**STRICTLY EMBARGOED UNTIL 9AM, FRIDAY 20 DECEMBER, 2013**

# Board publishes Serious Case Review into death of child

Released: Friday 20 December, 2013

Wolverhampton Safeguarding Children Board has today (Friday 20 December, 2013) published the Overview Report of its Serious Case Review into the death of a 23-month-old boy.

The review recommends ways in which agencies should work more effectively to better safeguard children.

Daniel Jones, who was 23 months old, died on 29 May, 2012. A post mortem found heroin toxicity as a cause of death, a result of ingesting a quantity of the drug.

Daniel's father Simon Jones subsequently pleaded guilty to manslaughter and his mother Emma Bradburn to causing or allowing the death of a child. They were jailed for six and four years respectively in July 2013.

The review found that Daniel died as a result of an event which "had not been foreseen by any of the professionals involved with the family" – but which may have been avoidable had they acknowledged the full extent of the potential risks Daniel faced as a result of his parents' drug and alcohol abuse.

As a result of the review, an action plan detailing 44 recommendations for ways in which the agencies involved should work better was drawn up.

They cover a range of issues, including making the family – rather than individuals – the focus of drug and alcohol treatment services, the way practitioners deal with "resistant" families and how inter-agency working should be improved.

Alan Coe, Chair of Wolverhampton Safeguarding Children Board, said: "The death of Daniel Jones was an absolute tragedy, and on behalf of Wolverhampton Safeguarding Children Board and the agencies involved in this case, I would like to offer an apology and express our deep sorrow to his family for the loss of a much-loved child.

"Everyone we spoke to, without exception, described Daniel as a happy, healthy little boy who was developing exactly as he should. What comes across very strongly from this Serious Case Review is that practitioners who worked with Daniel and his family should have looked beyond his apparent well-being and understood what life was like from his perspective.

“That they failed to do this is clearly unacceptable, and we have a duty to Daniel to ensure that, as far as is possible, the same thing doesn’t happen again. The Serious Case Review has therefore looked closely at everything that happened to see what could and – importantly – should have been done differently.”

He continued: “It is important to stress that there are many mothers and fathers in Wolverhampton who struggle with addiction and yet still parent their children well.

“It was acknowledged that Daniel’s parents both used drugs regularly, and what is very clear in this case is that their capacity to meet his needs was compromised.

“Practitioners missed opportunities to better manage the parents’ drug use, and, crucially, failed to fully understand the potential impact of their drug use on Daniel – their focus was too much on the parents, and not enough on their son and the family unit as a whole.

“Their assessments depended on the parents’ cooperation and candour, and this was not always forthcoming – had the practitioners challenged them properly, they may have appreciated the full extent of the potential risks that Daniel faced.”

Six agencies were involved in the Serious Care Review, including Wolverhampton City Council, Wolverhampton City Clinical Commissioning Group, Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust – the providers of addiction services in Wolverhampton at the time of the review – West Midlands Ambulance Service and West Midlands Police

As a result, a total of 44 recommendations are being implemented by service providers. They include giving practitioners the training, skills and support they need to work with resistant families and overcome any barriers that are put up, and ensuring that assessments relating to safeguarding children are carried out by appropriately qualified and experienced practitioners.

Other recommendations include ensuring that drug and alcohol services for substance-using parents have a whole family focus as well as person-centred care, and improving the effectiveness of inter-agency working.

Many of these recommendations have already been implemented, with the remainder due to be completed in the next few months.

Mr Coe said: “It is important to stress that things do change as a result of tragedies like this – that things do get better.

“Already, we’ve seen a number of improvements in Wolverhampton. A new drug and alcohol treatment service, the Wolverhampton Substance Misuse Service, has been commissioned and focuses much more on the child and

family. I have met with social workers and I am greatly impressed with the quality of work that they are now undertaking.

“The way that organisations work together is also being strengthened, particularly with regard to the way inter-agency meetings are held.

“There is much more that will be done, and while it is impossible to say that an incident like this could never happen again, I’m confident that the actions we are taking will go some way to making sure that we keep our children and young people safer in the future.”

Mr Coe added: “I would like to give my sincere thanks to Daniel’s family. This remains a very difficult time for them all and I would like to express my gratitude for working closely with us during this Serious Case Review process.”

More information about the Serious Case Review, including a copy of the overview report, action plans and a video statement from Alan Coe, can be found on the Wolverhampton Safeguarding Children Board, www.wolvesscb.org.uk.

**ENDS**

**Notes to editors:**

1/ Alan Coe, Chair of Wolverhampton Safeguarding Children Board, is available for interview today (Friday 20 December, 2013). To arrange an interview, please contact Paul Brown on 01902 555497 or 07900 805793, Gurdip Thandi on 01902 551256 or Tim Clark on 01902 554076.

2/ A Serious Case Review is initiated if a child has died, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in that death.

An extraordinary meeting of the Serious Case review Sub-group of Wolverhampton Safeguarding Children Board (WSCB) held on 13 December 2012 agreed that the criteria for undertaking a Serious Case Review were met and recommended that a Serious Case Review should be carried out.

The Serious Case Review seeks to:

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

The panel comprised senior representatives of agencies represented on WSCB. It was chaired by an independent social care consultant and an experienced chair of Serious Case Review Panels. Panel members represented Wolverhampton City Primary Care Trust/Wolverhampton Clinical Commissioning Group, West Midlands Police, Wolverhampton City Council and Wolverhampton Safeguarding Children Board. The overview report was written on behalf of the panel by an independent author.

Individual Management Reviews (IMRs) were requested of all agencies involved with the family: Wolverhampton City Council, Wolverhampton City Clinical Commissioning Group, Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust (providers of addiction services in Wolverhampton at the time of the review – these have subsequently been recommissioned as the new Wolverhampton Substance Misuse Service, introduced in April 2013 and provided by Nacro, Aquarius and Birmingham and Solihull Mental Health NHS Foundation Trust), West Midlands Ambulance Service and West Midlands Police. The IMRs looked openly and critically at individual and organisational practice to establish whether changes could and should be made.