health, which concluded with the case closing as the parents were consenting to support from Team Around the Family, Housing, Flying Start and parenting support.

The professionals meeting was attended by representatives from health and housing. The outcome of the meeting was for the Health Visitor to make a home visit and for the Health Visitor to monitor the Team Around the Family Intervention.

Following the Professionals meeting, housing provided tenancy support and presented a further safeguarding report.

Health representatives shared at the learning event that they continued to be concerned about the family and felt frustrated that their concerns were not being escalated.

A further Part Two What Matters conversation was held, this time a request by the Gateway manager was made that the visit was undertaken jointly with the Health Visitor.

Following the joint visit the child's case was considered within the Intake and Intervention Team Transfer meeting, this meeting signified the case becoming open to the childcare Social Work team and a Part Three What Matters Conversation assessment commencing. This assessment concluded that the threshold of significant harm was not met, and the family were engaging well with other professionals and that Flying Start Family support would continue weekly.

Reflection and changes already made

During the learning event there was an opportunity to discuss how agencies can work together to improve each other's understanding where agencies have different opinions regarding the level of concerns in relation to children and families.

It was noted that once the Part Three What Matters Conversation assessment had started there was now a named social care practitioner and team manager, and it would have been beneficial for health and social services to share information regarding the level of concern.

Prior to the allocation for the Part Three Conversation the health representatives had tried to contact the Local Authority to share their concerns following submitting safeguarding reports, but their attempts were not fruitful, as messages were being left on what were essentially closed cases and no one picked up the messages.

An attempt was made to raise concerns via the professionals meeting, however on reflection this was not productive as social services did not attend.

The learning event identified that it would be more productive for any agency who continues to have concerns to either: -

- Submit a further safeguarding report to Social Services to escalate the concerns.
- For health to escalate their concerns to the BCUHB Safeguarding and Public Protection Team for support with addressing their concerns to Social Services.
- For other agencies to escalate to their managers.
- Or if the above options did not resolve the issue to refer to the North Wales Protocol for the Resolution of Professional Differences.

Learning event

A learning event was held and nine agency representatives from Health, Social Services and Housing attended. North Wales Police were invited but did not attend. The learning event gave participants the opportunity to share processes and to discuss how best to promote co working. There was discussion around how to gain understanding of each other's roles and there were suggestions made around sharing the Local Authorities' Threshold document and around joint training around understanding each other's professional language and terms.

Meeting with the family

The reviewer met with the parents, and they shared their experience on the day the little girl died.

The family were aware that health had concerns about the child's weight, but they were not concerned themselves as there was a history of "big" babies in the paternal side of the family. The parents said they had agreed for her to be referred to the Dietician and they said that the fact that the dietician did not want to see the child and only sent dietary advice sheets suggested that they must not have been concerned about the child's weight.

The parents did not think there was any reason for the Review as there was nothing for Social Services to be concerned about.

Conclusion

Following the child's death a postmortem examination concluded that the cause of death was 1a Invasive Group A Streptococcus (IGAS) Infection. The postmortem report noted that she also had Coronavirus and Respiratory Syncytial Virus (RSV).

Since the postmortem, Public Health Services have published the Four Nations Rapid Review into Invasive Group A Streptococcus (IGAS) Deaths in children in March 2024.

The Four Nations Rapid Review Report noted the rapid deterioration of children affected by IGAS and some common factors within children who had been affected, co infection being one such factor.

The Four Nations Rapid Review into Invasive Group A Streptococcus (IGAS) Death's concludes that "Clinical presentations, which were often initially mild and non-specific, combined with rapid deterioration meant that children were unable to access sufficiently timely emergency care to potentially prevent death, despite often best attempts by caregivers and health services.

Sadly, it would suggest that despite consideration of any information considered within this review the outcome for the child would have been the same.

The Four Nations Rapid Review Report outlines specific recommendations regarding the specific risk in relation to IGAS and these s will be monitored by the relevant public health bodies.

Learning from the Child Practice Review

The Four Nations Rapid Review report also noted that “Children with health and social complexities may be particularly at risk of poor outcomes.”

Given the concerns expressed by agencies prior to the child’s death, the review has considered whether the child’s home circumstances could have contributed to the risk of a poor outcome for this child.

The review found that agencies were identifying concerns regarding the family and that when these were presented to the parents, the parents agreed to engage with preventative services from Team and around the Family and Family sSupport from Flying Start services. This engagement was seen as a positive factor which diminished the concerns and provided a positive strategy to address any concerns.

However the most significant finding within this review was the fact that despite this engagement with preventative services being noted several times as a protective factor, no one checked whether the family had been referred, whether the family were engaging, and more importantly questioned whether the engagement with preventive services was making a difference to the family.

Recommendations

Whilst it appears that nothing could be done to avoid the death of the child, the review makes recommendations for improvement to general safeguarding management and co working arrangements.

- **Review of the Was Not Brought Standard Operational Procedure following publication of the All-Wales NHS Was Not Brought Guidance.**

The review felt that the number of health appointments the family cancelled or missed could have been significant. As there is no central digital process for capturing missed appointments across all health services the extent of missed or cancelled was not known until the population of the timeline for the review. Analysis of this information could have provided insight into whether the family were engaging with universal or preventative health services.

The review heard that the continued reliance on BCUHB keeping paper records has meant that the necessary information has not been available to health practitioners which would have enabled them to have clearer understanding of the child’s circumstances especially the range of health appointments to which the child “Was Not Brought”.

The review heard that the BCUHB task group, established in November 2024 will further review the Was Not Brought Standard Operational Procedure following publication of the All-Wales NHS Was Not Brought Guidance.

- **Wider use of the Aware Mnemonic.**

The review found that a fuller picture of the child's home circumstances could have been appreciated had the Police presented CID16's following all the times they were called to the child's home. This information could have provided information regarding the condition of the home and the living environment for the child.

North Wales Police have developed the AWARE Mnemonic to assist police officers to gather information about children as part of their assessment and reporting role. The mnemonic is an asset that could be considered by all agencies. The use of the mnemonic in this instance would have highlighted the need to consider the child's whereabouts and the child's daily lived experience whilst witnessing poor home conditions.

It is recommended that the use of the mnemonic is promoted within response police officers and this is reflected within the quality of CID16s.

- **The Local Authority's process for managing safeguarding concerns.**

The review found that each time a safeguarding report was presented to the local authority, they responded with an assessment in accordance with their procedures at the time. These processes have since reviewed and changed. Each assessment concluded in that the threshold for significant harm was not met. However, health and housing have expressed concerns that they were not receiving a response from the Local Authority following presenting safeguarding reports and when they made enquiries, they were told their messages were being passed on to the relevant worker, which was not the case as the case was closed. This system has now been reviewed and changed.

The review found three areas to be improved in relation to joint working around safeguarding concerns.

- **Raise awareness of safeguarding thresholds.**

The Local Authority to arrange multiagency sessions to raise awareness regarding the safeguarding thresholds and to promote better understanding around each agencies' professional language and terms.

- **Raise awareness of the process of escalating safeguarding concerns**

There were some agency representatives that felt frustrated that their concerns were not given sufficient consideration.


That all agencies need to be aware of the need to continue submitting safeguarding reports when they continue to be concerned about a child, even when they believe a family is open to social services.

If agencies continue to be concerned, they need to consider the North Wales Protocol for the Resolution of Professional Differences.

Awareness of this protocol to be raised with all agencies.

- **Sharing of outcomes to Safeguarding reports with agencies.**

Local Authority to review their processes to relay the outcome of safeguarding reports to agencies that have made reports.

REVIEWER 1	
Statement of independence from the case <i>Quality Assurance statement of qualification</i>	
<p>I make the following statement that. prior to my involvement with this learning review: -</p> <ul style="list-style-type: none"> • 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 one <i>(Signature)</i>	
Name <i>(Print)</i>	Valerie Ann Owen
Date	04/12/2025

Chair of Review Panel <i>(Signature)</i>	<i>Anne Flanagan</i>
Name <i>(Print)</i>	Anne Flanagan
Date	04/12/2025

Child Practice Review process
<p><i>To include here in brief:</i></p> <ul style="list-style-type: none"> • <i>The process followed by the Board and the services represented on the Review Panel</i> • <i>A learning event was held and the services that attended</i> • <i>Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.</i>
<p>The panel board met five times, and the agencies were well represented.</p> <p>A learning event was held and nine people attended representing Health, Social Services and Housing.</p> <p>The parents were consulted as part of the review and as a result a request was made for the Paediatrician to meet with the parents to go through the findings of the postmortem.</p> <p>Family declined involvement.</p>