# Serious Case Review

## Relating to Child K

2009 - 2011

Ethnic Origin: White British

## Overview Report

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### About the Author

A qualified nurse and health visitor since 1976 the author had been, until November 2008, Consultant Nurse, Safeguarding Children and Designated Nurse for Child Protection and Looked After Children in Somerset for 8 years; prior to that she was Named and Designated Nurse for Child Protection in Cambridgeshire. She has experience as a member of a number of Serious Case Review Panels and has written both Individual Management Reviews and Overview Reports. She now works as an Independent Consultant.

## 1. Introduction

1.1. 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) [1]. 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

1.2. Child K, a boy aged 2 years, was found unresponsive at home by his mother at approximately 12.15 pm on 21 August 2011. An ambulance attended the scene where Child K was found to be deceased and he and his mother were transported to [redacted] Hospital [redacted]. Post mortem toxicology 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[2]) and following trial both have been convicted and sentenced for offences relating to the death of child K..

1.3. The case was initially considered for a Serious Case Review at the Bristol Safeguarding Children Board Serious Case Review Sub-group on 12 September 2011. It was agreed the criteria for a Serious Case Review were met and recommended that a Serious Case Review (SCR) should be carried out.

1.4. The SCR was carried out under the guidance from Working Together to Safeguard Children, 2010, Chapter 8.

1.5. As described in Working Together to Safeguard Children 2010 (8.5), 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;

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

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

- 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.

1.6. 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 David Dungworth, 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.

1.7. The role of the independent chair is to ensure that the SCR process is completed in as timely way as possible so as to provide a full set of reports for the Safeguarding Children Board and ultimately Ofsted for evaluation. He is responsible for quality assuring the process and reports and requiring changes and further work where necessary, including challenging where there appears to be insufficient or missing information. The independent chair is responsible for ensuring that there is sufficient independence in the process.

**Panel Members represented the following services:**

| **Agency/Authority** | |
|---|---|
| NHS Bristol. | Designated Doctor<br>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 Service (CYPS) | Safeguarding Business Unit manager |
| ▪ Housing Solutions | Service Manager |
| Bristol Safeguarding Children Board (BSCB) | Policy and Projects Officer – Safeguarding |
| Safer Bristol | Service Director |
| Legal Advisor | Independent lawyer |

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

1.9. 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 the overview report.

1.10. 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.

1.11. 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

University Hospitals Bristol NHS Foundation Trust

General Practitioners (Bristol)

Great Western Ambulance Service NHS Trust (GWAS)

Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)

Pharmacy

Avon and Somerset Police

Shelter

1.12. 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.

1.13. Organisations were asked to identify IMR authors who were who were independent of any line management responsibility for services provided to the family members and asked to certify thus in the IMR.

1.14. 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.

1.15. IMR authors were provided with a standard template used by Bristol Safeguarding Children Board; this helped to ensure consistency and completeness of the reports.

1.16. 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.

1.17. 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?

1.18. In order to ensure that the IMRs were of a sufficient standard and that they addressed all aspects of the terms of reference the SCR panel requested that the completed IMR be agreed and signed off by the Senior Manager in the organisation who commissioned the report and who will be responsible for ensuring that the recommendations are acted upon in a timely manner.

## 2. Serious Case Review Process

**2.1.** As described above a Serious Case Review Panel (the panel) was convened and chaired by an independent consultant. The role of the panel was to oversee the process of the SCR on behalf of the Bristol Safeguarding Children Board, to ensure close contact with IMR authors and to ensure robust, independent scrutiny and critique.

**2.2.** The panel endorsed the Terms of Reference for the Review and met at strategic points during the process.

**2.3.** IMRs and detailed chronologies were submitted to the panel and an Integrated Chronology was constructed. This formed the basis for the examination of significant events contained within the overview report.

**2.4.** The Panel met on six occasions to oversee the SCR process. The overview author was in attendance at some panel meetings but was not a panel member. Draft IMRs were scrutinised by the panel and authors were invited to a meeting at which the panel were able to clarify issues arising from their IMRs. The meeting also provided an opportunity for authors to receive feedback about the quality and content of the IMRs before submitting a final version. Final versions were submitted to the panel after additional quality assurance and final 'sign off' by senior managers in the organisations.

**2.5.** The finalised IMRs were scrutinised by the panel and overview author. It was confirmed that all had been signed off by a senior manager in the organisation to ensure appropriate ownership within the organisation for implementation of recommendations and action plans. Action plans from the IMRs were collated.

**2.6.** All of the IMRs were of at least adequate quality. They were all presented in standard format ensuring that all elements of the requirements of the Terms of Reference were

addressed. The methodology used to complete the IMR was clear in all cases and an appropriate range of personnel were interviewed by the IMR authors. The detail provided in the section on Agency Involvement varied and a number of the IMRs did not fully address Section 3 with respect to the SCR Terms of Reference.

**2.7.** Each of the IMRs gave some consideration to the cultural issues that were relevant to the family who were White British and English was their first language. There is nothing in any of the IMRs to suggest that there were specific issues of race, language, religious identity or disability with respect to the parents that needed to be taken into account. All IMRs identified that the parents had a culture of substance misuse and identify the potential for negative impact on children.

**2.8.** The independence of the IMR authors was clear for all of the reviews.

**2.9.** Most of the IMRs provided an appropriate level of analysis of agency involvement highlighting both deficits in practice and examples of good practice. The level of analysis in the CYPS IMR was of particularly high quality. The Housing IMR contained little or no analysis but related to very limited, and no direct, contact with the family. It did however offer helpful contextual information. Some, but not all, of the IMRs demonstrated the overt use of research evidence to underpin the analysis. There was an obvious attention to the needs of the child and the recommendations mostly focused on improving outcomes for children although this was not always made explicit. In all of the IMRs the recommendations, in most part, flowed appropriately from the lessons learned and were Specific, Measurable, Achievable, Realistic and Time bound.

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

## 3. 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. The [redacted] grandparents were invited to make contribution. The [redacted] has declined to make any comments.

**3.2.** The SCR Panel Chair and the Safeguarding Policy and Projects Officer met with the mother she was able to offer minimal insight into work of agencies with the family which are taken account of in the report, specifically at 5.8.4 & 6.2

**3.3.** The SCR Panel Chair and the Safeguarding Policy and Projects Officer also met with the [redacted] grandmother, [redacted] She described Child K as a ‘happy smiling child’ who had been doted on by his parents. [redacted] felt that a second child had put excessive additional stress on the parents and considered that the two children should not have been allowed to go home as soon as they did after Child L’s discharge from hospital. She had provided support to the family and Child K had stayed with her a number of times, including several days the week before his death. [redacted] indicated that she felt that she could have been more involved by professionals and would have been able to offer more support. She expressed the view that more

frequent unannounced visits should have been made to the family. She expressed the view that the family home was unsuitable for young children to live in, especially when the hot water and toilet were not working. [redacted] said she was aware that the parents were not always honest with professionals and wanted to maintain their lifestyle and found the children stressful.

**3.4.** [redacted]

# 4. The Facts

## 4.1. Family Background

The couple were thought to have been together for approximately 10 years at the time of Child K's birth.

## 4.2. The mother – Ms M

The GP IMR indicates that the mother was using cannabis from the age of 15 years and started using other drugs including heroin and crack cocaine between aged 17 and 19. The AWP IMR confirms the long term multiple substance use with treatment dating back to when she was 21, including a short episode of residential drug detoxification. [redacted] She was also known to use alcohol and benzodiazepines. [redacted] In 2006 [redacted] at the time she told hospital staff that had stopped intravenous drug use seven months previously and was on a methadone programme. In mid 2007 she was again injecting heroin and using benzodiazepines and crack cocaine, she was referred to Drug Agency A and commenced a methadone programme; she was not always compliant with appointments. [redacted] She was injecting heroin daily when she became pregnant with Child K.

## 4.3. The father – Mr N

Other than the CYPS IMR the IMRs contain little detail about the father's background however he was known to be a drug user since his teens, [redacted]. From the age of 15 he had a pattern of drug use considered similar to an adult and work with him [redacted] indicated that he had little insight into his drug use and an unwillingness to address [redacted] The Drug Agency A IMR indicates that he had been in receipt of a Shared Care service with Drug Agency A since 2007 however there is no entry in their chronology in relation to him until January 2009 when he was referred by the GP to Drug Agency A Family Support Service. There is information about a number of

attendances at A&E [redacted]

## 4.4 Summary of Significant Facts from the Integrated Chronology of Agency Involvement

### Prior to pregnancy with Child K

**4.3.1.** The Drug Agency A IMR states that Ms M was referred by the GP for shared care in January 2008, however it would appear from GP entries in the chronology that she had contact with the service in the GP practice during 2007, although did not appear to engage well.

**4.3.2.** [redacted] It was noted by the GP that she had registered at a new surgery and in March Drug Agency A indicate that they lost contact with her. [redacted]

**4.3.3.** In May 2008 an episode of care with Drug Agency A recommenced at the new surgery although direct contact was limited. [redacted]. It is not entirely clear but it would appear that this related to the change of GP in March. [redacted] It was noted in the referral that she was seeing the GP for prescription of methadone and benzodiazepines. Ms M defaulted a number of appointments with the specialist team during July and August and did not make contact with the midwifery service as advised by the GP both in face to face consultations and in a letter to her.

[3]The communication GP to GP and the identification of the need for the Drug Agency A workers to exchange information is an example of good practice.

**4.3.4.** [redacted] During the rest of the year Ms M was seen by the GP and Drug Agency A worker for methadone prescriptions, although she missed appointments and did not appear to be engaging in a treatment programme. She disclosed increased consumption of alcohol and one episode of 'on top' use of heroin. During this period she moved into a new flat with Mr N.

There is no comment in the IMRs or chronology whether [redacted] nor is there indication that Ms M was offered any support [redacted]

[3] Comments by the author appear in shaded boxes

[redacted] which may have been related to her increased use of alcohol and heroin. This may have been a missed opportunity more fully to engage her in drug reducing strategies to improve [redacted]

**4.3.5.** [redacted] He gave his address as his mother's. He described engagement with opiate substitution therapy with Drug Agency A, he disclosed that his partner Ms M was also 'clean' [redacted]

The information provided about [redacted] was incorrect [redacted] His motivation for giving this information is not evident

### Up to the birth of Child K

**4.3.6.** In January 2009 the service offered to Ms M by Drug Agency A was terminated, she continued to see the GP who prescribed methadone, at this point she was taking 50mls daily and denying any on top use. A pregnancy was confirmed in mid February and she admitted injecting heroin regularly. She was referred by the GP to Drug Agency B for specialist prescribing and maternity service.

The clinical management of pregnant women who are using drugs or who are on opioid substitution treatment is of extreme importance to safeguard the welfare of the unborn baby and to ensure the best possible outcomes for the baby. There is increased likelihood of low birth weight, premature delivery, perinatal mortality and cot death. Structural damage to the foetus may occur in the first trimester and later in pregnancy opiates, their substitutes and other drugs can affect growth or cause intoxication and abstinence syndromes. A comprehensive assessment of the mother and her situation is essential for the development of a care plan that is well coordinated and realistic. The model of a multidisciplinary team focussed on the maternity care of drug using women is recognised as the most effective model[4]. The Bristol Specialist Drugs and Alcohol Maternity Service has been set up to offer this model of care. The assessment and consequent care plan are dependent upon the woman's cooperation and provision of accurate information. It is recognised that this is often problematic as women fear that revealing their drug use will result in negative consequences[5,6].

[4] NICE clinical guideline 110 – Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors
[5] Day, E and George, S (2005) *Management of Drug Use in Pregnancy*; Advances in Psychiatric Treatment 11: 253-261
[6] Cleaver, H, Unell, I and Aldgate, J (2011) *Children's Needs – Parenting Capacity (2nd Edition)*, London, TSO

**4.3.7.** She attended a booking appointment with the community midwife in the GP surgery. As indicated in the North Bristol NHS Trust (NBT) IMR the community midwifery records have not been traced and therefore detailed information about that element of care is not available. The community midwife appropriately (in line with the South West Child Protection Procedures Unborn Baby Protocol and the Bristol SCB Expected Baby Protocol) made an early referral to Children and Young Peoples Service (CYPS) on [redacted] indicating concerns for the welfare of the unborn baby due to her poly substance use and her partner also being an 'ex-substance user', Ms M was aware of the referral. This was received by the Social Work Team [redacted] The CYPS chronology states that there was little information on the referral and no indication of the parents' perspective.

There is no indication of any immediate feedback to the midwife about the referral, if there was insufficient information on the referral it would have been appropriate for CYPS to seek further information and clarification. Working Together 2010[7] 5.33 clearly indicates the need for referrers to receive feedback on their referral and be engaged in discussion about the outcome of the referral. There is no indication that the midwife gave any consideration to undertaking an assessment using the Common Assessment Framework (CAF), presumably because her view was that the situation met the threshold for a child protection referral without assessment at the 'lower level' of the CAF. In view of the interagency input to the family it would have been appropriate for there to have been an interagency meeting as early as possible in the pregnancy to plan the input to the family, this was particularly important in this case due to Ms M's early and, as it turned out, ongoing failure fully to engage with the multidisciplinary Specialist Maternity Service

**4.3.8.** Bristol Specialist Drugs and Alcohol Maternity Service attempted to see Ms M but she failed to attend two appointments during March, a third appointment was offered on [redacted], said to be the earliest date acceptable to Ms M.

**4.3.9.** In mid March the GP saw Ms M and a plan was made to gradually reduce her benzodiazepine intake. At the end of March Ms M attended a hospital ante-natal clinic, accompanied by Mr N, and was seen by the specialist drug midwife, a worker from Drug Agency B and by a social worker, although this was not a planned contact. The social worker noted that Ms M had used heroin 4 or 5 days previously, by injection into her groin, Mr N had also used heroin at the same time. Ms M denied use of crack cocaine; she described her prescription as being for 50mls per day methadone and 20mg diazepam, with daily collection and supervised consumption from the pharmacy [redacted]. The midwife noted that both prospective parents were pleased with the pregnancy, had supportive families and Ms M indicated that she hoped to reduce her drug intake.

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

**4.3.10.** [redacted] Ms M was seen by the Drug Agency B for a full assessment. A care plan for weekly contact with a key worker and drug screens, reduction in methadone and diazepam and engagement with other services. Ms M reported that she lived alone with Mr N staying occasionally. She failed to attend appointments with Drug Agency B over the next month. She also failed to attend appointments with midwives; she continued to see the GP for prescriptions for methadone and reducing doses of diazepam. She indicated to the GP that she did not want to work with Drug Agency B, preferring to be seen at the GP surgery in spite of being informed of the need for more specialist input than could be provided by shared care with Drug Agency A.

Ms M's engagement with drug support agencies appears to be consistently unreliable and on her own terms. The practitioners were faced with the dilemma of maintaining some contact with Ms M, allowing some monitoring of her drug use and compliance with substitution therapy, which may have been lost if they had challenged her further and insisted upon transferring her care to Drug Agency B contrary to her will. However Ms M's non-compliance with the expected level of antenatal care which focussed on providing optimum care for her and her unborn baby appears to indicate that she is not prioritising the needs of the unborn baby and should have increased the level of concerns of practitioners and led to more authoritative child protection practice.

**4.3.11.** At the beginning of May Ms M and Mr N attended the specialist antenatal clinic, they were seen by the specialist midwife and the social worker. Ms M was in her 20th week of pregnancy. In view of the lack of engagement with Drug Agency B, the GP, in consultation with Drug Agency B, informed Ms M that the methadone would not be issued unless she was seen by Drug Agency B. There was liaison between the GP, Drug Agency B and the social worker in attempts to encourage Ms M to engage with Drug Agency B.

**4.3.12.** [redacted] Ms M was seen by the GP who had a discussion with her about non-engagement with the specialist maternity services. She disclosed concerns about the baby being taken away and agreed to work with services in an attempt to prove her suitability as a mother. It was agreed that she would return to supervised consumption of methadone with twice weekly contact with the GP and random urine testing. The dosage of methadone was to be slowly decreased and the prescription for diazepam stopped. Due to her continued failure to engage Drug Agency B discharged Ms M. The GP was informed of the decision to discharge and was offered liaison and advice on prescribing. It was suggested that Ms M should be re-referred if she indicated a greater willingness to engage with the service.

**4.3.13.** The discharge was apparently not effected immediately and at the beginning of June Ms M and Mr N attended the specialist drug clinic at the maternity hospital, they were seen by the social worker. Both parents said that they had reduced their substance use. There was discussion about parenting abilities and family support, it was agreed that the social worker would make a home visit and the couple agreed that the social worker should meet members of the extended family. A home visit by the social worker had been arranged for the following week but did not take place. A urine

screen was positive for benzodiazepines, opiates and methadone indicating use of unprescribed drugs. A further urine drug screen 3 days later was again positive for benzodiazepines, opiates and methadone, Ms M denied use of heroin or benzodiazepines. She continued to see the GP twice weekly and by the end of June was on 40mls methadone supervised daily although she was requesting longer prescription periods and unsupervised consumption.

The presence of unprescribed drugs in Ms M's urine indicated not only that she was lapsing but also that she was not being entirely honest, making it more difficult to manage her care appropriately and indicating that she was not prioritising the needs of the unborn baby.

**4.3.14.** In early July the couple both attended for an ante-natal appointment at the maternity hospital and a growth ultrasound was done, this indicated a gestational age of 28.5 weeks. The health visitor made a second attempt to have contact with the mother; she spoke to Ms M's parents who were unable to provide an exact address for her.

In view of the fact that Ms M was citing a high level of support from extended family it is perhaps surprising that her parents did not know her address.

**4.3.15.** [redacted] the social worker completed an Initial Assessment; this was four months after the referral by the midwife and more than half way through the pregnancy. It was identified that there was discrepancy between Mr N's reports of clear drug screens and information from the GP that his most recent result in May had been positive to heroin. The social worker had previously identified that [redacted] This additional information and Ms M's failure to engage with the specialist drug and maternity services led to a decision made in the social worker's supervision that a Child Protection Conference would be held.

The CYPS IMR indicates that there were capacity issues in the social work team during this period which may have impacted on the significant delay in completion of the Initial assessment. It is also noted that although there was some scrutiny [redacted] this had not been as thorough as would have been expected and failed to identify a number of significant issues that would have impacted on the assessment of Mr N's parenting capacity. [redacted]

**4.3.16.** The social worker visited the home on [redacted]. The appointment was sent to the mother and it is noted in the CYPS chronology that the father was not included. It is not documented whether the father was present during the home visit. The visit apparently focussed on prescribing issues, housing issues and meeting extended family members with little evidence of exploration of attitude to her pregnancy,

parenting capacity, the impact of substance use on children or the capacity of Ms M to change her behaviour to optimise the welfare of her baby.

**4.3.17.** At the beginning of [redacted] Ms M again failed to attend the specialist antenatal clinic, the community midwife was informed and another appointment sent.

The patient held Community midwifery records were not available. It was noted in the IMR from North Bristol NHS Trust that these had been collected from the mother and sent to the birth hospital but could not be located. Consequently it is not possible to ascertain how much antenatal care Ms M had received, nor is there much detail about the progress of her pregnancy.

**4.3.18.** [redacted] the social worker made another home visit, both parents were present but had to be woken at 10 am. The discussion focussed on housing issues and debts. The social worker gathered further information about the couple's backgrounds [redacted] Mr N disclosed recent, previous heavy use of alcohol but that he had now stopped. Again the CYPS chronology indicates lack of analysis of the information gathered by the social worker.

**4.3.19.** The following week Ms M again failed to attend an appointment at the specialist antenatal clinic. Contact was made with the community midwife who confirmed that Ms M was continuing to see the GP twice weekly and was now on 35mls methadone per day, consumption of which was now unsupervised. The community midwife had seen Ms M the previous week and she had been seen in the hospital due to reduced foetal movements reported by Ms M.

**4.3.20.** At the beginning of [redacted] Ms M again failed to attend the antenatal clinic, the social worker was informed, a new appointment was sent for the following week; also defaulted. In supervision with the social worker it is noted by the Team Manager that the parents have stabilised their drug use with no 'on top use', there is however no obvious evidence to support this assertion. [redacted] the social worker was informed by Ms M that she had missed her hospital appointment due to a house move this was the second occasion on which the social worker had been contacted by Ms M when it would have been more appropriate for her to have contacted a midwife, indicating avoidance of contact with the maternity service; this is of particular concern when she had identified reduced foetal movements in previous weeks..

**4.3.21.** [redacted] a Strategy Discussion is recorded as having been held and a decision to convene a Child Protection conference on [redacted]. There is no detail about who was party to the strategy discussion; there is nothing in the police chronology to indicate that they were directly involved at this point. There was however contact on the same day between the social worker and the health visitor informing her of the date of the Child Protection Conference. The health visitor was also informed of the new address which was in a different GP practice catchment area, but Ms M had yet to reregister. The health visitor shared this information with the Child Protection Supervisor who ensured that the health visitor in the new GP

practice area was made aware of the circumstances. Also on the same day Ms M attended an antenatal clinic at the hospital, after 7 non-attendances. There had been contact between the community and the specialist midwives. Information was shared about the infrequency of antenatal contact with both services. Urine toxicology tests done in late July and mid-August had indicated use of unprescribed benzodiazepines.

It is of note that a decision to convene a Child Protection Conference had been made by the social worker and team manager in supervision on [redacted], but not arranged until 2 months later, there is no explanation given for this delay. The status of the Strategy Discussion is ill-defined. The delay meant that the conference was held very late in the pregnancy allowing little time for implementation of the plan. According to the SWCPP Unborn Baby Protocol a Child Protection Conference should be held, or a child in need plan in place, by week 28 of the pregnancy at the latest, unless the referral is late. The referral had been made early in the pregnancy because of both parent's drug use, it had taken four months for an Initial Assessment to be completed, by which time it had become obvious that the mother was not compliant with the appropriate antenatal care and there were indication that she was not always open with professionals; both of which made the concerns for the unborn baby more significant and the need for timely planning for the postnatal period even more important. The failure to convene an earlier Child Protection Conference was a significant missed opportunity. The failure or reluctance of other professionals, especially the midwifery team, to challenge this lack of progress by use of the relevant escalation processes was also a missed opportunity to prevent this drift as identified as a 'Key message for health professionals' in Davies and Ward (2011) p93[8]

**4.3.22.** A Child Protection Conference was held on [redacted], details of who was present are not included in the chronology, however it would appear that neither the health visitor nor a representative from Drug Agency A was present, the specialist drug midwife [redacted] attended. The police and GP provided reports. The CYPS chronology suggests that different levels of concern were expressed by professionals, the highest levels of concern were identified by the specialist drug midwife and the GP. The CYPS IMR indicates a lack of appropriate analysis in the core assessment with a failure to give due consideration to the effects of the parents' history and culture on their ability to prioritise the needs of a baby. The presence of [redacted] was considered to be a protective factor. The Conference agreed on the need for a Child Protection Plan but with indication from the Chair that this could be a short term measure. The Plan included agreement that the baby, once born, would be discharged home with his parents with support [redacted], fortnightly visiting by the social worker for the first two months, contact with the Child and Family Support Service, weekly visits by the health visitor for 2 months and for the couple to work with Drug Agency A Family Support Service.

[8] Davies, C and Ward, H (2011) *Safeguarding Across Services: Messages from Research* , London, Jessica Kingsley

Significant weight appears to have been given to the protective effect of support from [redacted]. There is little indication of assessment of the quality of the support that would be offered, [redacted]

### From the birth of Child K

**4.3.23.** The following day Child K was born and mother and baby were admitted to the postnatal ward for observation. Baby K was formally assessed using for symptoms of neonatal abstinence which did not meet the threshold for treatment. Information about this period is limited due to failure to locate the maternal hand held records. Ms M cared appropriately for the baby with good input from Mr N. On 22nd September there was indication that Mr N was consuming alcohol on the ward, a can of lager having been found in the baby's locker. It is unclear whether this information was shared with the social worker at the time.

**4.3.24.** A Discharge Planning meeting was held on [redacted], it was attended by Mr N and [redacted], but there is no detail about professional attendance. No concerns about Ms M's ability to care for the baby were noted and Mr N explained the lager as celebrating the birth.

Mr N's explanation for the presence of the can of lager appears to have been accepted and the unacceptability of his action in leaving it in the baby's locker was minimised and not seen as a possible indicator of a lack of child focus.

**4.3.25.** Child K and Ms M were discharged from hospital on [redacted], discharge summaries about Ms M and Child K were sent to the GP, health visitor and community midwife. Ms M was noted to have had a urine testing positive to benzodiazepines but no details of when this was done are given. It was noted that Child K had been monitored for signs of withdrawal, had showed mild signs but had not needed treatment.

**4.3.26.** On discharge from hospital Ms M resumed daily supervised consumption of methadone, 30mls per day.

It is assumed that there was contact by the community midwifery service to provide postnatal care for the mother and baby, again this detail is not available due to loss of the records

**4.3.27.** [redacted] a core group meeting was held at the home address, it is not clear who was present at the meeting, but it was noted that neither of the parent's Drug Agency A support workers was present. The Drug Agency A chronology indicates that an invitation had not been received, a significant oversight. There were positive

reports of the care of Child K although there are no details of what that meant. On the same day Drug Agency A Family Support Service sent a letter to Mr N arranging an appointment for a home visit to provide support as requested by the GP in a referral in June. The Drug Agency A Family Support Worker visited on [redacted] the first two visits were unsuccessful.

**4.3.28.** The Child and Family Support Worker (CFSW) from CYPS visited the home on [redacted]. Both of the parents were present, Child K was said to be clean and alert and the parents expressing joy about the baby. The worker continued to visit approximately weekly until [redacted]. The main focus being discussion of practical parenting issues.

**4.3.29.** [redacted] the health visitor visited the home; both parents and Child K were present. Child K was described as well, alert and responsive. A Family Health Needs Assessment was completed. It had been agreed at the Child Protection Conference that there would be weekly contact by the health visitor for 8 weeks. The health visitor provided information about baby centred activities at the local family centre.

**4.3.30.** On the same day there is an entry from Drug Agency A in relation to a urine test for Ms M that indicated the presence of benzodiazepines suggesting 'on top' use. A repeat sample was requested.

**4.3.31.** [redacted] the GP saw Child K with what was diagnosed as infantile colic, the mother was advised to discuss this with the health visitor. Mr N was also seen by the same GP. His substance use was discussed, he said that he had been off heroin for 20 months and had been slowly reducing his methadone and diazepam intake. The GP indicated a plan to refer to Drug Agency A and to send urine for toxicology.

There is some discrepancy in the information about this urine screen. Entries [redacted] in the chronology from Drug Agency A record urinalysis that was positive to methadone metabolite and benzodiazepine but negative to cocaine, opiates and amphetamines, both were however very dilute and the laboratory requested repeat tests. The dilution of urine, either directly or by drinking large quantities of water before production of the urine, is used as a means of falsifying screening results.

**4.3.32.** The second planned core group meeting was held at the family home on [redacted], the parents, [redacted], the health visitor and the CFSW were present. Unfortunately the social worker was not present and there was no representative from Drug Agency A. Although the formal core group could not proceed, because of the absence of the social worker, a plan of contact with the CFSW and the health visiting team was agreed to include home visits and clinic attendance. It was also agreed that the health visitor would make a referral to Shelter for support with the family's housing difficulties. A community nursery nurse (part of the health visiting team) visited on the same day; Child K was weighed and appeared to be thriving, his weight was just under the 9$^{th}$ centile, no birth weight is recorded in the chronology therefore it is not possible to comment on the growth.

**4.3.33.** [redacted] the CFSW saw both parents at home and was told about a urine screen for Ms M, carried out on [redacted], which had been positive to opiates, indicating relapse. The information was shared with the social worker.

**4.3.34.** The health visitor referred the family to Shelter for support on their housing. The referral was received on [redacted]. The referral included information about the parents' drug use, identifying them as now 'clean' (rather than engaged in substitution therapy as was the case) and therefore wanting to move away from the 'known drug-using area'. The referral also gave information that Child K was subject of a Child Protection Plan.

**4.3.35.** [redacted] it had been expected that Child K would be taken to a child health clinic at a different GP surgery as the health visitor was unavailable. He was not taken to this appointment as it clashed with a visit by the Drug Agency A Family Support worker. Ms M informed the CFSW and the health visitor at the next contact.

**4.3.36.** At the beginning of November the newly allocated social worker wrote to the professional network working with the family informing them of the change of allocation. At a home visit by the health visitor on [redacted] the family were seen, Child K was described as well, alert, well–dressed and enjoying floor play. The parents expressed concern about a 'clicky' arm; they were advised to discuss this with the GP at Child K's eight week check. Advice was given about child care issues including passive smoking. The health visitor ascertained the parents' involvement with Drug Agency A. The parents had been booked on a first aid course in [redacted]

The health visitor was providing an enhanced service to the family, as defined by the employing Trust, which comprises a minimum of 3 monthly contacts. The Child Protection Plan had identified the need for more regular contact – weekly for 8 weeks. The health visitor also appeared to be attempting to engage the family in activities for parents outside the home.

**4.3.37.** The two social workers made a joint home visit to introduce the new social worker to the family and the case was handed over to the new social worker.

**4.3.38.** Mr N was seen by the Drug Agency A worker at the GP surgery on [redacted]; a urine sample was positive to opiates, Mr N denied any on top use indicating that it may have been the result of painkillers prescribed by his dentist. There is no indication that this was confirmed by the Drug Agency A worker either by checking the formulation of the painkillers or checking with the dentist.

**4.3.39.** [redacted] at a home visit by the CFSW Mr N showed a mark on the back of Child K's head which was said to have been caused by Child K hitting his head on the skirting board when lying on a changing mat on the floor. The parents were advised to show the mark to the health visitor. The baby was seen by the GP on the same day for review of his colic, which had not resolved on the prescribed medication consequently changed to Gaviscon™, the parents raised concerns about 'clicking shoulders' and were reassured. There is no recorded information about the mark on the baby's head.

There is no time recorded for the GP consultation therefore it is not known whether it was before or after the contact with the CFSW which was timed as 14.30. There is no indication that the CFSW discussed the injury with any other practitioner. There is no description of the mark – size, shape, colour etc or whether the worker considered the explanation acceptable. Child K was just over 7 weeks and therefore largely non-mobile. It is recognised that any injury to a non-mobile child should be considered with a high degree of suspicion[9]. The description given by the parents - that he had moved up the changing mat and hit his head does not seem to explain fully a mark on the back of the head. It would have been appropriate for the mark to have been assessed by a health professional as soon as possible. It is not clear whether the CFSW knew when the health visitor was next to see the child. The CFSW should have passed the information to the social worker with a view to onward referral to the health visitor or preferably the GP. This was a significant missed opportunity for appropriate investigation of a possible non-accidental injury.

**4.3.40.** Child K was taken to a child health clinic the following day. He was weighed and measured by a community nurse (part of the health visiting team). His weight was on 9th centile, length on 25th centile and head circumference on the 2nd centile. There is no mention of the mark on his head.

The differences in the centiles for the baby's weight and length suggest that Child K may have been underweight, he was however on the same centile as previously recorded. There are no other recorded length and head circumference measurements to make comparison.

**4.3.41.** Ms M was seen by the Drug Agency A worker at the GP surgery on [redacted] and her methadone was increased at her request because she felt she had reduced too quickly during pregnancy and although she not used any heroin she felt 'wobbly at times'. She continued daily supervised consumption. The change of prescription started on [redacted]. Ms M was accompanied by Child K and he was described by the Drug Agency A worker as 'seemed happy and bright'.

**4.3.42.** Child K was seen at home by the CFSW, he was described as 'clean and tidy as usual'. Issues of housing and money were discussed. Ms M indicated that she had not attended any mother and baby activities. It is not stated whether or not these were encouraged; the health visitor had previously encouraged attendance at the local family centre for such activities which are considered helpful for parents, especially first time parents. There is no mention of the mark on Child K's head seen the previous week.

**4.3.43.** [redacted] Child K attended the GP surgery for his first immunizations and eight week check. The chronology indicated that the examination was normal there is no mention of the 'clicky' arm or the mark on his head. An entry in the pharmacy chronology

[9] Maguire S. Bruising as an indicator of child abuse: when should I be concerned? Paediatrics and Child Health 2008;18(12):545-9.

indicates that he had been prescribed Gaviscon™ (a treatment for reflux – a fairly common ailment in babies) and liquid paracetomol (often advised after immunizations)

**4.3.44.** Mr N was seen by a Drug Agency A worker at the GP surgery, he was not well possibly due to food poisoning. It was agreed that his prescription of diazepam would be reduced from 16 mg per day to 14 mg per day as part of a gradual reduction programme.

**4.3.45.** At the end [redacted] Ms M was seen by the Drug Agency A worker. She expressed concern that the use of Orajel (a dental gel used for treatment of toothache which contains benzocaine) would interfere with her urine screen. She was requesting twice weekly prescriptions of methadone rather than daily supervised administration as she found daily attendance at the pharmacy difficult with a young baby. This was agreed but would be dependent on a negative urine screen. The screen is recorded as being negative to methadone metabolite, cocaine, opiates, benzodiazepines and amphetamine. In view of the continued daily supervised consumption of 40mls methadone but the lack of methadone metabolite in the urine it would appear that the sample was falsified in some way. Nonetheless the prescription was changed to unsupervised consumption and from [redacted] Ms M collected a 5 day supply of 200ml methadone in a child resistant bottle. There was a return to supervised consumption from [redacted].

**4.3.46.** [redacted] a core group meeting was held at the family home. The health visitor, CFSW, the Drug Agency A family support worker and manager and the new social worker were present as were both parents and [redacted]. The CFSW service was reviewed and it was agreed that fortnightly visits would continue until the end of [redacted] Support from the Drug Agency A family support service was to continue for another six months. There is no indication that there was any discussion about the parents' opiate substitution therapy or the urine screen anomaly. Ms M agreed to attend a group at the local family centre. The health visitor also wrote a letter to support rehousing due to the damp and mould in the flat. The following day Shelter invited Ms M to their office the following week for a Housing Needs Assessment.

**4.3.47.** [redacted] Child K was seen by the GP and treated for conjunctivitis. Ms M and Mr N both had appointments with the Drug Agency A worker in the GP surgery. Mr N's urine screen was negative to methadone metabolites but positive to methadone. Ms M's was negative to all tested substances including methadone metabolites.

This is the second occurrence of apparent falsification of the urine screens, this time by both parents. There is no indication that there was discussion about this with other professionals or that the parents were challenged about the results. However Ms M's prescriptions reverted to daily supervised consumption. The likely falsification of the urine was a significant concern, indicating lack of cooperation and presumably relapse and use of illicit drugs. It is also the second occasion on which one of the parents has used treatment of dental problems as a reason for apparent relapse. The

impact of this on Child K does not appear to have been given appropriate consideration and certainly should have been shared with the social worker as part of the Child Protection Plan

**4.3.48.** [redacted] Child K was seen by a GP with a 'fresh graze to the top of his head', the explanation given was that he had been on a changing mat, pushed back with his legs and hit his head on the skirting board. It was documented that the mother acted appropriately and was well. The GP also appropriately discussed her drug use.

This was the same explanation given to the CFSW for a mark on Child K's head on [redacted] There is the possibility that one or other of the entries in the chronology is incorrectly dated, although there are no indication that this is the case and some evidence that they were two separate incidents. Thus this was the second occurrence of a similar injury to a non-mobile child with the same explanation given by the parent. The GP IMR indicates that the injury did not fit with the clinical presentation and although the information was shared with the social worker via a faxed letter it was not discussed with either the health visitor or advice sought from the on-call community paediatrician as would be expected. The information was shared with the social worker but not immediately and was not made available to the Child Protection Conference held 2 days later. This was another failure to follow child protection procedures.

**4.3.49.** On the same day Ms M failed to attend an appointment at the Shelter office. Mr N telephoned the CFSW to rearrange an appointment. He said that the appointment with Shelter had been changed by the agency. The CFSW contacted Shelter and was informed that there was no record of the appointment having been changed. The CFSW also indicated that Ms M had stated a perception of being pressurised to attend parent and baby groups that she did not want to.

These are further indicators of lack of cooperation with agreed plans and lack of honesty.

**4.3.50.** [redacted] the first Review Child Protection Conference was held. A decision was made that Child K would no longer be of a Child Protection Plan based upon positive reports on Child K's care and presentation, the ongoing support of the grandparents and the belief that both parents were fully engaged in opiate substitution therapy and not using any on-top heroin. The plan was for Child K to continue to be reviewed as a Child in Need. This decision was reversed the following week when information about the injury to Child K and the falsification of the urine screens was received by the social worker from the GP and Drug Agency A.

It would appear that the information about the urine screens should have been available for the Child Protection Conference. The Drug Agency A representative at the conference was the Family Support worker, rather than the Shared Care Worker, who would not necessarily have access to the urine results, however it would be expected that a representative to a conference would have access to and collate all information relating to input of the agency to the family and provide a report prior to the conference. The agency should have been aware of the date of the conference as it would have been set at the initial conference in September and therefore been able to provide a comprehensive report and appropriately briefed the person who attended. This also applies to the GP who also would have been expected to provide a report if unable to attend the conference.

The conference appears to have placed much importance upon the input of [redacted] to support the family, however, other than the presence of one or other [redacted] at the two core groups there is no specific mention of any contact with them by any of the professionals. There does not appear to have been any assessment of their capacity to support the parents in safe care of Child K or their specific role in supporting the family. [redacted] It is not known whether this information was made available to the Child Protection Conference.

There is no indication that the injury to Child K's head seen by the CFSW in November was discussed or given appropriate consideration as an indicator of concern for the safety of Child K. Had the GP shared the information about the injury seen on [redacted] both of these injuries would have been seen in context and raised the level of concern for the safety of Child K.

**4.3.51.** [redacted] Child K received his second course of immunisations at the appropriate time. Ms M contacted the health visiting team to say that she could not attend an under 1's group that day as she had to attend the Shelter Office; this appointment was also failed. This is another indication of avoidance or disguised compliance. The following day Ms M attended an appointment with the Drug Agency A worker in the GP surgery, she denied substituting her urine which contained methadone but no metabolites.

**4.3.52.** Mr N's likely falsified urine screen was addressed with him by the Drug Agency A worker at the GP surgery; there was discussion of supervised urine screens and consumption. Both Ms M and Mr N were given take away doses of methadone to cover the Christmas period. There is no documentation of communication with the social worker.

**4.3.53.** [redacted] the social worker visited the home, Child K was seen and well but no detail of the contact was documented.

**4.3.54.** During the first week in [redacted] the CFSW visited the home; Child K was reported to be well and sleeping through the night. The parents said that they had

started to give solids and were advised that this was not appropriate and advised to wait until he was six months. There was discussion about the urine screening and the parents admitted that they knew 'the tricks' to get around this, they said that they were both going to ask for complete supervision. They had attended one under 1s group with Child K. The father failed to attend a Drug Agency A appointment at the GP surgery for urine testing.

It would appear that the CFSW had developed a sufficiently strong relationship with the parents that they were prepared to be more candid than they were with other practitioners. There is no indication however that the information was shared with other practitioners.

**4.3.55.** [redacted] a community nurse from the health visiting team visited the family at home as they had failed to attend a child health clinic on 5th. His weight was now above 25th centile. The NBT chronology indicates that the parents were aware of the child's needs and appeared to be enjoying him. Weaning on to solid food was discussed and advice given.

**4.3.56.** Mr N was unwell and appointments with Shelter and Drug Agency A were not attended. Child K was also unwell and taken to the GP on [redacted]. Both parents continued to attend the pharmacy daily until 22nd when they both requested and were given methadone prescriptions for a week as they were unwell. It was agreed with the Drug Agency A shared care worker that both would return to daily supervised consumption the following week.

**4.3.57.** [redacted] both parents attended the Shelter office to complete a housing needs assessment. In addition to the housing concerns details of the family's finances, [redacted] and substance use and their engagement with professionals were discussed. The case was allocated to a housing support worker.

**4.3.58.** Two days later Mr N failed to attend a planned appointment at the GP surgery with the Drug Agency A worker. It was decided that he would have to see the GP before another prescription was issued. A letter explaining this and enclosing an appointment for [redacted] was left at the pharmacy.

**4.3.59.** [redacted] the Drug Agency A worker contacted the social worker expressing concern that the parents were not fully cooperating with the child protection plan for regular contact with Drug Agency A and urine testing. Neither of the parents had attended since mid December and the last urine screen for Ms M was [redacted] The Drug Agency A worker informed the parents of this contact with the social worker by letter.

**4.3.60.** The following day the CFSW visited the home, Child K had a visible rash. Ms M said that she had sought advice from the GP who had reassured her that it was just dry skin which needed moisturising. The last GP contact for Child K had been on [redacted] The parents told the worker that they were reluctant to attend the Under 1s

group because it was in an area they did not want to visit because they would be offered drugs. [redacted]

**4.3.61.** The Shelter worker unsuccessfully attempted to contact Ms M but her phone was unavailable. The worker discussed the family with the social worker; [redacted]

**4.3.62.** Mr N was seen by the GP on [redacted], he told the GP that the methadone dose was 'not quite holding him', he denied any use of illicit drugs but said that he was drinking a couple of cans of alcohol per day. This information was shared with the social worker by the Drug Agency A worker. A urine specimen was provided which was very dilute but negative to opiates and amphetamine. The chronology does not confirm that it contained methadone metabolites. Ms M and Mr N both attended appointments with the Drug Agency A worker at the GP surgery on [redacted] as previously arranged. Mr N disclosed increased alcohol consumption; [redacted] It was agreed that his methadone dose would be increased to 45ml daily and that daily supervised consumption would continue. A urine sample for Ms M was recorded to be positive to methadone metabolite and opiates and negative to cocaine, benzodiazepine and amphetamine. There is no comment about it being dilute. The result was discussed with Ms M by the Drug Agency A worker on [redacted] on the phone when she rang to cancel an appointment due to bereavement. She explained that she had taken over the counter codeine when she was unwell; she was advised to see the GP for alternative pain relief that would not impact on the urine screen.

**4.3.63.** [redacted] the social worker visited the home, there were no details recorded of the content of the contact. On [redacted] the Shelter worker made a home visit, Child K was described as seeming to be 'a happy, well loved little baby'. The identified concern was the detrimental effect that the damp was having on Child K's health. The Shelter worker supported completion of a 'Rehousing on Health Grounds' form and agreed to write a supportive letter; this was sent on [redacted] and received by Housing [redacted]. An application for rehousing form had been received by the Housing Department on [redacted]. Ms M was accepted for social housing in the Bristol area with Band 4 priority based on composite need and supported by the agencies working with the family. The application was made in the name of Ms M [redacted]

**4.3.64.** [redacted] Mr N attended an appointment with the Drug Agency A worker; he denied diluting his urine sample.

**4.3.65.** At the beginning of [redacted] a new health visitor took responsibility for the family. She arranged a home visit for [redacted] and liaised with the social worker.

**4.3.66.** Ms M attended an appointment with the Drug Agency A worker, she admitted to having taken an unprescribed diazepam tablet 'to give her a good night's sleep'.

**4.3.67.** The new health visitor visited the family at home immediately before the core group on [redacted]. Child K, now aged almost 6 months, was observed to be developing within normal limits, his growth was continuing along previous lines; he was

vocalising and interacting with his parents and other family members. The health visitor offered advice on weaning, sleeping, vitamin supplements and skin care. Child K had some raised lesions on his forehead which the health visitor thought may have been ringworm. He was taken to the GP the following day and prescribed anti-fungal cream.

**4.3.68.** The core group meeting was attended by the health visitor, social worker, CFSW both parents and [redacted] The Drug Agency A worker had sent apologies, it is not recorded whether information or a report had been provided for the core group. Details of the meeting are included as part of the health visiting chronology. It was identified that Mr N [redacted] his methadone had been increased and his alcohol intake had increased. It was suggested that he should see his GP [redacted] Both parents said that they had been providing urine samples; it is not clear whether there was discussion about the likelihood of these having been falsified. There was discussion about the concerns about damp and a leaking window in the home; the family were to be supported in making a housing application to a neighbouring authority as the parents were keen to move away from previous drug links. The focus of the core group appears to have been the parents rather than Child K.

**4.3.69.** Ms M and Child K were seen by the GP [redacted]; both were suffering from respiratory symptoms. Both were seen again [redacted]; Child K had a cough, Ms M was complaining of not sleeping. She had been taking diazepam which had helped, she said that she was taking it every night and had felt symptoms of dependence. She requested prescription so that she would not have to buy them illegally. The GP declined prescription of diazepam but instead prescribed [redacted]

**4.3.70.** [redacted] Mr N attended an appointment with the Drug Agency A worker; he was again challenged about the likely substitution of his urine sample as it did not contain methadone metabolite. Mr N denied this but did not supply a spot sample. These concerns were shared with the social worker. On the same day the Shelter worker discussed the acceptance of the housing application by Bristol City Council, Ms M claimed to understand the bidding process for properties, which required on-line bidding for desired properties, but requested support to make application to an adjoining authority.

The Bristol City Council Strategic Housing IMR indicates that 58 applications were made between [redacted] when Ms M was first accepted on the list and [redacted]; none were successful. It is suggested in the IMR that had there been more flexibility in the bidding i.e. if they had bid on flats rather than exclusively houses and bungalows they would have been more likely to succeed. There is no indication that they were advised about this; had the Shelter worker maintained contact they may have helped Ms M to be more realistic in her applications.

**4.3.71.** The social worker visited the home [redacted], again there was no detail of the visit documented.

**4.3.72.** The Shelter worker visited on [redacted] and completed a housing application for the nearby authority. It was agreed that Shelter would withdraw support unless further support was needed for resettlement once alternative accommodation was found. The CFSW failed to gain access for a pre-planned home visit, the social worker was informed.

**4.3.73.** The following day Mr N attended an appointment with the Drug Agency A worker, in spite of agreeing to twice weekly urine screening he had failed to provide samples. His explanation was that he had been taking opiate based analgesia for back pain and was concerned that it would show up on the drug screen.

**4.3.74.** [redacted] the CFSW visited the home; her observations were less positive than they had been previously. She had already noted that Mr N was less engaged in Child K's care having spent the whole period of the previous three visits on the computer and not engaging in conversation with the worker. She had been sufficiently concerned about this to raise it at her supervision. On this occasion Child K was initially in the garden with his father. Ms M was observed feeding Child K in a hurried way and he may have not had enough food. Ms M indicated that the social worker had said that the contact with the CFSW would end at the end of the month. The CFSW later confirmed with the social worker that the CFSW would continue working with the family until a family support worker from Drug Agency A had been allocated.

The significance of Ms M's comment about the end of the episode of care by the CFSW is unclear. It is possible that the CFSW had been more challenging about the parenting which had antagonised Ms M.

**4.3.75.** [redacted] a new Family Support worker from Drug Agency A visited the home. This is the first recorded contact with this service since October 2009. [redacted] the social worker had been informed that the Drug Agency A support worker would be off work for an extended period and therefore the service would be suspended. There is no recorded detail of this visit. Another visit is recorded for [redacted] again with no detail. It is not clear what the focus of the work of the Drug Agency A support worker was to be and whether it was in line with the support offered by the CFSW which was focused on the parenting.

**4.3.76.** A urine sample from Ms M recorded [redacted] was positive to methadone metabolite, opiates and benzodiazepines. Mr N's sample was negative to opiates and amphetamine, there is no mention of methadone metabolite. Ms M was seen by the GP and prescribed temazepam for insomnia, other types of prescribed medication having been perceived as unsuccessful.

**4.3.77.** The CFSW visited the home on [redacted] The contact with the Drug Agency A support

worker was planned to be weekly, consequently the contact with the CFSW was ended.

It is possible that the lack of internet may have impacted on the ability to make housing applications which needed to be done on line. There is no evidence that this was explored by any of the practitioners.

There is no indication of any handover between the two family support workers or any discussion about whether their roles with the family were complementary or overlapping.

**4.3.78.** Ms M failed to attend an appointment with the Housing Department [redacted] to discuss the rehousing with particular reference to [redacted] this followed a letter from Ms N's solicitor sent the previous month.

**4.3.79.** Ms M attended a Drug Agency A appointment [redacted], a urine screen from [redacted] was positive for methadone metabolite, opiates and benzodiazepines. Ms M asserted that the opiate was dihydrocodeine that she had been buying not heroin. Her dose of methadone was increased to 45mls per day to reduce the likelihood of on top use of heroin. A sample from [redacted] was negative to opiates.

Ms M's assertion that she was using dihydrocodeine rather than heroin suggests a minimisation of her relapse and illicit drug use.

**4.3.80.** [redacted] the GP recorded that there had been concern expressed by a third party that Child K looked unkempt and may have a black eye. The GP phoned the mother, by chance a Drug Agency A worker was present at the time, the GP spoke to them and was informed that Child K was well with a small red mark on his cheek. The GP documented a more confrontational discussion with the father. The information was shared with the social worker but not, apparently, the health visitor. The social worker documented that the concerns had been raised by colleagues based in the pharmacy next door to the GP surgery. The Drug Agency A chronology indicates that Mr N attended the GP surgery that day and saw the Drug Agency A worker, he was accompanied by Child K. He supplied a urine sample. He said that he was bored at times an offer of attendance at groups was declined. He was issued with a prescription for a week as he said that the family were going on holiday.

Although the mark on Child K's cheek was considered insignificant by the Drug Agency A worker there is no detail recorded of any discussion about how it had been caused or whether the explanation was consistent with the injury. The record of a contact between the Drug Agency A worker and Mr N that day suggests that the contact was in the surgery but may have been in the home as there is comment about advice having been given about storage of medication. It is noted that Child K

was seen but there is nothing in the chronology about observations of the child or a conversation with the GP.

Child K was just under 8 months; there is no recorded detail about whether he was mobile, at best he would be crawling and therefore unlikely to have fallen. The GP appears to have relied upon the Drug Agency A worker to assess the significance of the mark. It would have been more appropriate for the GP to have seen the child to assess the significance of the mark.

**4.3.81.** The following week both Ms M and Mr N were seen at the surgery. Mr N's prescription was amended as the holiday date had changed. Ms M's last urine had showed use of morphine not dihydrocodeine as previously claimed, a further sample was supplied which did not contain opiates. Both were issued with weeklong prescriptions to cover their holiday.

**4.3.82.** [redacted] Mr N presented to his GP [redacted] he said that he had injected several weeks previously although the bruising appeared fresh. Mr N had self-medicated with anti-coagulant for four days previously. The GP record indicates a plan for a scan in hospital the next day. There is no record of this having occurred.

**4.3.83.** Ms M and Child K were seen by the GP [redacted], Child K had a respiratory infection advice was given and paracetomol prescribed. Ms M was said to be doing well, having enjoyed her holiday and taking prescribed temazepam on alternate nights. The entry from the pharmacy that day indicates that the previous prescription for temazepam for 28 days had been filled less than 4 weeks previously. A urine sample was positive for methadone metabolite and benzodiazepines. On the same day there is record of the Drug Agency A Family Support Service having been closed as mutually agreed with Ms M 'as not meeting her needs at the time'. The engagement with the Drug Agency A Shared Care Service at the GP surgery continued for both parents.

It is of concern that the support from both the Child and Family Support Service and the Drug Agency A Family Support Service had ended within a month of each other. The ending of the CFSS had been predicated on the Drug Agency A Family Support Service being involved on a weekly basis. However there was only one recorded contact with the service after the CFSW finished visiting. There is no indication that there was any discussion between Drug Agency A and the social worker about the ending of their involvement as would be expected for a child with a Child Protection Plan, There were indicators at the time that there was additional stress for the family, [redacted] Ms M was suffering with insomnia and possibly finding the child care stressful and Mr N's alcohol consumption had been a concern. It would seem to be inappropriate that the family support should be entirely withdrawn at this point. This indicates a deficit in interagency planning.

**4.3.84.** The Review Child Protection Conference was held on [redacted], Child K was almost 9 months old. There is no detail in the chronology or IMRs about who attended the conference other than the social worker and health visitor. A report was apparently available from Drug Agency A although the chronology does not make it clear if this was through attendance at the conference, a written report or if the information was presented by the social worker based on regular previous contact. The police provided a report which recommended continuation of the Child Protection Plan. It is recorded that there were no concerns about Child K who was described as happy, alert, well presented and interacting well with his parents. Mr N was said to be 'back on track' and not drinking; urine samples had been positive to methadone metabolites and benzodiazepines only on three occasions [redacted]. Ms M's urines over the previous 6 weeks [redacted] were positive only to methadone metabolites and benzodiazepines although one on [redacted] was also positive to opiates. Both parents were said to be cooperating with Drug Agency A. The CYPS IMR does however note that the lack of a drugs specialist at the meeting reduced the opportunities for discussion and evaluation of the drug use and the significance of the urine screens. Since the previous conference there had been one core group and the social worker had visited the family five times, the last visit had been on [redacted] The social worker had discussed the case in her supervision two weeks before the conference and it had been decided that the social worker would advise continuation of the CP Plan. The health visitor had last seen the family in March. There is no indication of contribution, either report or attendance, from the Child and Family Support Worker who was the practitioner who had had the most contact with the family. The Conference decided that Child K should no longer be subject of a Child Protection Plan but would continue to be considered as a Child in Need with three monthly reviews.

It would appear that the decision to discontinue the Child Protection Plan was based upon an optimistic view of the progress of the family. Improvements in cooperation had not been long lived and other sources of professional support were limited. The apparent improved engagement with the opiate substitution treatment had been over a period of six weeks. The Drug Agency A Family Support Service had withdrawn as it was not meeting 'Ms M's needs', this indicates a focus on the needs of the adults rather than a focus on the child. Mr N had not taken up the counselling offered by Drug Agency A. There had been little engagement with parenting activities on offer through the family centre. There appears to have been limited in depth assessment [redacted] and their parenting capacity. There were ongoing environmental concerns with respect to the housing which, although they had been accepted for rehousing they had not been successful in finding more appropriate accommodation and there was no ongoing support from Shelter. It is unclear why the social worker changed their mind and there is no detail in the chronologies or IMRs which gives more detail about the decision making process. It would appear that continuation of the Child Protection Plan would have been more appropriate to ensure consolidation of the perceived improvements in the family circumstances.

**4.3.85.** At her next contact with the Drug Agency A shared care worker Ms M's benzodiazepine prescription was changed from temazepam, which she had overused, to diazepam which was to be dispensed daily with her methadone.

**4.3.86.** The health visitor made a home visit on [redacted] to carry out Child K's 9 month developmental review. No concerns about his care and development were identified. He was crawling and babbling, he was described as having a good routine. His growth was following the same centiles. Both parents are documented as being well. [redacted]

**4.3.87.** At her next contact with Drug Agency A Ms M agreed to start reduction of the diazepam and twice weekly collection of both methadone and diazepam subject to ongoing negative urine screens.

**4.3.88.** At the beginning of [redacted] the social worker discussed the family in supervision and, although there is very little information in the chronology or IMR, a decision was made to convene a Child in Need Review and then close the case. The social worker made a home visit two weeks later; again there is no information about the content of that visit.

**4.3.89.** [redacted] Child K was seen by a GP accompanied by his father on the first occasion and his mother the second. He was seen by two different GPs. He was presented with mild diarrhoea and vomiting, not sleeping and a non-specific rash. He was prescribed a mild steroid cream for the rash and antibiotics on the second visit. When next seen by the Drug Agency A worker Ms M appeared stressed, expressed concerns that the appointment was too early, in spite of it having been changed on the previous visit to suit her. Her stress was explained by the illness of Child K. Her urine screen on this occasion was positive only to methadone metabolites and benzodiazepines. The plan to reduce the diazepam prescription was put on hold. [redacted] Mr N denied any on top use although his alcohol intake had increased somewhat.

**4.3.90.** Child K was again seen by a GP [redacted] with ongoing diarrhoea, again he was seen by different GPs, one that he had seen previously.

**4.3.91.** When Ms M was next seen by the Drug Agency A worker a plan to reduce the diazepam was agreed. It was also agreed that there would be a move to weekly collection of medication contingent on negative urine screening. Mr N was also on twice weekly collection and had successfully reduced the diazepam.

**4.3.92.** At the beginning of September the Community Nursery Nurse contacted Ms M to inform her of a new under 1's group in a local Children's Centre. She was also encouraged by the GP, who saw her the same week, to attend local groups to increase socialisation opportunities for both mother and child.

**4.3.93.** Ms M supplied a urine sample on [redacted] that was positives to opiates indicating on top use. The urine was also dilute and a repeat sample was suggested

by the laboratory. There is no indication that there was any challenge of this result in view of the agreement that weekly prescription was based upon clear samples.

**4.3.94.** Child K attended a child health clinic with his mother on [redacted]. The health visitor was asked to write a letter of support for housing; it was indicated that a move out of Bristol would be desirable. Ms M also disclosed that she was pregnant, confirmed by a home pregnancy test. The health visitor liaised with the social worker and saw the mother at home when dropping off a housing support letter. Child K was seen, he was almost a year and walking. Further advice about suitable 'Stay and Play' groups was offered.

There are many instances of advice being given about attendance at parenting, mother and baby groups etc, however it is evident that this was not followed through by the mother. It is often the case that some parents find accessing groups difficult and there is no indication that this was followed up or that she was offered additional support to help her access them. This may have been a role that the CFSW could have fulfilled; acceptance of such support would have indicated a willingness to put the needs of Child K ahead of the parents' own needs.

### Pregnancy with Child L

**4.3.95.** Ms M failed to attend a booking appointment with the community midwife on [redacted]. Three days later she attended an appointment with the Drug Agency A worker at the GP surgery. She stated that she was engaging with the midwife and receiving support for rehousing. [redacted]

**4.3.96.** Ms M attended a second booking appointment with the community midwife on [redacted] She was unsure of her dates and a gestational dating scan had been requested. The midwife completed a referral form (Child in Need form) informing CYPS that Ms M was pregnant and identifying child protection concerns with a view to coordinated pre-birth planning. A referral was also made to the Specialist Maternity Drug Clinic. Ms M indicated to the Drug Agency A worker that she did not want to engage with Drug Agency B preferring to continue work with the Drug Agency A Shared Care Service. This was agreed dependant on urine screens being negative to illicit substances.

It is of concern that Ms M appeared to be dictating her engagement with services, the urine screens had not been as regular as had been agreed and there were ongoing indications of use of opiates in samples in mid September and mid October. Her engagement had previously been less than optimal but became more important in light of the pregnancy and avoidance of professional contact was escalating and continued to do so. Ms M was also not being honest with the Drug Agency A worker about her engagement with antenatal care.

The referral by the community midwife to CYPS was with a view to early planning for interagency work to safeguard the welfare of the unborn baby. It would have been appropriate for a meeting either at the Child in Need level or a Child Protection Conference to be convened early in the pregnancy. The midwifery service have ongoing responsibility to follow through any referrals and to escalate their concerns if they consider they are not being responded to appropriately.

**4.3.97.** During the remainder of October Ms M failed to attend two appointments with the community midwife at the GP surgery and an initial appointment at the Specialist Maternity Clinic, also Child K was not taken for immunisations. Ms M did however attend for an ultrasound scan which showed a single foetus of approximately 16 weeks with an expected date of delivery [redacted] She also failed an appointment with the Drug Agency A worker. Twice during the month she was stopped and searched by the police having been seen in the vicinity of known drug suppliers.

**4.3.98.** Mr N attended appointments with the Drug Agency A worker, he too provided a urine sample that was positive to opiates at the end of October, he was keen to continue reducing the diazepam.

**4.3.99.** [redacted] Ms M failed to attend three more midwifery appointments. [redacted] Ms M attended the midwifery clinic at the GP surgery but failed to take her notes. She went home to retrieve them but failed to return to the clinic. The community midwife appropriately later visited the home. Ms M was described as looking pale, thin and not well and noticeably different from when she had been seen the previous month. Ms M confirmed lack of appetite; she indicated that she was [redacted] worried about coping with two young children. [redacted] She also disclosed that her relationship with Mr N was strained. She was unable to provide a urine sample on request saying that she would take one into the surgery the next day. She failed to do this.

During this period concerns were escalating, Ms M was failing to engage with maternity care, there were indications that both of the parents were not being open and cooperative with professionals.

**4.3.100.** The midwife liaised with the health visitor (a change of practitioner) because of her concerns about Ms M and it was agreed that the health visitor would visit the following week and that both would liaise with the social worker to emphasise their escalating concerns. The health visitor arranged a visit with Mr N by telephone. The midwife informed the social worker of the concerns about non-attendance, failure to comply with urine screening and family stressors. There was an expectation that the social worker would act upon these concerns. There was telephone liaison between the social worker and the health visitor and the specialist midwife.

The telephone conversations between the health professionals and the social worker that were identifying concerns about lack of progress, although documented by the professionals were not confirmed in writing. Doing so may have formalised and added weight to the expressed concerns which were considered by the health practitioners to have reached a child protection threshold but were not responded to immediately by CYPS. It may have been appropriate at this stage for the health practitioners to have escalated their concerns in a more formal way by discussion with their managers/supervisors in line with SWCPP Escalation policy.

**4.3.101.** Ms M attended an appointment with the Drug Agency A worker and there was discussion between the GP and the Drug Agency A worker about the management of Ms M's prescriptions. It was agreed that although it would be most appropriate for Ms M's care to be managed by the specialist service, Drug Agency B, she was very reluctant to engage and would return to street drugs if prescribing by the Shared Care Service was to be stopped. The stated advantages for continued care at the surgery were the proximity to home, avoidance of a difficult journey to the hospital and ongoing involvement with a familiar, skilled drugs worker. It was agreed that the care would continue but that Ms M must attend appointments and would engage in a benzodiazepine reduction programme over the next four weeks.

Ms M again appears to be dictating terms of engagement, there was already significant evidence that Ms M did not cooperate well. This suggests a level of misplaced professional optimism that does not appear to have been challenged. As indicated in research and in many serious case reviews the tendency of practitioners working with barely cooperative or overtly avoidant adults is to identify minimal changes in cooperation as more significant than they are. Such tendencies need to be challenged through authoritative and skilled supervision.[10,11]

**4.3.102.** Ms M failed to attend an ante-natal clinic appointment on [redacted] in spite of two reminders by phone and text message. The midwives continued to make significant efforts to ensure that Ms M received antenatal care.

**4.3.103.** [redacted] the health visitor visited the home by prior arrangement; she completed a Family Health Needs Assessment. Both parents and Child K were seen. Minimal concerns were identified for Child K other than his reported susceptibility to chest infections, some sleep disturbance and a delay in his immunisation programme. The housing situation was the main concern for the parents. They were very keen to move because of the state and size of the flat, [redacted] and the perceived negative impact on Child K's health. Ms M discussed her opiate substitution programme, saying that she was reducing her intake and not using any illicit drugs. The health visitor liaised with the social worker.

[10] C4EO (2010). *Effective practice to protect children living in 'highly resistant'* families . London: Centre for Excellence and Outcomes in Children and Young People's Services (C4EO).
[11] Brandon, M et al. (2008) Analysing child deaths and serious injury through abuse: What can we learn? A biennial analysis of serious case reviews 2003-2005 . Research.Department for Children, Schools and Families.

The CYPS chronology states that the health visitor had visited and had no concerns. There is a comment reporting "A man was present in the home [redacted] He was drinking". This is not included in the health visiting information which detailed an account by the parents of a neighbour who was either drunk or confused who walked into their flat about a month previously and attempted to pick up Child K, Mr N had intervened and Child K was not harmed in any way. It is not clear whether these are the same incident in which case very differently documented.

**4.3.104.** On the same day there was liaison between the Specialist Drug midwife and the Drug Agency A worker at the GP surgery. The discrepancies between the information given by Ms M about her engagement with the two services were revealed. It was agreed that Ms M would be seen jointly by the Drug Agency A worker and the Specialist Drug Midwife. It was agreed with the GP that specific targets should be set to determine continuation of her treatment in primary care. Ms M was informed of this by the Drug Agency A worker.

**4.3.105.** The social worker visited the home on [redacted]; this was the first recorded contact between the social worker and the family since July 2010 although the family had been discussed in the social worker's supervision in September and October and Child K was still a 'Child in Need'. Child K was not seen, as he was staying with the [redacted] to give the parents a break. The social worker checked the safe storage of methadone, on the top of a cupboard but there is no indication that they had a 'locked box' for storage. The social worker was introduced to a [redacted] it was noted that 'this did not ring true' but there is no indication why this was the case or what the response was.

**4.3.106.** [redacted] the community midwife telephoned Ms M, she was described as sounding more positive, that she was taking iron tablets and keeping a food diary. Ms M said that she was feeling tired, exacerbated by Child K teething, and not sleeping well. The midwife informed Ms M that she would need to provide urine samples at each antenatal contact and reminded her of the joint appointment later in the week. That afternoon the health visitor visited them at home primarily to share the contents of a letter that she had written in support of re-housing in a different authority, closer to Ms M's family. The health visitor discussed the need to attend for antenatal care; Ms M indicated that she was aware of appointments and intended attending. Ms M told the health visitor that she had found a toddler group that she would attend with Child K. Following the visit the health visitor contacted the social worker who agreed to arrange a date for a Child in Need meeting. The meeting was arranged for [redacted], the health visitor was told by the social worker on [redacted], but there is no record of other practitioners being told about the meeting.

**4.3.107.** Ms M failed to attend the arranged meeting with the Drug Agency A worker and the Specialist Drug Midwife, in spite of being reminded. A further appointment was sent by letter for [redacted]. She failed to attend for a scan and another antenatal appointment; this was the 10th appointment that she had failed to attend during the pregnancy.

**4.3.108.** [redacted] the social worker made a home visit, again no details are available. There was a meeting held at the GP surgery attended by both of the parents, the social worker, health visitor and community midwife; the Drug Agency A worker sent apologies, there is no indication that the Specialist Drug Midwife or the GP were invited. is recorded in the midwifery and health visiting chronologies but not the CYPS. [redacted] was eating better. The couple continued to express concern about the accommodation and [redacted] Ms M indicated that her difficulty with antenatal appointments was because they were too early in the day. Both parents confirmed their ongoing engagement with Drug Agency A and both were reducing their medication. The plan was for the social worker to speak to the [redacted] and to complete a pre-birth assessment to ascertain the need for family support. The health visitor offered support and arranged a visit in February but was available should the parents want to contact her. Ms M agreed to attend antenatal appointments, especially if arranged later in the day.

This is the first multi-agency meeting held to share information and plan for the welfare of the unborn baby, it was two months after the initial referral to CYPS by the midwife but nonetheless appropriately early in the pregnancy, before 28 weeks.

It is not clear how practitioners were informed of this meeting or how much notice was given. It was most unfortunate that neither a representative from Drug Agency A or the GP was present at the meeting to provide specialist information about the cooperation of both parents with the service, especially as the meeting was held at the GP surgery where the Drug Agency A worker was also based. Their attendance would also have provided the opportunity for closer information sharing about and ongoing monitoring of cooperation with plans. Again the meeting appears to have concentrated on the parents and their needs with little focus on either Child K or the unborn baby. The meeting was six months after Child K's Child Protection Plan was discontinued and therefore the meeting should have served as a Child in Need meeting. The concerns about the unborn baby, indicated by Ms M's failure to prioritise her antenatal and specialist drug service intervention, should have resulted in a Child Protection Conference which may have resulted in a more structured and authoritative response through a Child Protection Plan.

**4.3.109.** [redacted] Ms M again failed an appointment at the Specialist Maternity Clinic. The midwife contacted the family and was told by Mr N that Child K was unwell and had a GP appointment. Child K was indeed seen by the GP with an upper respiratory tract infection. The social worker was informed of the failure to attend. It is not documented who took Child K to the GP but there had been previous occasions when Mr N had taken him to the GP, if he had done so it was not a reason for Ms M's failure to attend her antenatal appointment.

**4.3.110.** At a contact on [redacted] with the Drug Agency A worker Ms M acknowledged her failure to engage well with the treatment plan and was told that she should attend

at least the next five consecutive appointments and provide a urine sample at every appointment otherwise she would be discharged from Shared Care and referred to the Specialist Service, she agreed to the contract.

This was a clear delineation of the expectations of the service but needed to be followed through authoritatively to be effective.

**4.3.111.** During the remainder of the month Ms M failed another 3 antenatal appointments and an appointment with Drug Agency A. Both Ms M and Mr N were unwell. Mr N was treated by his GP for a chest infection and was prescribed nitrazepam, having completely withdrawn from diazepam but complaining of insomnia. Ms M was prescribed antibiotics. [redacted] Ms M was seen by the community midwife at the GP surgery. Although she was talking more positively about the baby she looked very unwell, pale and thin. She was also seen by the Drug Agency A. She expressed concern to both workers [redacted] She said that the police had been informed but had not offered any support. Ms M had also stopped taking diazepam and reportedly coping well without. There is no mention of this incident in the police chronology.

**4.3.112.** [redacted] Ms M attended a Drug Agency A appointment but very late and after being reminded. She expressed a wish to manage methadone reduction herself, she was collecting a daily dose of 45 ml per day twice weekly and was expected to attend appointments weekly. There is no documentation of urine screens. She failed to attend the next appointment and attended too late to be seen the week after. The Drug Agency A worker discussed the lack of engagement with the midwife and a decision was made to refer to Drug Agency B and end treatment management in primary care. She failed to attend antenatal appointments [redacted]

It had been agreed in [redacted] that continuation with prescribing in primary care was dependent upon Ms M's engagement by attending appointments, regular urine screening and attendance at antenatal appointments. This had been allowed to drift for two months; there is no record of a urine screen since [redacted] which had been positive for opiates. She had, by this time, failed to attend 17 antenatal appointments and was very obviously non-compliant. Although there had been some communication between the midwifery service and Drug Agency A and the social worker had been informed of each failure to attend appointments with the midwife there was no feeling of a coordinated approach to the professional input. This led to a missed opportunity to address the lack of compliance in a more authoritative way as a child protection issue.

**4.3.113.** [redacted] Ms M attended an appointment with the community midwife at the GP surgery, albeit very late and having been phoned to remind her, she had forgotten her hand held records and returned home to collect them. She provided a

urine sample for toxicology, this was later reported to be positive for methadone, benzodiazepines and trace opiates, which could have been codeine. She was due to see the Drug Agency A worker on the same day but again had arrived too late to be seen. She was informed of the need to refer to Drug Agency B due to her lack of engagement.

**4.3.114.** [redacted] the Specialist Drug Midwife and worker from Drug Agency B visited the home together. Both parents were present, as was Child K. Child K was described by the midwife as well kempt, well behaved and appropriate behaviour and development were observed. The Drug Agency B worker described him as happy, clean and looking healthy, he engaged appropriately once he had overcome appropriate stranger awareness. The flat was described as clean and warm although there was damp evident around the bedroom window, there were toys in evidence. A supportive housing letter was requested so that they could move house before the birth of the baby. Ms M denied any on top use since the start of her pregnancy; she was currently on 45mls methadone daily and had stopped taking diazepam. A urine result dated the same day was positive to methadone, opiates and benzodiazepines therefore at odds with Ms M's report. Saliva samples were also taken. Advice was given about safe storage of methadone, including the need for a locked box. A leaflet "keeping your baby safe" was given. An appointment with the DRUG AGENCY B doctor was made for [redacted] to take over the methadone prescription.

**4.3.115.** [redacted] Mr N was seen by the Drug Agency A worker, he remained stable and apparently abstinent. He expressed displeasure that Ms M had been referred to Drug Agency B but was advised that it could not be discussed with him. Ms M attended an appointment with the Drug Agency B worker, a referral having been received from Drug Agency A, after an initial assessment was completed using a standard tool. A plan for a gradual reduction of methadone was agreed and Ms M was prescribed 40mls methadone, a reduction of 5mls per day, there is no record of the reason for this, although presumed to be part of a plan to reduce her intake. She was offered fortnightly appointments. Letters were sent to the GP and the midwives. Ms M attended an antenatal appointment with the specialist drug midwife on [redacted] she was described as obstetrically well.

**4.3.116.** During the [redacted] Ms M failed to attend six antenatal appointments and two appointments with Drug Agency B. Her methadone prescription was reduced to 35mls daily [redacted]. [redacted] Ms M did not attend specialist antenatal appointment, when contacted by phone she said that she was unable to walk due to painful leg. [redacted] id not confirm the diagnosis. On the same day Mr N failed to attend a Drug Agency A appointment. A report was made by the pharmacy reception to the GP indicating that Mr N was observed to have swollen hands and lip, appeared rather unsteady and less communicative than usual. When seen by the Drug Agency A worker [redacted] he was advised to see the GP about the swelling, he denied any on top use; he agreed to provide a urine specimen. There is no record of this having been done. Mrs M was seen by the Drug Agency B worker [redacted], a urine sample was taken, she said she was 'feeling fine' on 35mls methadone and it was reduced to 30mls. The urine drug screen was positive for methadone, benzodiazepines and

opiates (dihydrocodeine); indicating on top use, this was communicated to the social worker [redacted] when the result was received.

It is not clear whether the GP further investigated the possible DVT which are a common complication of injecting drugs, especially in the groin.[12]

The AWP IMR indicates that the plan was consistent with Department of Health Guidelines on Clinical Management on drug use and dependence[13]. It would appear that this was a change in treatment direction from maintenance to reduction with a view to reducing the risks to the unborn baby. Ms M had been prescribed 45mls daily since [redacted] which had been increased in [redacted] from 40mls because she had lapsed into use of illicit dihydrocodeine. It is not documented who initiated this reduction and how committed Ms M was to moving towards abstinence. It may have resulted in Ms M being under-medicated and therefore accessing illicit substances which in itself may have exacerbated Ms M's avoidance of professional input because of the demand for regular urine screening. It is recognised that there is a challenging balance between maintaining engagement with services by meeting the individuals prescribing demands/needs and reduction of the risk of foetal withdrawal.

**4.3.117.** The social worker phoned to arrange a visit at [redacted], both parents were asleep, she visited at 3.15 on the same day – no details are recorded. On the same day the midwifery chronology includes an entry about a pre-birth core assessment having been completed indicating that Ms M would be likely to need additional support once the new baby was born, that the parents have coped well with Child K but notes 'sporadic' attendance at appointments. The plan was for the baby to return home with the mother, that CYPS were to be informed when Ms M is admitted in labour, for drug testing on the ward and for any social concerns to be reported to CYPS.

The fact that both parents were asleep at 10.30 should have raised concerns for the welfare of Child K, now 17 months old and ideally subject to a regular routine. It is not known if he had been asleep until this time, if he had been fed etc it is also not known if this was a regular occurrence. There is no indication that these concerns were identified and followed through by the social worker.

Although there is evidence of good information sharing with the social worker by the midwifery service about Ms M's failure to attend antenatal appointments as they occurred, her failure to engage with the drugs service and evidence of likely on top use there is no indication that this was a coordinated multi-agency plan. As previously indicated the communication was by phone and not formalised. The description of the attendance as 'sporadic' is an understatement. This was a significant missed opportunity for collaborative working. It would have been appropriate for a professionals meeting to be convened to discuss how best to

[12] McColl MD, Tait RC, Greer IA, Walker ID., (2001) *Injecting drug use is a risk factor for deep vein thrombosis in women in Glasgow*. Br J Haematol. 2001 Mar;112(3):641-3.
[13] http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

manage the remainder of the pregnancy to ensure the safety and well being of the unborn baby.

**4.3.118.** [redacted] the health visitor failed to gain access at a home visit, she spoke to Mr N later on the phone and arranged another appointment for the following week. Ms M failed to attend appointments with Drug Agency B and the specialist antenatal clinic. A telephone conversation between Ms M and the specialist midwife the following day identified that Ms M had very swollen and uncomfortable legs about which she was anxious. She was advised to attend the Day Assessment Unit. The next day the community midwife visited at home, Mr N was seen, Ms M was not at home in spite of giving her swollen legs as the reason for not attending the appointment. It is also of note that Ms M collected Mr N's prescription from the pharmacy.

**4.3.119.** Ms M again failed the appointment with the community midwife. The midwife contacted Ms M by phone at 11.30, she had just got up; Child K was said to be with his grandparents. Ms M sounded tired and her leg was still swollen, she was again advised to attend the Day Assessment Unit at the maternity hospital, she did not do so.

**4.3.120.** [redacted] the health visitor had a failed prearranged home visit. The health visitor ascertained that Child K was overdue immunisations; she liaised with the community midwife and telephoned the social worker to express her serious concerns about Ms M's avoidance and lack of prioritisation of the needs of the unborn baby. On the same day Ms M failed to attend appointments with the community midwife and at the specialist drug antenatal clinic, the specialist midwife also contacted the social worker to express similar concerns to the health visitor. It appears that there was some confusion over the date of the health visitor's visit as Ms M contacted the community midwife the following afternoon to complain that she had waited in all afternoon for the health visitor who had not arrived. When the health visitor contacted Ms M by phone there was a short exchange during which Ms M became angry and verbally abusive.

**4.3.121.** The police chronology indicates that [redacted] warrant was served at the family home. The conduct and outcome of that search is not detailed; it is not known if Child K was present.

There is no indication that this information was shared with other agencies. It would have been relevant information to share with the social worker as a number of individuals known to the police were witnessed entering the home over a short period of time. This may have put Child K at significant risk of contact with unsuitable people. Details of the search would have been helpful especially if Child K was present. A recommendation of a previous Serious Case Review undertaken by Bristol SCB addressed this issue.

**4.3.122.** [redacted] Ms M failed to attend an antenatal appointment for the 31st time and an appointment with the Drug Agency B worker. Contact was made with the social

worker and it was confirmed that a child in need meeting was to be held [redacted] Ms M requested that her prescription be posted to the pharmacy but was told that she would need to collect it, which she did [redacted]. The community midwife attempted a home visit [redacted] when Ms M was not in; a message was left with Mr N about clinic appointment the following day. Ms M did not attend that appointment but phoned to say that she thought she may be in labour. She became angry and defensive when challenged by the Specialist Drug Midwife about her failure to engage.

**4.3.123.** The following day the social worker had a phone conversation with the mother who refused to attend the meeting the next day. The health visitor and social worker liaised and shared the common experiences of Ms M's anger in phone conversations.

**4.3.124.** A child in need meeting was held at the GP surgery [redacted]. It was attended by the social worker, the health visitor, the specialist drug midwife and the community midwife. There is no indication that the GP was invited or attended. There was no representative from Drug Agency B as the worker was on leave. Ms M and Child K arrived approximately 50 minutes into the meeting after Mr N had been contacted by the specialist midwife. [redacted] She confirmed that she was on a daily dose of 30mls of methadone, dispensed twice weekly, no benzodiazepines and denied any 'on top' use. According to the health visiting record her latest urine was entirely clear indicating likely substitution. This is not documented in any other chronology entries. Ms M apologised for the way that she had spoken to professionals explaining that she felt very stressed and anxious. It was agreed (prior to Ms M's arrival) that the social worker would discuss convening a child protection conference with her manager. Ms M promised to attend for a scan [redacted] and antenatal check. It would appear that Ms M produced a urine sample which was recorded on 30th in the maternity hospital notes as positive to methadone.

**4.3.125.** Ms M failed to attend [redacted] but called to say that she was unwell and seeing the GP; there is no record of her having done so. The social worker was told of the failure to attend for assessment of her potentially significant medical problems. She attended an antenatal clinic on [redacted], no concerns were identified other than Ms M and Child K both had colds. Child K was seen by the GP on the following day. The CYPS Team Manager agreed that Child Protection Conference should be convened.

### From birth of Child L

**4.3.126.** Child L was born on [redacted] CYPS and the health visitor were informed appropriately. Shortly after birth Child L exhibited signs of significant neonatal abstinence syndrome; he needed support with breathing during his first day and was treated with morphine and antibiotics and cared for on the Neonatal Intensive Care Unit (NICU). It was obvious that Child L's withdrawal symptoms were more extreme than would be expected from the maternal prescribed medication indicating likelihood that she had been using illicit substances. This was confirmed by toxicology on Child L's urine that was positive to benzodiazepines and opiates and negative to methadone. Ms M denied on top use and refused to provide a urine sample for toxicology which was essential for the appropriate treatment of Child L; she

maintained her reluctance to provide a sample throughout the day and became verbally aggressive when pressed. She eventually provided a urine sample on the evening of the following day which was positive to cocaine and opiates.

Ms M's failure to be honest about her drug use during pregnancy and her continued refusal to provide urine samples potentially put Child L at significant risk of harm. Child L's clinical presentation was significantly worse than would have been anticipated with the Ms M's claimed medication and medical staff needed to know her actual use in order to provide appropriate treatment of Child L. This demonstrates a serious failure to prioritise the needs of the baby above her own.

**4.3.127.** On the evening of [redacted] Child L was transferred from NICU to the Transitional Care Ward which allowed for Ms M to remain resident with Child L. This would not have been possible had Child L stayed in NICU as Ms M was fit for hospital discharge and there was no facility for her to stay in hospital, she was very reluctant to be discharged without child L. Part of the expectation of Ms M's residence on the ward was provision of urine samples for toxicology in line with the hospital's guidelines "Methadone and Buprenorphine prescribing during maternity in patients stay of antenatal and postnatal women".

**4.3.128.** The following day Child L showed gradual improvement although Ms M found him difficult to feed and he continued on morphine. In the early morning Ms M was found asleep in bed with the baby lying loosely in the crook of her arm; the baby bottle was found on the floor having been dropped.

**4.3.129.** Ms M cared independently for Child L although she was happy for staff to care for him when fractious or whilst she went for a cigarette. There was another incident when Ms M was found asleep with Child L on the bed; he was put into the cot by staff without Ms M waking. Other patients on the ward informed staff that Ms M had asked them to provide urine samples that she could give to staff. Consequently staff were asked to ensure that provision of urine samples was fully supervised. Concerns were also expressed by other patients [redacted].

**4.3.130.** [redacted] ward staff identified some concerns about lack of appropriate care of Child L – dirty nappy on the bed whilst feeding and dirty clothing which was replaced with hospital clothes. Ms M was asked to provide a urine sample, she was only able to provide a small amount. Staff were informed by other patients that Ms M had concealed a glove with urine in her vagina to provide a false sample, she was apparently boastful that she had 'got one over on the staff'. She was aggressive with staff when challenged about this. Ms M later disclosed to the Specialist Drug Midwife that she had attempted to deceive by use of a urine filled glove, that she had used heroin 2 days previously whilst in hospital and had been using both heroin and crack towards the end of her pregnancy. In view of the heroin use whilst an in patient Ms M was discharged from hospital and Child L was transferred back to NICU for ongoing treatment with morphine.

Although Ms M was expressing appropriate level of concern about Child L and the desire to remain resident in the hospital so that she could care for him there were some concerns about the level of care that she was providing and particular concern about her failure to comply with the expectations of the ward. This should have raised very serious concerns about the welfare of Child L. The welfare of Child K should have also been considered in the light of these observations

**4.3.131.** The social worker was informed of the progress of the case by telephone calls and e-mails. The social worker contacted Ms M, she and Child K were said to be staying [redacted]. She was keen to talk about the housing situation but became angry when told that a Child Protection Conference was to be convened because of concerns about Child L.

**4.3.132.** Late in the evening of [redacted] Mr N arrived on NICU with a woman, not Ms M, both refused to confirm her identity to staff; they were informed that only parents were allowed access to the ward out of hours. They left after midnight and Mr N returned half an hour later and fed Child L and left NICU after another half hour. He left a bag by the side of Child L's which was found and opened by staff later in the morning. The bag contained a phone charger, a baby's dummy and a box containing drug paraphernalia including needles, spoons and residue of some sort. Police were contacted and attended NICU; they removed and disposed of the items. The Child Abuse Investigation Team (CAIT) was informed of the incident and contact with both the hospital and community social work team contacted with a view to convening a strategy discussion. [redacted] warrant had been executed at the property the previous month.

There is no indication that there was any further criminal investigation or forensic examination of the contents of the box. There is also no indication that there was information sharing with respect to the [redacted]. Both of these were possible missed opportunities for improved interagency collaboration.

**4.3.133.** Ms M arrived on NICU [redacted], she attended to Child L's needs. She attempted to ascertain the identity of the woman who had visited with Mr N, [redacted] she was unable to contact Mr N who had not returned home that night. Ms M left the hospital mid-morning and returned in the evening, she appeared to be tired and upset, saying that she had problems (undefined) with Mr N.

**4.3.134.** [redacted] the social worker met with the parents and [redacted] The professionals' concerns were addressed but the parents were said to be 'in denial' with 'an explanation for everything'. The parents requested a change in social worker, which was not acquiesced to. It was agreed that Child K would stay in the care [redacted] with Ms M. There was discussion of the need for a partnership agreement. Later in the day Ms M attended NICU, she was very upset and disclosed

relationship difficulties with Mr N. There was no indication of this documented by the social worker or that the information was shared with them by the hospital.

**4.3.135.** Ms M and Mr N both signed a partnership agreement to the effect that Child K would remain in the care of the [redacted] and that neither parent would have care of him whilst under influence of substances. The police carried out a 'welfare check' on [redacted] at the home address [redacted] at the request of the Emergency Duty Team; there is no detail of the reason for this request. Arrangements for a Child Protection Conference were made for the following week.

**4.3.136.** [redacted] Ms M spent the afternoon on NICU and contributed to Child L's care. Ms M left in the early evening, Mr N arrived at 22.00; he was agitated and complaining of burning eyes, he was advised to go to A&E. He indicated that he intended visiting Child L daily at night to avoid meeting Ms M as there were relationship problems.

**4.3.137.** [redacted] there was communication between a CYPS Area Manager and a Team Manager about a meeting to be arranged with the legal department to discuss the case unfortunately the Team Manager was unable to attend. The Area Manager was asked to find another Team Manager to liaise with the legal department. The social worker was requested by a lawyer from the legal department to provide appropriate documentation and timescale for a meeting at which point the case would be allocated to one of the legal team. This was responded to the following day with a request for an urgent legal planning meeting.

**4.3.138.** A Child Protection Conference was held [redacted]. It is unclear from the chronology who attended, although evident that the health visitor, GP, Drug Agency B and Drug Agency A workers were not present, it is not known if they were invited or when invitations were sent. The police provided information in a 'confidential slot' [redacted] family's home address. There was discussion about the long term drug use of both parents, concerns about lack of engagement in services and about honesty of the parents. It does not appear that there was any discussion of the parents' apparently strained relationship. Both children were made subjects of Child Protection Plans. On the same day there was communication between the social worker and lawyer, the social worker had identified the probable need to issue care proceedings the lawyer agreed that the threshold was met and agreed that proceedings should be issued. The lawyer discussed the case with a colleague who sent a memo to the social worker the following day advising that the application process should be started and agreement sought from the Area Manager. There was discussion about the possibility of the children being accommodated [redacted] It is not clear whether there was any discussion about the initiation of care proceedings at the Child Protection Conference.

CYPS is a client department of the Legal Team which provides legal advice and issues care proceedings when instructed to do so by CYPS; the accountability for making this decision lies with Area Managers in CYPS. Care proceedings cannot be issued without the express instruction of CYPS. If care proceedings are instituted the legal department drafts the application form and the documentation required to

provide evidence of significant harm or the likelihood of such in relation to Section 31 of the Children Act 1989. The CYPS provides the chronology and care plan. The pre-proceedings process was introduced in 2008[14]. This requires the Local Authority to seek legal advice and to communicate, by letter, with the parents the nature and extent of their concerns enabling the parents to obtain legal advice prior to a meeting with the Local Authority. The intention of the meeting is either to deflect proceedings, or at least to narrow and focus the issues of concern.

**4.3.139.** Ms M spent the afternoons with Child L daily between [redacted] and attended to all of his needs. Child L continued to require treatment with morphine which was being gradually decreased. Mr N visited in the evening [redacted] and carried out Child L's care.

**4.3.140.** [redacted] both parents visited NICU at the same time; they arrived separately but left together after about 2 hours. Ms M failed to attend an appointment with Drug Agency B, however she arrived later and collected a prescription. She claimed not to have used since she was discharged from the hospital and was worried that Child L may go in to foster care when discharged from hospital. She provided a urine sample that was negative to illicit drugs.

**4.3.141.** The following day the social worker saw Ms M at home [redacted]. It was ascertained that Ms M and Mr N were living apart. A plan was made for Child L to be discharged to the care of Ms M at home and that Child K would stay with his [redacted] for the week beginning [redacted]. It was agreed that all contact between Mr N and Child L would be supervised. Ms M was informed that a pre-proceedings meeting would be held and that care proceedings would be initiated if the partnership agreement was not adhered to.

It is not clear when and how the decision for Child L to be discharged into Ms M's care was made and why the agreement to initiate care proceedings was not pursued immediately. The social worker's Team Manager was on leave during this period and the social worker sought advice from a covering Team Manager about the formulation of the care plan to recommend to the court, however a pivotal decision was made not to issue care proceedings at this point, as Child L was in hospital and Child K was with [redacted], but to use a partnership agreement and hold a pre-proceedings meeting. There is no indication of any interagency discussion about the discharge plan which was a change from the plan agreed at the Child Protection Conference.

**4.3.142.** [redacted] the parents arrived at NICU together with Child K, they stayed for a fairly short time and did not return when they said they would. The following day both parents again visited together although they arrived at different times. There were witnessed having an argument when Mr N left. Ms M attended an appointment with Drug Agency B and was issued with a prescription for 30mls methadone daily.

[14] The Children Act 1989, Guidance and Regulations, Vol. 1 – Court Orders.

Neither parent visited [redacted] although Ms M telephoned. They both visited the following afternoon, arriving separately, both were keen to know when Child L could be discharged but he had yet to be weaned off the morphine.

**4.3.143.** [redacted] updated the social worker on Child L's progress; the social worker discussed the family at supervision which confirmed that care proceedings would not be initiated immediately but that the social worker would have weekly contact with the family.

**4.3.144.** [redacted] Mr N attended an appointment with the Drug Agency A worker; he was accompanied by Ms M. He had previously missed some appointments for which he apologised. He agreed to provide a urine sample the following week for toxicology. The health visitor liaised with NICU and the social worker to update herself on the developments with respect to the family. She had not been invited to the Child Protection Conference. The health visitor made contact with Ms M and offered advice about some health problems she was experiencing.

Although health visitors would normally make a primary visit approximately 2 weeks after birth the local agreement is that if there a child is in hospital or if there is extended midwifery care they will take over the care on transition. The health visitor maintained some contact with NICU.

It was unfortunate that the health visiting service was not represented at the Child Protection Conference. It appears that this was due to a misunderstanding about the date by the midwife who communicated this to the health visitor, the absence of the health visitor on leave and the lack of a formal, written notification of the Child Protection Conference.

**4.3.145.** Over the next few days Ms M visited Child L in the afternoons, Child L continued to need morphine, and although the dose was being decreased slowly it had not been possible to withdraw it entirely. Ms M admitted to the Drug Agency B worker at an arranged appointment that she had had at least twice weekly 'binges' on benzodiazepines during the pregnancy which she had not previously disclosed. She was urged to tell the NICU staff because of the impact that the information may have on Child L's treatment. The information was passed to NICU, but not the social worker, by the Drug Agency B worker; Ms M had not done so. [redacted] Ms M resumed the daily supervised consumption of 30mls methadone at the pharmacy.

**4.3.146.** [redacted] the social worker made a home visit, there are no details available of the content. Mr N was seen by the Drug Agency A worker, he was accompanied by Child K. He expressed discontent about the plan suggested by the social worker that Ms M and Child L should stay with [redacted] for a period after Child L was discharged from hospital. The Drug Agency A worker liaised with the social worker and was updated about the concerns about the couple's previously undisclosed drug use during the pregnancy. Mr N provided a urine specimen that was positive to opiates as well as methadone metabolites.

**4.3.147.** The following day a core group meeting was held at the GP surgery. No notes were made by the social worker. The health visitor documented an agreed plan for Child L to be discharged to the care of Ms M but initially supervised [redacted]. The health visitor would visit regularly and there would be support from the Child and Family Support Service. The health visitor liaised with NICU and updated about the plan to have a discharge planning meeting on [redacted].

It is surprising that this meeting was held no more than a few days prior to the Discharge Planning meeting. It may have been more appropriate for the two to have been combined to ensure that all practitioners involved with the family were present or represented. It is not clear whether the GP was invited to this meeting but as it was held at the GP surgery it would have been a good opportunity to involve a wider team in the protection plan.

**4.3.148.** A legal planning meeting was held [redacted] there were no notes of the meeting in the CYPS chronology; some details are included in the legal services chronology. The information given is that the parents are more cooperative and in spite of the previous high level of concern and the high risk that, in the view of the social worker, advice had been received that care proceedings should not be issued immediately and that the parents would be sent a pre-proceedings letter. A pre-proceedings meeting was arranged for [redacted].

There appears to have been significant uncertainty about the initiation of care proceedings and both the advice and the status of that advice received from the lawyers. It is notable that there are a number of social work managers and lawyers involved in the decision making. The social worker appears to be somewhat ambivalent about whether or not proceedings should be initiated. This was a significant missed opportunity to safeguard these two children. Legal advice had clearly been offered that the threshold for care proceedings had been met but the decision not to initiate proceedings immediately but to follow the pre-proceedings route appears to have been based on degree of professional optimism that the parents were cooperating, based on very little evidence.

**4.3.149.** A discharge planning meeting was held on [redacted], it was attended by the social worker a nurse from NICU, the parents and [redacted], the health visitor had sent apologies and Drug Agency B provided information. A partnership agreement was signed by the parents which confirmed that Child L would be discharged to the care of his parents, that [redacted] would be in the family home for the first four days, the social worker would visit weekly, the Child and Family Support Service would visit twice weekly, Ms M would attend all Drug Agency B /Drug Agency A appointments and Mr N to attend appointments with Drug Agency A.

**4.3.150.** Child L was discharged from hospital [redacted] the morphine having been stopped [redacted]. After an appointment with the Drug Agency B worker Ms M was referred

back to Drug Agency A for management of her treatment and prescription. It was planned that she would continue on 30mls methadone with daily supervised consumption. The CFSW phoned Ms M to introduce herself to Ms M and arrange twice weekly visits.

**4.3.151.** [redacted] Mr N saw the Drug Agency A worker he complained of swollen legs; he acknowledged that he had been injecting (heroin) again over the past few weeks. The information is appropriately shared with the social worker. The social worker visited the home [redacted]; both parents and both children were present. Child K was having his breakfast at 9am; Child L was reported not to have slept well. The parents stated that they wanted to maintain the routine for Child K that had been established when he was with [redacted].

**4.3.152.** [redacted] was seen by the Drug Agency A worker, he was accompanied by Child K. Mr N reluctantly acknowledged that he had been injecting heroin regularly for the last few months. He said that he did not use at home or store any drugs or equipment there. He agreed with a plan to maintain abstinence, to provide regular urine samples and to collect his methadone three times per week. His urine was negative to opiates, positive to methadone metabolites, however it was also negative to benzodiazepines which he was prescribed, although apparently only taking it occasionally. The information was shared with the social worker.

In view of Mr N's disclosure of regular use of heroin good clinical practice would indicate daily supervised consumption of the methadone with regular urine screens to assess compliance.

**4.3.153.** The health visitor visited the home on the same day. Child L was generally well although colicky, he was gaining weight. Child K was seen, there were no concerns identified. The parents both said that they had stopped taking illicit drugs. The health visitor liaised with the social worker and a visit by a member of the health visiting team was arranged for the following week.

**4.3.154.** The pre-proceedings meeting was held [redacted]. There is nothing recorded about it in the CYPS chronology. The lawyer made a note of the meeting. Mr N and Ms M attended with legal representatives, also present were the social worker, team manager and Legal Services lawyer. All of the concerns were highlighted and it was agreed that weekly urine testing would be requested and although the parents were thought, at the time, to be more cooperative and honest with professionals and had been available for visits it was acknowledged that it was early days and Child L may be more demanding because of level of his Neonatal Abstinence Syndrome which had needed several weeks of treatment to manage. It was agreed to hold a review meeting [redacted].

**4.3.155.** [redacted] the CFSW visited the family at home. Although both parents were present Mr N and Child K were asleep, Ms M explained that they had been up late the previous night because the washing machine had broken. Ms M apologised for the state of the flat although there is no detail of this in the documentation. Ms M discussed their relapse in drug misuse; Ms M disclosed smoking crack which she had

not done for a long time. The precise details of the relapse – timing and substances are not documented. Child K was seen asleep and there was evidence of toys and safety equipment. There is no mention of Child L.

**4.3.156.** On the same day the social worker emailed the Drug Agency A worker requesting regular updates on Mr N's engagement with the service and results of drug screens. The social worker attached details about the PLO process and a copy of the partnership agreement made with the parents. This ensured that the Drug Agency A worker was aware of the plans for monitoring the family situation and their part in it. The following day the social worker was informed that Ms M's last urine screen done [redacted] was positive to methadone only.

In view of both of the parents' lack of candour in the past and their failure to provide regular urine specimens and the strong suspicion that samples that were supplied were not theirs it may have been appropriate for supervised urine samples to be collected or for saliva specimens to be used. Daily supervised consumption of their methadone by both parents would also have been clinically appropriate.

**4.3.157.** The following day the Community Nursery Nurse (CNN), part of the health visiting team, made a prearranged home visit at 11am but was unable to gain access. When she phoned Ms M at 12.15pm Ms M answered the phone, saying that she was sleepy and requesting a visit later in the afternoon. When she visited at 3pm the CNN saw both parents and Child L. Child L was weighed, his weight was on 9$^{th}$ centile (the same as at birth), he was described as feeding well, his colic had resolved It is noted that Ms M spent much of the visit in the garden putting out washing; Child L was with Mr N. There is no comment about the whereabouts of Child K. Mr N was complaining of dental pain and advised to contact the dental hospital. It was planned that the health visitor would visit the next week.

The CNN does not appear to have enquired about Child K or addressed the issue of lack of routine and late mornings, which although less concerning for Child L who would be expected to be asleep much of the day, Child K now aged 21 months would be expected to be awake most of the day and in need of play and stimulation.

**4.3.158.** When seen by the Drug Agency A worker [redacted] Mr N's urine was positive only to methadone and benzodiazepines. He expressed desire to remain abstinent, he agreed to provide urine samples at each appointment and to collect methadone 3 times per week. The Drug Agency A worker updated the social worker with the detail and expressed concerns about the parents' ability to manage the children and the increased chaotic drug use.

There is no detail of why the Drug Agency A worker had increased concerns about the parents' management of the children, but in view of the expressed concerns

about more chaotic drug use it may have been appropriate for Mr N to have been changed to daily supervised consumption the same as Ms M.

**4.3.159.** [redacted] the CFSW visited the family, Ms M had signed a partnership agreement, the details of which are not included in the chronology. Mr N and Child K were asleep at the beginning of the visit but got up sometime after 10am. The CFSW discussed routines, feeding and budgeting. Ms M was maintaining a calendar of appointments. The CFSW continued to visit twice weekly. Ms M failed to attend an appointment with Drug Agency B [redacted], a new appointment was offered for the following week, it was planned that a saliva test would be done.

**4.3.160.** The next day Mr N was seen by the Drug Agency A worker and the GP. He complained of swollen legs possibly due to a DVT as a result of injecting in his groin, although not recent as he claimed abstinence. The GP arranged a hospital appointment for an ultrasound scan although Mr N was reluctant and inflexible about the appointment. He attended on [redacted] A urine screen was positive to opiates as well as benzodiazepines.

**4.3.161.** The social worker visited unannounced on [redacted], no details available but discussion at supervision the following day led to a decision to maintain weekly visits for 2 more weeks then reduce to fortnightly. It is noted that there were no concerns but there is no evidence that there had been any challenge to the parents' drug misuse and their failure to be honest with professionals or the likely impact on their children of their behaviour and attitude.

**4.3.162.** [redacted] Ms M failed to attend her appointment with Drug Agency B however she arrived after a reminder; she was accompanied by Child K. Ms M became angry when asked to provide a saliva test, she was only willing to provide an unsupervised urine sample. There is no comment on how Child K responded to Ms M's outburst. The urine sample was positive for methadone only. Liaison between the Drug Agency B worker and the social worker led to an agreement for Ms M to be seen weekly with screening at each visit.

Ms M's reluctance to provide a saliva sample suggests that she is attempting to disguise further relapse. There is no indication that she is challenged over this as a deviation away from the partnership agreement or the impact on the children.

**4.3.163.** [redacted] the health visitor visited the home, Child K was out with Mr N. Child L was weighed, he was above 9$^{th}$ centile; he was noted to have mild nappy rash and was reported to be unsettled at times. The health visitor offered advice. There is no indication that she explored the parents' substance use.

**4.3.164.** [redacted] the CFSW visited, both parents were present, it was noted that Child K was limping, the CFSW advised the parents to seek medical advice. There is no detail about who identified the limping or any explanation given by the parents. The parents were also reminded about Child L's developmental review by the GP. Ms M planned to contact Environmental Health in the pursuit of new housing. Child K was

seen by the GP, it is not recorded who accompanied him. The limp was said to have started that morning, no obvious explanation for the limp was ascertained although some bruising mid shin was noted (not unusual at his age). The GP plan was to send Child K for an x-ray if the limp did not resolve itself. The CFSW informed the social worker of the incident but there was no liaison with the health visitor nor was the social worker informed by the GP. The same day Child K had failed to attend an appointment for immunisations; this was followed by appropriate liaison between the practice nurse and the health visitor and Child K had his immunisations [redacted]. The times of the different appointments are not known, therefore the GP's awareness of the failure to attend for immunization is not known.

**4.3.165.** The GP spoke to Mr N on the telephone [redacted] with respect to [redacted] There was also discussion about Mr N's prescription for nitrazepam, the GP was expressed reluctance to prescribe more because his previous urine had been negative to benzodiazepines. Mr N explained that he only took it irregularly; the GP noted that if that was the case he should have sufficient especially as prescriptions had been issued [redacted] both of which had been dispensed by the pharmacy. This is another incident of lack of honesty about use of medication.

**4.3.166.** Ms M failed to attend a Drug Agency B appointment [redacted], her prescription was sent to the pharmacy and she was sent another appointment reminding her of the requirement for drug screening.

**4.3.167.** Ms M cancelled the visit by the CFSW [redacted] Ms M and Child L were seen, Mr N and Child K were both still in bed. The CFSW described observation of good interaction between mother and baby and Ms M spoke fondly of both children. It was noted that Child L had missed his 8 week check that week; Ms M undertook to make another appointment.

**4.3.168.** The health visitor visited the home [redacted]. Both children were seen Child L was said to be more settled and apparently thriving. Child K had a small laceration and bruise on his nose for which there was a reasonable and accepted explanation. The parents also told the health visitor about his limp which had resolved. The health visitor had previously made referral for an Early Years place for child K which was to be discussed at the panel [redacted]. The health visitor planned to visit again [redacted]. The health visitor attempted to update the social worker who was on leave.

**4.3.169.** [redacted] Ms M attended a Drug Agency B appointment and reluctantly provided a saliva sample for toxicology; this was positive to methadone only. Ms M reported a planned holiday and arrangements were made for methadone dispensing. The CFSW attempted a home visit in the morning, there was no reply. Mr N answered a phone call and requested a visit later in the day as Child L was said to have had a bad night. There was no reply when the CFSW returned in the afternoon, there was also no reply to a phone call.

**4.3.170.** [redacted] there was correspondence between the legal services lawyer and the social worker following a request from Mr N's solicitor for update prior to the planned pre-proceedings review. The social worker indicated concerns that the situation with the family seemed to be slipping – illustrated by missed appointments by both parents with the drug services, missed visits by the CFSW and failure of Child L to

attend for an 8 week review. A conversation between the lawyer and the social worker [redacted] addressed concerns that would need to be covered at the pre-proceedings meeting the following day. The meeting was held although no details are available, the lawyer was unable to attend and there is no record of this meeting in the Legal Services IMR. Ms M arrived 2 hours late; it is not documented if Mr N was present or their legal representatives. An entry from Drug Agency A for the following day suggests that he did not attend because the letter about it had a different date. The CYPS chronology indicates that a pre-proceedings meeting was held on [redacted] but no details are available.

**4.3.171.** [redacted] Ms M failed to attend a Drug Agency B appointment although later collected her prescription and provided a urine sample that was positive to methadone and benzodiazepines. The following day Mr N attended an appointment with the Drug Agency A worker. He was described as very argumentative. He was challenged about not collecting his methadone; Ms M had been collecting it for him regularly since the middle of May. He was described as secretive and contradictive. He initially denied drug use but then admitted to smoking heroin the previous week. He disputed a previous drug screen; the sample given on that day was positive for opiates and methadone metabolite but negative to benzodiazepines.

**4.3.172.** A Review Child Protection Conference [redacted], it is not clear from the chronology who was present but information was received from both drug agencies. It was confirmed that neither parent was fully engaging with the drug agencies and therefore not having any therapeutic intervention. Both children were said to be settled, happy and developing normally. Ms M was described as defensive and angry and wanting professionals out of her life. It was noted that the family had yet to obtain a lockable box for storage of methadone in spite of numerous reminders by professionals. The child protection plan was continued for both children although no detail of the plan is included. There was recommendation for hair strand testing to assess Ms M's drug use, Ms M agreed to be open and to attend appointments.

**4.3.173.** The following day both the CFSW and the health visitor visited the home, their visits overlapped. Child L was continuing to put on weight satisfactorily and had attended for an 8 week review and first course of immunisations.

**4.3.174.** The health visitor saw Ms M and the two children opportunistically at the GP surgery [redacted]. Ms M said that she had been in the pub that afternoon with friends; the children had been cared for by Mr N who had not been drinking. Ms M was described as animated and chatty but not obviously intoxicated. Ms M failed to attend another appointment with Drug Agency B on that day, her last urine screen [redacted] had been positive for methadone and benzodiazepines. Ms M was discussed at a Drug Agency B Team meeting; it was identified that prescribing of methadone by the service was inappropriate and unsafe due to the lack of engagement in any therapeutic work. It was agreed that the service would withdraw prescribing unless she agreed to engage with them or if the care was transferred back to Shared Care in primary care.

**4.3.175.** An Environmental Health Officer visited the family home at Ms M's request and submitted a report to the re-housing service, this resulted in an increase in the

Banding because of deficits in the dwelling. The family needed to continue bidding for properties in order to be re-housed but the change in banding would increase their chances of success. The Housing IMR indicates that no subsequent bids were made.

**4.3.176.** The CFSW visited [redacted] 10am, again she found Mr N and Child K asleep, although he woke during the visit and appeared tired. Ms M and Child L were present.

**4.3.177.** The following day Ms M was arrested [redacted]. The police report indicates that both parents were returning home from a pub (the time of the incident is not documented), they were intoxicated and the children were with them. Both of the adults were said to have [redacted] Ms M was arrested and bailed. The police went to the home to arrest Mr N who was not there. A small, nascent cannabis factory was found on the premises. The whereabouts of Mr N and the children was not ascertained. Mr N was arrested [redacted].

Although the details of the incident were passed to the Child Abuse Investigation Team and the social worker in view of the serious concerns that both adults were heavily intoxicated [redacted] in front of two small children and that there was the possibility of illegal drugs being cultivated on the property it is surprising that the police did not use their powers to protect the children.

This is the second incident in which it is noted that Ms M has consumed alcohol, it is not known if this was a regular occurrence. There had not been previous recorded occurrences of her using alcohol although there was history of her having done so. The [redacted] indicated that she was aware that Ms M was drinking at the time.

**4.3.178.** [redacted] Ms M saw the GP complaining of bruising [redacted] is documented that the police were involved but there is [redacted]

**4.3.179.** On the same day a duty social worker visited the home but did not gain access, contact was made with [redacted] who had not seen the family but reported that [redacted] had seen them the previous day. The police undertook a 'welfare check' visit. It is reported that Ms M and the two children were seen and there were no concerns – no other details are recorded. The social worker liaised with other practitioners engaged with the family to update them about the incident.

**4.3.180.** It was agreed that Drug Agency A would take over the care of Ms M from Drug Agency B. The Drug Agency B worker contacted the social worker to discuss the situation. It was identified that Ms M was engaging a little better since the Child Protection Conference but that the worker had a 'gut feeling that she was not authentic'. It was also indicated that Mr N was not complying with treatment and although he was supplying urine samples it was thought that they were not his. The

social worker consequently contacts a Team Manager requesting the need to initiate care proceedings. This is pursued by the Team Manager with an Area Manager with a view to requesting a legal planning meeting. [redacted] an informal discussion between the social worker and the lawyer suggests that advice is given that, although the threshold for care proceedings had been met, CYPS 'may struggle to get evidence for removal of the children at this stage'. The need for further information to be gathered from all agencies involved is identified. The Legal IMR suggests that CYPS had, in principle, already made the decision to initiate proceedings but had not decided on the care plan for the children. The lawyer was not in a position to proceed unless specifically instructed to do so and was waiting for confirmation. The legal meeting would give the opportunity for CYPS and the legal section to clarify the care plan and explore the evidence that would support removal of the children.

There appears to have been a lack of robustness in the pre-proceedings process and recognition of the parents' failure to adhere to the partnership agreements.

**4.3.181.** [redacted] the social worker made two attempts to visit the family at home but there was no reply. The police were again asked to undertake a welfare check, this was refused as one had been carried out the on the previous weekend and the rationale for them doing another was not clear. The social worker asked [redacted] to visit the home over the weekend. On the same day Ms M contacted Drug Agency B to say that she would be unable to attend to collect her prescription as she was unwell, she requested that Mr N collect it for her. She also requested a change to twice weekly rather than daily supervised consumption.

**4.3.182.** [redacted] the CFSW visited the family, they were all present although had obviously just got up. Child K was described as smiley and responsive. They had started weaning Child L in spite of advice to delay solids until 6 months. The CFSW liaised with the social worker and health visitor.

**4.3.183.** The CYPS chronology indicates that another pre-proceedings meeting was held that afternoon, There is, however, no record of this in the information from the legal services, therefore the status of this meeting is uncertain Ms M attended but Mr N was said to be unwell and therefore not present. Ms M was said to be defensive, denying intoxication [redacted] she denied using more drugs than she was admitting to and was feeling coerced into engaging in further detoxification. However she agreed to discuss it with her drug worker.

**4.3.184.** [redacted] Ms M was seen by the Drug Agency B worker she refused to provide a saliva sample as a hair strand test had been requested by CYPS. She denied the incident [redacted] and was unwilling to attend any group work.

**4.3.185.** The health visitor visited the home on [redacted]; Child K was [redacted]. Ms M stated that the Environmental Health Officer had condemned the flat as unsuitable, which she hoped would improve the family's likelihood of re-housing. As previously noted the banding had been increased but no bids had been made on properties.

Child L was thriving she confirmed that she had started weaning him and was advised.

**4.3.186.** The CFSW made a regular visit [redacted], all of the family were present, they were said to be in good spirits. Child K had sustained a cut on his eye whilst playing with some wood, possibly indicating lack of safety and supervision. This was the same explanation that had been given when the health visitor has seen an injury on Child K's face [redacted]. He was seen to be clean and tidy and very active. Mr N spoke sternly to him to stop him throwing toys. The flat was said to be in a poor state, messy, cluttered, with no hot water and the toilet was not flushing. The CFSW discussed safety issues with the parents. Mr N failed to attend his appointment that day with the Drug Agency A worker.

**4.3.187.** Ms M was seen at Drug Agency B the following day with both children. She reported feeling positive, not using on top and awaiting the hair strand test result. The social worker visited on the same day, Child K's eye injury was seen and the explanation accepted.

**4.3.188.** At 12.27, on 21st August after a 999 call, an ambulance arrived at the home; Child K was unconscious and not breathing. Mr N had made the emergency call and was said to be shouting and screaming on the phone. Ms M had 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 Children's 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. 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 are in progress 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 Serious Case Reviews, including Child Z Bristol LSCB, Case 0109 Gloucestershire LSCB and Child 2, Gwynedd & Anglesey LSCB that administration of methadone by parents to their children is known phenomenon. There is thought to be a belief amongst some drug users that administration of methadone to children is not as dangerous as it is and may be used as a means of calming children and helping them to sleep. Although this is shocking it would be

naïve to believe that parents who use drugs to treat their own physical and emotional distress, would not sometimes do the same for their children. Parents are aware that babies who are born drug-withdrawing can be given narcotics to manage their withdrawal symptoms, particularly irritability and crying and parents may be tempted to use their own Methadone – in what they believe to be small doses – as a "home treatment" for unsettled, irritable behaviour. Parents may not realise the danger of the drug for the child, for example users who can tolerate a large dose themselves may underestimate the serious toxicity of Methadone. Some parents believe their baby is "tolerant" to Methadone because they were exposed to it in utero. They therefore may believe that small amounts should not present a real danger; the parent may believe that the child, like themselves, will just "sleep off" a dose, and may therefore be reluctant to present the child until the symptoms become life-threatening. Drug using parents because of their general attitude to authorities, may be fearful about reports being made and hence may try to avoid the child being seen at hospital. A presentation at the 9th Australasian Conference on Child Abuse and Neglect in 2003 described a series of children who had died or been seriously harmed by ingestion of methadone. The research into accidental poisoning by any substance through ingestion suggests that most children are older toddlers whereas those who have been poisoned with methadone are, on average, younger. This seems to indicate the greater likelihood of Methadone being administered to young children by the carers, either accidentally or intentionally, rather than the child procuring it himself. Therefore the focus on prevention must be on educating methadone using parents of the dangers of giving their children methadone rather than specifically on safe storage of the medication. In support of the Serious Case Review process a meeting of the User Feedback Organisation (UFO) in Bristol held in January 2012 was asked if methadone was regularly given by parents with access to the drug to children to sedate or pacify them. The majority felt that this was not a regular occurrence. However they recognised that it may happen on occasions. Many in the group said that the practice of giving children alcohol or other drugs as a sedative or pacifier may be fairly common practice.

**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. It was reported that at least one practitioner had said that this was the family that they had least expected something like this to happen. Local data about admissions to acute hospitals in Bristol between 2003 and 2011 identified 19 children or young people who had been admitted following drug ingestion. Nine of the children were under 4 years old, the remainder over 13 years. Five of the children had ingested methadone or buprenorphine (opiate substitutes) and 3 other opioids. Referrals were made to CYPS for 5 of the children, 2 of which led to child protection plans. The UFO meeting offered a number of helpful suggestions to improve safety for children of parents who are prescribed methadone.

**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[15],[16] 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[17]. As identified in Cleaver et al (2011) p43 *"Research which explores the association between parental problem drug misuse and child abuse suggests parental drug use is generally associated with neglect and emotional abuse (Velleman 2001). Parents who experience difficulty in organising their own and their children's lives are unable to meet children's needs for safety and basic care, are emotionally unavailable to them and have difficulties in controlling and disciplining their children (Hogan and Higgins 2001; Cleaver et al. 2007)".* 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. Where expectations of actions, such as attendance at appointments and provision of urine specimens, were set out by practitioners there was no evidence of the consequences of non-compliance being clearly set out for the parents or followed through. The practitioners' resolve to follow through on the consequences was tested by the parents and although the required changes in their behaviour was not sustained this did not result in penalties.

**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*."[18]. In this case there were a number of missed opportunities for practitioners fully to understand the circumstances of Child K. Barlow and Scott report that: *"a recent overview of the evidence about effective interventions for complex families where there were concerns about (or evidence of) a child suffering significant harm, showed the importance of providing 'a dependable professional relationship' for parents and children, in particular with those families who conceal or minimise their difficulties"*[19].

## 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

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

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

[17] 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

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

[19] Barlow, J. with Scott, J. (2010), *Safeguarding in the 21st century: Where to Now?*, Dartington, Research in Practice. P24

serious concerns that were overlooked by practitioners. Descriptions of Child K generally suggested that he was a well loved, happy and contented child who was growing and developing within normal limits. The practitioners who had the most contact with the family in the home and therefore the most opportunity to observe the children were two Children and Family Support Workers; one of whom was involved during Child K's early months and a second from when Child L was discharged from hospital. They provided advice and support on general parenting matters. There are regular, documented comments that Child K is 'clean and well', 'clean, tidy and well'. The CFSWs described appropriate child care and responses to the developmental stages of Child K, for example toilet training. There are also a number of comments about positive interaction between both children and both of his parents, for example the parents are reported as expressing joy with Child K when he was 3 weeks old. There are a small number of occasions on which one or other of the children accompanied the adults to appointments with the drugs services each time there is comment about the child – "Child K happy and bright", "Mr N nurturing and attentive to child K", "Child L looked settled in buggy" thus indicating an awareness of the responsibility to consider the welfare of the child.

**5.6.2.** Observations of Child K and Child L by members of the health visiting team members were also consistently positive, the parents were said to respond appropriately to their needs and to advice offered. No concerns were identified about Child K's development. He received most of his immunisations on time and medical care was sought appropriately in response to illnesses and injuries. There is no record of Child L having received immunisations; he attended for an 8 week review with the GP albeit late.

**5.6.3.** 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.

**5.6.4.** 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 with his [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.

**5.6.5.** On one occasion in April 2010 the CFSW noted that the parents were not as attentive to the needs of Child K 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.

**5.6.6.** 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. 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.

**5.6.7.** 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. There are indications that the parents were minimising their use of alcohol and there was certainly at least one incident when Ms M was intoxicated apparently with alcohol. The fact that a can of lager was found in Child K's hospital locker the day before his discharge was not robustly challenged by practitioners may indicate a different attitude towards alcohol in comparison to other substances.

**5.6.8.** 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.

**5.6.9.** 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.

**5.6.10.** 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.** "The effectiveness with which a child's needs are assessed will be key to the effectiveness of subsequent actions and services and, ultimately, to the outcomes for the child. p viii"[20]; "Fundamental to establishing the extent of a child's need is a child-centred, sensitive and comprehensive assessment. p28"[21] As suggested by these quotations good assessments are fundamental to identifying and addressing the needs of children. However 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.** Good assessment of the needs of children requires practitioners to take full account of all of the relevant information including the history of the parents. Information needs to be gathered but in order to understand how that information will impact on the health and welfare of children it needs to be analysed. 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.[22] In order to assess the parenting capacity practitioners have the challenge of overcoming the secrecy and denial that characterises much substance abuse. Parents who misuse substances perhaps have more reasons than most for being guarded in their sharing of information with professionals. 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 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 clearly indicates deficits in the assessments completed by the social workers involved in this case. This particularly references the importance of family and social history of the parents which was not explored in sufficient detail either directly with the parents [redacted] The IMR also highlights the 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 from November 2009 was so limited that it is difficult to judge the depth or quality of their assessments, although 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.

[20] Department of Health (2000) The Framework for the Assessment of Children in Need and their Families
[21] Lord Laming (2009) The Protection of Children in England: A Progress Report , TSO
[22] Kroll, B and Taylor A (2003) *Parental Substance Abuse and Child Welfare*, London, Jessica Kingsley Publishers

**5.7.4.** The health visiting IMR indicates that at least two Family Health Needs Assessments were completed by a health visitor. The format of the assessment is based upon the Framework for Assessment of Children in Need and their families (DH 2000). The details of the outcome of these assessments is not included in the chronology or IMR from the service but there are judgements by the IMR author that the assessments were detailed and appropriate and resulted in appropriate levels of intervention with the family. 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 noted that the standard assessment and planning process was not adhered to by the DRUG AGENCY B worker when working with Ms M in 2011. It is also 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 [redacted] especially at the time that Child K became subject of a child protection plan in 2009. 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)[23] 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. This was evident through Ms M's pregnancy with Child K but became even more pronounced when she became pregnant the second time. As already mentioned it is not unusual for parents who use substances to be suspicious of services. Unfortunately it is often the failure to engage and to be honest with practitioners which increases the concerns of professionals. Had both parents, but Ms M in particular, been more open about their lapses into drug use, the services would almost certainly have responded in a supportive way rather than punitively as presumably feared by the parents. 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.

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

**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. On numerous occasions agreements were made with the parents about their cooperation with plans for example urine testing and partnership agreements as part of Child Protection and Child in Need plans and at times there was token compliance, at other times complete resistance, however when these agreements were broken there was no enforcement of consequences. There was a lack of challenge by practitioners across the range of agencies.

**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 by Morrison (2006)[24] using an adapted version of Prochaska and DiClemente's model of change there are seven sequential elements of motivation necessary for genuine and lasting change, there is also the need for parents to have the capacity as well as the motivation to change. As identified above the lack of comprehensive assessment of the parenting capacity meant that there was never a clear understanding whether motivation or capacity 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.

[24] Morrison, T. (2000) *Staff supervision in social care: making a real difference for staff and service users*, 3rd ed. Pavilion, Brighton

## 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 - although a social worker was already allocated there was little direct contact and there were no multi-agency meetings until the Initial Child Protection Conference two weeks after his birth. 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[25] is that substance misuse and child protection systems have 'different professional missions';

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

the drug services are focussed on the needs of the adult and the child welfare services on those of the children. Although, as demonstrated in the chronology 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. It is also of note that during one of the Legal Meetings a CYPS Team Manager suggested that drug screens should be weekly rather than fortnightly without consultation with either of the drug agencies about efficacy or associated cost of these tests, although this was later negotiated.

**5.9.7.** Details of contribution to and presence at the Child Protection Conferences are not included in the chronology. However there are indications that there were significant gaps in attendance at some conferences. The first review conference with respect to Child K in December 2009 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 in June 2010 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 in April 2010 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 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 Child Protection Plan with respect to Child K in 2009 ensured that there were fairly regular meetings of practitioners at Child Protection Conferences and Core Groups, and there was a child in need meeting convened but not until nine months after the discontinuation of Child K's Child Protection Plan in June 2010, the required timeframe being within 6 months. This followed repeated concerns about the welfare of the unborn Child L being expressed to the social worker by the midwives and health visitor. There was no indication that either of these considered convening a meeting themselves. The 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.** Supervision is defined by Morrison 2005[26] as "A process by which one worker is given responsibility by the organisation to work with another/other workers in order to meet certain organisational professional and personal objectives which together promote the best outcomes for service users and stakeholders". It is recognised as having a number of functions including management oversight to ensure maintenance of standards, professional development and support; defined in Proctor's model as normative, formative and restorative with focus on meeting organisational, professional and personal objectives. In exemplary supervision the three elements are maintained in overall balance, although one may have to take precedence over the others in response to different circumstances.

**5.10.3.** Within the CYPS IMR it was identified that there were resource issues in the Hospital Social Work Team during the time that the case was allocated to a member of that team. These were addressed by management action and a management review resulted in increased establishment in the team. It is also noted that the social worker had sick leave at the time. There was a delay of three weeks before the case was

[26] Morrison, T (2005) *Staff supervision in social care: making a real difference for staff and service users* Brighton: Pavilion

allocated and further delay of three months before an Initial Assessment was completed, well outside the required timescales; the assessment then completed was said not to be thorough or rigorous and based on minimal contact and a failure to take full account of the available historical information. The core assessment/report for the CP Conference in [redacted] was also said to be inadequate. Although the delay was noted in the supervision records there is no indication that there was any robust challenge or exploration of the reasons for the deficits. [redacted] there was agreement between the social worker and the team manager that a CP conference should be convened. This did not happen until September, after Child K's birth. There is no explanation given for this unacceptable delay.

**5.10.4.** The issues of high caseload numbers and competing pressures were identified as having an impact on the allocated social worker from November 2009 until Child K's death. During the period there were two Team Managers who supervised the social worker. Supervision with respect to the family was regular. There were serious deficits in case recording throughout the period that this social worker was in contact with the family. There were also delays in holding a Child in Need meeting following discontinuation of Child K's CP Plan, and especially in responding to the initial referral by midwives when Ms M was initially pregnant with Child L and then throughout the pregnancy when she was failing to cooperate with antenatal services. There is no indication that this was appropriately addressed in supervision as significant failures to meet acceptable professional standards, nor is there indication that the concerns were raised with more senior management.

**5.10.5.** Once Child L was born the engagement with services was supposedly structured through use of partnerships agreements. The first was signed [redacted] agreeing that Child L would stay with the [redacted] on discharge from hospital. A second agreement was made [redacted] for Child L to be discharged to the care of his mother but with support from [redacted]. A third was agreed on [redacted] after Child L had been discharged from hospital and was subject of a Child Protection Plan. It is of concern that written agreements were made but not followed through. The third agreement followed a meeting between parents and the CYPS Team Manager who informed the parents that Care Proceedings were being considered and a Public Law Outline, pre-proceedings, meeting was to be held. 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.

**5.10.6.** 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 both CYPS and the legal section were clear that the threshold was met and that care proceedings were to be issued it would appear that the pre-proceedings process went on too long, was not robustly overseen and was not effecting sufficient change for the children. This led to a muddled approach and a failure to use appropriately the only remedy that could ultimately have prevented Child K's death.

**5.11.2.** The Legal Services IMR indicates that the first approach from CYPS was by the social worker [redacted] requesting a legal planning meeting - the request should have been a formal referral completed by a Team Manager. It is noted that the Team Manager with responsibility for the case was on leave and had asked the Area Manager (a senior manager) to arrange for another Team Manager to complete the process. The Team Manager who was on leave had expected care proceedings to be issued whilst they were away. Information, but not the relevant referral form was received by Legal Services the following day and a request made for a legal planning meeting the following week. The lawyer initially dealing with the case was unable to attend the following week and it was to be dealt with by a duty lawyer as team lawyers were working to capacity and the case could not be allocated. The duty lawyer was not initially of the opinion that proceedings were required immediately. On [redacted] a lawyer sent a memo to the social worker confirming the outcome of a telephone conversation with another lawyer the previous day. The legal advice was that the threshold criteria for initiation of proceedings had been met but that there would need to be confirmation from an Area Manager that this was the intention of CYPS and if so whether the plan was for immediate issuing of proceedings or to start the pre-proceedings process. The social worker was asked to provide assessments, a chronology and a plan. Being unsure about the appropriate content for the care plan the social worker sought advice from the covering team manager who advised against issuing proceedings. A face to face legal planning meeting at this point would have allowed for more meaningful discussion of the situation and may have resulted in a different decision. In view of the difference in response from the covering team manager it would have been appropriate for the social worker to seek advice from a more senior manager, especially as their agreement for issuing proceedings was required.

**5.11.3.** The case was allocated to a lawyer [redacted]. There had been no decision communicated to legal services by CYPS to date but the following day the social worker sent a copy of the partnership agreement that had been made that day. This confirmed that a pre-proceedings meeting was to be convened, indicating a decision in principle that care proceedings may be issued at some stage dependent on the welfare of the children and parental cooperation. This was said to have acted as 'a wake-up call to the mother". However at this stage Child L had not been discharged from hospital and the parents' ability to sustain their cooperation with services had not been tested.

**5.11.4.** A legal planning meeting was held [redacted] - this was attended by the allocated social worker, the team manager and the allocated lawyer. It was agreed that the written agreement should be revised to include a more robust plan for monitoring of drug use and engagement with other agencies. The legal services IMR indicates that the CYPS practitioners acknowledged that it was a high risk strategy but the desire was to keep the family together and the lawyer was reassured that the decision not to issue proceedings at this point was not unreasonable. This was an optimistic assessment based on limited evidence to support it and overwhelming evidence of the potential risks. The parents' cooperation was entirely untested as Child L was still in hospital and they had not been cooperative throughout the pregnancy and since. This was exemplified by falsification of urine tests, using drugs whilst in hospital and leaving a bag containing drug paraphernalia and a child's dummy in the baby's cot. Also untested was the ability of the parents to manage two children, one of whom was a baby who, due to exposure to a variety of substances during the pregnancy, was especially vulnerable. The plan was also based upon cooperation from other agencies e.g. drug testing and welfare visits by the police, neither of which had been formally agreed. It may have been more appropriate to have put the matter before a court at this point before Child L was discharged from hospital. There was sufficient evidence that Child L had already suffered significant harm *in utero* and that the risk was ongoing. The grounds for proceedings with respect to Child K were less clear, most of the indications being that he had been a well loved, well cared for and normally developing child. The evidence of Ms M's continued, probably chaotic, drug use during her pregnancy may have provided sufficient concern about her parenting capacity to have also applied to Child K. It may therefore be argued that care proceedings with respect to Child L would not have influenced the outcome for Child K unless a court had considered all of the evidence and weighed the risks to both children and alternative arrangements for his care could have been agreed at the same time. However if Child L had not been discharged from hospital to the care of his parents, it is possible that the parents may have continued to offer, what had appeared to be, appropriate care to Child K.

**5.11.5.** A pre-proceedings meeting was held [redacted]; both parents with their legal representatives were present. Concerns were acknowledged by the parents, the agreement was reviewed although there is no evidence of it having been formally updated. Records of this meeting and the legal planning meetings were not in the CYPS files – this is a significant procedural failure.

**5.11.6.** A further meeting was planned [redacted] Ms M arrived two hours late for the meeting which was rearranged [redacted]. There are no details of these meetings in either the Legal Service or the CYPS files. Concerns about the family had escalated in this period; the parents were not complying with the written agreement and not engaging in any drug treatment programme other than the receipt of methadone. It is of concern that failure to comply with the written agreements was not followed through robustly and there were no clear consequences to the parents for non-compliance.

**5.11.7.** At the beginning of August the social worker's concerns were escalating and considered there was a need to issue care proceedings. This was discussed and the Area Manager agreed that "the children should be looked after elsewhere and that

consideration should be given to explore [redacted] possible carers." (CYPD IMR p6). There was discussion between the social worker and the allocated lawyer and it had been suggested by the lawyer that court agreement for removal of the children may be difficult to achieve. According to the CYPS IMR and chronology another pre-proceedings meeting was held on [redacted], but there is no record of this in the Legal Services IMR. Mr N did not attend as he was unwell - it is not clear whether the parents were legally represented but there was no representation from Legal Services. Ms M apparently presented well and agreed to hair strand testing that had been arranged. Although it would appear that a decision to issue proceedings had been made by CYPS, this was again postponed and the lawyer considered that instructions had not been formally given and therefore no action taken. 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 an 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. 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:

- In-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

## 6.2 Lessons from this Serious Case Review

**6.2.1** 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.

**6.2.2** 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.

**6.2.3** 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.*"[27] (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 use South West Child Protection Procedures Guidance on Working with Uncooperative Families.

**6.2.4** 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.

[27] 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.

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.

**6.2.5** 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.

**6.2.6** 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.

**6.2.7** 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.

**6.2.8** 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 multiagency 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.

**6.2.9** 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.

**6.2.10** 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. 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.** In 2008 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. Recommendations

**8.1.** 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:

**8.1.1.** 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.

**8.1.2.** 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.

**8.1.3.** 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.

**8.1.4.** 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.

**8.1.5.** 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 multi-agency audit.

**8.1.6.** 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

**8.1.7.** 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 multi-agency contribution to other types of interagency meetings which includes standards for attendance, provision of reports, meeting notes and action plans.

**8.1.8.** 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.

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

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

## 9. 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 (NBT)

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 (UHBT)

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, Drug Agency A 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), Drug Agency B

**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