Child Practice Review Report

Cwm Taf Safeguarding Children Board

Concise Child Practice Review

Re: CTSCB 01/2014

Concise Review	☒
Extended 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*
- *Summary timeline of significant events to be added as an annex*

A Concise Child Practice Review was commissioned by Cwm Taf Safeguarding Children Board in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews (2012). The criteria for this Review were met under section 6.1 of the above guidance namely:

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 Child was a twin who was born in 2013. The family was supported by universal health services and was not known to social services. The Child died at the age of 2

months.

After the death of the Child agencies engaged with the family, initially to support them and later through targeted interventions prompted by bruising to the surviving twin. A post-mortem (PM) examination of the Child was undertaken 4 days after the death and the preliminary report was sent to the Coroner's office on the same day raising a query about a possible healing injury. The final report was received by the Coroner's office 4 months later however the full details of this report were not shared until the inquest 6 months after the Child's death. The final PM report described significant non-accidental injuries. These injuries did not directly contribute to the death but their presence required an explanation. Following investigations, the surviving twin was accommodated by the Local Authority.

The agreed timeframe for the review was from the first antenatal appointment to the date of the Inquest into the Child's death.

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

1. **The many family stresses imposed by multiple birth and the increased risk of child abuse and neglect for children who are twins are well-documented[1]. When one twin is abused the likelihood that the other twin has also experienced abuse should be considered[2] [3].**
   Prior to the injuries to the first twin being recognised there was nothing to suggest that practitioners were considering the increased risk to multiple birth children in their work with the family. Once the injuries to the first twin were known practitioners rightly considered the possibility of injury to the second twin and initiated child protection procedures.
2. **The importance of sharing relevant information between primary care professionals following the first antenatal appointment**
   Father's history was not shared at the first antenatal appointment (history of mental ill health, significant episodes of selfharm, substance misuse) and this information may have had an impact on practitioners' perception of family risk and vulnerabilities. There was a crucial period during which the family moved and attempts to contact the family failed. Participants at the Learning Event heard that this may have coincided with the occurrence of at least one of the injuries. Had the Midwife and Health Visitor been aware of the father's history they may have managed the family differently and considered it important to

[1] Groothuis J et al. Increased Child Abuse in Families with Twins. Pediatrics. 1982;70(5):760-773
[2] Lang C A et al. Maltreatment in Multiple-birth Children. Child Abuse & Neglect (2013)
[3] Maltreatment in Multiple-birth Children. Commentary by: James Anderst. AAP Grand Rounds 2014; 31(4): 43

remain in contact to support the family whilst they moved home.

3. **If any person has knowledge, concerns or suspicions that a child is suffering, has suffered or is likely to be at risk of harm, it is their responsibility to ensure that the concerns are referred to social services or the police, who have statutory duties and powers to make enquiries and intervene when necessary.**[4]
   In this case a safeguarding concern was identified but not effectively communicated which had implications for the safety of the surviving twin.
4. **When any findings at post-mortem examination have safeguarding implications these should be explicitly stated. It is not sufficient for such findings to be simply stated without further exploration of their possible implications.**
   In this case the preliminary post-mortem report, had its implications been understood, could have alerted other agencies to the risk of significant harm to the surviving twin much earlier.
5. **Paediatric pathologists need to have an adequate understanding of the principles of safeguarding children. They need to understand child protection practice issues and be fully engaged in the child protection process.**
   The review identified that communication between the Coroner's office and paediatric pathology operated as a "closed" network, with the pathologist believing he could only contact others with the Coroner's express consent. As a result the paediatric pathologist's safeguarding responsibilities did not take precedence over other considerations.
6. **This review demonstrated that in some instances the paediatric pathologist's report can be a critical piece of information that may need to trigger child protection activity.**
   In this case the post-mortem report was received by the Coroner's office but, despite it containing crucial child protection information, this was not shared with multi-agency partners and thus no action was taken until the inquest 2 months later.
7. **The Coroner's office needs to consider what actions should be complete before the post mortem report is made available to the family.**
   During the 2 month period when the report was in the possession of the Coroner, but its contents were unknown to police and social services, the Coroner's office wrote to the family informing them that the report was available to them on request. Had they made such a request they may have been made aware of the concerns for the safety of the second twin and evaded services before any protective action could be initiated.
8. **All Pathology reports need to include the date of the post mortem examination and the date on which the report was written.**
   The final report contained the date of the examination but not the date on which the final report was written.
9. **The review recognised the need to fully implement the revised Procedural Response to Unexpected Deaths in Childhood (PRUDiC)**[5] **and in particular to hold the Case Discussion Meeting.**
   Practitioners at the Learning Event endorsed PRUDiC and underlined the

[4] All Wales Child Protection Procedures 2008
[5] Procedural Response to Unexpected Deaths in Childhood (PRUDIC) Guidance – May 2014 revision

importance of the Case Discussion meeting. They recognised that a Case Discussion meeting would have enabled full discussion of the post-mortem findings and their implications. The review welcomes the commitment from Paediatric Pathology to engage in this process in future. It is likely that the family health visitor and the paediatrician would have been present and thus fully informed of the injuries and their implications. This was critical information for them and for other agencies in future contacts with the family.

10. **The importance of accurate recording of information and of records containing all relevant information.**
    As a result of the review and the Learning Event it became clear that the purpose of a strategy meeting was incorrectly recorded in the Social Services child protection record for the surviving twin. The Health Visitor identified that she did not file PRUDiC meeting minutes in the child's record. The Panel heard that normal practice would be to do so and in addition to make a recording in the family record card and the chronology of significant events in the records of each sibling.
11. **The importance of following the 'Bruising and soft tissue injuries in children not independently mobile' protocol**
    When there were concerns about bruising to the surviving twin the protocol was not followed in the first instance. Participants at the Learning Event underlined the importance of adhering to this policy to deliver effective safeguarding practice.
12. **The importance of invoking the 'Cwm Taf Safeguarding Children Board Resolution of Professional Differences Policy'**
    Practitioners at the Learning Event were not aware of it. Although health staff escalated the issue within the Health Board the matter was not resolved and neither they nor Children's Services staff could identify mechanisms for resolving differences in a timely manner compatible with the requirement of urgent child protection practice.
13. **The importance of the role of Named Doctor for Safeguarding Children**
    The reviewers wish to endorse and highlight the importance of this role, now in place in Cwm Taf University Health Board, in strengthening and supporting effective practice. At the time of these events there was no Named Doctor in post. The Named Doctor may have had a role in the interpretation of the significance of the preliminary post-mortem findings and in resolving professional differences which arose in this case.
14. **The importance of avoiding the use of emotive language and the fostering of optimism in PRUDiC information sharing and planning meeting minutes which may have an impact on any subsequent investigation. Practitioners need to exercise what Lord Laming referred to as 'respectful uncertainty'.[6]**
    The PRUDiC information sharing and planning meeting minutes concluded that '*At this point the death is being considered an unexplained death. There is nothing currently that would suggest the death was anything other than tragic'.* Whilst this is factually correct it may have discouraged practitioners from being more curious about the subsequent preliminary PM report of a possible healing injury. This was compounded by the fact that there was no Case Discussion Meeting.

[6] The Victoria Climbie Inquiry Report, 2003.

15. Effective practice identified:

a. Care Of Next Infant (CONI) programme: It is likely that the CONI programme for the surviving twin played a positive preventative role for this family. It was delivered in an effective and timely manner and should be commended.
b. The speed of the Ambulance service response was noted as exceptional in responding to the emergency call.
c. Liaison Health Visitor alerted others to a safeguarding concern and this was effective practice, involving a difficult element of professional challenge.
d. The Review recognised the forthcoming Cwm Taf development around implementation of a MASH (Multi-Agency Safeguarding Hub) to enhance and strengthen professional decision-making and information sharing as relevant to this case.

Improving Systems and Practice

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

The panel identified the following action points for Cwm Taf Safeguarding Children Board;

1. That Cwm Taf Safeguarding Children Board ensures that relevant research regarding the increased risk of child abuse and neglect for children who are twins is included in training to ensure that it is embedded in practice.
2. That Cwm Taf University Health Board should adopt the Sharing Information Pregnancy Pathway (Safeguarding Children) being developed nationally in Wales, to share relevant information in family members' health records between midwives, health visitors and general practitioners in order to ensure an effective assessment of family needs and risks.
3. That Cardiff and Vale University Health Board ensures that all their pathologists have a clear understanding of their safeguarding responsibilities.
4. That Cwm Taf Safeguarding Children Board engages with the Royal College of Pathologists to make it aware of the circumstances of this case and include a requirement for all Paediatric and Perinatal pathologists to undertake Level 3 Safeguarding Children training in line with the Intercollegiate Document[7] as part of their initial training and ongoing professional development. This will ensure they are aware of their safeguarding children responsibilities and have a heightened awareness of multi-agency safeguarding practice issues.
5. That Cardiff and Vale University Health Board ensures that all paediatric

[7] Safeguarding children and young people: roles and competences for health care staff: Intercollegiate Document (ICD March 2014)

pathology reports include the date of the report and the date on which the report was written and are written in language which is clear and accessible. It should further ensure that when any findings have safeguarding implications these are explicitly stated and appropriately shared and actioned in line with the All Wales Child Protection Procedures.

6. That Cwm Taf Safeguarding Children Board engages with the Office of the Chief Coroner to make it aware of the circumstances of this case and ensures that all Coroners and their staff are aware of their responsibilities and understand their roles in relation to safeguarding children particularly around sharing information which has child protection implications with the appropriate authority in a timely manner.
7. That Cwm Taf Safeguarding Children Board offers Level 3 Safeguarding Children training to all Coroners and Coroner's Officers, and Level 2 Safeguarding Children training to their administrative staff, in the Board's constituent local authority areas.
8. That Coroners in Cwm Taf Safeguarding Children Board's constituent local authority areas devise a system so that, when they receive post-mortem reports which contain information with possible child protection implications, they can be assured that a child protection referral has already been made or make such a referral themselves. They should further consider with whom and when such post-mortem reports are shared and the implications for any concurrent child protection processes.
9. That Cwm Taf Safeguarding Children Board assures itself that all agencies' records for families and sibling groups clearly inform across sibling records about potentially relevant past family history and future risks.
10. That Cwm Taf Safeguarding Children Board reviews their "Resolution of Professional Differences" policy to ensure it includes the learning from this review.
11. That Cwm Taf Safeguarding Children Board advises practitioners that when the cause of death is unknown PRUDiC information sharing and planning meeting minutes should contain the statement that 'the PRUDiC process cannot be concluded and no conclusions can be reached before the final post mortem report has received multi-agency consideration'. The PRUDiC process should always be followed to completion and include a Case Discussion meeting and a Case Review meeting.