reconstruct
improving services for children
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SERIOUS CASE REVIEW
BABY Z

EXECUTIVE SUMMARY

1. Introduction

1.1 This is the second version of the executive summary of the serious case review into the death of BabyZ. Bristol Safeguarding Children Board decided that as Ofsted stated that the original review failed to come to the correct conclusions they initiated a new, and more independent, review.

2. Reason for the serious case reviews

2.1 Baby Z died at home on 21st July 2007, aged 14 months, whilst in the care of his mother SZ, and her friend X. Both SZ and X have a history of drug misuse. When police attended they found evidence of drug taking, including spilt methadone. The cause of Baby Z's death is recorded as 'morphine and methadone intoxication'. SZ was charged with manslaughter and was remanded in custody shortly afterwards. She pleaded guilty and received a 5-year prison sentence at Bristol Crown Court on 26th June 2008.

3. Purpose and scope of the serious case reviews

3.1 In line with "working together to safeguard children", (TSO 2006) the chair of the Bristol safeguarding children board requested that a serious case review (SCR) panel be established. The purpose of the SCR, was to establish whether there were lessons to be learnt from this case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. The SCR decided that enquiries should cover information and events relating from August 2005 until July 2007. The SCR could only be completed after the mother's criminal trial had concluded.

4. The panel and contributors to the first review

Alison Comley, Head of Community Safety & Drugs Strategy, Safer Bristol (Chair)
Angela Clarke, Strategy Leader Safeguarding, Bristol City Council
Dr Kim Hearn GP Named Doctor Bristol PCT
Detective Inspector Andy Gwyther, Public Protection Unit, Avon & Somerset Police
Maggie Telfer, Chief Executive Bristol Drugs Project
Sean Tarpey, Safeguarding Manager, South Gloucestershire Council
The Panel received written reports from all the agencies involved, including several Health trusts,
Police, Probation, children's social care, and drugs services.

4.1 Attempts were made to engage Baby Z's mother in the process but, having previously agreed to meet the Chair of the panel, she subsequently decided not to.

5. The panel and contributors to the second review

Marion Saunders	Independent Chair	
Lucy Young	CYPS Social Care	Children in care manager
Simon Crisp	Police	Detective Inspector
Dr. Jane Schulte	Health	Consultant Community Paediatrician
Martin Siddorn	Safer Bristol	Young People's Substance Misuse Manager
Jo Grant	Connexions	Executive Manager
Annie Medhurst	Minute Taker	(CYPS Social Care)
Richard Hurst/ Angela Clarke	In attendance	Representing BSCB

6. Family History and Concerns

Mother (SZ)

6.1 SZ was 29 years old when she gave birth to Baby Z. She had been known to social care services during her adolescence relating to concerns about her offending behaviour and drug use. In her adult life, SZ's drug use continued to escalate, with her injecting both heroin and crack. She was also very vulnerable in terms of selling sex to fund this drug use. She received support and monitoring from several organisations, including Probation and drugs services.

6.2 In November 2005, the Probation service and hospital became aware that SZ was pregnant and a referral was made to the specialist drug service. SZ commenced a treatment programme and accessed daily dispensing of methadone. A pre-birth initial assessment was completed by a social worker in liaison with other agencies. SZ attended all of her antenatal appointments, supporting the assessment that her drug use had stabilised and she was well motivated to change her drug using behaviour because of the impending birth of her child. She was described as "doing amazingly well."

6.3 When Baby Z was born in hospital in May 2006, he was admitted for observation and treatment for methadone withdrawal. SZ and Baby Z were discharged from hospital 3 weeks later to temporary accommodation. SZ continued to remain stable on her methadone prescription and continued to see her probation officer.

6.4 In July 2006, SZ started a new relationship with AW, but shortly afterwards he was diagnosed with cancer. Nine months later he returned to live in London to receive terminal care. SZ's methadone prescription returned to daily-supervised consumption.

6.5 In May 2007, a misuse of drugs warrant was executed by police at another address in Bristol. SZ and Baby Z were present at the address but no referral was made to the police child abuse investigation team.

6.6 In May 2007, the specialist drug service became concerned due to SZ missing appointments and her admission that she had returned to using crack and heroin on top of her methadone. A referral was made to children's social care and the GP and health visitor were informed. As a result, a joint visit was made by a children and families social worker and the health visitor. The social worker felt that SZ was committed to getting back on track with her methadone programme. The home environment appeared clean, and Baby Z looked well cared for. The conclusion was that there were no immediate concerns for Baby Z's welfare and that the health visitor would provide enhanced visits to monitor the situation.

6.7 In June 2007, SZ reported to the drugs worker that she was pregnant and suffering from morning sickness. She requested daily pick up of methadone, rather than supervised consumption. This was agreed as clinically appropriate. Her pregnancy was not reported to children's social care.

6.8 SZ's last contact with any agency before Baby Z's death appears to have been with the specialist drug service five days before the baby's death. SZ was still reporting vomiting and using heroin and crack on top of her methadone twice a week. She reported that AW had died two weeks previously.

6.9 On 21st July 2007, SZ called an ambulance, having discovered that Baby Z was dead. She admitted to having left the house 3 times during the evening, leaving Baby Z in the care of X.

6.10 None of the agencies had any information about the relationship between X and SZ and it is still unclear as to the nature of that relationship, although it appears to have centred on drug use. X was originally arrested but was subsequently released with no charges brought.

6.11 SZ gave birth to her second child in December 2007. This child is the subject of family court proceedings and is placed in foster care.

Father (KZ)

6.12 There is little information in agency records on KZ. He has a history of criminal convictions going back to 1999 and appears to have had limited contact with his son. He is currently in HMP Dartmoor having been recalled on a drug treatment and testing order.

Baby Z

6.13 The information received in respect of this review focuses on factual information about Baby Z, and there is little recorded about him as an individual. He was a Black child but there is no indication in any of the information received from agencies that there has been consideration of this factor as part of any assessment or planning.

6.14 When Baby Z was born he was put on a morphine programme to manage his withdrawal. He appears to have settled on this programme, and is described as being well before discharge. He was breast-fed and steadily gained weight and was seen regularly in clinic, where no concerns about him were identified. He was assessed by the health visitor as being developmentally on target, and is described as a 'good eater' and as a 'happy child'.

6.15 In September 2006 a referral was made to children's social care from the hospital where AW was being treated as an inpatient for cancer. AW was observed to pick Baby Z up by the ankle and 'swing him' onto the bed. An initial assessment was completed by a social worker following a home visit to SZ and Baby Z. A very warm relationship between them was observed. AW's handling of Baby Z was assessed as being a result of his own limited mobility.

6.16 In October 2006, Baby Z was taken by his mother to hospital where he was reported to have fallen from the bed and hit his head, but no ongoing concerns were identified.

6.17 There appears to have been little recorded agency contact between October 2006 and January 2007, when SZ and Baby Z attended for his 8-12 month check, which did not identify any concerns.

6.18 There was a further attendance at A&E in February 2007, when Baby Z reportedly fell down the stairs. This was assessed by A & E staff and Baby Z was followed up by the health visitor in terms of home safety.

6.19 Baby Z was seen by a social worker and health visitor in May 2007, with no concerns being noted in relation to him.

7. Analysis of inter-agency work

7.1 SZ's drug use was well known and documented by all of the agencies involved in both her and Baby Z's care. In general terms, both Panels found evidence of appropriate information-sharing between the agencies; information was recorded on individual agency files; and assessments were undertaken. However, there were several opportunities where a more in-depth assessment of Baby Z's needs would have been warranted.

7.2 The post natal records indicated a mixed picture of SZ's care of Baby Z during their stay in hospital, but these concerns do not appear to have been conveyed to children's social care. Specifically the ward staff made notes indicating that SZ was heard shouting at BabyZ and other parents present complained about her behaviour. Given that they noted this it is worrying that referrals were not made to social workers. There are similarities here to Victoria Climbie's case.

7.3 Given that SZ and Baby Z were being discharged to temporary accommodation, that there was a mixed picture of her care, plus her success in treatment was relatively new, a further social work assessment would have been helpful.

7.4 The second social work initial assessment was completed in September 2006, following the inappropriate handling of Baby Z by AW on the ward. The assessment involved the midwife and health visitor. At this time agencies were aware that SZ's partner was terminally ill and that this was likely to be a stress factor for her and Baby Z.

7.5 There is no evidence of that being pursued by any agency in terms of access to increased support or counselling. Given the relapsing nature of substance misuse, this stressor should have been identified as a treatment risk for SZ, in terms of using drugs as a coping mechanism.

7.6 Between January 2007 and April 2007 there were a number of indicators held within individual agencies that SZ was starting to get into difficulties. From an individual agency perspective those indicators were not followed up or shared with all the other agencies. If they had been, a collective picture may have emerged which would have indicated a higher level of concern.

7.7 The presence of SZ and Baby Z during a police execution of a drugs warrant also presented a missed opportunity to link up increasing concerns about what was happening.

7.8 The assessment completed by a social worker in May 2007, was again an initial assessment, conducted with the health visitor as a joint visit. A more in depth assessment may have elicited more detailed information about SZ's drug use, as recommended in the "Practice Guidance on Drug Using Carers". The social worker's view was that the health visitor would undertake future monitoring of Baby Z, with SZ's treatment progress being overseen by the drugs worker. The information from Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) indicates that whilst this decision was shared with the drugs worker, it was not the result of discussion and agreement. It appears to have been passively received by the drug service, not really agreed with, but not challenged.

7.9 At the time of Baby Z's death, SZ was still on daily pick up of her methadone. AWP records indicate that she was advised to keep the methadone safe at home, but this was not formally entered into a risk management plan or shared with the other agencies involved with this family.

8. Conclusions

8.1 A study of the original overview report and individual management reviews, together with subsequent discussions and consideration, leads the second panel to conclude that Baby Z's death was not predictable but may have been preventable. The lack of predictability is based upon the fact that his mother had been caring well for him and staff are not aware of how to identify the effects of drug ingestion in children. The panel believes that the incident was preventable because:

1. there were sufficient concerns from the ward staff and drugs workers to merit a co-ordinated response to his care, and
2. his mother was facing considerable stress from April 2007 which was likely to lead to a relapse.

8.2 The re-review of the Baby Z case has developed different conclusions to those contained in the original serious case review. The Panel are confident that the recommendations in this report, once they have been refined and ratified by the Safeguarding Children Board, will help to improve outcomes for children of drug using parents.

8.3 Family situations involving parental substance misuse are complex and require co-ordinated assessment and activity, particularly as situations may change quickly. Relapse, particularly in the early stages of treatment, is likely.

8.4 Through her journey from chaotic drug use, into structured treatment, and then relapse, SZ appears to have been open with agencies as to her needs and issues.

8.5 It seems likely however that professionals were being over optimistic about her progress and were not considering whether any real improvements were taking place in regard to Baby Z nor what would be the effect on him of any relapse by SZ.

8.6 For those families who do not come within the threshold of child protection concerns, the co-ordinating processes between adult and child-focused services do not seem to be in place, as they are when child protection processes have been invoked. There are various points in this case, particularly where it was recognised that SZ was relapsing, where greater multi-agency working may have assisted SZ sooner and ensured that professionals were more vigilant in their monitoring of her.

8.7 Baby Z's death was clearly avoidable, but the information considered by the panel does not indicate that any agency could have reasonably known that he was at risk of methadone ingestion, and at this point it is still unclear as to how he came to ingest it.

8.8 SZ's life was becoming pressurised and stressful in April 2007; it was clear that a relapse in her drug taking was likely. Baby Z's name was never on the child protection register so he was not receiving a co-ordinated service. Had he been it is more likely that professionals would have been able to assist SZ through this period.

8.9 Hospital ward staff had concerns about Baby Z, during the first few days of his life, which they should have communicated to children's services; indeed had Baby Z been allocated to a hospital social worker it is likely that these concerns would have been communicated. Had children's services known of these concerns it is more likely that Baby Z's name would have been on the child protection register.

8.10 However the second panel believe that 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, particularly those whose parents are involved in illegal drug taking.

8.11 The second panel are pleased to see that much work has gone on in Bristol in terms of strengthening the working relationships between children and drugs workers; in particular the introduction of the document "Delivering a Better Service to Drug Misusing Parents and their Children" which includes initiatives on care pathways, greater co-ordination under the common assessment and better identification of parents who misuse drugs.

8.12 The main recommendation which will arise from this re-review will be that Bristol better develop the co-ordination of services for all children in need.

9. Lessons learned

9.1 There was a failure to continually monitor Baby Z's progress and his mother's drug use. Reflective supervision is required to enable managers to assist workers in guarding against the "rule of optimism".

9.2 Ward staff seemed to be unaware of their responsibilities towards protecting children.

9.3 Drugs workers from Bristol Drugs Project put their clients' needs above those of their clients' children.

9.4 Children in need cases are not as well co-ordinated as they could be.

9.5 There needs to be a finite number of initial assessments before consideration of a core assessment.

9.6 Social Care Initial Assessments that rely on one home visit do not always allow sufficient gathering of information when conducting an assessment where parental capacity may be impacted on by problematic drug use.

9.7 There was a lack of care co-ordination amongst drugs workers.

9.8 In relation to inter-agency practice, it is important that there is an agreed and shared understanding of the risk management plan when several agencies are involved.

9.9 Telephone discussions held between professionals are not always as well recorded as they should be.

9.10 Police officers do not routinely inform children's social care when they find children in a house where illegal drugs are being used.

10. Recommendations

10.1 The LSCB should audit supervision to discover how much time is taken up by compliance issues as opposed to case issues.

10.2 There needs to be an analysis of child protection awareness at UBHT to enable some targeted training to take place there.

10.3 Safer Bristol should conduct a review of child protection knowledge and practices at Bristol Drugs Project and consider how they will change the requirements in their commissioning and monitoring procedures.

10.4 Bristol Safeguarding Children Board need to develop systems to co-ordinate children in need cases.

10.5 Bristol Children's Services should consider introducing a policy which limits the number of initial assessments a child can have before a core assessment is carried out.

10.6 Assessments of children of drug using parents should be detailed enough to allow sufficient gathering of information.

10.7 Safer Bristol needs to consider whether its care co-ordination systems are robust.

10.8 All child protection and children in need plans should be put in writing.

10.9 Telephone discussions held between professionals should be fully recorded.

10.10 The officer in charge of any police drugs search warrant will ensure that every person on the premises at the time the warrant is executed must record the names of all those present, including infants and children. The details of ALL infants and children will be the subject of a referral to the relevant Public Protection Unit for their District. This will be done at the conclusion of any drugs warrant by the officer in charge ensuring that an intelligent report is submitted on the police Guardian intelligence system. This will ensure that the Public Protection Unit is aware of such incidents and take the necessary action in relation to the well being of that infant/child.

10.11 Team caseload management amongst drugs workers should take account of the capacity needs for joint working in families to protect children.

10.12 Avon and Wiltshire Partnership (AWP) practitioners making a referral to CYPS should be explicit as to the nature of the referral and should express those concerns in relation to the child (not the parent or adult).

10.13 Where joint working involves working within complex services and/or families, clear arrangements for service co-ordination should be agreed. In very complex situations, appointment of a single family service co-ordinator should be considered.

10.14 All AWP practitioners should be aware of their duty to challenge CYPS or other services if their concerns about a child are not considered to be fully addressed or responded to appropriately following a referral.

10.15 All AWP practitioners should be aware of their duty to use the required risk assessment and management templates in relation to safeguarding children, each time they assess or reassess risk in the service user's care pathway

10.16 Each practitioner and manager should be aware of their duty that, if they do not resolve all safeguarding children concerns when challenging CYPS or other services, they must escalate these concerns until they are resolved using the recently introduced South West Child Protection Procedure professional disagreement policy.

10.17 All practitioners working with adult service users should record when they see children within the family, the details and condition of the child or children, and (in the child's own words) what the child says.

10.18 AWP practitioners should record the racial, ethnic and religious background of each child in the adult service users family, in order to take this into account when considering appropriate interventions within the family.

10.19 Where there are specific risks within an adult care pathway to children in the family (e.g. prescribed methadone stored at home) the risk should be discussed at each care plan review with the service user, the information shared with other relevant services working with the family, and appropriate written information provided to the service user.

10.20 Where a parent is taking prescribed methadone at home, a safety plan for the storage of the methadone should be agreed with the service user, entered into the risk management plan, and a copy given to the service user and to other agencies working with the family (subject to the appropriate consent). All service users prescribed methadone should be given appropriate written information in relation to the significant risks to the child of using methadone, and storing it at home.

10.21 All referrals should be explicit as to the nature of the referral and of the concerns raised, and should express those concerns in relation to the child. Where the referral is under S17 (child in need) or S47 (child protection) this must be stated explicitly in the referral

10.22 The requirement to complete a Core Assessment for Pre-Birth Assessments of Drug Using parents should be re-enforced.

10.23 Social workers and their managers should be made aware of the revised Bristol Safeguarding Children Board Guidance for Working with Children of Problem Drug and/or Alcohol Using Parents, and supported to use it in practice.

10.24 Team Managers should ensure that those practitioners who require it can access training re working with drug using parents.

10.25 Team and senior manager auditing of recording practice should include:

a. monitoring the use of ICS exemplars and managing any concerns about recording practice that follow;
b. identifying any suspected 'gaps' in the social care record and address with practitioners;
c. monitoring the quality of the recording of management decisions

10.26 The LSCB guidance on substance using parents has recently been revised and has been published. The revised guidance includes a checklist for children's social care managers, as well as issues for practitioners to consider when assessing parental substance use. This guidance will need to be widely understood, be integrated into training courses, and used by managers and practitioners in children's social care.

10.27 Team Managers need to ensure that assessments undertaken in relation to drug using parents have allowed sufficient exploration of the potential risks to children.

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