Review concerning an infant child
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7 POINT BRIEFING

1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a Rapid Review concerning a 2 year old following their sudden and tragic death at home. The areas the review considered included the following:

- The impact of long-term neglect and risk of harm to children
- Timeliness of escalating powers to protect when reoccurring harmful behaviour presents
- Managing complex safeguarding risk in families where there are multiple children
- Effectiveness of communication between services who were supporting the family
- Analysing presentations in elder children within a family household as a means to understand the impact of children's lived experience at home

2 WHO WAS THE CHILD AND THEIR FAMILY?

The child and their siblings were subject to Public Law Outline (PLO) Framework at the time of their death due to concerns in respect of neglect. Though concerns about the level of care provided to the children had been longstanding, there had never been indication of the likelihood of immediate harm to the children.

3 SUMMARY OF THE INCIDENT

The child tragically died after being found submerged under water whilst in the bath at home.

4 AUDIT FINDINGS - AREAS FOR DEVELOPMENT

1. **The impact of long-term neglect and risk of harm to children**
    - The child and their family had come into contact with multiple services from 2014 onwards after moving to the district from a neighbouring area. Services reflected if there would have been opportunities to potentially escalate to PLO at an earlier opportunity, when there were instances of home conditions deteriorating. Mother's engagement and responsiveness in making changes when required to do so resulted in the appropriate decisions made at the time to not escalate. With hindsight, it was recognised however the changes made had a pattern of unsustainability and identifying this cycle may have enabled services to escalate at an earlier stage
    - When reviewing service records, there were examples of good practice demonstrated as to how the issue of neglect was recognised and continually monitored by services. This included the use of the partnership's neglect toolkit by services as instructed to by the Conference Chair as part of a Review Child Protection Conference (RCPC), helped to recognise the need to escalate to PLO. The partnership has undertaken work in updating its neglect toolkit, moving it online, along with a new multi-agency shared responsibility neglect training to ensure the use of the toolkit is better embedded as part of routine practice
    - When home conditions deteriorated periodically, professional challenge was robust and mother continued to engage with services and responded to improving the conditions at home. The review recognised that there was not a single incident of significance which would have triggered the threshold of immediate removal of the children based on the level of neglect they were experiencing

2. **Timeliness of escalating powers to protect when reoccurring harmful behaviour presents**
    - There was discussion within the review as to whether there is a need to have a timescale in place within which a Child Protection case involving lack of sustained change should be considered for PLO. Children's Social Care (CSC) have a process in place which requires management oversight of child protection cases between 9 - 12 months in order to avoid drift and delay where escalation should be considered
    - The children's good school attendance and attainment, mother's engagement with services, good availability for home visits, the children being visible, mother's pro-active response to challenge and seeking of medical attention limited the extent to which a legal resolution would have been available. The review reflected that the work of services minimised the impact of accumulative harm upon the children, but in doing so, also had a limiting effect on the evidence available to support a legal application for removal
    - Mother had a history of low mood and periodically took Sertraline medication. There were no reports of any side effects of the medication nor were there any records from services documenting concerns. As part of standard routine, each prescription of medication came accompanied with patient advice, known as *package leaflet: information for the patient*. Service records shared information regarding the children's bedtime routine which was unsuitably early resulting in them waking up early in the morning. Although recorded in discussions at multi-agency meetings, there was limited evidence as to how services assessed any potential wider impact of the medication and mother's mental health on her parenting capacity and her ability to supervise effectively

3. **Managing complex safeguarding risk in families where there are multiple children**

- Records reflected services generally articulated the lived experience of the children which informed planning and interventions and services demonstrated, understanding the children's needs individually as well as collectively. The children's health needs were well documented, of which all had additional need. There was acknowledgement that given there was several specialist supporting interventions put in place to address aspects such as continence, dietician and speech and language, it would have benefitted from a School Nurse remaining involved to oversee engagement with the different health services and be able to make appropriate escalations when the children were not being brought to appointments. Missed appointments did occur for some support for children such as continence and cow's milk protein allergy due to these services being opt in
- The use of reflective supervision would have benefitted from being more effective to support practitioners being able to unpack concerns and consider what was driving the presentation and behaviour being seen
- There was recognition in cases, there is a need to explore developing multi-agency group supervision where there is a high level of complex need within households. This would enable all practitioners who are working with a family to have a safe space to slow thinking down, have opportunity to reflect upon situations which feel complex and stuck or are drifting, in addition to understanding how they are working together to effect change

4. **Effectiveness of communication between services who were supporting the family**

- Service records indicated the communication and joint work between services was strong. The level of engagement of partners within multi-agency meetings such as Strategy Meetings, Core Groups and Child Protection Conferences was high. When reviewing how services engaged with the family, there was evidence that information was being triangulated to ensure all what was being heard, observed, and told was accurate. Services reported on the good relationships practitioners held and there were some good examples of challenge of each other
- There is a system development required to enable Mid Yorkshire Hospitals Trust (MYHT) to be in receipt of all minutes and invitations where a Child Protection Plan is place for a child. In addition, there is a good system in place with primary care health providers undertaking a Multi-Disciplinary Team (MDT) safeguarding meeting which allow for relevant information to be shared between the GP, midwifery service and 0-19 service

5. **Analysing presentations in elder children within a family household to understand the impact of children's lived experience at home**

- The eldest sibling was presenting with several health needs and worrying presentations, which although were recognised by services, there were limitations as to the extent these were analysed more widely. Further curiosity as to what was potentially causing these presentations and behaviours beyond what was being observed, heard, and told may have further strengthened the understanding of the children's lived experience at home in the context of accumulative harm
- Although there was recognition medically of all the children's health needs, there was limited analysis evidenced as to whether services considered these needs were being contributed or caused by the adverse childhood experiences they were being exposed to. Developing a system-wide trauma informed response across the district is an ongoing development area which the partnership is contributing to

5 WHAT WILL WE DO WITH THESE FINDINGS?

- The review generated individual, group and system recommendations which are being overseen and implemented by WSCP multi-agency subgroups which are represented by services who work or volunteer with children and families
- WSCP will hold practice review briefings to disseminate the learning and analysis to the children and families workforce

6 NEXT STEPS

- The findings of the review has been approved by WSCP and work is underway in implementing the learning from the incident

7 RESOURCES

There are a range of national and local resources, guidance, and training in relation to safeguarding children on the WSCP website.

Wakefield Safeguarding Children Partnership