Serious Incident Learning Review Summary (SILR12B)

Introduction

The Derbyshire Safeguarding Children Board Serious Case Review Sub Committee met on 05/10/2012 to consider the issues surrounding the recent death of the child. It was agreed that agencies involved with the child and family would present a written summary of their involvement, which would inform a reflective facilitated workshop. The aim of the Review was to consider how agencies had worked together to safeguard the child and to identity any lessons which could be learned to inform future practice.

Purpose of the review

A one off reflective workshop was held involving practitioners and managers who worked directly with the child and family. The purpose of the review was to:

- Consider any issues in relation to this specific case and similar cases
- Examine practice across agencies and develop learning
- Contribute to the development of practice
- Make recommendations to the Derbyshire Safeguarding Children Board in relation to the outcome of the review.

Agencies involved in the review

- Derbyshire Children and younger Adults Department (Area and Disabled Children's Team, Children's Centre)
- Derbyshire Police
- Nursery and Primary School
- Health visiting
- North Derbyshire Drugs Team
- Sherwood Forest Hospitals NHS Trust
- Parental Substance Misuse Social Worker

Family History

The child was the youngest of four children; the eldest child was subject to a Residence Order and placed with her maternal grandmother. Following the death of the child the other two children were made subject to Care Proceedings and placed with their aunt under an Interim Care Order. Mother and Father were long standing drug users of Heroin and had been known to drug treatment services for some years. The couple had been on Methadone programmes for a long period of time. Parents had a range of criminal convictions including shoplifting, burglary and possession of drugs. Father has one conviction of violence for having a bladed article in public. Mother had been convicted of child cruelty in December 2001 leaving a child in the house alone in dangerous circumstances.

The family originated from the Nottinghamshire area.

The child's death was not suspicious; she was born with significant heart problems and died in surgery. At birth the child was found to have drug withdrawal problems as a result of mother's Heroin use prior to birth.

Agency Involvement

Drug Treatment Services have been involved with both parents over many years; parents had opted in and out of services, using Methadone programmes sporadically.

Midwifery and Health Visiting Services had been provided in line with expected protocols. The health visitor had been proactive in encouraging parents to ensure the child attended health appointments. The health visitor had noted that parents were not good at setting boundaries and did not encourage age appropriate development and needed support with this.

Specialist health professionals were involved with the child there appeared to be little co-ordination of the complex number of appointment which the child needed to attend.

Children's Social Care in Nottinghamshire had been involved previously in 2006 and 2008 although these recorded were not accessed.

There had been six referrals to Children's Social Care in Derbyshire; four of which resulted in no further action. The concerns appeared to have been regarding neglect issues and parental drug use. On one occasion, there were concerns that father was under the influence of drugs whilst driving the children to nursery and school. On 29/06/2012, the children's centre worker requested additional support and a CAF was completed. A referral was made on 01/07/2012 in relation to practical and financial support as it was known that the unborn child had medical problems.

Derbyshire Police held information regarding parents shoplifting with the children and other intelligence this was not shared with other agencies.

Key Issues Identified within the Review

<u>Assessment of Neglect</u>

There was failure on the part of parents to ensure that all medical appointment for the children was kept. The health visitor was proactive but the DNA policy by some health providers means that children are discharged after two failed appointments. The two older children did not attend nursery and school on a regular basis, there was excellent input from agencies to encourage attendance. There was evidence that the parents failed to address the children's developmental needs in terms of feeding and toileting. The level of neglect had become apparent following the older two children's admission into the care of the local authority.

<u>Assessment of Parental Drug Use</u>

The drug services and the police were aware of the long standing drug issues but there was little communication with children's agencies. Long standing offending behaviour was evident and on occasions this behaviour was undertook whilst the children were present.

Communication between drug workers and midwifery services needs to be improved. In this case the child's mother stopped collecting her Methadone prescription when 7 months pregnant this should have been identified as a potential risk factor.

Professional Assessments

The referrals made to children's social care did not result in an assessment being undertaken. The child had significant disabilities and was clearly a child in need. Earlier services should have been provided in a co-ordinated way which may have resulted in a fuller picture of the environment these children were living in and highlighted the concerns that have been raised in this review. It is understood that there has been a change in the process in relation to children with disabilities which should now ensure a 'team around the child' approach.

Communication

The information regarding the mother's previous conviction for child cruelty was not taken into account. The fact that an older child had been subject to care proceedings should have informed the assessment. The review has highlighted the need for thorough checks and good communication between agencies. The GP appeared to be totally absent in terms of involvement with this family but would have almost certainly held relevant information.

Good Practice

The health visitor in this case was proactive in trying to ensure the children's needs were met and was tenacious in following up appointments.
School were very proactive in ensuring that any absences were followed up, this included visits to the home.

Conclusion

The death of the child was neither preventable nor predictable; although it was known before birth the child had a significant heart problem. It is known that parental drug use impacted upon the care of the children this however was not fully assessed and when referrals were made to children's social care they did not result in assessment or services being provided to the family.

Recommendations

- Adult drug services should routinely ask questions in relation to any children who are being cared for, or who are in contact with drug users.

Consideration should be given to factors which should indicate a referral to Children's Social Care and other agencies.

- Communication should also take place between drug services and other professionals, especially where parental co-operation with a plan changes. This is particularly important where services are provided across geographical boundaries.
- Where a child with disabilities is not receiving appropriate care, (appointments, stimulation, general care), a multi-agency meeting should be convened in order to consider necessary action. The CAF could be used for this purpose.
- Initial assessments should include checks with all agencies, including adult drug services and the police.
- Nurseries should consider monitoring attendance of children with disabilities or additional needs.
- The police should take account of children who are 'used' by adults who offend and safeguarding issues should be considered.
- Once Care Proceedings have been initiated, a system should be in place to ensure that good communication is in place with all agencies, in particular those who are continuing to work with parents.
- Where appointments are not attended, the specialist should complete a risk assessment in relation to the importance of the appointment and if necessary, communicate concerns to the GP and the referrer.
- The LSCB Escalation Policy should be highlighted to staff in all agencies via the LSCB Bulletin.
- The planned multi-agency audit should consider issues raised in this review.