

Serious Case Review
Child 2
Executive Summary
3 December 2010

BWRDD LLEOL DIOGELU PLANT

GWYNEDD & YNYS MŌN

LOCAL SAFEGUARDING CHILDREN'S
BOARD

ADOLYGIAD ACHOS DIFRIFOL /
SERIOUS CASE REVIEW

EXECUTIVE SUMMARY REPORT

PLENTYN 2 / CHILD 2

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1. INTRODUCTION.

- 1.1 Child 2, the subject of this Serious Case Review was born on 11 June 2009, the third child of her birth mother and first child of her birth father.
- 1.2 Child 2's extended maternal birth family is of White Welsh ethnicity. Whilst they are bilingual, Welsh is their first and preferred language of communication.
- 1.3 Child 2's birth father is of White English ethnicity.
- 1.4 On the 4 January 2010 as a result of toxicology tests it became apparent that Child 2 (then aged 6 months), who was at that date hospitalised due to chest and respiratory problems had Methadone in her system. Child 2's mother was arrested and later admitted that she had been administering Methadone to Child 2's milk through her feeding bottle since Child 2's birth.
- 1.5 On the 18 February 2010 Child 2's birth mother pleaded guilty to the charges of 'Supplying methadone and ill treating her child' and she is currently serving a three year prison sentence.
- 1.6 Child 2's father was arrested on the 7 July 2010 and charged with eight offences: 4 charges of supplying methadone, 2 charges of supplying heroin, the assault/ill-treat/neglect of a child and threats to damage property. His case will go to trial in Crown Court at a later date.
- 1.7 Child 2 is now a child looked after on an Interim Care Order under The Children Act 1989 s.38 as are her siblings. Care Proceedings in respect of the three children are ongoing.
- 1.8 At a meeting of the Gwynedd and Anglesey Local Safeguarding Children Board's Serious Case Review Panel on 16 March 2010 it was agreed that Child 2's case fell within the criteria for undertaking a Serious Case Review in accordance with Regulation 4 of The Local Safeguarding Children Board (Wales) Regulations 2006.
- 1.9 It was agreed that ongoing care or criminal proceedings should not unduly delay the writing of the Serious Case Review report.

2. THE SERIOUS CASE REVIEW

Terms of Reference

2.1 Purpose of the Serious Case Review (SCR):

- The purpose is not to apportion blame but to establish whether there are lessons to be learned from the case about the way in which professionals and agencies work together to safeguard children.
- To identify clearly what the lessons are, how they will be acted upon, and what is expected to change as a result.
- To identify good practice.
- To consider whether the actions of each agency were in accordance with the relevant legislations, regulations and, statutory guidance.
- Where appropriate, to make recommendations.

2.2 Scope of the Serious Case Review

- The Gwynedd and Mon Local Safeguarding Children Board SCR Panel is responsible for overseeing, convening, and chairing the Serious Case Review.
- The Independent Chair of the SCR Panel is an Assistant Director of Children's Services, Barnardo's Cymru.
- The independent Author will be recommended by the SCR Panel and commissioned by the LSCB.
- The period covered by the review will commence from first known contact between Child 2's Mother and Father which is estimated as 01/01/07 to Child 2 placement with foster carers on the 11/01/10.
- Relevant information regarding the wider family will be included.

The Serious Case Review Panel

2.3 The membership of the Serious Case Review Panel is made up of representatives from the agencies detailed at 2.7 below along with Public Health Wales. The panel was independently chaired.

2.4 The Serious Case Review Panel met on the following occasions to consider this case: 16 March 2010, 14 May 2010, 22 June 2010, 7 September 2010, 30 September 2010 (IRM authors) and 12 November 2010.

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- 2.5 The overview author met with the Chair of the SCR Panel on 15 June 2010, 19 July 2010, 2 November 2010 and 10 December 2010.

Process and Timescale of the Review

- 2.6 The initial timescale for presenting a draft SCR report to the SCR Panel was 7 September 2010. A combination of factors meant that this timescale was no longer attainable. The Wales Assembly Government has been kept closely informed as to progress throughout this process.

Basis of the Report

- 2.7 The following agencies completed Chronology Of Events and Single/Internal Management Reviews in accordance with the helpful templates agreed by the LSCB: BCUHB [includes contact with Midwifery Service, Health Visiting Service, School Nursing Service, inpatient care at Ysbyty Gwynedd, Speech and Language Therapy Services and Substance Misuse Service]; North Wales Police; Gwynedd Social Services; Cyngor Gwynedd LEA [including education provision, SEN Joint Committee, and Education Welfare Service]; National Probation Service, and SSD 2 .
- 2.8 The individual agency chronologies were merged by the overview author.
- 2.9 Additional information and clarification was sought and obtained by BCUHB, NWP, Gwynedd SSD and Cyngor Gwynedd LEA.
- 2.10 The author had access to the transcribed Judgment in the Finding of Fact Hearing held within the Care Proceedings process.
- 2.11 The author had separate face to face meetings with the birth mother and the maternal grandparents who were identified as significant persons in this case.
- 2.12 It is recognised that the role of Child 2's half siblings was and remains a pivotal one in this case. As they are now looked after by the local authority their needs in expressing their 'voice' in this regard will be addressed by the local authority.

Messages from the SCR Process

- 2.13 The provision of central administration has been a critical factor in maintaining the momentum of this process.

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- 2.14 All agencies have complied with and responded openly to the request to provide information and have given careful consideration to the pertinent factors.
- 2.15 The difficulties in gleaning the child's 'voice' and experiences (subject and siblings in this instance) and reflecting it in the SCR process and report.
- 2.16 The overview author wishes to thank everyone for their contribution to this process. The overview author recognises that this process signifies a particularly sad and difficult time for all the family members.

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3. SUMMARY OF THE AGENCIES' INVOLVEMENT DURING THE DESIGNATED PARAMETERS OF THE SERIOUS CASE REVIEW, 1 JANUARY 2007 - 11 JANUARY 2010.

- 3.1 The National Probation Service (NPS) has gleaned historic information from other Probation Departments in relation to Child 2's birth father's criminal activity between 1990 and June 2004.
- 3.2 SSD 2 has been primarily involved with A and B's birth father, his partner and her child who live in their authority area. SSD 2's direct involvement with A and B was limited to a request by SSD to SSD2 to undertake an Initial Assessment (IA) in relation to contact arrangements between A and B and their birth father at his home and the referring of allegations against Child 2's birth father which resulted in the S.47 (TCA 1989) investigation dated 13 January 2009.
- 3.3 Gwynedd County Council LEA became involved with Child 2's siblings, A and B in relation to their schooling prior to the time parameters of the SCR. Their continued involvement has included pre-school and continuing assessment of SEN needs, primary school provision and EWO services.
- 3.4 The NWP became involved initially on 26 June 2007 as a result of a shoplifting incident. They have been further involved in incidents of expressed concern in relation to the children and domestic abuse. They were also involved in relation to Child 2's birth father.
- 3.5 Following some involvement with Child 2's family during November 2005 and March 2006, SSD became involved again following the shoplifting incident and the subsequent referral by the NWP. The case remained open to SSD throughout the period of the SCR. Involvement included the assessment of need, dealing with expressions of concern, S. 47 child protection enquiries, the impact of substance misuse, relationship difficulties (including wider family) and housing difficulties.
- 3.6 BCUHB's [Midwifery Service, Health Visiting Service, School Nursing Service, inpatient care at Ysbyty Gwynedd, Speech and Language Therapy Services and Substance Misuse Service] involvement is as detailed:
 - The School Health Service were involved in monitoring A and B regularly throughout this period.
 - The SMS became involved with Child 2's birth mother following the SSD referral emanating from the shoplifting incident and

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remained involved up until her case was closed in late December 2009.

- The SMS became involved with Child 2's birth father following his self referral to the service.
- Midwife involvement began at the ante natal 'booking' stage and continued until the post natal discharge following Child 2's birth.
- Health visiting involvement began following Child 2's birth and continued throughout this period.
- Hospital staff were involved at the time of Child 2's birth and during her subsequent three admissions to hospital during November and December 2009.

4. SUMMARY AND CONCLUSIONS

- 4.1 Hindsight with the benefit of an overview of all the agencies' involvement and related information is a privileged vantage point from which to reflect and make observations whilst considering a specific case in a vacuum devoid of other pressures and competing priorities.
- 4.2 This highly complex case illustrates the challenges facing practitioners in the field of social welfare within the current context of balancing and negotiating a tight rope between the two conflicting social policy tenets of partnership and paternalism (Blom Cooper Jasmine Beckford Inquiry 'crossroads of competing social policies').
- 4.3 The 2009 Ofsted Review of Serious Case Reviews acknowledges the challenge:
- "It is really important to recognise that social workers and others...are working with some of the most difficult, chaotic and unpredictable families in the community" (2009 p.6).
- 4.4 It is clear that the practitioners involved with Child 2 and Child 2's family were highly committed and conscientious professionals and any comments or suggestions proffered are done so within this context. Identifying lessons to be learnt is a positive aspect of the SCR process.
- 4.5 This is an exceptional case in terms of its outcome and in the overview author's opinion no one could have foreseen this particular outcome. However, in the overview author's opinion the case provides valuable learning points.

Expressions of Concern

- 4.6 It appears that the birth father was perceived by the agencies involved as being a peripheral figure in this case.
- 4.7 In retrospect there may have been opportunities to identify Child 2's birth father earlier and establish the nature of his relationship with Child 2's birth mother and his role in relation to the children.
- 4.8 Child 2's case highlights the need to undertake a comprehensive core assessment informed by a consideration of all the known factors

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including the role and relationship of all family members including partners, concerns of neglect, substance misuse, domestic violence, of which direct work with the children of the family is an essential element.

- 4.9 The SSD conducted an Initial Assessment and concluded that substance misuse was a feature in this case. The SSD rightly identified the need to address this aspect and made an appropriate referral to the SMS. The SSD accepts that this should have led on to a Core Assessment and the development of an inter agency Child in Need Plan which would have provided mechanisms for inter agency monitoring, reviewing and communication and a basis for revisiting thresholds determining the status of the children as children in need rather than as children in need of protection (if that became necessary).
- 4.10 The status of the case in terms of whether it was open or closed to SSD appears to be a central factor around which there was the potential for confusion, particularly in the context of inter agency working vis a vis safeguarding responsibilities, sharing of information and referral protocols.
- 4.11 Child 2's case has provided an opportunity for the NWP to clarify the categorization processes of emergency calls particularly in regard to the categorization of domestic abuse concerns and triggering the appropriate protocols.
- 4.12 Child 2's case has provided an opportunity to address the identified deficits in designating whether child protection investigations become single agency or not and to ensure that arrangements in this regard comply with the requirements laid out in the All Wales Child Protection Procedures 2008 at 3.4.1 - 3.4.3, including agency representation, clear referral process and clear recording of strategy discussions.
- 4.13 Child 2's case has provided an opportunity for the BCUHB to consider internal protocols within the hospital and recommendations have been made in this respect.

Child development

- 4.14 Regarding the child development concerns in this case it is important to note that the initial involvement of the NWP and SSD and subsequent referral to the SMS resulted from an incident of shoplifting food. Whilst in themselves the references in this case to child development, failure to keep medical appointments and a level of non school attendance are not in themselves indicative, in the overview author's opinion they contribute to the wider picture.

It was very important to disregard other potential causes such as neglect and lack of nutrition and good practice for the SHN and SSD to refer to the Community Paediatrician and obtain medical reassurance in this regard. The school health service continued to monitor this aspect diligently throughout this period.

Drug Misuse and Treatment

- 4.15 Child 2's case provides an opportunity to consider the use and validity of drug testing in cases of concern for the welfare of children whose parents are or have a history of misusing drugs.
- 4.16 There is evidence that both the process for urine testing and its contribution to the sphere of monitoring concerns about the welfare of children in this case is unclear. This finding can undoubtedly be applied more generally to cases as echoed at a recent conference, helpfully referred to by the BCUHB IRM author :

"A review of current use of testing, its benefits and limitations, and guidelines for where it could be used would be helpful, from an impartial group including forensic physicians and others involved in child protection" (Dr Heather Payne, Consultant Paediatrician Concateno Conference July 2010).

- 4.17 In the overview author's opinion, the agencies' response to:
- the siblings' situation,
 - the pregnancy of Child 2's birth mother,
 - Child 2's birth, and
 - the period following Child 2's birth,

would (and indeed should) have been different if it were known, or indeed if there was doubt, that Child 2's birth mother had continued to misuse drugs prior and throughout her pregnancy. In my opinion, the 'belief' that Child 2's birth mother was 'clean' of drugs erased the question mark regarding substance misuse and its impact on and implications for parenting capacity. This assumption was a

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significant contributor to the lowering of the level of perceived concerns about the family.

- 4.18 With regard to the matter of both birth parents working with the same SMW, following the realisation that the service users' were partners in a relationship, in the overview author's opinion consideration should have been given to the allocation of two separate workers. These two individuals, both with their own stresses and vulnerabilities, were in a relationship of which conflict was a feature which inevitably led to conflicting interests at times. The added dimension of dependent children introduces another dimension of responsibility and highlights and reinforces the need for objectivity. The provision of separate workers would protect practitioners from being placed in a situation of a conflict of interest - particularly when the situation involves children.
- 4.19 The need for specific guidance and tools in the application of the Assessment Framework to families where parents have drug / alcohol problems' in order to facilitate and inform the assessment process is identified in the SSD IMR.

Domestic Violence

- 4.20 It is evident to the overview author that domestic violence / domestic abuse was a current and previous feature in the life of Child 2's birth mother. Undoubtedly, therefore it was a feature in the lives of Child 2's siblings.
- 4.21 Whilst it is clear that 'domestic violence/ abuse' concerns were expressed by the SMS and the SSD on identified occasions the explicit nature of those concerns were not recorded in the information available to the overview author.
- 4.22 NWP were involved in a clear incident of domestic violence when threats to kill Child 2's birth mother were made by Child 2's birth father. Unfortunately, this incident was wrongly categorised and as a result the agreed domestic violence protocol was not adhered to, and as a result the relevant agencies were not informed. This experience has informed a resulting recommendation.
- 4.23 The impact of domestic abuse / violence on children is now recognised in legislation with the inclusion of 'impairment suffered from seeing or hearing the ill treatment of another' within the definition of 'harm' in TCA s.31 (9) (as amended by the ACA 2002).
- 4.24 It appears to the overview author that there may have been an unhelpful distinction made in this case between 'domestic violence'

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and 'domestic abuse' (SCWT 2006 9.49 - 9.51) and a lack of awareness:

- that 'domestic abuse' encompasses a wide spectrum and is not confined to domestic violence alone
- about the relationship between domestic abuse and the harm experienced by dependent children

Engagement and Compliance

4.25 Missing medical appointments appears to have been a historic feature in this family. There are also numerous examples of appointments being missed and changed during the period of the parameters of the SCR.

4.26 There is a distinction between missed appointments due to a chaotic and pressured lifestyle and the deliberate manipulation which characterises the condition which is now recognised as 'disguised compliance'

4.27 In hindsight the later difficulties in engaging the family whilst indeed a chaotic and pressurised lifestyle were a feature were due to deliberate non compliance:

"It is likely that the mother was avoiding contact ... for fear of detection because as we now know she was administering dangerous doses of Methadone to the baby's feeds at this time" (BCUHB IMR 5.5.12)

4.28 The timescale of Child 2's birth mother's pregnancy, the birth of Child 2 and the months following coincided with a lessening of contact with agencies, in particular the HV, SMW and SW. The combination of the withdrawal of agencies' involvement (based on the SMS and SSD presumption that the situation did not warrant further intervention) and Child 2's birth mother's avoidance of agencies' attempts to engage happened at the same time that Child 2 and her family were becoming increasingly more vulnerable.

4.29 It is important to state that the agencies involved had no indication of the reasons for the difficulties in engaging Child 2's family. During our meeting when asked what the agencies could have done which would have been helpful to her, Child 2's birth mother clearly stated that during that period of her life no intervention would have shifted her focus from herself as the main priority.

4.30 The term 'disguised compliance' was first attributed to Reder & Duncan (1993). It is often difficult for practitioners who are involved

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with complex and challenging families to maintain an objective view of progress and to contextualise the 'rule of optimism' (Beckford Inquiry). It is recognised that working in these circumstances can have a disabling effect on the practitioner, on practice and process and therefore on the focus on the child. This feature was highlighted in the Climbie Inquiry and in this context Lord Laming (Climbie 2003) advocated the importance of applying critical evaluation, keeping an open mind and employing a 'respectful uncertainty' when dealing with families.

The Voice of Child 2

- 4.31 The difficulties in representing the voice of the child within the SCR process are widely recognised. Throughout this process whilst I have strived to do justice to everyone involved with the case I am mindful that the overriding responsibility is ensure that Child 2's 'voice' resonates throughout this consideration of events.
- 4.32 Child 2, the subject of this review is too young to be able to contribute or even contemplate what she has experiences. However, a time will come when she will have to try and comprehend what happened to her and her family.
- 4.33 Child 2's siblings, whilst not direct subjects of this report, have their own 'truth' regarding these events and it is important that they are enabled to express their voice in this regard.

The Voice of significant others

- 4.34 Child 2's maternal grandmother felt that there should be stringent testing and more information available to pregnant mothers about the adverse effects of drug use on their babies, particularly if drug misuse is or has been a feature.
- 4.35 Child 2's maternal grandfather's felt that awareness about the lessons to be learnt from this case should be raised amongst lay and professional people. He also felt that the agencies involved following such events need to recognise and understand the continuing impact and shock of such an event on family members.

Working Together

- 4.36 The three components of this aspect
- Working together between adult and children's services
 - Working together across agencies
 - Working together within agencies

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have been addressed in the individual IMRs, in the sections above and reflected in the recommendations made.

- 4.37 The roles and responsibilities of all agencies (including adult services) under Section 28 of the Children Act 2004 are clearly detailed in Section 2 of the WAG guidance SCWT (2006)
- 4.38 All professionals [including those working with adults] need to be alert to the needs of children ... should routinely enquire about and consider:
- ✓ dependant children (or significant others)
 - ✓ children acting as young carers
 - ✓ compromised parenting capacity
- (WT 2006 para.2.127 etc).
- 4.39 There is no evidence to suggest a reluctance to work together nor a reluctance to share information across and between agencies. There is clear evidence of liaison and sharing of information, although at times the liaison, and at other times the content is not clearly recorded.
- 4.40 In the overview author's opinion a written plan such as the CIN Plan would have provided a mechanism and structure to ensure that this multi agency process was formalised in accordance with established procedures.
- 4.41 It is positive to note that one of the BCUHB recommendations recognises the need to develop a coordinated approach in respect of the variety of services included within their agency.

5. **RECOMMENDATIONS:**

Recommendation 1:

It is important that any recommendations arising from this case made within individual agencies/LSCB are included within the SCR Action Plan including timescale, with appropriate cross referencing, permission and acknowledgement where relevant.

Recommendation 2:

When an initial assessment of a child's needs is undertaken which determines that a child is in need, the nature of any services required and from where and within what timescale and that a further more detailed assessment should be undertaken, then a core assessment must be completed.

Recommendation 3:

'CIN plans should be in place for each child receiving a service. These plans should be formulated through meetings with service users and appropriate agencies and should be reviewed on a regular basis'.

Recommendation 4:

NWP - 'Operational Communications Divisional Command Team to be included in the action plan for this SCR to consider what are perceived to be weaknesses in the processes surrounding this particular incident and to take whatever action they deem necessary'

Recommendation 5:

The arrangements for Strategy Discussions should comply with the requirements of the All Wales CPP (2008) and include a recognized formal and written referral process in respect of each strategy discussion, and that these strategy discussions are formally recorded

Recommendation 6:

The inter - agency 'referral' process for cases that are currently open to the SSD should be considered and clarified with regard to a shared understanding regarding process and terminology between SSD and professionals in other agencies

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Recommendation 7:

The case closure processes and protocols in respect of the closure of child care cases within the SSD, including the role of supervision should be considered and clarified

Recommendation 8:

The use of the Safeguarding Children Notification Form and The Discharge from Hospital Protocol used within the hospital setting should be considered and clarified to ensure a shared understanding about their use and significance

Recommendation 9:

The Safeguarding Issues Concerning Children / Young People Record (green form) should be reviewed to ensure its fitness for purpose.

Recommendation 10:

BCUHB should require managers to ensure that training needs in respect of safeguarding are addressed in the appraisal system and that their staff attend appropriate training courses detailed in the Health Board Safeguarding Training Strategy.

Recommendation 11:

BCUHB should require all clinical leads to ensure that where staff record safeguarding concerns on supplementary records then these are recorded in full on the appropriate clinical record. This should be actioned on receipt of this report.

Recommendation 12:

BCUHB should alert doctors to the need to consider a toxicology urine check as part of the routine investigations included for that child's admission when a child of parents who are known to be or have been drug users, is admitted to hospital with an acute illness. The number of tests taken and the number of positive results should be collated and reported to the Board after 12 months.

Recommendation 13:

BCUHB in conjunction with the SMS and primary care staff should consider developing a survey to determine whether the activity of

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administering small amounts of Methadone to babies is commonplace in the community following the identification of this individual case.

Recommendation 14:

The overview author concurs with the BCUHB IMR author that the highly complex matter of drug testing within a child welfare context already highlighted at local and national level should be the subject of review.

Recommendation 15:

That BCUHB in conjunction with the LSCB, SMS and CSP develop a policy with regard to the SMW allocation of service users who are in a relationship with one another, if either or both of them have children.

Recommendation 16:

The LSCB, the BCUHB and the Community Safety Partnership (CSP) responsible for co-ordinating substance misuse services should:

- a) Conduct joint training in substance misuse including identification and assessment of impact on parenting capacity, monitoring and individual agency role and responsibility
- b) Develop / adopt relevant assessment tools in identified cases.

Recommendation 17:

The LSCB should:

- a) Conduct joint training in domestic abuse including definition, identification and assessment of impact on parenting capacity and individual agency role and responsibility
- b) Develop / adopt relevant assessment tools in identified cases.

Recommendation 18:

Multi agency training should be provided and a protocol developed in working with cases involving children in which resistance and disguised non compliance may be a feature.

Recommendation 19:

BCUHB should develop and implement a protocol to support health professionals in delivering a coordinated approach to family care when there are a number of health professionals involved in providing primary and secondary care services to a family and

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vulnerability in parenting capacity is implied. This to be actioned within 6 months of receipt of this report.

6. APPENDIX - KEY

Child 2	Subject of this Serious Case Review
A	Child 2's sibling
B	Child 2's sibling
AWCPP	The All Wales Child Protection Procedures (2008)
Assessment Framework	Framework for the Assessment of Children in Need and their Families, National Assembly Wales 2001.
BCUHB	Betsi Cadwaladr University Health Board
ACA 2002	Adoption and Children Act 2002
CIN	Child in Need
CP	Community Paediatrician
CSP	Community Safety Partnership
HV	Health Visitor
IA	Initial Assessment
IMR	Internal Management Report
LEA	Local Education Authority
LSCB	Local Safeguarding Children's Board
NPS	National Probation Service
NWP	North Wales Police
SCR	Serious Case Review
SEN	Statement of Educational Needs
SHN	School Health Nurse
SHS	School Health Service
SMS	Substance Misuse Service
SMW	Substance Misuse Worker
SW	Social Worker
SSD	Social Services Department
SSD 2	Social Services Department - other
TCA 1989	The Children Act 1989
TCA 2004	The Children Act 2004
WT 2006	Safeguarding Children: Working Together under the Children Act 2004 (WAG 2006)