OXFORDSHIRE
SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD H

15.09.14

Contents

1 INTRODUCTION

1.1 BACKGROUND & DECISION TO INITIATE A SERIOUS CASE REVIEW

1.1.1 Emergency services were called to the home of child H (then 21 months of age) on a Saturday evening in September 2013. The child's mother indicated that she had left prescribed opiate based medication in her handbag, placed on a chair whilst she went to another room. Child H reportedly picked up the bottle and appeared to have drunk from it. Emergency services were not called for approximately 1.5 hours. Once called, Ambulance staff arrived promptly.

1.1.2 In the ambulance, child H stopped breathing and needed resuscitating. Upon arrival at hospital, the child was admitted, required intensive care treatment and subsequently made a full recovery.

1.1.3 Child H was thought to have ingested between 40-50 ml of prescribed opiate based medication that had been in the bottle (which has a child-resistant lock).

1.1.4 Child H's 24 year old mother had been known to Children's Social Care since the age of 15 and had a history of drug use. When child H was born the case was monitored via a 'child protection plan'. This was stepped down to a 'child in need plan' in September 2012 and closed in February 2013. The case remained open to other services.

1.1.5 Mother was arrested on suspicion of neglect and later bailed by Police. Child H was initially accommodated with mother's agreement and subsequently made subject of an interim Care Order. Mother later pleaded guilty to charges associated with her care of child H and received a custodial sentence.

1.1.6 Child H has an older sibling who was removed when 5 months old because of concerns about mother's substance abuse and its impact on her ability to parent.

1.1.7 The agency bringing the case to the Safeguarding Board for review had particular concerns and the serious case review panel agreed that this met the criteria for a serious case review, mainly because of a need to evaluate inter-agency work

1.1.8 On 26.06.13 the then Local Safeguarding Children Board (LSCB) chairperson supported the above recommendation and the Department for Education and regulatory bodies Ofsted and Care Quality Commission were subsequently notified of his decision. This introduction explains the purpose and process of the serious case review (SCR) and includes an executive summary of events, learning and required improvements.

1.1.9 The remainder of the report explores the experiences of child H and mother, evaluates the services and systems that sought to support and safeguard the child, and offers overall conclusions and recommended system improvements.

1.2 PURPOSE & CONDUCT OF THE SERIOUS CASE REVIEW

PURPOSE

1.2.1 Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with procedures in *Working Together to Safeguard Children* HM Government [latest edition 2013]. A 'serious case' is one in which abuse or neglect is known or suspected and either the child has died or been seriously harmed, and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

1.2.2 Its purpose is to:

- 'Establish what lessons can be learned 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 within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

1.2.3 A serious case review (SCR) is not concerned with the attribution of culpability which is a matter for a criminal court. Terms of reference were established and section 5 (analysis) addresses each element of them in turn. Sections 6 and 7 respectively, offer conclusions and proposed improvements to local systems respectively. A copy of this report is being sent to the government-appointed national panel of experts and to the Department for Education (DfE).

CONDUCT

Serious case review panel

1.2.4 The panel consisted of the:

- Designated Doctor Oxford University Hospitals NHS Trust
- Trust Lead Nurse for Safeguarding Children Oxford Health NHS Foundation Trust
- Designated Nurse Oxfordshire Clinical Commissioning Group
- Deputy Director Oxfordshire Children's Social Care & Youth Offending Service
- Safeguarding Manager Oxfordshire County Council
- Deputy Director Education & Early Intervention Service Oxfordshire County Council
- Detective Chief Inspector Thames Valley Police
- Head of Service Child & Family Courts Advisory and Support Service (Cafcass)

1.2.5 The need for further expertise was recognised and the commissioning manager of the Public Health Drug and Alcohol Action Team joined the panel.

Independent authorship

1.2.6 An independently authored overview report was commissioned from **www.caeuk.org** (an independent consultancy with experience of over 50 SCRs). It was agreed that upon submission of relevant material, author Fergus Smith would, in accordance with the appended terms of reference:

- Collate and appraise individual management reviews (IMRs)
- Develop for consideration by the serious case review panel an analysis, conclusions and recommendations for action by Oxfordshire's Safeguarding Children Board, its member agencies and (if relevant) other local or national agencies

Independent chairperson

1.2.7 The panel was chaired by an independent consultant Paul Kerswell who has no operational links with any of the agencies that provided services. Paul has extensive experience as a senior manager in child protection work and has chaired or written overview reports for over a dozen serious case reviews.

Anonymisation

1.2.8 To protect the identity of child H, family members and involved professionals, identifying detail has been removed from what is in all other respects a complete and transparent account.

1.3 EXECUTIVE SUMMARY

DECISION TO CONVENE, & CONDUCT OF THE SERIOUS CASE REVIEW

1.3.1 The decision to initiate a serious case review was made within 2 weeks of the overdose and in the view of the author, the time period selected for review an appropriate and proportionate one. Individual management reviews (IMRs) from each relevant agency were written by suitably experienced professionals who had had no involvement in the provision, supervision or management of services provided. Initial drafts were returned for clarification of facts or further explanation and all final versions were of a good or very good standard.

1.3.2 So as to maximise learning, authors were invited to attend panel to discuss and share with other authors their findings or experience. This provided a valuable further opportunity to reflect on judgements and decisions made in the course of the period under review. At the same time as publication by the Local Safeguarding Children Board of this report, a multi-agency learning event is being conducted with relevant professional stakeholders to share and debate findings from this and other recently completed case reviews. Agency-specific learning events are also planned.

1.3.3 The SCR was initiated in mid-November 2013 and its findings accepted by Oxfordshire Safeguarding Children Board in July 2014. This report is due for publication on the Board's website in September this year.

FINDINGS

Insufficient appreciation of risk

1.3.4 S*trategic* obstacles to achieving a clear and complete picture across the local agency network (in spite of a good deal of inter-agency information exchange) were:

- A relative passivity amongst medical staff in the Practice contracted to provide 'shared care', implying a need for clearer governance / commissioning arrangements
- A number of examples where professionals made unjustified presumptions about what colleagues in other agencies would / should do
- Some technical obstacles within Thames Valley Police to internal information transmission and an unjustified reluctance to share with Children's Social Care, intelligence about mother's drug-related lifestyle

Good practice

1.3.5 There were examples of sound agency systems or commendable individual practice:

- Quality and continuity of ante-natal care by hospital's specialist midwife
- A thorough assessment of need and risk by the hospital and other agencies following the birth of child H
- A comprehensive written handover from the first involved drugs worker DW1 to her successor DW2
- The perseverance of the paediatric infectious diseases clinic in trying to provide hepatitis C screening to child H and in asking the GP Practice for an answer to the question about potential safeguarding concerns

Sub-optimal practice

1.3.6 There were also a number of discrete failings:

- There was no recorded contact with health or other professional colleagues by GPs and a failure to respond to repeated and legitimate queries raised by a hospital clinic
- An arbitrary distinction was drawn by a health visitor (who otherwise liaised well with Children's Social Care and the Harm Minimisation Service) between the issue of safe storage of prescribed opiate-based medication / illicit drugs and the hazards represented by other household materials
- A tendency across agencies to accept at face value, mother's claims

1.3.7 The net result was that there was insufficient exploration or appreciation of the day to day experiences of child H and their likely impact on development and life chances. Mother's condition made crises likely but the overdose that triggered this serious case review could *not* have been predicted with any significant level of certainty.

1.3.8 Readers should also note that *even if* the all the potentially available evidence had been aggregated it is unlikely to have been sufficient to convince a court that a Care or Supervision Order was justified.

Societal context

1.3.9 Panel members' collective experience and consideration of this case prompted the observation that there exists a 'societal ambivalence' about substance mis-using parents. There is no assumption in law nor amongst the Judiciary or a proportion of professionals that a child raised by a drug-dependent parent is necessarily being exposed to an unacceptable level of risk to safety, health or emotional wellbeing.

1.3.10 The very large number of children living with drug-dependent parent/s anyway far exceeds any potential substitute care that might (by some) be considered justified. As early as 2003 it was estimated that between 250,000 and 350,000 children in the UK were affected by parental drug use. By 2009, a reported 120,000 children were living with a parent currently engaged in treatment and data collated in 2011-12, indicated that 60,596 adults with an opiate problem had parental responsibility and were receiving a prescribing intervention.

1.3.11 The above report also considered available serious case reviews of the last 10 years and revealed that there had been 17 fatalities and 5 non-fatal ingestions of opiate substitute therapy (OST) medication by children during this period (these figures are of necessity underestimates and exclude 'near misses' or incidents that failed to culminate in a serious case review for which there is no data publicly available).

1.3.12 This societal ambivalence leaves practitioners across professional boundaries with the task of evaluating risks to a child's immediate safety or longer-term welfare and (when the need becomes apparent) collating sufficient evidence to convince a court of the need for compulsory intervention and sometimes substitute care.

1.3.13 In this case and with the advantage of hindsight, it is clear that throughout the period under review child H's mother (without regard to her observed love for the child) awarded priority to her own drug-related needs. Her physical care of her child was though, generally 'good enough' and none of the involved agencies had reason to evaluate child H as being at high risk or a priority case.

1.3.14 The reader also needs to keep in mind that mother had little, if any, motivation to cease drug dependency. At times, she deceived agencies and used the tactics of diversion and dishonesty to minimise or obscure the impact of her lifestyle on child H, from whom she was desperate not to be separated.

1.3.15 Retrospective aggregation and consideration of the totality of information held by the local network has unsurprisingly served to identify some scope for improvements in local systems and professional practice. The remainder of this report encapsulates the learning that emerges from the case of child H.

RECOMMENDATIONS

1.3.16 36 recommendations for improved systems / practice have been accepted by the Oxfordshire Safeguarding Children Board which is monitoring progress toward their completion.

2 REVIEW PROCESS & RELEVANT BACKGROUND

2.1 RELEVANT AGENCIES

2.1.1 The following were identified as likely to have information of relevance:

- Oxford Health NHS Foundation Trust (Health Visiting & Specialist Community Addictions Services (SCAS) subsequently known as Harm Minimisation Service)
- Oxford University Hospitals NHS Trust (Emergency & Acute Care)
- Oxfordshire Clinical Commissioning Group
- Oxfordshire Children's Social Care & Youth Offending Service (Child Protection and Child in Need Services)
- Oxfordshire Education & Early Intervention Service (Children's Centres)
- Child & Family Courts Advisory & Support Service (historical services to older sibling only)
- Thames Valley Police (investigation of crimes committed by the mother and emergency protection on day of overdose)
- Thames Valley Probation (Community Order on mother)

2.2 FAMILY INVOLVEMENT

2.2.1 The chairperson of the SCR panel made contact with both parents, informed them of the decision to convene a serious case review and explained the process it would follow. A further letter inviting her contribution was also sent to the maternal grandmother who had been a significant source of support to her daughter during the period under review and before it**.** When the panel had established the basic facts and developed tentative findings, the overview author sought to engage family members in discussions as follows.

MOTHER

2.2.2 Mother was invited by letter to contact the overview author but did not do so. A further attempt to involve her was made following completion of the associated criminal process and a meeting was negotiated. Mother's overall evaluation of the services provided was a fairly positive one and she offered no criticisms of systems or individuals. She did (understandably) regret the turnover rate of her drugs nurses. Mother also acknowledged that because of her fear that her child might be removed from her care, she had been less than open and honest at all times.

FATHER

2.2.3 Though confirmation was received that he does not have parental responsibility and had no significant contact with his ex-partner during the review period, a letter inviting involvement was sent to his last known address. No response was received.

MATERNAL GRANDMOTHER

2.2.4 Child H's maternal grandmother was invited by letter to contribute her views and experiences of local services. Family illness prevented what was to have been a negotiated face to face meeting and required instead an extensive conversation by phone at a pre-arranged time.

2.2.5 The maternal grandmother of child H challenged the accuracy of Thames Valley Police records formulated *following* child H's overdose. With respect to her views about services provided whilst child H was in mother's care (which was the focus of this SCR), her overall comment was that her daughter was better focused on compliance with professional expectations whilst her child was subject of a child protection plan and that, in her view) stepping down to child in need status was premature.

2.2.6 The maternal grandmother was robust and realistic in acknowledging that her daughter (like many substance-dependent individuals) could seek to deceive agencies.

FAMILY DETAILS: MEMBERSHIP & LOCATIONS

Name	Gender	Relationship	Year of birth	Ethnicity
	Female	Mother	1984	White British
	Withheld	Half-sibling to child H	2003	Not known
Child H	**Withheld**	**Subject of serious case review**	**2012**	**Dual heritage White / Black African**
	Female	Maternal grandmother	Not known	White British
	Male	Birth father of child H	1963	Black African

3 AGENCY CONTACT WITH MOTHER PRIOR TO REVIEW PERIOD

3.1 INTRODUCTION

3.1.1 The historical context for agencies' involvement with mother is that she had endured a difficult and disrupted childhood, an early introduction to heroin and gave birth at when 19 to a child, subsequently removed from her care. Those issues were known to involved agencies and will or anyway should, have informed services provided.

3.1.2 Aged 7, mother had witnessed and reported domestic violence. Her parents subsequently split up and she went to live with her mother. When 11, mother was noted to have emotional difficulties and be suffering respiratory symptoms from passive smoking and later skin and ear, nose and throat problems.

3.1.3 Sometime in 2007 mother and daughter returned from elsewhere and began to live in Oxfordshire. At the age of 14, mother was suspended from school and a year later records indicate that she had begun to use heroin. Medical records indicate a dependence on morphine / cocaine and clinical depression by the year 2000 (mother was then 16). When mother was first prescribed opiate substitute therapy in 2002, she dropped out of treatment after 3 months. Upon resumption of treatment she was injecting heroin daily.

3.1.4 A pre-birth conference for mother's first child was convened in 2003 and that child was registered at birth under the category of 'neglect'. Care Proceedings were initiated and following the granting of an interim Care Order an agreement was reached that the child would be placed with a relative.

SUMMARY OF KEY CONCERNS ABOUT CARE OF FIRST CHILD

3.1.5 A report prepared by the Court and Family Advisory and Support Service (Cafcass) at the time of legal proceedings on the first child usefully summarised the concerns:

- Little or no antenatal care had been provided
- The birth was traumatic and without medical assistance
- The baby was born addicted to heroin
- A chaotic lifestyle
- Limited / sporadic contact
- Mother had discharged herself against medical advice and left her baby
- Concerns about her partner (not the child's father) who had a history of violence and drug offences
- An arrest 10 days pre-birth for conspiracy to supply class A drugs
- Poor engagement with professionals including addictions nurse
- Refusal of a drug rehabilitation placement

3.1.6 The above list may usefully be compared with the narrative and analysis about mother's care of her second child.

4 AGENCY CONTACT WITH FAMILY WITHIN REVIEW PERIOD

4.1 INTRODUCTION

4.1.1 The period for formal review extends from April 2011 (the estimated start of mother's pregnancy with child H) until mid-September 2013 (the child's removal from her care following hospitalisation). The review period has been divided into periods that have some developmental significance to child H.

4.1.2 Although some job titles and employing agencies changed across the period of review, the following abbreviations have been used with any following number indicating in which order they appeared: drugs worker (DW), health visitor (HV), social worker (SW), Probation employee (PO).

INITIAL LEVEL OF DRUG DEPENDENCY

4.1.3 At the point in April 2011 that the 'drug rehabilitation requirement' (DRR) element of her Community Order ended, mother's record of testing throughout the previous 18 months showed a consistent use of cocaine (positive in every test), and several positive tests for morphine and opiates. This usage was in addition to the prescribed methadone (100mls daily).

4.1.4 Mother herself claimed that she was using crack cocaine about 3 times per week; that she was not interested in rehabilitation and wanted to stay near her home and then boyfriend.

4.2 ANTENATAL PERIOD

AGENCY AWARENESS OF PREGNANCY

4.2.1 In mid-May 2011 mother informed DW1 that she was pregnant. Her methadone prescription remained 100mls daily and its ingestion was supervised daily by the pharmacist (except for Saturday when she would collect the dose for use next day). As well as her methadone, mother admitted to using crack cocaine daily.

4.2.2 Mother reported that she was keen to stop crack cocaine usage and reduce the methadone[1]. DW1 explained the need to reduce slowly starting in the second trimester of pregnancy. The rationale for this is that too early tapering can induce premature labour morbidity and mortality of the foetus.

[1] Methadone was being used as part of a drug addiction maintenance programme. It is a narcotic pain reliever, similar to morphine; it was used in this case to reduce the withdrawal symptoms when stopping the heroin without causing the high associated with drug addiction. Reduction programmes have to be carefully considered, as many women relapse into drug use, especially during the third trimester of pregnancy when the therapeutic effect from methadone may decrease.

ANTENATAL CARE & MIDWIFE'S REFERRAL TO CHILDREN'S SOCIAL CARE

4.2.3 Midwife 1 initiated a prompt and well-informed referral in mid-May 2011. As well as addressing a wide range of medical / obstetric issues, she passed on known health-related information, the fact that mother was living in a shared house and that she was about to move on. She named the putative father and indicated mother's involvement with Probation was about to cease. No estimated date of delivery for the baby was captured in the electronic records of Children's Social Care.

4.2.4 Much of mother's antenatal care was delivered by one identified midwife for expectant mothers with drug and alcohol problems. This afforded good continuity of care. The Hospitals Trust IMR author was able to confirm that throughout the pregnancy there was evidence of considerable attention being paid to drug use and wider social circumstances e.g. changes in methadone dose, level of support offered by her partner and a recognition that she had not previously cared for a baby.

4.2.5 Mother attended the majority of the antenatal appointments and those she missed were always re-booked. Missed antenatal appointments are relatively unusual and might be seen as evidence of mother awarding insufficient priority to her own and the health needs of her child to be.

VARIATIONS IN COMPLIANCE: PROBATION & HARM MINIMISATION SERVICES

4.2.6 Management of her methadone reduction was discussed in late May 2011 with the pharmacist present. DW1 reported that mother was receiving good support from what the author has been told is a local self-help service and her probation officer (mother was the subject of a Community Order after conviction for theft). In fact mother's actual level of involvement with the local group was extremely limited. At this point mother was compliant with 'pick-ups' of prescribed medication and attended 75% of planned appointments. DW1's intention was that mother should attend all appointments and have regular urine screens for illicit drugs.

4.2.7 At the end of May 2011 DW2 was introduced to mother and received a commendably comprehensive handover. Mother was 8 weeks pregnant and fully compliant with daily methadone pick-ups. The importance of attending all appointments was stressed by DW2 who also engaged the support of the pharmacist to explain methadone treatment in pregnancy. This was DW2's first experience of the role of a drugs worker. She was reassured when mother referred to good support from her probation officer and from the self-help service.

CRIMINAL ACTIVITY DURING PREGNANCY

4.2.8 In June 2011 mother was arrested on suspicion of handling stolen goods. She failed to appear at court and was arrested, held in custody and presented in court. At a delayed court appearance in October she pleaded guilty and received an 18 months Conditional Discharge.

4.2.9 Mother had anyway been further involved in crime in mid-June when she admitted taking items from a supermarket and was subsequently issued with a summons to appear in court in mid-October. On neither occasion were other agencies notified by the involved police officers.

4.2.10 At an appointment with PO1 on in late June 2011 mother spoke of an intention to reduce use of methadone and to be down to 50mls by the time of the birth. She admitted to ongoing use of crack cocaine and was no longer interested in rehabilitation. The declared target of 50mls per day was seen in no other records.

4.2.11 When mother attended in mid-July 2011 she admitted smoking crack cocaine[2] weekly and acknowledged a need for support. DW2 provided contact details for the local self-help service. There had been no urine tests for drugs since pregnancy had been confirmed. When interviewed for this serious case review, DW2 recalled mother lacked motivation and was dismissive or ambivalent about advice given.

4.2.12 By late August 2011 during a call made by SW1 to midwife 1, it was revealed mother had moved to a new address. Her daily usage of 100ml of methadone was confirmed. A 'new partner' was mentioned, though this may have referred to the acknowledged father of child H.

ACCEPTANCE OF REFERRAL BY CHILDREN'S SOCIAL CARE

4.2.13 It remains unclear what status had been awarded the midwife's earlier contact but in response to a subsequent telephone conversation, a formal referral was logged and an 'initial assessment' begun in the hospital social work team.

4.2.14 Having had no success by phone SW1 made an unannounced visit and met mother, who said she 'had been in a mess'. A further visit in early September was agreed and completed. SW1 also liaised with the allocated probation officer and was told mother did not want to attend rehabilitation.

REDUCED CO-OPERATION WITH DRUGS WORKER

4.2.15 DW2's plan had been to see mother weekly but her attendance dropped to 50% during DW2's involvement (6-24 weeks of gestation). DW2 suspected mother was continuing to use crack cocaine and this was confirmed when mother (then 20 weeks pregnant) admitted giving up was 'proving difficult'. Given the potential impact of crack mother's conduct offers a pre-natal example of putting her child's life at risk.

4.2.16 At mother's request, DW2 began to reduce the methadone from 100mls to 95mls. Mother failed, in spite of reminders, to attend the next 3 appointments. DW2 consistently checked with the pharmacist that mother was compliant with methadone pick-ups, as did all the specialist drug staff. The plan was to reduce the methadone by 5mls at each prescription but *only* if mother attended appointments[3]. DW2 had had no communication with midwives or anyone in Children's Social Care.

[2] Crack cocaine is a strong central nervous system stimulant. The 'high' begins almost immediately after the vapours are inhaled and lasts for 5-15 minutes and after the initial rush the user experiences an intense desire for more. Users quickly develop a tolerance needing more to achieve the desired effect. Crack cocaine is expensive and ways of funding a supply have to be found. Research demonstrates that crack cocaine can negatively impact on foetal growth and development and risks continuation of pregnancy.

[3] It is important to ensure that prescribed methadone is sufficient in quantity to deter heroin use.

FURTHER INVOLVEMENT IN CRIME

4.2.17 PO1 initiated contact with an unidentified hospital midwife in September 2011 and was given confirmation of mother's ongoing use of crack cocaine but not heroin.

4.2.18 In mid-September mother was arrested for shoplifting then and on a previous occasion in late August. She was verbally abusive, refused to provide an address and provided a 'no comment' interview. Following an enforced strip search, she was found to have smoked from a pipe concealed about her person, what was assumed to be crack cocaine. She later informed officers that she always carried a crack pipe and lighter.

4.2.19 Mother was remanded and appeared in court next day when she was sentenced to a 6 month Community Order to include specified activity and attendance at a 'Think Ahead for Women' course (TA4W). Only an oral report was provided to the court. Probation Trust policy requires that any reports which have an element of child protection or domestic abuse require completion as a full written report.

4.2.20 Because there was no longer any DRR, the management of the case transferred to the generic Probation team and was allocated to a 'probation service officer' PO2 undertaking qualifying training and jointly managed by PO3. The assessment at the outset of this sentence was a 'high likelihood of reconviction' and (though the history of her first child was known and concerns about the current pregnancy acknowledged) a 'low risk of harm to children'.

4.2.21 For the purposes of offender assessment, the Ministry of Justice defines 'harm' as 'serious harm' i.e. death, or physical or psychological harm from which it would be impossible or difficult to recover. 'Low risk' is when current evidence does not indicate a likelihood of serious harm. On these definitions, the assessment of 'low risk' was reasonable, though the minimal adjustments being made by mother to her usual lifestyle offered an insight into her limited capacity and motivation to prioritise the well-being of her baby over drugs.

4.2.22 An oppositional attitude was also apparent at her induction for her Community Order when she refused to consent to information sharing with her GP.

PRE-BIRTH SAFEGUARDING PLANNING

4.2.23 SW1 tried in the remaining antenatal period to meet with mother (whose compliance with appointments varied). SW1 also liaised with extended family members. Child H's maternal grandmother described a positive change in her daughter.

4.2.24 By mid-September the manager of SW1 (referred to in this report as TM1) had determined that a strategy meeting was required. However in order to avoid the possibility that the review conference which is required within 3 months of an initial conference would appear 'overdue'[4], the manager deferred the formal strategy meeting (required to trigger safeguarding procedures).

[4] One of the performance measures collected by the DfE is the proportion of review child protection conferences convened within 3 months of the initial conference that determined a need for a child protection plan.

4.2.25 In exchanges between SW1 and DW2 the latter was 'surprised' mother did not wish to access a rehabilitation service, recalling that she had 'always been keen for this'. It is not clear when, how or to whom mother had ever expressed any personal motivation for rehabilitation rather than being maintained on methadone.

4.2.26 SW1 helpfully wrote to the hospital maternity service in late September 2011. She confirmed mother's current circumstances and use of prescribed and non-prescribed drugs. SW1 asked to be alerted when mother appeared to be in labour. In the event the pre-birth conference provided a substantive opportunity for information sharing.

4.2.27 A week later TM1 noted there had been no change since the last supervision session. She directed completion of a 'core assessment'. TM1 also suggested a family group conference (FGC) be initiated and noted (correctly) that the planned November strategy meeting was likely to result in a pre-birth protection conference

4.2.28 Only an 'initial assessment' had been begun in August. The expectation at the time was that these should be completed within 10 working days. A further 35 working days was the then standard time allowed for completion of the more comprehensive 'core assessment' (since October 2013 Oxfordshire like most local authorities, has introduced needs-driven rather than government-imposed time limits).

4.2.29 At a meeting with SW1 in early October 2011 following an antenatal consultation, mother claimed to have attended all her antenatal appointments. She had in fact attended the majority, though missed 4 (these had been re-scheduled).

4.2.30 It emerged during October that mother had yet to inform child H's father of her pregnancy. After further efforts by the social worker, contact with child H's father was established. Children's Social Care records indicate an expected date of delivery in January 2012 and note a supportive letter written to Housing seeking a new home for mother and her expected baby.

4.2.31 In early October mother was issued with a warning by Probation because she had missed her last appointment. Mother reported that she was not using on-top and (inaccurately) that Children's Social Care was drug testing her weekly. She offered a more accurate account at her next appointment of her fortnightly testing being with the Specialist Community Addiction Service (SCAS) nurse (now the Harm Minimisation Service) at the Health Centre.

CHANGE OF DRUGS WORKERS & AMENDED CARE PLAN

4.2.32 Toward the end of October DW3 took over from DW2 (mother was then 26 weeks pregnant) and remained the specialist addiction worker for a 10 month period up until child H was 8 months old. During that period 24 appointments were made for mother and she achieved an attendance rate of 75%. Initial appointments were not attended and DW3 saw mother (by then 32 weeks pregnant) for the first time in mid-November 2011. It appears that no handover report was provided by DW2.

4.2.33 Mother claimed she had not used crack cocaine for 3 months or heroin for 2 years. Records though, demonstrate that she *had* admitted heroin use 1 year previously. Her misinformation influenced future risk assessments.

4.2.34 DW2, with mother's agreement began to reduce the daily dose of methadone by 5ml to 85mls. A Children's Social Care record a week later suggests mother was at that point being moved from twice weekly collection to weekly. SW1 liaised further with midwife 1 in late October and they noted mother had then 3 missed ante natal appointments.

4.2.35 The Probation Service officer PO2 had alerted DW3 to her concerns about mother's lack of commitment and engagement and to her breach of her Community Order .In spite of the circumstances, DW3 who had been involved at the time of mother's previous pregnancy perceived there to be significant improvement in her current presentation and commitment. When mother was 33 weeks pregnant, mother discussed planning for the baby and appeared to DW3, to be more open and making good eye contact (her more usual demeanour was passive without any spontaneous engagement).

INDICATORS OF MOTHER USING 'ON-TOP' [OF PRESCRIBED MEDICATION]

4.2.36 In early November, mother (29 weeks pregnant) was involved in a street fight with another woman. There were no visible injuries and mother declined an ambulance. Police took no further action and no notification was provided to any other agency.

4.2.37 At a home visit by the social worker, the maternal grandmother offered useful observations of how to discern when her daughter was using 'on-top' i.e. instant weight loss, becoming dirtier than usual, slurring her speech, eyes glazed; she also referred to behavioural changes such as being shaky and stopping calls and visits.

4.2.38 At an appointment in November 2011 DW3 completed a care plan which was scanned into the medical records. Such plans should be reviewed if there is a change in circumstances or an incident. Mother's plan was not reviewed for the 10 month duration of DW3's involvement.

4.2.39 DW3 was receiving positive feedback from the pharmacist and reported her sense that mother was turning her life around. At this point her prescription was 85mls of methadone with a daily supervised pick up from the pharmacist (on a Saturday she would take home the methadone for Sunday). Mother was reliable in following this routine. Mother continued to resist a referral to a Children's Centre.

'BREACH' HEARING

4.2.40 Mother appeared in court in November 2011. She had not been attending her Probation appointments and walked out of a session in October. Though initially angry, she accepted that SW1 had contacted her baby's father and explained her initial response as a fear that he might seek care of the child.

4.2.41 Mother's Community Order was extended by 12 months. Mother told SW1 she was 'keen' to attend the Children's Centre. Mother was asserting entirely opposite views to her probation officer and social worker respectively. It is known that she actually visited a Children's Centre once only (for advice). The father of child H met SW1 at the local hospital. She learned his real name and other significant details e.g. his origin from a Christian family in North Africa.

COMPLETED CORE ASSESSMENT

4.2.42 The core assessment was formally signed off by Children's Social Care team manager (TM1) in mid-November 2011. It had taken approximately 3 months to complete. Risks and protective factors were comprehensively outlined and a decision made to proceed to a pre-birth child protection conference alongside a family group conference (FGC). Some so-called 'protective factors' were questionable e.g. mother's insufficiently tested claim to be drug-free and the absence of (detected) criminal offences whilst pregnant. There were also discrepancies in mother's accounts of the last time she had used heroin viz: 2 years ago according to DW3 but only 1 year ago according to other agency records.

4.2.43 A further issue that arose immediately after completion of the core assessment was that of a threatened eviction as a result of rent arrears, albeit there was a consensual view that mother need alternative accommodation to get away from the influence of other known drug users and to offer more space for care of a new baby.

4.2.44 Health visitor HV1 first became aware of the case in late November following notice from FGC1 (the family group conference co-ordinator) that a family group conference (FGC) was to be arranged. The purpose of a FGC is to provide an opportunity for a family to identify sources of support from within its ranks and from local services and in this case, to find ways of ensuring the baby's needs would be consistently met. HV1 had received no recorded communication from midwife, GP or the drugs worker and met mother for the first time at the forthcoming FGC.

4.2.45 It was reported that mother was gathering baby equipment for the imminent arrival. She failed though to attend an ultrasound appointment in early December and a further ante natal appointment 4 days later (possibly because she was viewing potential new accommodation). Mother's subsequent failure in mid-December 2011 to attend a further ante-natal appointment caused concern because her hepatitis C+ status meant that a liver function test was advisable. The delayed ultrasound was re-scheduled and upon its completion revealed nothing abnormal. Though no specific reason was noted, a letter was composed and sent to a neonatologist 1.

CONDUCT OF FAMILY GROUP CONFERENCE (FGC)

4.2.46 A well-attended FGC was held in mid-December. DW3 and midwife 1 were unable to attend and the birth father later explained his absence as work-related. Probation was *not* represented (mother had been resistant) but had provided a report from PO3. The availability of a Children's Centre, Housing Support and Home Start were discussed. Given the history of poor clinic attendance, HV1 agreed to visit every 7-10 days for 6 weeks after the midwife handed over 10-14 days following the birth.

4.2.47 A review FGC was planned for early March 2012 (though later cancelled at the family's request). SW1 within days questioned how much support the birth father was actually providing. At a further supervision of SW1 by TM1 the social worker's concern about insufficient family support was discussed. Contact with the paternal grandmother 'when she knows about the baby' was contemplated.

4.2.48 Just before Christmas 2011 'neonatologist 1' wrote to midwife 1 and advised mother's use of methadone should be included in her notes, the baby offered hepatitis B vaccine and that mother's blood needed to be tested ante-natally for hepatitis B and C. She also indicated the baby needed to be on withdrawal observations after delivery and there should be written assurances from Children's Social Care before discharge.

4.2.49 Following a discussion between SW1 and TM1 a decision was reached to initiate s.47 enquiries (Children's Social Care is obliged by virtue of s.47 Children Act 1989 to make enquiries if it 'suspects a child is suffering or is likely to suffer significant harm') with the possibility of convening a pre-birth child protection conference. On the same day mother was observed at her attendance with the drugs worker DW3 to 'look well physically, be bright in mood and less anxious'. Her urine test was negative to opiates and crack cocaine and mother denied any substance misuse.

PRE-BIRTH CHILD PROTECTION CONFERENCE

4.2.50 Invitations to attend were issued after Christmas to HV1, midwife 1, Connections Floating Support Service, SCAS, Police and Probation. A proposed home visit to meet parents together was thwarted by mother who also failed next day to attend a 'Floating Support' assessment. The pre-birth conference was convened on a date in early January 2012. DW3 was unable to attend because, according to Children's Social Care she had clinics that day (material submitted during the course of the SCR indicates that she was on annual leave). She *had* submitted a brief report to social worker SW1 which included a chronology of appointments. She repeated the misinformation that mother had not used heroin for over 2 years.

4.2.51 Other professionals who attended were the hospital midwife, a housing officer and PO2 and PO3. Police had provided a report of their checks. According to Children's Social Care records (though its origin is unspecified), the birth father had been planning to attend but did not do so because of a text from mother indicating she did not want him there. The conference was held only 5 days ahead of child H's birth and included mother. An earlier date would have ensured more time for planning and presence of DW3.

4.2.52 Independent chairperson 1 decided (with unanimous agreement) that the baby would at birth need to become subject of a child protection plan (for neglect). Mother remained at imminent risk of eviction. HV1 agreed to see mother and baby weekly at home for 4 weeks and then to review. HV1 at interview stated she had been aware that if there was evidence of increasing concern e.g. use of illegal drugs, failing health or other professional appointments the social worker would consider requesting authorisation for pre-proceedings i.e. legal intervention to be initiated.

4.2.53 At the pre-birth conference, SW2 from 'Family Support South' team was nominated to take over from SW1. On the same day, mother failed a further consultant clinic meaning no bloods were taken prior to the birth of child H.

4.2.54 At TM1's supervision next day of SW1, the latter was able to report that mother had re-homed some (unspecified) animals and there was no evidence of current drugs use. SW1's view was that the family were now more willing to support than they had been at the FGC in December. The approach agreed at this supervision session was that there should be a core group / discharge meeting held after the baby was born and that the case would be formally transferred to SW2 at that point.

4.3 PERINATAL PERIOD

BIRTH

4.3.1 The birth of child H in mid-January 2012 was relatively straightforward. Mother was supported by her own mother. Mother and baby remained in hospital and the baby observed for signs of drug withdrawal. No significant symptoms were noted and attending staff indicated mother was coping; changing nappies competently and beginning to express breast milk. Mother was asking for appropriate help and cared for her baby all day 'except for 6 cigarette breaks' and an occasion when mother had fallen asleep with the baby in her arms. Advice on the risks of 'bed sharing' was provided after the latter observation.

4.3.2 On a subsequent occasion mother insisted (contrary to advice from the midwife) on leaving her baby at the front desk whilst she left the building to smoke a cigarette. This episode illustrates the comprehensive record-keeping of ward staff as well as the fragility of mother's care for her baby.

4.3.3 The birth had occurred on a Saturday and the hospital social work team was alerted on the Monday. SW1 in turn alerted the Housing Department and as a result of the birth, the priority for re-housing mother became greater. SW1 also informed Probation of the birth. 3 days after the birth, mother texted the father of child H to inform him of the news and in a telephone conversation with SW1, he agreed to meet up with SW2 who would be accepting case responsibility.

4.3.4 During the remaining time in hospital, other medical interventions were initiated. Child H was given the first hepatitis B and routine vaccinations and at completion of the 'initial check' next day the examining doctor commendably noted the child should not be discharged until an ultrasound had been completed, an infectious disease referral made (hepatitis screening) and the planned conference next day concluded.

DISCHARGE FROM HOSPITAL

4.3.5 A discharge planning meeting (which also served as a core group meeting) was convened and minuted. Present were mother and baby, SW1, SW2, Connections Floating Support worker 1 and the hospital's safeguarding midwife. SW2 from Family Support South became case accountable from this point. Probation had been invited but neither PO2 nor PO3 were able to attend at such short notice and DW3 was on leave. GP1 received prompt and comprehensive confirmation of the various medical interventions as well as the fact that the baby was subject of a child protection plan.

CHILD PROTECTION PLAN

4.3.6 The plan agreed was for discharge next day and daily visits from community midwives for 4 days, then probation and housing officers over the following 3 days. Next day a consultant indicated that they would not process the hepatitis C blood test at the moment because a negative test could be misleading i.e. there remained a chance of manifesting a 'hepatitis C +' status for some time to come.

4.3.7 Mother and child H were as planned, discharged. A note from midwife 2 indicates that the patient was sent out with 'no care plan'. There *was* a lack of communication from the hospital to community midwives at discharge about the plan agreed.

4.3.8 Following the pre-discharge meeting a detailed care plan was documented in the child's hospital notes, but not written / transcribed into the discharge summary sent home with mother for the community midwives to follow. An entry in the electronic notes indicates that community midwives had a written plan, but there is no evidence for this in the maternity notes. This raises the possibility that the community midwife saw this information but it was not then filed appropriately. If that was so, the community midwives would not have been clear about what had been agreed, and what was required to care for and assess this vulnerable family.

4.3.9 Next day mother made what was her only visit to Children's Centre 1 and was provided with housing advice. On her registration form, mother acknowledged daily use of prescribed methadone. Mother and baby were visited at home over the next few days by midwives 2, 3 and 4 none of whom noted any concerns. Child H at 9 days old was discharged into the care of the GP Practice and HV1.

LEVEL OF MONITORING

Contacts in first month after birth of child H

4.3.10 HV1 and SW2 completed a joint home visit in late January 2012. Mother was mostly formula-feeding and still living in her 1 bedroom flat in a multiple occupancy house. She reported support from her own mother. A follow up visit was agreed a few days later. On the same day as the home visit, mother failed to attend an appointment GP5 for a 'pregnancy care' appointment and a message was left on her telephone.

4.3.11 GP1 did see mother and child at her Practice in late January and early February 2012 and DW3 saw mother briefly when she came to collect a script. At a further visit HV1 was told by mother that she was prop feeding child H (then less than 3 weeks old). The risks of choking were explained and she was reminded of the need to bring her baby for a second hepatitis B jab, postnatal checks and 6 week check. HV1 was also told child H's father wanted to meet his child and a rendezvous in town was planned. HV1 (who kept in constant touch with Children's Social Care throughout her period of involvement) made contact with SW2 and reported her concerns about prop feeding.

4.3.12 At a visit by HV1 and school nurse 1 about a week later, mother was again seen to be prop feeding. She was again reminded of the associated risks. HV1 planned to report the event to SW2 and provided mother with written advice. Because mother had overlooked the appointment her management of child H was probably closer to everyday practice than if she had been expecting professional visitors.

4.3.13 HV1's later call to SW2 spoke of mother's intention to meet child H's father and the advice given to do so in a public place because HV1 was 'unsure of his history'. During her meeting with DW3 later that day, mother's presentation was noted to be unchanged. She spoke of being tired, denied seeing old [and the implication was drug-using] friends, and made a reference to 'hearing things'. Her urine test was negative. The reference to auditory hallucinations was apparently not explored.

4.3.14 An attempted home visit by HV1 was unsuccessful and she informed SW2. Neonatal screening of child H at 1 month old revealed no concerns. In mid-February SW2 tried to advocate for more suitable housing. DW4 indicated in a call to Children's Social Care that the agency did not believe mother was using 'on top'.

4.3.15 An opportunistic visit was completed that day by HV1 who had been receiving no responses to calls to mother's mobile. Mother reported being unhappy about the very cramped accommodation and HV1 agreed to liaise with SW2 with a view to adding pressure to the Housing Service. HV1 also recorded that child H's father had visited. HV1 subsequently liaised with SW2 and directly with the Housing Service.

Contacts during second month after birth of child H

4.3.16 When her child was about a month old, mother consented and child H was given a second hepatitis B immunisation. Mother claimed she had forgotten the Personal Child Health Record (PCHR – often called the Red Book) and undertook to bring it next time. Child H was noted to look well. Mother failed her next SCAS appointment though was still collecting methadone from the pharmacy. At a further visit 5 days later HV1 noted mother was bidding for an alternative local property. A further visit a week later was agreed. In an email exchange on the same day as HV1's latest visit, SW2 reminded SCAS of an email sent 2 days before in which she had raised concern that mother had not provided a urine sample for 'some time now'. SW2 was informed that mother had failed today's appointment.

4.3.17 SW2 discussed the case next in supervision with TM2 and concerns were summarised. Child H (2 months old) was seen by GP5 for a routine 6 week examination. No concerns were noted about mother or child.

4.3.18 During a home visit SW2 was told that mother was spending a lot of time at her own mother's home. She alluded to the ongoing housing issue and promised to get a urine test completed. SW2 and FGC 1 liaised and the latter asked for the family's view on the now imminent review FGC. After referring to pressure from the local MP the Housing Service discussed with SW2 the options for re-housing. HV1 continued her efforts to get mother re-housed though her description of a 'recovering addict' (when she was actually on a maintenance dose of methadone) was a little optimistic.

DRUG MONITORING DURING SECOND MONTH AFTER BIRTH OF CHILD H

4.3.19 Mother had completed a urine test in late February 2012 which was negative to opiates, crack cocaine and benzodiazepines. The agreed child protection plan had stipulated she should attend Drug Service appointments and produce urine for screening *weekly.* In fact 1 month later the documented plan of DW3 (to whom conference minutes had been sent) had become to review mother every 2 weeks and carry out *random* sampling. There was, in consequence a distinction between the formal child protection plan and the actual service provided.

4.3.20 By February 2012 the floating support worker had been replaced. By March, mother was apparently managing well and had told FGC1 that she had enough support and there was no need for a further conference.

4.3.21 Mother failed to bring child H to see the paediatric infectious diseases consultant in March. A further appointment was made for April and also failed. In response to her contact with Children's Centre 1, the manager commendably made 4 follow-up calls. She made a 5th final call in March and heard nothing more until learning of mother's move which placed her in the catchment area of Children's Centre 2.

CORE GROUP 2

4.3.22 In mid-March 2012 (child H 2 months old), a second core group was convened (the plan had been 6-weekly meetings). Though no minutes have been seen by the author, it is reported those present were SW2, HV1, PO2 and housing officer 1 i.e. DW3 did not attend. Reference was made to a 'Connections' worker who would help with grants and financing for a new property. SW2 referred to the negative urine test the week before and spoke of progress and a 'better relationship with her parents'.

4.3.23 It was reported that alternative accommodation was expected soon. Child H's father was, according to mother, having limited contact. Mother agreed to bring her child for the first primary immunisations and to be weighed a week later. She failed both appointments and HV1 immediately emailed SW2 to inform her.

4.3.24 At supervision session in late March provided by TM2 to SW2, mother's progress was noted but it was agreed that there was a need for continuation of the protection plan and that this would be recommended at the review conference in April. A change of social worker was also planned because SW2 was about to begin her maternity leave. SW3 would become the case accountable social worker.

4.3.25 SW2 was informed by PO3 that mother was at risk of being 'breached' by Probation for missing 2 appointments. A third such failure would trigger action (in fact mother failed to attend her next 3 appointments and managed to avoid being breached).

4.3.26 Child H (2.5 months old) received the first set of primary immunisations in late March. A home visit by SW2 a couple of days later noted the accommodation to be chaotic because mother was packing up to move. Child H was 'fine'. The move to new accommodation was imminent. It is now thought likely that mother was still involved in class A drug dealing at this stage.

REVIEW CHILD PROTECTION CONFERENCE

4.3.27 The review conference in early April 2012 noted progress but also the missed drugs testing appointment and a reluctance to engage with the Probation Service 'thinking skills' course. Mother's lack of organisation was attributed to her living arrangements, though the connection is not obvious. It seems more likely that it was intrinsic, albeit worsened by insufficient space and unsuitable neighbours.

4.3.28 PO3 was unable to attend though had shared her view with SW2 that child H should remain subject of a plan. Police were not represented though a fax of contacts with mother was sent in advance. It excluded any information from intelligence reports.

4.3.29 DW3 also sent her apologies though had provided the social worker with an update. Others who attended included mother, Connections support worker, SW2, SW3, HV1 and a student social worker. HV1 undertook to make one home visit after Easter Monday to the new home and then ask her to attend the clinic with child H once a month. Clearly verbal updates carry a higher risk of misinterpretation and mis-recording than written briefings. This may have been an early indication of HV1 removing mother from 'health visiting partnership plus status'.

4.3.30 The decision was made that child H (then nearly 3.5 months old) should (justifiably) remain subject of a child protection plan. The GP Practice was informed promptly. At DW3's next contact with mother, her urine test provide negative to all but prescribed methadone. On that same day mother failed to bring child H for his further hepatitis B immunisation. Messages were left for mother to call and re-arrange an appointment and a further appointment for May was offered.

4.3.31 HV1 made a home visit in mid-April 2012 and once again mother 'had forgotten'. The home was noted to be clean and tidy and mother said she was well and was 'happy' to see HV1 at the Health Centre monthly.

FURTHER CHANGE OF WORKER / FAILURES TO PRESENT CHILD H AT CLINIC

4.3.32 By late April 2012 child H received the 3rd hepatitis B and 2nd DTP, polio and Hib. immunisations and the 'Red Book' was updated. A further (negative) test of mother was completed and DW3 (by then employed in the 'Harm Minimisation Service') was told by mother of her new social worker SW3. A planned child protection visit by SW3 found the new home to be clean and tidy with child H clean and well dressed. SW3 was assured by mother she had taken her child to health visitor appointments.

4.3.33 A couple of days later DW3 raised the subject with mother of reducing the level of supervision of methadone use. DW3 suggested waiting to discuss this possibility at the scheduled core group.

4.3.34 For the third time mother failed to bring child H to infectious diseases consultant 2 and a further appointment was made for late May. A letter was sent to the GP highlighting missed appointments and follow-ups. A further letter from this consultant asked…'if you have any safeguarding concerns about this child in view of these recurrent DNA ['did not attends'] would it be possible for you to inform us ?'. It is uncertain whether GPs had been informed prior to this, of failed appointments.

4.3.35 At a meeting of DW3 mother and child H at the Practice, mother claimed previous drug-using associates did not know where she lived and that she wanted to keep in that way; she had not been attending the Children's Centre because she was 'too busy'. In fact, mother never attended a Children's Centre with child H.

CORE GROUP 3

4.3.36 In mid-May 2012 SW3, HV2 and DW3 held a further (minuted) core group meeting with mother at the Health Centre. Mother's compliance with health appointments was noted to be 'good' and drugs tests had all proved negative. Mother asserted that some of her drug and Probation appointments had been clashing. SW3 agreed to visit at fortnightly intervals and DW3 agreed to meet with her every other week and to liaise with Probation to ensure no conflicts in the times of appointments. Mother reaffirmed her agreement to attend monthly the child health clinic.

4.3.37 The rating of 'good' overlooked the hepatitis C issue as well as the less than planned frequency of testing. Arrangements subsequently negotiated between the Harm Minimisation Service and Probation reflected good inter-agency working.

EPISODE OF ILLNESS / ONGOING MONITORING

4.3.38 In mid-May 2012 mother presented child H (5 months old) at an out of hours Minor Injuries Unit (MIU) because of diarrhoea and vomiting. Commendably, the MIU discerned that child H was subject of a protection plan and agreed to examine him. The follow-up up 3 days later by GP1 also represented good practice.

4.3.39 As a result of revised reporting arrangements agreed by mother, Harm Minimisation and Probation, the proposed 'breach action' was withdrawn. A planned home visit by SW3 in late May 2012 had reportedly been overlooked by mother who nonetheless allowed her in. Child H was noted to be well cared for and the home in good condition. Mother confirmed that Probation and drugs appointments now alternated. DW3 met mother at the Practice next day and recorded no concerns about mother or child. On the same day mother reported early to PO3 and left before being seen. She then put the phone down on a follow-up conversation by PO2.

4.3.40 2 days later HV1 was informed by a GP about mother's ongoing failure to bring child H for screening. She followed this up with calls to mother and maternal grandmother. The latter said that she had been providing and would continue to offer support. This professional exchange was a rare example of documented GP / health visitor liaison.

4.3.41 HV1 completed a lengthy home visit in late May. Daily routines were discussed and mother was offered contact details / literature about a Home Start Family Group and a 'baby group' on the local estate. HV1 followed up immediately with a phone referral to Home Start for child H (aged 4.5 months). Next day, GP1 was again alerted to mother's failure to bring child H for a hepatitis C screen (a further appointment had been offered for June). Reasons for the persistent failure to attend were sought from the GP Practice. No response to that enquiry has been found.

4.3.42 Toward the end of May routine immunisations were administered in the GP Practice by its nurse. On the following day, at what was a regular supervision session of SW3 with TM2 mother was noted to have made 'good progress' though her loneliness following her house move was acknowledged. It is unclear whether further discussion between HV1 and SW3 took place before or after the latter's supervision.

4.3.43 In early June DW3 observed nothing remarkable about mother's interaction with child H. She noted they had spent the weekend with maternal grandmother. Mother denied any substance misuse and her urine screen had not revealed 'on-top' use.

BREACH OF COMMUNITY ORDER & ONGOING MONITORING

4.3.44 At a home visit in early June 2012 6 month old child H appeared well. Mother reported feeling 'low' and was considering reducing her methadone prescription. She reported she was due in court for failing to sufficiently comply with her Community Order. This fact and a court date in late June was subsequently confirmed by PO3. During that week the Home Start worker asked (helpfully) that she be included in future core group meetings. Unfortunately she was unable to attend the July meeting.

LIAISON INITIATED BY PROBATION

4.3.45 In mid-June 2012 having tried to contact her by phone over the previous days, PO3 emailed SW3 and shared her concern about mother's persistent failure to attend appointments. Mother was to be breached and was due in court toward the end of the month. Mother failed to appear at the court and the case was adjourned until early July (at which time she pleaded not guilty).

4.3.46 A few days later mother failed a promise to return in order to provide a urine screen. Mother also indicated that she would be unable to attend the core group scheduled for the following day. In fact, because of illness amongst the involved professionals the planned meeting was anyway postponed. HV1 anyway reminded mother of the need to bring child H to the clinic the following week and was told that the time / date conflicted with a court appearance but that she would, via her solicitor, try to award priority to the medical appointment.

4.3.47 PO3 made further attempts to obtain updates from DW3 and SW3 in early July. In a phone exchange DW3 confirmed she had not seen mother for about 4 weeks. PO3 left at least 2 messages with SW3 before eventually obtaining from her the view that all was well. The date for the postponed core group was discussed and SW3 indicated that this would offer an opportunity for an open discussion by involved agencies with mother present.

4.3.48 A planned visit by SW3 had proceeded albeit mother claimed that she had forgotten it. The flat was clean and child H (7 months old) appeared well. At her supervision next day SW3 reported child H was 'developing well' and that mother's tests were clear. The only negative issue specified was her breach of the Community Order.

4.3.49 Mother failed an appointment with DW3 in mid-July but feedback from her and other involved agencies e.g. Connection Support suggested that mother was managing without 'on-top' use of illicit drugs. In mid-July mother was though suspended from a substance misuse group because of failure to attend.

CORE GROUP 4

4.3.50 The 4th core group meeting was convened at mother's home in late July. It included Probation but not HV1 or a representative from Harm Minimisation. Mother's engagement with most agencies except Probation was considered satisfactory. A few days later mother again failed to bring child H to the infectious diseases clinic and a further opportunity was provided for September. Mother continued to fail to attend appointments with PO3 through the Summer and once again this professional tried hard to obtain an update from SW3.

4.3.51 At an appointment with DW3 in early August 2012, records confirm (for the first time) that safe storage of methadone was discussed. The worker was leaving and left 'several messages' for SW3 with a view to a briefing. She received no response. Children's Social Care records neither confirm nor explain why messages from her and the probation officer were overlooked or ignored.

AGENCIES' SUPPORT OVER SUMMER / AUTUMN 2012

4.3.52 HV1 made an unannounced home visit in early August 2012 having had no reply to several messages left on mother's mobile. She noted how thin mother was. Because a friend was present, HV1 postponed until an agreed visit a few days later, discussion about the failure to take up hepatitis C screening. Child H (nearly 8 months old) was noted to be clean and appropriately dressed. At her follow-up HV1 advised on an imminent need for stair gates. She also drew mother's attention to the 4 missed screening appointments. Mother asked for a text reminder the day before her next appointment. HV1 observed mother was loving and attentive with child H and she provided advice about how to meet developing needs for socialisation.

4.3.53 In mid-August 2012 SW3 completed what had been a planned visit (once again mother claimed to have forgotten it). Mother said that she was engaging with Home Start and was due to attend an event next day. Mother reported that the involvement of Connections was ceasing because financial issues were now sorted.

4.3.54 At her (regular) supervision session in late August 2012 SW3 recommended that child H no longer required a protection plan. She reported that the child was developing well; the home was clean and tidy and that 'Home Start was involved' (the latter assertion was uncorroborated). At a further child protection visit at the end of August SW3 learned that mother and child had not attended Home Start because (mother said) it had been raining. She also indicated that she no longer wished to use Home Start and preferred to depend upon her own mother for support. SW3 noted that because she was between drugs workers, the GP Practice was directly prescribing mother's methadone. What would have been a 5th core group on the same day was abandoned for lack of any representation by involved agencies, the (unjustified) rationale being that the review conference was anyway imminent.

4.3.55 In mid-September, SW3 (who described a positive picture of mother and child H's progress) provided Probation with a supportive letter to inform the imminent court hearing. DW3 also had a phone contact with mother who reported no problems. GP3 saw mother at this time and records spell out clearly the agreed arrangements for her collection and consumption of prescribed methadone. On the same day mother again (for the 5th) failed to bring child H to hepatitis C screening.

4.3.56 Breach proceedings were withdrawn as not being in the public interest. The Probation Service attribute that decision to a positive report of progress from SW3.

4.3.57 Following the 5th failed appointment, infectious diseases consultant 2 phoned HV1 to discuss his concerns. Later that month the clinician's records refer to that conversation and note 'a chaotic family…and a further outpatient appointment to be offered when child H is 15 months old'. The doctor followed up with a letter to GP1 in which he confirmed the conversation with HV1 and asked that mother be supported to get her child screened for the estimated 1:20 chance of being hepatitis C +.

4.3.58 Though in essence a parental choice, the expert advice was to undertake screening. The fact that child H had been defined as in need of a protection plan might have prompted a discussion about the justification for an application for a Specific Issue Order under s.8 Children Act 1989.

REVIEW CHILD PROTECTION CONFERENCE

4.3.59 The report drafted by SW3 for the September 2012 review conference (child H then 9 months old) recommended that there was no ongoing need for a child protection plan. The conference was attended by mother, SW3, HV1 and a Connections support worker. Neither Thames Valley Police, Probation nor the Harm Minimisation Service (DW3 had by then left) were represented. The former had sent in a copy of 'checks' prior to the meeting. HV1 at this conference shared what later transpired to be misinformation about mother attending the Children's Centre once a week.

4.3.60 The independent chairperson concurred with the social worker's recommendation (which was also supported by the other 2 professionals in attendance) and the case was stepped down to 'child in need plan' status. On the basis of the evidence available to the conference, that was a reasonable and proportionate decision albeit one that in hindsight can be regarded as insufficiently informed. The GP Practice received an immediate notification of the decision made.

REDUCED LEVELS OF CO-OPERATION WITH PROFESSIONALS

4.3.61 SW3 also emailed Probation to inform that agency of the change of status and to confirm the remaining period on the Community Order. Throughout September and October mother failed to attend most of her appointments with PO3. In early October 2012 HV1 made telephone contact with mother who reported that she and child H were well. Mother agreed to being sent information about Children's Centre activities. A home visit was agreed.

4.3.62 In mid-October mother used as an excuse for non-attendance at the Children's Centre, having been on holiday with her own mother (a similarly unconvincing excuse was offered to explain her unavailability for the last 2 weeks of October).

4.3.63 Mother continued to miss Harm Minimisation appointments (DW5 was by then the allocated worker). At an appointment with GP6 it was noted she had also failed to comply with prescribed post-natal anti-coagulant medication.

CHILDREN'S SOCIAL CARE CASE CLOSURE

4.3.64 At supervision in mid-October 2012 TM2 and SW3 agreed the case could be closed. They noted an appointment was in place for the required medical screening and that HV1 and a drugs worker remained involved. A 'team around the child' (TAC) was not considered necessary. Given 5 failures by mother to present her child at the clinic, the fact a 6th was on offer some months later offered no genuine reassurance. The judgment to close the case was, based upon the available evidence, premature.

4.3.65 HV1 failed to get a response to a planned home visit (mother had 'forgotten'). She agreed to call next day when again mother 'forgot'. Mother agreed to bring child H (10 months old) to the clinic next day and when she failed to arrive was phoned. She claimed to be 'en route' but did not appear. Mother was also failing appointments with her drugs worker at this stage. This level of disorganisation and/or apparent deceit seems likely to have been of relevance to her ability to organise care of child H.

4.3.66 By late October HV1 pointed out to SW3 that mother had not been tested for illicit substances since the beginning of August. The social worker subsequently visited though no notes of that visit have been provided. Although *not* shared at the time, information held by the Police suggests mother had considerable debts, was 'dealing' throughout the period of review and (presumably in exchange for money) may have been smuggling drugs into prison for a friend / associate.

4.3.67 PO3 consulted her 'legal proceedings manager' in late October 2012 because mother was again in breach. A view was formed that there was little purpose in taking formal action because:

- The Order itself was due to end in mid-November
- There had already been 3 attempts to breach mother
- The current Order was itself a function of previous breaches (with originating offences now old)
- Options were anyway limited to revocation or a re-sentence

4.3.68 Nonetheless at the end of October 2012 the court was asked and did revoke the current Order and imposed a new Community Order to include a curfew requirement for 4 months. No ongoing supervision was included. Messages were left for SW3 to update her on this which represented the end of Probation Service involvement.

ONGOING INVOLVEMENT OF HEALTH VISITING & HARM MINIMISATION SERVICE

4.3.69 HV1 became aware and concerned about the proportion of mother's failed appointments and commendably initiated contact with DW5. It was agreed that if mother failed her next session with DW5, he would alert SW3. Mother failed a health review appointment with the health visitor scheduled for later that day (having been reminded by phone at which point she said she 'would be there in 10 minutes').

4.3.70 HV1 made contact with SW3 and shared her concerns. SW3 agreed to follow up with a visit and let HV1 know the result.

SHOPLIFTING AT THE PHARMACY & FOLLOW-UP OF CONCERNS BY SW3

4.3.71 Though the report of it was received a few days later, in late October 2012 an incident occurred at the pharmacy where mother collected her methadone. Mother had apparently been caught shoplifting there some 3 weeks previously though no action had been taken. On this occasion she was spotted via CCTV to be stealing. When confronted by the manager, mother could not remember the incident because she had 'taken diazepam'. The pharmacy manager was rightly concerned for mother's child though had not alerted Police, Children's Social Care or health visitor at the time. The pharmacist *had* notified GP2 and DW5, neither of whom took any further action in response. A recommendation about this is included in section 7.

4.3.72 At an unannounced home visit by SW3 at the end of October 2012 mother claimed she had been staying at an aunt's mobile home for the last 2 weeks and that her mother had been with her. She indicated she was due in court today for breach of her Community Order and agreed to a urine test 2 days later; also to take child H for an 8 month developmental check 'if she had time' after her court appearance.

4.3.73 Mother's claims as to whereabouts in the previous fortnight conflict with HV1's records and with closed circuit television (CCTV) evidence of her shoplifting. SW3 would not have known about the pharmacy incident but could potentially have recognised and challenged mother's fabricated story (reported to her by HV1) of having been 'on her way' to the clinic. Sensibly, SW3 told mother that although her case had been due to close, it would remain open because of her failing appointments. SW3 subsequently emailed HV1 the results of her home visit.

4.3.74 Mother failed to appear for the urine test and DW5 relayed this in a message to SW3 and asked her to contact him. TM2 responded and deployed a duty worker to undertake an unannounced visit. SW4 visited later that same day. Mother arrived home in a car driven by an unknown man (whom she named). She sought to explain the incident in the pharmacy by explaining that she had bought 25mg of valium from a friend because she had fallen out with another friend on the day in question.

4.3.75 Mother said she would like to return to weekly testing. Child H was noted to be 'well attached' and home conditions gave no cause for concern. SW4 emphasised the importance of remaining 'emotionally available' to child H. Issues of mother fabricating her whereabouts, misuse of valium and avoiding agreed tests were not pursued. Child H received the overdue developmental assessment when 10 months old. Nothing of concern was reported at what was HV1's final face to face contact. Later that week mother attended her appointments with DW5.Though challenged she denied any on-top use except for diazepam the day she had stolen.

4.3.76 There was a significant level of liaison and information exchange at this time between HV1, SW3 and DW5. Concerns about her non-compliance with drug workers remained and DW5 was concerned that mother might have relapsed. There were also acknowledged positives such as the interaction of mother and child and the fact that both appeared well. In addition, child H was always well turned out.

RENEWED PROSPECT OF CASE CLOSURE BY CHILDREN'S SOCIAL CARE

4.3.77 A week later when SW3 received her monthly supervision, TM2 decided that after 2 further unannounced visits and, subject to compliance with DW5 contacts and clear urine tests, the case could be closed. Next day, mother failed her appointment with DW5. Information held by the Police though not shared at the time, indicated that mother was continuing to be involved in drug dealing in Autumn 2012.

4.3.78 Mother's further failures to attend Harm Minimisation appointments were shared with HV1 and SW3. In mid-November 2012 a duty social worker SW6 made an unannounced visit to check on why mother had failed her latest appointment with DW5. Mother was not in and later claimed she has been unwell on the day in question. She agreed to attend the next weekly appointment.

4.3.79 Mother finally attended an appointment and her urine test proved negative to anything except methadone. She was reminded of potential support from OASIS and that the agency was liaising with Children's Social Care and Health Visiting Services. Weekly appointments ensued and all completed tests were negative. Mother indicated she would like to start reducing her dose in the New Year.

4.3.80 By early December, mother reported that as a result of her shoplifting she was now obliged to wear an electronic tag (her curfew was 8pm-6am). She also reported attendance at appointments with DW5. SW3 told mother that unannounced visits would continue for the moment.

ARREST FOR SHOPLIFTING

4.3.81 In early December 2012 mother was arrested for earlier shoplifting (nappies) and received a Police caution[5] . She claimed to have stolen because she had had no money and reported (inaccurately) that she was on 60 mls per day of methadone.

4.3.82 On the day after her arrest she failed an appointment with DW5. By mid-December SW3 was again reporting to supervisor TM2 that the case was 'settled', that mother was doing well and engaging with DW5 (actually an appointment the week before had been failed). The hope was that a team around the child (TAC) could be put in place after Christmas when mother's does of methadone could begin to be reduced.

4.3.83 On the same day, DW5 met mother and re-emphasised the importance of appointments. Mother agreed to use 'Open Access Social Inclusion Support' (OASIS), though did not do so and also failed her first appointment with DW5.

4.3.84 At an announced visit by SW3 early in January 2013 child H was noted to be well and able to crawl and stand against furniture (the increased mobility would have represented additional pressure on mother). Mother reported (inaccurately) that they went to the Children's Centre every 3 weeks and went out to town most days. Mother was again told that once she engaged with professionals for a period, her case could be closed. By late January, mother's pick-up of methadone was changed to 3 times weekly and she was told this could continue for as long as there was no evidence of 'on-top' usage. Safe storage was again discussed. It was noted that mother had not used OASIS. A reduction to 80mls of methadone per day was discussed.

CHILDREN'S SOCIAL CARE CASE CLOSURE

4.3.85 At her supervision session in late January 2013 SW3 referred to the likely agreement of HV1 and DW5 that the case be closed. Confirmation of their views was subsequently sought and obtained by SW3, albeit DW5 qualified his agreement by suggesting further monitoring before case closure. Neither expressed the view that a team around the child (TAC) meeting was required in advance of case closure.

4.3.86 At the beginning of February 2013 the case was formally closed. Mother presented child H (13 months old) for further routine immunisations in early February. DW5 and mother agreed to reduce mother's methadone dose by 5mls later that month. Safe storage was again emphasised. At her appointment in late February mother, who had provided a negative urine sample, said she no longer wished to reduce her methadone.

[5] A Police caution is a non-statutory disposal for adult offenders and offers a means of dealing with low level, mainly first-time offenders when specified public interest and eligibility criteria are met (Ministry of Justice 'Simple Justice for Adult Offenders' p.4)

MOTHER'S FURTHER ARREST & LIAISON FROM DW5

4.3.87 In mid-March 2013 mother was arrested for breach of her Community Order and failing to report. She indicated she had left her child in the care of an elderly male who could provide good enough care during the day but not overnight.

4.3.88 Mother postponed an appointment with DW5 reporting she had breached tagging conditions and was in court. A few days later the GP Practice was informed of a presentation of child H (15 months of age) by his mother to the minor injuries unit (MIU). The records suggest that the child, whom mother reported had been ill with a raised temperature all day *may* have suffered a febrile convulsion. DW5 emailed Children's Social Care to confirm that mother was testing clear and being moved to weekly screening. Because the case was closed, the email was regarded as 'for information' only. The need for a more precise system to ensure an informed response to incoming information on closed cases is provided in section 7.

ONGOING SUPPORT FROM HARM MINIMISATION & UNIVERSAL HEALTH SERVICES

4.3.89 In late March and into April 2013 mother continued to insist she was not using un-prescribed drugs. Records confirm safe storage of medication was again emphasised. Mother readily referred to the incident when child H might have 'fitted' and had apparently ended with him being seen at the local hospital.

4.3.90 Mother's then weekly urine test proved negative. She remained on 3 times a week collection. Mother told DW5 she was taking 16 month old child H to a toddler group once a week. No evidence was sought or been located since to confirm this claim.

ARREST & FURTHER FAILURE TO ATTEND SCREENING APPOINTMENTS

4.3.91 Mother was arrested in early April for theft and later pleaded guilty. The date was close to the occasion on which she was observed buying crack cocaine. She was also questioned about other thefts and it is likely she continued to shoplift at various locations after her conviction and sentencing to a 2 year Conditional Discharge. Some activities took place at night raising questions about who was caring for child H. Children's Social Care was not notified of mother's arrest or its outcome

4.3.92 HV1 phoned mother and was reassured that she and her child were managing. Mother claimed she was taking child H weekly to the Children's Centre (though never took him there at all). Mother once again failed to bring her child for the latest appointment in mid-April 2013. Infectious diseases consultant 1 notified the GP Practice and offered late April as a further opportunity. The consultant also asked whether HV1 might actually bring mother and toddler to the clinic and wrote …' I would be very grateful if either the health visitor or GP surgery could let us know if there are any child protection concerns affecting this family'. No response was provided to that request.

4.3.93 As well as missing the screening appointments, mother continued to be unreliable about meeting DW5. She was though *very* reliably collecting her methadone. At the point that she had missed 3 appointments in a row, DW5 asked the dispensing pharmacist to relay to mother that there would be no more prescriptions *until* she attended an appointment.

4.3.94 In spite of the position adopted by DW5 and confirmed in writing, mother failed to appear for her next appointment. However, she presented some 5 hours after her appointed time and tested positive only for methadone. Mother was 3 hours late for her next scheduled appointment in May 2013 and again tested positive only for methadone. She reported that she was managing well and had not needed to seek support from OASIS. In spite of advice that she should not rely solely on prescriptions, she wished to remain on 70mls per day of methadone.

4.3.95 Toward the end of that month mother was again caught shoplifting and using the buggy of child H as a means to hide the stolen goods. There is no record of an arrest on this occasion and no notification was sent to Children's Social Care.

4.3.96 Mother missed 2 Harm Minimisation appointments in June 2013 and was offered (via the pharmacy) the chance to meet on a third date that month. A letter was sent to warn her no further prescriptions would be issued *unless* she attended. When finally seen, mother admitted to using crack cocaine 3 times over the last 2 months. DW5 notified SW3 and HV1 though received no response from Children's Social Care where the information was treated as 'information only'. Mother told DW5 she was taking her son to a local commercial play centre. It is not possible to verify that claim. DW5 did not ask where child H may have been when mother was using cocaine.

4.3.97 At her next appointment, mother denied any further use of illicit substances and wanted to remain on her current dose of methadone. She failed in July to present child H at the clinic and another appointment was booked (and failed) in August.

ARREST FOR BURGLARY & CHILD H'S OVERDOSE

4.3.98 In early July 2013 mother was arrested on suspicion of a burglary. Though it appears likely (from a number of associated events known to Police at this time) that she *had* committed the offence, there was insufficient evidence for Police to pursue the case.

4.3.99 At her July appointment mother was still denying any 'on-top' usage and her urine tests confirmed only methadone. She had lost a further kilogram and was advised to consult her GP. HV1 was informed in mid-July that although referred in late May, mother had not attended any Home Start sessions. A further appointment with DW5 later that month revealed that mother had lost a further kilogram which might have been an indicator of a health problem and/or drug misuse. Mother again claimed to be taking child H to a toddler group. Mother failed further Harm Minimisation appointments in August (though continued to collect her methadone reliably) and was again told that further prescriptions depended upon her compliance. By late August DW5 discussed his concerns with HV1. She noted his intentions to return to a daily pick up routine and to notify Children's Social Care of the latest situation.

4.3.100 HV1 was then notified of the latest failure to bring child H (20 months of age) to the infectious diseases clinic (in spite of the HV1 reminding her of it) and provided the clinic with contact details for Children's Social Care.

4.3.101 DW5 managed to make contact by phone about a week later and also reminded mother of what he described as 6 (it is thought there were as many as 8) missed appointments for hepatitis C screening. At her last session with DW5 before her child's overdose, mother revealed that she did not want her child tested but would let the health visitor know if she changed her mind. Mother remained on daily pick-ups at this point. Child H's accidental overdose occurred in mid-September 2013.

5 ANALYSIS

5.1 INTRODUCTION

5.1.1 Each element of the terms of reference for this SCR is addressed below.

5.2 HOW WELL WERE PARENTAL VULNERABILITIES & THEIR IMPACT ON PARENTING CAPACITY IDENTIFIED?

- How well were issues of substance misuse and any other vulnerabilities e.g. domestic abuse, financial circumstances, parental mental health, parental conflict and unstable accommodation assessed and understood?
- What were the key relevant points / opportunities for assessment and decision making in this case in relation to child H and his family? If opportunities were missed, why were they?
- Do assessments and decisions appear to have been reached in a timely, informed professional way to include an assessment of the impact these decisions made?

SUBSTANCE MISUSE / IMPACT ON PARENTING

5.2.1 Because she had had no recorded communication with the midwife, GP or Harm Minimisation Service HV1's opportunity for comparative assessment post-birth was significantly limited; no robust assessment of vulnerability was undertaken and no written reports submitted to child protection conferences as required by the Trusts' safeguarding children policy (prior to child H's birth and throughout the review period, HV1's clinic was short of 10 hours per week of health visiting time).

5.2.2 Mis-information provided at the initial conference that mother had not used heroin for over 2 years provided a false sense of mother's stability. Though HV1 liaised well with Children's Social Care, an 8 month delay in forging a partnership with the Harm Minimisation Service was rooted in that reassurance. It was also a result of insufficient awareness of the effects of cocaine, and a surprising opinion that any drug use and related behaviour was the remit and the responsibility of the drug worker, *unless* there was an observed impact on a child.

5.2.3 HV1 (and others) accepted missed appointments as reflecting mother's disorganisation. The implications for child H should have been considered more and self-evident deceit challenged. DW1's records demonstrate concern and recognition of vulnerability and when mother's pregnancy became known, the impacts of heroin and crack on the developing foetus *were* discussed. DW2 utilised the expertise of the pharmacist and Oxford Health NHS Foundation Trust's IMR confirmed that at interview, all staff demonstrated more understanding of mother's vulnerability than that seen in records. Vulnerability of child H was inadvertently increased by an unjustified readiness to accept information from mother e.g. attending midwifery and probation appointments.

5.2.4 DW3 had direct knowledge of mother's history and her considerable progress since the birth of her first child. This reduced the level of concern though DW3 remained aware of and addressed the risk of relapse in pregnancy. Because mother's engagement with DW3 was better than with colleagues it enabled a greater exploration and risk analysis to take place.

5.2.5 DW5 had not familiarised himself with mother's history, accepted her failure to attend appointments as commonplace and was reassured by her compliance with methadone pick-ups. He did not identify the distinct decrease in engagement following taking over the case. The absence of representation from the SCAS / later Harm Minimisation Service at either child protection conference was an obstacle to optimal multi-agency working.

5.2.6 All of the Police staff in contact with mother were aware of her long standing struggle with illegal drugs and understood this motivated her offending. Few believed the situation represented any significant risk to child H or required a referral to the Police 'Protecting Vulnerable People (PVP) Referral Centre. More extensive research could have alerted officers to the fact that, for some time, child H was subject to a child protection plan. That knowledge would have raised the level of concern. PO2 did raise concerns with Children's Social Care and SCAS (the provider which later became the Harm Minimisation Service) about 'gaps' in periods when mother should have been being tested regularly as part of the child protection plan.

5.2.7 Mother's wish to parent this child and become drug free were taken seriously by Children's Social Care, and Care Proceedings were not considered necessary because of the perceived change and support from wider family. Mother had reported using crack cocaine pre-birth and was reticent to consider a rehabilitation centre, which might have suggested a higher incidence of drug reliance than was being presented. Her then housing situation was regarded by social work staff and mother as heightening the risk of drug use.

5.2.8 The risks of drug relapse were well recognised and understood though agencies involved assessed (on the basis of partial information) that mother was managing to remain drug free, despite her apparent lack of co-operation at times.

5.2.9 Antenatally, appropriate referrals to Children's Social Care, to addiction and smoking services, health visitor and Connexions were all promptly made. It was also clearly identified that her accommodation was not ideal, but that she 'would be moving shortly'. No financial difficulties or conflicts within the family were identified, and her support network was identified as parents rather than a partner. Thus vulnerabilities were very thoroughly assessed and appropriate action taken to involve relevant agencies to support mother. No mention was made of mental health issues (which might imply this was thought of and no concerns were identified) and there is an almost complete absence of any comment about her partner.

5.2.10 Appropriate plans were made (with input from hospital social workers) for the baby to be observed in hospital after birth and mother seems to have been well-informed about the medical risks to child H of her drug use, and why the new-born baby needed observation in hospital. It was recognised that mother had not looked after a baby before and detailed notes written by the midwives demonstrate that mother's ability to complete baby routines was carefully observed.

5.2.11 Hospital care therefore included thorough assessment of mother and child's needs, recognition of the various vulnerabilities, and good liaison with Children's Social Care leading to a robust discharge plan. There was some poor communication about that plan from the hospital to community midwives at discharge.

5.2.12 From the age of 3 months to 15 months child H was not brought to numerous appointments (which were always re-booked). There is little evidence that the relevance of mother's substance misuse to these missed appointments was considered, possibly because the medical risks to child H of missing the appointments were relatively low. Levels of concern were not high and the wider picture of what was going on in the child's life was not considered.

5.2.13 It was not clear from the records who had overall control of prescriptions and responsibility for when mother did not attend appointments. Interviews conducted by the Oxford Health NHS Foundation Trust IMR author clarified the position and explained that some of the allocated drugs nurses were authorised to prescribe methadone and some were not (in which instance the responsibility reverts to the GP as it did during the period when no drugs nurse was allocated).

OTHER VULNERABILITIES / IMPACT ON PARENTING

5.2.14 HV1 had been alert to the negative impact on mother and child of their cramped accommodation which they were obliged to share with other substance misusers and actively lobbied the housing department for alternative accommodation. Her administration of specific questions recommended by the National Institute for Clinical Excellence (NICE) to assess mental health in pregnancy and in the post natal period was tardy. The Healthy Child Programme stipulates that this it should be done when a child is 6-8 weeks old but child H was 10 months old before its completion. An absence of any concerns about mental health following mother's move to her new accommodation in the context of workload explains why.

5.2.15 HV1 *was* sensitive to the possibility of domestic abuse and (based upon the history shared with her at the initial conference) had urged mother to take precautions when meeting with the father of child H. From a Probation perspective, mother's several convictions for theft (shoplifting) were indicative of having to fund drug use and she had previously had significant rent arrears. The cost of all travel to and from Probation reporting appointments was helpfully met by Probation.

5.2.16 Mother was not identified as being in a relationship during her period of supervision, nor regarded as having any mental health issues. Attempts were made to involve the father at an early stage without fully understanding the risks he might have posed. Mother was initially unaware that the father *was* being contacted and both individuals subsequently disguised their contact from professionals. Concerns about the father of child H were not recognised until Police intelligence was shared with the child protection conference chairperson.

5.2.17 There is no evidence in GP records about financial circumstances, parental conflict, domestic abuse or accommodation, none of which would routinely be recorded within a patient's GP records unless the information was given directly by the patient or from a third party e.g. a health visitor. Such information would have been useful in building a better picture of the home situation and was potentially available had the GPs been more involved.

KEY POINTS / OPPORTUNITIES FOR ASSESSMENT / DECISION MAKING?

5.2.18 The opportunities for assessment / decision-making by **Health Visiting and Probation** services may be highlighted as follows.

Ante-natal period

5.2.19 Midwives and health visitors are expected to communicate so that vulnerable clients recognised ante-natally can receive a targeted visit by the health visitor. In this case, information exchanges between HV1 and midwife 1 were informal and opportunistic and there was no written exchange. Given the shortfall of health visiting hours at the time, it is not certain that HV1 would have had the capacity to do more than she did.

5.2.20 DW1 when he learned of the pregnancy, took the opportunity to assess the appropriate management of mother's methadone in view of foetal development / obstetric risk. He assessed mother's attitude as positive and physical health as good. He addressed her emotional health and liaised with a local self-help source, Probation, and the pharmacy. His 'care plan' was followed by his successor DW2. At the FGC, an extensive package of support was agreed. The lack of a specialist drug worker at the pre-birth child protection conference *may* though have impacted on the understanding of risk for those who did attend.

First visit following birth of child H & case transfer

5.2.21 HV1's first visit to the home was (usefully) a joint one with social worker SW1 after the birth of child H. Their assessment of the environment prompted a referral to housing. DW2 received a comprehensive handover from DW1 including an introduction to mother. This sound practice was atypical and reflected extra effort to support DW2 for whom it was the first post in that specialist role.

5.2.22 DW3 received only a verbal handover from DW2 and completed her own assessment which included liaison with Probation and through that, with the social worker. It included mother's physical health plus a urine screen, community support and engagement, a review of progress to date and her mental health status. When DW3 left there was no one available to hand over to. During her care of mother, the Drugs Service provider changed from 'SCAS' to become the 'Harm Minimisation Service'. Although this transition had not immediately impacted on the care delivered DW3 has reported that the reduction in specialised practitioners meant it was difficult to manage a face to face handover. DW5, at his initial meeting with mother appropriately challenged her about the shop lifting reported by the pharmacist.

6- 12 month health assessment

5.2.23 When child H was 10 months old HV1 completed a health assessment covering all aspects of growth and development including an assessment of mother's mental health. To that point, service provision had been 'universal partnership plus'. Following the assessment HV1 reported she offered a 'universal plus intervention' and attributed the change to an absence of identified concerns. It is unclear whether other agencies appreciated the implications of the status change. HV1 also addressed home safety but *not* safe storage of methadone.

When considering a change in methadone prescription.

5.2.24 When child H was just less than 1 year old DW5 changed the methadone prescription from daily supervised pick up, to 3 times per week (consumption unobserved). DW5 reported that he had assessed mother's suitability for this based upon continued compliance with pickups and 2 clear urine screens. Mother had attended less than 30% of his appointments in the previous year and DW5 had himself raised the possibility of a relapse less than 2 months before his decision. His still-remaining doubts about which he spoke at the time, meant that he had been reluctant to accept the proposed case closure by Children's Social Care though he took no action to challenge its decision.

Prior to case closure by Children's Social Care

5.2.25 SW3 consulted HV1 and DW5 about the intention within Children's Social Care in early 2013 to close the case. DW5 responded via email explaining that he still had some (unspecified) concerns. HV1 and DW5 spoke with one another about mother's failure to attend hepatitis C screening for child H, and her own with DW5. HV1 had not seen child H since he was 10 months old and her next contact with mother was by phone 6 weeks later and concerned a further attempt to get child H screened.

5.2.26 HV1 accepted what is now known to be an untrue assertion by mother of weekly attendance at a Children's Centre. HV1's focus on the general health and development of child H excluded current and future impact of illicit drug use.

5.2.27 The absence of a face to face meeting with all involved professionals to discuss the pros and cons of case closure and perhaps agree a team around the child (TAC) could be regarded as a missed opportunity.

Significant incidents

5.2.28 2 other incidents offered an opportunity to re-assess and take relevant decisions:

- Receipt of the letter from the pharmacist informing of the shop lifting episode (child H was then 10 months old)
- Mother's disclosure in late June 2013 of a relapse into illicit drug use (child H 17 months old)

5.2.29 Key assessments / decision-making opportunities by **Police and Probation** were as follows.

Use of crack cocaine whilst in custody

5.2.30 When mother (then 21 weeks pregnant) was discovered to be smoking in a cell a referral to Children's Social Care should have been initiated. The incident provided clear evidence of mother's drug misuse on top of her methadone prescription and of the risk of harm to which she was exposing her unborn baby. The reasons why this referral was missed appears to be largely because many people were involved and no one single person accepted responsibility for informing the Child Abuse Investigation Unit (CAIU) (this incident pre-dated PVP Referral Centres).

Sharing of Intelligence

5.2.31 If details of Police intelligence pointing toward illicit usage and dealing had been shared, Children's Social Care might have had a clearer understanding of mother's involvement with illegal drugs above and beyond her methadone prescription. The failure to relay all relevant information reflected the Police 'conference writer's belief that Children's Social Care was already aware of mother's drug use and a lack of confidence in how carefully such intelligence might be handled.

Categorisation of events

5.2.32 In late February 2013 (informed by intelligence received) officers attended the home address to complete a 'welfare check'. *If* a 'child protection – non crime incident' had been created straight away for child H it would have ensured immediate oversight by the child protection referral manager within the PVP Referral Centre.

5.2.33 Within Probation too much reliance was placed on positive feedback from other agencies. Had checks with the Police 'area intelligence team' been carried out at point of offender assessment review, behaviours might have been identified which could have raised the assessed level of risk mother posed to children.

5.2.34 For **Children's Social Care**, key assessments and decisions were as follows.

Pre-birth

5.2.35 Whilst an initial referral was received in May, the assessment did not start until August 2011. The previous Care Proceedings and history of drug mis-use should have prompted an earlier response.

5.2.36 The most significant issue pre-birth appears to be the deliberate delay in holding a strategy meeting, so that ensuing responses would not lead to a review child protection case conference pre-birth. The unintended consequence was that the initial conference was held too close to the baby's birth, leaving little time to adequately address risk including that perhaps posed by father of domestic violence. It is unlikely however that Care Proceedings would have been commenced because of the progress mother was making and her stated wish to care for this baby (regarded as different from a lack of motivation to do so with her first child).

5.2.37 The Family Group Conference (FGC) was successful in engaging wider family which in turn had a significant influence on the decision not to seek legal advice. Observations of the maternal grandmother about mother's apparent drug-free state was highly influential.

Ending child protection plan

5.2.38 The child protection conference made a timely decision to end child protection planning and recommended continued child in need planning. The early closure of child in need planning (after 1 month) recommended by the team manager was influenced in part, by pressures the team were under. When there were signs that mother was not managing as well shortly afterwards, the case was kept open.

Case Closure (no use of 'Team around the Child' (TAC))

5.2.39 At the point of case closure (February 2013) the use of a 'Team around the Child' was discounted as there was ongoing support from the health visitor and Harm Minimisation Service. Another influence upon the decision making at this point was mother's reluctance to engage with other professionals. In the absence of any signs of 'significant impairment' (s.17 Children Act 1989) the case closed. A team around the child *might* have been effective at this stage.

Contacts / referrals after case closed

5.2.40 There was further contact from the Police indicating that mother had taken her child with her to buy crack cocaine. When visited, mother denied the allegation and viewed it as a malicious allegation by a [named] male. The case remained closed. The event *should have* been dealt with as a new Contact / Referral, although it is likely that the outcome would have been the same.

5.2.41 There was a further email from DW5 in late March 2013 to Children's Social Care reporting that mother was testing clear for drug use and being moved to weekly drug screening. As the case was closed this was viewed as 'information only' and did not prompt any further action. DW5 emailed again in May 2013 stating that mother was missing appointments and he would not be providing any further methadone scripts if she missed the next one. These contacts, after the case was closed, were not recorded effectively on the Integrated Children's system (ICS) system.

5.2.42 With respect to **hospital and GP services,** key opportunities for assessments and decisions were as follows.

Ante-natal care

5.2.43 The first chance of an assessment was mother's initial attendance at ante-natal clinic. The midwife completed the health and social care assessment well and all appropriate referrals were made. The next opportunity was observation during the pregnancy and in the postnatal period when mother and baby were still in hospital. Ante-natally, mother missed 4 appointments suggesting that she was not prioritising her own health needs. In some instances, SW1 was informed, in others she was not. For 2 missed appointments, there is no evidence that anyone (Children's Social Care or midwives) was informed; appointments were simply rebooked. The missed appointment were early examples of what was to become typical behaviour with respect to routine appointments.

5.2.44 It is clear that thorough formal (discussions and meetings with Children's Social Care) and informal (observations of mother's behaviour on the postnatal ward) assessments were made and decisions taken in the light of these assessments.

5.2.45 The next key opportunity for assessment related to the missed infectious disease appointments. Their primary purpose was to assess the child's medical status rather than social well-being but because they were regarded in purely medical terms, the opportunities to feed back to Children's Social Care observations on mother's abilities to recognise, and prioritise her baby's needs were not taken.

5.2.46 A policy for what to do if children are not brought to medical appointments in the hospital - the '*Procedure for Ensuring Children and Young People's Access to Healthcare is Safeguarded'* (Did Not Attend (DNA) policy)' - has been in place since October 2009. Even for children deemed 'low risk' a referral to Children's Social Care is indicated after the third missed appointment. In child H's case, it was not until the 3rd missed appointment that a letter was written to the GP and at no point was direct contact made with Children's Social Care.

5.2.47 HV1 was phoned both by the screening co-ordinator and one of the clinic doctors to discuss the situation. HV1 described the family situation as 'chaotic'. Although all but one of these contacts took place at a time when child H was still subject of a child protection or child in need plan, this fact was not provided to the clinic by the GP (from whom there was *no* reply at all) or the health visitor. The potential consequences of the above were compounded by the fact that there was no record in child H's notes that the child *was* subject of a child protection plan. This latter fact was an omission due to human error. Electronic Records had been introduced only 1 month previously and this significantly affected the way in which midwives needed to make these notifications.

5.2.48 The doctors involved were unaware of the policy so that all 'DNAs' were considered and acted upon individually. Subsequent discussion has confirmed that awareness of the policy in general is poor with most paediatricians relying mainly on contact via the GP unless they are already aware of very specific child protection concerns. The policy has recently been revised and it is clear that it needs to be 're-launched'.

5.2.49 In addition, the purpose of the clinic visit was 'screening' a healthy baby for a potential health problem. Such babies are unsurprisingly 'over-represented' amongst non-attenders. Advice provided to the serious case review panel indicates that the chance of the baby of a hepatitis C positive mother becoming infected is about 20% and blood tests cannot give a clear answer until the baby is about 15 months of age. If a baby is affected s/he would not become noticeably unwell until the age of 2 or 3 years (and active treatment not offered until at least 2 years of age). Thus, in a medical sense, missing an appointment at ages up to 1 year or 15 months has no immediate consequence. Like all such screening tests, there is parental choice.

5.2.50 Thus, non-attendance is pursued less vigorously than for a child with an established medical problem who would become avoidably more unwell if not treated. All in all, the response of clinic staff of trying persistently to secure attendance via contact with GP and HV for a screening test was reasonable.

5.2.51 Child H's direct encounters with GPs were limited to a 6 week check, attendance for a routine matter and 2 encounters with the 'out of hours service (the first when it was noted 'mum was coping well' and that 'appropriate safeguards were in place'). There were letters from the infectious diseases clinic informing the Practice that mother had repeatedly failed to present her baby for follow up testing for hepatitis C. There is no evidence any GP responded to any of the 6 letters. An assertion in the GP IMR that responsibility anyway lay with the health visitor is questionable. Even if the GPs had believed that to be so, when further letters offered evidence that child H had *still* not been presented, then at the very least, a recorded conversation with the health visitor was required.

5.2.52 The Practice reportedly holds a weekly primary healthcare team meeting attended by GPs, health visitor, midwife and Practice and district nurses where any relevant information on ill or vulnerable patients would have been shared. No documents have been located which would confirm that child H was discussed at these events. (which are now formally minuted). The absence of response by GPs to the clinic letters reflected beliefs about roles rather than being a function of poor administration.

5.2.53 The Practice has a good system in place for the management of incoming information. Letters are scanned onto 'Docman' (a system which stores letters / documents and which is linked to the patient's medical records) and are then read by the GP who is involved with that patient's care. If that GP is not available to read the incoming letters then a 'buddy' system is in operation. This means that a 2nd GP will read the unavailable GP's post / results and action these appropriately. S/he can also 'flag' any important issues with the unavailable GP by sending a message. The arrangement sounds robust but it is of concern that no GP responded to any of 6 letters and to the specific question about any safeguarding concerns.

ASSESSMENTS / DECISIONS REACHED IN A TIMELY, INFORMED & PROFESSIONAL WAY?

5.2.54 An overall evaluation of the quality of assessments and decisions by **Health Visiting, Harm Minimisation Service**, **Police and Probation** follows.

5.2.55 Had the pre-birth conference been convened earlier the health visitor would have had the opportunity to establish contact and complete an antenatal assessment. This would also have promoted opportunities for collaborative care planning and enabled comparative assessments to be done (mood, attitude, motivation, integration etc.).

5.2.56 Historical evidence suggested a highly vulnerable mother. From when child H was 10 months old mother's engagement with the Harm Minimisation Service was minimal. The decision to change to 3 times a week pick-up in spite of mother's non-compliance and recent misuse of diazepam reduced the level of monitoring and entrusted larger amounts of methadone to store safely. This prescription continued even after her disclosure that she had used cocaine over the previous 3 months.

5.2.57 A number of examples have been identified where no, or insufficient research was conducted on mother by the police officers and staff dealing with her. The Police IMR also found inefficiency in internal communication about children subject of child protection plans. If child H had been more visible within Thames Valley Police as a child in need of protection then officers / staff dealing with mother and child might have had his care and welfare at the forefront of their mind rather than viewing the interaction as 'just another shoplifting' or 'just mother again'.

5.2.58 With respect to Probation, reviews of the offender assessment required by National Standards were completed in a timely way, in accordance with policy. In the earlier part of Probation's involvement, the emphasis on drug testing was the focus. During the period of this review, staff felt that multi-agency meetings were convened with little notice. The fact that other agencies had such a positive view of mother's progress and apparent engagement, in stark contrast to her engagement with Probation, impacted on the supervising officers involved.

5.2.59 Probation staff were influenced by this perspective in how they managed the enforcement of mother's sentence e.g. the decision to revoke her supervision and replace this with a Curfew Order was guided by the 'good progress' being identified by Children's Social Care, health visitor, and Harm Minimisation Service.

5.2.60 With respect to the quality of other key assessments / decisions, ending child protection plan status appears to have been made at the right time, based upon (what is now known to have been an incomplete) information from the agencies involved and agreed within a multi-agency setting. Mother was viewed to be drug-free and her housing issues were resolved. The care of child H was viewed as adequate. The child's need to be screened for hepatitis C was still outstanding at the time, but it was legitimate for this to be followed up under a child in need plan. The next appointment for that screening was not until April 2013 (6 months away).

5.2.61 The incident at the pharmacist shop in October 2012 was not reported to Children's Social Care for some days, by which time a social work home visit had already taken place. Mother's claim that she had been away for 2 weeks is likely to be false. No effort was subsequently made to clarify the event, even after the valium use was discovered. The incident did though prompt the case to remain open for a further 3 months, during which time care of child H was viewed as good and there were no further concerning incidents known to the professionals involved.

5.2.62 By February 2013 it was known that mother was attending her Harm Minimisation appointments and had moved to 3 times weekly methadone pick-ups. It is understandable that Children's Social Care viewed this as the right time to close the case, as care of the child continued to be good and mother appeared to be coping well. At this time it was known that there was the change in methadone script routine, a further imminent change of drugs worker and a request that the case remain open to for longer. This information does not seem to have prompted a question as to whether a further few weeks of CiN planning was required.

5.2.63 With respect to the timing and quality of assessments and decisions by **hospital and GP services**, hospital staff contributed effectively to the initial decision-making in pregnancy and after delivery by referring to and liaising with Children's Social Care. With respect to the *medical* implications of child H not being presented for screening, staff made considerable efforts to alert the GP Practice.

5.3 WHAT ACTIONS WERE TAKEN TO SAFEGUARD CHILD H ON THE BASIS OF VULNERABILITIES & HOW WELL AGENCIES WORKED ON THEIR OWN & TOGETHER, WHERE RELEVANT ?

- Were appropriate services offered / provided, or relevant enquiries made, in the light of parental requests, identified needs and the professional referrals?
- Were the appropriate assessments and plans made including the antenatal period?
- Was there adequate and clear communication between agencies?
- How well was information recorded and analysed to reduce risk?
- If opportunities were missed, why?

Health services offered & communication

5.3.1 Mother would typically agree to a service and then fail to engage. Her lack of motivation was explained by professionals as disorganisation. With hindsight it appears increases in personal chaos were at least in part related to increased drug use / dealing and an inevitable reduction in her capacity to focus on child H. Mother failed to make proper use of advice or other services on offer from Children's Centres, Home Start as well as from Probation and the Harm Minimisation Service.

5.3.2 Initially mother did (according to DW1 and DW2) engage with local drug support services, however the organisation changed and became the OASIS service with many different workers. There is no information about the work the former source of support undertook nor any evidence she attended OASIS though she was encouraged to do so. GP2 was involved in pregnancy care and also regularly prescribed mother's methadone. The GP IMR refers to an expectation of frequent communication between doctors and health visitors. Though HV1 had and used her access to medical records to add information, she was unable to recall or indicate any recorded conversation with GP2 about mother. There was no GP present at any of the 3 conferences. The Practice had known mother for some 12 years. The absence of any record of information sharing and assessment suggests missed opportunities.

Shared care

5.3.3 Shared care is described as the joint delivery of care for patients with a drug misuse problem. All drugs nurses said they would seek out the GP if they wished to discuss a patient. There was though, no evidence of *organised* liaison. In interview DW5 stated that he trusted the GP to read what he had documented in the records and vice versa. This was one of a number of unwarranted assumptions made by professionals which are summarised in section 6.

Communication

5.3.4 Before child H was 10 months of age there was no communication between DW5 and HV1 (who initiated contact after numerous failed appointments when attempting to complete the baby's 6-12 month health assessment). By looking at the medical records she was aware that DW5 was having a similar problem obtaining compliance from mother. From this time, there was ongoing information shared (largely by email) between these professionals and SW3. Both health professionals were aware when the other had an appointment pending with mother and encouraged her to attend if they encountered her.

5.3.5 Neither health visiting nor SCAS / Harm Minimisation records contain core group minutes though formal records of most were made (and it believed circulated). DW5 in a brief email in January 2013 questioned the decision in Children's Social Care to close the case. The basis of his concerns were not documented and an offer apparently made in a conversation with SW3 to speak with her manager was not followed up. Communication with the pharmacist was frequent for all drugs workers and this role offered an important source of expertise as well as regular feedback on the patient's presentation.

Recording

5.3.6 HV1 had access to and recorded on Rio (the Health Trust's database) and GP records for mother and child H. Drugs workers had no access to Rio but added information to GP records. Records made by DW1 and DW2 were considered and reflective. Sometimes mother's assertions were accepted as fact, thus reducing the possibility of a well-informed assessment of risk. Records maintained by DW3 were thorough and included an on-going assessment of risk and a future plan. There was a sense from the records that the appropriate information had been collected from which a knowledgeable risk assessment could be made.

5.3.7 At the outset of her involvement, DW3 had drafted a care plan that was scanned onto the GP system. The plan was due for review in 3 months though in practice it never was. The explanation provided was that scanning renders it hard to use the plan as a continuous working document. DW3 compensated for this system weakness by documenting her risk assessments on the medical records as events unfolded. Although this did not disadvantage child H, standardised ways of documenting a risk analysis would offer an improved chance of continuity of care.

5.3.8 The contents of DW5's records were described by the Health Trust IMR author as 'variable and at times lacking analysis and an assessment of risk'. Though DW5 regularly recorded that he had contacted HV1 and SW3 he did not record the content of those contacts. Therefore there is no evidence whether this included collaborative analysis or was just notification of missed appointments.

5.3.9 Mother was a patient in 'shared care' for the duration of the period under review. Records suggest that the appreciation of risk reduced though her behaviour had become less stable and engagement with the Harm Minimisation Service decreased.

5.3.10 HV1 clearly documented actions taken and her liaison. The Health Trust IMR confirms she retained a child focus documenting observations of child H at contact. Paper records were well organised with up to date summaries of inputs. What was lacking in documentation was analysis. Failed appointments were repeatedly recorded though records offered no consideration of why. It appears that HV1 was operating on an assumption that all drug users fail to attend appointments. HV1 never recorded any observed cause for concern and her records lacked inclusion of a plan of care rendering it difficult to identify the outcome of any visit and what consequent service provision would be.

Why were opportunities missed?

5.3.11 HV1 had little knowledge about the impact on parenting of drug use or the risks associated with being on a methadone and did not consider it her role to address the safe storage of methadone. Because clients on a methadone programme were / are common on her case load, HV1 should have accessed training via the Oxfordshire Safeguarding Children Board website.

5.3.12 DW5 at interview referred to a finding that 20% of people fail to attend NHS appointments and his belief that mother was one of that cohort. He also stated that assumptions about the use of drugs or abstinence could not be based on whether people were engaged with drug services or not. Such fixed thinking may have reduced his ability to identify that there was a significant reduction in her engagement with him as opposed to with predecessor DW3.

5.3.13 There were also additional issues to be considered e.g. shop lifting, weight loss, missed methadone pick up and admission of cocaine use. The 'quality' of discussion between professionals was insufficient to promote consideration of alternative hypotheses or conflicting versions of events e.g. when it was reported to DW5 via the pharmacist that mother was 'out of it' when caught shoplifting, there was no exploration about child H's safety. The incident was not considered in the context of history, risk of harm, protective factors etc. Mother's assertion that she had taken diazepam on a 'one off' basis should not have been considered sufficient.

5.3.14 It remains unclear, though asked by Children's Social Care to do so, why HV1 and DW5 did not consider or discuss forming a team around the child (TAC). There was insufficient reflection by professionals about the impact on child H of parenting described in interview by DW5 as 'chaotic' and by HV1 as 'extremely disorganised' e.g. could the child (albeit loved) *depend* upon a feeding or bedtime routine, any planning for safety and meeting the need for socialisation ?

Police & Probation Services & communication

5.3.15 Each time that mother came into Police custody she was asked whether she would like to speak to a 'custody interventions programme' (CIP)[6] worker. She declined this service on each occasion. Thames Valley Police was invited to contribute to the assessments and plans as part of the child protection conferences. Historically officers from CAIUs would only attend if there was *current* Police involvement with a child / family or the case was complex and clearly needed Police involvement at the conference. Child H's case satisfied neither of these criteria. The other lost opportunity was the incident in February 2013 when Police received intelligence to suggest child H was being neglected due to mother's drug misuse. The child was never actually seen by officers, though the decision made by the intelligence officer to request a welfare check was a good one.

[6] The CIP offers support to vulnerable adults who have been taken into police custody. CIP staff work in the designated custody suites alongside custody staff to identify and work with those who may need help in terms of people using illicit drugs, experiencing problems with alcohol, those with a mental health condition or a learning difficulty

5.3.16 Police records indicate that a phone referral to Children's Social Care *was* made by an attending officer but that has not been confirmed by Children's Social Care's IMR. Formal communication between Police and Children's Social Care was limited to:

- An invitation from Children's Social Care to attend the initial conference.
- A record of the conference minutes and copy of the protection plan provided by Children's Social Care (the review conference dates were included at the end of the minutes)
- Reports submitted to the conferences by Police in lieu of attendance

5.3.17 Officers / civilian staff had commendably gathered a large amount of information submitted by them in relation to mother. The majority was recorded correctly on either the intelligence or crime recording databases. The systemic weakness was in the flagging of the intelligence to the correct department and in the failure to share with Children's Social Care that which could be relevant to the well-being of child H.

5.3.18 Probation officers made every effort to inform Children's Social Care knowing that any remand in custody would have impacted upon care of child H. Within Probation, assessments of mother and the risk she posed to children were completed at the required points in supervision, and there is evidence of management oversight. The supervision task was re-allocated to a qualified probation officer once the risks were identified ante-natally and the case was co-worked with a trainee officer for the remainder of her involvement with Probation.

5.3.19 Probation records indicate that communication with some Children's Social Care and Drug Services workers was not easy. Records indicate several attempts to contact them and on occasions voicemail messages left without a response for some days. Once communication did take place the outcomes were positive e.g. the avoidance of 'double-booking' of appointments with Harm Minimisation Service which had been used by mother to explain her failures to attend.

5.3.20 Information that Probation staff obtained was incorporated into the assessment of the risk posed by mother to her child. In hindsight there were gaps in information which could have informed the assessment i.e. mother's lifestyle and associates, and her offences pointed toward continued drug misuse and could have led to her being assessed as a higher risk to children.

Children's Social Care Services & communication

5.3.21 The likely needs of the unborn child had required an earlier multi-agency meeting. The risks of the baby arriving early were significant. Whilst the decision to initiate a safeguarding approach was justified, any implications for 'performance indicators' should have been outweighed by what was in the unborn child's interests. The belated pre-birth assessment, was good, and utilised available information. A significant issue identified related to poor housing. Despite efforts from agencies to assist, the only effective intervention was from the local MP.

5.3.22 There were attempts made to integrate mother and child H in to Sure Start activity. Care of her baby was viewed as good, and the failure to engage with early years support not viewed as indicative of poor parenting. Mother was engaged with drug services and there was communication from these services to other professionals.

5.3.23 A common perception was that the biggest hurdle for practitioners was working with mother's 'dis-organisation' and 'scattiness', rather than a deliberate attempt to undermine the support being offered. In contrast though, there was a different perception in relation to missing Probation appointments, which were widely acknowledged to reflect active avoidance. The perception of mother being 'dis-organised' probably overshadowed times when mother was being manipulative.

5.3.24 The 2 contacts received after case closure raise issues as to whether they should have prompted further involvement of social workers. In the first, after visiting, the child's well-being was viewed as no different from when the case closed. The second contact was clearly made outside any formal referral mechanism and there was no follow up from Harm Minimisation or Children's Social Care.

5.3.25 There was a clear pre-birth assessment that prompted a family group conference and initial child protection conference. The assessment acknowledged that mother had a background of significant drug use, but viewed her presentation, wider family support and her wish to care for her new baby as mitigating factors that reflected a positive outlook on her abilities. The assessment acknowledged that mother would effectively be a 'first time mum' and the report to the initial child protection case conference noted that engagement with ante-natal services had been unreliable (70% attendance for appointments with the midwife). At this point the assessment viewed her ability to 'organise and attend appointments' as a 'significant concern' recognising that this was the first time she appeared to be 'drug free'.

5.3.26 The assessment noted 'it is unclear if mother is concealing her drug use at times or failing to understand the importance of demonstrating she is drug free'. Throughout subsequent involvement, social workers and managers expressed a 'frustration' in that they could see how much mother loved her child and how well child H was doing, but her ability to organise and attend appointments remained a worry.

5.3.27 During the child protection planning process there were appropriate plans made. In hindsight, it is unclear whether she was co-operative with the child protection planning because there was a Community Order in place. Once formal monitoring by Probation lessened, a possible relapse took place quickly (shop-lifting and valium use in October 2012). Core groups and information sharing between agencies appears to have been appropriate during child protection planning.

5.3.28 Once child protection planning ceased there was no clear child in need plan in place. Child in need planning processes are now reported to be improved within the Family Support Teams. At the point of case closure there was a view from Harm Minimisation that Children's Social Care should remain involved, though the purpose of ongoing involvement was not clearly outlined. At the point of closure child H's care and development were not of such concern that the s.17 Children Act 1989 ('significant impairment') could be said to be present.

5.3.29 Communication with the Probation Service was not adequate. There are records indicating the Probation Service thought Children's Social Care undertook drug testing with mother and the clash between the Drugs Service and probation appointments was not recognised for some time. Relevant information does generally appear to have been communicated at conferences.

Children's Social Care recording & analysis

5.3.30 There was a clear focus upon the potential risks to a new born child, while balancing the mitigating factors relating to mother's presentation and wish to care for this child. The information relating to the child's father was limited at first and the apparent collusion between both parents to limit the information to which Children's Social Care had was not fully recognised (visits by the father that were not reported). The housing situation and need to evidence a drug-free lifestyle was fully recognised.

5.3.31 During the child protection planning period, new information was included in an assessment of risk and a gradual picture of improvement and good care of child H appears to have been valid, based upon the information available at the time. Following child H ceasing to be the subject of a child protection plan information that indicated a heightened risk appears to have been reacted to appropriately though reflection on the longer term implications was not always fully considered. The shoplifting incident did prompt further involvement and child H's situation appeared to be settled at the time that the case was closed.

Hospital & GP services

5.3.32 Appropriate referrals were made by hospital services to other agencies during pregnancy; and midwifery staff contributed their observations on mother's capabilities when asked to do so. There was one request for information - the health visitor's request in May 2012 to be informed if mother did not bring child H to the next appointment. This was not acted upon as the appointment was changed by the hospital, and the request then not recorded in the section initially looked at by clinic staff. Thus when child H was *not* brought to the re-scheduled appointment, the information was not readily apparent to clinic staff. This minor human error was of relatively little significance

5.3.33 During the antenatal period, robust plans were in place. Appropriate plans were also made, and followed, for the medical management of child H during the first few days of life. Documentation of Children's Social Care plans with respect to discharge from hospital as a neonate was not as good as it might have been.

5.3.34 Antenatally mother appeared to engage in the services that were offered to her and information from Children's Social Care concerning their assessment and plans, and a copy of the pre-birth child protection conference was received and filed in mother's ante-natal notes, indicating that unborn child H was subject of a child protection plan. Postnatally, whilst there is plenty of contemporaneous information about ongoing assessments and communications, there is lack of precise documentation in child H's notes about the protection plan e.g. there is no copy of any notes following the meeting with mother and Children's Social Care (merely a summary of key points written by the midwife who had attended). In addition, information which was readily available within mother's notes was not transferred to child H's notes.

5.3.35 *Interagency* communication about pre-birth assessments was therefore good: but *internal* communication about it was not as good as it should have been. There was communication between the health visitor and hospital but no response from the GPs to letters sent. The absence of response by the GP to letters specifically asking whether were safeguarding concerns was interpreted as 'no concern'.

5.3.36 It would have been prudent to confirm this fact with Children's Social Care, but there was no communication with that agency initiated by hospital staff. Had there been clearer documentation in the notes about the initial child protection plan, hospital staff could have contacted Children's Social Care. Handwritten or directly entered electronic information in the hospital notes at all stages was generally of a good quality. Analysis of information pre-birth and in the post-natal period was good. There are though concerns about the filing of items which originated from outside the hospital such as minutes of meetings.

5.3.37 During pregnancy, information relevant to mother and baby can only be filed in maternal notes. Until a baby is born and allocated an NHS number, s/he does not have notes. Any information in maternal notes relevant to baby (medical or social) must be transferred by a midwife. Thus the record which made 'unborn child H' subject to a child protection plan was filed in maternity notes, but *not* subsequently transferred into child H's own notes. Because the same midwife would be looking after mother and baby, she would anyway be aware of the circumstances. Such an oversight became important later when child H did not attend clinic and the only available notes were those of the child which did not contain *all* relevant information.

5.3.38 There is no evidence of the minutes from the pre-discharge meeting in the notes of child H. There is clear evidence of what was decided in a handwritten note, about who was to visit mother and baby at home post-discharge, but it seems that this was not passed on to community midwives. This was a significant omission. An alert was placed on child H's Electronic Patient Record (EPR), and 'case notes' (an older electronic system being phased out, but still in use) stating the child was subject to a child protection plan for neglect. The EPR however, was not used in children's *outpatient* notes, so the absence of transfer of written information within them was a significant factor leading to the paediatrician's erroneous analysis of non-attendance as 'low risk'. One of the doctors at interview said that if he had known child H was subject to a protection plan, he would have 'looked at the DNA in a different light'.

5.3.39 GP records show very little evidence of contact with GP services for child H although the child was seen for the appropriate developmental checks and the records show good documentation of this by HV1. *In theory*, any concerns would have been raised at the weekly Primary Healthcare Team meeting or by direct contact with GPs. No concerns were raised by GPs. When child H was not presented for routine childhood appointments at the GP Practice, this was followed up appropriately by HV1 and the child subsequently received the routine immunisations.

5.3.40 There is good evidence in the GP records that when mother's pregnancy was confirmed she was referred for appropriate ante-natal tests (blood testing and scan). As mother was known to be having prescriptions of methadone and had previously had multiple blood clots in the lungs with possible inflammation of the inner lining of the heart, she was appropriately referred to secondary care for obstetric services. There is evidence of comprehensive history taking (physical and social), awareness of her having her first child taken into care and that her then current relationship was documented as 'not a stable relationship but will support the baby'.

5.3.41 GP records confirm that when child H was 5 days old a child protection plan was in place. There is no mention in the records of GP involvement at this stage and it seems likely that GPs would presume that the mother and baby would be under regular review by the social worker and midwife and subsequently health visitor.

5.3.42 There is evidence that a discussion took place between HV1 and a consultant paediatrician about the importance of attendance for hepatitis C screening. Because HV1 was in direct contact with mother and child, it seems to have been presumed by GPs this was being followed up by her. The GP IMR author refers to 'clear entries in the GP records of encounters with the health visitor and Harm Minimisation Team'. No evidence has been provided of a recorded discussion between health visitor and GP on this or other aspects of the health care of child H and his mother.

5.3.43 In addition to weekly Primary Healthcare team meetings the Practice holds a quarterly meeting with GPs and health visitors at which all 'at risk' patients (those subject of a child protection plan or where domestic violence has taken place) are reviewed. This helpful potential opportunity for debate about child H was not taken.

Hospital & GP recording & analysis

5.3.44 There is good evidence of appropriately recorded medical documentation throughout GP records of the consultations. This conforms to the requirements of the General Medical Council (GMC's) 'Good Medical Practice' 2013. Although methadone was being prescribed by the GPs leading up to the methadone overdose, responsibility for reviews was with DW5 from the Harm Minimisation Service.

5.3.45 There was no evidence that information about non-attendance had been passed directly on to the GPs but after discussion with the Practice it is clear that there were 'conversations'. Best practice requires that such conversations or the actions from them should be recorded in medical records.

Any 'missed opportunities'?

5.3.46 It is arguable that seeking a legal order at the point of the FGC might have helped to safeguard child H. The assessment at the time however, was that mother could adequately care for child H in the community. Tunnard (2002) notes that a number of research studies have found the support from family and friends networks to be crucial with drug using parents, providing closer monitoring and practical support than professionals can. There is evidence that the maternal grandmother was involved in helping to assess risks at various points, though as time went on, contact with her reduced. Maintaining contact with this individual and providing her with some support would have helped to build a more accurate picture of risk.

5.3.47 Following the ending of child protection planning mother's mis-use of valium did prompt further involvement. The incident was viewed as a 'blip', but could have resulted in a further s.47 enquiry. It is clear that the social work team was under significant pressures at this point, and while staff assured child H's immediate safety there was a propensity to look for positive signs rather than question whether mother was covering up a more significant return to drug use.

5.3.48 The lack of recording following case closure is a significant issue that has been referred to the worker's manager. In interviews the manager was clear that she would anyway have maintained the decision to close the case (following allegations that mother and child were seen at a drug users house), however the social worker's actions were undertaken with no management oversight or awareness of the case.

5.3.49 With respect to the hospital, there were no missed opportunities antenatally. Post-natally, an opportunity to take action and share information with Children's Social Care was missed when child H was not brought to outpatient appointments because:

- There was no record that child H was subject of a child protection plan for neglect
- A narrow medical approach was taken with insufficient thought given to wider social issues underpinning non-attendance

5.3.50 Some of these missed appointments were at a time when child H was no longer subject to a child protection or child in need plan. Knowledge of the failure to present child H *might* have prompted Children's Social Care to respond differently. It is unlikely it would have led to the case remaining open. Children of substance abusing families *should* though be regarded as 'increased risk' no matter how trivial the medical problem itself may be. Plans emerging from the conferences in April and September 2012 were found in GP records but it is unclear which GP was taking responsibility. GPs took no proactive steps in consequence of the plans.

5.4 POLICIES & PROCEDURES

- What local single agency and inter-agency procedures (safeguarding and general practice) and professional practice standards were in place?
- Were they followed and were they effective?
- Supervision

5.4.1 The SCR has identified a number of examples (outlined below) where the internal or inter-agency procedures or professional practice could be improved.

HEALTH VISITING & HARM MINIMISATION SERVICES

5.4.2 The Trust's IMR confirms that the health visiting service had in place adequate policies and procedures. The position of the specialist addiction service was rendered more complex by Oxford Health NHS Foundation Trust, replacing in 2011 service provider SCAS with the Harm Minimisation Service. No new policies of relevance to this case have been developed since then. The most relevant operational policy was one developed by the SCAS (dated 2011) which does not cover the entire review period.

5.4.3 A 'care plan' was used by all drugs nurses. The expectation was that it should have been reviewed at 12 week intervals but there is no evidence this was achieved. Each drugs nurse developed her/his own approach to its management. All these staff were aware that a 'medicines management policy' 2012 existed. The practitioners were guided by the National Treatment Agency (now Public Health England) and the Department of Health, Drug Misuse and Dependence, UK guidelines on Clinical Management 2007.

5.4.4 There was no evidence that sufficient 'joined up' working was achieved at the GP Practice. There was no evidence that any audits had been undertaken within SCAS or the Harm Minimisation Service (aside from the existence of an audit undertaken by the Public Health Drug and Alcohol Team) during the review period.

5.4.5 The Healthy Child Programme (HCP) highlights the importance of ante-natal contact by the health visitor. Oxfordshire HCP Framework for ante-natal contact indicates that the midwife remains responsible for the care of mother and infant until discharge post-delivery. However, health visitors should be notified of all ante-natal women via the 12 week 'midwifery health and social assessment' process which should generate a form to be sent to the health visiting team. Health visitors are then to review the information, identify the level of service / support required and liaise with other professionals as required.

5.4.6 Those clients identified as requiring additional or progressive intervention will be offered a face to face contact with a member of the health visiting team during the last 2 months of pregnancy. This should allow a more detailed assessment of vulnerability and promote early identification of additional risks. In reality, communication between midwives and health visitors was variable across Oxfordshire during the period of this review. HV1 reported that health and social care forms were not received and meetings with midwives were opportunistic.

5.4.7 The 'Healthy Child Programme' offers every family a programme of screening tests, immunisations and developmental reviews, along with information guidance and support with parenting. HV1 ensured that these aspects of the government's programme were offered to this family. She was persistent in her approach to missed appointments and managed to see child H on her 4th attempt for the 6-12 month health assessment. She also followed up on all immunisations and made every attempt to encourage attendance for the hepatitis C screen.

5.4.8 Universal services use the RIO data input system as the main record keeping tool. In addition, complex cases had a paper file in which there was a front sheet detailing significant details of family composition and key professionals, a summary sheet of key events and an individual health action plan for the child. There was evidence that HV1 accurately recorded all contacts and failed contacts with mother plus all relevant professionals in a timely manner. Use of the complex paper record complied with documentation guidelines apart from the lack of a health action plan for child H. HV1 has stated that this was because the child had no identified health needs. The failure to indicate 'no health needs identified' on a plan suggests a lack of assessment. The absence of structured approach to writing up consultations resulted in a difficulty defining the visit objectives, assessment and consequent plan.

5.4.9 Oxford Health NHS Foundation Trust non-engagement guidelines acknowledge that 'disengagement with health services by parents and carers can be partial, selective, intermittent and persistent in nature. It may signal an increase of stress within a family and potential abuse or neglect of children. Practitioners must take account of each child's circumstances and the possible implications of failure to receive appropriate services. All staff must assess the risk to any children when a family disengage from health services and if there are safeguarding concerns, should discuss them with relevant colleagues, line manager or the safeguarding team'.

5.4.10 Oxford Health NHS Foundation Trust has recognised its statutory duty under s.11 Children Act 2004 to work in partnership to keep children safe and ensure the agency's functions are discharged with regard to the need to safeguard and promote the welfare of children. The most relevant aspects of this policy are:

- Training: identification of vulnerability / assessment / analysis
- Contribution to child protection planning
- Supervision
- Escalation

5.4.11 All staff reported being up to date with the mandatory triennial child protection training, which is monitored and reported upon within the Trust. Attendance at initial, pre-birth and review child protection conferences as well as child in need conferences should be prioritised by health visitors for unborn babies and children under 5 years of age. HV1 did (commendably) attend all such conferences and the core groups that were convened after child H was made subject of a protection plan.

5.4.12 Though invited, neither DW1, DW2, DW3 nor DW5 attended any child protection conference. DW3 attended 1 of the 3 core groups. Policy requires that a report should be submitted by the health professional to the independent chairperson in advance of the conference and a copy be retained within the child's or parent / carers records. *No* comprehensive report was prepared and submitted by the health visitor or any drugs worker. This insufficiency of commitment to the child protection process impacted on the quality of assessment and subsequent planning.

Supervision

5.4.13 The Trust's 'safeguarding children team' offers child protection advice, support and supervision to all staff and aims to balance support and professional challenge which supplements clinical supervision. All clinical staff working directly with children should access supervision commensurate with their role. HV1 was a regular attender at group child protection supervision. However this particular case was (understandably) never discussed due to there being cases of greater concern.

5.4.14 The Harm Minimisation Service has been receiving supervision from the 'safeguarding children team' since December 2012. DW5's attendance at supervision was verified, however there is no record of DW3's attendance. DW5 was very positive about the quality of supervision given by the 'named nurse'.

Escalation (within child protection & safeguarding policy)

5.4.15 Staff should try and resolve disagreements at practice level. If they remain unresolved staff should contact the Trust's 'safeguarding children team' for advice and support. DW5 objected to the proposed case closure in January 2013 but did not escalate or seek advice in order to do so.

THAMES VALLEY POLICE

Referral of concerns to Children's Social Care

5.4.16 The Police IMR very usefully explored what appears to be the simple term 'referral' – the passing of information from Police to Children's Social Care if an officer forms the view a child may be suffering or be at risk of suffering significant harm. The IMR author comprehensively explored which staff within the Service are best positioned and how such referrals might be made with respect to incidents within the home or relating to a parent detained in a custody suite. Recommendations about required system changes are provided in section 7.

Processing of Intelligence reports

5.4.17 A large number of Intelligence reports about mother were submitted to Police. They suggested she regularly shoplifted and committed other thefts alongside active involvement in drug supply, so as to fund her addiction to crack cocaine. Apart from a single (unconfirmed) report of February 2013, there is no record of any of those intelligence reports being shared with Children's Social Care. Recommendations for more effective information-sharing are included in section 7.

Visibility of child H on Police systems

5.4.18 A related procedural issue is how information about those subject to child protection plans is recorded by Police. The fact is only recorded on 2 generally accessible databases. In consequence, without conducting a significant amount of research, an officer can easily miss this vital information. Interviews with relevant staff confirmed this to be a real rather than a theoretical issue. Recommendations for system improvement are included in section 7.

Police provision of information to / representation at child protection conferences

5.4.19 A further issue of policy / procedure was identified during the course of the SCR. Thames Valley Police had been invited to all conferences and although not present at any, had on each occasion supplied a report ahead of the meeting. Established policy / procedure is that following receipt of an invitation to a conference a 'case conference writer' (a civilian role within the Service), having completed checks against systems and databases, drafts a report containing all relevant information. This is sent to a detective sergeant from the Child Abuse Investigation Unit (CAIU) who make a decision about attendance at, and/or provision of a report to conference. In this case, no information from recent reports was included lest it be inappropriately shared with mother or others. It was also thought that Children's Social Care was anyway aware of mother's drug use the information would add nothing to a risk assessment. Such assumptions were mistaken.

5.4.20 The IMR author points out that whilst the current version of the statutory '*Working Together To Safeguard Children'* lacks detail, its 2010 predecessor (still widely regarded as reflecting best practise) indicates that 'those attending conferences should be there because they have a significant contribution to make, arising from professional expertise, knowledge of the child or family or both.'

5.4.21 Established practice in Oxfordshire has been that officers would only attend if there was *current* Police involvement with the child / family *or* the case was complex. At the time of the initial and review conferences for child H, none of the investigations involving mother were 'ongoing'. Neither could her recorded history be described as complex. Thus, whilst the decision *not* to send a representative was consistent with policy, it did deny those at the conferences a more complete appreciation of the lifestyle mother was leading, the centrality or drug usage and dealing and the inevitable risks this posed her child.

5.4.22 A preferable policy would be one that that is closer to the criteria included in the 2010 *Working Together to Safeguard Children*. A recommendation to that effect is included in section 7.

PROBATION

5.4.23 Thames Valley Probation staff are expected to work in a manner consistent with the Trust's 'Policy and Practitioner Guidance on Safeguarding Children, National Standards for the Supervision and Assessment of Offenders, including Enforcement Policy and Working Together to Safeguard Children 2010 (now 2013 edition).

5.4.24 Policies *were* followed. The supervision of mother was allocated to the appropriate level of qualified staff, and there is evidence of management oversight in this process. The supervising officers attended conferences when possible, and submitted written contributions if unable to attend. Mother was visited at home on a number of occasions.

CHILDREN'S SOCIAL CARE

5.4.25 There are pre-birth assessment procedures (Oxfordshire Safeguarding Children Board Procedures section 3.1) that the hospital social work team followed. In light of the evidence emerging, there is a need to review the appropriateness of waiting to start risk assessments for cases where significant drug mis-use is known and when a mother has already been through Care Proceedings. In addition, the practice of delaying strategy discussions for unborn babies needs to be reviewed.

5.4.26 The Oxfordshire Safeguarding Children Board has on-line publication of procedures relating to child protection conferences and thresholds of need. At the time of Children's Social Care involvement these would have complied with *Working Together to Safeguard Children* 2010. Within these procedures is a section relating to drug mis-using parents (section 3.12) and it outlines issues to be considered. Observations of child H re-assured professionals that the potential risk factors listed were not impacting upon the child's development or care. It is notable that for as long as there was increased scrutiny e.g. child protection plan and the Community Order, the above factors were mitigated or not present.

OXFORD UNIVERSITY HOSPITALS NHS TRUST

5.4.27 The IMR provided by the Hospital Trust identified a comprehensive range of relevant policies. 'Maternity pathways' were potentially effective enough to ensure that mother's needs were identified and appropriate support put in place. The hepatitis B policy was effective and child H received appropriate vaccinations prior to and after discharge. The hepatitis C policy was effective insofar as child H was flagged as in need of follow-up. The 'Procedure for Ensuring Children and Young People's Access to Health Care is Safeguarded' (did not attend / was not brought) was not strictly followed, though some actions recommended in it were complied with. There was good communication with health colleagues though not with Children's Social Care. Child H was perceived as being 'low risk' (medically) and there was a lack of clarity amongst medical staff about the policy.

5.4.28 Because child H was eventually brought to clinic at a time when still medically relevant, actions *could* still be described as effective in terms of ensuring access to health care. There was though, a very long time lag and the lack of response to letters to GPs containing direct questions about safeguarding is concerning.

GP SERVICE

5.4.29 Oxfordshire Safeguarding Children Board has encouraged the system of 'Practice leads' for child protection in Primary Care. The relevant Practice has a nominated doctor with whom concerns should be raised. If a GP has specific urgent concerns these may also be discussed with the 'named nurse' or directly with Children's Social Care. None of those options was employed. All GPs have to undertake child protection training for 'continuing professional development' (CPD) purpose and provide evidence for re-validation. GPs are also bound by General Medical Council (GMC) rules cited above. There was no inadequacy of policy or procedure.

5.5 CO-OPERATION & ENGAGEMENT OF SERVICES WITH PARENTS & CHILD

- How did professionals understand child H's behaviour, wishes and feelings and support the child?
- How well did professionals engage with the family?
- Was father's potential impact included and assessed and responded to appropriately?
- Were the wider family members included and assessed?

5.5.1 Child H was assessed by HV1 as developing normally and mother-child interactions noted to be loving and sensitive. Mother reported she had visited her child's father twice though the relationship had been casual with no plan for its resumption.

5.5.2 Recorded evidence refers only to child H's behaviour as being settled and age appropriate. DW1, DW2 and DW3 established reasonable relationships with mother. Records include very few references to child H's behaviour unless it related to the needs of mother e.g. a discussion by DW3 of the positive impact of child H's improved sleeping pattern on mother. There is little evidence that professionals discussed how mother felt about the loss of her first child or her level of anxiety about losing child H. At the author's meeting with mother, she indicated that fear was of central relevance to the (often deceptive) way in which she related to agencies.

5.5.3 Mother was generally described as passive, quiet, unchallenging and welcoming of opportunistic visits. She *apparently* listened attentively to advice and was supported by her family. One IMR author neatly encapsulated these observations by suggesting that because of mother and child's unremarkable presentation (and greater demand from many other service users) professionals were 'under-whelmed'.

5.5.4 HV1 attended the family group conference (FGC) in 2011 and was therefore aware of the support that had been agreed. She had little knowledge of the family's background, apart from the fact that parents were separated and mother's first son was resident with extended family. Mother informed HV1 in the post-natal period that she saw her mother every week (she confirmed to the author that she saw / sees little of her father. There is no record of the health visitor service engaging with family members or exploring their relationships with one another.

5.5.5 The maternal grandmother of child H attended occasional addiction appointments with her daughter. DW5 spoke of her presenting as a typical mother of a long term drug-abuser i.e. worn down, wanting to be optimistic but with a suspicion that all was not well. Exploring these fears might have highlighted or exposed additional risk.

5.5.6 Very little was recorded about the father of child H. Mother's stated intention was to be single. There was awareness that he had been abusive in a previous relationship and HV1 had discussed mother's need to stay safe if meeting him. No health care professionals reported or recalled having contact with wider family members.

5.5.7 Police had very little contact with child H. The child was only seen by Police once following a 'fear for welfare' incident following threats to harm mother. On this occasion the toddler was spoken to briefly and assessed as being happy and content. Police did not engage with mother beyond (appropriately) completing required processes (arrest, interview, charge) to further crime investigations. No Police records or interactions with mother / child H suggested they had contact with the child's father. Checks *were* completed and included details of previous and impending convictions. Thames Valley Police did not have any reason to contact wider family members in any of the interactions with mother or child.

5.5.8 Observations by Probation staff indicated child H was in a clean and tidy home, and well cared for. Staff were reassured by health visitor and social workers that the child's development was normal. Probation had no contact with the wider family since historic contact several years earlier at the point of mother's release from her prison sentence. Information about the father of child H and mother's wider family came via input to professional meetings from other agencies and from mother.

5.5.9 Child H was a pre-verbal infant throughout the period of review and professionals relied upon their observations. In addition to observing a positive bond with mother information provided by the health visitor presented a picture of a child being well cared for. As a 'first time mother' issues such as the time a child should be in a 'baby walker' or 'prop feeding', were seen to be about maternal learning not neglect.

5.5.10 After the move to the current address, the household was seen to be in good order and child H was clean and presented well. This may have served to reinforce the notion that mother's problems had been more external than internal.

5.5.11 Social workers within the hospital and Family Support team appear to have made good efforts to engage with mother prior to the birth of child H and subsequently. Mother challenged the hospital social worker for insisting on developing her support network, but there continued to be a good working relationship. Throughout the initial assessment and during child protection planning there was a good balance of support and challenge to mother.

5.5.12 Mother was clear at the outset that she did not want the father to be contacted and cited a concern that he would want to take her child from her. Mother appears to have maintained some contact with him after knowing about allegations of domestic abuse and both parents sought to hide the details of the amount of contact that they had with one another. Risks from father were recognised, but after initial efforts to include him in his child's life, his lack of support and motivation to help enabled him to disappear from professionals' focus. Following cessation of child protection planning there was far less contact with the maternal grandmother of child H, although she continued to be seen as a significant support for mother and child.

5.5.13 During the pregnancy, there was an effective relationship with mother and good continuity of care with evidence that the midwife worked hard to ensure that mother remained engaged. Child H's father did not attend hospital at any stage, so there was no opportunity to engage with him.

5.5.14 With respect to missed appointments, relevant letters to the GP were copied to mother and fresh appointments sent to her, and one of the doctors did try, unsuccessfully, to telephone her. Attempts to engage her were mainly via the health visitor – a common and generally successful strategy used by hospital staff to engage families. Information received back from the health visitor, whilst *not* specifically mentioning the child protection plan, indicated she knew the family well.

5.5.15 There are only two brief mentions of a partner in mother's notes (it is even unclear if the partner she is referring to was child H's father). There is no mention in mother's maternity notes, nor child H's medical notes of any member of the wider family.

5.5.16 Due to the infrequency and short time spent in GP consultations it is difficult to say from the records whether behaviour, wishes and feelings were understood. There was an entry in the GP records from the midwife at the start of the pregnancy which stated that the father's relationship with mother was not stable. GP involvement in a patient's wider family is only likely in cases where specific concerns have been raised or if noted at the time of a GP consultation. In consequence of the vulnerability of child H, the health visitor was closely involved with the family and one would expect there to have been regular discussions between the health visitor and a GP. *No* documentary evidence of any such discussion was found in either GP or health visitor records.

5.6 ADDITIONAL ISSUES FOR THE REVIEW

5.6.1 The extensive terms of reference required that in addition to the above key issues the SCR should:

- Establish whether practitioners were sensitive to the cultural needs of the child and the family in their work, and their needs were taken into consideration
- Make recommendations for local, regional or national multi- agency practice
- Identify commendable good practice as well as learning
- Provide a multi-agency overview report in accordance with 'Working Together 2013' guidance including a clear multi-agency action plan that addresses any areas highlighted for change or improvement
- Include an executive summary
- Put in place a process for publication and ensure that findings are communicated to ensure public confidence in the safeguarding arrangements for children / young people in Oxfordshire
- Establish a clear action plan for individual agency implementation and disseminating learning
- Put in place a process for monitoring the implementation of the individual and multi-agency actions identified
- Scrutinise the commissioning arrangements for health services

5.6.2 The first of the above additional issues is addressed below. The remaining elements of the list above are considered to have been addressed elsewhere in this report and the measures now in place to implement those changes that have been recommended and agreed by respective agencies and/or the LSCB.

SENSITIVITY TO THE CULTURAL NEEDS OF THE CHILD & FAMILY & THEIR NEEDS TAKEN INTO CONSIDERATION: ALL AGENCIES

5.6.3 Child H is of dual heritage but was too young during the period under review to directly experience any of the prejudice that can be experienced by such children in predominantly White areas.

5.6.4 Agencies showed a considerable sensitivity to the needs that existed in consequence of mother's apparent inability to organise her life e.g. Probation made more home visits than officers would normally do and HV1 went out of her way to enable mother to present her child at health-related appointments.

5.6.5 With hindsight, some examples of sensitivity toward mother e.g. accepting her reluctance to take up Home Start and accepting at face value that she was involved with family and (non-drug using) friends may have cost child H some opportunities.

6 CONCLUSIONS & LESSONS LEARNT

6.1 CONCLUSIONS

PREDICTABILITY & PREVENTABLITY

6.1.1 Given the priority mother awarded drugs (usage and dealing) coupled with the growing demands of a healthy toddler, crises of one sort or another were likely.

6.1.2 In spite of a good deal of information exchange across agencies Children's Social Care had not been able to develop a *complet*e picture of child H's day to day experiences (a significant proportion of what was known or suspected by Police was not made available), nor what risk they implied. On the basis of the partial picture understood by each agency, actions (including case closure by Children's Social Care) fell within the range that can be described as 'rational and reasonable'.

6.1.3 Hence, though accidents such as ingestion of methadone was to some *very* limited extent 'predictable', it cannot reasonably be claimed to have been 'preventable' by decisions or actions available to the professionals working with the family.

6.1.4 Even if the all the potentially available evidence had been aggregated it is unlikely that a court would have concluded that a Care or Supervision Order was justified.

STRATEGIC CONTEXT

6.1.5 Professionals in England are obliged to work within a framework of legislation and policies that indicates an ambivalence toward those who are substance-dependent and (often) using additional illicit drugs. A proportion of those who combine Opiate Substitution Therapy (OST) with parenting may do so well enough; a further significant proportion do not, sometimes with fatal results.

6.1.6 *Medication in Drug Treatment: Managing the Risks to Children*[7] examines cases where children have died or come to harm from ingesting OST medicines prescribed to help people overcome drug addiction. It cites 17 serious case reviews involving ingestion of OST drugs by children plus potentially more incidents that did not reach that level of inquiry.

6.1.7 In recent years, there has been an acceptance that those who wish can opt for 'harm minimisation' i.e. to continue to be provided prescribed substitute drugs such as methadone. The SCR panel was informed and welcomed the advice that national policy is moving toward a position whereby OST clients will all be encouraged toward cessation of use of prescribed and illicit drugs i.e. the goal will be abstinence not maintenance.

[7] Medication in Drug Treatment: Managing the Risks to Children a research report published by ADFAM in 2014

NORMALISATION OF ABERRANT BEHAVIOURS

6.1.8 In this case, the network came to regard mother's drug-dependent lifestyle as normal and her manipulative (often dishonest) behaviour as simply a lack of organisation. Clearly, the misuse of drugs was mother's paramount priority e.g. she never missed a 'pick-up' of methadone whilst persistently failing to present her baby / toddler to health-related and other appointments that were in child H's best interests.

6.1.9 The evidence was that mother was not motivated to adjust her lifestyle and examples of dishonesty came to be accepted without challenge, in part because of what has been termed professional optimism e.g. a good deal of self-reported information was accepted as fact and not corroborated.

INWARD FOCUS

6.1.10 There was a widespread tendency to focus narrowly on a particular or central role of each agency so that it would appear:

- From the absence of documentation, that GPs initiated little liaison with the drugs workers (specialist nurses) and virtually none with the involved health visitor
- Police officers responded frequently to mother's ongoing criminal behaviours with insufficient thought about the growing significance of mother involving her toddler in the commission of her crimes
- The health visitor (who otherwise initiated and maintained a commendable level of effective liaison with Children's Social Care and Harm Minimisation Service) made an artificial and unjustified distinction between the risks to child H arising from everyday items / issues and from the presence of dangerous prescribed (and other illicit) drugs
- The Specialist Community Addiction Service (SCAS) and later Harm Minimisation Service did not provide a representative to either the pre-birth or review child protection conferences

DAY TO DAY EXPERIENCE OF CHILD H

6.1.11 No professional could have described with any level of accuracy or confidence how a typical day might be experienced by child H.

6.1.12 Retrospective examination of agency records suggest that the life of child H was probably fairly limited and involved accompanying mother to methadone collection, screening visits and shop-lifting outings.

6.1.13 The social opportunities that mother claimed to have been introducing her child to e.g. visits to Children's Centres seem to have been predominantly fabricated.

TECHNICAL OBSTACLES TO RECOGNITION OF RISK

6.1.14 In addition to strategic and systemic weaknesses, some technical obstacles have been highlighted in the course of this serious case review e.g the:

- Fact that a child is subject to a child protection plan is not sufficiently visible on Thames Valley Police databases and systems
- Apparent absence of shared records of *all* core groups further undermining a shared understanding and approach across agencies to ensuring the safety and well-being of child H

WEAKNESSES IN PRACTICE & COMMUNICATION

6.1.15 Beyond oversight of prescribing, GPs were essentially passive and failed to respond to written requests from the infectious diseases clinic. There was no evidence that child H was discussed at quarterly meetings as suggested in the IMR supplied. Poor recording of claimed exchanges between DWs and GPs has been found. Nor was there clarity about which GP was taking the lead role for child H and the child protection plan.

6.1.16 When information was exchanged, its receipt failed to sufficiently inform respective agencies' assessments and planning i.e. facts were exchanged but their meaning not jointly explored and agreed. Nor, was any corroboration found in medical notes of any HV / GP debate about wider family issues.

LESSONS LEARNT

6.1.17 When professionals are working with substance-dependent service-users, they need to guard against undue optimism and against any assumptions that can serve to add to the level of risk being experienced by a child, e.g.:

- The assumptions at investigating police officer / custody sergeant levels that GPs / Health Services would take any required action to safeguard the unborn, later child H
- GPs' assumptions that health visitors would initiate action on behalf of the Practice including chasing hepatitis C screening
- The health visitor's assumption that her role was to look forward not back (and avoid any discussion about drugs)
- The Police conference writer's view that Children's Social Care already knew about the drug misuse and did not need further briefing
- An assumption within the very attentive paediatric infectious diseases clinic that an absence of response from GPs to the question of 'safeguarding concerns?' meant there were none
- The assumption by GPs and drugs workers that the other would initiate a conversation if need be
- An assumption within Children's Social Care and Harm Minimisation that mother was (as she claimed) socialising and providing child H with time with other non-drug using families (it is likely that a considerable proportion of time, whilst with child H, was committed to acquisitive drug-related crime)

6.2 IMPROVEMENTS ALREADY INTRODUCED

6.2.1 To reduce an otherwise excessively lengthy and unmanageable list of recommendations, the following improvements to service design and delivery have (in response to this case) already been put in place:

- Thames Valley Police policy is now clear that an unborn child is to be treated as a child and details entered on its 'Crime Evaluation and Data Analysis Recording (CEDAR) database – this position has been promoted with frontline staff in the 'Domestic Abuse Master Class' training delivered between November 2012 and February 2014 and shown in an audit completed by the PVP Strategy Unit to have achieved a high level of compliance
- Guidance and training on safeguarding and the role and expectations of police community support officers (PCSOs) has already been, or is currently being rolled out
- Midwifery safeguarding training now includes reminders on the importance of prompt, accurate transfer of information from maternal to baby notes; and of clear communication of discharge plans to community midwives in the case of babies with social concerns
- Since the beginning of January 2014, if a woman misses a hospital maternity appointment, a note is made in her 'electronic patient record' (EPR) record of who has been contacted which should encourage positive action and more effective information sharing in future
- Children's Social Care has already introduced mandatory 'toolkits' (covering neglect and substance misuse) and is currently undertaking work to clarify expectations of 'team around a child' arrangements
- Children's Social Care now routinely monitor and report attendance rates of partner agencies at child protection conferences and core groups
- An 'ante-natal pathway' now stipulates that ante-natal visiting following communication with the midwife is part of the health visitors' core work
- The Harm Minimisation Service is improving its service provision through a robust system of audit of clinical practice to provide an up to date picture of the quality of practice and identify trends or issues regarding joint working
- There has been audit work undertaken by Public Health Drug & Alcohol Team and an action plan is in place led by a team manager with support from the 'safeguarding children' team to address safeguarding responsibilities including child protection conference attendance and core group working
- Health Visiting Services are currently considering the need to maintain a continued support period for children and families following formal removal from s.17 Children Act 1989 support i.e. children could receive a 'universal plus service' until a robust assessment has confirmed all known concerns are resolved

6.2.2 At a national level, the introduction of an inspection framework for GP Practices should serve to highlight insufficiently clear arrangements in the commissioning or delivery of 'shared care' arrangements.

7 RECOMMENDATIONS

7.1 INTRODUCTION

7.1.1 Of the recommendations below, the first 3 for the LSCB were generated by the overview author and panel. The rest were identified by IMR authors. When effectively implemented in accordance with detailed 'action plans' accompanying this report, they should further strengthen local safeguarding arrangements for children.

7.2 RESPONSIBILITY FOR IMPLEMENTATION

Oxfordshire Safeguarding Children Board
1. The independent chair of the Board should propose to Children's Social Care that a well-informed and sensitively worded letter is drafted and retained in records so that when child H is of sufficient age to do so, s/he can establish why, when and how alternative care became necessary and that a serious case was completed
2. The Board should recommend that pharmacists in the County be reminded of the expectation that Children's Social Care or Police should be informed if they are concerned a drug dependent person might pose a risk to their own or another child
3. The Board should recommend that the Commissioners of GP Services and Public Health Commissioners review their monitoring processes to ensure collaborative management of contracted services provided in General Practice in particular drug and alcohol services.
Oxfordshire NHS Foundation Trust
Health Visiting Service
4. Review training needs of health visitors in relation to parental substance misuse and its impact upon parenting
5. Raise awareness (by means of amended guidance, and audits of compliance) of the need to include the safe storage of methadone in discussions about accident prevention
6. Continue to promote the use of assessment tools, neglect tool kit and the threshold matrix to inform risk assessment and robust care planning
7. Review joint working between health visiting and Harm Minimisation Service with respect to substance misusing parents to ensure risks are fully assessed and robustly managed
Harm Minimisation Service
8. The service should review arrangements for attendance at child protection conferences and core groups so as to ensure compliance with Oxfordshire Safeguarding Children Board and Trust policies
9. Review and ensure that all documentation is standardised and subject to regular audit and review
10. Ensure that comprehensive risk assessments including client's history are undertaken and recorded
11. Ensure within all shared care arrangements (addiction services) regular joint reviews and assessments are completed with the responsible GP

Thames Valley Police (TVP)
12. TVP should lead a scoping exercise into the viability of making routine referrals to Children's Social Care about parent / carers presenting with substance misuse
13. TVP should effectively communicate to staff the importance of thorough research into parents, children and unborn children (to provide a full picture) and to then consider the effect of any drug or alcohol misuse identified on parenting ability. If there are concerns a 'child protection – non crime incident' should be created for referral to PVP Referral Centre.
14. TVP should liaise with the Police National Computer to assess the viability of flagging the children (to include unborn children) and the parents of children subject to child protection plans; consideration also to be given to what other databases within Thames Valley Police (NICHE) could be flagged to increase awareness of the existence of Child Protection Plans.
15. TVP should run a pilot in Oxfordshire whereby the Neighbourhood Policing Teams are made aware when children in their area become subject to child protection plans
16. TVP should effectively communicate to relevant staff that it is the responsibility of an officer identifying safeguarding concerns to create a 'child protection – non crime incident' and not assume that: • it will be created by someone else; or • other agencies already know the information
17. TVP should ensure custody sergeants are aware that any safeguarding concerns identified in custody are communicated to the investigating officer and they are instructed to create a 'child protection – non crime incident'; the custody sergeant is responsible for ensuring this happens and the reference number is placed in the custody record
18. TVP should create guidance for 'case conference writers' about sharing intelligence information in child protection conference reports; this guidance is to be effectively disseminated to the writers to promote confident and effective information sharing in this area
19. TVP should draft and provide guidance for source managements officers in relation to child safeguarding information and how to deal with it
20. TVP, in consultation with Children's Social Care and other relevant agencies should expedite completion of its current review of policy across the three counties with the intention of ensuring a physical presence at child protection conferences based upon the criterion of need rather than previous or current level of agency involvement
Thames Valley Probation Service
21. The Probation Service should confirm (and initiate any further actions required) that all staff working with substance misusing parents have attended specialist training on the particular risks posed to children (including unborn) by those individuals
Oxfordshire Clinical Commissioning Group
22. The learning from this and other SCRs should be shared with the GP practice that provided a service to mother and with other practices across the County; summaries should be circulated in locality newsletters and briefings undertaken within the locality; training events should include a section on SCR learning
23. The safeguarding lead in each GP Practice needs to be supported so that they can ensure the Practice is meetings expectations of safeguarding child patients
24. A safeguarding information resource hosted by Oxfordshire CCG should be established on the GP intranet and used to update practice guidance and procedures
25. The documentation process in the involved GP Practice should be reviewed and best practice guidelines developed so as to ensure accurate and timely information sharing across the Practice and with multi-agency professionals

26. When invited to child protection conferences, GPs should ensure that they provide direct feedback to the conference chairperson about their involvement or ensure representation by active agreement with others in the primary care team
Children's Social Care
27. Pre-birth assessment practice procedures should be reviewed and amended to ensure that assessments start at latest by 28 weeks of gestation where previous Care Proceedings
28. Pre-birth conferences should be held at least 1 month before the child's estimated date of delivery
29. Training and guidance in relation to working with drug mis-using parents should be developed and highlight the importance of maintaining a close working relationship with wider family and friends to assist with ongoing risk assessments
30. When a professional provides information on a closed case a decision as to whether to respond to it as a 'contact' or new 'referral' should be made within 24 hours by a team manager and confirmed with the professional providing the information
Oxford University Hospital NHS Trust
31. A policy for actions to be taken, including who should be informed, in the event of cancellation or non-attendance at routine antenatal appointments (including scan appointments) should be developed
32. Mechanisms for transferring information from maternal to baby notes about medical or social issues relevant to baby need to be made more secure
33. Midwifery safeguarding training should include reminders of the importance of prompt, accurate transfer of information from maternal to baby notes and of clear communication of discharge plans to community midwives in babies with social concerns
34. The children's did not attend (DNA) policy should be re-written to reflect the fact that children of parents about whom there are concerns relating to substance misuse, domestic violence or mental health, or those already subject of child protection plans should automatically regarded as high risk if they are not presented at appointments
35. All paediatricians should be notified of the re-written policy and the flowchart that summarises it laminated and displayed at each outpatients clinic; the importance of careful assessments of 'DNAs' should be highlighted in training
36. The neonatal referral form to the paediatric infectious disease clinic should be amended to highlight in relevant cases, the fact that if a baby is the infant of an intravenous drug user; a system of flagging such babies on the clinic list should be developed

8 GLOSSARY OF ABBREVIATIONS

Agency / Abbreviation	Meaning
AIT	Area Intelligence Team
CAFCASS	Court and Family Advisory and Support Service
CAIU	Police Child Abuse Investigation Unit
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CCTV	Closed circuit television
CEDAR	Crime Evaluation & Data Analysis database
CHC	Child Health Clinic
CSC	Children's Social Care
CPD	Continuing professional development
DRR	Drug Rehabilitation Requirement
EDT	Emergency Duty Team (an out of office hours service provided by Children's Social Care)
HCP	Healthy Child Programme
IA	Initial Assessment
IOM	Integrated Offender Management
IMR	Individual management review
IVDU	Intravenous drug user
LASAR	Local Single Agency Assessment & Referral Service
LDU	Local Delivery Unit (of Probation Service)
MIU	Minor Injuries Unit
OASIS	Open Access Social Inclusion Support
OST	Opiate substitute therapy
PCHR	Personal Child Health Record
PNC	Police National Computer (history of previous convictions)
PCSO	Police Community Support Officer
PVPU	Protecting Vulnerable People Unit
SCAS	Specialist Community Addiction Service
TAC	Team Around the Child
TVPT	Thames Valley Probation Trust
Roles	**Meaning**
DW	Drugs worker (specialist nurses)
GP	General practitioner
HV	Health visitor
PO	Probation officer
SW	Social worker
TM	Team manager (in Children's Social Care)

9 BIBLIOGRAPHY

General

- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial study of serious case reviews 2003-2005 Marian Brandon, Pippa Belderson, Catherine Warren. David Howe, Ruth Gardner, Jane Dodsworth, Jane Black, DCSF 2008
- Learning Lessons, Taking Action: Ofsted's evaluations of serious case reviews 1April 2007 to 31 March 2008 Published December 2008
- The Child's World Jan Horwarth Jessica Kingsley 2008
- Learning Together to Safeguard Children: A 'Systems' Model for Case Reviews March 2009 SCIE
- Healthy Child Programme DH 2009
- A Study of Recommendations Arising from Serious Case Reviews 2009-2010 M Brandon, P Sidebotham, S Bailey, P Belderson University of East Anglia & University of Warwick
- Understanding Serious Case Reviews and their Impact a Biennial Analysis of Serious Case Reviews 2005-07 Brandon, Bailey, Belderson, Gardner, Sidebotham, Dodsworth, Warren & Black DCSF 2009
- Building on the learning from serious case reviews: A two-year analysis of child protection database notifications DFE – RR040 ISBN 978-1-84775-802-6 2007-2009
- Working Together to Safeguard Children, HM Government 2010 & 2013
- Ages of Concern: learning lessons from serious case reviews: a thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011
- Munro Review of Child Protection: A Child-Centred System TSO www.tsoshop.co.uk Professor Munro 2011
- New learning from serious case reviews: Marian Brandon et al RR226 DfE 2012
- Improving the Quality of Children's Serious Case Reviews Through Support & Training@ NSPCC, Sequili, Action for Children; DfE 2013 (revised Feb. 2014)

Case-specific

- Think child, think parent, think family: a guide to parental mental health and child welfare: Social Care Institute for Excellence. 2009
- Think Family Toolkit (Improving Support for Families at Risk). DCSF 2010 The National Institute for Health and Clinical Excellence Guidelines
- All Babies Count Rayns, Gwynne, Dawe, Sharon, Cuthbert, Chris (2013): Spotlight on drugs and alcohol. London: NSPCC. http://www.nspcc.org.uk/spotlight
- Derbyshire Local Safeguarding Children Board: Serious Case Review Overview Report In respect of Child BDS12 November 2013
- Serious Case Review 'Daniel' Wolverhampton Safeguarding Children Board 2013
- Medications in Drugs Treatment: Tackling Risks to Children ADFAM 2014