Learning from the Serious Case Review – Child H

A summary of the case reviewed:

This case concerned a one year old child accidentally ingesting 40-50ml of prescribed methadone that had been in a bottle in the mother's handbag, whilst temporarily alone in the room. There was a delay in emergency services being called and Child H needed resuscitation. However Child H made a full recovery.

Child H's mother had been known to Children's Social Care since the age of 15 and had a history of drug use. Child H's older sibling was removed at the age of 5 months due to concerns about mother's substance abuse and its impact on her ability to parent.
When child H was born the case was monitored via a 'child protection plan'. This was stepped down to a 'child in need plan' when he was aged seven months and closed five months later. The case remained open to other services.

At the time of the incident, child H lived with their mother and the father was not involved in child H's upbringing. Mother was known to a number of different universal and specialist services including adult drug services, police and social care.

How was learning achieved?

The case review followed the more traditional SCR model. It was overseen by a panel representing all agencies involved. They were led by an independent chair and jointly drafted a terms of reference. Each agency nominated a colleague to complete a chronology of events and written reports.

An overview author read these reports and met with those colleagues to collate an overview report. The aim was to learn the following:

- were there issues with individual professional judgment or actions?
- how effective was the family–professional interaction?
- were there any issues with systems including IT in managing the case?
- was there independent oversight of the case?
- how well had they worked together in assessment and longer term work?
- how well had they worked together in response to incidents and crises?

This approach generated the learning detailed below. The family also contributed to review and provided their perspective on work undertaken with them.

The review 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.

Themes in common with other case reviews in Oxfordshire

- **Neglectful parenting** over a protracted period leading to increased risk levels
- **Effort and attention paid to mother** led to the focus on the child often being lost
- **Lack of professional's curiosity** about self-reported information

Learning points for managers

- **Supervision:** the structure for supervisions should be reflective and ensure that the practitioner is making decisions based on all information and focus is maintained on the child
- **Management:** ensure that all practitioners are using all available tools especially the Parental Substance Misuse Toolkit and plan actions in a SMART way. Ensure practitioners are trained in responding to neglect, physical injury and sexual abuse.
- **Escalate:** if risks are not reducing, despite interventions, escalate to senior manager and make use of legal panel/ complex case panel according to criteria met.
- **Support:** debrief difficult events when there have been hostile or difficult interactions with family members.

Action points for practitioners

- **Do not automatically take the parents/Individual's information as fact**, check it with the social worker/drugs worker

- **Language**: ensure you have a joint understanding of the language used, such as 'illicit drug free' or 'in recovery' as these can mean different things to different people.

- **Use the No Names Consultation** for practical advice if you have a concern and are unsure whether to make a referral

- **Refer the child** to the CAN substance misuse worker at the local Early Intervention Service hub for support around their parent's drug and/or alcohol use

- **Understand the referral process** to ensure you make the right kind of referral and know what to expect. Provide complete information to the best quality that you can

- **Support the parent/s** throughout the time that they receive safeguarding support, contribute to joint plans and contingency plans, and help determine risk, with the social worker

Key messages for inter-agency learning

- **Good Practice:** means that you ensure that you are using all available tools and resources, especially the drug and alcohol screening tools, the neglect toolkit, the Model of Good Multi-Agency Practice and Information Sharing Protocol, and making use of the training available from OSCB and Drug and Alcohol Services

- **Be proactive:** ensure you are aware of the relevant support services available and have identified the social worker/drugs worker working with the child/family and have on-going communication and share information

If you do one thing, take the time to…

- Find out about the local drug and alcohol services and understand what interventions and support they can offer to adults and young people.
  Are you getting the best out of joint working with them? Are you able to constructively challenge their safeguarding practice?

Training and resources

- OSCB training – OSCB offers a variety of face-to-face and online courses including Substance Misuse & Parenting and Drug & Alcohol Awareness
  Training | Oxfordshire Safeguarding Children Board

  The OSCB recommends:
  - Drug and Alcohol – Increasing Knowledge/Reducing Risk
  - Substance Misuse and Parenting

- Multi-agency safeguarding procedures – The OSCB multi-agency procedures cover a wide variety of situations you may encounter. You can access them at http://oxfordshirescb.proceduresonline.com/
- Good multi-agency practice guidance – The OSCB have created a model of good multi-agency practice incorporating the Local Assessment Protocol http://www.oscb.org.uk/user_controlled_lcms_area/uploaded_files/OSCB%20Local%20Assessment%20Protocol.pdf
- Seven Golden Rules for Information Sharing – Professionals should familiarise themselves with the golden rules for sharing information. There is a downloadable flyer available on the OSCB website: http://portal.oxfordshire.gov.uk/content/publicnet/other_sites/oscb/documents/professionals/Neglect/7_Golden_Rules.pdf
- Drug and Alcohol Screening Tools – In the Parental Substance Misuse Toolkit http://www.oscb.org.uk/user_controlled_lcms_area/uploaded_files/PSM%20toolkit.pdf
- Drug and Alcohol Team, Public Health Tel: 01865 328607 www.oxfordshiredaat.org for up to date information on all drug and alcohol services for adults and young people

The purpose of a serious case review 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’

A serious case review (SCR) is not concerned with the attribution of culpability which is a matter for a criminal court.