Serious Case Review

Child M

Overview Report

April 2011

Contents

1 INTRODUCTION

1.1 Circumstances Leading to a Serious Case review

1.1.1 Child M, a boy aged 2 years, was brought to the Emergency Department at [redacted] by ambulance [redacted] June 2010. He was pronounced dead [redacted] June 2010. He had been found lying face down in a pond at his maternal grandmother's home by his father, Mr B. At the time of the incident, Child M had been in the care of his maternal grandmother, Ms C.

1.1.2 Prior to the fatality, he had been left in the care of the grandmother by his mother, Ms A, and father, Mr B. Subsequently, concerns regarding the death were raised and, specifically, the suitability of Ms C as a carer for Child M, given the amount of alcohol consumed by Ms C during the day. Three adults have pleaded guilty to charges relating to child neglect and were sentenced in July 2011.

1.1.3 It is a requirement that Bristol Safeguarding Children Board (BSCB) 'should undertake a serious case review when a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death'[1].

1.1.4 The case was initially considered for a Serious Case Review at the Executive Sub-group of BSCB on 30 June 2010. At this time, there was not agreement that the criteria for a serious case review were met. The Executive group agreed the Social Care Institute for Excellence (SCIE) multi agency systems approach would be used to identify key learning issues for the Board and member agencies.

1.1.5 Following the decision by the Crown Prosecution Service to charge three adults with the manslaughter of Child M as well as child cruelty, the case was reconsidered by BSCB at a meeting of the full Board on 20 October 2010. It was agreed that BSCB would conduct a Serious Case Review and the chair of BSCB, Dr Ray Jones, took the decision, as per the 'Working Together' requirements.

1.2 The Child Death Overview process

1.2.1 This case has been reviewed locally as an unexpected death in keeping with the requirements within Chapter 8 of Working Together. The BSCB Policy and Projects Officer – Safeguarding, attended and received information from the Child Death Overview Panel (CDOP) meetings. This information was provided for the Overview Report Author with the consent of the CDOP.

[1] Working Together to Safeguard Children, (2010), Chapter 8, s8.5)

1.3 Current criminal investigations and coroner's inquiries

1.3.1 The CPS and Coroner were informed of the Serious Case Review Process. The Detective Inspector on the Serious Case Review Panel liaised with the Senior Investigating Officer to ensure the panel was kept up to date with the criminal proceedings.

1.4 Terms of reference (ToR) of review.

1.4.1 In addition to the general requirements set out in Chapter 8 Working Together to Safeguard Children (2010), the serious case review and Individual Management Reviews were specifically asked to consider in relation to Child M:

ToR 2.1 In relation to this child, was there a failure by agencies in working with this family in not recognising evidence of risk of significant harm? If such evidence exists, was this shared and/or acted upon in an appropriate and timely manner?

ToR 2.2 In relation to the parents (and anyone who had care of Child M) are there any relevant medical, mental health, substance misuse (including alcohol) issues, previous convictions, intelligence, domestic violence reports which were known. Is there any information available about the parents' own childhood experience which is relevant?

ToR2.3 Did any agency working with this family fail to recognise previous evidence of risk of significant harm or need? Where such evidence exists was it shared and/or acted upon in an appropriate and timely manner?

ToR 4 Do any issues emerge in relation to the provision of services to persons in the immediate or extended family who misuse alcohol?

ToR5 Do any issues emerge in relation to the use of and accessing of services within another local authority?

ToR 2.6 Were members of the immediate and extended family assessed as supportive and appropriate carers for Child M and/or was the appropriateness of these persons considered in the management of the case?

1.4.2 The scope of the Serious Case Review (SCR) is about Child M and he needs to be the focus of the review's enquiries. However, consideration will need to be given to: the relevant history; known abilities and/or impairments; medical history; education; and social functioning of Child M's parents and, where appropriate, other extended family members who were significant to Child M, in order to provide some context of the life of Child M.

1.4.3 The SCR Panel will not be prescriptive as to the range of records and time-frames to be considered by the IMR authors in their reports. Their professional judgement should be exercised in order to locate relevant

information and outline the pertinent factors to include in their Individual Management Review (IMR) reports. However, the SCR Panel would expect as a minimum to include all agency involvement from the period of Ms A's pregnancy with Child M, until his death on 5 June 2010.

1.4.4 Consideration should be given to a thorough evaluation of records held regarding the situation of the following family members: Child M's Parents, Mr B and Ms A; his Maternal Grandmother, Ms C; and Child M's maternal uncle, Mr A, [redacted]

1.4.5 Family involvement in the SCR process was included in the Terms of Reference, led by the SCR Panel Chair. See paragraph 1.5.4.

1.5 Methodology

1.5.1 A Serious Case Review Panel was set up to manage the process. Child M and his parents and grandparents lived in both South Gloucestershire and Bristol City local authority areas. Services were provided by statutory, voluntary and private sector organizations covering both areas. The panel knowledge and expertise reflected this spread of organizations. [redacted], Consultant Psychiatrist expertise was helpful in enabling the panel to consider mental health and substance misuse issues. An additional element of independence was provided by the inclusion of a panel member from the NSPCC.

1.5.2 Independent Consultants were commissioned to Chair the Serious Case Review and write the Overview Report. The Overview Report Author was not a member of the panel but was invited to all meetings. The Independent Chair supported the Independent Overview Report Author throughout the process. Most IMR authors were independent of the case and this is confirmed in the IMRs. As noted, the NSPCC were included in panel membership.

1.5.3 IMR authors were briefed by the panel and provided with face to face guidance and training. IMR authors presented draft reports to the panel for scrutiny and discussion. Most IMR authors provided additional information as requested by the panel and Overview Report Author. Revised versions were then submitted. All staff were invited to a briefing by the Bristol Safeguarding Child Board Chair. A debriefing event is being planned for all staff.

1.5.4 Contact with the family was by letters sent to Ms A and Ms C [redacted] and [redacted] grandparents [redacted] Further efforts were made to engage with Ms C, Ms A and Mr B through their legal representatives but this has not been successful to date. Mr D was interviewed by David Dungworth and the BSCB Projects Officer – Safeguarding, and a summary of his contribution was provided for the Overview Report Author.

1.5.5 Documents read by the Overview Report Author review include:

- Bristol City Council Ofsted Inspection of Safeguarding and Looked After Services April 2010
- Bristol City Council Ofsted Annual Children's Services Assessment December 2010
- South Gloucestershire Ofsted Annual Children's Services Assessment December 2010
- South Gloucestershire Ofsted Unannounced Inspection of Children's Services July 2010
- Previous Bristol Safeguarding Children Board Serious Case Review Executive Summaries in relation to Baby X (October 2006), Child A (June 2007), Family W (October 2006) and Baby Z (February 2007)
- Previous South Gloucestershire Safeguarding Children Board Serious Case Review Executive Summaries Baby S (June 2010) and Child R and Child K (March 2009)
- Ofsted Inspection Report Private Day Nursery attended by Child M
- Making it happen: it's in our hands. Social Care and Common Assessment Framework thresholds. Practitioner Handbook. Bristol City Council 2009
- Guidance for Working with Children of Problem Drug/Alcohol Using Parents BSCB April 2008
- Bristol City Council CYPS Child in Need Review Policy, Procedure and Guidance
- Bristol City Council Supporting People Services in Bristol
- Home Office Final Warning Scheme Guidance for the Police and Youth Offending Teams
- Report on Youth Offending Work in Bristol 2010 Criminal Justice Joint Inspection

1.6 Contributors to the review

1.6.1 A Health Overview Report was prepared by NHS Bristol

1.6.2 Individual Management Reviews were prepared by:

- North Bristol NHS Trust
- United Hospitals Bristol NHS Foundation Trust
- General Practitioners (Bristol and South Gloucestershire)
- Bristol Community Health
- Great Western Ambulance Service (GWAS)
- Children's Social Care, Bristol City Council Children and Young People's Service
- Children's Social Care, South Gloucestershire Council, Department for Children and Young People
- Avon and Somerset Constabulary
- Private Day Nursery attended by Child M

- Barnardo's
- Connexions
- Children and Family Court Advisory and Support Service (Cafcass)
- Youth Offending Service
- 1625 Independent People (formally Wayahead)

1.6.3 The school attended by Ms A provided a chronology.

1.6.4 A report of the family's contribution to the Serious Case Review is used in paragraphs 2.2.4, 2.3.14 and 3.6.2. The family members who contributed to this Serious Case Review will be consulted before this report is published to ascertain whether they want their contribution to be redacted.

1.6.5 Review Panel Members:

- Chair, David Dungworth, Independent Consultant
- Designated Doctor for Child Protection, NHS Bristol/South Gloucestershire PCT,
- Designated Nurse for Safeguarding, NHS Bristol
- Service Manager – Safeguarding and Quality Assurance, Bristol CYPS,
- Service Manager – Safeguarding, South Gloucestershire Department for Children and Young People
- Principal Solicitor, Community Services, Bristol City Council
- Chief Executive, PEYTU (Play and Early Years Training Unit)
- Consultant Psychiatrist, Colston Fort Assessment Unit (AWP)
- Detective Inspector, Bristol Public Protection Unit, Avon & Somerset Constabulary,
- Assistant Director, NSPCC
- BSCB Policy and Projects Officer - Safeguarding

1.6.6 Independent Author of Overview Report: Julia Oulton

1.7 Evaluation of IMRs

1.7.1 Bristol CYPS

1.7.2 Bristol Children's Social Care Services [redacted] were involved in January and February 2008 prior to Child M's birth following a referral by a midwife because of late booking and social concerns. At that time Mr B and Ms A were living in Bristol in supported housing. An Initial Assessment was completed and the case closed without further involvement. A second period of involvement was from August to December 2009 following a referral from GWAS (Great Western Ambulance Service). An Initial Assessment was completed and the case allocated for social work intervention under S 17 Children Act 1989. Bristol Social Services also had involvement with Mr B as a child following an anonymous referral through the NSPCC.

1.7.3 The report author is the Safeguarding Business Unit Manager. She is independent of the case.

1.7.4 The report is comprehensive and addresses the Terms of Reference. The investigation by the author is rigorous and includes interviews with staff. The report makes good use of all the available information. This has enabled the author to identify where practice fell short of acceptable standards and analyse why this occurred. Individual and systemic issues are addressed. Good practice and how it might be disseminated is included in the report. The lessons learnt follow from the issues raised and have been transferred to an action plan. The analysis refers to national SCRs and relevant research findings. However, no reference is made to the most recent local SCR on Baby Z which appears to be relevant. Arrangements for debriefing and dissemination of findings are in place.

1.7.5 Private Day Nursery attended by Child M

1.7.6 Child M had a place at this nursery [redacted] when Child M was 12 months old. His last attendance was [redacted]. During this period he attended the nursery on 33 occasions out of a possible 100 occasions. When he attended, this was for approximately four to six hours.

1.7.7 The IMR was prepared by the nursery proprietor who is the Nursery Manager. As this is a private business, it is not clear what steps could have been taken to provide an IMR author who was independent of the case. Both safeguarding boards will consider how this could be addressed in the future.

1.7.8 The report provides a chronology of attendance at the nursery based on nursery records. There is no information about Child M in the report despite an interview with the key worker. The IMR author explained that this information would have been held in a record held by the parents. The report is clear that there were no concerns about Child M but this is at odds with information shared with Bristol CYPS by nursery staff as recorded in the CYPS chronology.

1.7.9 The SCR Panel made several unsuccessful attempts to engage with the IMR author in order to improve the quality and accuracy of the IMR. A short report detailing the efforts made was provided to the Overview Report Author. It should also be noted that the IMR author attended a briefing session and a panel session. Despite these efforts, the nursery has not provided an adequate report which addresses the terms of reference. The panel had hoped that the nursery could have provided more knowledge about Child M as an individual.

1.7.10 Barnardo's

1.7.11 Barnardo's Community Family Work service is for families with children aged 0-5 living in Children's Centre catchment areas who need preventative and early intervention. The service is aimed at hard to reach families to enable them to engage in children's centre services and secure

better outcomes for vulnerable families. It is not a service for families with multiple current problems or those well known to social care. Ms A was referred to Barnardo's by the Health Visitor in April 2010. The involvement of the service was limited to one visit.

1.7.12 The IMR author is independent of the case and is an Assistant Director.

1.7.13 The IMR author is very thorough in analysing the service provided and identifying lessons. These have been transferred to an action plan. The report is child focussed and identifies good practice. It also uses an interview with the member of staff to good effect to provide information about the child and his mother. The report addresses the Terms of Reference. Arrangements are in place for debriefing and dissemination.

1.7.14 South Gloucestershire Children's Social Care (SGCSC)

1.7.15 Ms A lived with her parents and brother in South Gloucestershire. She left home when she was pregnant with Child M and lived for short periods in accommodation in Bristol City, which borders South Gloucestershire. However, Ms A also continued to spend time at the family home in South Gloucestershire with Child M. SGCSC was in receipt of information about Child M from the police in December 2008 but did not follow it up with any action. The authority did have involvement with Ms A and her brother Mr A from December 2003 to November 2010. This involvement included the completion of an Initial Assessment of Ms A in January 2007 and social work intervention until May 2007. The IMR also covers communication from the police regarding domestic abuse incidents between Mr F and Ms C from 2003 to the present time.

1.7.16 The IMR author is independent of the case and is the Safeguarding Children Strategy Manager.

1.7.17 The IMR is very thorough and utilises all the available information including staff interviews. The report addresses the Terms of Reference in particular providing helpful information on the family culture. It focuses on the needs of both Ms A and Mr A as well as Child M. Good practice is identified. Individual practice is carefully scrutinised against agency standards. Good use is made of lessons from Serious Case Reviews nationally and locally. The analysis is robust and identifies lessons learnt and relevant recommendations. There is a plan for debriefing staff and dissemination of the report.

1.7.18 Avon and Somerset Constabulary

1.7.19 This report is based on records of police involvement with members of the family using records from 2002 using a range of record systems, which are very helpfully described in detail.

1.7.20 The IMR author is based in a Public Protection Team, is independent of the case and has drawn on relevant experience.

1.7.21 The IMR is very open, thorough and self critical in its examination of the chronology and analysis of practice. The report is well structured and clearly addresses the Terms of Reference. The needs of Child M are kept

in focus and knowledge about risk factors are used to identify improvements required. The focus on information sharing and how to use this to improve safeguarding is very helpful. Lessons from national SCRs and recent reports are referenced. The actions required relate to the findings of the review and are clearly transferred to the action plan. Arrangements for debriefing and dissemination are set out.

1.7.22 NHS Bristol and South Gloucestershire GP Primary Care.

Child M and parents, Mr B and Ms A were registered with one general practice in Bristol. Child M's grandmother (Ms C) and uncle Mr A were registered with another practice in South Gloucestershire.

Both of these practices provided the full range of Primary Care. This consists of GP, practice nurse and treatment room services for both families.

Health visiting services were provided by a separate organisation and a separate IMR is provided.

1.7.23 The IMR author is the Designated Doctor (Safeguarding Children), is independent of the case and sets out why she was identified for the task.

1.7.24 The IMR is thorough, using interviews and records to analyse the factual information. The Terms of Reference are addressed fully. Interviews are used very effectively to engage the GPs in a methodical and analytical approach. The IMR author draws out and interprets relevant information about the family culture. At the request of the panel, the IMR author helpfully expanded on the explanation about the significance of the centile measurement of Child M. The action plan reflects the issues raised in the analysis. Reference is made to national SCRs and recent local SCRs. Plans for debriefing include what has already taken place to share lessons. Dissemination arrangements are detailed and link with the action plan.

1.7.25 North Bristol NHS Trust (Health Visitors)

1.7.26 The report covers the work of the midwife after the birth of Child M and the provision of Health Visiting service to Child M, Ms A and Mr B.

1.7.27 The IMR author is the Named Nurse for Child Protection for the trust and, as such, has no responsibility for the line management of health visitors. She is therefore independent of the case.

1.7.28 This report covers the Terms of Reference and is particularly thorough in addressing the issues relating to Health Visitor resources. Some good practice is identified as well as lessons to improve practice. The overall analysis is that the service provided was good however a more critical approach may have been prompted by access to the integrated chronology or Bristol CYPS IMR. The SCR process did not allow for this to happen for any IMR author because the panel believed that such access would have had an unhelpful impact on the individual IMR authors' analyses. The IMR author identified relevant recommendations which

reflect lessons learnt. Arrangements for debriefing and dissemination are thorough.

1.7.29 University Hospitals Bristol NHS Foundation Trust

1.7.30 This report covers historical information including the birth of Ms A and treatment of Mr A and Ms C. The trust provided care for Ms A during her pregnancy and the birth of Child M and subsequent treatment for medical illnesses. There are no records relating to Mr B.

1.7.31 The IMR authors are independent of the case during the period and have specific safeguarding responsibilities. One of the authors was involved after Child M was admitted to the hospital but this was outside the scope of this SCR.

1.7.32 The IMR is thorough and covers the terms of reference. It looks carefully at communication between its services and those of others. Practice is analysed and relevant improvements identified. Lessons from national and local SCRs are referred to. Recommendations relate to lessons and are set out in a clear action plan. Arrangements are in place for debriefing and dissemination.

1.7.33 GWAS

1.7.34 Great Western Ambulance Service took Child M to hospital in July 2009 and initiated a referral to Bristol CYPS. The service was also involved when Child M died in May 2010.

1.7.35 The IMR author is independent of the line management of the service and has the safeguarding lead for the trust.

1.7.36 The report is clear and well structured. It addresses the terms of reference and considers the child's needs. Good practice is identified. Lessons are clear, evidenced and made with reference to Working Together. Good use is made of an interview with a member of staff. The action plan addressed the recommendations and arrangements are in place to provide debriefing and dissemination.

1.7.37 Bristol Community Health

1.7.38 Bristol Community Health provides health services in the community. Ms A used a walk in centre which is nurse led on one occasion. Child M received his routine immunisation and vaccination at a health centre treatment room on one occasion.

1.7.39 The IMR author is independent of the case and is the named nurse for safeguarding.

1.7.40 The report reflects on practice in a thorough and considered manner. Learning is addressed in the action plan. The IMR includes a plan for disseminating the findings and learning.

1.7.41 Combined Health Management Review (Health Overview Report)

1.7.42 This report has been produced in line with Working Together 8.31. The author has used the process to quality assure the separate health IMRs.

The use of the IMR template is helpful in that it has summarised the contribution of all health IMRs and ensured that the Terms of Reference are addressed. National and local SCR references are made. Three themes are identified which inform lessons and recommendations. The production of a combined health action plan which included recommendations from the health overview is very clear and helpful. Arrangements for debriefing and dissemination are similarly thorough.

1.7.43 Connexions West

1.7.44 Connexions West is part of Learning Partnership West, which is a Local Authority controlled company. It provides impartial information and guidance including careers advice. The company provided a service for Ms A in 2006 in response to concerns from her school about behaviour. A further service was provided as requested by her mother Ms C when she withdrew Ms A from school in 2007. Connexions continued to provide a service for Ms A from February 2008 to the last personal contact in November 2009.

1.7.45 The IMR author is a Locality Leader and is independent of the management of the case.

1.7.46 The IMR report uses information from records and interviews with staff to reflect on the service provided and how it could be improved. This reflection was prompted by feedback from the panel following submission of the first IMR. The terms of reference are addressed. Lessons learnt are identified and inform the recommendations and action plan. Arrangements for debriefing and dissemination are outlined.

1.7.47 Bristol Youth Offending Team (YOT)

1.7.48 [redacted] Ms C contacted the YOT by telephone to refuse the assessment on Ms A's behalf and this was accepted by the YOT. Ms A was living independently at the time and was pregnant with Child M. The YOT therefore had no face to face contact with Ms C and no contact at all with Ms A.

1.7.49 The IMR author is the Early Interventions Team manager and is independent of the management of the case. The author attended the briefing for IMR authors and was invited to present the IMR to the panel meeting for the purpose of feedback. Although there is evidence that this invitation was given, the IMR author did not get the message and did not attend. Feedback was given to the IMR author via a panel member and these questions are used as headings in the revised report by the IMR

author. The action plan was produced after the draft Overview Report was presented to the Bristol Safeguarding Children Board.

1.7.50 The IMR analysis is limited because the YOT had no face to face contact with Ms A. The lessons learnt and recommendations suggest that there has been some reflection about the relevance of what was known about Ms A.

1.7.51 Recommendations have been transferred to an action plan and have already been commenced. The action plan also notes systems changes which occurred between the time Ms A was given a final warning and the production of the IMR. Information about the YOT response to an inspection report has been added to the action plan. This information would have been more helpfully integrated into the IMR analysis. The response by YOT to the request for this IMR, suggests that there is more work to be done on their safeguarding role. There is a plan for debriefing and dissemination.

1.7.52 <u>1625 Independent People (formerly Wayahead)</u>

1.7.53 This is a voluntary agency providing housing and support for young people. During the period covered by the SCR, the service was called Wayahead. Wayahead helped Ms A and Mr B to find suitable accommodation and were involved from January 2008 to December 2008 when the case was closed. A Housing Support Worker (HSW) helped Ms A and Mr B kit out the flat with all essential items, settle into the area and make the house a home before the arrival of Child M. The main focus was to maximise the family income and link the parents into agencies who could support them with parenting skills. There was a change of Housing Support Worker after August 2008. From this point there was little face to face contact with Ms A despite the efforts of the Manager and the new HSW. The case was closed in December 2008. It was considered that the support plan at that point had been completed.

1.7.54 Enquiries by the SCR Panel confirmed that the decision for the service manager to prepare the IMR was made on the basis that the manager was most aware of the case. It was accepted by the organisation that he was not therefore independent of the case. However, a senior manager was involved in the signing off process and the IMR author approached the investigation in a critical and reflective manner. The panel concluded that in the circumstances the lack of an independent IMR author had not had a negative impact on the preparation of the IMR.

1.7.55 The IMR provides a good deal of very helpful information from records and staff files. The report is thorough and addresses the terms of reference. Lessons were identified and linked to recommendations. An action plan has been produced. Arrangements for dissemination are in place.

1.7.56 <u>Cafcass</u>

1.7.57 Cafcass were involved from 30 July 2008 to 1 October 2008 when the case was closed. [redacted]

[redacted] A Cafcass Family Court Advisor (FCA) saw both parents [redacted] There was no further contact with the adults. In the time between the initiation of the case and closure, other members of staff completed administrative tasks relating to the case. The IMR helpfully sets out Cafcass responsibilities to undertake safeguarding checks, make an assessment of risk and provide a risk assessment to the court where there is given cause to suspect that the child concerned is at risk of harm.

1.7.58 The IMR author is independent of the case and is a member of a quality improvement team within Cafcass.

1.7.59 The IMR author uses interviews with staff effectively. Information about agency statutory responsibilities and context is provided in the report. The analysis section is thorough and self critical, clearly addressing all the terms of reference. Action already taken to address lessons is outlined. Good practice is identified although this did not impact on the management of the case. Recommendations and actions to be taken, follow logically from the analysis. The report identifies arrangements for debriefing and dissemination.

2 THE FACTS

2.1 Genogram

2.1.1 A genogram of the family is in appendix 1.

2.2 Ethnic, cultural and other equalities issues.

Determine to what extent was practice sensitive to any racial, cultural, linguistic and religious factors in respect of the child's identity and any disability needs or SEN of the child or family. ToR 1.10

2.2.1 Most agencies were able to identify that all the adults and child M were white British and spoke English. The family lived in predominantly White British areas of urban Bristol. No special needs were identified and there is no evidence to suggest otherwise. 1625 Independent People (housing) showed good practice in gathering information about sexuality and religion. [redacted]

2.2.2 Some IMRs reflected on relevant cultural factors and whether practice was sensitive to identified needs. [redacted].

2.2.3 [redacted]

[redacted] Treatment provided by GP's was assessed as being sensitive to the adult's needs but did not consider the impact on the care of Child M.

2.2.4 A culture of intermittent parenting, volatile relationships and alcohol was identified by some IMR authors as having an impact on family functioning for Ms A and her brother. The impact of this culture on the parenting capacity of Ms A was never explored. To an extent this culture was replicated by Mr B and Ms A in their relationship with each other and their parenting of Child A. [redacted].

2.2.5 The family culture in terms of poor physical environment and cleanliness and its impact on the care of Ms A as a teenager and later Child M whilst in her care, was identified by the police and ambulance services at different times. Mr B had similarly experienced very poor living conditions and neglect as a child but this did not appear to have been recognised as significant to his parenting capacity. The encouragement and practical help from the Housing Support Worker showed sensitivity to Ms A and Mr B's need for help in improving living conditions and financial situation. Ms A also responded positively to the offer of similar help from Barnardo's, which was facilitated by the health visitor.

2.2.6 Whereas Barnardo's identifies that the worker was aware of the immaturity of the parents and the implications for the safety of Child M, Cafcass notes that their staff gave insufficient weight to the vulnerability of Child M in the light of the concerns raised by Mr B and the needs of Ms A as a young and inexperienced mother. Cafcass also notes the stress Ms A and Mr B were experiencing as a result of their separation and court proceedings.

2.2.7 Connexions recognised that different ways of keeping contact with Ms A could have been considered which were more sensitive to her needs, for instance home visits.

2.3 Information about the parents/carers, any perpetrator and the home circumstances of the children.

In relation to the parents (and anyone who had care of Child M) are there any relevant medical, mental health, substance misuse (including alcohol) issues, previous convictions, intelligence, domestic violence reports which were known. Is there any information available about the parents' own childhood experience which is relevant? ToR 2.2

2.3.1 The following information about the family has been obtained from the IMRs. What life was like for Child M has been compiled in the last paragraph of this section.

2.3.2 Bristol CYPS records show that Mr B lived in poor conditions as a child. There is evidence of neglect by his mother. [redacted].

2.3.3 Ms A and her younger brother Mr A lived with their parents Ms C and Mr F. There were times when Ms C separated from Mr F but they were together at the point when Child M died. Ms A left home in [redacted] but continued to spend time at the parental home with Child M.

2.3.4 Avon and Somerset Constabulary records of contact with Ms C and Mr F show a history of domestic abuse incidents from [redacted]. Records show that alcohol abuse by both adults was a factor in incidents. The police also dealt with Ms A running away from home whilst a teenager [redacted]. School records note a decline in Ms A's attendance after year 8. The home conditions were observed by the police to be in a very poor state in 2006; [redacted].

2.3.5 Ms A and Mr B lived together from November 2007. They moved into a flat together with Child M when he was a few weeks old in May 2008.The most detailed picture of Ms A is revealed in the Housing Support Worker's (HSW) record of contact. This covers the period from November 2007 to September 2008 when Child M was 4 months old.

2.3.6 The good relationship between Ms A and the HSW is reflected in other agency records. These show that Ms A responded positively to the HSW help and support. The HSW liaised with the Health Visitor and reminded Ms A about Child M's 7 week check. The Housing Support Worker's records note that Ms A attended cookery classes arranged by the HSW and also a baby group, aerobics and swimming during this period.

2.3.7 The Housing Support Worker documents the amount of help the couple required to tackle bills and complex benefit issues. [redacted].

2.3.8 The police were aware of the presence of Child M at the home of Mr F and Ms C during incidents of domestic abuse in May 2008 when Child M was 2 days old and on 31 December 2008 when Child M was 7 months old. Information about this second incident was shared with SGCSC.

2.3.9 In hospital and during home visits by the community midwife, health visitors and Social Worker to see Child M, he was seen to be cared for appropriately by Ms A. At his 2 year development check Child M was seen to have reached developmental milestones and had had his inoculations. Ms A and Mr B were seen to behave warmly and appropriately to Child M who had age appropriate toys. Good attachment was observed with both parents. The Health Visitor was aware that Child M was cared for on week ends by Ms C and Mr F. Records show that the Housing Support Worker had shared information with the Health Visitor as noted above about the support provided by the maternal grandparents and their alcohol use.

2.3.10 The physical state of Ms A and Mr B's flat at times was noted as a concern. In July 2009 GWAS reported cat faeces on the floor and Child M in the living room in 'bodily mess'. The Health Visitor in 2010 identified hygiene and safety issues at the last visit. Doors and windows were left open which posed a risk to Child M. Records of the Child Death Review meetings seen by the Overview Report Author note the very poor state of Ms C and Mr F's home where Child M was known to spend time being cared for.

2.3.11 Mr B and Ms A had an intermittent relationship. 1625 Independent People (housing) and Cafcass records show that they split up in July 2008 when Child M was 2 months old. 1625 Independent People records show that they were back together in September 2008. In January 2009 police records show they were called to the flat. Ms A said that she and Mr B were arguing about money. In August 2009, Ms A reported that she and Mr B were not together and this remained the case in December 2009. By March 2010, Mr B and Ms A were together again.

2.3.12 Mr B periodically had work [redacted]. Ms A left school without any qualifications [redacted]. There is evidence of her attendance at college but this was not sustained. Child M had a place at nursery from May to October 2009 but his attendance was very sporadic. Payment for Child M's nursery was linked to Ms A's attendance at college. He lost his place when Ms A left college.

2.3.13 There is some evidence from GP records in October 2009 that Ms A had periods of [redacted]. Bristol CYPS records note concerns about her [redacted] when seen with Child M in October 2009. The Social Worker had concerns about how Ms A would

cope with Child M now that he had lost his nursery place. [redacted].

2.3.14 Cafcass were involved with Ms A and Mr B for a very short period in July 2008. They were seen by the Duty Family Court Advisor (FCA) regarding residence of Child M when they had separated. The FCA had a copy of the written allegations by Mr B [redacted] This information was not shared with any agency.

2.3.15 There is some corroboration the following year for some of these allegations made by Mr B to Cafcass. The Bristol CYPS Social Worker recorded concerns from Child M's nursery in August 2009 that Child M was frequently in soiled clothes and a dirty nappy. He wanted to sleep early in the day. Sometimes he was dropped off by Ms C who presented as 'dirty and smelly.' The Social Worker also recorded information from the Health Visitor about Ms C's alcohol use and alcohol fuelled violence in the extended family.

2.3.16 Mr B's father Mr D and his partner Ms I, looked after Child M periodically from October 2009 and this is corroborated by the Social Work records. In his contribution to this SCR, Mr D stated [redacted] However, they never felt he was at serious risk of harm. When he arrived he usually headed for the bathroom and appeared to enjoy the extra attention they gave him. They described him as always smiling and a very easy child. He enjoyed playing with a football and liked to dance to music. They claimed that Child M was often cared for by Ms C at the weekends. They described Ms C [redacted] but that they believed that she really cared about Child M.

2.3.17 In the months before Child M's death, Ms C was being treated by her GP for [redacted]. The GP and nurse noted her presentation as unkempt and occasionally smelly. Although at one point she revealed drinking 42 units in a week she denied a problem with alcohol. The day before Child M died she said she had started drinking again and smelt of alcohol early in the morning. She told the nurse that Ms A and Child M were coming back home to live.

2.3.18 A clear picture of what life was like for Child M has been difficult to ascertain despite very good efforts by the panel. More information from the nursery and from family members would have helped. His character was described as smiling and easy. He enjoyed football and dancing to music. He had toys to play with at home and was taken to the park to play. He was seen to relate well to his mother and father. He did not attend nursery and it is not clear whether he had any opportunities to play with other children in a structured way. His living conditions were relatively poor and unhygienic. His parents needed help to identify potential risks to his safety such as open windows and bleach and razors left out. He was not kept very clean. Both his parents smoked heavily and the flat was smoky. He spent time with both sets of grandparents at week ends on a regular basis. At the time of his death his parents were living together but the relationship was volatile and sometimes his father left the household. The family had substantial debts and this caused stress.

2.4 Integrated Chronology

A complete integrated chronology is provided in appendix 2. The following summary provides information relevant to the analysis in section 3. Key relevant opportunities for assessment and decision making are identified in numbered boxes.

Determine the key relevant opportunities for assessment and decision making in this case in relation to the child and family. Tor 1.4

2.5 Overview Chronology Summary.

2.5.1 **Mr B (Child M's father)**

2.5.2 [redacted].

2.5.3 **Ms A (Child M's mother) and Mr A (Child M's mother's brother) early years**

2.5.4 Early childhood health records do not identify any significant concerns or involvement with Children's Social Care.

2.5.5 **Ms C (Child M's maternal grandmother) prior to the birth of Child M**

2.5.6 Police records show involvement from July 2002 (Ms A would have been 11 years old) through to 2006 in response to calls from Ms C. There were allegations of domestic abuse by Mr F (Ms C's partner) towards Ms C and reports of Ms C's drunken behaviour. [redacted]. Referrals were made by the police to Children's Social Care in November 2003 and 2005 but did not result in any further action being taken.

2.5.7 [redacted]. She did not attend follow up appointments.

2.5.8 **Ms A (Child M's mother) teenage years**

2.5.9 Police records from February 2006 (when Ms A was 14 years old) show involvement in response to reports from Ms C that Ms A has gone missing. Five further calls to the police were made in October and November 2006. Ms C and Mr F were reported to be very drunk on the occasions when the police called to the house.

2.5.10 Children's Social Care records show a notification from the police in October 2006 in relation to Ms A being assaulted by Ms C. Records also show a fax to Children's Social Care from Ms A's school with concerns about her behaviour, [redacted].

An Initial Assessment should have been completed by SGCSC in October 2006 prompted by information from the police and school. SGCSC IMR author

2.5.11 January 2007 onwards police and SGCSC records show a pattern of Ms A running away and further evidence of a drunken, abusive relationship between Ms A's parents Ms C and Mr F. [redacted].

2.5.12 In February 2007 SGCSC completed an Initial Assessment. Records show that the recommendation was to allocate an Adolescent Support Worker for Ms A and for her to meet with Connexions via a referral from the Education Welfare Officer (EWO). Connexions records show that Ms A saw a Personal Advisor (PA) with her mother. Advice was given about requesting home tuition and options about nursery nursing and teaching.

An Initial Assessment was completed by SGCSC in February 2007. The assessment was limited in scope and did not take into account of the impact of parental domestic abuse, alcohol abuse or the poor state of the home on Ms A. SGCSC IMR author

2.5.13 20 March 2007 onwards SGCSC records show meetings with Adolescent Support Worker (ASW) and Ms A. Six sessions were offered but only two were attended by Ms A. It is not clear from any records whether Ms A was attending school at this time.

2.5.14 Police records in 2007 continue to show domestic abuse incidents between Ms C and Mr F. Recording shows both were often very drunk when police have contact.

2.5.15 30 November 2007 1625 Independent People Housing Records show that Ms A was assessed by a Housing Support Worker (HSW). Ms A and Mr B were referred to the agency when they were living in bed and

breakfast accommodation. (This same Housing Support worker continues to offer support to Ms A until September 2008.)

2.5.16 [redacted].

2.5.17 15 January 2008 1625 Independent People Housing records show Ms A states that she is pregnant.

2.5.18 17 January 2008 [redacted]. Ms A is already 20 weeks pregnant and is living in supported lodgings.

2.5.19 18 January 2008 1625 Independent People Housing Records show efforts made by the Housing Support Worker to find Young Mother's groups for Ms A to join. The HSW made referrals and followed these up.

2.5.20 18 January UHB records show a referral by the midwife to Bristol CYPS - Social Care.

2.5.21 1 February 2008 Bristol CYPS records show Initial Assessment 2 completed which included parental capacity assessment**.**

An Initial Assessment was completed and the case closed in February 2008 prior to Child M's birth. No consideration given to relevance of parent's histories. The assessment did not consider issues known about maternal grandmother despite knowledge of alcohol fuelled violence between maternal grandparents and a recent ban for drink driving. It was known that Ms C was the main source of support for Ms A. No plan to monitor the case was in place. Bristol CYPS IMR author

2.5.22 18 February Connexions records show a telephone interview with Ms A. Contact had been facilitated by the midwife who obtained Ms A's permission to share information. Ms A was bidding for more permanent accommodation.

2.5.23 YOT records in March 2008 show the short involvement of Youth Offending Team. [redacted] Ms C contacted the YOT by telephone to say that Ms A did not require any support because lots of agencies were involved. The decision was made for no further contact. The YOT were not aware of Ms C's involvement in the offence.

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The opportunity for the Youth Offending Team to complete an assessment and/ or share information with other agencies was missed. Overview Report Author

2.5.24 April 2008 UHB maternity records note that Ms A is living at home with her mother but a short time later, it is recorded that she is living with Mr B who is still at school.

2.5.25 28 April 2008 1625 Independent People Housing records note Mr B has been granted a tenancy for a flat. Mr B is the tenancy holder as Ms A is under 18.

2.5.26 1 May 2008 Child M born. It was a normal delivery. Ms A was noted as caring for him independently. Mr B was also present.

2.5.27 3 May 2008 UHB records show that Ms A was discharged home to live with Ms C. The Community Midwife did a home visit. No discharge plan was prepared because of the lack of a social report or 'green paperwork'.

2.5.28 4 May 2008. Police records show a call to domestic abuse incident between Ms C and Mr F. Child M, 2 days old, is shown to be present.

There was a missed opportunity in May 2008 to identify possible risks to Child M from alcohol and domestic abuse. Police should have shared information with partner agencies Avon and Somerset Constabulary IMR author

2.5.29 6 May 2008 1625 Independent People Housing records detail a telephone conversation between the Housing Support Worker and the midwife. The HSW was told that the health visitor will refer Ms A to a young parenting project.

2.5.30 June/July 2008.GP records show that Ms A, Mr B and Child M are in a new flat. They registered with a new GP practice. Child M had his 6 week review which showed no problems.

2.5.31 2 July 2008 1625 Independent People Housing records show that HSW took Ms A and Child M to a baby group. Previous records show efforts by HSW to find available groups. HSW expressed concern that Ms A was not bonding with Child M and intended to work on positive parenting

2.5.32 11July 2008 Connexions records show that Ms A called in with Child M to discuss childcare. She was going to college in September to take A levels and was looking for childcare. She was given information about nurseries and child care. Ms A said she was going to see places with her support worker.

2.5.33 23 July 2008 1625 Independent People Housing records note that Ms A texted the HSW to say that she has split up with Mr B. The HSW spoke to Ms A [redacted]

2.5.34 23 July 2008. Police records indicate that Ms A reported that Mr B has failed to return Child M. Ms A and Mr B have split up and that Mr B has [redacted] The police check Child M who is being cared for by Mr B.

A referral to Children's Social Care in July 2008 should have been done with a view to holding a Child Safeguarding Strategy Meeting Avon and Somerset Constabulary IMR Author

2.5.35 24 July 2008 Health Visitor records show that the HV made a planned visit. No one was at home. The HV had a discussion with the Housing Support Worker (HSW) who suggested that Ms A is probably back with her family following the separation of Ms A and Mr B. The HSW said that Ms A's family are helpful with the care of Child M but that the 'atmosphere is one of alcohol and alcohol related arguments'.

2.5.36 30 July 2008 Cafcass records note Mr B and Ms A were seen at [redacted] Court by a court duty FCA (Family Court Advisor). Ms A applied for Child M to be returned to her care. Mr B made an application for residence. R[redacted].

Mr B's allegations about Ms A's neglect of Child M in July 2008 should have prompted a S17 referral if there was consent or a S47 referral if consent was withheld Cafcass IMR

2.5.37 5 August 2008 1625 Independent People Housing records note that the tenancy is in Mr B's name. HSW gave advice to Ms A that she will need permission ([redacted]) to remain in the flat until she can sort out alternative accommodation. Mr B has changed the locks. M[redacted]. Ms A is very stressed.

2.5.38 12 August 1625 Independent People Housing records show that Ms A has been awarded the tenancy.

2.5.39 5 September 1625 Independent People Housing records show that Mr B and Ms A are back together. A new HSW has been allocated. Ms A said that she needed a lot of support and didn't know what to do regarding child care and benefits. (Records show that Ms A did not engage with new HSW).

2.5.40 September 2008 HV records show concerns that the HV has not had access to Child M since June although Child M had a check up with GP on 10 July.

2.5.41 September 2008 Connexions record show that Mr B has lost his job [redacted] and is looking after Child M. Ms A is to attend [redacted] college to do A/S levels.

The Health Visitor completed a Family Health Needs Assessment (FHNA) in October 2008. Records note that Child A is being looked after by Ms C and Mr F at week ends. There was insufficient information or detail to assess the potential risks to Child M. Child M was meeting his developmental milestones. North Bristol NHS Trust IMR author

2.5.42 December 2008 1625 Independent People Housing records show the Housing Support Worker case is closed.

2.5.43 31 December 2008 SGCSC records show a referral from the police. They attended the home of Ms C. Mr F was trying to get into the home. A child was present – this child is Child M aged 7 months. This information was linked to previous information about Ms A but no action was taken.

An Initial Assessment should have been completed in December 2008 when information that Child M was present during a domestic abuse incident was shared by the police. SGCSC IMR Author

2.5.44 Feb 2009 Health visitor records note that a FHNA was completed. Child M was seen. Age appropriate developmental milestones were achieved. Good attachment behaviour seen between both parents and Child M was observed. The following month Child M had his immunisations.

2.5.45 March 2009 Connexions records show Ms A is on an E2E (Entry to Employment) programme

2.5.46 20 March 2009 GP records show that Child M has had his third immunisations.

2.5.47 9 May Nursery records show that Ms A looked around the nursery. Child M first attended on 11 May. Child M is now aged 1.

2.5.48 May 2009 Connexions records show Ms A is at the YMCA. She is hoping to train to be a primary school teacher

2.5.49 31 July 2009 UHB records show that Child M was taken to hospital with a high temperature and fever. The ambulance crew made a referral to CYPS regarding concerns about the state of the flat. Cat faeces were on floor.

2.5.50 3 August Bristol CYPS records show Initial Assessment 3 commenced.

2.5.51 10 August, a home visit by 2 Social Workers was arranged by appointment letter. Ms A was seen but Child M was reported to be with his paternal grandparents. Ms A gave permission for nursery to be contacted. Ms A said that Child M has no contact with his father and [redacted] A

telephone call to the nursery is recorded. The nursery deputy identifies concerns that Child M is unkempt, ingrained dirt in fingernails, hands and feet. His nappies are soiled. His attendance at the nursery is sporadic.

An Initial assessment was completed by Bristol CYPS in August 2009. The analysis was that the condition of the home was not appropriate for Child M. Ms A admits to [redacted]; there are concerns from the nursery. The case is opened for a service to be provided. The assessment was not as thorough as might have been expected. No contact made with other agencies Bristol CYPS IMR author

2.5.52 19 August Bristol CYPS records note Social Worker supervision with team manager. The plan was for the case to be referred to Child and Family support regarding neglect.

2.5.53 8 Sept 2009 Bristol CYPS social work supervision notes record the plan for the Social Worker to see Child M at the nursery to assess him. This did not happen. This was followed up in supervision on 30 Sept which confirmed that there was no new information.

2.5.54 29 September Nursery records show last attendance by Child M.

2.5.55 13 October 2009 Bristol CYPS Social Worker did a home visit but no one was at home. A telephone call was made to Ms A who said that she did not get the letter about the home visit. She is seeing GP today [redacted] She is unhappy with the nursery. Chronology entries infer that a home visit was arranged for 22 October 2009.

2.5.56 13 October 2009 GP records show that Ms A self reported the possible [redacted]. She said that she had split with her boyfriend. The relationship broke down 4 months ago. She has an 18 month old to care for but has support from her parents. There is a social services meeting next week to assess her needs. A support worker is being provided. The GP noted she was tearful, no motivation, feeling hopeless and helpless, appetite poor, lost 1.5 stone in the last few months. [redacted].

2.5.57 22 October 2009 Bristol CYPS records show a home visit. Child M was seen by the Social Worker.(This is the first time Child M was seen after the referral for an Initial Assessment on 31 July 2009). The condition of the house had improved. Ms A said she had been asked to leave college as she had not been attending; therefore Child M was not entitled to a place at nursery. [redacted] Child M presented as clean and tidy, playful and interacted well with Ms A. Ms A responded appropriately to Child M but was 'flat in mood'. The Social Worker expressed concern in her records that Ms A would struggle with Child M on her own at home all the time now nursery had stopped.

2.5.58 4 November 2009 Connexions records show that a Personal Advisor (PA) telephoned Ms A as she was not attending her childcare course at the YMCA. Ms A informed Connexions that she was going to do an ICT course at college. The PA offered ongoing support and Ms A said she would contact if this was needed. This was Connexions last personal contact.

2.5.59 11 to 17 November 2009 Bristol CYPS and Health Visitor records show the Social Worker's first contact with the Health Visitor, gathering and sharing information about Child M. Social Worker telephoned the Nursery who noted that Ms C sometimes dropped Child M at nursery. [redacted]. Child M was frequently in dirty clothes and a soiled nappy. He wanted to sleep early in the day. Child M was no longer attending nursery because Ms A did not complete the paperwork. The Social Worker shared concerns with the Health Visitor about Child M's small stature. The health visitor records note that the Health visitor was unable to commit to a joint visit due to her workload. A Health Visitor had last seen Child M in February 2009. The HV had no concerns about Child M but concerns were raised about the maternal family, grandmother's alcohol use and alcohol fuelled arguments. CYPS records show that it was agreed that the Social Worker would ask Ms A to take Child M to the baby clinic for a developmental check. The Social Worker would do an early years referral. (There is no evidence that this was actioned). The Health Visitor [redacted].

2.5.60 Nov /Dec 2009 Health Visitor and Bristol CYPS records show that no one was at home when they made their separate home visits so Child M was not seen.

2.5.61 Dec 2009 Bristol CYPS records show that the case discussed in supervision. A CAF (Common Assessment Framework) or Child in Need review was considered.(Neither took place)

2.5.62 7 Dec Health visitor records show that a home visit took place. Child M was seen but not examined as he was asleep. This is the first time the Health Visitor saw Child M after the referral made by GWAS on 31 July 2009. Ms A reported she felt a bit better but has felt tearful and easily upset since Child M was born.

2.5.63 8 Dec Bristol CYPS records show that this information was shared with Social Worker. The Health Visitor would make a referral to a Young Mothers project and Barnardo's. Bristol CYPS records state an agreement to close the case if Ms A engages with these resources.

2.5.64 18 Dec Bristol CYPS records the decision to close case because of the progress made. [redacted] Ms A had applied for college, was engaging with services and was attending a young parents project. (There does not appear to be any evidence for these statements.)

Decision made by Social Worker in December 2010 to close case when the evidence from information gathered from October onwards was that the situation was not improving for Child M. None of the actions proposed by the Social Work manager had taken place. Overview Report Author

2.5.65 21Jan 2010 GP records show [redacted].

2.5.66 3 March 2010 University Hospitals Bristol emergency department records show Child M was suffering from a high temperature and unsettled. He was taken to hospital by Mr B.

2.5.67 11 March North Bristol Trust (NBT) health visitor records show a home visit to complete an assessment on Child M who was seen. Detailed records were made. Mr B and Ms A were back together. Positive relationships between Child M and both parents were observed. There were some issues about hygiene and safety. A referral to Barnado's was to be made. (This is the first referral completed although discussed earlier.) Problems include £1K arrears with utilities bill.

2.5.68 16 March NBT health visitor records show Child M was seen at the clinic. His weight and height had dropped to the 25 centile. (This confirms a concern raised by the Social Worker in November 2009). Child M was referred to his GP.

2.5.69 24 March GP records show Child M was seen with his parents Mr B and Ms A. Records note the query of failure to thrive. 'Was on 50th centiles for height and weight at birth. At 22/52 was on 25th for height. Now is just below 25th for weight (11kg) and on 2nd for height. Mum 5' 10" (177.8 cm) dad 5' 11" (180.34 cm.) Child M eats and drinks very well, no diarrhoea, active and otherwise developmentally normal. Mum and Dad have no concerns about health and are quite surprised by all the fuss.**'** The GP IMR provides an explanation of this information which did not suggest any cause for concern. The GP planned to review Child M in a month.

2.5.70 6 April Barnardo's records show the receipt of a referral from the Health Visitor requesting the Community Family Worker home visiting service. The case was put on the waiting list. The referral shows a list of issues.

2.5.71 15 April GP records show [redacted] She reports that her daughter (Ms A) is moving back home which she is looking forward to. Her daughter, aged 19 years, is very supportive.

2.5.72 17 May NBT HV home visit follow up. Review of issues raised completed. Child M was seen. Cleanliness, safety issues and [redacted] remain. Both parents seen to be responsive to Child M.

2.5.73 18 May. GP records note Ms C seen. She is still low and looks unkempt. Denies use of alcohol but GP notes suggest this is an issue.

2.5.74 27 May GP records note Ms C seen and is feeling better. She says her daughter is now living back home.

2.5.75 27 May Barnardo's and NBT health visitor records note joint home visit. Support needs were identified to be followed up by the Community Family worker. Ms A noted that Child M had a regular routine which included staying with his Nan (Ms C) on a Saturday night.

2.5.76 3 June 2010. GP records show that Ms C was seen by practice nurse. [redacted].

2.5.77 4 June 2010 Child M dies – drowned in pool at maternal grandparents home. GWAS IMR notes that there about 8 adults present when the ambulance arrived. The environment was 'filthy' with boxes of food and lots of alcohol bottles. The maternal grandfather was verbally abusive. The dad entered the ambulance and threatened physical violence.

3 ANALYSIS

This analysis pulls together the information and analyses from IMRs and discussion with the SCR Panel. Each section focuses on a theme which will link to lessons and recommendations. The relevant Terms of Reference (ToR) are highlighted in each section. Evidence from specific IMRs is identified as well as individual agency action to address the issues raised.

3.1 Applying knowledge of the likely impact of parental Alcohol Misuse and domestic abuse on children's safety and welfare would have led to more informed assessments and effective intervention.

Did any agency working with this family fail to recognise previous evidence of risk of significant harm or need? Where such evidence exists was it shared and/or acted upon in an appropriate and timely manner? ToR 2.3

In relation to this child, was there a failure by agencies in working with this family in not recognising evidence of risk of significant harm? If such evidence exists, was this shared and/or acted upon in an appropriate and timely manner? ToR 2.1

Were members of the immediate and extended family assessed as supportive and appropriate carers for Child M and/or was the appropriateness of these persons considered in the management of the case? ToR 2.6

Do any issues emerge in relation to the provision of services to persons in the immediate or extended family who misuse alcohol? ToR 2.4

3.1.1 There is a considerable amount of research on the impact of parental substance misuse (including alcohol) and domestic abuse on children. It is for this reason that systems have been set up for the police to share information with Children's Social Care. However, this information sharing is only effective if knowledge about the impact on children is used in analyses to prompt and inform assessments. Although information was shared by the police with Children's Social Care, the relevant knowledge of its impact did not inform assessments and subsequent interventions. This was a barrier to identifying intervention to safeguard Child M.

3.1.2 **South Gloucestershire Children's Social Care** had clear information about domestic incidents involving Mr F and Ms C and their use of alcohol. The first of these incidents was in 2003 when Ms A would have been 12 years old and her brother Mr A was 10. Over the next three years the police shared information which included reports of [redacted]. The very poor state of the home, and Ms A's living conditions in particular were reported when the police took Ms A home after she had run away. The collation and analysis of evidence from the police is identified by SGCSC as good practice.

3.1.3 The system for Ms A's school sharing information of concern also appears to have been effective. Ms A's attendance dropped dramatically during the summer of year 10. This is the period described above when the police reported on Ms A's living conditions and the parents' drunkenness. The school wrote to SGCSC to outline their concerns and view that Ms A was at significant risk and that her parents had withdrawn her from the school. The Education Welfare Officer provided information from the school which, combined with a telephone call from the police urging action, prompted an Initial Assessment.

3.1.4 However the focus of the Initial Assessment was on Ms A's behaviour and the stress this was causing her parents. Thus the good practice of sharing information was negated by the failure to use knowledge of the impact of alcohol misuse and domestic abuse on children when undertaking the assessment. The timing of this Initial Assessment was in 2007 at which point research on the impact had been well documented and shared for example in Howe (2005) The use of the Framework for the Assessment of Children in Need (2000) which all Social Workers must use in undertaking Initial Assessments, and research about the impact of domestic abuse and parents who misuse drugs (alcohol in this case), would have produced a very different assessment and subsequent plan. Particular risk factors in this case are that both parents are alcohol misusers and the children had been exposed to domestic abuse.

3.1.5 An effective Initial Assessment would have involved both Mr F and Ms C in the process. The impact of their alcohol misuse and domestic abuse on the functioning of the family needed to be explored with them. This would have challenged their view that Ms A was the problem. The safety of both the children in this environment needed to have been explored using the information available. The SGCSC IMR author notes that Ms A and Mr A may have been identified as children likely to suffer significant harm. In which case it would have been made clear to the parents by Children's Social Care that the parents had to address their alcohol misuse. Both children's experience through skilled interviewing could have provided more insight into their lives. Engaging the children's schools and health services in the analysis and plan may have enabled Ms A to be supported to remain at school and at home. Velleman (2007) notes how children can be helped to be more resilient to cope with the negative impacts of parental alcohol misuse.

3.1.6 What actually happened was that there was no challenge to the parent's behaviour or investigation into the risk of significant harm to either child. There was no response by SGCSC to Ms C withdrawing Ms A from school, possibly to avoid prosecution. The support plan for Ms A from the Initial Assessment failed to recognise and address her problems. She did not engage with the service provided and the case was closed in July 2007. There is no evidence that anything had actually improved. There was no consideration of any risks to Mr A who was only [redacted] at the time. The completion of the Initial Assessment number 1, without addressing the risk of significant harm to both children, is a key decision making point.

3.1.7 To summarise, despite the evidence of good information sharing and the potential for effective multi agency working, there was no assessment of the risks of significant harm posed to children cared for by Mr F and Ms C using what is known about the impact of parental alcohol misuse and domestic abuse.

3.1.8 Ms A subsequently had Child M the following year in May 2008. She returned to live with Ms C and Mr F when he was 2 days old. The following day the police attended the home and were aware that Child M was at the home during a domestic abuse incident. However, no referral to Children's Social Care was completed. This was a missed opportunity to identify the risk of significant harm to Child M. Later in December 2008 Child M was again at home with Ms C when the police were called to deal with a domestic abuse incident. On this occasion the information was faxed to SGCSC. There is evidence that SGCSC made the connection between this incident and previous information about Ms A and Mr A as children. The IMR Author notes that the decision not to investigate further was taken without looking at any of the history gathered the previous year. Had an investigation taken place, risk of significant harm to Child M could have been assessed taking into account further information from the police about not only this recent incident, but other evidence [redacted] It would have been clear that Child M was being cared for in a household where alcohol misuse and domestic abuse by adults was a long standing problem. Learning from Serious Case Reviews (Brandon 2010) highlights the risks in these circumstances. This includes the risk of poor supervision, which tragically proved to be the case for Child M.

3.1.9 *Actions to address issues raised.* The SGCSC IMR author has produced an open and critical analysis of practice. The same author completed an IMR on Baby S in 2009 which identified many of the same issues in relation to Initial Assessment practice. The practice in relation to Ms A and Child M as noted above, pre dates the Baby S Initial Assessment. It is therefore further evidence of the same issues which are now being addressed by SGCSC. However the specific issue of whether staff have good knowledge of the impact of alcohol misuse and domestic abuse on children has not been considered. This is a particular issue in the Child M Serious Case Review. There were two occasions when failures to complete an Initial Assessment would suggest that managers did not make those decisions based on knowledge of the impact of domestic abuse and alcohol misuse on children. This is true also of the manager who signed off the Initial Assessment on Ms A. It should be noted that the lack of resources were not seen to be an issue. The most recent Ofsted report on SGCSC in July 2010 stated that 'the quality of assessments was at least satisfactory in almost all cases seen by inspectors. The level of analysis is strong and effectively balances protective factors with area of risk.' This is evidence that current practice has improved.

3.1.10 **Bristol Children and Young Peoples Service** – Children's Social Care, (Bristol CYPS) completed two initial assessments. Both are analysed thoroughly and critically by the IMR Author. The Social Worker in the first initial assessment which was pre-birth contacted SGCSC and was provided with information about Ms A's difficulties as a teenager. A more

thorough Initial Assessment as outlined in paragraph 3.1.5 would have informed this fresh assessment and alerted the Social Worker to the potential risk of significant harm to Child M when born. This fresh assessment is itself inadequate in depth, failing to explore the reason for Ms A's late booking for ante natal care, [redacted]. Ms A clearly told the Social Worker that Ms C was a main source of support. However the Social Worker did not consider that the knowledge she had about Ms C's [redacted] and the history of domestic abuse had any implications for either the welfare of Ms A or Child M. The focus of the assessment and subsequent service provision was practical but did not consider any risk issues.

3.1.11 The second Initial Assessment was completed by a different Social Worker following a referral from GWAS with concerns about the physical conditions Child M was living in. The IMR author notes this assessment similarly took no account of Ms A's or Mr B's history.

3.1.12 *Action to address issues raised***.** The IMR author recommends action to improve the thoroughness and quality of Initial Assessments and this is described in detail in the action plan.

3.1.13 **Avon and Somerset Constabulary** has been shown in this Serious Case Review to have made efforts to identify incidents which need to be shared with Children's Social Care. This provides evidence that knowledge about the impact of parental alcohol misuse and domestic abuse is being used in practice. More recent practice is for the constabulary to also inform health and there is evidence that this is happening. Practice is not however consistent and there were two occasions highlighted in the integrated chronology where opportunities to share information were missed. These are in May 2008 when the police were called to a domestic abuse incident between Ms C and Mr F. Child M was at the house and was two days old. The second is in July 2008 when Ms A reported that Mr B had not returned Child M. It was at this point that Ms A and Mr B had split up. [redacted] This was a potential volatile situation. There was good practice by the police who checked that Mr B was capable of looking after Child M. However the IMR author notes the vulnerability of Child M and that the information should have been reported to the Public Protection Unit.

3.1.14 *Action to address issues raised.* The IMR author identifies improvements to practice and recent training has addressed the issues raised. The analysis is very thorough and transferred to the lessons and recommendations.

3.1.15 **The North Bristol Trust IMR** identifies that health visitors recorded information about the maternal grandmother's alcohol use. Information

known to health visitors is summarised in section 2.3 above. However this was not used in Family Health Needs Assessments to consider the potential risks to Child M despite the fact that it was clear she was caring for him regularly.

3.1.16 *Action to address issues raised.* A lesson identified by the IMR author is that there was insufficient information or details in the record to allow any practitioner to assess the potential risks this may have posed to Child M. This is followed through to a recommendation to improve information gathering.

3.1.17 **The GP IMR** evaluates the efforts made to assess Ms C's alcohol use and subsequent treatment. The SCR Panel expert noted that this was good practice. However, the GP IMR author notes that staff treating Ms C did not consider the impact on a child living with an adult using alcohol to excess. Similarly, the GP treating Ms A did not appear to consider the implications or her drinking to excess (see paragraph 2.5.56). One of the reasons behind this was uncertainty about what support was available for parents with alcohol dependency because of past experience of trying to get help. This will be covered in more depth in section 3.2.

3.1.18 *Action to address issues raised.* The IMR identifies two appropriate lessons and recommendations which address the need to 'Think Family'.

3.1.19 **Overview Author Summary.** There is good practice to highlight as noted where the police have identified concerns about the impact of alcohol misuse and domestic abuse on children and shared this information. However one of the themes of this Serious Case Review is that the knowledge from research is not embedded in practice, particularly by Children's Social Care in both local authorities. It is not clear from the action plans that this specific issue has been addressed. Research by Galvani (2008) highlighted that Social Work students felt ill prepared for work with service users to tackle substance misuse and domestic abuse. It could be that the poor practice revealed in this Serious Case Review reflects that same lack of knowledge and skills in putting research into practice. The fact that this is a theme across both authorities suggests that this is not limited to individual practitioners or managers. The assessment practice of GPs and Health Visitors is similarly lacking. The need to address this issue is further emphasised by national statistics about the prevalence of children living with hazardous drinkers reporting abuse and neglect (Manning 2009). BSCB has published guidance,' Working with children of problem drug/alcohol users' in April 2008. This too provides statistics showing the significance of parental alcohol use, making the point that the extended family, including grandparents, should be included in the assessment. However this guidance was not referred to in any of the IMRs which suggests that it needs to be revised and re-launched in the light of learning from this case.

3.2 Perceptions of high thresholds for Children's Social Care were a barrier to action.

Evaluate whether the work in this case was consistent with agency and LSCB policy and procedures for safeguarding children and wider professionals' standards and values. ToR 1.9

3.2.1 This issue was raised in two IMRs. **The GP IMR** noted that one GP believed that Children's Social Care would not accept a referral regarding the care of young children by an 'alcoholic' patient. This was raised as a barrier to considering whether the care of Child M by Ms C should have prompted intervention by the GP.

3.2.2 The **Cafcass IMR** notes that the reason given by the manager for not initiating a referral to Children's Social Care, was the manager's knowledge and understanding of thresholds, having worked in Children's Social Care. See paragraph 3.3.11.

3.2.3 **Overview Author Summary.** Both professionals use this barrier as a reason for failing to take any action. This perception prevented them considering that a referral to Children's Social Care would have been a means of sharing information. Even if it did not prompt an Initial Assessment, which in the Cafcass case it most likely would have done, the proposal could have been for a CAF.

3.2.4 There is no evidence that the practitioners interviewed knew of, or referred to, guidance on thresholds which both BSCB and SGCSC produced in 2009. This SCR and that of Baby Z, are both deaths of small children cared for by substance and alcohol misusers. The Baby Z SCR (paragraph 1.5.6) prompted the guidance as noted in paragraph 3.1.19 and guidance on thresholds produced by BSCB. The Baby S SCR in South Gloucestershire prompted the implementation of multi agency guidance on thresholds. On its own, this written guidance is unlikely to challenge perceptions based on a practitioner's own experience of referral thresholds. The issue of when and whether to make a referral is addressed in The Munro Review of Child Protection Interim Report: The Child's Journey (2011). This report considers the value of providing social work expertise to talk through a concern before a referral is made. Professor Munro notes that 'more sense is made of the presenting concern and information, and a consensus reached about the best next steps'. This expertise is provided in some areas by Social Workers based in the community with universal services.

3.2.5 It should be noted the Bristol City Council Ofsted Inspection of Safeguarding and Looked After Children Report in April 2010 noted 'clear and agreed thresholds for access to safeguarding services which are widely understood across the partnership' (page 10). Similarly South

Gloucestershire Ofsted Unannounced Inspection of Children's Services In July 2010 notes that 'thresholds for access to social care services are well understood and operate effectively across partner agencies' (p2). Both inspections took place around the time that Child M died. Whilst the Ofsted evidence indicates a broad understanding of thresholds, it could be that the perceptions which posed a barrier to referral, relate specifically to issues of alcohol misuse and neglect.

3.3 Managerial decisions about resource allocation impacted on the quality of the assessment and service provided to Child M

Establish whether actions taken accord with the assessments that were undertaken and the decisions that were made. Determine whether appropriate services were offered and/or provided for the child and family. ToR 1.5

Evaluate whether the work in this case was consistent with agency and LSCB policy and procedures for safeguarding children and wider professionals' standards and values.ToR 1.9

In relation to this child, was there a failure by agencies in working with this family in not recognising evidence of risk of significant harm? If such evidence exists, was this shared and/or acted upon in an appropriate and timely manner? ToR 2.1

3.3.1 As noted, resource allocation was not identified as an issue in relation to the service provided by South Gloucestershire Children's Social Care or the first Initial Assessment provided by Bristol CYPS, [redacted] However the second Initial Assessment and subsequent intervention under Section 17 Child in Need (Children Act 1989), was affected by resource problems.

3.3.2 **Bristol CYPS Social Care** made the decision to allocate the second Initial Assessment promptly in response to the referral from GWAS. Ambulance staff attended the Ms A's flat where she was living with Child M (aged 14 months) to take Child M to hospital. Staff were concerned at the state of the child's home with 'cat faeces on the floor, child in living room with bodily mess and in a poor state'. These are the details noted by the GWAS IMR author from the referral. The referral and focus on the child's living environment shows good practice in considering the impact of the environment on Child M.

3.3.3 Although the Initial Assessment was commenced promptly and progress regularly supervised by the manager, there are some issues of concern about the practice of the individual Social Worker and supervision of the case by the Manager. Part of the reason for these failures was resource

pressures on the team. The service offered to Child M is detailed as follows.

3.3.4 Despite the concern being about possible physical neglect, there is no evidence that the Social Worker saw Child M until 22 October, over two and a half months after the commencement of the Initial Assessment. Neither had the Social Worker contacted the Health Visitor as part of the Initial Assessment process; this was not done until 16 November. The case was allocated as a Child in Need case on 11 August without sufficient investigation to ascertain whether Child M was at risk of significant harm. In fact, information which was obtained from the nursery should have heightened concerns. Child M was reported to be unkempt with ingrained dirt under his fingernails. He was frequently in a soiled nappy and his clothes were dirty. His maternal grandmother (Ms C) sometimes dropped Child M at the nursery. [redacted]. Later information from the Health Visitor noted concerns about the maternal grandmother's 'use of alcohol and alcohol fuelled violence in the extended family'. Child M was no longer attending nursery, which would have been a protective factor. Ms A had dropped out of college [redacted]. She revealed to the GP that she was drinking excessively at weekend. There was conflict about access to Child M by his father Mr B which the Social Worker did not explore. This was all evidence that the situation was not improving for Child M. In the whole time between the Initial Assessment commencing and the closure of the case, the Social Worker saw Child M once on 22 October and the Health Visitor saw him once asleep on the sofa on 7 December. The decision to close the case was confirmed by the Manager without the proposed plan for a CAF or Child in Need Review having taken place. No referrals for services as discussed in earlier supervision with the manager took place. This included an Early Years Referral for nursery and referral to Child and Family Support. Before the case closed the Social Worker recorded that it was agreed that the Health Visitor would do the referral to Barnardo's but in fact this was not actioned until March 2010. This recording does not match the findings of the Health Combined IMR Author who notes that there is no indication in any health records when Child M's case was closed by the Social Care team or what actions were planned or expected of their service in relation to the neglect concern raised by GWAS.

3.3.5 It is clear from this description that an inadequate assessment of risk of significant harm was made and that even if Child M was correctly assessed as being a Child in Need, he did not get any service to address these needs. The supervisor's request for there to be a clear plan for Child M addressing the 5 outcomes does not appear to be followed through. In fact it could be argued that Child M was receiving less service when the case was closed because he was not attending nursery. No services to support Ms A were provided or enabled at the point when the case closed.

3.3.6 As noted in 3.3.3, the Bristol CYPS IMR author noted that part of the reason for these inadequacies is resource allocation. There is a process for Team Managers to quality assure Initial Assessments. However the volume of Initial Assessments in a month could be part of the reason why the inconsistencies in the Initial Assessment were not picked up.

3.3.7 Much of the explanation of the poor practice as described in 3.3.4, relates to a structural issue about resource allocation decisions. The Social Worker managing the case of Child M, was continuing to manage a high risk case, which should have been transferred to another team, in line with service policy at the beginning of August 2009. However, because there was insufficient capacity in the receiving team, it was not transferred until November 2009. This case required daily intervention until early October. In the prioritisation of cases, it was agreed that Child M was low priority. This decision must have been made before Child M had been seen by the Social Worker or contact made with the Health Visitor.

3.3.8 The report of the Ofsted annual unannounced inspection in September 2009 noted that Social Worker caseloads are too high, which impacts upon the capacity to close and transfer cases in a timely way. This appears to reflect the same issue as identified by the IMR author. The Annual Report of Safeguarding and Looked After Children's' Services published in April 2010 also noted action to be taken regarding caseloads. Another relevant development area was the need to improve the quality of Child in Need plans to ensure required actions are documented in measurable ways within set timescales. This is also relevant here.

3.3.9 The Baby Z Serious Case Review published in February 2009 similarly identifies the need for Bristol Safeguarding Children Board to develop systems to co-ordinate Children in Need cases. The outcome sought is for 'children assessed as being in need to have their needs assessed and a children in need plan drawn up, implemented and effectively monitored to meet their needs'. The action plan notes that that the implementation of new procedures was to be taken forward as part of the BSCB business plan for 2010.

3.3.10 *Action to address the issues raised.* Bristol CYPS initiated an action plan to address the case transfer difficulties in early 2010 which has reduced the transfer backlog. The IMR author is clear that this is still an area of concern. Other staffing and capacity problems are identified as having been addressed and there is supporting evidence provided in the IMR and to the panel. Recommendation 3 is that there should be a review of the Case Transfer policy. Although Recommendation 4 addresses the issues of care pathways, the issue above is more about the management of Children in Need cases by Children's Social Care. This is analysed in section 3.6.

3.3.11 **Cafcass** failed to follow through safeguarding checks and did not complete an adequate risk assessment using all the information available. This included allegations of the neglect of Child M by Ms A and concerns about Ms C with whom Ms A was living. The IMR author is clear that a referral should have been made to Children's Social Care in July 2008. One of the reasons for the failure to make a referral was that the Family Court Advisor (FCA) believed that the case did not meet the threshold for referral under S17. The FCA had previously worked for Bristol CYPS and based her decision on this experience as a Senior Practitioner (para 3.2.2). The IMR author also provides a thorough analysis of the impact of service restructuring, lack of management resources and high workloads on the effectiveness of Cafcass, which impacted on the management of this case. Priority was given to the production of Section 7 reports where there was a backlog. Additional resources could not be made available for work such as required in the Child M case.

3.3.12 *Action to address the issues raised.* The IMR notes that action was taken to improve management cover. However this was reactive. The need for a planned response is addressed in recommendation 4.

3.3.13 **Overview Report Author summary.** It is clear that managerial decisions about resource allocation impacted on the management of this case. Because of resource pressures, the case was given low priority by both Bristol CYPS and Cafcass. The perception that information about the neglect of a child is not a priority for Children's Social Care is evidenced in the interviews with the FCA, the GP and the decision made the Social Work manager as noted in paragraph 3.3.4. This is also addressed in section 3.2 above. Research by Broadhurst et al (2010) suggests that the practice of prioritising child protection when teams are under pressure, can lead to down grading of other work and errors through cutting corners. One such corner cut is the failure to contact the Health Visitor as part of the Initial Assessment. Similarly Cafcass failed to follow through safeguarding checks and complete an adequate risk assessment. Broadhurst notes that errors are most likely to occur in situations where there are high referral rates and/or worker inexperience, turnover or sickness. This appears to be the case as described by both the CYPS and Cafcass IMR authors. The research by Broadhurst et al asserts that it is dysfunctional practices which create the conditions which lead to such errors and this connection should be identified where relevant in Serious Case Reviews.

3.3.14 **NHS Bristol Health Visiting Service** IMR identifies the pressures on Health Visiting services during the period of the Serious Case Review. The author notes that despite these pressures all routine visits were undertaken. There was good practice in the persistence of the Health Visitors to track down Ms A to ensure she was seen, Family Health Needs Assessments were done as were routine developmental checks which did

not identify any serious concerns about Child M. Health Visitors were able to respond to requests from the Social Worker undertaking the most recent Initial Assessment (the only one relevant to Health Visitors).

3.3.15 What is most noticeable from reading this IMR is that no one Health Visitor established any relationship with Ms A until 2010. In the two years covered by this Serious Case Review, seven health visitors were involved out of whom four had direct contact with Ms A. There was no opportunity to develop a trusting relationship although there is evidence that Health Visitor 7, who worked with Ms A from March 2010 onwards, was engaging well with Ms A. Referrals to services were slow to be followed through because of a lack of continuity until Health Visitor 7 facilitated the involvement of Barnardo's. There was a lack of liaison with GPs. The GP IMR author notes that GPs need to 'Think Family'. It could be argued that it is part of the Health Visitor role to prompt and develop this concept through discussion with the GP. If Health Visitors had liaised with the Social Worker and GP to analyse what was known and the implications for Child M, a more rounded assessment of the risk of significant harm could have been made. There was telephone contact between the Health Visitor and Social Worker but such a discussion is not conducive to reflecting on all the information available in order to come to a considered assessment. However it should be noted at this time that two different Health Visitors were involved which would not have helped continuity of planning. It was work pressures which prevented the Health Visitor doing a joint visit with the Social Worker. Such a joint visit may have enabled better reflection on all the known information.

3.3.16 *Action to address issues raised.* The Health Visitor IMR includes a recommendation which focuses on improving recording routine work to ensure work plans are carried out. The Combined Health Management Review recommends a policy for all teams ensure planned work is held centrally to enable continuity of work.

3.3.17 **Overview Report Author Summary.** Managerial decisions about health visitor resources impacted on this case insofar that shortages were tackled by using Health Visitors from other bases and bank Health Visitors to help out. This was positive in that all necessary visits were made as noted and there was liaison with the Social Worker. The negative impact was that no one Health Visitor established a relationship with Ms A over time. Although the recommendations above address the issue of planned work being followed up, such as referrals, it does not address the issue of continuity of worker. The second negative impact was as noted above, was that the Health Visitor was not able to do a joint visit with the Social Worker in November 2009.

3.4 Decisions about needs were made using snap shots of presenting issues

Were members of the immediate and extended family assessed as supportive and appropriate carers for Child M and/or was the appropriateness of these persons considered in the management of the case ToR 2.6

3.4.1 Although most of the services described in IMRs have assessment processes, none used the information available to complete an holistic assessment of Ms A in order to identify her needs and offer services to improve outcomes. The information available was not used to assess the risk of significant harm as noted. The three Social Care Initial Assessments did not explore in any depth Ms A's background and the impact on her or her care of Child M. Information which might have prompted more exploration of her behaviour and experience such as her late booking for ante natal care was not identified as relevant to the assessment. Research, such as that available on the South West Child Protection Procedures (SWCPP), suggests that lateness in acknowledging a pregnancy may indicate ambivalence towards the pregnancy, immature coping styles and a tendency to disassociate, all of which are likely to have a significant impact on bonding and parenting capacity. There is no evidence that this research was used in the second Initial Assessment.

3.4.2 The assessments about how Ms A was coping with the new baby were taken as snapshots out of the context of looking after the baby in her own flat, managing her own finances. In hospital she was seen to be caring independently for the baby. She returned to live with her mother Ms C with the new baby and was assessed by the midwife as needing guidance but again coping. What those professionals did not see was that within 2 days of Child M returning to live with Ms C, Child M was in the midst of a domestic abuse conflict between adults who had a history of alcohol misuse and violence. Something of this history was known by the midwife whose notes included that Ms C had 'issues with alcohol'. When Ms A returned to her own flat to live with the baby and Mr B there was little monitoring of how she was coping. As noted in paragraph 2.2 there was a lack of sensitivity regarding Ms A's maturity and inexperience.

3.4.3 Within two months, Ms A and Mr B had split up. Ms A was living on her own. There was conflict over Mr B's contact with Child M. [redacted] It is to the credit of the Health Visiting service that efforts continued to see Child M. When this finally occurred, a Family Health Needs Assessment was completed. It was noted at this time that Ms A's maternal family home was chaotic and that the maternal grandmother Ms C had an alcohol problem. The records of this visit note that Ms C and Mr F looked after Child M on week ends. What the Health Visitor saw were

two parents, Ms A and Mr B relating well to their baby. There were no concerns about his physical health. Yet all the information the Health Visitor had did not prompt her to question whether Child M was at any risk when being cared for in a chaotic household by an adult with an alcohol problem. Shortly after this assessment, the Health Visitor received a notification from the police about arguments over money between Ms A and Mr B.

3.4.4 Subsequent home visits by different Health Visitors provided consistent reports of good attachment between Child M and both parents. There were no concerns about his developmental milestones. The point that Child M could be assessed as being bright and meeting developmental milestones but still could be at risk when looked after by the maternal grandparents was never explored. Even when Ms A revealed that she drank to excess on week ends, this did not prompt any concerns about Child M's safety by the GP.

3.4.5 Rose and Barnes (2008) in their study of serious case reviews 2001-2003 noted that children growing up in these circumstances 'showed astonishing resilience – they were bright, intelligent, alert and resourceful even as toddlers. It did not mean, however, that they were less prone to danger or harm, sometimes the reverse. Their very resilience meant that some children placed themselves in potential danger without appropriate parental or other adult oversight' (p15).

3.4.6 **Overview author summary.** There is considerable evidence from the IMRs that assessments were made using what was seen of Child M together with Ms A and Mr B without considering the possible risk of harm indicators as outlined in section 3.1. The evidence of these mainly visual assessments completely outweighed other information which should have prompted a consideration of the risks of poor supervision when Child M was looked after by his parents and maternal grandparents or even staying in the grandparents' home with his mother during domestic abuse incidents. The Bristol CYPS IMR includes a relevant recommendation to improve assessment practice using all the information available to complete the Framework for Assessment of Children in Need. The Health Visitor IMR is ambivalent about whether there should be an expectation for wider family members to be assessed as suitable carers in Family Health Needs Assessments. This case suggests that if all factors had been taken into account regarding parenting capacity, this would have been an appropriate expectation, albeit completed together with the Social Worker as noted in paragraph 3.3.15

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3.5 Some agencies need help in order to understand their role in improving outcomes for children

Evaluate to what extent practitioners involved were sensitive to the needs of the child in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about the child ToR 1.2

In relation to this child, was there a failure by agencies in working with this family in not recognising evidence of risk of significant harm? If such evidence exists, was this shared and/or acted upon in an appropriate and timely manner? ToR 2.1

3.5.1 The **Bristol Youth Offending Team** had information [redacted] attempts to contact her revealed that she was pregnant. Had the YOT officer investigated further it would have been revealed that the conviction was in the context of Ms C's behaviour. There was evidence that Ms C had driven with excess alcohol and that Ms A, already pregnant with Child M was a passenger in the car at the time. This was evidence of safety and supervision risks posed by Ms A's mother. Involving Ms C in the ASSET assessment in a skilled way could have prompted some education about the risks [redacted] to both Ms A and her then unborn child. Ms C declined involvement with the YOT on Ms A's behalf. The YOT did not consider contacting Children's Social Care to share the information it had and consider it's relevance to safeguarding Child M. This appears to be because of a narrow understanding of the agency responsibility for safeguarding.

3.5.2 *Action to address this issue*. The YOT IMR author has identified that there has been some learning through participating in the Serious Case Review process. Policy and systems have been changed, prompted by the panel feedback on the initial IMR. The action plan notes improvements in response to a recent inspection. It is not completely clear however from the IMR that the YOT understands how the assessment process could be used constructively to improve outcomes for young people and their children.

3.5.3 Ms A clearly valued the service provided by **Connexions**. She sought help from Connexions and there is evidence that she had aspirations to be a teacher and was willing and committed to this aim. The Connexions IMR author explains why Ms A only had very limited face to face contact with Connexions PAs (Personal Advisors). She chose to use drop in centres rather than her allocated PA. Connexions do have the facility to use an holistic assessment tool but this was never used because Children's Social Care were involved. Although some monitoring took place, Connexions has identified that more proactive monitoring of Ms A's progress could have taken place. Staff did not consider at the time what

approach may best engage with a young person in this situation. As a result, Connexions was unaware that Child M had lost his nursery place when Ms A dropped out of college or [redacted]. Connexions did not know that Ms A was not coping [redacted].

3.5.4 *Action to address the issues raised*. The IMR does include a set of learning points and recommendations which address most of the issues raised. However it would be good to be certain that Connexions understands how their work can impact on outcomes for the children of young people for whom they provide a service.

3.5.5 **The Private Day Nursery IMR** was not able to provide any information about Child M and it was not clear that the author understood how the nursery could have contributed to improving outcomes for Child M.

3.5.6 **Overview Report Author summary.** Although most agencies have used the Serious Case Review process to reflect on their practice and how they can improve outcomes for children, Bristol and South Gloucestershire Safeguarding Children Boards will need to consider how best to ensure that all agencies have a good understanding of their safeguarding role.

3.6 'Child in Need' processes did not involve the parents, wider family and professionals in making an assessment and identifying what services should be offered.

Evaluate whether the work in this case was consistent with agency and LSCB policy and procedures for safeguarding children and wider professionals' standards and values. ToR 1.9

3.6.1 There were three Initial Assessments completed by Children's Social Care as noted in the integrated chronology summary. Had a significant risk of harm been identified through a Section 47 (Children Act 1989) investigation, the process of assessment and planning would have involved multi agency meetings with the parents in order to pool information and make sense of the information available. A risk assessment would have identified protective factors and risks. There are occasions identified by IMR authors when such an approach should have been considered and these are identified in the integrated chronology. The barriers to this happening are identified by IMR authors and covered in other sections of this analysis.

3.6.2 What did happen on two occasions was that the case was allocated to a Social Worker to provide a service using S17 (Children Act 1989) legislation. This is referred to as Child in Need. However the practice of both Bristol and South Gloucestershire Children's Social Care Services in this case did not effectively enable multi agency involvement together with

the parents and wider family to complete an assessment and plan. It has been confirmed that Bristol CYPS policy, procedure and guidance states that Child in Need reviews should include all those involved in the Child in Need plan**.** There is also provision for family group conferences in difficult cases. Although the Bristol CYPS IMR author identifies that expected consultation with professionals did not occur, there is no expectation of a multi agency meeting to include family members as part of the Child in Need plan or review.

3.6.3 Multi agency involvement could have brought together information which would have helped identify the potential risks to Child M which paragraph 2.3 shows was known by agencies. Involving other professionals such as Connexions could have created a greater understanding of the role each had to play in safeguarding and meeting the needs of Child M. The interview with Child M's paternal grandfather as part of this Serious Case Review, confirms that grandparents had a significant role in the care of Child M and could have made a helpful contribution to assessment and planning. Mr D was however unaware of any agencies' involvement.

3.6.4 In contrast, had the case been identified as being below the threshold for Children in Need support, a Common Assessment Framework (CAF) the processes used could have included a multi agency meeting, involving the parents and wider family carers.

3.6.5 Some IMR authors consider whether the use of the CAF process would have helped to meet the needs of Child M. The following summary analyses the benefits of this process and the barriers to its use.

3.6.6 **UHB NHS Foundation Trust IMR** notes that a recommendation from the Family Q Serious Case Review (not a local SCR), was that a CAF should be considered for all teenage pregnancies. One of the trust recommendations is for local guidance including when to consider a CAF.

3.6.7 At the time Ms A delivered Child M, midwives were not trained in initiating CAFs. The midwife did initiate an Initial Assessment but the case was closed after the assessment was completed with no ongoing plan or monitoring in place.

3.6.8 **North Bristol NHS Trust – Health Visiting IMR** has identified the barriers to completing a CAF. This includes the training time for Health Visitors already under pressure and the time taken to complete an electronic CAF. Other barriers include the fact that the trust covers different local authorities who all have their own processes and training. The IMR author did consider whether a CAF would have been helpful. Her conclusion was that the Health Visitor was able as a single agency to refer to other services and that as such a CAF would have been just another process.

However, a CAF may have enabled co ordination of agency provision such as Connexions, Debt Advice and Family Support.

3.6.9 **Bristol CYPS** IMR author notes that a new process of completing a pre CAF assessment before closing the case is being used in one team. The form is completed with parents and then sent to the Multi Agency project for assessment and completion of a full CAF. This would provide a seamless route from a statutory service to universal services. The action plan includes a recommendation to ensure clear pathways between different levels of need. (Bristol CYPS Recommendation 3)

3.6.10 **Overview Report Author Summary.** What is striking is that had either Child Protection (s47) processes or CAF processes been initiated, a multi-agency meeting and involvement of the parents would have been assumed as being good practice. By contrast, Child in Need (s 17) review processes were not used by either local authority in this case to enable agency and family participation. IMR authors identify the barriers to CAFs and the need to clarify the pathways between different thresholds such as Child in Need to CAF. However, a significant issue appears to be how multi agency and family involvement is enabled in Child in Need cases. This was an issue raised in the Baby Z Serious Case Review as noted in paragraph 3.3.9. This review noted that 'greater multi agency working may have provided earlier assistance….and ensured professionals were more vigilant… The issue of whether Baby Z was a child at risk or not would matter less if Bristol Safeguarding Children Board had a more co-ordinated response to Children in Need'. The main recommendation of this review was that Bristol Safeguarding Children Board should better develop the co-ordination of services for all children in need. This conclusion appears to have relevance to the management of Child M although it should be noted that in the Baby Z case, the co-ordination issues were between adult and children's services. In the case of Child M, the key mechanism for co-ordinating services was the Child in Need assessment and review processes.

3.7 Summary of good practice

Is there good practice to highlight, as well as ways in which practice can be improved? ToR 3.2

3.7.1 The Housing Support Worker's engagement with Ms A showed good skills. She established a trusting relationship and provided a good link between agencies. Her approach was positive and sensitive to the needs of Ms A and Mr B and provided practical help (paragraph 2.2.5). She encouraged Ms A to take up opportunities. She put in a great deal of effort into finding suitable resources to tackle the issue of parental capacity. She had valuable insights into the issues for Child M and his parents. Her skills and knowledge could have been put to better

advantage if they had been co-ordinated with the Initial Assessment and a subsequent support plan.

3.7.2 Health Visitors showed persistence in tracking down Ms A and Child M to ensure family health needs assessments and developmental checks were completed (paragraph 3.3.14). Health Visitor 7 had begun to engage with Ms A and Mr B. She enabled the involvement of Barnardo's (paragraph 3.3.15).

3.7.3 The use of Connexions advice by Ms A suggests that she valued the service (paragraph 3.5.3).

3.7.4 Avon and Somerset Constabulary collation and analysis of information about domestic abuse incidents involving Mr F and Ms C and concerns about Ms A were shared with South Gloucestershire Children's Social Care. This prompted the first Initial Assessment relating to Ms A (paragraph 3.1.2).

3.7.5 Similarly, Ms A's school identified and shared concerns with SGCSC about the welfare of Ms A (paragraph 3.1.3).

3.7.6 The efforts made by the GP and other staff to assess and treat Ms C's alcohol use showed good treatment practice (3.1.17).

3.7.7 GWAS staff understood the significance of Child M's living environment when making a referral to CYPS (paragraph 3.3.2)

3.7.8 **Overview Report Author summary.** Although there is good practice identified, its impact was restricted because of the issues as raised in this analysis.

4 CONCLUSIONS AND RECOMMENDATIONS

4.1.1 The integrated chronology summary identifies the occasions when indications of the risk of serious harm should have prompted consideration of a Child Protection Investigation. In July and August 2008 when Child M was 2 months old both Avon and Somerset Constabulary and Cafcass note they should have taken action to assess the risks. Information already known to different agencies about the potential vulnerability of Child M is identified in detail in paragraph 2.3. The impact of domestic abuse, alcohol use and neglect on the parental capacity of Ms A and Mr B, if used in assessments, could have led to more effective interventions as noted in section 3. The suitability of Ms C as a carer was raised by Mr B with Cafcass and if followed up by a referral to Children's Social Care, could have initiated an assessment of the risk of significant harm to Child M.

4.1.2 Evidence of the neglect of Child M re-appeared a year later in July 2009. Many of the same issues emerge from information provided by GWAS and the nursery about poor living conditions and physical neglect of Child M. High caseloads and lack of resources impacted on the quality of assessment and joint work by the Social Worker and Health Visitor. No assessment was made of Ms C as a carer. No processes were used to bring together the family and professionals to contribute to the assessment and plan for the care of Child M. There is no evidence that outcomes for Child M had significantly improved when the case was closed to Children's Social Care in December 2009. It should be noted however that he was meeting his developmental milestones and there was no evidence of physical harm. More than one IMR author noted that the living conditions and problems faced by Child M and his parents were typical of much of the community in which they lived. As such Child M did not stand out as being at risk of serious harm.

4.1.3 In the time just before Child M died, Ms A and Mr B were engaged in working with the Health Visitor and Barnardo's to improve Child M's living conditions and development opportunities. Issues about his physical safety had been raised with his parents. Ms A and Mr B had taken Child M to see the GP as requested to check his height and weight. Ms A had earlier revealed to her GP that she was drinking heavily at week ends. The GP had concerns that Ms C was drinking heavily although this could not be confirmed. However, the impact of alcohol misuse on Ms A's and Ms C's ability to supervise an active toddler was not considered by any professional.

4.1.4 It is clear from this Serious Case Review that some agencies had information which suggested that the capacity of Ms C to care for Child M may have been affected by her alcohol use. However, no assessment by any agency identified whether any adult caring for Child M misused alcohol when he was in their sole charge. This means that, even with hindsight, it is difficult to conclude whether Child M's death was predictable. The need for improvements in assessment practice is the key lesson in this Serious Case Review.

4.1.5 The death of Child M could have been prevented by whichever adult was responsible for his care at the time. [redacted] The Serious Case Review Panel will need to review the conclusions and recommendations of this report when the criminal process has been completed to include any new information available at that point.

4.1.6 This Serious Case Review has been used constructively by most agencies to identify learning and relevant recommendations in order to improve their safeguarding practice. These recommendations are listed in appendix 4.

The following lessons and recommendations are drawn from the analysis in section 3.

Lesson 1
Professionals working with adults and children need to use their knowledge of how alcohol misuse and domestic abuse impacts on children's safety and welfare when undertaking assessments.

Evidence
Although professionals used relevant knowledge to identify what information needed to be shared, this knowledge was not used in assessments as identified in section 3.1.

Some IMRs reflected on relevant cultural factors and whether practice was sensitive to identified needs. The fact that Ms A's parents were described as [redacted] was recorded by some professionals but never explored fully to explain what this meant or how this impacted on Ms A as a child or on the care of Child M (paragraph 2.2.2).

BSCB has published guidance,' Working with children of problem drug/alcohol users' in April 2008. This guidance was not referred to in any of the IMRs which suggests that it needs to be revised and re-launched in the light of learning from this case (paragraph 3.1.19).

Recommendation 1

Bristol and South Gloucestershire Safeguarding Children Boards must ensure that knowledge from research about the impact of domestic abuse and alcohol misuse on the welfare and safety of children is embedded in assessment practice in all agencies. Action on this recommendation needs to include revision and re-launch of the BSCB guidance 'working with children of problem drug/alcohol users'.

Lesson 2.

Staff need to be clear about what should prompt a referral to Children's Social Care and their subsequent responsibility for responding to a concern raised.

Evidence
A barrier to making a referral to Children's Social Care was a perception that the case did not meet the threshold. This perception was used as a reason not to intervene. (paragraph 3.2.3)

Staff interviewed did not appear to be aware or refer to guidance issued by both safeguarding children boards on thresholds in relation to making a referral. (paragraph 3.2.4). The Munro report suggests that providing the opportunity to discuss possible referrals helps make sense of the presenting concern and information and agree next steps.

Recommendation 2

Bristol and South Gloucestershire Safeguarding Children Boards need to identify and promote how referrers can be helped to talk through a concern before a referral is made. This is in line with the solutions proposed in the Munro Review of Child Protection paragraph 2.38.

Lesson 3
Decisions about resource allocation impacted on the quality of assessments and services provided.

Evidence Resource pressures led to the case being given low priority by Bristol CYPS. This impacted on the quality of assessment and service provided (para 3.3.7).

Cafcass failed to follow through safeguarding checks and did not complete an adequate risk assessment. Lack of resources and high workloads were a factor in the management of the case (3.3.11).

There were resource pressures on the Health Visiting service during the period covered by the Serious Case Review. This meant that 4 different Health Visitors were involved with Child M. The impact was that there was not a chance to build up a trusting relationship with the family. The lack of continuity meant that referrals for services were slow to be followed through. Work pressures prevented the Health Visitor doing a joint visit with the Social Worker (3.3.17).

Recommendation 3

Bristol and South Gloucestershire Safeguarding Children Boards need to evaluate the impact of resource decisions on assessment practice**.**

Lesson 4
Visual assessments on their own are not sufficient to identify risks and needs. The Framework for the Assessment of Children in Need and their Families should underpin all agency assessments.

Evidence
Section 3.4 sets out how agencies did not use assessment processes to good effect. What was seen outweighed consideration of the risks to Ms A and Mr A as children and to Child M.

Recommendation 4

Bristol and South Gloucestershire Safeguarding Children Boards need to ensure that all agencies understand and use the principles underpinning the Framework for the Assessment of Children in Need in their practice. This could include an evaluation of assessment tools to identify whether and how they use the principles and framework for the assessment of needs.

Lesson 5
All agencies need to understand their role in improving outcomes for children

Evidence
Some agencies did not appear to understand how the service they offered, or information they had, could be used to improve outcomes for Child M and his parents. Section 3.5 sets this out in detail.

Recommendation 5

Bristol and South Gloucestershire Safeguarding Children Boards need to ensure that all agencies identify how the service they provide can improve outcomes for children and young people.

Lesson 6
The involvement of both parents and professionals from agencies in meetings together would have facilitated information sharing and understanding.

Evidence

Parents, wider family and other professionals were not brought together to contribute to assessment and planning (section 3.6). The impact was that wider family members who looked after Child M regularly were not involved in plans to

improve outcomes for Child M. Professionals worked in isolation and did not get the opportunity to contribute to information sharing or responsibility for providing services.

Recommendation 6

Bristol and South Gloucestershire Safeguarding Children Boards 'Child in Need' processes should ensure the involvement of parents and carers as well as other agencies in multi agency meetings to achieve improved outcomes for children.

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Appendix 2: Acronyms used in the report

ASSET	Assessment tool used by Youth Offending Services
ASW	Adolescent Support Worker
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BSCB	Bristol Safeguarding Children Board
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CDOP	Child Death Overview Panel
CPS	Crown Prosecution Service
CYPD	Children and Young Peoples Directorate
CYPS	Children and Young People's Service
E2E	Entry to Employment
EDT	Emergency Duty Team
EWO	Education Welfare Officer
FCA	Family Court Advisor
FHNA	Family Health Needs Assessment
GP	General Practitioner
GWAS	Great Western Ambulance Service
HSW	Housing Support Worker
HV	Health Visitor
IMR	Individual Management Review
NBT	North Bristol NHS Trust
NSPCC	National Society for the Prevention of Cruelty to Children
Ofsted	Office for Standards in Education
PA	Connexions Personal Advisor
PEYTU	Play and Early Years Training Unit
PNC	Police National Computer
PPU	Public Protection Unit
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SGCSC	South Gloucestershire Children's Social Care
SWCPP	South West Child Protection Procedures
SW	Social Worker
ToR	Terms of Reference
UHB	University Hospitals Bristol NHS Foundation Trust
YOT	Youth Offending Team

Appendix 3: List of IMR recommendations

IMR	Recommendations
North Bristol NHS Trust	1. The establishment of a shared system within each base of recording all planned visits and follow up's. 2. Sufficient information must be gathered by the practitioner, if a concern is reported, with regard to an extended carer and their ability to provide suitable child care.
United Hospitals Bristol NHS Foundation Trust	1. Review local guidelines for midwifery practitioners for the care of pregnant teenagers, across both acute hospital trust sites. 2. To introduce Local Guidance into the Children's Emergency Department to ensure that all information about social concerns etc shared by ambulance crews and any other professional, is included in discharge information to the Primary Health care Team which includes the GP, the Health Visitor and school nurse. 3. Ensure the teenage midwifery records are incorporated into maternal record. 4. To ensure that all social concerns highlighted during pregnancy are effectively transferred into the babies' main hospital notes and that the UHB Safeguarding Communication and Chronology 'green paperwork' is completed. 5. To continue to implement the trust medical records action plans regarding multiple notes: introducing mitigating actions wherever possible to reduce the risk.
General Practitioners (Bristol and South Gloucestershire)	1. (i).In addition to the general demographic data, GP records should contain information about which young people (under 18) live in a household, an assessment of any adult conditions and the impact that these may have on the young people who live in that household. (ii)All those delivering safeguarding training to primary care teams should highlight the 'Think Family' agenda in the training materials. 2. If an adult has a condition that may have an impact on a young child living in the household, for example depression or high alcohol use there should be documented liaison with the health visitor for the family. This should include acknowledgement of how this condition may affect the child. If health visitors are not located within general practices, there should

	be regular opportunities to have meetings and discussions about vulnerable families within their practices.
[redacted]	[redacted]
GWAS, Clinical Standards Manager	1. Review referral process to ensure that the child's GP is informed in the event of a referral being made 2. Ambulance service should ensure that they receive notification regarding the outcome of their referral and record this in their referral
NHS Bristol (Primary Care Trust) Integrated health IMR/Chronology	1. All health staff must record what actions are agreed between professionals, and ensure these actions are completed and reported to the other professional/ agency within the agreed timescale 2. To scope if GPs are informed in the midwifery discharge about any social care concerns and other agency involvement eg Social Worker, including names and contact details to seek assurance systems are in place if not develop guidelines and paperwork as soon as possible.
Children's Social Care, Bristol City Council Children and Young People's Service	1. An audit of thoroughness and quality of initial assessments is undertaken. 2. The CYPS Senior Management Team should review the implementation of the Case Transfer Policy by April 2011 3. That the Change Programme being undertaken by Children and Young People's Services should ensure that there are clearly understood and implemented care pathways between different levels of need. Children who have received social work intervention who require ongoing help should have their needs met by services for vulnerable children.
Children's Social Care, South Gloucestershire Council, Department for Children and Young People	A protocol in relation to notifications of incidents of domestic abuse and the response of locality social care teams is developed to include action in relation to children involved but not resident at the address.
Avon and Somerset Police (HQ Portishead)	1. "Recognising patterns" – Police to adopt a new approach to recognising trends in repeat Domestic Violence, and develop a menu of tactical options to respond to identified trend.

	2. "Providing information" – Leaflet/information pack to be adjusted by Headquarters Public Protection unit – signposting users to appropriate support agencies, and giving safety planning advice. 3. "Smarter information sharing" – Head of Police Public Protection Unit to continue consultation process with heads of partner agencies with a view to establishing one or more Multi-Agency Co-located Information Exchange Centres (as demonstrated by the current Multi-Agency Safeguarding Hub (MASH) in Devon) to cover the Avon and Somerset force area. Opportunities to develop aspects of this work to be progressed.
[redacted] Nursery, Proprietor	1. Nursery staff continue to access online training as part of their induction programme. This is arranged in the first week and training completed online within 5 working days of the log in access details being received. 2. The nursery records were well organised and easy to locate, they had been stored securely inline with EYFS requirements. This made it straightforward to investigate inline within the IMR remit.
Barnardo's, Assistant Director Children's Services	1. Referral forms should be amended to ask for information about previous as well as current involvement of agencies and workers should specifically ask the referrer whether the child/family has been known to Children and Young People's Services. 2. The Community Family Service should ensure that Referrers understand the importance of sharing all relevant information, by making it clear at the top of the referral form and on information given to agencies. This should be done by April if the service continues
CAFCASS	1. The Head of Service should ensure that supervision and team meetings reinforce those areas for practice improvement auditing programme of Work To First Hearing. 2. The HoS should ensure FCAs and Service Managers undertake specific mandatory training to improve:

	a) Recognition of the wider aspects of diversity including the vulnerability of parents and children as a result of their family history and social circumstances b) Understanding of the evidential links between these factors and risks to children 3. Service Managers reinforce learning from training in diversity and risk assessment in supervision. 4. The Head of Service should review the system established within the Area in 2010 to ensure that: • Planned and unplanned management absence is covered and information provided to all relevant staff. • The key management tasks are prioritised
Connexions, Manager – Learning Partnership West, North Somerset	1. Review communications between LPW advisers where a number of members of staff have been involved. Ensure that policies and procedures are clear and adhered to by all staff. As a minimum, links must be made between advisers, in writing and by telephone within specified timescales 2. Require and monitor the use of APIR, for all clients 3. Undertake discussions with related professional agencies to clarify roles and improve communications 4. Further training with staff should be undertaken, on the reasons for accurate and comprehensive recording. Current monitoring and internal audit arrangements should be updated to ensure this is taken into account 5. Procedures should be amended to require that PAs attempt to make contact with vulnerable young people through other involved agencies when their own attempts have failed
YOT	1. : In all cases dealt with by the YOT including our statutory work, where we become aware a young women's pregnancy that we should routinely (rather than on a risk based approach) check all intelligence sources available to us via our direct access to the Police Guardian system and local Childrens Services and Health Services information systems, and in those cases undertake routinely a vulnerability assessment and where necessary implement a vulnerability management plan and refer as

	appropriate to Childrens Services. In addition, in cases involving male young offenders where we are aware of their partner's pregnancy, or where their partner carers for children, similar procedures will be put in place. 2. The YOT needs to check with Childrens Services and Police information systems in the areas outside Bristol in which the Final Warning is issued, and in addition this will be applied to all out of area statutory cases where that information is not contained within the existing case history documents. 3. Improved practice in relation to the YOT's Final Warning work (as indicated in the IMR). 4. The YOT has responded to the HMI Probation/YOTs inspection that took place in January 2010 with an improvement action plan which has addressed the recommendations made in relation to safeguarding issues
1625 Independent People	1. 1625 Independent People Support Plans to note issues of child care and parenting skills to be used in staff training 2. 1625 Independent People Induction sheet to clearly note provision and coaching in child protection issues as core training. 3. 1625 Independent People to cover CAF and support for children in core training for support staff