Serious Case Review

Relating to Child K who died aged 2 years

Ethnic Origin: White British

Executive Summary

Contents

Introduction

1.1. This is the Executive Summary of a Serious Case Review commissioned by Bristol Safeguarding Children Board (BSCB) following the death of a two year old child who was subject of a Child Protection Plan at the time. To maintain anonymity the child is referred to as Child K. the sibling is referred to as Child L, the mother Ms M and the father as Mr N. Post mortem toxicology on Child K indicated the presence of methadone metabolites and hair strand sampling confirmed the ingestion of methadone over a period of time. Two adults were charged with the manslaughter of Child K and 'causing or allowing the death of a child under 16' (s.5 DCVC Act 2004[1]) and following a trial both have been convicted and sentenced for offences relating to the death of Child K.

1.2. Regulation 5 (1.e) of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of Working Together to Safeguard Children (2010)[2]. This states that: "When a child dies (including death by suspected suicide) and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family" Para 8.9. The decision to undertake the review was made by the Chair of BSCB on the recommendation of the Serious Case Review Sub-group.

1.3. The SCR was carried out under the guidance from Working Together to Safeguard Children, 2010, Chapter 8. which (8.5) states that the purpose of a Serious Case Review is to:

- establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

1.4. A Serious Case Review Panel (the panel) was established to oversee the process of the review. The panel comprised senior representatives of agencies represented on Bristol Safeguarding Children Board. It was chaired by an independent consultant who has previously worked as a senior manager in the NHS and is an experienced chair of Serious Case Review Panels. He was appointed by Bristol Safeguarding Children Board as someone of experience and authority and independent of each of the reporting agencies. The role of the independent chair is to ensure that the SCR process is effective and independent.

[1] http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/#familial

[2] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (2010) HM Government, London

Panel Members represented the following services:

Agency/Authority	
NHS Bristol.	Designated Doctor Designated Nurse
Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)	Consultant Psychiatrist
Avon & Somerset Police,	Detective Superintendent, Public Protection Unit
Bristol City Council	
▪ Children and Young Peoples Services (CYPS)	Safeguarding Business Unit manager
▪ Housing Solutions	Service Manager
Bristol Safeguarding Children Board	Policy and Projects Officer – Safeguarding
Safer Bristol	Service Director
Legal Advisor	Independent lawyer

1.5. All panel members had knowledge and expertise of the services provided to the family, but were independent of operational management of the services under review.

1.6. The Panel determined the key learning objectives for this SCR as:

- To look openly and critically at individual and organisational practice and to establish whether there are lessons to be learned about the way local professionals and agencies work together to safeguard children both in this specific case and more widely in other work.

- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and to consider how learning will be disseminated to practitioners and across agencies.

- To determine whether the circumstances of the case indicate a need to revise and update existing procedures, policies, practice or protocols.

- To lead to improvements in inter-agency working to better safeguard and promote the welfare of children.

- To determine whether any other remedial actions are necessary.

1.7 Individual Management Reviews (IMRs) were requested of all agencies involved with the family in accordance with Working Together guidance. Reviews were requested from the following agencies

Bristol City Council Children and Young People's Service, Children's Social Care

Bristol City Council – Legal Services

Bristol City Council Housing

Drug Agency A

North Bristol NHS Trust

United Hospitals Bristol NHS Foundation Trust

General Practitioners (Bristol)

GWAS

AWP, Drug Agency B

Pharmacy

Avon and Somerset Police

Shelter

1.8 A health overview report was also provided by the Designated Professionals; this constituted the IMR for the Primary Care Trust and considered the way that the health organisations interacted together.

1.9 The purpose of an IMR is to look openly and critically at individual and organisational practice, to establish whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about. Any significant concerns identified relating to practice should be responded to as soon as possible to ensure that all children receiving a service are safeguarded. The authors of the IMRs were expected to be independent of any line management responsibility for services provided to the family members

1.10 The time under scrutiny within the review was the period twenty one months before Child K's birth up to his death; to cover the pregnancy and one year before. Relevant historical information regarding the immediate and extended family members who were members of the household in which Child K lived, and in which he died, was also considered.

1.11 The areas of consideration required of IMR authors were:

General Safeguarding Issues

- Summarise your analysis of the involvement of the agency with this child and/ or their family or carers
- 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
- Establish whether the agency had in place policies and procedures for safeguarding children and acting on concerns about their welfare.
- Determine what were the key relevant opportunities for assessment and decision making in this case in relation to the child and family.

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

- Determine how effectively the management oversight of record-keeping, and written and verbal communications impacted upon multi-agency working in this case.

- Were staff provided with adequate supervision and support within your agency. Did the supervision provided accord with the agencies policy and guidance on supervision. Is this adequately recorded and did staff seek supervision and guidance appropriately?

- Evaluate when and in what way the child's wishes and feelings were ascertained and considered. Was this information recorded and how?

- Identify whether more senior managers, or other agencies and professionals, were involved at points where they should have been.

- 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. To further consider the relevance of any training that was undertaken or would have been available to the worker's involved.

- Were staff adequately trained in safeguarding children and the impact of parental substance misuse;

- 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?

- Consider whether there are any particular features of this case or issues surrounding the death of Child K that you consider require further comment in respect of your agencies involvement

Specific issues in relation to Child K

- 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?

- In relation to the parents (and anyone who had care of Child K) are there any relevant medical, mental health, substance misuse issues, previous convictions, intelligence and/or domestic violence or any children from previous relationships where these issues would apply?

- 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?

- Do any issues emerge in relation to the provision of services to persons in the immediate or extended family who misuse substances?

Lessons to be learnt from this case:

- Are there lessons from this case for improving the way in which this agency work to safeguard children and promote their welfare?
- Is there evidence of good practice to highlight?
- What are the implications for the agency's ways of working?
- What are the implications for training (single or interagency)?
- What are the implications for management and/or supervision?
- What are the implications for working in partnership with other organisations?
- What are the implications for service provisions?

1.12 Bristol LSCB commissioned a consultant with appropriate expertise and experience who is independent of all of the agencies involved in the SCR process to prepare an overview report to bring together the information and analysis of the IMR, draw overall conclusions and make recommendations.

2 Serious Case Review Process

2.1 The Serious Case Review Panel oversaw the process on behalf of BSCB. It met to review the IMRs and IMR authors were invited to a meeting to discuss their reports before final versions were submitted. The final versions were endorsed by the senior manager in each of the organisations who have the authority and responsibility for ensuring that action plans are enacted. Action plans from the IMRs were collated.

2.2 The panel scrutinised the overview report and agreed recommendations and the integrated action plan prior to submission to the Bristol Safeguarding Children Board for ratification.

3.0 Family Involvement

3.1 Both parents were informed of the Serious Case Review process via the Offender Management Service in their respective prisons where they were on remand and have been asked to contribute their views. [redacted]

3.2 The SCR Panel Chair and the Safeguarding Policy and Projects Officer met with the mother and [redacted] their comments were incorporated into the overview report.

3.3 Child K's younger sibling became Looked After immediately after the death of Child K and is currently in foster care.

4.0 Key Facts

4.1 Child K's parents were both known to have used drugs for most of their adult lives. Both parents had [redacted] as a direct consequence of intravenous use of substances. [redacted] Their relationship was longstanding. Child K was their first child. The mother was regularly injecting heroin during her pregnancy with Child K. Throughout the period of the review the parents were involved with the drugs services. Both parents had been in receipt of opioid substitution therapy through the Drug Agency A Shared Care Service in primary health care working with the GPs for several years. During the mother's pregnancies with Child K and his younger sibling she was referred to the Drug Agency B for specialist multiagency maternity and prescribing care.

4.2 Early in her pregnancy with Child K the community midwife referred to Children and Young People's Services (CYPS) for assessment of the safety and welfare of the unborn baby and interagency planning for provision of services after the birth. This was in line with the South West Child Protection Procedures Unborn Baby Protocol. The mother failed to attend many appointments with both the midwives and Drug Agency B specialist maternity service. There were indications that she continued to use heroin on top of the prescribed methadone. Due to her lack of engagement with specialist maternity services the GP continued to prescribe methadone and reducing doses of benzodiazepines, her consumption was supervised daily by the pharmacy. Both parents were also subject to urine drug screening to ensure appropriate methadone prescription.

4.3 An initial assessment was completed by a social worker during the 30th week of the pregnancy and commenced a core assessment, making a number of home visits prior to Child K's birth. A decision to hold a child protection conference was made and the day after his birth Child K became subject of a child protection plan.

4.4 After his birth Child K did not need specialist treatment for drug withdrawal. He was discharged home to the care of his parents with a support plan from professionals and [redacted]. The family were also offered support to obtain alternate housing as their home was cramped and damp. Child K was seen regularly by a Child and Family Support Worker and members of the health visiting team. He was observed to be happy, clean and tidy although during his first three months he had two minor head injuries one of which was seen by the CFSW and one by the GP; the same explanation was given by the parents for both injuries.

4.5 A review Child Protection Conference was held 3 months after the initial. The child protection plan was continued as there were concerns about the parents' full cooperation with the plan, especially their lack of engagement with Drug Agency A and apparent falsification of urine screens. They later admitted to the CFSW that they knew the tricks to get around urine screening.

4.6 A second review Child Protection Conference was held when Child K was 9 months old. It was noted that the family had been somewhat more cooperative with the plan over the

previous few weeks. No particular concerns had been noted about Child K although the family had not engaged in any parenting or mother and baby groups or activities. The CFSW had discontinued their contact and additional family support from Drug Agency A had not been accepted by the family. The child protection plan was discontinued and Child K was considered a child in need, although a review meeting was not held within the expected timeframe.

4.7 By the time Child K was a year old the mother was pregnant again. She was again referred to the specialist maternity service for prescribing and antenatal care. The community midwife informed the allocated social worker of the pregnancy with a view to multi-agency pre-birth planning. A meeting was held when the mother was approximately 20 weeks pregnant; unfortunately not all of the involved professionals were present. Throughout the pregnancy the mother failed to attend most of the antenatal and specialist drug service appointments in spite of significant professional persistence. The parents both continued to fail to comply with urine screening requirements of the opioid substitution programme. The mother's methadone was prescribed for daily supervised consumption. The home circumstances continued to be a source of stress for the parents but they had been unable to find alternative housing in spite of the support offered.

4.8 When the mother was eventually seen by the specialist maternity drugs worker it was agreed that she would start reducing her methadone. A second child in need meeting was held late in the pregnancy when it was agreed that a child protection conference should be convened.

4.9 Child K's sibling, Child L, was born and suffered a significant degree of neonatal abstinence syndrome and need intensive treatment. The mother was uncooperative in providing urine specimens that would support the appropriate treatment of her baby. During her stay in hospital it became evident that the mother was using illicit substances and she eventually admitted to having used a variety of illicit substances during the pregnancy. The mother was discharged from hospital the baby remained in the Neonatal Intensive Care Unit. During his extended stay in hospital the baby required extensive treatment to manage his withdrawal. The mother visited regularly and cared for the baby whilst she was there. A number of concerns were identified about the care, the parents' relationship was under strain and a bag containing drug paraphernalia, including needles and a child's dummy was left by the father in the baby's cot. The latter was seized by the police.

4.10 Child K spent time with both [redacted] whilst his sibling was in hospital.

4.11 A Child Protection Conference was convened when Child L was 2 weeks old and both children became the subject of child protection plans. CYPS sought legal advice with a view to initiating care proceedings. Although there were a series of pre-proceedings meetings held over the next four months care proceedings were not issued until after the death of Child K.

4.12 Child L was discharged from hospital when he was six weeks old. His discharge had been planned at a meeting in the hospital 3 days before his discharge, a core group meeting had been held 4 days before that. A series of written agreements about the care of Child K and his sibling was drawn up by the social worker and signed by the parents.

4.13 Both parents admitted having used heroin during the pregnancy and thereafter but committed to working with drug services and to abstain from illicit substances. A pre-proceedings Public Law Outline meeting was held when Child L was 7 weeks old and a further written agreement was made. The parents said that they had had a wake-up call and would cooperate with services.

4.14 Both parents continued to receive opioid substitution therapy; the mother received hers through daily supervised consumption; the father's was prescribed for twice weekly collection. There were both expected to provide urine samples for monitoring, there were indications that these were falsified at times.

4.15 A number of professionals were involved in offering support to the family; they made both announced and some unannounced visits. It was noted that on a number of occasions that Child K was asleep during morning meetings and did not have a good routine, although there were no specific major concerns about the welfare of either Child K or his sibling.

4.16 Three months after the initial Child Protection Conference a review conference was held and the child protection plans reviewed and retained. It was identified that the parents were not as cooperative with the drugs service as would be expected. It was noted that the family had yet to obtain a lockable box for storage of methadone in spite of numerous reminders by professionals.

4.17 Continued concerns about the state of the family home were identified and a visit by and Environmental Health Officer resulted in an increase in the housing banding that would have improved the likelihood of rehousing although this was dependent on the parents making appropriate online bids for specific properties. They had also applied for housing in other local authorities. The deterioration in the state of the home was noted by professionals and family members.

4.18 During the month before Child K's death both parents were arrested [redacted] when both were intoxicated, probably with alcohol. Both children were with them at the time [redacted]

4.19 When he was almost two years old Child K tragically died. On the morning of his death Child K was found unconscious and not breathing. The father had made the emergency call and was said to be shouting and screaming on the phone. The mother had apparently attempted resuscitation but the child was obviously dead. The history given by the mother was that Child K had got into her bed at about 6.45 that morning, she had left him 7.00 and next checked on him at 12.30 when she had found him collapsed. Death was confirmed at 12.40. Child K was transported to the hospital. The police were informed and full child death procedures were followed. Child L was examined by a Consultant Community Paediatrician; he was found to be a healthy baby.

5.0 Analysis

5.1 Serious Case Reviews provide the opportunity to consider complex cases with the benefit of hindsight and to have an overview of the involvement of a range of practitioners in the knowledge of the tragic outcome for the child. Neither of these is available to the practitioners engaged in providing the services for the family who

may be less able to see emergent patterns and are engaged in the complex tasks of developing and maintaining relationships with parents and other professionals whilst ensuring that there is a clear focus on the safety and welfare of vulnerable children.

5.2 The death of Child K is considered to have been the result of methadone ingestion on more than one occasion. Criminal procedures have concluded with respect to both parents. None of the professionals involved with the family had foreseen the possibility of either child being given methadone by one or other of their parents. There is some evidence through other Serious Case Reviews and research that administration of methadone and other substances including alcohol to children by their parents may not be uncommon.

5.3 Drug programmes for parents need to continually emphasise that no substance of this kind should ever be given except under medical supervision. In this case there is no indication that any of the practitioners had considered the deliberate administration of methadone to a child and had not addressed the issue with the parents.

5.4 Although the death of Child K could not have been predicted there were indicators that the long term outcomes for Child K and his sibling may have been negatively impacted by their parents' lifestyle. It is recognised that parents who use drugs can and do parent their children well but substance use can negatively affect parents' capacity adequately to meet their children's needs[3],[4] and Brandon et al (2009) found that in a third of the Serious Case Reviews there was a current or past history of parental drug use[5]. A number of the known risk factors were in evidence in this family, probably the most concerning of which was the parents' lack of will to work in an open and honest way with practitioners from all agencies. The extent of the parents' lack of engagement, avoidance and dishonesty grew over time and although this was recognised by practitioners there was insufficient challenge by professionals and no sustained, planned approach to protecting the children. The only way that Child K's death would definitely have been prevented was if he had been placed away from his parents, the opportunity to do this was lost due to the failure to follow through on the initiation of care proceedings. However a better planned and authoritative approach to the family may also have prevented his death.

5.5 The analysis of the circumstances of this case is considered in relation to a number of emergent themes. As Lord Laming said in his report in 2009 "*ultimately, the safety of a child depends on staff having the time, knowledge and skill to understand the child or young person, and their family circumstances*."[6]. In this case there were a number of missed opportunities for practitioners fully to understand the circumstances of Child K.

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[3] Cleaver, H, Unell, I and Aldgate, J (2011) *Children's Needs – Parenting Capacity (2nd Edition)*, London, TSO

[4] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (2010) HM Government, London

[5] Brandon, M., Bailey, S., Belderson, P., Warren, C., Gardner, R. and Dodsworth, J. (2009), *Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005 – 2007* London: Department for Children, Schools and Families

[6] Lord Laming (2009) The Protection of Children in England: A Progress Report, TSO Norwich p10

5.6 Focus on the child

5.6.1 There is little information in any of the IMRs that provides a picture of what life was like for Child K and his sibling. The information that is available does not indicate any serious concerns that were overlooked by practitioners. Descriptions of Child K documented by practitioners from most agencies working with the family generally suggested that he was a well loved, happy and contented child who was growing and developing within normal limits.

5.6.2 Child K sustained two injuries to his head when aged 7 weeks and 11 weeks, each was presented to a different practitioner, the explanation given was the same on both occasions and should have raised concerns that they were non-accidental in nature. Later in his life Child K, aged 21 and 23 months was observed to have sustained injuries to his face, again they were seen by different practitioners and the explanations were the same. Although they were accepted as accidental the mechanism (having hit himself in the face with a piece of wood) may have indicated a lack of appropriate levels of supervision.

5.6.3 There are however several instances during the second episode of care after the birth of Child L when the CFSW made prearranged visits when the family had just got up, especially Mr N and Child K who on a number of occasions remained asleep during the visit, perhaps unusual for a child of Child K's age if he had been put to bed at a reasonable time. Ms M noted that after Child K had been staying [redacted] a daily routine had been established which they would attempt to maintain. Other instances of Child K being sleepy in the mornings are framed in the context of lack of routine without apparent exploration of his pattern of life. There are therefore indications that the parent's routine was not child focussed.

5.6.4 On one occasion when Child K was a year old the CFSW noted that the parents were not as attentive to his needs as expected; Ms M was trying to rush Child K's feed and the worker felt that he had not had sufficient food. Challenge by the worker led to Ms M becoming defensive and discussing termination of the service. This is the only documented incident of significant deficit in providing good enough care or emotional unavailability; two of the most quoted concerns about substance using parents. Child K sustained a number of minor injuries none of which were considered of particular concern by practitioners although the injury to his head sustained when he was only 2 months old should have aroused more concern than it apparently did.

5.6.5 The evening before Child K's death he was in a pub with his father; it is not clear where his sibling was at the time. There is suggestion that this may have been a regular occurrence, at least weekly as disclosed by Mr N. There is also indication that both parents, at least on one occasion became intoxicated, when both children were with them. The use of alcohol by the parents is not addressed in any detail by practitioners, although there are references throughout the chronology of alcohol use by both of them and indication that their use was minimised. There is much evidence throughout the chronology that both parents used a variety of substances that may have had an impact on their ability to be physically and emotionally available to their children, including heroin, cocaine and alcohol. However Mr N asserted, when he disclosed use of heroin, that although the parents had used they had done so outside the family home and did not retain any substances other than those that were prescribed in the family home.

Because of the general lack of openness and honesty with practitioners from all agencies about their use this is difficult to assess, there are however very few occasions in the chronology when any practitioner documented that they considered either parent obviously intoxicated.

5.6.6 A concern that was raised a number of times was the failure of the parents to access activities outside the home to give the opportunity for Child K to socialise with other children in spite of regular encouragement by the CFSW, the health visitor and the GP.

5.6.7 All practitioners and the parents recognised the unsuitability of the home environment and several of the practitioners made efforts to support the family in their quest for a new home. It is of note that the parents had set their sights high and only bid for houses or bungalows for which they were less likely to succeed. The information from the housing IMR indicates that number of bids reduced after the first year, this may have been because the parents were pursuing applications in other authorities.

5.6.8 In spite of many positive observations of the care of Child K and the appearance that his health and development had not been adversely affected, the observations were limited and somewhat superficial. The most significant concern was that the parents were unable to prioritise the needs of the children above their own. This was particularly evident during the second pregnancy when both parents, but especially Ms M, were non-cooperative and dishonest in their dealings with professionals from every agency. This resulted in the health of Child L being put at risk during his first few days of life due to his withdrawal from unknown substances in unknown quantities.

5.7 Assessment

5.7.1 Assessment is a complex activity and the quality of assessment is key to the significant decisions that affect outcomes for children in both the short and long term.

5.7.2 In order to understand the impact that using substances will have on parenting capacity it is necessary to understand the pattern of use, the physical and emotional effects on the adults and to gain an understanding of the priority that the adult gives to their relationship with the substance in relation to other priorities. There is some evidence that parents whose 'principal attachment is to a substance' may have difficulty in forming attachments with their children.[7] The practitioners working with these parents do not appear to have been able to develop sufficiently trusting relationships to be able to overcome the resistance, secrecy and denial that characterises much substance abuse and fully to understand the motivation and capacity of the parents to adjust their lifestyle to meet the needs and demands of young children.

5.7.3 The CYPS IMR indicates a failure by the first social worker to develop sufficient rapport with the parents "to be able to gather a clear picture of their day to day lives". It also recognizes that the identified risk and protective factors were insufficiently analysed to provide a clear understanding of the impact on the child. The recording of contact by the second social worker who was involved with the family after the birth of Child K was so limited that it is difficult to judge the depth or quality of their assessments, although

[7] Kroll, B and Taylor A (2003) *Parental Substance Abuse and Child Welfare*, London, Jessica Kingsley Publishers

the CYPS IMR states that the "their observations and assessments from the home visits were recorded in the child protection reports." This is clearly not best practice.

5.7.4 The health visiting IMR indicates that at least two Family Health Needs Assessments were completed by a health visitor. The main focus of the service being monitoring the health and development of the children.

5.7.5 Assessments by the two drug services involved with the family were focussed on the substance use and used for development of care plans to address this. The assessments are standardised. It is recognised that the assessment, planning and intervention offered by both of the drugs services was based on a person-centred approach, each parent was considered separately and therefore there was no co-ordinated approach to assessment of risk and provision of services taking account of the two adults as part of a family.

5.7.6 Professionals placed a considerable reliance on the protective influence of [redacted] especially at the time that Child K first became subject of a child protection plan. Their presence at the Child Protection Conferences was viewed as an indicator of that commitment. There was however no indication that there had been any assessment of the quality of the support that was provided. This was perhaps an indicator of a degree of misplaced professional optimism that was pervasive in this case.

5.8 Working with resistance and avoidance

5.8.1 Barlow (2010)[8] states *"Lack of cooperation on the part of families is a key factor preventing effective assessment and needs to be included as a key indication of risk in the assessment process. Lack of cooperation should be used to justify compulsory interventions"* p57.

5.8.2 There is a significant amount of evidence from the chronology and IMRs that these parents were both resistant to and avoidant of engagement with services. It is recognised that professionals have to perform a difficult balancing act of developing helping alliances with parents whilst retaining a clear child centred focus, this is made even more difficult when parents do not work openly and honestly.

5.8.3 The lack of cooperation was evident with all of the services evidenced by failure to attend appointments (Drug Agency A, Drug Agency B, midwifery services, Housing, Shelter, heath visiting, social work), failure to be present for home visits (health visiting, Child & Family Support Services, midwifery), failure to cooperate fully with opioid substitution therapy (by denial of relapse and falsification of urine samples), failure to engage with support and therapeutic activities offered by the drugs services and failure to engage with parenting and child focussed activities. What was lacking was the authoritative challenge to this lack of cooperation there was a lack of enforcement of consequences. There was a lack of challenge by practitioners across the range of agencies.

[8] Barlow, J with Scott, J (2010) Safeguarding in the 21st Century: where to now Darlington; research in practice

5.8.4 There is little evidence that the parents had a full understanding or acceptance that there were specific requirements for them to significantly change their behaviour or their parenting styles. As identified above the lack of comprehensive assessment of the parenting capacity meant that there was never a clear understanding whether motivation or capacity to change were present. The IMR from CYPS indicates that the social worker had, on a number of occasions, challenged the parents which had resulted in them becoming defensive, this was acknowledged by the mother. It is also suggested that the social worker perceived themselves as alone in making the challenge, leading to a feeling of professional isolation. This is reflected below in 5.9.3.

5.8.5 One of the identified risks in working with highly resistant families is the tendency towards over optimism, small positive changes or lack of obvious negative impact on children are imbued with more significance than is justified. In this case the apparent close relationship between parents and children and the lack of obvious concerns about the health and development of Child K in particular, distracted practitioners from the risks to the children's health and welfare in the longer term.

5.8.6 In order to overcome the resistance and lack of candour, practitioners need to have the skills to develop and maintain relationships and have a well developed capacity for empathy with adults whilst retaining a focus on risks to children. It is also well recognised that in order for practitioners to work in this way they need highly skilled supervision to provide additional insights on the family, space and opportunity for reflection in and on practice and emotional support to workers who are intervening with emotionally demanding families.

5.9 Interagency working

5.9.1 There is evidence throughout the chronology of some good interagency working. Referrals were made to Children's Social Care at appropriate times by the midwifery service when Ms M became pregnant. There was good communication with the social worker from most agencies about changes and developments in the family, especially when the children were subjects of child protection plans. An exception to this was a gap in sharing of information by the police in respect of the concerns [redacted]

5.9.2 Referrals were made by the midwives to CYPS early in both pregnancies as required by the SWCPP Unborn Baby Protocol. There was however lack of immediate and expected response to the referrals which gave rise to significant concern and frustration for health practitioners. There was a four month delay in completion of the Initial Assessment with respect to Child K and a further two months before the Child Protection Conference was held, the day after Child K was born. There was a similar pattern with Child L. This delay in response not only leads to drift in progress of cases which can increase risk to children it also seriously undermines professional trust and thus interagency working.

5.9.3 However there is a sense that the social worker was a repository for information with lack of clarity about what practitioners expectations were of what action would follow the sharing of information. There is a sense that practitioners had a view that the sharing of information with the social worker absolved them of responsibility for authoritative action.

5.9.4 There is a sense of a lack of clarity about the plans to safeguard both Child K and his sibling. This is exemplified in the responses to information from the drug services about lack of engagement of both parents, the lack of cooperation with plans for urine screening and the apparent confusion about initiation of care proceedings. There was also lack of clarity about plans for Child L, which changed several times during the period before his discharge from hospital. There was concern from health practitioners in particular that the plans were changed without consultation and without practitioners being informed.

5.9.5 There is evidence of good communication within agency teams, where they existed, but there are a number of instances that can be characterised as 'silo working'. For example there was good communication between the Drug Agency A workers and GP as part of the shared care service, but little evidence of information sharing and communication between the GPs and the health visitors. What appears to be lacking is a sense of collaborative working between the agencies.

5.9.6 One of the recognised challenges of working with substance using parents[9] is that substance misuse and child protection systems have 'different professional missions'; the drug services are focussed on the needs of the adult and the child welfare services on those of the children. Although there was a level of integration and cooperation between the two services, exemplified by an integrated service for pregnant substance users, there were still tensions between the services and the focus of the interventions. This was particularly evident with respect to urine screening. From a drug service standpoint screening is a clinical tool for managing safe prescribing of opioid substitution. From a child welfare perspective, urine testing was used to assess compliance with plans for abstinence from illicit drugs. This led to a degree of tension between the services and probably increased the lack of candour by the parents with respect to their lapses/on top use, which may, of itself, have increased the risk to the children.

5.9.7 There are indications that there were significant gaps in attendance at some conferences. The first review conference with respect to Child K had to be reconvened due to the lack of key information. The CYPS IMR noted that the absence of a drugs specialist at the second review meeting which reduced the opportunity for other practitioners to have a clear understanding of the implications of the parents' urine screens. The health visitor was unable to attend the Initial CP Conference due to leave but there had been less than a week's notice given, making finding a deputy impossible. The convening of the first Initial Conference in 2009 had also been at very short notice. It is recognised that the notice given for Initial Child Protection Conferences is determined by the fifteen day timescale defined in Working Together (5.83). The effectiveness of Child Protection Conferences and other interagency meetings is highly dependent on the presence of appropriate professionals to provide information and contribute to risk assessment and decision making processes. When practitioners are unable to attend meetings it is essential that they provide reports that not only offer information but also analysis of that information with respect to the risks and protective factors for children. This is especially important for adult focussed services but it should also be recognised

[9] Taylor, A and Kroll, B (2004) *Working with Parental Substance Misuse: Dilemmas for Practice* Br J Soc Work 34 (8): 1115-1132

that it can be more challenging for 'adult workers' who may feel less skilled or knowledgeable in making judgements about parenting and children. Such practitioners need training and support and it is good practice for such reports to be overseen by an experienced practitioner before submission. It is however also important that practitioners have sufficient notice of meetings to allow attendance and/or provision of reports.

5.9.8 The first Child Protection Plan with respect to Child K ensured that there were fairly regular meetings of practitioners at Child Protection Conferences and Core Groups. At other times there was no specific framework for interagency working and health visiting and midwifery services IMRs both indicate some frustration on the part of practitioners that the safeguarding concerns were not responded to as quickly or taken as seriously as they expected. They continued to raise concerns with the social worker but did not formally escalate their concerns using the relevant protocols (SWCPP Escalation Policy, Bristol SCB Escalation Procedure; Resolution of professional disagreements in work relating to the safety of children).

5.9.9 A number of interagency meetings were held at the GP surgery. Unfortunately it does not appear that the GPs or the Drug Agency A workers were present at these meetings. In order to ensure good interagency working and information sharing it is essential that all practitioners working with families have the opportunity to attend such meetings and are encouraged to do so in any way possible. Although it is recognised that holding meetings without parents' presence is not a practice that is advocated as a routine, there are times when, in order to address professional concerns and differences, they are appropriate and effective especially when dealing with avoidant and resistant parents. Professionals meetings would have been very appropriate within this case to ensure that all practitioners were clear about theirs and others roles, responsibilities, perceptions of the family and plans for future engagement with the family. It is essential that records with clear action plans of all interagency meetings are made and distributed in a timely way to all relevant practitioners.

5.10 Management oversight and supervision

5.10.1 It is well recognised that in order for professionals to work successfully with families, but especially those who are challenging, resistant, avoidant and complex they need access to skilled, professional management and supervision. This is especially important where resources are stretched, caseloads are high and practitioners and managers are under pressure. The IMRs of each of the frontline services in this case give indications that this was the context in which they were working.

5.10.2 Although resource issues in the social work teams were identified within the CYPS IMR there were delays in completion of assessments, convening of meetings and inadequate record keeping which do not appear to have been appropriately addressed in supervision as significant failures to meet acceptable professional standards.

5.10.3 Once Child L was born the engagement with services was supposedly structured through use of partnerships agreements. It appears that the terms of the agreements were changed without obvious good reason and seem to have been based on what the parents would agree to, rather than robust plans for the safety of the children.

5.10.4 It was evident through the chronology that there was a lack of clarity about the leadership responsibility for managing the care of Ms M as a pregnant drug user. The AWP IMR confirms this stating that although the Bristol Drug Service Operational Guidelines are clear this was not reflected in the working arrangements. This was particularly evident in relation to the drug screening. Workers in all agencies worked hard to engage Ms M in appropriate antenatal care but there is little evidence that they were robustly supported by a management structure that both challenged practitioners perceptions of the family, as providing good care for their children in spite of their likely escalating drug use, and offered appropriate support in making difficult decisions when working with resistant adults. Practitioners, for example the midwives, were also not sufficiently supported by assertive management when they were frustrated by a perceived inertia in CYPS.

5.11 The Legal Process

5.11.1 The lack of clear management oversight was especially evident in the process of issuing care proceedings. Although clear procedures are said to be in place there was a lack of robustness in the way that they were operated which resulted in a failure to use appropriately the only remedy that could ultimately have prevented Child K's death. The lawyers had provided advice that the threshold criteria for care proceedings had been met but needed mandate from CYPS to proceed; this was not agreed in a timely way. A number of pre-proceedings meetings were held. The first was seven weeks after Child L's birth, the last two weeks before Child K's death. Only the first was attended by all of the appropriate people – the parents and their legal representatives, CYPS and council lawyers.

5.11.2 The CYPS IMR comments "SW4 stated that in some ways they felt that the PLO process delayed the inevitable which was to initiate care proceedings in respect of Child K and Child L and the PLO process 'tailed off a bit'." p17. This appears to be a understatement and that a more assertive approach was required when it was obvious that the written agreements were being breached.

5.12 Working with substance using parents

5.12.1 It is well recognised that substance and alcohol misuse can have an adverse impact on parenting capacity often because parents often find it difficult to maintain a consistent focus on the needs of their children. The links between substance misuse and neglect are strong and substance misuse is often associated with other problems, especially adverse socio-economic circumstances. It is also known that substance misuse can have a negative impact on parent-child attachment. Substance misuse is also often associated with secrecy, denial, chaotic lifestyle and with criminal activity. It is also acknowledged that substance misuse services and child welfare services have different 'professional missions' and inter-professional tensions are almost inevitable. Therefore close attention to the need for collaboration or, at a minimum, good communication between the services is vital.

5.12.2 Difficulties in maintaining engagement of adults who misuse substances with services are also well documented and evident in this case. Services seeking to help parents in meeting their parental responsibilities need proper engagement by the adults, however they may be viewed by the parents as intrusive and potentially threatening and

their fears get in the way of full engagement. It is a difficult balancing act for practitioners from all services in developing and maintaining a helpful alliance with the parent whilst retaining a child-centred focus. There is also a difference between the goals and timescales for the two services. Adult focussed substance misuse services work in the context of a chronic and long term problem where relapse may be considered as a stage in recovery whereas child welfare services must to respond to the acute safety needs of children and must consider the negative impact on their health and development whilst the adults address their own problems. Throughout the progress of this case the impact of substance abuse on the parents and their capacity for parenting is a major feature and is evident in each of the aforementioned themes.

5.12.3 In spite of the potential for difficulties there is evidence in this case that the different professional constructs of the adult focussed services and the child focussed services were not a major obstacle and there is evidence of instances of good information sharing between agencies. However there remains a need to ensure that the services work in a collaborative way and practitioners have training, protocols, guidance and support to help them work in the 'crossover' to provide services that are parent friendly, child centred and family sensitive.

6.0 Lessons to be Learned

6.1 Response to Baby Z Serious Case Review

6.1.1 Baby Z died in 2007 aged 14 months as a result of 'morphine and methadone intoxication'. A Serious Case Review completed in 2009 made twenty seven recommendations for actions within agencies to reduce the likelihood of a similar occurrence. Although a number of the lessons learned have obviously been embedded in practice in agencies, there are a number of parallels between the cases that indicate that this has not entirely been the case.

6.1.2 Issues about awareness of child welfare concerns in adult focussed services such as the recording of whether children have been seen, timely referrals and ongoing information sharing appear to have been addressed. There was evidence of awareness and sharing of concerns with other agencies by hospital staff. There is evidence of consideration of safety issues with respect to methadone use.

6.1.3 Areas where recommendations do not appear to have been fully embedded in practice relate to:

- depth assessments of the parenting capacity of drug using parents
- The need to complete pre-birth core assessments for drug using parents
- Case recording and recording of meetings
- A family focus on service coordination
- Information sharing when drug warrants are executed by the police
- The appropriate use of challenge between agencies and escalation procedures

Lessons from this Serious Case Review

6.2 Provision of advice about safe storage is of limited effect if parents are unaware of the serious risk to their children of methadone ingestion. It would be naïve to believe that the insistence on daily supervised consumption of methadone for all adults who are parents will entirely reduce the risk of ingestion by children, either accidental or deliberate. There is also the balance to be struck between the safety offered by parent's engagement or not in opioid substitution programmes. However if methadone was only available to parents of young children through supervised consumption, albeit on a 6 day a week basis, the risk of accidental ingestion by children would be significantly reduced and the message about the risk to young children may be more overt. However the risk of accidental ingestion remains if even one day's dose is 'takeaway'. The mother, when interviewed as part of the SCR process, expressed a clear view that 6 day a week dispensing is inappropriate and should be available 7 days per week. This will have significant implications for parents being able to access pharmacies that are open 7 days a week or significant resource implications for health services if the access is increased. It seems obvious that if supervised consumption is required for one parent in a family the same should apply to all household members. It is essential that all users of methadone are given clear information and direction about the dangers to any naïve user but especially to children. It is important that practitioners acknowledge to themselves and service users that there are occasions when parents deliberately administer drugs, including methadone, to their children.

6.3 The management and treatment of drug using pregnant women is complex especially where the women is not fully engaged and is resistant to the intervention. It is recognised that chaotic substance use is likely to put the unborn baby at most risk of harm and services need to be sufficiently flexible to maintain engagement and thereby monitor the safety and welfare of the unborn baby. If women are not prepared to work with the specialist maternity service, but will engage with services in primary care, rather than risk total lack of engagement and the potential increased use of 'street drugs' it is essential that practitioners in primary care have not only appropriate training but also have access to specialist addiction services for consultation and advice. It is also important that practitioners whose main focus is children also have an understanding of the management of addiction including the relevance and appropriateness of routine drug screening.

6.4 Assessment of parenting capacity is a complex task and made especially challenging when parents are not open and honest. It must take account of the perspectives of all practitioners involved with the family especially those who are in most direct and regular contact with the family, for example, in this case, the Child and Family Support worker. Assessments must be dynamic, not based on fixed views that may be over optimistic. "*One of the most common, problematic tendencies in human cognition … is our failure to review judgements and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture.*"[10] (p9). Assessments must be based not only on how children are presenting at the time of contact but also on what is known about the impact of parental behaviour on the long term outcomes for children. Practitioners and managers need to be fully aware of and

[10] Fish, S., Munro, E. and Bairstow, S. (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews, London: Social Care Institute for Excellence.

use South West Child Protection Procedures Guidance on Working with Uncooperative Families.

6.5 It is essential that practitioners are supported by skilled supervision that supports them in the challenging tasks of working with families. When working with complex and challenging families especially when resources are limited and professionals feel pressured, it is essential that practitioners have access to skilled supervision to support challenge, reflection and professional development, but also to provide emotional support and opportunities for personal development. It is particularly important when practitioners feel overwhelmed and lack confidence, especially when this leads to a failure to take key decisions. Supervisors need to help practitioners to have a sense of direction, to keep them on track, especially giving thought to whether the current approach is working and to maintain a clear record of decision-making. Supervisors need to be able to stand back and have oversight of a case and have clear processes for regular review and follow-up. The management function of supervision must also be acknowledged and managers must exercise their responsibilities for monitoring standards of professional practice and addressing deficits. Agencies need clear lines of management accountability for decision making and all managers and practitioners must be aware of them.

6.6 Practitioners in all agencies need to be reminded of the importance of comprehensive record keeping that maintains a focus on children and their welfare. Observations of children and their interactions with parents and other adults are essential for assessing attachment behaviours which are central to a clear understanding of the welfare of children. Detailed chronologies, analysis of the family and social history of adults who are parents or who are part of the support structure for children, such as grandparents, are also an essential component of good safeguarding practice. Managers and supervisors in all services have a responsibility for ensuring that records are appropriately maintained and include analysis, in respect of the impact on the safety and welfare of children, of information that is gathered or received.

6.7 The dilemmas that different agencies face when working with parents who misuse substances cannot be underestimated. It is recognised that the best way to address these is though good interagency working. The systems need to be in place to support this collaboration with a clear understanding of the different roles, responsibilities and perspectives of the different agencies. Practitioners need to have the opportunities to understand one another's different responsibilities and to reflect on their own within a safe environment. This is supported by interagency training and other professional development activities.

6.8 The challenges of working with families who are resistant and avoidant also should not be underestimated. Practitioners need the skills and tools to assess parenting capacity and their willingness and capacity for change. Complexity is often also a feature of the lives of such families, making assessment even more challenging. In order to make these assessments and to offer effective interventions, practitioners require the skills to develop relationships and to maintain those relationships in circumstances when challenge is necessary. The same skills are also needed to maintain a collaborative working relationship with colleagues from other agencies when perspectives and priorities differ and challenge of the professional perspective or activity is required. There are times when this professional, interagency challenge needs to be supported by clear

procedures to address them. Practitioners must be aware of and feel empowered to use such protocols as the Escalation Procedures.

6.9 Successful interagency collaborative working is underpinned by structures such as Child Protection Conferences and other interagency fora. It is essential that practitioners are given the opportunities and tools necessary to contribute effectively. Procedures and guidance with respect to arrangements, including timescales, for convening of CP conferences and other interagency meetings must be followed if they are to be effective in safeguarding children. In order to foster good interagency working relationships there are times when it is essential that there is a multi-agency forum for practitioners to explore their perspectives and their challenges in their work with families. There are occasions when a meeting of professionals alone is necessary to allow this to occur. There has been a perception developed over the past few years that this in unacceptable and practitioners should be empowered to convene 'professionals only' meetings within the framework of agreed criteria.

6.10 There are times when working with families in partnership through the use of written agreements is insufficiently robust to ensure the safety of children. Where legal remedies are sought it is necessary to ensure that pre-proceedings processes are not allowed to drift. Managers in both CYPS and the Legal Services must take appropriate accountability for ensuring that this does not happen.

6.11 The number of pregnant drug using women has been increasing and continues to do so. This inevitably puts pressure onto the specialist service leading to the risk of dilution of the service being offered to the individual women, the likelihood that effective and trusting professional relationships will not have the opportunity to develop and the potential of risks to children not being fully identified or addressed.

7.0 Good Practice

7.1 The pharmacy which dispensed the medication for both Ms M and Mr N was clear about the responsibility towards the welfare of the children and ensured that information was shared with both Drug Agency A and Children's social care.

7.2 When Ms M changed GP practices, having been removed from the list of the previous practice, the new GP was proactive in gaining information from the previous practice and ensuring that there was handover between the Drug Agency A workers in the two practices.

7.3 All services, but especially the specialist midwifery service, were extremely persistent in trying to ensure that Ms M received appropriate antenatal care during each of her pregnancies. During the pregnancy with Child L, Ms M failed to attend more than thirty antenatal appointments. Her failure to attend was followed up by communication with the community midwifery service and with the allocated social worker.

8.0 Inter-Agency Recommendations

This was a family that had numerous contacts with a number of statutory and voluntary agencies. The review identified concerns about the effectiveness and quality of some of the interventions that were aimed at both helping the whole family and keeping the children safe. Four key themes have emerged as a result of this Serious Case Review:

- practitioners demonstrated a level of optimism that was not reflected in significant positive changes in the family situation or for the children.
- there was a lack of focus or understanding of the daily lives of the children.
- at times the supervision and management of staff was ineffective.
- there were gaps in communications and collaborative working both within and between agencies.

In light of the above the following recommendations are made to Bristol Safeguarding Children Board

8.1 To ensure improved outcomes for children, Bristol Safeguarding Children Board (BSCB) should endorse the recommendations and action plans of the individual agency IMRs and ensure that there is a robust mechanism for monitoring their implementation and evaluating their effectiveness.

8.2 BSCB should assure itself that actions resulting from the Serious Case Review into Baby Z have been fully implemented and are embedded in practice in all agencies.

8.3 BSCB should explore with service commissioners and providers of drug and alcohol services ways in which services to substance using parents have a family focus as well as providing appropriate person-centred care, this should include consideration of the feasibility and efficacy of the restriction of methadone prescription to parents of young children to daily supervised consumption. The commissioning process should take account of the increasing numbers of drug using pregnant women, it should also ensure access to specialist training, consultation and advice from addiction services for frontline practitioners in non-specialist services.

8.4 BSCB should assure itself that practitioners and managers in partner agencies are fully cognisant of procedures, guidance and best practice with respect to:

- assessment
- interagency communication
- record keeping including use of chronologies
- contribution, through attendance and provision of reports of appropriate quality, to Child Protection Conferences
- use of legal processes

and that there is management oversight of their operation.

8.5 To improve outcomes for children and to ensure practitioners are appropriately skilled, BSCB should assure itself that training and other professional development opportunities are available to practitioners and managers/supervisors in partner agencies about how best to work with avoidant and resistant families and which provides

an understanding of barriers to parental engagement and strategies to overcome these barriers. The impact of this should be evaluated by multiagency audit.

8.6 To ensure effectiveness of interagency working with children and families, Bristol SCB should be assured that practitioners and front line managers in partner agencies are aware of, understand and apply the Escalation policy and procedures

8.7 To ensure effectiveness of interagency working with children and families Bristol SCB should develop and disseminate guidance about the use of 'professional only' meetings; this should be set within the context of practice guidance about the operation and multiagency contribution to other types of interagency meetings which includes standards for attendance, provision of reports, meeting notes and action plans.

8.8 To ensure the safety and welfare of children BSCB should seek assurance from partner agencies that practitioners and managers in partner agencies have clear lines of management accountability at all levels for decision making with respect to child protection, especially the initiation of care proceedings.

8.9 A 'control/monitoring' measure for testing babies and young children for the presence of controlled drugs in high risk categories should be considered.

8.10 Consideration to be given to a short and powerful social media campaign to tackle a culture where administering methadone is perceived as acceptable.

9.0 Individual Management Review Recommendations

Bristol City Council Children and Young People's Service, Children's Social Care

1. The planned review of the Case Transfer Policy (Action Plan Child M) to include guidance on joint handover visits to families and direct communication between social workers about the family at the point of case transfer.

2. The revised BSCB Guidance for working with children of problem drug and/or alcohol using parents should refer to detailed areas to focus on in order to assess the impact of parental drug use. Guidelines to assessment within Forrester and Harwin (2011) should be referred to.

3. Inter-Agency Learning Sets to be established to explore the issues of parental compliance and the use of motivational interviewing as recommended by Forrester and Harwin (2011).

   The Learning Sets should be established and led by the BSCB between April 2012 and April 2013. At the end of this process an evaluation of the workers confidence in this area of work should be undertaken.

4. Opportunities are created for peer supervision groups to be established and embedded in each social work team. To be established by September 2012.

   Area Managers to audit the issues discussed and cases raised and discuss implications of these with Team Managers.

   Evaluation of the impact of these opportunities to be undertaken with social workers to evaluate whether they felt this had an impact on the way they were working and their professional judgments.

5. Bristol Children & Young Persons Services should become further involved in the ongoing development of the multi-agency Integrated Offender Management response of Avon & Somerset Constabulary.

Bristol City Council – Legal Services

1. There needs to be agreement between lawyers and CYPS about how requests for Legal planning meetings are be dealt with when it is not possible to arrange a meeting within the requested timescales.

   A checklist and guidance document for legal planning meetings has been drafted by legal services and agreed with senior managers in CYPS, and deals with this issue.

The document should be added to the legal handbook and circulated to all lawyers and Team managers.

2. There needs to be a standard format for legal advice following a legal planning meeting. Advice should also be given in this format where a request for a legal planning meeting has been dealt with by other means. Advice in writing should be sent to the Social worker, Team manager, the Area Manager and copied to the lawyer's manager within an agreed timescale.

   A checklist and guidance document for legal planning meetings has been drafted to include guidance on issues to be considered at the legal planning meeting, what advice should be given following the meeting, how this should be set out and who it should be sent to. This has been agreed by senior managers in CYPS. A template to give advice in a standard format is being developed.

   The guidance and checklist document should form part of the legal handbook and be circulated to all lawyers and team managers. Managers in the legal services child care team should audit advice given for compliance.

3. Requests for Legal planning meetings must be accompanied by the proper referral form and agreed list of documents. If the request for legal advice is dealt with by the duty scheme as an emergency, as a general rule, lawyers should not advise solely on the basis of the social work chronology as chronologies do not always contain sufficient information about the child(ren) and do not include a social work assessment. If the chronology is the only document available, lawyers need to obtain information and an assessment of each child from the social worker before giving advice in these circumstances.

   A checklist and guidance document for legal planning meetings has been drafted by legal services and deals with how referrals should be made to legal services and the information required. This document has been agreed by senior managers in CYPS. It should be added to the legal handbook and circulated to all lawyers and team managers. Requests for legal planning meetings should be monitored by legal services child care team managers for compliance.

4. There needs to be a clear understanding by social workers and team managers that a decision to pursue the pre proceedings process requires the threshold criteria to be met and an in principle decision to issue proceedings made by the Team manager in consultation with the Area manager. This decision should normally be made following a legal planning meeting. Legal services should be involved in checking the letter before proceedings sent by the team manager.

   The decision making process and procedure for the pre proceedings process is made clear in the legal handbook and has been clarified in the checklist and guidance document for legal planning meetings drafted by legal services and agreed by senior managers in CYPS. A flow chart setting out process may be useful.

5. Lawyers and Social Workers should be clear about their respective roles in the decision making process around the issue of care proceedings. The role of the lawyer is to evaluate the evidence and advise on whether the threshold criteria are met and any other legal issues that arise. The role of the Team Manager (in consultation with the Area Manager) is to decide whether to issue proceedings, whether the child(ren) need immediate protection or whether there is the time and opportunity to work with

the parents in the pre-proceedings process with the aim of avoiding the need for care proceedings.

A guidance and checklist document for legal planning meetings has drafted by legal services and agreed by senior managers in CYPS and deals with this issue. This document should form part of the legal handbook and circulated to all lawyers and team managers. Work needs to be done to ensure that this is well understood by lawyers Social workers and team managers. A flow chart may be useful.

Bristol City Council Housing

1. Arrange training that is relevant to the work of the Rehousing Service by 31st March 2012

2. Contact relevant teams and provide training by 30.6.2012

Drug Agency A

1. That the expanded risk assessment piloted by Drug Agency A from November 2011 is used for all patients receiving OST (agreed at Shared Care Monitoring Group 15.12.11) and that it is incorporated into the Bristol Drug Misuse Case Management Systems Theseus as a 'flexible form' in the next Theseus upgrade at April 2012.

2. That Drug Agency A's in-house training is adapted to include lessons learnt from the death of Baby K.

3. That Drug Agency A actively participates in the review of the 'NHS Bristol Protocol for the Management of Drug Misuse' by the Shared Care Monitoring Group. That this specifically addresses:

    - the role of urinalysis in treatment compliance
    - review of an appropriate treatment model for co-habiting parents/carers with children subject to a CP Plan or Child in Need interventions
    - development of a mechanism to enable historical review of an individual's treatment.

4. Drug Agency A adapts its centralised monitoring of Safeguarding referrals and communication between staff and CYPS to include a diary function to facilitate increased engagement with Reviews by 31.12.11.

    Drug Agency A has organised with the management of Bristol City Council's Case Conference Service for communication to be via secure e-mail rather than by post.

North Bristol NHS Trust

1. Practitioners need to improve their ability to challenge families and to challenge within the multi-agency arenas.

2. There is a need to ensure the transfer of information between Midwifery and Health Visiting service for drug misusing parents.

University Hospitals Bristol NHS Foundation Trust

1. To review the UHB Safeguarding Children training matrix to ensure that the right level of safeguarding children training is delivered to the right staff, supported by the guidance within the Inter Collegiate Document (2010) .

2. All children in whom child protection concerns have been identified should be discharged safely with all the safeguarding concerns being fully considered and documented. (Laming 2003)

General Practitioners (Bristol)

1. That where a primary care team is managing a child or unborn child about whom there are concerns, that a designated senior professional (such as a community paediatrician or a named doctor for safeguarding children) is responsible for supervising and providing support so that no professional is working in isolation. That includes concerns about parenting capacity due to drug and alcohol abuse but may also include parental mental health problems.

   Specific – member(s) of the safeguarding team could liaise with the named GP (for safeguarding) for each practice to see how effective supervision might look.

   Measurable – the PCT safeguarding team and individual practices would be able to record whether supervision is happening
   Achievable – this is achievable depending on the time costs particularly to the supervisors as they would probably be covering many different primary care centres.
   Realistic – the details of time, costing and practicalities need establishing.
   Timeframe – to be discussed at PCT level and LSCB within 6 months.

2. That individual practices devise their own systems of ensuring vulnerable families are discussed within their agency and, when needed, with other agencies.

   Specific – practices should plan regular meetings involving the key professionals

involved with vulnerable children and families to reflect on the case, share information and plan ongoing management. The professionals involved may vary according to circumstances and variations in practice set up. Typically the meetings might involve the practice lead GP for safeguarding, health visitors, BDP and, where appropriate, practice manager, community psychiatric nurse, alcohol support worker etc. The outcomes of these discussions should be visible on the child's/parents records.

Measurable – meetings would be evident from looking at the practice calendar

Achievable – many practices are already undertaking these type of meetings. The frequency and people invited could be reviewed and will vary from practice to practice.

Realistic – as above, this is already happening to varying degrees. It is realistic that relevant outcomes from discussions get recorded on to the child's records

Timely – it would be reasonable for the practice to have reviewed and set up their systems for discussing vulnerable families even if the meetings haven't started yet, by six months.

Great Western Ambulance Service (GWAS)

1. During the safeguarding training and by way of an update session, call handlers must be made aware of the importance of conveying information regarding all references of children to the ambulance crew on the scene

2. Ambulance service to consider ambulance clinicians working independently, i.e. those who use the rapid response cars attending level 3 safeguarding training so that they are knowledgeable about child welfare issues when working alone and are equipped to provide safeguarding advice when responded to incidents involving other ambulance crews

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 1

a) That the RiO clinical manual should be amended to ensure that practitioners comply with the requirements to record information on children and child protection information

b) That an "easy to read" guide on recording safeguarding children information should be developed and made available on the Trust intranet safeguarding pages

c) That the RiO clinical manual should be updated to reference a process to mark received data and information with the time and date of receipt prior to the upload of documents into RiO.

Recommendation 2

a) That the Drug Agency B specialist maternity service safeguarding training plan is reviewed to ensure that the wider group of key workers managing maternity cases develop and maintain appropriate competencies through access to relevant multi agency child protection and Think Family training

b) That Drug Agency B practitioners working with families with children should be able to demonstrate their knowledge of the SWCPP Guidance of Working with Uncooperative Families, its application to their practice and the thresholds to escalate concerns if non cooperation is not being effectively addressed by agencies.

c) That an audit of Drug Agency B practitioners working with families with children, regarding their awareness of the SWCPP Guidance of Working with Uncooperative Families and their use in practice of Think Family principles will therefore be completed. Findings from this will inform further actions to be taken

Recommendation 3

a) That a standardised RiO library care plan should be developed setting out best practice for safety planning when methadone or other potentially dangerous drugs are taken home.

b) That this care plan should include confirmation of parental understanding and actions to demonstrate compliance with their safety plan, the timescales applicable within the care plan, and the actions to be taken if safe storage is not achieved.

c) That an audit of the full completion and use of the standardised RiO library care plan for safety planning when methadone or other potentially dangerous drugs are taken home will therefore be completed. Findings from this will inform further actions to be taken

Recommendation 4

a) That a standardised RiO library care plan should be developed setting out best practice on risk management of cases with children on child protection or child in need plans, including need for crisis and contingency plans, and the need to attend key safeguarding meetings with defined cover arrangements in the absence of the key worker

b) That an audit of the full completion and use of the standardised RiO library care plan on the management of risk in cases with children on child protection or child in need plans, and of the attendance levels at key safeguarding meetings in Drug Agency B specialist drug maternity services will therefore be completed. Findings from this will inform further actions to be taken

Recommendation 5

a) That an audit in Drug Agency B specialist drug maternity services of the completion and review of required risk assessments and care plans to manage risks to children

will therefore be completed. Findings from this will inform further actions to be taken

b) That an audit in specialist drug maternity services of the review of risk assessment and care plans following birth and Child in Need or Child Protection meetings will therefore be completed. Findings from this will inform further actions to be taken

Recommendation 6

a) That a review of the Trust Guidance on S47 reports should be undertaken, including clarifying the purpose, focus and management overview of such reports, and expanding the guidance to cover reports to all Safeguarding Children multi agency meetings.

b) That an audit in Drug Agency B specialist drug services of the completion, standard and oversight of Child Protection reports to comply with the revised Trust Guidance on S47 reports and the South West Child Protection procedures guidance on reports will therefore be completed. Findings from this will inform further actions to be taken.

Recommendation 7

a) That Drug Agency B should coordinate a review of the Bristol Maternity Drug Service Operational Guidelines to ensure that pathways to specialist ante and post natal and specialist maternity drug services are clear, that the role and authority of coordination is explicit, and that the arrangements are fully understood by all practitioners working with the family, to ensure consistent and effective practice in managing these pathways in the ante and post natal periods.

b) That Drug Agency B should ensure that there is a record of meetings, including actions agreed, and monitoring of delivery of actions at made at drug ante natal clinics, and that these are shared with relevant attending services/agencies.

c) That an audit of the application of the Bristol Maternity Drug Service Operational Guidelines in Drug Agency B specialist maternity services including delivery of actions agreed at ante natal clinics will therefore be completed. Findings from this will inform further actions to be taken.

Recommendation 8

a) That a Bristol protocol for prevention of child exposure to synthetic opiates is developed for use in specialist drug maternity services and drug services working with parents covering:

- safety planning
- provision and use of lockable boxes
- prescribing and administration of medication
- home consumption
- drug testing practice
- review of risk post birth
- identifying and managing uncooperative parents

- withdrawal of services from uncooperative parents
- thresholds for child protection referral to prevent exposure to synthetic opiates
- thresholds for escalation to prevent exposure to synthetic opiates
- coordination between adult drug services in the family

b) That the BSCB Guidance for working with children of problem drug and/or alcohol using parents is reviewed to address the issues of both parents having drug and/or alcohol problems, the need for the coordination of care and risk management by drug and alcohol services working with the parents of unborn and born children, the need to plan withdrawal of services in the context of delivery of a child protection plan, and to reference the Bristol protocol for prevention of child exposure to synthetic opiates and SWCPP Guidance on working with uncooperative families.

Pharmacy

1. Company specific Recommendation.
   - Company (IMR author) to review training and guidance and to incorporate specific training relating to children with parents taking drugs/ Methadone. This should incorporate the signs and symptoms of Methadone ingestion in children and an insight into the life of the child and when to refer or challenge professionally. The review and writing of the guidance to be completed by 31/1/2012. Training of all branch colleagues to be completed in 31/3/2012 and to be confirmed by the completion of a web form monitored by Head Office.
   - The IMR author to review the CPPE safeguarding training currently available for content relating to parents taking Methadone and to contact CPPE and the Royal Pharmaceutical Society (RPS) if appropriate to highlight the potential need for additional training resource to be available for pharmacists and pharmacy technicians. To be completed by 31/12/2011.

Wider Recommendation or Points of Discussion for other agencies e.g. PCT/Safeguarding.

- To discuss the review of the Level 2 training for pharmacy contractors to incorporate additional information relating to the signs and symptoms of methadone ingestion in a child.

- Website access and dedicated site for all health care professionals including pharmacists of simulated case studies to raise awareness and knowledge and to be used as an adjunct to any training. The site could enable access to the Level 2 training materials and link to the ordering of any leaflets discussed within the training.

- I am not aware of a PCT led pharmacy contractor safeguarding audit having been completed in NHS Bristol. Audits have been completed in other PCTs to ensure pharmacy contractors are trained to the required level.

- To raise awareness to pharmacy contractors of the Medicines Management community pharmacy website and the process for ordering additional health promotion leaflets within Bristol NHS.

2. Company specific recommendation

- Company (IMR author) to ensure the importance of good inter agency communication and working is highlighted in the review of the company safeguarding training and guidance. Reference to be made to the importance of discussing the children of parents taking Methadone and related medication with the prescriber / community drug teams if appropriate and the importance of appropriately recording any shared information securely in the pharmacy. The updated company safeguarding training and guidance to be completed by 31/1/2012 and to be completed by branch colleagues by 31/3/2012.

Wider Recommendation or Points of Discussion for other agencies e.g. PCT/Safeguarding/Community Drug Teams

- To improve the inter agency communication and sharing of relevant information on individual cases with pharmacists. Any substance misuse client with children or living with children should be highlighted to the appropriate agencies including the pharmacist. The pharmacist should be made aware of any child protection plan if the pharmacist has regular contact with the child or parents as in this case.

- To build on the good practice of community pharmacies receiving annual Child Protection Newsletters. Community pharmacists would benefit from access to relevant policy documents to ensure the pharmacist is aware of the correct procedure and can professionally challenge if appropriate e.g. The Community Drug Team policy relating to supervision of Methadone of clients with children.

- Review policy and procedure documents if appropriate to ensure the male of the household is adequately assessed and to aim to reduce the quantity of Methadone in any household with children to a minimum.

NHS Bristol

1. It is **recommended** that there should be a consideration of one drug service for dependant drug using parents. The child's needs are paramount in UK Law and must been seen as the priority because they are dependent on the adults they live with. This service should be embedded in effective multi-agency practice which works to established guidance. This should be reviewed within the next six months.

   There needs to be effective joint commissioning for specialist drug services. Commissioners of this service's must include the Clinical Commissioning Groups, Public Health and the LA. Any new contracts for drug services must consider the whole family (any adults who have regular contact and care for children) and include

standards and performance indicators on safeguarding children.

2. The Designated professionals should facilitate a multi-agency meeting of front line practitioners to identify if there are any barriers to these protocols being followed. This combined health review can contribute to any future multi-agency policy development to ensure the policy will be implemented.

Avon and Somerset Police

1. Current practice for implementing child protection plans is reviewed in line with recent training developed on behalf of NOMS to ensure best practice is adopted. Future training for Police safeguarding co-ordination units should incorporate other agencies

2. Head of Public Protection to continue strategic discussions with Local Safeguarding Boards over the development of Safeguarding Co-ordination Units. Alternative solutions that increase and improve communication should be progressed.

3. The approach to Case Conference reports is standardised as Safeguarding Units are established based on the Bristol model. The reports will be scanned and linked to intelligence reports and used as a reference for TAU or other Flags.

4. The recommendations and process recommended by [redacted] for the co-ordination of Police visits is implemented.

5. Review the current training provided for Offender Managers (Police) and establish if there is value in extending aspects of the training for social care particularly in relation to the conduct of home visits in often hostile circumstances

6. Support further involvement of CYPS in the ongoing development of Integrated Offender Management response

7. Adults directly connected with children on a child protection plan must be 'flagged'.

8. The procedural guidance for applications of drugs warrants contains a checklist that will be amended to ensure children are fully considered

Shelter

1. Shelter services to be reminded that completion of 'Additional Information Form is mandatory, and plan to effect this by: re-issuing guidance in this area; stating this requirement in the learning points from this SCR to be cascaded throughout the organisation; considering how checks on the completion of this form can be better incorporated into the organisational quality assurance programme; and explore the feasibility of altering the Case Information and Case Management system so that users

are unable to proceed through the system without first completing this form. Guidance also to be made clearer and re-communicated so that staff are more aware of the requirement to discuss with their line manager the feasibility of offering support in situations where there is insufficient, or a reluctance to provide, information deemed necessary to make an effective judgement on what support should be provided.

Timescale for Completion: By end of March 2012

Responsible for ensuring completion: Business Support Team

2. Guidance is reviewed and re-communicated so that there can be no misunderstanding as to what is required of staff when completing risk assessments, and more specifically, remove any opportunity for staff to be under the impression that risk should exclusively focus on risks that may be present to them as workers. Completion of risk assessment forms, and the signing off of them by team leaders is to be more robustly monitored via the organisation's quality assurance programme.

   Timescale for Completion: By end of March 2012

   Responsible for ensuring completion: Business Support Team

3. That the case note form is amended to include a column for recording which family members are present at each contact and that Shelter's training courses in Safeguarding and Writing Effective case notes include reference to recording the demeanour of those family members present, where possible.

   Timescale for Completion: By end of March 2012
   Responsible for ensuring completion: Business Support Team