Confidential

Significant Case Review

Child D

[redacted] HSCP

Date 7.8.2021

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Introduction

Findings

Please note – no attempt should be made to identify the individuals in this report

Introduction

1. Why This Case Was Chosen to be Reviewed?

1.1 Child D is born on [redacted] 2016. During the pregnancy Child D's parents are advised by medical staff that Child D was going to be born with spina bifida and her prognosis was poor. If Child D survives she would have multiple health needs and would require life-long care. This is a twin pregnancy and the other twin has no known health issues pre-birth

1.2 Child D is discharged home to the care of her mother and father on [62 days after birth] following a post birth planning meeting and a separate ward discharge meeting. Due to Child D's multiple health needs she is required to attend hospital very regularly to see a range of medical specialities and undergo a number of medical procedures. The child requires to be catheterised daily and the hospital assesses the parents as competent to perform this task. Catheterisation is fundamental to Child D's health and well-being.

1.3 On 2 July 2017 [age less than one year]while in the care of her father, Child D is admitted to hospital having been found by her father in the early hours of 2nd July to be lifeless. Hospital staff are unable to resuscitate the child. At the time of the child's death the parents were separated although both living in the family home. Child D and her 4 siblings are open to social work services and partner agencies.

1.4 Against these tragic circumstances, Glasgow Child Protection Committee took the decision to undertake a Significant Case Review (SCR) in accordance with the National Guidance for Child Protection Committees: Conducting Significant Case Reviews (Scottish Government, March 2015). The guidance specifies that an SCR is a multi-agency process for establishing the facts of and learning lessons from, a situation where a child under the age of 18 yrs has died or been significantly harmed.

2. Summary of Case

2.1 The [ ] family are known to social work services, universal services and third sector providers for several years due to concerns relating to Child D's older siblings. Since 2015 there are a number of concerns about the elder sibling's attendance at school and nursery, behavioural issues resulting in referral to CAMHS for Sibling 2 and a referral to speech and language for Sibling 4.

2.2 Both mother and father are known to social work services since childhood having been the subject of supervision orders through the Children's Hearing system. Dad has a history of offending and

drug/alcohol misuse and Mum antisocial behaviour and mental health difficulties. Dad is attending addiction services at the time of the child's death and Mum is being supported by health professionals for her mental health.

2.3 There are ongoing concerns about parental capacity which resulted in three of the older children being accommodated by the local authority in 2011 following concerns about the state of the family home and Dad drug dealing from the family home. The children return to their parents care in July 2012.

2.4 In 2016 the family are assessed to have made significant progress and the case is to be closed with third sector agencies continuing to work with the family. However, Mum becomes pregnant with Child D and is advised that she is pregnant with twins. In April 2016, the midwife refers mum to the Vulnerable Pregnancy Liaison Group (VLPG) for assessment. The group review the case and do not feel there are any CP concerns that require to be addressed through the pre-birth process and the family are receiving support from third sector services. The group are aware that there are concerns that Child D may not survive and if survives she will have multiple health needs.

2.5 In May 2016 the nurse team leader re-refers mum to the VLPG. The group are concerned about the couple's ability to cope with Child D and her twin, while caring for 4 other children in the home. The case is referred to the area team for pre-birth assessment. The case is assigned to a social worker to complete the assessment and liaise with the social care manager and colleagues from other agencies. The assessment is late in commencing due to the late acceptance by the VPLG resulting in the worker having limited time to complete the assessment.

2.6 Child D is born on [redacted] and remained in hospital until [redacted – 62 days later] when she is discharged home to the care of her parents. The pre-birth meeting does not have any representation from acute health specialities that are involved in Child D's care. The view of the meeting is that the couple are co-operating with services and they are organised for the birth of the twins. There is limited discussion around the child's complex medical needs and what is expected of the parents with regards to the child's daily health and care needs.

2.7 Following the child's discharge home, she continues to require regular attendance at hospital and the parents are required to attend different health specialities. On occasion they are unable to attend appointments as there is an overlap in appointments. Child D undergoes several medical procedures. She is attending acute services in the hospital and is also being followed up by community paediatrics, occupational therapy, physiotherapy and speech and language services. No lead professional is appointed to co-ordinate her care.

2.8 In September the renal nurse advises that the consultant wants the child's weight to be monitored. In October Child D is noted not to have gained weight and is admitted to hospital for three days

following a urinary tract infection (UTI). Dad continues to attend his addiction appointments and is noted to be doing well on opiate replacement treatment (ORT). He indicates to his worker that he is not comfortable catheterising Child D and leaves this to Mum.

2.9 Between September and December the child is seen by 13 health professionals from a number of different specialties including Spina Bifida Clinic, Neurology, Cardiology, Opthalmology, Orthopaedics, Ear Nose and Throat, Dietician and Health Visitor.

2.10 In December the couple confirm with the staff nurse that they are regularly catheterising Child D. In January Mum attends GP saying she is crying a lot and GP refers her for counselling.

2.11 During February and March discussion takes place between the health visitor and dietician about Child D's feeding and poor weight gain. In March Child D is admitted to hospital for sleep study and breathing concerns. The ward staff note that they do not see Dad catheterising the child while she is on the ward. She is seen once again in April at the Emergency Department with a pressure area on her head near her shunt. The family are not engaging with community speech and language services.

2.12 In May concerns are raised by the health visitor and dietician that the child's weight has fallen below 0.4th centile. As advised by the health visitor Child D is taking a larger feed than normal and is still not gaining weight. The couple tell medical staff they are catheterising four times daily.

2.13 In June Dad tells his addiction worker that the couple are separating, but he is living in the family home until he finds somewhere else to stay. He continues to be part of the children's lives. He states he is caring for the children at week-ends when Mum has a break.

2.14 The police chronology, which was compiled after Child D's death, has shown that during the preceding three months there are a number of text messages between Mum and Dad when Dad is asking Mum to come home as he is not coping. The text messages also provide evidence that Dad is supplying drugs from the house.

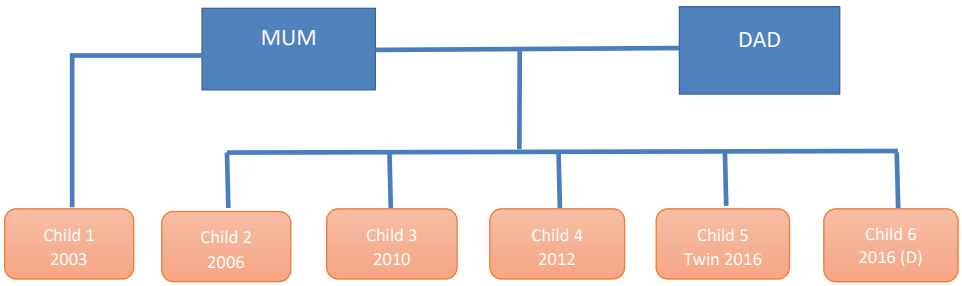
2.15 This period corresponds to concerns around Child D's health regarding her weight gain, poor sleeping and need for oxygen therapy every night. It is of note that medical staff who know the child well at one out-patient appointment comment that Child D is not her normal smiley self and is quite flat.

2.16 On the night of the child's death there are several text communications when Dad is begging Mum to come home as Child D is being sick and he does not know what to do. He sends pictures of the child but Mum refuses to come home or answer his texts. This goes on for several hours before Dad

and Child D fall asleep at midnight. Dad wakes at 2 am to find Child D lifeless. The child later is pronounced dead at hospital.

2.17 When the police attend they are concerned about the state of the family home. There are indications that the parents are not catheterising Child D 4 x times daily as is necessary to ensure her health and well-being. They would appear to have been intermittently undertaking this procedure and the child ultimately dies due to a poor care regime by the parents.

Family composition



3. Methodology

3.1 The Significant Case Review Panel agreed to undertake a SCR for Child D and to use the SCIE methodology. The case met the criteria for a SCR as defined in the national guidance[1].

3.2 The focus of a case review using a systems approach is on multi-agency professional practice. The aim is to move beyond the specifics of a particular case – what happened and why – to identify the underlying issues that are influencing practice more generally. It is these generic patterns that inform findings or lessons from a case and changing them will contribute to improving practice more widely.

3.3 Central to the Learning Together model are three key questions –

- ***What happened*** – reconstructing the case and surrounding context as experienced by the professionals involved
- ***Why did it happen*** - analysing practice in detail appraising individual practice and looking at individual, local and national influences

[1] National Guidance for Child Protection Committees, Conducting a Significant Case Review (2015)

- ***What are the implications for wider practice*** - exploring whether issues identified apply widely in consultation with staff and managers and their relevance to achieving better safeguarding

Review Group and Case Group

3.4 The learning review was undertaken by two lead reviewers who had no connection to the case. The reviewers were supported by a Review Team whose membership was drawn from agencies involved in the case but who had no decision making responsibility in relation to the case. They contributed to the analysis of data and informed the final report. The reviewers were supported by colleagues from SCIE who provided methodological oversight and quality assurance.

3.5 Membership of the Review Team included -

Service Manager	Social Work Services
CP Advisor & Ed Psychologist	Education Services
Consultant Paediatrician	NHS
DCI & DI	Police Scotland
CPC Lead Officer	Glasgow CPC

3.6 The SCIE model involved gathering and making sense of information about a case through meetings with the Review Team and a Case Group of practitioners who had been directly involved in the case. Draft research questions were shared and refined in consultation with the Review Team. Individual and group conversations took place with the Case Group who were involved in the case and assisted with the case reconstruction. Both groups were involved in the analysis of practice and in discussions to identify the wider system findings. Attendance at all meeting was requested but not always possible.

3.7 The lead reviewers met the Case Group on two occasions and the Review Team on three occasions.

Research Questions

3.8 The Child Protection Committee (CPC) identified that this review held the potential to shed light on particular areas of practice and the following research questions were agreed -

1. What can we learn about the quality of our pre and post birth assessment and planning processes with families that are known to be vulnerable?

2. What can we learn about factors that strengthen or inhibit our GIRFEC team around the child practice for children living under Sect 22 care arrangements?

3. How effectively are our practitioners weighing the value and significance of different information as part of their responsibility to conduct ongoing assessment of children's well-being?

Methodological comment and limitations

3.9 The focus of this review was the period from January 2016 to July 2017. There is information in this review that came to light during the police investigation that no professional was aware of. We have commented on this within this report as it has bearing on the family situation at the time of the child's death, but needs to be reviewed within the wider context of what was known by professionals when they were working with the family.

4. Data Sources Conversations and case group

4.1 The lead reviewers conducted semi-structured individual conversations with workers and met with staff in small professional groups. Staff in the following roles formed the Case Group for the review –

Social Worker	HSCP
Social Care Manager	HSCP
SW Team Leader	HSCP
SW Service Manager	HSCP
Addictions Worker	HSCP
Addictions TL	HSCP
Health Visitor	HSCP
Health Visitor	HSCP
GP	
Staff Nurse HV	HSCP
Consultant Paediatric Surgeon	NHS GC&C

Consultant Urologist	NHS GC&C
Consultant Neurosurgeon	NHS GC&C
Speech & Language Therapist	Community/ SCS
Speech & Language Therapist	Community / SCS
Neuropaediatric Outreach Nurse	NHS GC&C
Special Liaison Pregnancy Lead	NHS GC&C
Senior Charge Midwife Comm	NHS GC&C
Specialist Midwife Foetal Medicine	NHS GC&C
Paediatric Disability Nurse	NHS GC&C
Nursery Team Leader	Education Services
Deputy HT	Education Services
Class Teacher	Education Services
Head Teacher	Education Services

5. Engagement with Family Members

5.1 Both parents have been charged in connection with Child D's death therefore it was not appropriate during this review to engage the parents in this process at this time.

6. Structure of the Report

6.1 Statutory guidance requires that SCR reports follow a consistent structure, to make it easier for people to read and to read-across to other reports (p.21). The report structure and content is outlined in full in Annex 5 of the guidance and in compliance with these requirements, this report includes –

- A contextual introduction
- A factual summary
- An analysis of the quality of practice, considered in the context of circumstances at the time, highlighting the key areas that impacted upon practice

- Clear learning points, or Findings for consideration by the CPC

The Findings

7. Introduction

7.1 A case review plays an important part in efforts to achieve a safer child protection system, one that is more effective in its efforts to safeguard and protect children. Consequently, it is necessary to understand what happened and why in the particular case and go further to reflect on what this reveals about gaps and inadequacies in the child protection system. The case acts a 'window on the system'. (Vincent 2004, p13),

7.2 Case review findings exist in the present and potentially impact in the future. It is important to pinpoint those that most urgently need tackling for the benefit of children and families; these may not be the issues that appeared most critical in the context of a particular case, however they may present the most risk to the system if left unaddressed. In this review, the prioritisation of the findings is a matter for Glasgow Child Protection Committee.

7.3 In order to help with the identification and prioritisation of findings, the systems model that SCIE has developed includes six broad categories of underlying patterns, each of which relates to different aspects of multi-agency child protection work -

- Innate human biases (cognitive and emotional)
- Family-professional interaction
- Responses to incidents
- Longer term work
- Tools
- Management Systems

7.4 This section contains seven priority findings that have emerged from the review. The findings explain professional practice in this case and lay out the evidence identified by the Review Team that indicates that these findings may present systematic challenges for the CPC.

7.5 First, an overview is provided about what happened in this case and how timely and effective the help that was given to Child D was. The section identifies the ways in which features of this particular case are potentially common to the wider work undertaken by professionals with families and therefore provides useful organisational learning to promote improvement.

8. Appraisal of Practice

8.1 Historical Context

Due to the history and vulnerability of this family there was the potential that the parents would find it difficult to care for Child D and to meet her multiple health needs. Therefore, the importance of robust multi-disciplinary sharing of historical information, taking account of the views of partner agencies, was essential to ensure the child's care plan was well co-ordinated and appropriate supports identified and put in place. Child D's older siblings had a history of child protection registration and accommodation due to neglect and lack of adequate parenting. Mum had longstanding mental health issues and dad longstanding addiction issues. The family history was essential to understanding current and future risk, and in this instance, there was an inadequate sharing of past historical information. While the review focuses on the period following Child D's birth, the family history is important in understanding need and potential risk within this family.

Period 1 Quality of Information Contained in the GP Referral Letter to Maternity Services (4th – 9th December 2015)

8.2 On 4th December 2015, Mum engaged early with her GP to confirm her pregnancy and was advised to contact the Central Booking Office (CBO) to arrange a booking appointment with maternity services. The CBO as routine send a Scottish Care Information (SCI) information request to the GP. This was completed and returned by the GP on 9th December 2015 via SCI gateway. The information request prompts the referrer to include relevant information from medical notes both current and historical, this includes prescribed medications, general physical health and wellbeing, lifestyle, risk factors and any alerts.

8.3 GP information to maternity services is a key component of the health care continuum and the vehicle for communication between primary care into specialist health services. Proportionate, but comprehensive sharing of relevant information is critical within the information sharing process as this contributes to the assessment of the receiving clinician. Despite this family being registered with their GP practice since 2013, important relevant information held in the medical notes such as maternal mental health, parental addiction, and previous child protection registration was not included in the completed request for information.

8.4 The culture in this GP practice is that the GP who undertakes the consultation with the patient completes the request for information. The document poses the question 'are you aware of any vulnerability or child protection in relation to this pregnancy'. The GP in this instance recorded 'not known'. A GP's personal knowledge of a family can have a significant bearing on the content and quality of information provided and where records are not reviewed, insufficient information sharing

can result. If the GP making the referral does not know the family personally, the current process allows them to share minimal and insufficient information despite this being readily available within GP records. There is no reference to clinical notes by the GP completing the information request resulting in minimal descriptive information being shared with no professional view or analysis. There appeared to be no consideration of the need for support from a GP practice perspective for this woman or the other children in the family.

8.5 There was no evidence of this GP practice having practice discussions about vulnerable families. Such discussions improve information sharing within the practice, whereby all practice staff and other relevant primary care/community staff are alerted to any vulnerable pregnancies and any other children thought to be at risk. In addition, this ensures information sharing with health visitors and colleagues in other agencies and agreement as to when concerns have reached a threshold for submitting a notification of concern.

Period 2 The Pre-Birth Assessment Process and the Interface with Vulnerable Women in Pregnancy Liaison Group (January to July 2016)

8.6 The GP information to maternity services was received by the midwife, however, it took from December until April for the midwife to identify potential vulnerabilities. In April 2016 the midwife appropriately completed a Notification of Concern detailing professional concerns and forwarded to the Vulnerable Pregnancy Liaison Group (VPLG).

8.7 Mum had a number of pregnancy related medical issues resulting in several hospital admissions throughout January 2016. On 22nd January at the 12 week scan, medical concerns are noted in relation to the health of one twin. The 16 week scan carried out 23rd February 2016 confirms a diagnosis for one twin (female) that should the child live at birth, she will have multiple care needs including spina bifida and would require life-long care. Discussion took place between medical staff and the family in relation to the extent and impact of health issues for both the baby and the family. The family was given the option to terminate the pregnancy, however, they declined this. Obstetric services updated the GP in a clinical letter in March 2016, and noted that the family had social work involvement advising that another referral to social work via the VPLG be made.

8.8 The family was advised that Child D would require a range of specialist care into the foreseeable future if she survived the birth. Multiple health professionals were involved from obstetrics, neonates and paediatrics and it is unclear how the family's social history was being communicated each time the child's care moved to a new specialist service. Services had a limited understanding of the child's needs within a wider social context resulting in silo working.

8.9 The VPLG meet on 16th April 2016 when the Notification of Concern (NoC) from midwifery was discussed. Despite the VPLG being made aware of family history, the serious health concerns

pertaining to one of the twins, concerns about the impact on the other siblings, poor household conditions and professional concerns about how the family would cope, the VPLG did not accept the referral. The records note that the VPLG were of the view that the family was being supported by 3rd sector services, were engaging positively, appeared to be doing well and were prepared for the birth of the twins.

8.10 The nurse team leader continued to have concerns and made a second referral to the VPLG in May 2016 which was accepted. The delay from first referral contributed to the late commencement of the pre-birth assessment which did not commence until the end of May 2016 which resulted in the worker having limited time to complete the assessment. The pre-birth assessment should have been completed prior to 28 weeks gestation as per Glasgow's Pre-Birth Pregnancy Protocol.

8.11 The Social Worker commenced the pre-birth assessment and spoke with key services via telephone. The worker liaised with the family's Social Care Manager (SCM) who had been working with the family for some time prior to this pregnancy. The social worker reflected that, notwithstanding the challenges resulting from the delay and engagement via telephone, a robust pre-birth assessment incorporating information shared by other professionals was undertaken. The pre-birth assessment was informed by information shared by key stakeholders, who were reassuring of the family's progress and engagement and consequently the worker concluded that the family were sufficiently supported at that time. Supports included involvement of 3rd sector providers, increased support from social work along with increased nursery hours.

8.12 The family health visitor who knew the family well went off on maternity leave before Child D was born.

8.13 Based on information shared, all professionals were satisfied that the family were stable prior to the birth of the twins and a pre-birth case conference was not considered necessary by the social worker and team leader. The service manager agrees with the pre-birth assessment recommendation and signs this off taking account of the positive feedback from services working directly with the family. A post birth planning meeting was to be held prior to the child's discharge.

While those services working with the family were of the view that the family situation was stable prior to the birth of Child D, there was a degree of uncertainty as to the impact of the birth of the twins on parenting capacity, and needed to be explored in detail at the post-birth planning meeting.

Period 3 Post Birth Planning Arrangements ([redacted] – 29th August 2016)

8.14 Child D was born on [redacted] 2016. Social work services contacted maternity services via telephone on [the same day] to advise that they were involved with the family and that there were four other

siblings three of whom have previously been in care. Ward staff were also advised that Dad was engaged with addition services. There was no attempt at this point, either by social work or specialist health staff, to establish professional relationships, which would have assisted future multi-agency collaboration and planning.

8.15 From birth, Child D required various medical interventions including surgery. She remained in the neonatal high dependency unit for seven weeks until she was well enough to be discharged home. Child D required various clinical interventions such as catheterisation four times per day, and her parents were shown how to do this on the ward in order that they could competently perform the health tasks when she was discharged. The parents were given advice and guidance in relation to actions required if certain symptoms present.

8.16 Appropriately, a post birth planning meeting was held on 9th August 2016 chaired by social work allowing 20 days for services and plans to be put in place prior to discharge. Post-birth meetings should provide opportunities for discussion in relation to supports required for families and individual children along with plans and actions to mitigate any risk.

Once again professional discussions within the meeting were extremely positive, however, the comprehensive understanding of need and risk was compromised as key professionals from neonatal and specialist children services were not in attendance. This resulted in a lack of information about the child's physical health care needs and the potential demands this would place on the parents especially when, in the past, there had been concerns about their parenting capacity.

8.17 Child D was discharged home on [redacted – 62 days after birth] into the care of her parents. A neonatal discharge summary was sent to the GP detailing equipment and medication requirements. A ward discharge planning meeting took place, however, social work services were not invited and there was no co-ordination of care planning.

8.18 A new health visitor was appointed just before Child D was born and had little knowledge of the family. The SCM advised the new health visitor that he is relying on her to raise any health/medical issues as he was not familiar with Child D's health needs.

Period 4 General Case Management (29th August 2016 – 3rd July 2017)

8.19 The post-birth discharge planning meeting was a missed opportunity to commence and build effective collaboration between services engaged with the family including social work, health, education and third sector. There was some evidence of collaborative working however this was minimal in respect of the number of different professionals involved in this child's life.

8.20 In December a third health visitor was appointed to the family and at transfer the health visitor advised her colleague that she had never had any cause to speak to mum or dad about the children or the state of the house. The new health visitor undertook a Girfec assessment and assigned a health plan indicator of "additional" due to parental vulnerabilities and history of CP involvement. This contradicted the information provided by the previous health visitor at transfer.

8.21 During August to December 2016 Child D was seen 13 times by health professionals and concerns were noted about her weight gain. Parents assured professionals they were catheterising the child four times per day, but no professional witnessed this within the family home. In February concerns arose about Child D's poor sleep pattern and she was admitted to hospital for a few days for observation and insertion of nasopharyngeal airway. On discharge she required overnight oxygen at home. The GP increased mum's anti-depressant medication and Dad advises his addictions worker that he is not comfortable catheterising his daughter. It is not clear how this information was shared across the professional group working with Child D. From April 2017 onwards there was an ongoing concern about her weight gain. In June 2017 Dad informed his addictions worker that the couple were separating, although he was remaining in the house until such times as he found alternative accommodation.

8.22 There was no integrated child's plan and therefore no review process assigned to this. The family's history indicated that they would benefit from regular multi-agency review and assessment to ensure appropriate and enough support was in place.

8.23 There was a lack of co-ordination of services resulting in insufficient communication and information sharing. This together with the continued silo working by all agencies and services resulted in practitioners not identifying increasing stress within the family and early intervention opportunities were missed. Similarly, the deteriorating health of Child D was not seen within the child's wider social context. Each medical specialist focussed on their own specialist service without questioning or understanding the wider family context and how this might impact on the child's overall health and well-being.

9. Good Practice: What Worked Well?

9.1 There was extensive attendance at multiple specialities within Royal Hospital for Children and on each occasion the GP received a written update.

10. In What Ways Does this Case Provide a Useful Window on Our Systems?

10.1 This case provides a useful window on the system because much of the learning is in relation to families with whom practitioners are working on a regular basis. Assessing risk and understanding the evidence are challenges practitioners face daily with many of the families they work with. This case highlights the challenges practitioners face in assessing parental competence in cases of neglect and how well systems in Glasgow support this.

11. Summary of Findings

11.1This significant case review has identified seven system findings –

Finding 1 **Midwifery/Obstetric Interface with GP's** - There is no consistent approach across the City to the completion of the SCI gateway information request, with the result that the sharing of information with all relevant professionals cannot be relied upon. This is potential flawy in the early identification of vulnerability and risk. (Organisational Culture and Management)

Finding 2 **Pre-Birth Assessment** - Across the City there is significant variation as to how the Vulnerable Women Liaison Groups (VPLG) are operating resulting in a lack of consistency in how pregnant women are overseen and managed. (Organisational Culture and Management)

Finding 3 **Medical Services Representation at CP Meetings** - The lack of specialist health knowledge at a post birth planning meeting may lead to the needs of the child not being fully understood and multi-agency assessment and decision making compromised. (Inter-agency/Inter-professional Factors)

Finding 4 **Health Lead Professional to Co-ordinate Multiple Health Specialties Within the Child's Plan** - There is no one single health lead professional responsible for co-ordinating the health care plan for children who attend a number of health specialities across acute and community services. This means that there is no one health professional ensuring the child's holistic needs are being fully considered and acting as the single point of contact for all professionals involved. (Organisational Culture and Management)

Finding 5 **The Health Visitor Role** - At the point of review, due to health visiting shortages within NHSGGC, some families were not consistently seeing the same health visitor which had the

potential to lead to a lack of engagement by some families and challenges for health visitors building relationships and assessing need and risk. (Organisational Culture and Management)

Finding 6 **Assessment & Care Management** - Across Glasgow, due to service demands and capacity issues, not all children have an up to date GIRFEC child's plan that is being regularly reviewed and updated. Where plans are not being regularly reviewed outcomes for children can be compromised. (Communication and Collaboration in Longer Term Work)

Finding 7 **Multiple Health Recording Systems** - NHSGGC has multiple information systems which detracts from ease of access of patient information and the sharing of this. Where health professionals do not have access to all relevant information this impacts on the quality of assessment, decision making and robust child's planning. (Management Systems)

12. Findings in Detail

12.1Finding 1 Interface Between Midwifery/Obstetrics and GP

There is no consistent approach across the City to the completion of the SCI gateway information request, with the result that the sharing of information with all relevant professionals cannot be relied upon. This is potential flawy in the early identification of vulnerability and risk. (Organisational Culture and Management)

NHSGGC has a clear pathway between maternity and GP services, however, the review has identified variations in practice across the City in the information provided by GP's through SCI Gateway. When proportionate, comprehensive information is not shared there is the potential that the woman's care needs and those of her unborn child could be compromised.

How does it manifest in this case?

12.1.1 In this case, there is an inadequate sharing of historical information that has significant bearing on the care management of Mum. The GP SCI gateway document contains limited historical information regarding maternal mental health, parental addiction, previous child protection registration and ongoing concerns regarding neglect and parenting. This family is well known to the GP practice and reference to medical notes would ensure that all relevant historical and current information is available at the commencement of Mum's ante natal care.

12.1.2 The information request asks the specific question *"are you aware of any vulnerability or child protection in relation to this pregnancy*" and the GP in this instance records "not known". The GP's general knowledge of the family has significant bearing on the content and quality of the information provided and the impact of a lack of professional curiosity can lead to significant inconsistency in the information provide by GP practices across the City

12.1.3 While there are established processes for information sharing between GP services and maternity/obstetrics the focus is on maternal health and wellbeing and does not seek information about other family members or social circumstances and the potential impact of these factors.

12.1.4 It is of significance that a GP Practice can be compliant with current processes despite providing limited information.

How do we know it is an underlying issue and not unique to this case?

12.1.5 While NHSGGC has an agreed process by which the Central Booking Office request information, all GP practices have busy workloads and competing demands and organise internal processes differently. In some practices this is completed comprehensively by the GP and in other practices GP's will assign the task of pulling information to admin support.

12.1.6 Work has been ongoing for some time to update Glasgow's Pre-birth Pregnancy Protocol and as part of the review of current practice it is identified that there is significant variation in the quality of the information provided by GP's in response to the SCI gateway request.

12.1.7 In some areas of the City GP practices have developed vulnerable family meetings to ensure all GP staff and other relevant primary care/community staff are alert to the vulnerabilities within some families including vulnerable pregnancies and risk enabling appropriate support to mitigate and manage risk. This has been identified as good practice[2] but is not consistent across the City. An audit[3] undertaken by NHSGGC in 2014 found that 84% of the audit sample (sample = 84 health visitor returns) noted regular vulnerable practice meetings had led to improved information sharing and the identification of vulnerable families.

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[2] Woodman J, Gilbert R, Glaser D, Allister J, Brandon M. Vulnerable Family Meetings: A Way of Promoting Team Working in GP's Everyday Responses to Child Maltreatment? Social Sciences 2014 3 341-358

[3] Sharing Information on Vulnerable Families. Child Protection Unit. NHSGGC 2014

12.1.8 The GP in this case indicated that GP's have been advised by their Medical Defence Union to write "none known" in relation to child protection concerns unless they are personally aware of the family, despite having access to historical and current information both within health records and other colleagues in the practice. From the work undertaken as part of the re-write of the pregnancy protocol, GP's are applying the advice of their Medical Defence Union differently as evidenced in the variation of information provided on the SCI gateway request.

How widespread and prevalent is the issue?

12.1.9 The Case Group and Review Team are clear that there is significant variation in the content and quality of information provided by GP practices across the City.

Why it matters?

12.1.10 GP's no longer refer pregnant women to midwifery services, women themselves contact the central booking office and arrange their first midwifery appointment. At the point of booking limited information is known about the woman and midwifery/obstetrics are reliant on the GP information to inform their assessment and identify any necessary additional supports. The GP is the link between the woman's medical and social history and maternity/obstetric services.

12.1.11 The quality of maternity assessment is significantly informed by the information forwarded by the GP. In some instances, we know, women will not inform the midwife about something that may have a significant bearing on their pregnancy such as domestic abuse or addiction issues.

Finding 1 Midwifery/Obstetric Interface with GP Services

There is no consistent approach across the City to the completion of the SCI gateway information request, with the result that the sharing of information with all relevant professionals cannot be relied upon. This is a potential flaw in the early identification of vulnerability and risk.

Organisational culture and management

There needs to be a consistent approach across the City to the completion of the SCI gateway information request ensuring all relevant information is shared and is viewed by all as a vital step in the early identification of vulnerability and risk informing the maternity assessment.

Questions for the CPC to consider -

- What is the expectation of NHSGGC with regard to the comprehensiveness of information provided by GP's in response to the SCI gateway request
- What is the impact of the advice given to GP's by their Medical Defence Union that they should write "not known" in relation to section requesting information about CP concerns unless the family are known to them personally
- How many GP practices across the City have adopted vulnerable family discussions and what has been the impact on outcomes for vulnerable families

12.2 Finding 2 Pre-Birth Assessment

Across the City there is significant variation as to how the Vulnerable Women Liaison Groups (VPLG) are operating resulting in a lack of consistency in how pregnant women are overseen and managed. (Organisational Culture and Management)

How does it manifest itself in this case?

12.2.1 Midwifery is the first of the acute obstetric services notified of this pregnancy. There is a delay by midwifery identifying the family vulnerable and had information from the GP been more comprehensive this delay may have been avoided.

12.2.2 Following notification of pregnancy and attendance at a booking appointment an initial assessment is carried by the midwife. The midwife, through her contact with Mum, identifies her as vulnerable

and completes a Notification of Concern (NoC) and forwards to the VPLG in April 2016. The group do not accept the referral. The nurse team leader re-refers in May 2016 when it is confirmed that Child D may not survive birth and if survives will have life-long care needs and at that point the referral is accepted.

12.2.3 The VWP procedures indicate that the pre-birth assessment should, where possible, be completed by 28 weeks. This assessment did not commence until the end of May/early June only weeks before Child D's birth in July.

12.2.4 Due to the complications identified within the pregnancy mum's care moves to a SNIPS pathway. The criteria for the SNIPS pathway is well defined and due to historical and current concerns the VPLG should have accepted the initial referral.

12.2.5 In light of the identified complications, obstetric services involve neonatal services to begin to plan care and treatment required following the child's birth. This appears to solely focus on medical interventions with no consideration given to the family's social situation and the vulnerabilities of parents and siblings.

12.2.6 The assessment is allocated to a social worker who liaises closely with the social care manager (SCM) who has been working with the family for some time and whose focus of intervention is sibling school/nursery attendance. The SCM has limited understanding of family dynamics and parental capacity.

12.2.7 The social worker liaises appropriately with the health visitor, education and third sector services. The worker comments that due to the late acceptance of the NoC by the VPLG group, there is a delay in allocating the assessment within the team and, with the workers' competing caseload demands, they have a very short period of time to complete the report. The worker is unable to spend as much time with the family as they would have wanted to do time permitting.

12.2.8 The assessment recommends that there is a need for continued support to the family, but that the risks are manageable. Information from partner agencies is positive and presents an optimistic view of the parent's ability to cope. Professionals indicate that the couple are stable, there is evidence that the couple is ready for the birth of the twins and the family is well supported by 3rd sector services. The decision not to proceed to child protection case conference is reasonable based on the professional view of the family, however, the family situation required to be re-assessed post-birth at a post birth planning meeting.

How do we know it is an underlying issue and not unique to this case?

12.2.9 Pre-birth assessments are allocated as part of the team report writing rota and social workers complete these within an already demanding case load. Assessments can be time consuming and workers need to manage this work within their wider caseload with competing demands.

12.2.10 It is not clear how information held by midwifery services is communicated to the wider health specialties where there are such complex maternal and child health needs. The Review Group highlighted the need for information to follow mum and baby across the different specialties. In this case, the child's social circumstances are central to understanding whether parents would manage to care for 6 children, one child having life-long multiple health needs.

12.2.11 As part of the wider review of the Glasgow pre-birth pregnancy guidance the VPLG 's were reviewed and there was variation across the City as to whether they were actually being held, who attended, how information was recorded and what oversight was given by the group to ongoing pre-birth risk assessments.

How widespread and prevalent is the issue?

12.2.12 The Case Group and Review Team were of the view that the re-write of the pre-birth procedures is required and needs to be concluded as soon as possible as this work has been ongoing for over 2 years. This has resulted in variation in practice across the VPLG's and there needs to be an alignment of process and practice across th e City.

12.2.13 The review noted that a test of change has been undertaken in the North East of the city to develop antenatal joint support groups (AJST) to replace the existing VPLG's. South and North West are applying the learning from the test of change and implementing AJST's in their localities. However, there is a lack of clarity as to how the model is being applied and the outcome of this work stream remains outstanding.

Why does it matter?

12.2.14 Across Glasgow there needs to be an agreed process for identifying early in pregnancy vulnerable women and unborn babies who may require additional support. Where child protection measures are not deemed necessary, this does not mean the woman and her unborn child are not vulnerable and require additional supports. There needs to be a robust process in place to ensure all partner agencies are sharing information and care plans are well informed. The AJST would support the early identification of vulnerability and co-ordinate service intervention.

Finding 2 Pre-Birth Assessment

Across the City there is significant variation as to how the Vulnerable Pregnancy Liaison Groups (VPLG) are operating resulting in a lack of consistency in how pregnant women are overseen and managed.

Organisational, culture and management

Within Glasgow the Inter-Agency Procedural Guidance for Vulnerable Women During Pregnancy (2008) emphasises the need for early identification of vulnerability and the thresholds for intervention should be applied consistently across the City. Delays in referring women can compromise the women's medical and social needs. This reaffirms the work undertaken by the Glasgow multi agency group who are tasked with re-writing the pre-birth guidance.

Questions for the CPC to consider -

- How well informed is the CPC regarding the current review and re-write of the vulnerable women in pregnancy guidance and the timeline for completion
- How well engaged has the CPC been with the test of change in the north of the city creating a Joint Pre-Birth Support Team to replace the VPLG
- Has the CPC had the opportunity to review the effectiveness of the model and to discuss how the model has impacted on outcomes for vulnerable pregnant women and their unborn child

12.3Finding 3 Post Birth Planning Meeting

The lack of specialist health knowledge at a post birth planning meeting leads to the needs of the child not being fully understood and multi agency assessment and decision making compromised. (Inter-agency/Inter-professional Factors)

The purpose of a post birth inter-agency planning meeting is to ensure that all professionals involved in the child's care contribute to the assessment of need and risk and to contribute to the child's plan. Social work does not have a single point of contact within health to seek advice as to who from health should be in attendance and how this can be facilitated.

How does it manifest itself in this case?

12.3.1 Appropriately a post birth planning meeting in accordance with Glasgow City Council Child Protection Procedures is held on [the day Child D was born] to plan for Child D's discharge. The planning meeting, chaired by social work services, is an opportunity for a comprehensive assessment of the family's circumstances with all relevant professionals involved with the family.

12.3.2 This is a crucial meeting in determining -

- parent's ability to care for the twins
- the impact of the birth of the twins on the parent's ability to care for the older siblings
- parental understanding of Child D's multiple health needs
- parenting capacity within the context of previous parenting concerns and the parent's ability to provide daily life-long care to Child D

12.3.3 Specialist health services are not in attendance which results in the meeting not having full access to health information to base their assessment of the parent's ability to provide the level of daily care that Child D requires to keep her well. Social work relies on both the health visitor and ward midwifery staff for health information, both of whom do not have a comprehensive understanding of Child D's medical needs. The parent's ability to catheterise Child D four times daily is not fully understood. There is conflicting information about what training has been given to parents on the ward and this is crucial in understanding their competence to adequately care for their child, as to fail to do so, could severely compromise the child's health.

12.3.4 The pre-birth assessment concludes that the couple are doing well and are prepared for the birth of the twins. The view is that both Mum's mental health and Dad's addiction are stable and the couple are excited at the birth of the twins. The long history of poor parental engagement, parental addiction/mental health concerns and poor sibling school attendance, while known, is not fully explored with regard to their capacity to care for 6 children and the pressure this places on the couple's relationship and their parenting skills. The focus of previous social work intervention focuses on sibling school/nursery attendance and there is limited understanding or analysis of the impact of Child D's health needs on all members of the family.

12.3.5 Workers at the meeting are relieved that Child D has survived and are sensitive to the situation, however, this may have taken the focus away from the question of parental capacity and risk, resulting in an over-optimistic view of the parent's abilities. While a broad plan is outlined at the meeting, there is no child's plan ever put in place and this results in a lack of clarity around agency roles and responsibilities and a lack of a holistic understanding of Child D's needs.

How do we know it is an underlying issue and not unique to this case?

12.3.6 The Case Group gave many examples where social work have difficulty in identifying who from health should attend child protection meetings and who they could contact to ensure the right professionals are in attendance. Social work will move the location of the meeting to the hospital if this will assist medical personnel, but the challenge remains that it is difficult for external partners to link with acute medical services

12.3.7 This was also confirmed by the Review Team who identified that there was no central point of contact for partner agencies, such as social work, to seek advice as to who should be at the meeting and be supported by health colleagues to facilitate this.

12.3.8 The Review Group and members of the Review Team spoke about the need for information to follow the child where they are involved with a range of health specialties. The review was not able to gain clarity as how information is passed from one health speciality to another, as in this case, from maternity to neonatal and on to specialist paediatric services. No individual health professional was identified along this pathway to co-ordinate and have oversight of the child's health care plan and the review has identified that the child's social history was not known by some of the acute specialist services, and therefore, was not considered by them when reviewing the child's health care needs.

How widespread and prevalent is the issue?

12.3.9 This does not appear to be unique to this case as the Case Group and Review Group were of the view that this is a recurring difficulty and the interface between external partner agencies, such as social work, and acute health services requires to be addressed and a central point of contact established to support and inform partner agencies.

12.3.10 Within Glasgow the Child Protection Team meet team leaders and assistant service managers on a quarterly basis. This group of managers has identified on, a number of occasions, the challenges they face in trying to ensure that the relevant health personnel are in attendance at key child protection meetings. They have identified a single point of contact as something that would be helpful and would be time efficient.

Why does it matter?

12.3.11 As this case has highlighted, there is a need to ensure that all relevant agencies are represented at child protection meetings. There needs to be a streamlined process that allows social work to have a single point of contact to seek advice and support in ensuring that the correct specialists are invited.

Child protection decision making requires to be informed by robust information sharing and professional knowledge and skills.

Finding 3 Post Birth Planning Meeting

The lack of specialist health knowledge at a post birth planning meeting leads to the needs of the child not being fully understood and multi agency assessment and decision making compromised. (Inter-agency/Inter-professional Factors)

Social work do not have a single point of contact within health to seek advice as to who from health should be in attendance and how this can be facilitated. If there is a lack of specialist health knowledge available to the meeting, decision making will be compromised, and the needs of the child will not be fully understood.

Inter-agency/Inter-professional factors

Post-birth child protection meetings are the opportunity to ensure that all information about the child's needs is understood and that robust child plans are put in place to address the need. The discharge planning meeting was crucial in determining the parent's ability to cope and to ensure that Child D received the appropriate medication and health care interventions which were being provided by specialist health service.

Questions for the CPC to consider -

- Is the CPC satisfied that all vulnerable children have a child's plan that is regularly reviewed and updated to reflect changes in the child's circumstances
- How assured is the CPC that all relevant health professionals attend child protection meetings and contribute to assessment and care planning

12.4 Finding 4 Lead Professional to Co-ordinate Information Sharing Across Health Specialties

There is no one single health lead professional responsible for co-ordinating the health care plan for children who attend a number of health specialities across acute and community services. This means that there is no one health professional ensuring the child's holistic needs are being fully considered and acting as the single point of contact for all professionals involved.

This case has highlighted that no one single health lead professional was assigned to be the child's lead professional. If there is no health lead professional, there is no holistic understanding of a child's

needs and there is no co-ordination across health specialties to ensure robust information sharing and care planning.

How does it manifest itself this case?

12.4.1 The family attend the majority of hospital appointments for Child D but they fail to engage with community services such as speech and language therapy (SLT) from where the child is discharged without having been seen.

12.4.2 The review has highlighted that the complex nature of Child D's family history is not known to the acute hospital team. Child D's care involves multiple specialities which is initially co-ordinated in the hospital by the neonatal team. Concerns around Child D's vulnerability is not adequately considered or effectively communicated between and across the various health specialities.

12.4.3 Child D's health care following discharge is co-ordinated through the spina bifida clinic which is a multi-specialty team. This should ensure robust information sharing in relation to the child's medical care and an awareness of the child's social circumstances. However, as there is no lead health professional co-ordinating the care plan, the child's social circumstances are not understood by clinicians responsible for her care.

12.4.4 Acute health services do not proactively seek to engage social work services in their care planning and the two processes (post birth planning and ward discharge planning) work independently of one another.

12.4.5 It is unclear what role the GP has in sharing information received from acute services. The practice continues to prescribe pharmaceutical equipment without discussing with community staff such as the health visitor. We know that following the child's death there was a stockpile of catheters in the home suggesting that Child D was not being catheterised with the frequency required.

12.4.6 There is no co-ordinated integrated child's plan that reflects Child D's multiple needs and how these are to be addressed and managed. This is challenging due to the many medical/surgical specialties involved in Child D's care and had there been an integrated child's plan this would have supported better information sharing and regular review of the child's progress.

How do we know it is an underlying issue and not unique to this case?

12.4.7 The Case Group indicated that there was formerly a disability nurse who had a specific role in supporting and co-ordinating input from specialist children's services for families such as Child D's. This role has changed and provides a more generic role with the impact of reducing continuity of care formerly received by families.

How widespread and prevalent is the issue?

12.4.8 Both the Case Group and Review Team identified the need for an identified health lead professional to co-ordinate a child's care. Acute services do have specialist nurses within the specialties, however, there needs to be one health professional assigned the role of lead professional who will have an overview of the child's medical and social circumstances and can act as the conduit for information sharing and care planning and be the single point of contact for partner agencies and community based health services.

Why does it matter?

12.4.9 This case highlights the complexity of caring for a child with multiple health needs and the challenges faced by professionals in addressing need and ensuring a co-ordinated response. When children are being seen by a number of health specialties it is crucial that each specialty understands, not just the child's health/medical needs, but that they are understood within the context of the child's wider social world. A single health worker who can oversee the child's health plan, who can link with the respective acute specialties, link with community services and who would be a single point of contact for partner agencies would ensure the social circumstances of the child are being shared and understood by clinicians responsible for the child's care. The lead professional needs to have authority within this role to raise practice issues/concerns if they believe they are impacting on the child's care.

Finding 4 Lead Health Professional to Co-ordinate the Child's Plan in Cases Where a Child Has Multiple Health Needs

There is no one single health lead professional responsible for co-ordinating the health care plan for children who attend a number of health specialities across acute and community services. This means that there is no one health professional ensuring the child's holistic needs are being fully considered and acting as the single point of contact for all professionals involved.

Organisational Culture and Management

This case has highlighted that no one single health lead professional was assigned to be the child's lead professional. If there is no health lead professional, there is no holistic understanding of a child's needs and there is no co-ordination across health specialties to sure robust information sharing and care planning.

Questions for the CPC to consider -

- Is the CPC satisfied that all vulnerable children have co-ordinated health care plans
- The CPC may wish to seek clarification from health as to how information held by health specialties is shared as children move through the health care pathway

Finding 5 The Role of Health Visiting

At the point of review, due to health visiting shortages within NHSGGC, some families were not consistently seeing the same health visitor which had the potential to lead to a lack of engagement by some families and challenges for health visitors building relationships and assessing need and risk.

How does it manifest itself in this case?

12.5.1 The family have three health visitors during this period and this results in a lack of consistency and knowledge of both the family's needs and the specific needs of Child D.

12.5.2 Following the Birth of Child D the SCM is dependent on health visiting updating about the child's medical needs and to alert if concerns arise as the SCM is not familiar with the child's health needs.

There is a good working relationship between the SCM and the health visitor with regular contact and sharing of information which predominately focuses on Child D's older siblings. The health visitor does not highlight any concerns when they transfer the case to a colleague.

12.5.3 The last health visitor undertakes a GIRFEC assessment and the family is assigned a health plan indicator of "additional" considering parental vulnerabilities and history of CP involvement which is contrast to the previous health visitor assessment.

12.5.4 The health visitor has a broad understanding of the family's vulnerabilities but does not appear to fully understand the implications of Child D's multiple health needs and how this impacts on the child's growth and development.

12.5.5 The health visitor is also a team leader covering a vacant case load and has limited experience of working with vulnerable families. The Team Leader is overseeing the case load as a result of maternity leave while awaiting recruitment of staff to vacant posts. The team leader is not based in the GP practice.

12.5.6 It is unclear how information from the GP is being shared with the health visitor. Information from acute services is not always copied to the health visitor and the health visitor is dependent on the GP sharing information and having access to client data bases for updates.

How do we know it is an underlying issue and not unique to this case?

12.5.7 This case was not unique as there was a shortage of health visitors nationally and this was reflected within Glasgow. The Review Group highlighted that over the last 2 years there has been an increase in the number of health visitors by 123 across the City and the impact of this requires to be understood and services re-aligned. While health visitor numbers have been significantly increased, this has resulted in a workforce with limited practice experience.

How widespread and prevalent is the issue?

12.5.8 Both nationally, and within Glasgow at the time of this case review, there was a shortage of health visitors which was challenging for NHSGGC and resulted in changes to health visiting practices.

12.5.9 Over the last 2-3 years there has been significant investment and recruitment of health visitors in the City. The impact of these new practice developments needs to be understood within the context of positive outcomes for children and their families

Why does it matter?

12.5.10 This review has identified that the family over a two year period had contact with three health visitors. The information transferred from one worker to the next was limited and there was no sense that the health visitor had a good understanding of the child and her needs. With each change of worker there is the danger that information is not appropriately shared or understood by the new worker. Relevant historical information can get lost or its significance not properly understood and assessment can be compromised.

Finding 5 The Role of the Health Visitor

At the point of review, due to health visiting shortages within NHSGGC, some families were not consistently seeing the same health visitor which had the potential to lead to a lack of engagement by some families and challenges for health visitors building relationships and assessing need and risk.

Organisational Culture and Management

Glasgow has seen a significant increase in health visitors within the City and this has impacted on service delivery, however, where there is no seamless handover from one worker to another there is the potential for the assessment of need and risk to be compromised.

Questions for the CPC to consider -

- What has been the impact of the appointment of additional 123 health visitors within the City and how will this additional resource support and protect vulnerable children and their families

Finding 6 Assessment & Care Management

Across Glasgow, due to service demands and capacity issues, not all children have an up to date GIRFEC child's plan that is being regularly reviewed and updated. Where plans are not being regularly reviewed outcomes for children can be compromised.

It is essential that every child should have a GIRFEC Child's Plan that clearly outlines the needs of the child and the outcomes to be achieved. The plan allows professionals to measure their intervention, assess and review the quality and effectiveness of their support in improving outcomes for the child and their family.

How does it manifest itself in this case?

12.6.1 While there is evidence of good information sharing and multi-agency collaboration between the health visitor, SCM and education services, it is evident that there is an over reliance on the health visitor as the Named Person to provide information about Child D's additional medical/health care needs. This is particularly relevant in light of the health visitor's limited experience of working with a child with multiple health needs.

12.6.2 There is no multi agency child's plan in place and therefore no regular reviews of the plan involving key professionals and the following issues are not addressed -

- the changes in family circumstances - parents separation
- the concern around Child D's weight
- Mum's mental health and changes in medication
- Dad's ongoing engagement with addictions
- concerns being raised by Education Services regarding to Child D's siblings.

12.6.3 While the family say they are coping professionals do not sufficiently explore the accumulating impact of increasing care needs, not only in relation to the parent's as care givers, but also on the time this would detract from the parental availability for Child D's siblings.

12.6.4 The SCM's focus is very much on the older siblings and working with education to try and support their attendance at school/nursery. There is good communication between social work and education, however, there is no care plan in place and social work are not regularly reviewing the child's circumstances. The focus of activity is entirely on the older siblings.

12.6.5 When Dad reports to his addictions worker that the couple are separating this is appropriately shared with C&F social work colleagues. There is no re-assessment of the parent's ability to care for their children as potential single parents.

12.6.6 There is no proactive consideration around respite to support the parents to provide long term care to ensure a sustained high level of care for Child D.

12.6.7 In January 2017 an addiction parental impact assessment is undertaken as part of the annual review by addiction services. The information contained in the assessment was solely based on information provided by the SCM who indicated that the family were doing well. In light of this information, no home visit is undertaken or link with health visiting services made. Dad is only ever seen at the clinic and never at home.

12.6.8 The completed parental impact assessment is not shared with Dad or with any other professional and there was a lack of clarity as to who this report should be shared with. In this instance information should have been fully discussed with Dad, C&F social work and other key professionals working with the family.

How do we know it is an underlying issue and not unique to this case?

12.6.9 The Review Group are of the view that this circumstance could arise in the future as Child D was not on a statutory order and all casework requires to be prioritised with child protection and statutory work prioritised over other areas of practice such as children with disability.

12.6.10 At some point in the future, this case would have been transferred to the locality disability team, who potentially have greater knowledge and understanding of the many needs of a child with disability and the impact this may have on parent's caring for a child with multiple needs. However, there appears to be a lack of clarity across the City as to when a case like this would be transferred to the disability team

How widespread and prevalent is the issue?

12.6.11 While every child receiving social work support should have a robust child's plan which is regularly reviewed against the agreed outcomes for the child, the view of both the Case

Group and the Review Group was that not all children will have an up to date child's plan that is being regularly reviewed.

Why does it matter?

12.6.12 GIRFEC practice guidance[4] states that a personalised child's plan will be available when a child needs a range of extra support planned, delivered and co-ordinated. All children with complex needs should have a child's plan in place which is reviewed on a regular basis and updated to reflect changes in the child's circumstances.

Finding 6 Assessment & Care Management

Across Glasgow, due to service demands and capacity issues, not all children have an up to date GIRFEC child's plan that is being regularly reviewed and updated. Where plans are not being regularly reviewed outcomes for children can be compromised.

Communication and Collaboration in Long Term Work

It is essential that every child should have a GIRFEC Child's Plan that clearly outlines the needs of the child and the outcomes to be achieved. The plan allows professionals to measure their intervention, assess and review the quality and effectiveness of their support in improving outcomes for the child and their family.

Questions for the CPC to consider -

- How does the CPC satisfy itself that all children within Glasgow who require to have a child's plan have a plan in place and is reviewed on a regular basis
- How often does the CPC receive information from addiction services on the impact of parental addiction and how does the parental impact assessment support C&F risk assessment
- Is the CPC satisfied that there is a clear pathway for children to move from generic C&F services to children with disability locality teams

[4] Getting it right for every child Child's Plans Scottish Government

Finding 7 Multiple Data Sources

NHSGGC has multiple information systems which detract from ease of access of patient information and the sharing of this. Where health professionals do not have access to all relevant information this impacts on the quality of assessment, decision making and robust child's planning. (Management Systems)

How does it manifest itself in this case?

12.7.1 There is no one child health record and the Case Group indicated that there are multiple patient records that hold information about an individual child. Not all health professionals have access to the same information systems. This was evidenced in the reconstruction when workers from community SLT indicated they were hearing information about the child/family for the first time.

12.7.2 There are three main clinical records that staff would be inputting for Child D. GP EMIS record, child's EMIS record and acute records (Clinical Portal and Trakcare). They do not interface nor do acute practitioners have access to either community EMIS systems

How do we know it is an underlying issue and not unique to this case?

12.7.3 This has been an issue for some time and work has been ongoing within NHSGGC to address this issue. Work continues to develop systems that will support and assist information sharing across the different areas of health.

How widespread and prevalent is the issue?

12.7.4 Considerable work has been undertaken by NHSGGC to address this issue and work continues.

Why does it matter?

12.7.5 This is a missed opportunity to improve quality and co-ordination of health care and information transfer from neonatal to antenatal and paediatric services. Whilst this may not have been considered detrimental from an acute perspective, this did result in silo working. Community based staff identified access to patient records was challenging particularly in relation to the co-ordination of services, effective communication and information sharing.

Finding 7 Multiple Data Sources

NHSGGC has multiple information systems which detract from ease of access of patient information and the sharing of this. Where health professionals do not have access to all relevant information this impacts on the quality of assessment, decision making and robust child's planning.

Management Systems

Child D's health information was recorded in a number of different client records, but there was no one system that allowed her journey through health to be recorded within a single system that allowed all professionals involved in her care to access and record information.

Questions for the CPC to consider -

- How aware is the CPC of the work being undertaken by NHSGGC to address the issue of multiple health records for patients who attend different health specialties