BRIDGEND COUNTY BOROUGH COUNCIL

CORPORATE PARENTING CABINET COMMITTEE

REPORT OF THE CORPORATE DIRECTOR, SOCIAL SERVICES AND WELLBEING

29th MAY 2019

CHILD PRACTICE REVIEW

1. Purpose of Report

1.□.1 To provide Corporate Parenting Cabinet Committee with information in respect of the most recent Child Practice Review from Bridgend.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 This report assists in the achievement of the following corporate priorities:-

- **Helping people to be more self-reliant –** taking early steps to reduce or prevent people from becoming vulnerable or dependent on the Council and its services

3. Background

3.1 In 2013, Child Practice Reviews replaced what were known as Serious Case Reviews (SCR). This new process stems from the Care and Social Services Inspectorate Wales report published in October 2009 - *Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews.* This work was pivotal to where we are today, and concluded that action was required to replace the SCR process which had become ineffective in improving practice and inter-agency working.

3.2 A key element of the new framework is different types of review – known as 'concise' and 'extended' – depending on the circumstances of the chid involved. Child Practice Reviews will be effective learning tools where it is more important to consider how agencies worked together. The formal review process is underpinned by multi-agency professional forums that are critical to improving practice, and will allow practitioners to reflect on cases – to include the rights and wrongs of practice – in an informed and supported environment.

3.3 The guidance sets out arrangements for multi-agency Child Practice Reviews when a significant incident has occurred where abuse or neglect of a child is known or suspected.

3.4 The overall purpose of reform of the review system is to promote a positive culture of multi-agency child protection learning and reviewing in local areas. The Regional Safeguarding Children's Board is responsible for ensuring that reviews are carried out effectively. Future reviews concerning any Bridgend children will come under the Cwm Taff Morgannwg Children's Safeguarding Board.

3.5 A Multi-Agency Professional Forum is a multi-professional event facilitated for practitioners and managers Its purpose is to examine case practice and provide opportunity for consultation, supervision and reflection, and to disseminate findings

from child protection audits, inspections and reviews. The outcome of all reviews are used as a learning process in order to improve local knowledge and practice and to inform the Board's future audit and training priorities.

3.6 Concise Reviews: a 'concise' Child Practice Review is carried out in cases where 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.

3.7 Extended Reviews: an 'extended' Child Practice Review is carried out in cases where 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 on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –
- the date of the event referred to

3.8 On 17th April 2019 Bridgend County Borough Council published a Child Practice Review. The review commenced January 2018 and was commissioned by the Western Bay Safeguarding Children's Board following the identification of concerns where the above criteria for a 'concise review' was met. This review relates to a 9 week old child who died during the night whilst co sleeping with his parents.

4. Current situation/proposal

4.1 The subject of this review was a 9 week old child who died in November 2017 whilst co-sleeping with his parents. Following an inconclusive post-mortem examination and a coroner's inquest concluding an open verdict, the death was viewed as a result of Sudden Infant Death Syndrome (S.I.D.S)

4.2 Between 2008 and 2017 there were 10 referrals received in respect of the child's mother who was under 18 years of age at the time of the child's birth due to family instability, homelessness, substance misuse and mental health issues. The review highlighted that significant information in respect to these issues was not shared between professionals particularly between health professionals.

4.3 There were 9 historical referrals received in respect of the child's father when he was a child. The father was also "Looked After" for short periods due to his mother's poor mental health and domestic abuse within the family.

4.4 Whilst there was nothing to suggest the infant's death could have been prevented, there was evidence within the timeframe that the young family may have benefited from a pre-birth assessment and targeted support services.

4.5 The referrals considered in this review took place in the months leading up to pregnancy, continued into pregnancy and were instigated due to the ongoing lack of stability within the family.

4.6 Children's Social Care carried out an assessment of the young couple prior to the birth of the child but its focus was on housing issues. The assessment did not consider the mother in her own right nor did it explore historical and presenting factors which may have influenced the future parenting and support needs of this young family.

4.7 At the time of the infant's death, the young family were living in private rented accommodation and, their family support structure was unclear. They were not receiving any local authority intervention and home conditions were noted to have deteriorated.

4.8 The child's mother had visited the GP with regard to her low mood and self-harming. A referral to the Perinatal Response and Management Service (PRAMS) had been made by the GP following a previous suspected pregnancy at the age of 15 years but this was not shared with the Midwifery and Health Visiting service. The mother's frequent change of address led to her seeing 8 different midwives.

4.9 The themes highlighted from the review were:

- The G.P did not share relevant information around the mother's mental health with health colleagues and the extent of family support available to the parents was also not adequately explored.
- The mother was not assessed in her own right as a child and the assessment of the child did not consider the wider risk factors about the parent's experiences e.g. parental domestic abuse, mental health, lack of family support.
- There was no specific risk assessment undertaken to consider the above matters.
- Referrals were dealt with in insolation and focused on housing being the dominant factor.
- There was no report to the Police by agencies about the mother having under age sex.

4.10 The reviewers and members of the Practice Review Subgroup were concerned to note the reoccurring theme of the absence of the G.P in the practice learning event convened as part of the review process and an important component to future learning.

4.11 The family have not engaged with the reviewers in this case during the review process or upon notification of the publication of the report.

4.12 The implementation of actions recommended within the report will be reported into both the Cwm Taff and the Western Bay Child Practice Review Management group. In addtiion BCBC will covene team based learning events for practitioners and the findings will also be encorporated into core safeguarding training for employees.

5. Effect upon Policy Framework and Procedure Rules

5.1 There is no impact on the Policy Framework and Procedure Rules

6. Equality Impact Assessment

6.1 There are no equality matters relevant to this report.

7. Wellbeing of Future Generations (Wales) Act 2015 Implications

7.1 The implementation of the duties and responsibilities under the Social Services and Wellbeing (Wales) Act 2014 (SSWBA) supports the promotion of two of the seven goals of the Well-Being of Future Generations (Wales) Act 2015 within the County Borough of Bridgend. By promoting an environment that maximizes people's physical and mental well-being and by supporting children, young people, adults and their carers and families to fulfill their potential no matter what their circumstances, the well-being goals of a Healthier and more equal Bridgend and Wales are supported.

7.2 The Well-being of Future Generations (Wales) Act 2015 provides the basis for driving a different kind of public service in Wales, with five ways of working to guide how the Authority should work to deliver wellbeing outcomes for people. The following is a summary to show how the five ways of working to achieve the well-being goals have been considered in this report:

- Long Term – The SSWBA places a requirement on the Local Authority to meet the needs of people in the longer term and as such the themes and lessons learnt from Child Practice Reviews will be considered for practice when remodeling and transforming future service provision.
- Prevention – the report highlights themes within practice across agencies and the need to share information and provide support at an earlier stage. This will ensure that need is anticipated and resources can be more effectively directed to improve service delivery and the safeguarding of children.
- Integration – the report notes areas of improvement in information sharing between agencies and these will be closely monitored to ensure care and support for children, young people and carers is prioritised.
- Collaboration – the partnership working between agencies and professionals is critical to ensure the safeguarding and protection of children. This report clearly identifies the importance of collaborate working and the need to ensure learning is recognised by all professionals working with children and young people.
- Involvement – the professionals involved in this review have been included in a learning event to inform the report and its recommendations for future learning. This report has also been published by the Western Bay Safeguarding Children's Board allowing a wider audience, namely the public and professionals who have not been involved in this review. This provision of accessible information helps to ensure that the voice of adults, children and young people is heard.

8. Financial Implications

8.1 There are no specific financial implications linked to this information report

9. Recommendation.

9.1 It is recommended that Corporate Parenting Committee notes and provides comment about this report.

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Background documents:
None