WOLVERHAMPTON SAFEGUARDING CHILDREN BOARD

Serious Case Review relating to Daniel. who died aged 23 months

Ethnic Origin: White British

Overview Report

Summary

Daniel died in May 2012 when almost 2 years old, the death was as a result of ingestion of heroin. Post mortem hair sampling indicated that Daniel had been regularly exposed to heroin and occasionally to cocaine and amphetamines. Both parents were prosecuted in relation to the death and are currently serving prison sentences.

Wolverhampton Safeguarding Children Board completed a Serious Case review as required by Regulation 5 (1) (e) of the Local Safeguarding Children Board Regulations 2006. The review was undertaken as described in the statutory guidance Working Together 2010 having been commenced prior to the publication of the 2013 version of the guidance. As described in Working Together to Safeguard Children 2010 (8.5), the overall purpose of a Serious Case Review is to:

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

A panel comprising senior agency representatives from Wolverhampton Safeguarding Children Board, Wolverhampton City Council, Wolverhampton City Clinical Commissioning Group and West Midlands Police, chaired by an independent consultant, was established to oversee the process of the review. None of the panel members had any direct involvement with the family or line management responsibility for practitioners who worked with the family. An independent consultant was commissioned to bring together the overview report. Both consultants were independent of all organisations involved in the review and had considerable experience of Serious Case Reviews.

Each organisation that offered services to Daniel's family produced a detailed chronology of their involvement and an Individual Management Review (IMR). IMRs were provided by:

Wolverhampton City Council
- Children and Young People's Social Care
- Early Intervention and Children's Centres

Wolverhampton City Clinical Commissioning Group
- General Medical Practice

Royal Wolverhampton NHS Trust
- Acute and Emergency Services
- Maternity and Health Visiting

Black Country Partnership Foundation Trust[i]
- Addiction Services

West Midlands Ambulance Service

West Midlands Police

[i] Providers of addiction services in Wolverhampton at the time of the review. These services have been re-commissioned and are now provided by a consortium of NACRO, Aquarius and Birmingham and Solihull Mental Health NHS Foundation Trust.

Reports were also received from West Midlands Probation Service and Occupational Therapy Services who had contact with the father and mother respectively before the timeframe of the review. A Health Overview report that brought together an overview of health service involvement and was the IMR for the health commissioners was provided by the Designated Professionals for safeguarding children for Wolverhampton City Clinical Commissioning Group. The IMRs looked openly and critically at individual and organisational practice, to establish whether the case indicated that changes could and should be made and, if so, to identify how those changes will be brought about. The IMR authors, identified by organisations, were senior officers who had no direct involvement with provision of services to the family.

Significant Events

Daniel's parents had been known to Addiction Services for some time before the timeframe of this review. Both were known to have used heroin and during the timeframe both were on a methadone programme prescribed by the Addiction Service. Their involvement with the service continued throughout Daniel's life. The parents had separate keyworkers to manage their care. The mother had disabilities, including mobility difficulties, as a consequence of a major accident several years prior to Daniel's birth. When the mother became pregnant she was referred to a Specialist Midwife for substance using mothers and a Consultant Obstetrician managed her obstetric care. In view of the known potential impact on parenting capacity of substance use and mother's impaired mobility the addiction workers made a referral to Children's Social Care when the mother was 22 weeks pregnant. A Social Care Worker undertook an Initial Assessment, and a parenting assessment was completed over an eight-week period starting during the 29th week of the pregnancy.

Daniel's delivery was well planned to take full account of the mother's health issues. Daniel's health and development was monitored by health visitors through some home visits and clinic attendance. Daniel received immunisations at the appropriate times and no concerns about health or development were identified.

During Daniel's life there were eleven multiagency Child in Need meetings, convened by Children's Social Care and attended by practitioners involved in the care of the family. Unfortunately there was lack of consistency in attendance at the meetings and on occasion relevant information, especially about the parents' substance use and engagement with other services was not available. The meetings recognised the potential negative impact of the parents' drug use on Daniel and focussed on supporting them in addressing this. There were indications that the parents did not always fully engage in services offered to them. The Child in Need plans developed at these meetings were not robust and did not sufficiently address the risks to Daniel of his parents' substance use. There was insufficient enquiry by the practitioners about the specifics of the parents' drug use and their consideration of Daniel's safety.

The mother, as a result of her accident, had significant physical difficulties and pain. She was prescribed medication for pain by the GP. Pain was her cited reason for use of heroin in addition to her prescribed methadone. Unfortunately there was no collaborative working between the GP practice and the Addiction Service, which may have better addressed her pain and reduced her need for illicit drugs.

During Daniel's life there were a number of domestic incidents in which the police were involved and for the six months before the death the father was not fully resident in the family home. There was appropriate information sharing by the police about the domestic incidents although they had no on-going involvement and were not part of any interagency intervention with the family.

Analysis

Daniel died as a result of an event that had not been foreseen by any of the professionals involved with the family. However the full extent of the potential risks were not acknowledged by any of the practitioners and, had they been more professionally curious, had more 'respectful uncertainty' and been more assertive in their approach to the family, Daniel's death may have been avoidable. It is well recognised that parents who use drugs can and do parent their children well but substance use can sometimes negatively affect parents' capacity adequately to meet their children's needs. The assessment of this is dependent upon parents' cooperation and candour, which were not always evident in this case.

The analysis of the information available from the chronology and IMRs focussed on a number of emergent themes and identifies a number of missed opportunities for practitioners to understand fully Daniel's circumstances.

- Child focus – practitioners did not fully understand, or seek to understand the day-to-day experience of the child.
- Working with substance using parents – including missed opportunities to better manage the mother's substance use as pain control and to address safety issues around safe storage and use of substances.
- Assessment – missed opportunities for in depth, rigorous, family centred assessments of the parenting, the impact of substance use and the mother's disability.
- Working with resistance and avoidance – missed opportunities to recognise and address lack of compliance and engagement with services.
- Interagency working – there were examples of good interagency working but also some missed opportunities for information sharing and collaboration between professionals.
- Management oversight and supervision – recognition of importance of supportive yet challenging supervision of practitioners to guard against 'over optimism' and 'fixed thinking' and to maintain a child focus.

Lessons to be Learned

- 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.
- 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.
- Practitioners in all agencies need to be reminded of the importance of comprehensive record keeping that maintains a focus on children and their welfare.
- Working with substance using parents and families where there is resistance and avoidance is challenging. It is recognised that the best way to address these issues

is through 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. 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. Professional, interagency challenge must be underpinned by clear procedures.

- Successful interagency collaborative working is underpinned by structures such as Child Protection Conferences and Child in Need meetings. It is essential that practitioners have the opportunities and tools necessary to contribute effectively to these meetings.

Recommendations

The way that Daniel died may not have been predictable but may have been avoidable. Indicators identified by practitioners suggested that, although there were potential concerns for the long term well being of Daniel, these did not amount to serious and immediate risk to Daniel. From the information gathered in the Serious Case Review process there were lessons to be learned about the interventions with Daniel's family and a number of recommendations have been made as a result.

1. To ensure improved outcomes for children Wolverhampton Safeguarding Children Board (WSCB) 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.
2. To ensure the quality and effectiveness of Serious Case Reviews, no matter what methodology is used in the future, WSCB must seek to ensure that partner agencies recognise the importance of SCRs and allow authors and other contributors sufficient time and resource to complete IMRs or other reviews that are timely, of appropriate quality and are signed off by an officer/manager of sufficient seniority to ensure ownership of recommendations and to drive through implementation within the organisation.
3. WSCB should assure itself that all assessments that relate to safeguarding children are undertaken by appropriately qualified and experienced practitioners who are supported by appropriate levels of supervision.
4. WSCB should develop an interagency pathway and protocol for assessing the needs of unborn babies in all circumstances where there is the likelihood of compromised parenting.
5. To ensure interagency collaboration and provision of effective interventions WSCB in conjunction with the Adult Safeguarding Board should review and if necessary update the recently produced interagency guidance 'Hidden Harm - parental substance misuse and the effects on children' and any guidance with respect to the 'Think Family' agenda and ensure that there are mechanisms in place to assure themselves of their implementation and effectiveness.

6. WSCB should be assured by service commissioners that providers of drug and alcohol services to substance using parents have a safeguarding and a family focus as well as providing appropriate person-centred care.
7. WSCB should seek assurance from partner agencies that practitioners and managers are fully cognisant of procedures, guidance and best practice with respect to:
    a. thresholds for intervention at different levels
    b. assessment
    c. interagency communication
    d. record keeping including use of chronologies
    e. contribution, through attendance and provision of reports of appropriate quality, to interagency safeguarding meetings including Children in Need meetings as well as Child Protection conferences

    and that there is management oversight of their operation.
8. To improve outcomes for children and to ensure practitioners are appropriately skilled, WSCB should assure itself that training and other professional development opportunities are available to practitioners and managers/supervisors in partner agencies about how best to work with avoidant and resistant families and which provides an understanding of barriers to parental engagement and strategies to overcome these barriers. The impact of this should be evaluated by multiagency audit.
9. To ensure effectiveness of interagency working with children and families, WSCB should develop, disseminate and implement policies, procedures and guidance for practitioners and front line managers in partner agencies in respect to management of professional disagreements, professional challenge and appropriate escalation. Once implemented the effectiveness should be evaluated by audit.
10. To ensure effectiveness of interagency working with children and families WSCB should develop and disseminate practice guidance about the operation and multiagency contribution to Child in Need and other interagency meetings which includes standards for invitations, attendance, provision of reports, meeting notes, action plans and monitoring of progress towards clear, agreed outcomes for children.

Single agency recommendations were made in each of the IMRs and endorsed by the panel. Action plans have been drawn up by each of the organisations and the progress will be monitored by WSCB.

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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 now works as an Independent Consultant. She has experience as a member of a number of Serious Case Review Panels and has written Overview Reports, for a number of LSCBs in England and Wales, and Individual Management Reviews.

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 and advise authorities and their Board partners on lessons to be learned. A serious case is defined as one where:

> "(a) abuse or neglect of a child is known or suspected; and
> (b) either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child."

1.2. In May 2012 Daniel, aged 23 months, was found unresponsive and not breathing at home by the mother in the early morning. An ambulance attended the scene where Daniel was found to be pulseless and not breathing. Basic life support was performed by ambulance personnel and Daniel was transferred to the nearest hospital but was pronounced dead. Post mortem toxicity investigations were reported several months after Daniel's death and showed heroin toxicity as a cause of death.

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

1.4. The review having been commenced prior to the publication of the 2013 of Working Together in March the SCR was carried out under the guidance from Working Together to Safeguard Children, 2010, Chapter 8, however principles of the new guidance were taken into account.

1.5. As described in Working Together to Safeguard Children 2010 (8.5), the overall purpose of a Serious Case Review is to:

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

1.6. 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 WSCB. It was chaired by Fergus Smith, an independent Social Care consultant and an experienced chair of Serious Case Review Panels. He was appointed by WSCB 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. 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.

1.8. Panel Members represented the following services:

Wolverhampton City PCT/CCG	Designated Doctor for Safeguarding Children
	Designated Senior Nurse for Safeguarding Children
West Midlands Police,	Detective Chief Inspector, Public Protection Unit
Wolverhampton City Council	Head of Service, YOT
	Lead Manager for Children's Centres
Wolverhampton SCB	Head of Service, Safeguarding Children
	Coordinator CDOP/SCR (Admin Support)

1.9. 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.

1.10. WSCB 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.

1.11. 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.

1.12. 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:

Wolverhampton City Council
Children and Young People's Social Care
Early Intervention and Children's Centres
Wolverhampton City Clinical Commissioning Group
General Medical Practice
Royal Wolverhampton NHS Trust
Acute and Emergency Services
Maternity and Health Visiting
Black Country Partnership Foundation Trust[1]
Addiction Services
West Midlands Ambulance Service
West Midlands Police

Reports were also received from West Midlands Probation Service and Occupational Therapy Services

1.13. A health overview report was also provided by the Designated Professionals. This constituted the IMR for the Clinical Commissioning Group (previously the Primary Care Trust) and considered the way that the health organisations interacted together.

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

1.15. 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.

1.16. IMR authors were provided with a standard template used by WSCB; this helped to ensure consistency and completeness of the reports.

1.17. IMR authors attended a training session that addressed the purpose and process of SCRs and IMRs and were offered support from experienced IMR authors.

[1] Providers of addiction services in Wolverhampton at the time of the review. These services have been re-commissioned and are now provided by a consortium of NACRO, Aquarius and Birmingham and Solihull Mental Health NHS Foundation Trust.

1.18. The time under scrutiny within the review was the period of Daniel's life and antenatal period.

1.19. In line with the Working Together guidance the areas of consideration required of IMR authors were:

- Were practitioners aware of and sensitive to the needs of the child in their work, and knowledgeable both about potential indicators of abuse or neglect, and about what to do if they had any concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to Daniel and the family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the Daniel and his family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the WSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

What do we learn from this case?

- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources?
- Are there implications for current policy and practice.

In addition to the above generic terms of reference, the Serious Case Review Panel agreed that agencies should address the following issues, which are specific to this case:

- were threshold decisions clearly outlined, if so how?
- what was the quality of the Child in Need Plan, its implementation and the planning and review process?
- what consideration was given to the impact of historical parenting experience in the assessment process?
- what was the impact of parent substance misuse and domestic abuse on the care provided to the children?
- what was the analysis and rationale for closure of the case and the understanding of the on-going care provision;
- where there are multiple staff involved within an agency, was there continuity of care planning.

1.20. 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 Officer in the organisation who had commissioned the report, was responsible for the quality and timeliness of the report and who will be accountable for ensuring that the recommendations are acted upon in a timely manner within their organisation.

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 Wolverhampton 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 seven occasions to oversee the SCR process. The overview author was in attendance at panel meetings. 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 final ‘sign off’ by senior managers/officers in the organisations who were expected to provide additional quality assurance.

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 officer/manager in the organisation to ensure appropriate ownership within the organisation for implementation of recommendations and action plans. Each organisation developed an action plan to ensure implementation of the recommendations.

2.6. The IMRs were generally of at least adequate quality, although the panel required significant redrafting of one in particular. There was a significant delay in receipt of the final draft of one IMR. The panel expressed concern that some organisations did not adequately recognise the work involved in producing a good IMR and did not afford authors sufficient protected time to complete the task. This has led to a recommendation to the Wolverhampton Safeguarding Children Board and its partner agencies. All IMRs were 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 however the interviewing of personnel by the IMR authors was restricted due to the ongoing criminal investigation; this was a limitation of the review.

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

2.8. Most of the IMRs provided an appropriate level of analysis of agency involvement highlighting both deficits in practice and examples of good practice. Some, but not all, of the IMRs demonstrated the 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. The IMR recommendations, in most part, flowed appropriately from the lessons learned and were Specific, Measurable, Achievable, Realistic and Time bound.

2.9. The panel scrutinised the overview report and agreed recommendations and the integrated action plan prior to submission to the Wolverhampton Safeguarding Children Board.

2.10. As indicated above the on-going police investigation and criminal process impeded the full involvement of practitioners in the review process because of their possible involvement as witnesses. IMR authors were therefore generally restricted to examination of professional records and other documentation in their preparation of reports. It can be argued that good documentation should provide sufficient data to examine the professional intervention and decision making processes. However more involvement of practitioners in the process of serious case reviews increases opportunities to understand practice from the viewpoint of the individuals involved and reduces the impact of hindsight bias. The panel considered this dilemma but agreed that it was preferable to go ahead with the review, taking account of these restrictions, rather than delay the process thereby delaying the learning from the review.

3 Family Involvement

3.1. Family members were informed of the review and the parents' consent for access to their medical records obtained. Legal reasons meant that it was not possible to gather the views of the parents or involve them in the review due to the on-going criminal process

3.2. Following the completion of the criminal procedures both parents were convicted in relation to Daniel's death. Both parents pleaded guilty, father to manslaughter and the mother to causing or allowing the death, and were given prison sentences.

3.3. Following the completion of the review the parents were given the opportunity to discuss the findings of the review. The overview author and one of the panel

members saw the mother in prison. She was accepting of the findings of the review and the recommendations.

3.4. Following this contact with the mother a member of her extended family wrote to the Chair of the LSCB to offer reflections on agency involvement with the family. Consequently they, and thereafter several other members of both sides the extended family, were seen by an SCR panel member, their comments and observations have been incorporated into a revised overview report.

3.5. All family members who contributed information indicated that Daniel was a delightful child, who appeared happy and healthy although grubby at times. They were reassured that services were involved with the family but members of the mother's family considered that they should have been contacted for information about their involvement and support that they were offering.

4 The Facts

Family Background

4.1. The mother

4.1.1. Daniel was the mother's second child; she was aged 32 years when Daniel died. The mother's first chid did not live with the family and had no connections with the case.

4.1.2. The mother was involved in a serious accident seven years before Daniel's birth. This resulted in her receiving significant financial compensation, which allowed her to buy a house, when Daniel was six months old, for the family to live in. Initially the accident resulted in the mother being a wheelchair user with other health problems, although her mobility improved during the timescale of the review. Unfortunately the mother's primary medical records for a five-year period, which included the time of the accident, could not be located within the timescale of the review; therefore relevant details of her disability are limited.

4.1.3. The mother was known to use a variety of substances both prescribed and illicit. She was first assessed by the Addiction Service when she was 22 years old when she disclosed daily use of heroin. A substitution prescription (methadone) programme was started but not sustained and she was discharged from the service two months later. She recommenced a methadone programme two years later. It was noted that she had injected heroin in the past but during the course of the review she disclosed only use by smoking. She also took prescribed opiates as a means of pain control. Family members indicated that she also regularly consumed significant amounts of alcohol. The mother was involved with the Addiction Service before and throughout the period of the review; a keyworker was allocated to work with her.

4.1.4. The mother had an offending history from the age of twenty until the time of the accident, having been arrested on a number of occasions and ten crimes reported. The offences were theft and loitering. There was no formal police involvement from the time of the accident until her arrest in relation to the death of Daniel.

4.2. The father

4.2.1. The father had a significant offending history that began when he was sixteen and mostly relates to offences of theft of and from vehicles. His criminal behaviour was linked to his heroin dependency. He reported to the probation service that he had

started using illicit drugs aged 12 years and heroin when 16 years. He served a fourteen-month prison sentence for robbery when he was 26 years. Due to his offending behaviour the father was classed as a prolific offender until the age of 26 and was managed by the police Offender Management Team. The last involvement with this team was a year before the birth of Daniel and his offending history declined thereafter.

4.2.2. The Probation service were involved with the father between the ages of 19 and 22 years when he was involved in persistent criminality and again when he was 26 years in relation to the robbery offence.

4.2.3. The father was known to be a drug user although had minimal criminal history for drug related offences.

4.2.4. The father was known to the Addiction Service since he was aged 24 years and was in and out of treatment thereafter. He was re-referred to the service on his release from prison several months before Daniel's conception. He attended an initial appointment but disengaged. A practitioner from the Addiction Service was allocated as a keyworker for the father throughout most of the period of the review.

4.2.5. None of the IMRs indicated how long the parents had been in a relationship.

4.3. Summary of Significant Facts from the Integrated Chronology of Agency Involvement

(Comments and author's analysis are included in shaded boxes throughout the narrative chronology)

The antenatal period

1st Trimester

4.3.1. The first practitioner to be made aware of the pregnancy was the mother's key addiction worker who appropriately referred to the specialist midwife who was, at the time, part of the Addiction service. The parents then saw the GP to discuss the pregnancy. It is noted by the GP that the mother was taking a number of medications and was smoking and taking alcohol, that she was involved with the Addiction Service and was on a methadone programme. The GP referred to the midwife attached to the practice who appropriately confirmed that the specialist midwife in the Addiction Service would be the responsible midwife.

The mother's alcohol use was not specifically identified as an issue in any of the agency chronologies but was raised as a significant issue by all extended family members who offered information to the review. Family members suggested that she regularly drank heavily throughout Daniel's life. Excessive alcohol consumption and related problems are common among clients in methadone maintenance treatment[2]. It would appear that practitioners did not perceive alcohol intake as a significant issue either because it was not disclosed, the mother was not questioned about it or it was normalised by practitioners. The risk of heroin related overdose is significantly increased by alcohol use. The risks to children of the impact of alcohol are as

[2] Hillebrand J, Marsden J, Finch E, Strang J.(2001) *Excessive alcohol consumption and drinking expectations among clients in methadone maintenance.* J Subst Abuse Treat. 2001 Oct;21(3):155-60

significant as those of other substances both in relation to the short term intoxicant effects and the longer term health effects. Use of alcohol should always be continually considered as a part of any assessment of substance using parents.

4.3.2. The specialist midwife first saw the mother during the ninth week of pregnancy and completed a comprehensive assessment of her health, social circumstances and obstetric needs. In view of the mother's physical disability, as a result of the accident, and her substance use she was referred for consultant obstetric care. She was seen the following week in the hospital antenatal clinic by a midwife specialising in work with vulnerable women.

4.3.3. The father was seen for an initial assessment by an outreach addiction worker during the early weeks of Daniel's gestation. This was a further attempt to engage him in service provision after his failure to engage in the previous months. This was a wide-ranging assessment during which the father disclosed having been abused as a child, there were no other references to this in any IMRs or any indication that it was pursued further with him. An appointment was made for him to be medically assessed within the service. He attended this appointment and it was noted that the father was injecting heroin into his groin. He was started on buprenorphine - an opioid used as a heroin substitute. It is noted in the Addiction Service IMR that the doctor does not appear to have referred to the previous assessment completed by the outreach worker two weeks previously and there is no indication of consideration of the father's disclosure of child abuse.

4.3.4. During the same week there is a police intelligence system entry in respect of the father that mentions the pregnancy and indicates concerns about a third party living at the family address and the possibility of drugs being sold from the premises. This information was not shared with other agencies.

4.3.5. A consultant obstetrician saw the mother during the eleventh week of pregnancy, she had an ultrasound scan and in view of the problems that were a result of her previous accident an elective Caesarean section at 39 weeks was planned. It was noted that she was taking MST (slow release morphine) and methadone; it was also noted that she had a history of taking amitriptyline (an antidepressant) although no details of this are included in the chronology. She was also seen at this time by an addiction practitioner and requested an increase in her methadone prescription; she was offered an appointment with a doctor in the Addiction Service two days later but declined, a further appointment was arranged in two weeks time.

The mother's substance use is not clearly detailed in the chronology; it would appear that there was little coordination between services with respect to prescribing. The heroin substitution with methadone was managed by the Addiction Service and the morphine (MST or Zomorph) was prescribed by the GP. [3]Methadone substitution during pregnancy is encouraged as it carries lower risk than continued illicit use of

[3] Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: and Black Country Partnership NHS Foundation Trust, Addiction Services, Service Procedures Handbook (undated)

heroin. The aims of the maintenance approach, also known as 'substitution' or 'harm-reduction', are to provide stability by reducing craving and preventing withdrawal, eliminating the hazards of injecting and freeing the person from preoccupation with obtaining illicit opioids, and to enhance overall function. To achieve this, a substitution opioid regimen (a fixed or flexible dose of methadone or buprenorphine to reduce and stop illicit use) is prescribed at a dose higher than that required merely to prevent withdrawal symptoms. The aim is generally to prescribe a maintenance dose that stops or minimises illicit use. If illicit opiate use continues, increasing the dose of the prescribed opiate may be necessary. There is often a need to increase methadone prescription during pregnancy, in order to minimize 'on-top' use of heroin due to increasing blood volumes. Detoxification can be attempted during the second trimester but is not recommended in early or late pregnancy; it should not generally be undertaken in the third trimester because there is evidence that maternal withdrawal, even if mild, is associated with foetal stress, foetal distress, and even stillbirth. It is not clear if the mother's methadone prescription took full account of the morphine being prescribed by the GP. It would appear that the mother had been prescribed methadone over a long period and as such prescriptions were regular and issued for longer periods than would be expected for users newly engaged in a maintenance or substitution programme.

There is indication throughout the chronology that the mother was not fully compliant with the requirements of the Addiction Service for regular contact and review. It would appear that practitioners were tolerant of this, possibly because she had been involved with the service over a long period or it may have been influenced by her disability. This resulted in prescriptions continuing to be issued even when she did not attend for expected medical review in the Addiction Service. As already indicated there did not appear to be a coordinated approach to the medicines management and limited medical oversight of the prescribing.

2nd Trimester

4.3.6. The mother did not attend the medical appointment or one arranged for the following week. A methadone prescription was made available at a pharmacy; it is unclear what dosage had been prescribed.

4.3.7. During the week in which the mother had failed to attend the second medical appointment the father's keyworker referred him to an outreach worker to follow up his failure to collect his methadone for three days; he was on daily, supervised consumption at a pharmacy. Normally failure to attend the pharmacy would result in the withdrawal of a prescription. This resulted in a home visit two days after the referral. A further keyworker appointment was made and kept for the following day. The father disclosed continued use of heroin, cocaine, cannabis and alcohol. A further medical appointment was made for the following week at which a further methadone prescription was issued. He attended review appointments for next two consecutive weeks and two further appointments at two weekly intervals. His disclosed use of heroin was reducing and the methadone increased as part of the substitution programme. At the last of these appointments he said that he had not

used heroin for three days and expressed a desire to be drug free in time for the baby's birth.

There is some confusion in the chronology about the opioid substitution that is being prescribed for the father (methadone or buprenorphine). Clinical guidelines[2] suggest that people in receipt of opiate substitution should be required to take their daily doses under the direct supervision of a professional (often a pharmacist) for a period of time contingent upon compliance; this is often three months. After this time methadone is prescribed for unsupervised consumption, sometimes restricted to daily pick up by the individual, otherwise weekly prescriptions are issued. Prescriptions would normally be issued during contact between the individual and a keyworker. It would appear, although it is not entirely clear from the IMR that the mother's prescriptions were for a longer period than a week. The Addiction Service has a procedure for follow up of missed appointments but there are indications that these were not fully adhered to, although the procedure offers limited direction about timescales for follow up.

4.3.8. During the 20th week of the pregnancy the mother attended an Addiction Service medical appointment with the father. She admitted 'dabbling with heroin' and a urine test was positive for it. She attended an antenatal appointment and a routine anomaly scan was done; this was normal. The mother attended antenatal appointments at 28 weeks, 30 weeks (at home), 32 weeks, 33 weeks (obstetrician), 35 weeks and 37 weeks. These contacts were in line with NICE guidance[4].

4.3.9. The following week the father's addiction worker and the team leader in the Women's Team, who was also a specialist midwife, discussed the case and it was agreed that a referral should be made to Children's Social Care to safeguard the welfare of the unborn baby. The referral was discussed with the parents, by the mother's keyworker at a home visit and by the father's keyworker at a clinic appointment. It was noted that the father had made progress in his drug reduction and that he would be the main carer for the baby due to the mother's disability, therefore framing the Social Care referral in the context of the provision of support rather than focussing on the impact of the parents' drug use on the unborn baby.

This is the first indication of any communication or collaborative working between the addiction practitioners involved in the care of the two parents that focussed on the unborn baby. The Black Country Partnership NHS Foundation Trust, Addiction Services undated documents "Services for Women and their Children" and "Maternity Pathway" indicate the requirement for earlier referral and in view of the lack of full engagement of both parents with the service this may have been appropriate. If the practitioners had low level concerns about the welfare of the unborn baby it may have been appropriate for a CAF (Common Assessment Framework) to have been initiated very early in the pregnancy; this could have facilitated a more wide-ranging, interagency approach to assessment of the needs and welfare of the unborn baby.

[4] National Institute for Health and Care Excellence, Clinical Guideline CG62 Antenatal Care Issued 2008.

The CAF process could have resulted in interagency intervention as a Team Around the Child involving a wider range of practitioners.

A clear interagency LSCB process or protocol for managing the care of unborn babies for whom there are safety and welfare concerns would have provided a framework for more robust interagency collaboration and clearer decision making about the level of response that is needed in individual cases (CAF (early help), Child in Need (Section 17) or Child Protection (Section 47).

4.3.10. The referral to Children's Social Care, made in the 22nd week of the pregnancy, provided details of the parents' drug use and their engagement with the Addiction Service including involvement of the specialist midwifery service; there was also referral to mother's disability. The Social Care IMR indicates that the focus of the referral was more on the mother's disability than the impact of the parents' drug use. The case was allocated to an unqualified Social Care Worker in the Duty and Assessment Team who completed an Initial Assessment over the next week. There is no indication in the chronology of direct contact between the Social Care Worker and the parents as part of this assessment, although this is presumed to have occurred, as there is reference to information about their drug use and access to family support. Nor is there indication of contact with other practitioners for contribution to the assessment other than the specialist midwife.

It is of concern that an assessment of a potential child protection concern was undertaken by an unqualified worker, albeit one with experience. The details of the contact made with the family – number of contacts, with whom, where they took place etc. are not included in the chronology. The outcome of the assessment however was that further assessment was required, via a core assessment which appears to have been appropriate. Initial Assessments undertaken, at the time, under The Framework of Assessment of Children in Need and their Families (HM Govt. 2000) [5] are time limited assessments undertaken to determine whether the child is in need, the nature of any services required, from where and within what timescales, and whether a further, more detailed core assessment should be undertaken, it is expected that any professionals involved with the family would contribute to the assessment.

4.3.11. The initial assessment was authorised by a Team Manager and it was recommended that the case should transfer to a locality team within Children's Social Care for a pre-birth Core Assessment and a Child in Need Plan. A referral was made for a pre-birth parenting assessment, this was assigned to a Family Centre to complete. These on-going referrals were completed within two days, however the case was not allocated within the locality team for a further three months.

The delay in allocation to complete a core assessment meant that any interagency planning to address the safety and welfare of the unborn baby was delayed until after the baby's birth.

[5] This guidance has been superseded by the new version of Working Together to Safeguard Children (HM Govt. 2013).

4.3.12. During the 27th week of the pregnancy a Duty Social Worker from the locality team attended a joint home visit with the Family Centre Family Worker, at the request of the Family Centre worker to plan the parenting assessment. After the home visit the Family Centre worker was sufficiently concerned for their manager to contact a manager in the Children's Social Care Locality Team to expedite allocation as they considered that a Child Protection Conference would be appropriate.

4.3.13. Three days after this visit the father attended a police station requesting help with completion of a DVLA application. The officer completed a standard information sharing log (WC392) to share information with Children's Social Care about the father's past history of drug use and abuse when a child, which may impact on his parenting capacity. Two weeks later there was a conversation between a social worker and a police officer recorded in the Social Care chronology but not in the police chronology. The police officer reconfirmed the concerns about the parents' drug use documented in the proforma.

There is no indication that this information sharing led to any action or that the police were involved in any of the future planning. This was a missed opportunity for on-going interagency working.

3rd Trimester

4.3.14. A Family Worker from the Family Centre started a parenting assessment during the 29th week of the pregnancy; it comprised six contacts over an eight week period. On the first and subsequent visits the mother was complaining of morning sickness and unable to tolerate her methadone and had consequently been using heroin. There is no indication that the worker discussed this with other practitioners working with the family; it would have been appropriate for consultation with the Addiction Service who were prescribing the methadone and the GP who may have been able to offer advice about management of the vomiting. Issues addressed in the parenting assessment included feeding, play and stimulation, home safety, childhood and drug use, impact of drugs on parenting capacity, emotional warmth, guidance and boundaries and stability. At the end of the assessment a referral was made to a Children's Centre for outreach support, it was received on the day of Daniel's birth.

At the time of Daniel's birth the worker who completed the parenting assessment reported to the, by then, allocated social worker recommending that the baby should be cared for by the parents at home. As identified by the Social Care IMR author this was a decision that should have been part of a core assessment undertaken by a qualified social worker in collaboration with other professionals. The delay in allocation to a social worker precluded this.

4.3.15. Between the referral to Children's Social Care and Daniel's the father attended appointments with the Addiction Service nine times and did not attend on a further three occasions. Prescriptions for methadone were provided but he continued to disclose use of heroin, both injected and smoked. He claimed to only use heroin

when unable to collect the methadone, however all drug tests were positive for heroin. A month before Daniel's birth a doctor in the Addiction Service agreed to the father stopping supervised consumption of methadone, it is not clear if he continued on daily pickup or longer term prescriptions were provided. The doctor was apparently aware of the pregnancy and the involvement of Children's Social Care but there is no indication of any interagency communication.

4.3.16. The father failed to attend the next medical review citing his partner's illness as the reason. The specialist midwife had made a home visit on the same day, documented that the father was present but there was no indication that the mother was unwell. There was no communication between the two workers to gain an understanding of this discrepancy and a possible indication of the parents' lack of candour.

The decision making around the father's change from supervised consumption to take home is unclear. The NICE guidance[6] and Department of Health Guidance recommend supervised consumption for a minimum of three months until compliance is assured. The father requested several times to stop supervised consumption however his attendance was unreliable and his compliance inconsistent. The IMR indicates that the relevant risk assessment was not undertaken. The presence of a child in the home should have added another dimension to the risk assessment; there is no indication that this was considered.

There is no indication in any of the IMRs that the issue of safe storage of both prescribed and non-prescribed drugs was raised with the parents. Once methadone is prescribed for unsupervised consumption, or even supervised when pharmacies are not open on a Sunday and at least one dose is given to take away, it is essential that advice is given about safe storage to prevent accidental overdose, especially if there are children in the household. This should be the responsibility of all professionals involved including prescribers and dispensers (pharmacists). The advice needs to be reiterated frequently and by all involved professionals as there is some evidence that it is not always remembered or acted upon by users.[7] Some Addiction Services provide lockable boxes to individuals to ensure safe storage of methadone etc.

4.3.17. During the same period the specialist midwife visited the mother, at home, six times, during which the mother disclosed continued use of heroin. Only one drug test is documented which was positive for heroin. It is assumed that the mother continued to be prescribed methadone although it is not clear how much was prescribed or for what period. She was seen once for a medical review in the Addiction Service a month before Daniel's birth, by the same doctor who had seen the father the previous

[6] National Institute for Health and Care Excellence Drug misuse: psychosocial interventions' (NICE clinical guideline 51) and 'Drug misuse: opioid detoxification' (NICE clinical guideline 52) Issued July 2007: National Institute for Health and Care Excellence, Clinical Guideline CG62 Antenatal Care Issued 2008

[7] Mullin, A, McAuley, RJ, Watts,DJ, Crome,IB and Bloor, RN (2008) *Awareness of the need for safe storage of Methadone at home is not improved by the use of protocols on recording information giving* Harm Reduct J. 5: 15.

month. Her relationship with the father was noted and there is evidence that the doctor appropriately discussed the impact of drug use on the unborn baby. She disclosed continuing use of heroin. It is unclear if the mother was also taking prescribed morphine at this time.

4.3.18. Two weeks before Daniel's birth the case was allocated to an agency social worker, this was three months after the completion of the initial assessment.

Daniel's life

Birth - 6 months

4.3.19. The mother was admitted to hospital the day before a planned Caesarean section. This planned admission allowed for assessment of her disability etc. and was an example of good practice. Daniel was born in good condition and showed minimal withdrawal symptoms. The mother requested discharge from hospital on the day after delivery but was encouraged to stay and care for Daniel. The specialist midwife who cared for the mother during her pregnancy also led her care in hospital; this was another example of good practice in providing continuity of care. Daniel and the mother were discharged home from hospital on Day 3. Children's Social Care was informed of the birth and discharge from hospital and a discharge notification was sent to the GP and health visitor.

There was no formal interagency planning around Daniel's discharge from hospital. A discharge planning meeting would have offered an opportunity for all professionals involved with Daniel's care to be clear about their roles and responsibilities and the potential risks to Daniel. It is probable that the risks to Daniel were not considered sufficiently high for it to be considered necessary to hold such a meeting.

4.3.20. A community midwife visited the home on the next two days; no concerns were identified and it was noted that the father was sharing the care of Daniel.

<u>1st Child in Need Meeting – Daniel 1 week old</u>

4.3.21. A Child in Need meeting was held when Daniel was one week old. It was attended by the parents, the allocated social worker and the Family Support Worker from the Family Centre; none of the other involved practitioners were present.

It is not clear who had been invited to the meeting or when it had been arranged. All professionals involved in the care of the family should have been invited to the meeting and given sufficient notice of the meeting to enable them to attend, to send deputies or at very least to have provided written information about their involvement. The effectiveness of interagency meetings is dependent on the availability of all of the relevant information and preferably the attendance of all relevant professionals. It is important that records are kept of invitations to and attendance at interagency meetings to allow monitoring of appropriate interagency engagement. There were no health professionals present at the meeting and there is no evidence that the

resultant Child in Need plan was distributed to practitioners who should have been present, had an on-going role to play with the family and were indeed assigned responsibilities in the plan.

4.3.22. There were midwifery visits on days 8, 10, 14 and 21; no concerns about mother or baby were identified. The records contained no reference to on-going social care involvement and there was no formal handover to the health visitor.

4.3.23. A home visit was made to the mother by a new addiction worker on Daniel's 8th day. The mother stated that she had not used any illicit substance and was continuing with her methadone programme. The worker noted that the baby appeared well although there is no indication of discussion of the impact of drug use.

4.3.24. The following day the father attended an appointment with his keyworker; the mother and baby accompanied him. He denied any use of heroin or crack since Daniel's birth, this was confirmed by drug testing. He disclosed use of cannabis and alcohol; the worker discussed the potential impact of these on parenting. There was a change of father's addiction keyworker and appointments were arranged at a different venue.

4.3.25. The social worker referred both parents for counselling to Adult Mental Health Services, possibly in relation to their disclosures of abuse in their childhoods, although this is not clear. There is no indication of how this referral had been negotiated with the parents or whether the worker had discussed the referral with other practitioners. The parents did not engage with the service and a letter was sent four months later closing the case without any intervention. This appears to be the only action taken by this agency social worker, who left the service two weeks later. The case remained unallocated again for another two months.

4.3.26. On Daniel's 14th day the specialist midwife who was also the mother's addiction worker, visited the family and gave the mother a methadone prescription. No drug testing was done which may have confirmed the mother's claim that she had not used any illicit substances since Daniel's birth. Daniel was noted to be well and to have gained weight.

4.3.27. On the same day the health visitor made a primary visit as part of the normal health visitor programme. It is unclear how much the health visitor was aware of the parents' drug use or whether it was addressed during the contact. The mother informed the health visitor that she would be changing GP practices; this would result in a change of health visitors. The health visitor transferred Daniel's records to another health visitor when the new GP practice was confirmed.

There does not appear to have been any formal handover between the midwifery service and the health visitor. This would have been good practice for all families but especially important where there are potential concerns about the welfare of the Danielnd the parenting capacity. It is not obvious that the health visitor was aware of involvement of Children's Social Care or the previous parenting assessment that had been undertaken through the Family Centre. Had the health visitor and the addiction workers attended the Child in Need meeting held the previous week a coordinated approach to working with the family may have been possible; this would have been advantageous. There is no indication that a detailed Family Health Needs

Assessment was undertaken by the health visitor, this would have been good practice to provide a baseline for planning of ongoing care for Daniel and other family members.[8]

4.3.28. When Daniel was 23 days old the mother's addiction worker visited, both parents were present, a drug screen was negative. On the same day the father cancelled an appointment with his addiction worker ostensibly due to his illness that had not been noted by the mother's worker. There was no communication between the two workers. On the same day a worker from the Children's Centre made a prearranged visit to assess the family's needs for Children's Centre involvement. It does not appear that the worker was aware of the involvement of other services. The appointment was rearranged for the following week, as the parents were about to go out. The Children's Centre worker consulted with other agencies and the next visit was carried out jointly with the Family Centre worker who had undertaken the parenting assessment. This allowed for handover between the two workers and is good practice. The Children's Centre worker completed an assessment; although the CAF format was used it was not formally registered as a CAF and was not made available to other practitioners. The Children's Centre worker discussed the family with a Duty Social Worker and with the Family Centre worker who had completed the parenting assessment.

4.3.29. For the next five months the Children's Centre worker had contact with the family almost every week, either by telephone or home visits.

4.3.30. Daniel was taken to the child health clinic when one month old, nutritional advice was offered. Daniel was noted to be feeding well and settled. When six weeks old Daniel was seen by the GP for a routine medical examination, no concerns were identified. The mother also had a postnatal check, this was the first time that she had been seen at the new GP practice and, at the time, the GP did not have access to her medical records. There was discussion about her medication, the mother was requesting further prescription of morphine and the GP arranged to see her again in two days to discuss this in more detail. The mother did not attend that appointment but did attend three days later and saw a different GP. The GP contacted the keyworker in the Addiction Service to discuss the drug programme and the parallel prescription of morphine and it was agreed that the worker would discuss the issue with the medical team in the Addiction Service. The GP requested the medical records and the week after the appointment and, on receipt of the records, wrote to the Addiction Service. The following week the GP decided to prescribe the morphine as requested by the mother and issued a prescription for one month. The Children's Centre worker became involved in negotiations between the two GP's surgeries and the Pharmacy to access the correct prescription.

4.3.31. Daniel was taken to the clinic at 9 weeks for weighing. There was also attendance at 12, 16 and 22 weeks for immunisations.

4.3.32. Over the same two week period the Children's Centre worker also mediated with the Housing provider over repairs of a broken window, which had not been done as quickly as the mother wished. There is indication that the Children's Centre worker

[8] Shribman, S and Billingham, K (2009) Healthy Child Programme – Pregnancy and the first five years, London Department of Health

was aware of relationship difficulties and arguments between the parents. There is no record of the Children's Centre worker communicating with other practitioners, which would have been appropriate.

4.3.33. The following week the mother's addiction worker visited the home, this was the first time she had been seen by the service for a month, the mother having cancelled an appointment due to unspecified 'personal problems' although the nature of these were not pursued. The mother disclosed use of heroin the previous night, confirmed with a drug screen. This home visit was a missed opportunity for the worker to assess the safety and welfare of Daniel with respect to the parents' substance use.

4.3.34. Since Daniel's birth the father had seen his addiction worker five times having failed three appointments. He disclosed having continued using heroin regularly, although he claimed a four week period of abstinence. He also disclosed continuing use of cannabis at night. He had been on a programme of gradual reduction in methadone at his own request. He also disclosed that the mother was using both heroin and cannabis, especially at night as a means of pain relief.

4.3.35. There is no indication that the worker ascertained where and when the parents were using the heroin or cannabis, where Daniel was at the time and their ability to care for the baby when under the influence. There is some evidence to suggest that the parents were both using heroin at the same time; if this had not been the case it may have lessened concerns, as there may have been a better chance of one being more able to meet the needs of the very young baby. There is no indication that any of the workers asked about or saw Daniel's sleeping arrangements.

4.3.36. When Daniel was 10 weeks old an unqualified worker from Children's Social Care was allocated the case and undertook a home visit two weeks later. There is little detail about the purpose, content or outcome of this visit; the main focus was the family's potential house move. This was the first contact with a worker from Children's Social Care for three months.

4.3.37. When Daniel was fourteen weeks old the police attended the family home. The mother had called an ambulance because she had apparently been pushed to the ground by the father in an argument; she cancelled the ambulance before it arrived. The police, being aware of the call, attended to carry out a 'safe and well check', they entered the property, only the mother was present and there were no signs of disturbance. The mother had no visible injuries and declined to make a complaint. It appears that the father and Daniel were not at the home and it is not known where they were. Although this was a minor incident and officers did not consider it necessary at the time to share information about the incident with Children's Social Care, this was a missed opportunity.

Albeit this was a fairly minor domestic incident it is well recognised that the domestic abuse has a detrimental effect on the welfare of children and is a frequent feature of serious case reviews and when combined with parental substance misuse can have a significant negative effect on the welfare of children[9,10] and therefore information should have been shared with Children's Social Care about the incident.

[9] Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers

4.3.38. The mother was seen on the same day by the GP with a viral infection. This prompted the GP to follow up the request for information from the Addiction Service, it was ascertained that the mother had an appointment for a medical review the following month. The GP did not pursue this any further at the time. The prescriptions for morphine continued to be issued monthly for the next six months. It was noted that the mother had failed to keep a number of orthopaedic appointments that were aimed at addressing her hip pain. This could have been seen as an indicator of the mother's lack of compliance with services.

4.3.39. The following day the mother's addiction worker visited the home. The mother was upset by the domestic incident, she admitted using some heroin due to the stress of being on her own with full care of Daniel. There is no indication of challenge of the heroin use, especially having sole care of the child, although the worker recognised that the mother's physical disability may impact on her parenting capacity and therefore contacted Children's Social Care the following day. It was mooted that the mother may need support from Adult Services but there is no indication that this was pursued. The Children's Centre worker also saw the mother at home that day and appropriately discussed the impact of the relationship difficulties on Daniel. The Social Care Worker next visited the family three weeks later.

4.3.40. The following week the father saw his drugs worker, he discussed the domestic incident, and he said that he had been stressed due to cramped living conditions in the family home, lack of sleep and childcare responsibilities. The worker explored ways of managing stress. There is no indication that this information was discussed with the mother's keyworker or other agencies; this was a missed opportunity for a more collaborative approach to considering the needs of the couple.

4.3.41. The next day the Children's Centre worker made a home visit. Both parents were present having reconciled. It is noted that the family would be moving house in six weeks time. Daniel was reported as well other than having a cold. The Children's Social Care worker visited on the same day, also noted that Daniel had a cold and that the family were moving home. It was agreed that the core assessment would be delayed until the family had moved home, the rationale for this delay is not clear.

4.3.42. Over the next two months the Children's Centre worker made weekly contact either by telephone or home visits. The father saw his drugs worker two weekly. The mother was seen by her drugs worker once. Both parents continued to use heroin 'on top' of their prescribed methadone and, in the case of the mother, prescribed morphine.

2nd Child in Need Meeting - Daniel 5 months old

4.3.43. When Daniel was 22 weeks old a Child in Need meeting was held at the family home. The Children's Centre worker, the Social Care worker, the father's drugs worker and both parents attended. It does not appear that the health visitor or GP were invited to the meeting. There are no minutes taken of the meeting and professionals did not provide any written reports of their involvement. The process and outcome of the meeting are not documented in the chronology, although the father's addiction worker recorded that the plan was for the father to engage with the service to address his

[10] 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.

use of illicit drugs and provide consistent negative tests. Any interventions by any of the practitioners to safeguard Daniel are not apparent, therefore the effectiveness of the Child in Need plan must be questioned.

As highlighted by the Children's Social Care IMR the lack of management oversight and support is of concern. The case had been allocated to an unqualified worker, a core assessment had not been completed and the plan to safeguard Daniel appears to have entirely focused on the father's drug use. There is little apparent focus on the child's experience of day-to-day life or the way that the needs are being met. Daniel was a very young, vulnerable baby, entirely dependent upon the parents to provide for his needs. There is no apparent assessment of the parents' attitudes to or interactions with Daniel, nor any assessment of his attachment behaviours.

6 months – 1 year

4.3.44. By the time that Daniel was six months old his parents had moved into a new home. The mother's engagement with the Addiction Service was inconsistent although her methadone prescriptions continued. The father's engagement was better although his lack of candour about his heroin use was illustrated by positive drug tests when he had denied 'on top' use of heroin. The Children's Centre worker continued weekly contact with the family until transfer to another Children's Centre had taken place.

4.3.45. Two weeks after the house move the mother called the police asking for the father to be removed from the house, however she then cancelled the call as he was leaving. The police attended the house the following day to conduct a 'safe and well' check. The mother was present she indicated that she had asked the father to leave as he was not 'pulling his weight around the house'. Officers described the house as 'immaculate and well maintained' and saw no evidence of drug abuse. It is unclear whether or not they saw Daniel or how much of the house they saw. The incident was assessed by the police safeguarding team and deemed low risk. Information was shared with Children's Social Care and the GP using a standard reporting method.

<u>3rd Child in Need Meeting – Daniel 7 months old</u>

4.3.46. A Child in Need meeting was held in the family home a month after the house move. It was attended by the Children's Social Care allocated worker, supported by a social worker, father's addiction worker, the Children's Centre worker, the health visitor and both parents. The focus of the meeting again appeared to be the parents' drug use. Accurate, detailed information about their attendance at Addiction Service appointments, drug screens, prescribing levels etc. was not provided. The parents claimed clear drug screens for six weeks but this was not confirmed and was in fact inaccurate. There was discussion about the incident to which the police had been called two weeks previously, but it is not clear whether the father was resident again or not. Daniel had been seen by the health visitor in clinic in the week prior to the meeting his growth and development were documented as satisfactory, and he was noted to be bright, alert and sociable. There is no apparent discussion of the domestic incident by the health visitor with the mother.

4.3.47. Two weeks after the Child in Need meeting the Children's Centre responsibility was transferred to another Children's Centre following a joint visit by workers from both. This provided a good opportunity for handover and continuity and was good practice. A care plan for engagement with the new Children's Centre was drawn up to cover the next nine months. At the visit the parents expressed keenness to attend groups and activities at the Children's Centre with Daniel. The health visitor and Children's Social Care worker were informed of the transfer, again this was good practice.

4th Child in Need Meeting – Daniel 8 months old

4.3.48. At the beginning of the next month, when Daniel was 8 months old another Child in Need meeting was held, attended by the Social Care worker, with the support of a social worker, the health visitor, father's addiction worker and the parents. There was no representation from either Children's Centre. The health visitor completed a developmental assessment on the same day and Daniel was noted to be meeting all developmental milestones. There was no evidence of significant progress of the Child in Need plan. The parents continued to deny illicit drug use to some practitioners in spite of positive drug screens. The impact on Daniel of his parents' lifestyle does not appear to have been robustly assessed by any of the workers.

4.3.49. Two weeks after this meeting the father was arrested in Scotland and charged with a drug offence, he was initially remanded in custody and the mother became the main carer for Daniel. There was good information sharing between the Addiction Service and Social Care. The allocated Social Care worker offered support to the mother which she declined saying that she had family support; the details of which were not pursued. There is no indication that other practitioners were informed, it would have been appropriate for the Children's Centre worker to have been told as they were in regular contact with the family and may have been able to offer more accessible support.

5th Child in Need Meeting – Daniel 10 months old

4.3.50. Another Child in Need meeting was held two months after the previous one; Daniel was ten months old. In the intervening period father had regular contact with the Addiction Service, the mother had only one brief contact at home when it had been inconvenient for her for a keyworking session and she had failed to attend a medical review; her methadone prescriptions were, however, maintained. The Children's Centre worker had repeatedly attempted to engage the family in a variety of activities but the family had not attended. The Social Care worker made one unannounced home visit although this appears to have been somewhat superficial. Daniel was seen at a child health clinic on the day before the meeting and was noted to be growing well. The meeting was attended by the Children's Centre worker, father's addiction worker, the health visitor and the parents. It was chaired by the Social Care worker. Although the parents' non-engagement in groups was noted by the Children's Centre worker details of invitations, attendance and non-attendance was not made available. It was noted that the parents continued to use illicit substances in addition to prescribed methadone, although details of frequency etc. was not provided. The aim of the plan continued to be 'to ensure Daniel is cared for in a safe and secure environment and that the parents cease to use illegal substances', there appears to

be little detail that suggests that the plan was specific or measurable, other than the provision of safety equipment by the Children's Centre worker. A further meeting was planned for the next month.

4.3.51. Two weeks after the meeting the mother saw the GP to request an increase in her morphine prescription to manage her pain. It was noted that she had missed a specialist hospital appointment and was asked to follow this up. The GP IMR author suggests that in view of the pattern of missed appointments it would have been appropriate for the GP to have liaised directly with the hospital. On the same day the mother also attended an appointment with the drugs worker also complaining of pain she disclosed use of heroin to manage the pain. The father cited the mother's pain as a reason for them both using heroin.

> There is no indication of any communication between the parents' addiction workers or with the GP, all of which would have been appropriate. There was a failure of the practitioners to give full and appropriate consideration of Daniel's needs and welfare given that the mother was complaining of severe pain and both parents were using heroin possibly at the same time. It is possible that the pain level, as well as impacting on her drug use may have had an impact on her parenting capacity.

4.3.52. Prior to the next Child in Need meeting the Social Care worker discussed with the Children's Centre worker a plan to step down the case to a CAF level, rather than a Child in Need, therefore closing the case to Social Care, the suggestion was that the Children's Centre worker should be the Lead Professional. This plan had been agreed between the Social Care worker and the manager. The Social Care worker visited the family at home. The mother discussed her pain and the resultant need to take heroin as pain relief, she told the Social Care worker that the GP had prescribed paracetamol and ibuprofen which was insufficient pain control, she also complained that the GP was treating her differently because of her addiction. There is no indication that the Social Care worker was made aware that the mother was also being prescribed morphine by the GP.

> It would appear that the mother was not being entirely candid with the children's workers and it would have been appropriate for the Social Care worker to have liaised with both the mother's addiction worker and the GP or in view of the imminent Child in Need meeting invited the GP to the meeting or at least have sought information from them.

<u>6th Child in Need Meeting – Daniel 11 months old</u>

4.3.53. At the meeting, attended by both parents' addiction workers, the health visitor and Social Care worker, the Social Care worker proposed the downgrading of the case this suggestion was challenged by the mother's addiction worker. In view of the continued heroin use by both parents, the mother's poor pain control and the failure to attend any activities in the Children's Centre as previously agreed it was

considered that the parents were prioritising their own needs over Daniel's and therefore the Child in Need plan should be maintained.

4.3.54. The Social Care worker went on planned, extended leave soon after the meeting and the case was not reallocated and there was no Social Care intervention for the next five months.

4.3.55. The week after the meeting the mother saw her GP to discuss her pain relief, although information is gathered about the social situation there does not appear to have been detailed consideration of the impact of the mother's disability and drug use on her parenting capacity. The morphine prescription was issued monthly up to and beyond the scope of this review without any further medication review.

There is no evidence of liaison with other involved practitioners. At the very least it would have been expected that the GP discuss the situation with the health visitor as part of the primary health care team. It would also have been appropriate for there to have been liaison with the Addiction Service to coordinate the opiate prescriptions and to consider alternative strategies for pain management. It was noted that the mother had a specialist hospital appointment in two months time; although it was known that she had previously failed to attend appointments there is no indication that this was addressed directly with her. This was a significant missed opportunity for a multiagency response to managing the mother's drug use, both prescribed and illicit. The GP had previously attempted to establish dialogue with the Addiction Service but with little success. A letter was received by the GP with respect to a medical review in the Addiction Service but not until four months after the consultation. The mother's addiction worker was also aware that the mother misused morphine by saving tablets on days that she took heroin, then taking double doses. Although it is documented that this is discussed with the mother there is no indication that there was any proactive response or consideration of liaison with the GP. On one occasion the mother informed the addiction worker that she was seeing the GP to further discuss the morphine prescription, there was no indication that this occurred.

1 - 1½ years

4.3.56. When thirteen months old Daniel was seen in the hospital Accident and Emergency Department with a bleeding lesion on the cheek. A referral was subsequently made by the GP for specialist treatment and after a single specialist consultation Daniel had day surgery to remove the lesion when 20 months old.

4.3.57. Over the next three months there was limited intervention with the family. The father continued to have mostly fortnightly contact with the addiction worker. The mother attended three Addiction Service appointments. Daniel was seen once in the clinic for an immunisation and observed to be growing and developing well. The Children's Centre continued encouraging attendance at groups and activities with limited success. Concerns about an uncovered pond in the garden were raised regularly by the Children's Centre worker but not addressed by the parents.

7th Child in Need Meeting – Daniel 15 months old

4.3.58. When Daniel was fifteen months old a Child in Need meeting was held. It was attended by the father's addiction worker and the Children's Centre worker, the Social Care worker was reported as arriving late for the meeting and there is no record of the meeting in the Social Care chronology and it does not appear that the meeting was documented in any way other than by the practitioners who attended. The mother claimed to be heroin free, no drug test had been documented for six months. The father was seen by his addiction worker on the same day, he tested positive for heroin.

4.3.59. Three weeks after this meeting both of the parents were seen by their respective addiction workers. They both disclosed heroin use again citing the mother's pain as the reason.

4.3.60. The following month the case was allocated to a new Social Care worker. A new health visitor saw the family at home and undertook a family assessment; the parents discussed their previous history and their drug use. The health visitor noted that the home was clean and tidy and that there were age appropriate toys for Daniel who was noted to be well apart from a cold. The health visitor was told that Daniel was to see the GP about this, although there is no record of this contact. The health visitor documented that she had detected a 'stale smell of drugs in the home' there is no indication that she shared this observation with other practitioners or discussed it with the parents; it should have raised concern that Daniel had been exposed to substances in the home. Having been told by the mother that a Child in Need meeting was planned for the following day, although unable to attend the meeting the health visitor very appropriately contacted Social Care to ensure an awareness of the change of responsibility.

8th Child in Need Meeting – Daniel 16 months old

4.3.61. The Children's Centre worker and both of the parents' addiction workers attended the family home for a Child in Need meeting however it would appear that the Social Care worker failed to attend. The mother indicated that there were relationship problems, she denied any 'on top' use of heroin, no drug test was done. The father disclosed continuing heroin use two or three times a week, a drug screen was positive for heroin. There is no record in the Social Care chronology of the meeting.

4.3.62. Three days later the police were called by the father after the parents had argued and the father had removed Daniel from the family home. Officers attended the address where Daniel and the father were and confirmed that Daniel was 'safe and well'. Officers visited the family home and saw the mother; they detected a strong smell of cannabis. The mother denied any use of Class A drugs but said that the father continued to use heroin. The incident was reported to Social Care using both the normal reporting mechanism and directly by telephone with the allocated Social Care worker. Both parents also independently contacted the Social Care worker about the domestic incident. The father indicated that the mother had accidentally struck Daniel. The following day the Social Care worker spoke to the father on the telephone; the father claimed to be drug free and that he and the mother had agreed that they would live apart and share the care of Daniel. There is no indication that the

Social Care worker made any attempt to see and assess the health and safety of Daniel in situ with either of the parents.

4.3.63. Two weeks after the domestic incident the father, accompanied by Daniel, was seen by his addiction worker, a drug screen had been positive to opiates, morphine, cannabis and methadone. There is no recorded comment about Daniel's welfare or presentation. On the same day the Children's Centre worker telephoned the mother, she complained that she had no pain relief but was not using heroin. The worker encouraged the mother to contact PALS[11] presumably to seek advice about or possibly complain about the pain management by the GP. The mother agreed to attend 'Play and Stay' at the Children's Centre.

> It is unclear whether the worker was aware of the extent of prescription of morphine as pain relief by the GP or the failure of the mother to attend specialist hospital appointments the purpose of which were to address the seat of the pain. There is no indication that the worker sought advice about this from any of the other professionals but responded to the mother's version of events.

4.3.64. Two weeks later the health visitor attended the family home for a prearranged visit, the father answered the door but had forgotten the appointment and access was denied; a follow up at the clinic was arranged for one week, they did not attend. It is not clear if the father was resident in the family home or visiting.

4.3.65. Two days later the mother contacted the police wanting assistance to remove the father from the premises, no offences were disclosed and no 'domestic incident' referral was made. On the same day the mother requested a home visit by a GP who attended and prescribed antibiotics for her for a chest infection. It does not appear that there was any discussion about the 'domestic incident' that day or the previous one of which the GP had been notified. It does not appear that issues of pain relief or the mother's failure to have a surgical procedure, because she had not wanted to stay in hospital, were addressed.

4.3.66. Two days later the mother's addiction worker visited the home. The mother was complaining of a chest infection and said that she was expecting a GP visit – none is documented. She denied any illicit drug use and requested a drug screen, no result is recorded. On the same day the Social Care worker visited the home, both parents were present, although there are no details in the chronology of the content of the visit it is recorded that the worker planned to hold a Child in Need meeting the following month with a view to closing the case.

4.3.67. The next day the Children's Centre worker visited the home both parents were present. Daniel's general development was reported as good. The mother said that she still had no pain relief but appeared to be coping well, it is ascertained that she had not contacted PALS. The father was claiming to have been heroin free. It is unclear whether the parents had reconciled or not.

[11] Patient Advice and Liaison Service and NHS service that offers confidential advice, support and information on health-related matters

18 months until death

4.3.68. Three weeks later the mother was arrested for shoplifting, she was arrested and admitted the offence. She was subject of community resolution and paid for the goods therefore there was no further action.

4.3.69. Over the next three weeks Daniel, now eighteen months old, was taken by the mother to a 'Stay and Play' group. Daniel had little interaction with other children but was said to have enjoyed the session, this was appropriate behaviour for a child of this age. The father attended an appointment with his addiction worker, he tested positive for heroin; he also disclosed regular cannabis use, including immediately before the appointment. Daniel was with him; it does not appear that the risks to Daniel were addressed. The worker discussed the possibility of detoxification and rehabilitation over the next year. On the same day the health visitor made a home visit and saw the mother and Daniel. Daniel was said to be well although had seen a GP the previous week – there is no record of this in the chronology. The health visitor was told by the mother of the planned Child in Need meeting the next week. The health visitor informed the Social Care worker that she would be unable to attend the meeting.

<u>9th Child in Need Meeting – Daniel 19 months old</u>

4.3.70. The father's addiction worker, the Children's Centre worker, the allocated Social Care worker, a student social worker and the parents attended a Child in Need meeting in the family home. It was noted that the parents' relationship had broken down and that the father was to stand trial in Scotland in relation to the drug offence the previous year. The detail of arrangements for the care of Daniel in light of the relationship split does not appear to have been addressed. The addiction worker had discussed an occasion when they had noted a strong smell of cannabis coming from the family home, the worker had not gained access to the home at the time and it is not clear of Daniel was present but it certainly raised the likelihood that Daniel would have been inhaling cannabis.

This was the ninth Child in Need meeting and there was no indication that there had been any sustained change in the parents' behaviour or in their engagement with activities that would benefit Daniel. There was indication that Children's Social Care had wanted to move towards closing the case but this had not been supported by other practitioners and therefore remained open.

The lack of clarity about the expectations of a Child in Need plan and the informality of the process resulted in difficulty in measuring change, progress or the reverse. The failure of practitioners to provide details of parents' attendance at appointments and groups, drug screens etc. also limited the opportunities to get a clear picture of their engagement.

4.3.71. The day after the meeting the mother attended a medical review at the Addiction Service, she claimed to have been drug free for two months but had used heroin two days previously, however it is recorded that she had tested positive in both of the two

previous months. A letter containing details of the contact was sent to the GP but not received until two months after the appointment.

4.3.72. The next day the father reported to the Social Care worker that there had been another domestic incident, the police were not involved, there was no follow up and it is not recorded whether Daniel was present.

4.3.73. The following week the father failed to attend an appointment with his addiction worker because he had been attacked. He was seen the next day by mother's addiction worker during a home visit to the mother. The father had injuries and appeared unsteady on his feet but did not want to report the incident to the police. The worker was unsure if the unsteadiness was due to the influence of drugs or the assault. The Social Care worker was informed and followed up with a home visit the following week.

4.3.74. Two weeks later the father failed to attend an appointment with his addiction worker, the reason given was that the mother had had surgery, this had also resulted in his prescription running out leading to several days of heroin use. He was due to appear in court in Scotland the following week. The Social Care worker spoke to the mother on the telephone and ascertained that she was recovering well from her operation and would be going to Scotland with the father; a family member would be caring for Daniel. There was no check made on the suitability of these arrangements.

> Details of the surgery were not recorded in either the GP or the hospital IMRs therefore the accuracy of the information cannot be confirmed. The lack of information may reflect on the completeness and quality of the IMRs.

4.3.75. A week later the Social Care worker telephoned the mother and was told that the father had been acquitted in Scotland. A home visit was made the following week when the worker observed the parents arguing in front of Daniel apparently because the father had stolen money from the mother, it would appear that they were living apart at this time.

<u>10th Child in Need Meeting – Daniel 21 months old</u>

4.3.76. Two weeks later, Daniel was 21 months old, a Child in Need meeting was held, it was attended by the Social Care worker, the Children's Centre worker, both of the parents' addiction workers, a manager from the Addiction Services and both parents. The mother's addiction worker provided details of negative drug screens over the previous three months, it does not appear that there was mention that there had also been positive tests or that the mother had disclosed heroin use on the previous day. The father also disclosed on-going heroin use. It was noted that the parents were living apart, Daniel was living with the mother and the father was having regular contact. It was noted that a core assessment had not been completed; there was further discussion of downgrading the case in spite of concerns about both parents' continued failure to remain abstinent, there were also concerns expressed about the mother's anger issues. It was noted that Daniel had benefitted from attendance at 'Play and Stay', however attendance had been erratic, details of numbers of sessions

attended or missed were not made available. Details of the mother's ability to be the main carer for Daniel was not explored.

11th Child in Need Meeting – Daniel 22 months old

4.3.77. A further Child in Need meeting was held after six weeks, the parent's were still living apart and the mother was said to be coping well with Daniel's care. Both parents continued to use heroin, although the mother's use was said to be less than it had previously been, however she had recently disclosed some use of cocaine, there had been discussion of the mother engaging in a methadone reduction programme. It is noted in the meeting that the father's living accommodation was unsuitable for Daniel although there is indication that Daniel had already spent time there. The plan remained largely unchanged although the Social Care worker restated the plan to close the case to Social Care.

It does not appear that the decision to downgrade the case from Child in Need was challenged by the practitioners present at the meeting.

As identified earlier the health visitor was not formally invited to a number of the Child in Need meetings and therefore was not always present. In view of health visitors' responsibilities for the health and welfare of pre-school children it is essential that they are fully engaged in any interagency meetings relating to such children and should be standard invitees. It is well recognised that attendance by GPs at such interagency meetings is limited and health visitors can often helpfully act as a conduit between GPs and other agencies.

4.3.78. The Social Care worker visited the father in his home the following week and ascertained that it was unsuitable for Daniel to be there, although it is not clear whether or not the father acted on this. The father had started a driving job; this was seen as a positive development. The following week a Social Care Team Manager a completed a case closure summary. It was noted that a core assessment had not been completed and that there were continued concerns about the parents continued use of illegal drugs. There is no evidence of consultation with other professionals about the closure and it is unclear if they were informed of the closure.

There do not appear to have been any significant changes effected by the Child in Need plan over the almost two years that it had been in place.

4.3.79. When seen the next day by his addiction worker the father confirmed that he was still in employment - this had prevented him attending an appointment and collecting his methadone prescription. He had moved back in with the mother and Daniel.

There does not appear to have been any challenge of the father about him being employed as a driver, it must be questioned whether this was a safe occupation for him in view of his known use of illicit opiates, over and above his opiate substitution

programme, which would be likely to negatively impact on his driving ability and he would have been at risk of committing an offence.

4.3.80. A week later an ambulance was called to the family home where Daniel was found to be not breathing, transferred to hospital and declared dead on arrival. Daniel had been sleeping in the parents' bed. A large quantity of dried and drying cannabis was found in the house and a number of cannabis plants were found growing in the roof space. Both parents were questioned by the police and bailed pending post mortem examination. Post mortem toxicology seven months after the death indicated that Daniel had died as a result of heroin poisoning and both parents were arrested and charged in relation to Daniel's death. Hair samples indicated that Daniel had been exposed to cannabis, opiates, cocaine and amphetamines. In court hearings the father admitted manslaughter and the mother admitted 'causing or allowing the death of a child' and a charge of manslaughter was not pursued. Both parents have been sentenced to custody.

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. Practitioners may be less able to see emergent patterns especially when they 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. Although the IMRs gave some consideration to some of the contextual issues facing practitioners involved with Daniel's family the individual context could not be explored because of the restrictions in interviewing staff. The Children's Social Care, Health Visiting and the Addiction Service IMRs identify high volumes of work and/or staff turnover and sickness as contextual issues that impacted on the case. In addition the addiction service was subject to restructuring and management changes, which can provide challenges for practitioners affected by transitions.

5.2. Daniel's death was the result of ingestion of a large quantity of heroin; no information was available to the review of the mechanism whereby Daniel accessed the drug. It also became evident through post-mortem hair strand analysis that Daniel had been regularly exposed to heroin and cannabis and occasionally to cocaine and amphetamine. None of the professionals involved with the family had foreseen the possibility of the child being given heroin by one or other of the parents or having access to it accidentally. However all professionals involved with this family were aware that both parents used illicit substances and both regularly admitted smoking both heroin and cannabis. There appears to have been insufficient consideration given, by all of the practitioners, to finding out about and challenging the parents' use of drugs in the presence of Daniel and therefore his exposure to secondary inhalation. Family members who visited the house were aware of a strong smell of cannabis, which must also have been apparent to professionals but was only documented by the health visitor.

5.3. Smoking of heroin is considered less harmful to the user than injection; it reduces the chances of contracting blood borne infections and drug overdoses and is therefore encouraged as part of harm reduction. This does not give any consideration to the potential impact on others of smoke inhalation.

5.4. Although the death of Daniel, in the way that it occurred, may not have been foreseeable the full extent of the potential risks were not acknowledged by all of the practitioners involved with the family. Daniel's death may have been avoidable had practitioners been more professionally curious, had more 'respectful uncertainty'[12] and been more assertive in their approach to the family. This may have led them to look beyond the presentation of the parts of the home that they saw and see the other areas, notably where Daniel slept. They may have looked beyond Daniel's apparent well-being and given more thought to what life was like from Daniel's perspective. Although Daniel was developing normally and appeared happy and well loved there were sufficient indicators that the parents were unable or unwilling to change their lifestyle. Had Daniel survived, the parents' lifestyle would almost certainly have negatively impacted on the child's outcomes. In view of Daniel's age the risks of access to noxious substances should have been fully addressed. It was noted that the home was well presented and there was evidence of the availability of age appropriate toys, however it would appear that practitioners were insufficiently curious to inquire into Daniel's sleeping arrangements. Had they done so the immediate risks to Daniel may have been identified and his death prevented. There appears to have been insufficient authoritative enquiry about when, where and how the parents used their drugs and insufficient emphasis given to Daniel's safety.

5.5. 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[13,14,15] 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[16]. As identified in Cleaver et al (2011) p43 *"Research which explores the association between parental problem drug misuse and 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' apparent lack of will to work in an entirely open and honest way with practitioners from all agencies. The mother's lack of engagement was worse than the father's exemplified by her repeated failure to attend appointments with the Addiction Service and to engage

[12] Laming, Lord, (2003) The Victoria Climbié inquiry: report of an inquiry by Lord Laming (PDF). Norwich: TSO p205.
[13] Cleaver, H, Unell, I and Aldgate, J (2011) *Children's Needs – Parenting Capacity (2nd Edition)*, London, TSO
[14] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (2010) HM Government, London
[15] Velleman, T and Templeton, L (2007) *Understanding and modifying the impact of parents' substance misuse on children,* Advances in Psychiatric Treatment 13:79-89
[16] 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

with activities in the Children's Centre with Daniel. However most health appointments for Daniel were maintained suggesting some prioritisation of his needs. Although the lack of engagement was recognised by practitioners it was often blamed on the mother's disability and level of pain and there was insufficient challenge by practitioners. Where expectations of actions, such as attendance at appointments and provision of urine specimens, were specified by practitioners there was no evidence of the consequences of non-compliance being clearly set out for the parents or followed through; there was a lack of authoritative response or escalation. The case was maintained throughout as a Child in Need, there were some indicators that suggested that Daniel was at risk of suffering significant harm but these were not extreme and Daniel was seen to be a child who appeared well and happy, who was developing well and for whom there were no glaring concerns, these concerns may have become manifest had Daniel survived.

5.6. 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*."[17]. In this case there were a number of missed opportunities for practitioners fully to understand the Daniel's circumstances. 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"*[18].

5.7. **Focus on the child**

5.7.1. There is little information in any of the IMRs that provides a picture of what life was like on a day to day basis for Daniel. Descriptions, including those from family members, generally suggested that he was a well loved, happy and contented child who was growing and developing within normal limits. Many of the practitioners had access to the family home on a number of occasions. The standard of the home environment, especially once the family had moved, appeared good. This was commented on in the Police IMR *"The home occupied by (the mother) was described by officers as well presented indeed 'immaculate'. Nothing seen in the home apparently indicated a chaotic or risky lifestyle*". It has been a feature of other Serious Case Reviews that home conditions have, on the surface, been acceptable but areas of the home not generally seen by visitors are not of the same standard. At the time of death Daniel was found in the parents' bedroom in which there was quantities of dried and drying cannabis and a variety of drug paraphernalia. It does not appear that the sleeping arrangements for Daniel were ever questioned or seen; because of the size of the house it was assumed that Daniel had a separate bedroom and that the upstairs would have been the same as the visible parts of the house. The Children's Centre worker provided the family with safety equipment and was persistent in repeatedly raising safety concerns about a garden pond; the parents' failure to address this should have been considered as a proxy indicator of their lack of cooperation.

[17] Lord Laming (2009) *The Protection of Children in England: A Progress Report,* TSO Norwich p10
[18] Barlow, J. with Scott, J. (2010), *Safeguarding in the 21st century: Where to Now?*, Dartington, Research in Practice. P24

5.7.2. Daniel was seen a number of times by Addiction Service practitioners both in clinic and home settings but as identified in the IMR there is little focus on the needs of the child, there is no documentary evidence that indicates that practitioners were aware of his presentation or interactions between the child and his parents. Adult focussed practitioners cannot be expected to be able to assess fully parenting capacity but should be able to provide insight into the impact of the individual's substance use on their ability to meet the day to day needs of a child at different ages and stages of development. It is recognised that the focus of the Child in Need plans was to help the parents control their substance misuse so that they could focus on the welfare of Daniel but there are indications that this was not robustly managed. There was a lack of clarity about the need for regular drug testing, interpretation of the findings and monitoring of the engagement with the service. In the context of interagency working, engagement with an adult service can act as a proxy measure for the importance that the parents put on the need to modify their behaviour to meet the needs of their child.

5.7.3. The health visiting service contact was minimal, based upon universal service only, the mother's disability and substance use should have been sufficient to indicate that the family should receive targeted support[19]. The Children's Centre workers did focus on the needs of the child but there is indication that they were also sidetracked by the needs of the mother for example by intervening in accessing her morphine.

5.8. Working with Substance using Parents

5.8.1. It is well recognised that substance and alcohol misuse can have an adverse impact on parenting capacity, often because parents 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. In this case the socio-economic circumstances were less of an issue than is often the case due to the mother's accident compensation, which allowed her to buy a house. It is also known that substance misuse can have a negative impact on parent-child attachment. Parents who use narcotics are often less emotionally available to their children. Substance misuse is also frequently 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.

5.8.2. Difficulties in maintaining engagement of adults who misuse substances with services are also well documented and to some extent 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 to develop and maintain 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 need to respond

[19] Department of Health (2009) *The Healthy Child Programme – Pregnancy and the first five years of life* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

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; the two timeframes may be at odds with one another.

5.8.3. 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 and engagement in interagency working. This is exemplified in the consistent attendance by addiction workers at Child in Need meetings However there remains a need to ensure that the services work in a collaborative way and that 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.

5.8.4. It is possible that practitioners viewed the family in a different light to other parents who misuse substance because of their relative affluence. Many substance users come to the notice of statutory agencies because of criminal activity to finance their addiction and it is often these circumstances that contribute to the negative impact on children. These parents were able to access drugs without recourse to regular criminal activity.

5.8.5. Practitioners in all services accepted the mother's disability and consequential pain as motive for her on-going substance use. She often cited her pain as a reason for using heroin in addition to prescribed methadone and morphine. She also disclosed continued use of heroin during the pregnancy because she was unable to tolerate methadone due to sickness. The parallel prescription of two opiates was not managed in a coordinated way. Methadone is prescribed by Addiction Services as a means of risk reduction in use of illicit substances. As identified above (4.4.5/6) in a maintenance or substitution programme methadone is prescribed at a level high enough to prevent withdrawal symptoms from the illegal opiate heroin. In many circumstances heroin addiction develops through an individual's need to dull pain, often this is emotional pain. It is also recognised that people who are on methadone maintenance programmes do not gain pain relief from the opioid in the same way as those who are not opiate dependent[20]. The fact that the mother was 'legitimately' suffering physical pain due to her injuries should have led to a more robust, specialist medical approach to pain management in collaboration between the Addiction Service the GP and a specialist pain management service. This may have improved the likelihood of her pain being managed in such a way that she would not have needed to misuse both prescribed and illicit drugs and have enabled her to focus on Daniel's needs.

5.8.6. The use of cannabis by both parents was known to all practitioners, a health visitor documented a smell of cannabis in the house, family members who visited the house indicated that it was ever-present but it appears to have been normalised by practitioners and not identified as a significant risk to the child.

5.8.7. One of the most obvious and immediate risks to the safety of young children when parents use substances is the potential of accidental ingestion. Home safety advice for all parents includes the need to keep all potentially dangerous substances away

[20] Alford, D.P, Compton, P. and Samet, JH (2006) *Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy*. Ann Intern Med. 2006 January 17; 144(2): 127–134.

from children and in childproof containers. It should be the responsibility of all professionals involved with families to consider home safety issues and to raise these with parents at every opportunity. This is of particular importance for substance using parents who should be regularly reminded of the danger to children of the substances that they use. Prescribers and dispensers have particular responsibilities and part of the role of keyworkers in Addiction Services should be to offer advice about safe storage of medications and to regularly check that this advice is understood and acted upon.

5.9. Assessment

5.9.1. "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"[21]; "Fundamental to establishing the extent of a child's need is a child-centred, sensitive and comprehensive assessment. p28"[22] 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.

5.9.2. 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.[23] 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. Practitioners need to be 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 a young child.

5.9.3. The need for support for this family was identified early on in the pregnancy by the Addiction Service and by the Police. It may have been appropriate for an early assessment to have been started using the Common Assessment Framework (CAF) but the addiction workers decided that a referral to Children's Social Care for a higher level assessment was required however this was delayed until after the twentieth week of pregnancy. A defined protocol for interagency involvement in the care of unborn babies where there are concerns about compromised parenting would provide a clear structure and process for pre-birth assessment.

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

5.9.4. The Initial Assessment completed by an unqualified worker in Children's Social Care was superficial and did not get a multiagency perspective of the family and, in spite of a number of workers being allocated to the case over a period of almost two years, a Core Assessment was not completed. Only one of the workers allocated to this family was a qualified, but locum, social worker and their contact was very short term. An assessment undertaken by a worker with the skills and knowledge of a qualified social worker, with the benefit of contribution from other professionals, may have taken more cognisance of the parent's own histories, included a better understanding of their substance use and its potential impact on the well-being of the baby and their capacity for change. The assessment may then have resulted in a more robust plan that recognised the potential risks to Daniel. Indeed the Children's Social Care IMR indicates that had the assessment been more comprehensive child protection procedures would have been initiated. This indicates a lack of appropriate management oversight at the time.

5.9.5. The significance of history of both of the parents does not appear to have been fully addressed. The father was known to have been abused as a child and there is indication that the mother had also. The social worker who was allocated the case for a month around the time of Daniel's birth made a referral to adult mental health services for counselling for both parents but this was done without consultation with other involved professionals and was not taken up by the parents. No other exploration or intervention was offered. Calder (2008) notes that care and control conflicts arise when: *'Parents' own childhood experiences of adverse parenting leaves them with unresolved tensions which spill over into their adult relationships ...Their children are most at risk during the early months/years when they are most dependent and when they carry meanings for their parents associated with unresolved parental conflicts."*[24]

5.9.6. The pre-birth parenting assessment undertaken by the Family Centre worker focussed on the provision of basic care and followed a format. The outcome of this parenting assessment was the basis for a decision within Children's Social Care that it was safe for Daniel to be discharged home with the parents. This decision should have been based upon a multiagency assessment of the parents' history and current drug use and their ability to meet Daniel's needs. It would have been more appropriate for this decision to have been made at a pre-discharge planning meeting, probably instigated by the maternity service and attended by representatives of all of the agencies involved.

5.9.7. The assessment undertaken by the Children's Centre worker at the beginning of their involvement when Daniel was a month old was an example of good practice. The relevant factors that may have impacted on the parenting of Daniel were identified and it was noted that the parents were able to meet Daniel's basic needs and to provide sufficient positive interactions, love and emotional warmth. The assessment led to a clear support plan involving regular visits by the worker and engagement in activities by the family and the Children's Centre. The former outcome was met but the family did not engage in any activities and the requirement was dropped from the plan. The Children's Centre worker made numerous attempts to secure interagency collaboration with little success. When the Children's Centre allocation transferred

[24] Calder, M. (2008) 'Risk and Child Protection' in Calder, M. (ed) Contemporary Risk Assessment in Safeguarding Children. Lyme Regis Russell House.

due to the family move there was some handover but it appears that the new worker did not have access to all of the previously gathered information.

5.9.8. It would appear that the health visitor undertook limited assessment of the parents' parenting capacity, in light of the mother's reduced mobility it was identified that the father would be offering most of the care. It is not apparent that a family health needs assessment was undertaken by a health visitor until there was a change in allocation when Daniel was 17 months old.

5.9.9. The assessment, planning and intervention offered by the Addiction Service 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.

5.9.10. The Child in Need meetings were the main vehicle for assessing the progress of the plan, however the plans were not well formulated, they lacked clear measurable targets or outcomes and when reviewed at subsequent meetings the information provided was not precise enough to assess progress or otherwise. Had the Addiction Workers provided clear details of treatment plans for the parents supported by data about drug testing and had the Children's Centre workers provided details of numbers of sessions attended or not, decisions about the effectiveness of the plan would have been more grounded.

5.9.11. Although practitioners were aware that Daniel had a sibling it does not appear that any consideration by any of the practitioners of their needs, safety and welfare whilst in the family home or of their impact on Daniel. Although the mother indicated that she was in receipt of support from her extended family the extent or suitability of this was not part of any assessment and was a missed opportunity.

5.10. Working with resistance and avoidance

5.10.1. Barlow (2010)[25] 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.

5.10.2. Daniel's parents were not overtly resistant to working with professionals, they allowed Child in Need meetings to be held in their home, attended most of Daniel's health appointments and responded to his health needs, although they were not always compliant with plans to meet their own needs. There was however evidence that they were not as compliant as practitioners thought they were.

5.10.3. 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 Horwath and Morrison (2001)[26] using an adapted version of Prochaska and DiClemente's model of change there are a number of 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

[25] Barlow, J. with Scott, J. (2010), *Safeguarding in the 21st century: Where to Now?*, Dartington, Research in Practice.
[26] Horwath, J and Morrison, T. (2001) *Assessment of Parental Motivation to Change in The Child's World: Assessing Children in Need (ed Horwath, J)* London, Jessica Kingsley

the parenting capacity meant that there was never a clear understanding whether motivation or capacity were present, nor was there real clarity about what changes were required.

5.10.4. One of the identified risks in working with 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 Daniel and his parents and the lack of obvious concerns about Daniel's health and development in particular distracted practitioners from the risks to the child's health and welfare in the longer term. The Child in Need plan throughout was focussed on the parents addressing their substance use. Later there was also a focus on home safety and providing opportunities for Daniel to attend activities, as identified above the plans were insufficiently robust to challenge the parents about their non-compliance with both of these issues.

5.10.5. The mother was probably more resistant than the father. She persistently failed to attend appointments with the Addiction Service, particularly medical reviews. Drug tests appear to have only been done when she wanted them. She resisted intervention by the Children's Centre worker to facilitate communication between the GP and the Addiction Service to regulate her medication in order to control her pain. In spite of pain control being the mother's stated reason for 'on top' heroin use as well as prescribed morphine she failed a number of medical appointments with a specialist to address the underlying physical cause of the pain. The father often cited the mother's use of heroin as the reason for his continued use.

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

5.11. Interagency working

5.11.1. When interagency work in child welfare is successful it is likely to best meet the needs of children, families and indeed practitioners. It allows for the different areas of practitioners' expertise to complement each other, leading to an understanding of individual families' problems from a comprehensive perspective and to form the basis of effective cooperative action. The basis of good interagency work is knowledge and acknowledgement of roles and responsibilities based within a shared understanding of the needs of children and a clear agreement about what works to meet these needs. This is a constant challenge to practitioners who have competing demands and limited resources. When interagency working is a challenge practitioners need opportunities to explore the situation and their feelings within safe and skilled supervision.

5.11.2. There is evidence throughout the chronology of some good interagency working although some gaps are evident. The initial referral to Children's Social Care resulted in a fairly prompt result leading to an Initial Assessment. The failure to allocate the case for a Core Assessment led to significant drift and practitioners such as the Family Centre and Children's Centre workers were left unsure with whom they should

communicate about their concerns. A more assertive approach and the use of escalation procedures by the Family Centre and other practitioners could have resulted in a more timely allocation of the case.

5.11.3. Child in Need meetings were held throughout Daniel's life, albeit with significant gaps at times. Attendance at these meetings was variable and health professionals were often absent, sometimes due to failure to invite them. The value of these meetings was questionable. The plans that were drawn up were insufficiently detailed and outcome focussed to allow for measurement or evaluation of their effectiveness, or to provide sufficient challenge to parents.

5.11.4. There is evidence of some good communication between practitioners but there are a number of instances that can be characterised as 'silo working'. This was particularly evident between the Addiction Service and the GP. When the mother registered with the second practice, some efforts were made by the practice to establish communication with the Addiction Service and to address the concerns about parallel prescribing of opiates. However when this collaboration was not forthcoming it was not pursued and although information about medical consultations in the Addiction Service was passed to the GPs it was not received until many weeks after the review and was thus of limited use to the GP. There was also little evidence of collaborative working between the GPs and the health visitors. This is a working relationship that is often viewed by other agencies as a close one and there is an expectation of a regular flow of information and teamwork. The lack of an allocated social worker for much of the period meant that there was no one practitioner with a coordinating responsibility making silo working even more likely.

5.12. Management oversight and supervision

5.12.1. 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.

5.12.2. Supervision is defined by Morrison (2005)[27] 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.

5.12.3. There were a number of indicators that levels of management oversight and supervision were insufficient across agencies. Within Children's Social Care, the case was almost entirely allocated to unqualified workers and high levels of management oversight, support and guidance should have been expected but were

[27] Morrison, T. (2005) *Staff supervision in social care: making a real difference for staff and service users*, 3rd ed. Pavilion, Brighton

not evident. Had there been more management oversight and challenge of the Child in Need plan the lack of progress may have been identified and a more robust plan implemented. The failure to complete a core assessment was not addressed and a manager considered it appropriate to close the case after two years of service involvement without the completion of a core assessment, without consultation with other professionals working with the family and without any real evidence that change had been effected by the parents sufficient to ensure Daniel's safety and welfare.

5.12.4. Different models of supervision are available for different practitioners and for some there is a differentiation between caseload management and professional (clinical) supervision. Children's Centre workers and Health Visitors for example bring selected cases for discussion with a supervisor. The choice of cases, albeit within an agreed framework, is determined by the practitioners. Where there has been normalisation thresholds for concern may be raised and risks may not be identified, practitioners may fail to recognise this and not bring such cases for consideration; supervisors must therefore be alert to this and employ strategies to overcome it.

5.12.5. A different aspect of management oversight highlighted is the need within Addiction Services for robust medicines management systems.

6 Lessons to be Learned

6.1. 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. 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.*" (p9).[28] 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.

6.2. 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 if this leads to a failure to take key decisions. Supervisors need to help practitioners to have a sense of direction, to keep them on track, especially giving thought to whether the current approach is working and to maintain a clear record of decision-making. Supervisors need to be able to stand back and have oversight of a case and have clear processes for regular review and follow-up. The management function of supervision must also be acknowledged and managers must exercise their responsibilities for monitoring standards of professional practice and addressing

[28] 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.

deficits. Agencies need clear lines of management accountability for decision making and all managers and practitioners must be aware of them.

6.3. 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 that are central to a clear understanding of the welfare of children. Detailed chronologies and analysis of the family and social history of adults who are parents 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.

6.4. 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 through 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. When parents are engaged with a service it is essential that in addition to person centred care there is a recognition of their role as a parent and if more than one family member is engaged there should be information sharing, cooperation and collaboration between practitioners – a "Think Family" approach [29]; this should extend to the wider family.

6.5. 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.

6.6. Successful interagency collaborative working is underpinned by structures such as Child Protection Conferences and Child in Need meetings. It is essential that practitioners are given the opportunities and tools necessary to contribute effectively to these meetings. Procedures and guidance with respect to arrangements, including timescales, for convening of Child Protection conferences and other interagency meetings must be followed if they are to be effective in safeguarding children. Child in Need meetings should be given the same importance by professionals as Child Protection conferences and although it is appropriate for there to be less formality in

[29] DCSF (2009) Think Family: Improving Support for Families at Risk

the process of the meetings it is essential that the relevant information is available to ensure robust planning to maintain the safety and well being of children.

Recommendations

The way that Daniel died may not have been predictable but may have been avoidable. Indicators identified by practitioners suggested that, although there were potential concerns for Daniel's long term well being, these did not amount to serious and immediate risk to him. From the information gathered in the Serious Case Review process there were lessons to be learned about the interventions with Daniel's family and a number of recommendations have been made as a result.

The single agency recommendations, set out below, are those made by IMR authors and are subject to action plans to address them within the agencies. A multiagency action plan will be drawn up by Wolverhampton LSCB to address the multi-agency recommendations.

7 Interagency recommendations

1. To ensure improved outcomes for children Wolverhampton Safeguarding Children Board (WSCB) 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.

2. To ensure the quality and effectiveness of Serious Case Reviews, no matter what methodology is used in the future, WSCB must ensure that partner agencies recognition of the importance of SCRs and allow authors and other contributors sufficient time and resource to complete IMRs or other reviews that are timely, of appropriate quality and are signed off by an officer/manager of sufficient seniority to ensure ownership of recommendations and to drive through implementation within the organisation.

3. WSCB should assure itself that all assessments that relate to safeguarding children are undertaken by appropriately qualified and experienced practitioners who are supported by appropriate levels of supervision.

4. WSCB should develop an interagency pathway and protocol for assessing the needs of unborn babies in all circumstances where there is the likelihood of compromised parenting.

5. To ensure interagency collaboration and provision of effective interventions WSCB in conjunction with the Adult Safeguarding Board should review and if necessary update the recently produced interagency guidance 'Hidden Harm - parental substance misuse and the effects on children' and any guidance with respect to the 'Think Family' agenda and ensure that there are mechanisms in place to assure themselves of their implementation and effectiveness.

6. WSCB should be assured by service commissioners that providers of drug and alcohol services to substance using parents have a safeguarding and a family focus as well as providing appropriate person-centred care.

7. WSCB should seek assurance from partner agencies that practitioners and managers are fully cognisant of procedures, guidance and best practice with respect to:

    a. thresholds for intervention at different levels

    b. assessment

    c. interagency communication

    d. record keeping including use of chronologies

    e. contribution, through attendance and provision of reports of appropriate quality, to interagency safeguarding meetings including Children in Need meetings as well as Child Protection conferences

    and that there is management oversight of their operation.

8. To improve outcomes for children and to ensure practitioners are appropriately skilled, WSCB should assure itself that training and other professional development opportunities are available to practitioners and managers/supervisors in partner agencies about how best to work with avoidant and resistant families and which provides an understanding of barriers to parental engagement and strategies to overcome these barriers. The impact of this should be evaluated by multiagency audit.

9. To ensure effectiveness of interagency working with children and families, WSCB should develop, disseminate and implement policies, procedures and guidance for practitioners and front line managers in partner agencies in respect to management of professional disagreements, professional challenge and appropriate escalation. Once implemented the effectiveness should be evaluated by audit.

10. To ensure effectiveness of interagency working with children and families WSCB should develop and disseminate practice guidance about the operation and multiagency contribution to Child in Need and other interagency meetings which includes standards for invitations, attendance, provision of reports, meeting notes, action plans and monitoring of progress towards clear, agreed outcomes for children.

8 Individual Management Review Recommendations

8.1. Wolverhampton City Council Children's Social Care

1. Specialist pre- birth Core Assessment which provides a balanced view of the history and functioning of the family together with ongoing specialist Core Assessments which provide analysis of the child's journey.
2. All children referred to Social Care, regardless of status to have a Core assessment together with genogram, eco-map[30] and on-going chronology
3. Clear direction and task assistance to be provided by Managers to the allocated worker at the point of allocation. Evidencing good management oversight and agreeing timescales for review of service and actions throughout the involvement of Social Care with the family.
4. Chronological information to be formatted from the onset of intervention and continually updated and attached to Case File.
5. Workers to develop strategies that support them in planning and organising workload and completing timely assessments and plans.
6. Good communication between Key partner agency Managers and Social Care Managers.
7. Refocus Family Support to offer early intervention whilst also providing families known to Social Care the opportunity of accessing ongoing services without the need for Social Care as a part of a new multi-agency Family Support.
8. All cases referred to Social Care and held within the service to be assigned a worker who is qualified and skilled in the process of assessment and planning.

8.2. Wolverhampton City Council – Children's Centre

1. A complete record of case history to held electronically for all families
2. Family assessments are carried out on an ongoing basis and make use of information from other agencies
3. A consistent approach to case management is implemented across Children's Centres
4. Ensure a robust process is in place for the transfer of cases from one Centre to another to ensure continuity of provision and understanding of case history
5. Establish a protocol for the escalation of issues through management routes across Children, Young People and Family Support.

[30] An Eco-map is a graphical representation that shows ecological systems in an individual's life

Health Services

8.3. Health Overview

1. Each health provider in the future submit one IMR of the services provided. This should include contributions from the different specialist departments e.g. Health Visiting, Paediatrics, Emergency Department and Maternity Services with authorship from the respective clinical specialities as appropriate and amalgamated into a single agency IMR for submission to avoid repetition and variance of recommendations.

2. All providers on receipt of a request for an IMR should nominate a senior officer on behalf of the chief executive to sign off and regulate quality and adherence to submission dates. Those tasked with authorship of an IMR or part of the IMR should be provided with dedicated, protected time to write their contribution and this should be monitored by the above senior officer

3. Once methadone is prescribed for unsupervised consumption, or even supervised when pharmacies are not open on a Sunday and at least one dose is given to take away, it is essential that advice is given and documented about safe storage to prevent accidental overdose, especially if there are children in the household. This should be the responsibility of all professionals involved including prescribers and dispensers (pharmacists). Health Visitors should include home visits as part of their planned intervention to families with under 5s where one or both parents is a substance user, a component of such intervention being to assess home safety arrangements.

4. All health practitioners working with families who are subject to interagency meetings (Team around the Child, Child in Need or Child Protection Conferences) should be fully involved in the care planning, provide reports of their involvement and ensure that details of meetings (minutes where available) are included in records.

8.4. Black Country Partnership Trust

1. All Addiction Service staff (including managers and medical staff) to attend Record Keeping Training to ensure clear and accurate recording, and filing of multi-agency minutes and care plans.
2. All Addiction Service staff (including managers and medical staff) to book on required safeguarding children's training
3. Review service policies and procedures to ensure child protection is incorporated appropriately, in particular the DNA, supervision, and 'use on top' policies. Review basic documentation to ensure child protection is incorporated i.e. risk assessments and care plans.
4. More robust working arrangements between staff who are 'key working' members of the same family.

5. All staff (including managers and medical staff) to access clinical / safeguarding supervision in line with local and national policy.
6. Increase in family interventions

8.5. General Practice

1. Neonatal discharge summaries are scanned onto both maternal and new neonatal records
2. GP practices on receiving medical records of new patients, to ensure that records are complete, and to track and trace appropriately
3. Consideration is given to increasing collaborative working between Addiction Services and primary care, in patients with complicated needs
4. On ascertaining pertinent medical knowledge regarding parents, the GP ensures that the health visitor is engaged with the family
5. If a child is being looked after outside the nuclear family, there should be evidence in the records as to who has legal parental responsibility.

8.6. Royal Wolverhampton NHS Trust

1. Develop robust hand-over mechanism from maternity to health visiting service for vulnerable women
2. Increase staffing levels of Health Visitors in line with the national Health Visitor Implementation Plan and local action plan agreed by HEE West Midlands & Department of Health
3. Identified staff to undertake agreed level of safeguarding children training
4. Training Needs analysis to be conducted to assess need for additional training to practitioners involved in child in need plans in terms of responsibilities and expectations
5. Child in need minutes and recommendations to be included in the medical record/accessible via portal for access by other professionals.

8.7. West Midlands Police

1. To improve the identification, recording, evaluation and sharing of relevant safeguarding intelligence with partner agencies