

Buckinghamshire Local Safeguarding Children Board Serious Case Review Executive Summary

Introduction

This document provides a summary to an Overview Report which was commissioned by Buckinghamshire's Local Safeguarding Children Board under the requirements of 'Working Together to Safeguard Children' 2006. It followed the death of child A, aged 2 years 1 month.

The report is based upon information provided, via the Serious Case Review Panel, from individual management reviews carried out by agencies that provided services to A. Individual Management Reviews (IMRs) were provided by:

- Children's Social Care, Buckinghamshire County Council
- Children and Family Court Advisory and Support Service (CAFCASS).
- The Probation Service.
- Buckinghamshire Primary Care Trust and Acute Trust.
- Oxfordshire and Buckinghamshire Mental Health Trust..
- Thames Valley Police.
- Legal Section, Buckinghamshire County Council
- District Council (Housing).
- Residential Drug Rehabilitation Unit

Any conclusions and recommendations are based on analysis of the information provided, with the benefit of hindsight and produced in an Independent Overview Report compiled by Paul Kerswell, Director of Eades Kerswell Strategic Ltd. They are intended to assist in the application of 'best practice' for the future.

Purpose of a Serious Case Review

The purpose of a Serious Case Review is to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of children;
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- as a consequence improve inter-agency working and better safeguard and promote the welfare of children.

(Section 8.2 of the Department of Health document 'Working Together Safeguard Children' 2006)

Serious Case Reviews are not enquiries into how a child died or was seriously injured or who was responsible. These are matters for Coroners and Criminal Courts. Therefore this report does not seek to apportion blame for the death of A.

This report examines the actions of the agencies that were involved with A and his family. It analyses individual agency policies, procedures and decision making and considers how agencies interacted with each other. The report provides recommendations that are intended to improve services and help to better protect children in the future.

Terms of Reference

The SSCR Sub Committee has considered in this case the scope of the review and have draw up agreed terms of reference. Relevant issues relating to the Part 8 review concerning the death of 'A' will include:

- The background of all the adults related to 'A' and their behaviours, their care of him and whether this impacted on his development and subsequent death.
- Whether processes/procedures that were in place at the time were followed correctly, and whether current processes and procedures are fit for purpose and are understood and carried out by all relevant agencies
- Analysis of the decision making processes in all of the agencies involved and did this achieve a positive outcome for 'A'.
- The quality of the assessments undertaken by all key partner agencies and how much was shared and contributed.
- How any Multi Agency analysis was drawn together at key times in 'A' s life
- How agencies continued to work together whilst 'A' was subject to a Supervision Order and whether all partners were aware he was subject to a Supervision Order and what that meant
- Any other relevant information contained in Individual agency files and records
- Recording of any lessons learned both for individual partner agencies and for individual services.
- Communication across all agencies and the mechanisms for exchange of information

Summary of the Case

1. A was born drug-dependent in 2005 and started his life in the Special Care Baby Unit. His mother and extended family had been known to the statutory agencies since her own childhood. By age 17, mother had admitted to a heroin habit (2000).

2. At the time of A's birth, mother, had attempted unsuccessfully to detoxify several times. A's birth and the subsequent placing of his name on the Buckinghamshire Child Protection Register and the initiation of care proceedings gave her new determination.
3. Subject to a statutory supervision order to the probation service, she was placed at a drug rehabilitation unit, as part of her sentencing requirement; Social Care agreed to fund A's place with his mother.
4. The 6 months of the placement was not always an easy time for A and his mother, but was not atypical. The placement ended slightly earlier than planned when A and his mother went to live with mother's partner, A's father, in accommodation which he provided. There is good evidence that mother remained drug free from April 2006.
5. In December 2006, the Family Proceedings Court made A the subject of a one year supervision order and the family were supported in parenting A.
6. During the summer and autumn of 2007 the relationship between A's mother and father deteriorated; mother sought accommodation from the District council and at the end of November, awaiting a place to live, moved with A back to her family home.
7. On 2nd January 2008 at just before 5.30 in the evening an ambulance was called to maternal grandmother's house. The paramedics found A asystolic with fixed dilated pupils, he was rushed to hospital where CPR was halted at 17.56.
8. Toxicology reports subsequently revealed that A had ingested a fatal amount of methadone. A rigorous police investigation followed but was inconclusive as to how he had ingested the methadone.

Analysis

1. The overview author's analysis explores, with the benefit of hindsight:
 - Issues from mother's childhood experiences and the impact of them on A and her ability to parent him.
 - The statutory agencies' responses, communication and co-ordination. In particular issues around case management and responsibility; changes as A's legal status changes and the planning and provision of appropriately co-ordinated support; the perception and understanding by professionals of risks posed to A by his changing environment.

- Mother's engagement with services provided and the impact of this.
- Issues arising from A's ethnicity.

Conclusions

1. Given mother's background and history, it cannot be denied she made a remarkable achievement in getting and staying free of drugs, clearly motivated by her ambition to be a good parent for A. Her commitment to A and her ability to parent him successfully is well documented.
2. The history of mother's family should clearly have given rise to significant concerns. These were expressed at times but not substantially incorporated into the understanding and management of the case throughout. I am concerned that some of the culture which led to this system failure is echoed in the response to A and his mother. (Poor multi agency working and resource led decision making). It is important that work on this is taken forward, particularly in light of the fact that many of the IMR recommendations are procedural.
3. From the point at which the pregnancy became known to professionals, there was not a coherent multi agency response. There appears to be much multi agency communication but little coordination or cohesive planning. The one forum that did seem to begin to make sense of a multi-agency approach was the core group. Unfortunately the de-registration of A at the first review meant that this group was short lived.
4. One has to wonder if the conflicting requirements of the different processes (eg Looked After Child, Family Court requirements of a case in Proceedings, Criminal Court expectations) each with their own set of targets driven by Central Government, make it too difficult for professionals to work together with the child as a focus. The use of these targets to measure performance do not always allow for the child to be at the centre of planning and decision making.
5. At the point at which A and his mother leave the Drug Rehabilitation Unit, move into a new home and the supervision order is granted, they might be deemed to be at their most vulnerable (albeit successful at that moment in time) and reports from both the Drug Rehabilitation Unit and the Psychiatrist recommend ongoing support. I also note the comments of the probation IMR author in respect of the need for a level of understanding which is unlikely to be gained by any single agency.

6. It is of concern that more information is not available about the Children's Guardian's involvement, due to records having been destroyed. Information from the County's legal section and the social care IMR author, reassures me that the appointment and instruction of the expert witness was appropriate, however neither social worker nor guardian appear to have challenged the implications that the conclusions of his report were based on not always accurate information given to him by A's mother.
7. I concur with IMR authors that the purpose of a supervision order was not widely understood by the different agencies and I note the recommendations to address this.
8. However, at the time of A's death, mother had been drug free for nearly two years during which time she had successfully parented him. She had secured accommodation and was due to move in to it shortly. Even had the concerns about the household been raised, I agree with the County Legal IMR author that there would not at that point have been the grounds for statutory intervention.
9. It is not possible therefore to identify any one significant event or action by any agency, which if done differently, would have changed the sad tragedy of A's death.
10. I would commend District Housing for their decision making in response to the information given to them.
11. Positive work and practice can be seen in the work of the staff from the Hospital in their care of mother and then A.
12. I would also recognise as good practice the probation officer's decisions in changing the venue of her meetings with mother and in not applying for early discharge of the order.
13. The response by the ambulance service to the 999 call on the day of A's death, seems to me to be exceptional.

Learning Points From the Process

14. Although the Terms of Reference reiterate the view in 'Working Together' that the police conduct of a serious criminal investigation should not affect the timescales of the Serious Case Review, it is the overview author's opinion that this case is an example of where it inevitably does. The reality is that the ability to inform parents that the review is being undertaken, its purpose, and the opportunity to engage them in the process, all in a sensitive and professional manner.

severely impacted upon when the parents are suspects in a continuing police investigation. Thames Valley Police were, as partners in the process of this review, cooperative and facilitative of the process and understanding of the demands, however their first priority had to be the criminal investigation and ensuring that potential evidence was not contaminated. The Detective Inspector leading the investigation was willing to communicate with the SCR Group and did attend one meeting to give a very full and open update.

15. The process developed by the Serious Case Review Group of Buckinghamshire LSCB was flexible and open to learning. Thus the overview author's meetings with the IMR authors developed with the process. Concerns were expressed by some authors that this discussion of findings may lead to 'group think' and influence authors' independence, however there was consensus that the awareness of this issue, coupled with the seniority, experience and professionalism of the authors would mitigate this risk.
16. The benefits of the process were that emerging issues were discussed and the IMRs were therefore able to address all issues. The Terms of Reference were able to be updated and it was as a consequence of these meetings and the information shared that it was decided to request IMRs from both Housing and the Drug Rehabilitation Unit as individual agencies. The meetings also provided a forum for the overview writer to explore and make any recommendations for immediate action that may have emerged as necessary during the course of the review.

Actions arising

In line with the recommendations in the Independent Overview Report the following actions have been put in place and progress against them will be monitored by the Local Safeguarding Children Board

1. The LSCB has required each agency to formulate an action plan in response to their Individual Management Review, which incorporates specific actions and timescales.
2. The LSCB has, within its Performance Management Framework, developed a mechanism for checking each agency response to IMRs and implementation of subsequent actions
3. The LSCB is actively promoting inter-agency working:
 - Modelling collaboration, communication, shared responsibility and joint planning.

- Commissioning training which will clarify an inter agency outcomes approach, incorporating clear planning with shared stated objectives and making clear statements about hard to reach and difficult to engage families.
- Developing statements or standards which give professionals “permission” and mandate to meet and plan together.

4. The LSCB is considering revising the Serious Case Review process to include learning from this review.

Recommendations from Internal Management Reviews:

1	The Cafcass Head of Safeguarding should consider and formulate a policy to provide support and cover arrangements that would be put into practice in such circumstances where the service manager is absent for longer than one month.
2	Cafcass senior managers should take responsibility during supervision with service managers for ensuring that Personal Development Plans and Appraisals are completed appropriately to meet the training and development needs of the individual practitioner and the service in accordance with the Performance Management Policy.
3	Cafcass takes steps to ensure that all staff are fully familiar with the case recording policy and that they comply with the requirements. Regional Directors should take responsibility for ensuring that service managers produce annual records of audited files.
4	Cafcass nationally seeks confirmation from service managers, in the form of written individual office procedures, that all teams have in place a system to monitor all reports before they are filed, even in situations where colleagues elsewhere are involved in the process in the absence of practitioners' own office colleagues.
5	Whilst the children's guardian in this case responded appropriately to the issues around drug use, there was no internal practice guidance to support her in assessing the impact of drug use and its implications for parenting. Such guidance is currently out for consultation. I recommend that, once this is agreed, the Head of Knowledge, Learning and Development in Cafcass should ensure that an effective strategy is in place to support staff in its use.
6	In view of the difficulty experience by the guardian in obtaining permission to access probation files; I recommend that the LSCB ensure that local protocols are in place to facilitate information sharing.
7	Individual agencies/worker(s) should be responsible for making a direct referral to SSD at the point at which they become aware of any matters which could place a child/unborn child at risk of significant harm irrespective of whether they are or are not the lead agency in respect of any child. Details of any such referral should then be communicated without delay to all other known agencies/workers involved in the case.
8	In the case of any residential or other placement involving a child there should be: (i) a clear written agreement/statement prior to placement detailing the specifics and scope of the agreed roles and responsibilities of the facility in respect of any child placed in that facility. This agreement should also include an agreed exit strategy detailing all necessary arrangements which can be put in place at short notice as required. (ii) a regular schedule for review of the agreement should also be put in place prior to the commencement of any placement to include an understanding of the process and mechanisms which would be utilised to facilitate the monitoring and evaluation of such work. (iii) this agreement should be made available to all other agencies/individuals involved in

	<p>the case.</p> <p>(iv) this agreement would be viewed as being an adjunct to or in addition to those which would be expected and are regularised under standard child protection policies or any other statements as to the same in more general information routinely provided by the facility.</p> <p>(v) a reciprocal agreement should be drawn up and made available to the facility in respect of the engagement with the facility of all other agencies/individuals involved in the case.</p>
10	All identified risk factors likely to have a detrimental affect on the welfare of the child to be clearly identified, recorded and subject to review throughout the period of contact with the family and a record of all risk factors arising should be retained on the current review document for the duration of the case.
11	Legal Services to send an explanatory memorandum to their Client Department at the conclusion of a case, which explains the effect of a Supervision Order and sets out how to consider if an Application should be made to extend the Order.
12	There should be consideration of a formal mechanism for reviewing Supervision Orders similar to the LAC Review Process - to consider inter alia whether an Application to extend the Supervision Order should be made
13	Improvements to be made in communication between Midwifery Dept. and Social Care. The provision of a 'Hospital Social Worker attached to the Referral and Assessment (R&A) team based at the Hospital as is in place in the North of the County would aid communication and improve 'joint working'.
14	Seminar for Neonatal Intensive Care Unit (NICU) to discuss how staff can identify and record parent/child attachment. This could be aided by development of a 'tool' to assist staff with the assessment and record keeping required. Development of Child Protection Clinical Supervision Better communication between NICU staff and Health Visitors (HV)
15	Improvements in Record Keeping – (to include the filing of faxed information and referrals made)
16	Social Services should keep the Council fully informed and up to date of the current and on-going progress of an individual case. There should be consideration of developing information on high profile cases, including advising the Council of any relevant child protection plans and a protocol and guidelines between both services.
17	The Council should consider improvement with regard to the permanent tenancy sign-up process that would satisfy the signing-up Officer that all family members of the household are currently residing with the applicant(s) at the time of the sign-up, for example through clarification that the dependent is living with the applicant at the time of sign-up, through relevant documentation rather than the applicant stating that the dependent lives with the applicant.
18	Staff in the Addiction Service must be aware of their responsibility to engage fully in the Child Protection process and follow the Trust Safeguarding Children Policy and Buckinghamshire Local Safeguarding Board Procedures and Working Together to safeguard Children 2006.
19	Substance misuse professionals must identify those adults who are parents, or who have regular care giving access to children, and share the information with Children's Social Care as early as possible according to Buckinghamshire Local Safeguarding Board procedures.
20	When a child is looked after by the Local Authority either a Section 20 or Care Proceedings, the birth certificate must be seen, and a copy obtained for the file.
21	When a child is placed under a Supervision Order at the end of Care Proceedings this means the criteria for significant harm has been proved. Therefore there should be a Child Protection Conference to decide whether a Child Protection Plan is required.
22	When a child is Placed under a Supervision Order at the end of Care Proceedings this

	should remain allocated to a social worker in the first instance, to acknowledge that there may be child protection issues current, and to assess risk, and to set up the multi-agency network.
23	If a child on a Supervision Order is not subject to a Child Protection plan, there should be regular Children in Need Reviews/ Supervision Order Reviews involving all relevant agencies so that there is a multi-agency plan, not just a social care plan.
24	When a Supervision Order is made, as part of the multi-agency plan, there should be a clear agreement with the parents about previous risk factors; for example in this case in regards to mother allowing A to stay or have contact with his uncle and his grandparents.
25	A month before the expiry of a Supervision Order there should be a multi-agency meeting to consider whether an application for renewal of the Order should be made.
26	If there are inaccuracies in an experts report, even if the conclusion is in agreement with the Local Authority these should be robustly challenged.
27	Procedures and Practice training should address the importance of taking a good family history and beginning with assessments that clearly evidence and highlight the risk factors, so that these can run as a thread through the rest of the case rather than getting minimised as time goes on.
28	At the end of Care Proceedings all agencies previously involved should be informed of the outcome in writing.
29	Placement with Parents Regulation procedures must be written or updated, The procedures should incorporate the recent recommendations from the Safe Care Sub Group of the Healthy Care Steering Group which was that if children were placed with their parents then there should always be multi-agency involvement, and consideration as to whether child protection procedures were appropriate considering the previous history of any family concern.
30	Team managers in Social Care should allocate a case to a person who is sufficiently experienced and qualified. That person should be given clear instructions so that they understand the parameters of the case. (Climbie recommendation)
31	The importance of reading files and the significance of history should be re-asserted.
32	When the recently updated Pre-Birth Procedures are launched, compliance should be monitored by Operational Managers, and reported to the relevant Safeguarding Divisional Manager
33	For vulnerable families the Health Visiting Transfer In policy: family should include contact time frame.
34	Transfer in records for vulnerable families to be in the possession of the relevant health professional before contact is made with the family concerned.
35	Provide training on Trust Record Keeping Policy
36	Audit to be undertaken by PCT management against record keeping standard.
37	Provide training to staff to enable them to understand the status of children under legal orders
38	Amend Trust Child Protection Clinical Supervision Policy to include cases of children under supervision or care orders
39	TVP Should comply with the National Guidance on Investigating Child Abuse and Safeguarding Children 2005 page 88 where it gives clear advice on CAIU attending Review Conferences or sending a report to the chair.
40	Consideration for the above to be specifically included in the main document section of the TVP Child Abuse Policy (at present it is included under the Office Manager Job Description only).
41	Consideration for the above to be included in all Local Authority Child Protection Procedures.

Paul Kerswell

Director Eades Kerswell Strategic Ltd