Cardiff and Vale of Glamorgan
Local **Safeguarding Children** Board
Bwrdd Lleol **Diogelu Plant**
Caerdydd a Bro Morgannwg

Child Practice Review Report

Cardiff and Vale of Glamorgan Local Safeguarding Children Board

Concise Child Practice Review

Re: C&V LSCB 01/2013

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

A concise Child Practice Review was commissioned by the Cardiff and Vale of Glamorgan Local Safeguarding Children Board (LSCB) on the recommendation of the Child Practice Review Sub-Group in accordance with the Protecting Children in Wales: Guidance for Arrangements for Multi Agency Child Practice Reviews, 2013.

The criteria for this review were met under subsection 5.1 of the guidance, namely a child 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 child's death.

The criteria for concise reviews are laid down in the Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012.

Circumstances resulting in the review:

This review was commissioned following the severe injury of a child, aged 6 weeks, who resided with his mother in the Cardiff area. Prior to the scope of the review the child and mother were known to universal services, including General Practitioner, Midwifery and Health Visiting Services. There were no concerns about the mother's ability to care for the child. Neither mother nor her boyfriend (who was not the child's father) were known to Children's Services prior to the injury resulting in the death of the child.

Four months prior to the child's injury the mother had started a new relationship. On the night the injuries to the child were sustained he was in the sole care of his mother's boyfriend who resided in a neighbouring Local Authority.

The child was admitted to hospital following a call to emergency services from mother's boyfriend stating that the child was not breathing. Ambulance crews arrived and commenced medical intervention and transported the child to a local district hospital. All health professionals tending to the child documented significant non accidental injuries which included head injuries. Due to the severity of his injuries he was transferred to a regional intensive care unit where he died 3 days later.

Child Protection Procedures were instigated promptly.

The time period of the review is from the 3rd December 2012 to the 17th

August 2013. This covers the period prior to the birth when contact with midwifery services commenced and up to the point that the child was transferred from a local hospital (Hospital 1) to an alternative hospital to assess his injuries further (Hospital 2).

The summary timeline of significant events is included in Appendix 1.

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).

Practice and organisational learning

Importance that practitioners obtain details of partners and/or other significant individuals.

Details of mother's new boyfriend/ child's father were not obtained/recorded within the antenatal care records as this information was not made available or not requested. There was no clear picture of the mother's previous or current partners and her relationship with them. Agencies need to ensure that forms used by practitioners to record information ask for this and the details of other significant individuals. It would have been unlikely however that there would have been grounds for any further checks to be undertaken in this case.

As part of the Police investigation, Police records showed that there were some historical concerns with regard to the mother's boyfriend, however, there was no cause to share this with the child's mother or other agencies as there were no known safeguarding concerns that would have lead to this prior to this incident.

No concerns about mother's ability to parent the child were raised, a high standard of care was delivered by health professionals following the incident and the child's death could not have been predicted or prevented.

Key examples of effective practice:

The Ambulance crews responded rapidly to undertake appropriate lifesaving work.
Excellent service was provided by the ambulance crew in attendance, who responded promptly from when the initial call was received by the call handler.

The Police attended when there was a life threatening emergency.
Police responded to the initial call promptly, arriving shortly after the

ambulance crew as a standard operating procedure in cases where there is a life threatening paediatric emergency.

Health professionals gave excellent care and treatment in response to the child's injuries.
Resources were appropriately utilised to diagnose and assess the child to increase the chance of life, unfortunately the injuries were so severe nothing could be done to prevent the child's death.

Midwifery and health visitor services gave good care and treatment.
Regular and consistent contact was maintained and there was a timely transfer from midwifery to the health visiting service.

All agencies involved documented their involvement correctly.
Agencies were able to provide coherent and clear timelines with regards to their involvement, and in particular, where multi-agency working took place.

All agencies responded and followed correct practices once safeguarding issues had been identified.
Good evidence of prompt and effective communication between Police, Children's Services and Health. Safeguarding procedures were followed in a timely way.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the LSCB and it's member agencies and anticipated improvement outcomes:- (what needs to be done differently in the future and how this will improve future practice and systems to support practice).

There were no details of mother's boyfriend or the child's father in the antenatal care records. It is not known if mother declined to share this information when asked or whether she was asked for this information.

There is a need for the Midwifery Service to review how the information collected in the National Midwifery Record (All Wales Record Booking) captures the social circumstances of the boyfriend/father of the child. However it is the recommendation of this review that Cardiff and Vale University Health Board consider the need for Midwifery Service to review how information is collected from mothers includes details of a baby's father and any partners or boyfriends, including the recording of any refusal to share this information. Midwives to be reminded during supervision and Personal Appraisal Development Review of the importance and relevance of asking and recording details of putative fathers and partners in a household.

Statement by Reviewer			
Reviewer 1	Carolyn Griffiths	Reviewer 2	Matt Osborne
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)	C J Griffiths	Reviewer 2 (Signature)	
Name (Print)	Carolyn Griffiths	Name (Print)	Matt Osborne
Date	30.10.2014	Date	29.10.2014

Chair of Review Panel:

Signature: ..... P.P

Name (print): Simon Williams

Date: 5.11.2014

Documents added as appendix	
Appendix 1: Summary Timeline	X

Child Practice Review Process

To include here in brief:

- The process followed by the LSCB 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 has been provided to them.

The processes followed to undertake this review are described in the Terms of Reference for the review.

In view of the recognition of good practice being followed, that there was no family engagement and that positive multi-agency practice has been identified by the Child Practice Review Panel and Sub Group, it was decided that a Multi Agency Learning Event would not take place.

A dissemination plan to share the good practice identified will be detailed in the action plan from the Review Panel.

The family have declined to engage with the review process to date however prior to publication the reviewers will contact the family again regarding this report and its contents.

☒ **Family Declined involvement**

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Date information received:

Date acknowledgement letter sent to LSCB Chair:

Date circulated to relevant inspectorate /Policy Leads:

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			