Serious Case Review in relation to Child C

Born: 2013
Died: 2015, age 2 years 4 months
Ethnicity: White British

Overview Report

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1. Introduction

1.1 Summary of circumstances leading to the Serious Case Review (SCR)

1. Born in February 2013, Child C was the youngest of five children. She was described by a number of professionals as lively and a sociable young child. Following an unplanned birth at home, Child C was admitted to hospital where paediatric assessment noted a cleft lip, a tremor and a raised temperature.

2. Five days after the birth, Child C was transferred to a neonatal intensive care unit with neonatal abstinence syndrome [1] resulting in significant withdrawal symptoms requiring medical intervention of an oramorph[2] regime. Both parents were known drug users and were engaged in a Drug Treatment Programme (Methadone).

3. On 5th June 2015 at 09:54hrs, an ambulance was called to the home of Child C. A paramedic on a rapid response vehicle and a double crewed ambulance were dispatched. On arrival at her home Child C was found to be cyanosed, not breathing, in cardiac arrest and the paramedics therefore commenced basic life support. Crew members were notified by the family that Child C had consumed approximately 20mls of mothers prescribed Methadone at around 07:30hrs. It was unclear at that time as to why no medical help was sought. The mother had attempted to make Child C vomit to expel the methadone. Child C underwent full advanced life support and was taken to the Accident and Emergency Unit. Resuscitation was unsuccessful and Child C was certified as deceased at 11:50hrs. The Police and Specialist Children's Services (SCS) were notified of the incident.

1.2 The SCR Process

4. The case was referred to the Kent Safeguarding Children Board (KSCB) on 12th June 2015 and was subject to initial discussion with the KSCB Case Review Sub Group.

5. A recommendation was made to the KSCB Independent Chair, Gill Rigg, who agreed to commission a SCR.

6. The decision to undertake the SCR was based on Working Together, Regulation 5 (2) of the Local Safeguarding Children Boards Regulations 2006 defines a Serious Case Review as one where:

(a) abuse or neglect of a child is known or suspected; and
(b) Either
(i) The child has died; or
(ii) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child

7. In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure

[1] Neonatal Abstinence Syndrome is a term used for a group of problems a baby experiences when withdrawing from exposure to narcotics.

[2] Oramorph is a drug containing the addictive ingredient morphine sulphate (an opioid pain killer) and is the most commonly used treatment for babies with neonatal abstinence syndrome.

children's home, or where the child was detained under the Mental Health Act 2005. This includes cases where a child died by suspected suicide.

It is considered that the case meets regulation 5(2) (a) abuse or neglect is known or suspected, and (b) (i) the child has died.

1.3 Scope and Terms of Reference of the SCR

8. The scope and terms of reference were set out by the KSCB SCR Panel as follows are outlined in Appendix A of this Report.

1.4 Independent Overview Report Author

9. The Independent Overview Report Author is Jane Appleby, who has compiled this Overview Report, contributed to the Integrated Action Plan and facilitated meetings with Individual Management Report Authors and a Practitioners Learning Event.

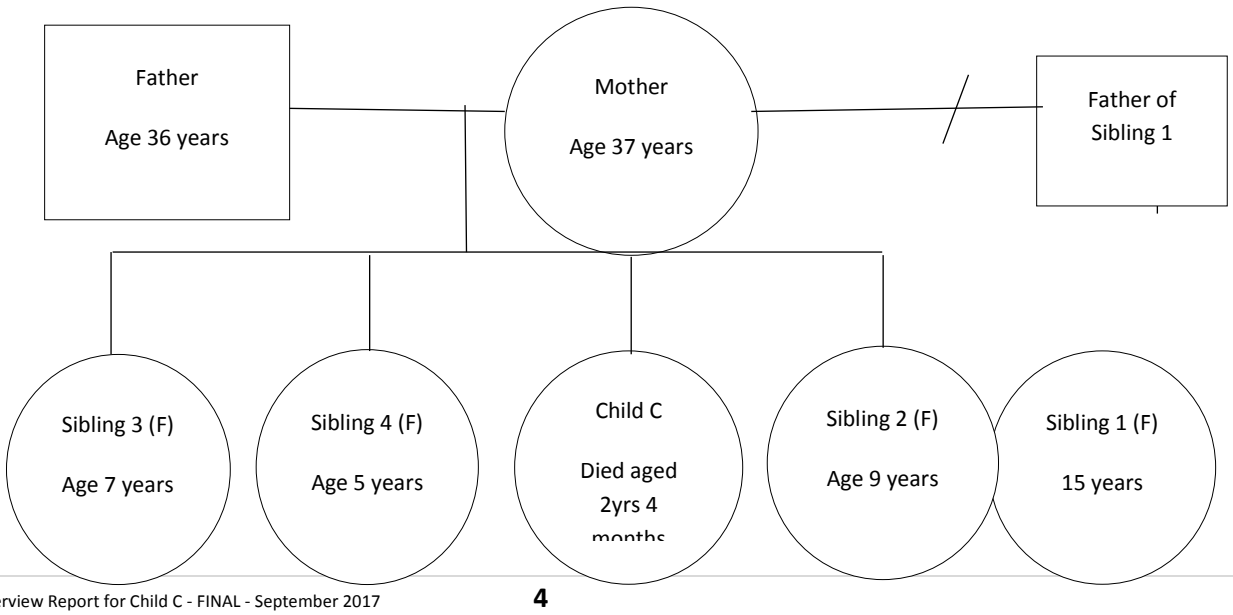
10. She is a qualified and registered Nurse and Manager with over 40 years' experience in the National Health Service across clinical, operational management and strategic leadership, and 12 years as a Lead for Safeguarding Children and Vulnerable Adults. In the last two years she has worked as an Independent Consultant having the opportunity to work with a range of public and independent services/agencies and providing a wide variety of work assignments.

11. The Independent Overview Report Author is not employed by any of the agencies of the Kent Safeguarding Children Board.

2. Family Background and History

2.1 Family Composition

12. There was no evidence in any of the reports submitted by the agencies involved with the family that any issues of race, religion, language or culture affected events in this case. The family's ethnicity was White British. The family lived in rented accommodation in a Kent coastal town.



13. Both the maternal and paternal grandparents were reported as supportive of the family, and specifically the maternal grandmother who undertook a number of caring duties for the children. Sibling 1 lived with the maternal grandparents for a period of time.

2.2 Family History

- Agencies were known to be involved with the family since 1998. There was no information in the agency records of the early history of either parent.
- At the time of Child C's death, the mother and father were separated. At the time of writing, the father was serving a 9 year sentence in Custody for Grievous Bodily Harm.
- Both the mother and father were known long term drug users on a Drug Treatment Programme (Methadone)[3].

There were a number of significant family themes that emerged from agency records:

- Both parents had on occasions been involved in criminal activity
- The mother booked late for four out of five pregnancies and four of the children were born out of a hospital
- All the children had some degree of neonatal abstinence syndrome
- All professionals observed good bonding and relationships between parents and children
- Turning Point, (the Drug User Support Service working with the parents), reported that parents generally worked well with and adhered to the Drug Treatment Plan (Methadone). Initially, Drugs User Support Services were provided through Kent Council for Addiction (KCA), then latterly, by Turning Point
- The family had contact with 21 different health services: there was consistent poor attendance at health appointments
- The children all had some degree of developmental needs ranging from minor heath issues to significant global developmental delay
- Parents on a number of occasions didn't respond to/seek help for their children's health needs
- There were 16 referrals to SCS, 5 professional contacts, 7 initial assessments and 1 core assessment
- Low level concerns for attendance at school
- Varying views of home conditions – sometimes clean and tidy whilst at other times reported there was no furniture, poor conditions, no heating and children sleeping in one bed and curtains drawn all day and rooms were dark
- There were reports of three domestic incidents, but this was not seen as a collective pattern

[3] Methadone is a synthetic opiate manufactured for use as a pain killer and as a substitute for heroin in the treatment of heroin addiction. It has similar effect to heroin but doesn't deliver the same degree of buzz or high as heroin. Opiates are drugs that depress the nervous system. They slow down the body functioning and reduce physical and psychological pain. A patient who is addicted to heroin will often be prescribed Methadone to take instead of heroin and the dose of Methadone is gradually reduced over time. This means that the patient can give heroin up avoiding acute withdrawal symptoms

3. Key Practice Episodes

14. The scope of this review was from 1st January 2012. However, it was felt that a summary of the significant events proceeding this time would be helpful to gather an overall picture of the issues relating to this family. Below summarises Key Practice Episodes between 1999 and 2012. This is followed by a greater focus on the Terms of Reference between January 2012 and June 2015. This evidence has been extrapolated from the Agencies' Individual Management Reports (IMR), the Integrated Agency Chronologies and the Practitioners Learning Event.

3.1 Key Practice Episode 1999 – 2005

15. The key agency known to the family at this time was the Police due to criminal activity associated with drug use and shoplifting. In August 1999, it was reported that the mother was 4 months pregnant.

16. Midwifery Services made an initial referral to SCS on 18th October 1999 regarding unborn Sibling 1. This referral was in accordance with Midwifery policy relating to a substance using mother. SCS completed an initial assessment and the case was closed in November 1999.

17. Sibling 1 was born in December 1999. Mother booked late at 27 weeks gestation. It is recorded that she was using heroin in early pregnancy and was subsequently placed on a Methadone programme (45mls daily which was then reduced to 15mls daily). Shortly after the birth it was noted that mother was determined to come off Methadone and stay clean and that she planned to see a counsellor.

18. KCA (Drug User Support Service) contacted the Midwife a few days prior to the birth informing her that mother was not attending all of her appointments and may be using other substances. Recent urine tests had been positive to opiates. A referral had been made to SCS by KCA. (There is no record within SCS of this referral).

19. There was no record of a discharge planning meeting taking place.

20. Although it was not recorded at the time where the birth took place, it is recorded later where it is noted at the birth of the second child that it was the second time that birth had taken place at home.

21. It is noted that Sibling 1 demonstrated a small level of neonatal abstinence syndrome in the first few days, but not enough to require medication.

22. Sibling 1 was reported to be living with the mother and grandparents and the family environment appeared to be stable. The father of Sibling 1 is not referred to in the records.

23. Child C's father was arrested by police on a warrant. He was known to be staying at the same address as the mother, for 3 or 4 nights a week. This was the first time that agencies became aware of him.

24. In May 2005, a referral was made to SCS by the school where Sibling 1 attended. The referral stated that Sibling 1 had been taken and collected from school by her mother's partner, Child C's father. She was often late arriving and he was "extremely verbally abusive and threatening to school staff".

25. Child C's father was subsequently banned from the school premises. The school felt that Sibling 1 may be at risk. SCS suggested that the school should contact the Education Welfare Officer to discuss.

3.2 Key Practice Episode 2006 – 2008

26. In April 2006, prior to the birth of Sibling 2, SCS received another referral from the Community Drug Worker, who stated that the mother had been accessing KCA and was being prescribed Methadone (130mls daily). The father was also using Methadone. It was also reported that the mother had presented herself to KCA when she was 7 months pregnant.

27. The case was allocated and an initial and core assessment were completed by a Social Worker. It is noted that the mother was engaging with health services and that Sibling 1 was being offered good care by her parents. Both the mother and father continued to use Methadone and it is recorded that the mother was said to have an awareness of the possible detrimental effects on the unborn baby of her use of Methadone.

28. At the time of the assessment, the mother was having 130mls of Methadone per day and stated that she felt her dose was high due to the impact of long term drug use raising her tolerance. She stated she had enquired with the KCA worker about reducing her use of Methadone, but was told that this would be unsafe in the last trimester. The outcome of the assessment was a Child in Need Plan. This enabled professionals to share information around the parents' drug use and any concerns there may have been around this and the possible effects on the unborn child.

29. The Child in Need Plan included a requirement for the parents to participate in the Drug Misusing Parent's Scheme arranged by KCA. The Child in Need Plan identified some concerns regarding Sibling 1's behavior, describing her as 'argumentative and willful' when asked to do something she did not want to. SCS stated that they would consider convening a Case Conference should the necessity arise.

30. Sibling 2 was born May 2006. The mother delivered the baby unattended and unplanned at home. Sibling 2 subsequently spent 12 days in Hospital due to Methadone withdrawal. The mother had booked late for her second pregnancy at 34 weeks gestation. She is recorded as being on a significantly higher dose of Methadone (130mls daily). A 'Concern and Vulnerability' form was generated by the Community Midwife at the time. It stated that the parents were on a Drug Treatment Programme (Methadone) and both had tested negative to opiates. There was an allocated Social Worker following a referral by KCA.

31. Between July 2006 and November 2006, there were a number of 'no access visits' where the Health Visitor has made attempts to visit the family home and also there were a number of 'non-attendance' at hospital appointments. When Sibling 2 was eventually seen by the Health Visitor, she was "very alert, excellent eye contact, a sociable and happy baby". It was recorded that there was excellent interaction and handling observed between the parents and sibling 2. Non-attendance and no access visits continued to be a problem through early 2007. There was no evidence as to whether the concerns around not being able to access the home were escalated to SCS.

32. On 3rd June 2008, a referral was made to SCS by the Midwife, as the mother was pregnant with her third child and was continuing to use Methadone, as was the father. The Midwife was concerned about the welfare of the unborn baby and made a referral to the Obstetric Consultant and Paediatrician to discuss possible effects on the unborn child. Although there was concern about the possible effects of drug use on the unborn baby, it was noted that there were stable relationships between the mother and father; they were compliant with the treatment drug programme and attended most of their appointments. SCS made a decision not to take any further action at this time.

33. Sibling 3 was born in August 2008 and remained in hospital for 9 days during which time she was closely observed for Methadone withdrawal symptoms. Symptoms were present and minor and did not

warrant medication. In November 2008, the GP made a referral to SCS due to the failure of the mother to bring the baby for the 6 week check. This resulted in an Initial Assessment being completed in December 2008 by a Social Worker. The Social Worker explored with the parents their use of Methadone. The parents confirmed they kept it high up in a cabinet as they did not want to keep it in the fridge due to the children and storing it with their food.

3.3 Key Practice Episode 2009 - 2011

34. Out of Hours contact was made with SCS on 15th June 2009 by a member of staff at the Children's Centre based within the local Community Centre. A member of the public had shared concerns with staff that the mother had been heard to shout excessively to the children and the children were often heard to be screaming at their home. Out of Hours did not progress the contact to a referral, but notes suggest that they would have done so if required by the duty senior from the local Duty and Initial Assessment Team (DIAT).

35. The mother was pregnant with her fourth child. On the 4th September 2009, a referral was made to SCS by the Midwife, due to late booking, reported missing appointments and scans, and the mother continuing to be a Methadone user.

36. An initial assessment was completed on the 12th October 2009 by a Social Worker and it was concluded that the mother had attended 3 Midwifery appointments and 3 scans, but that each appointment was with a different Midwife.

37. The outcome of the Initial Assessment stated that parents were considered as child focused parents who put the needs of the children first as 'best they could'. The Initial Assessment suggested that all children were observed as part of the work. It was not clear if any children were seen alone by the Social Worker. Sibling 1 was seen to be taking a mature role in the house and liked to help her mother with the care of the little ones.

38. The Social Worker's records indicate that a further referral was made by Midwifery services regarding non-attendance at appointments and being difficult to engage with. (*Given that the family was generally noted to be engaging with KCA in terms of Methadone, this was potentially significant as it may indicate avoiding toxicology screens*). It was noted that the Midwife was not happy with the response from the allocated Social Worker and she raised this with her Head of Midwifery and the Named Nurse for Child Protection.

39. A Professionals meeting took place on the 22nd October 2009 and a pre-birth plan was drawn up and distributed to relevant professionals. It was also planned to have a discharge planning meeting. The Social Worker was to be notified when the mother went in to labour and following the birth of the baby. Despite the pre-plan being distributed on the 23rd October 2009, no Midwife in the Maternity Unit had read the plan and had not informed the children safeguarding team or the Social Worker. The case was closed by SCS on 10th November 2009.

40. Sibling 4 was born in November 2009 and was kept in hospital for a week in case of Methadone withdrawal symptoms. Three days after discharge, Sibling 4 was readmitted with Methadone withdrawal symptoms and required a short regime of Oramorph in order to maintain her comfort. At the time, urine toxicology was requested by the Consultant Paediatrician; however, results were not reported back until two months later. The results did identify Methadone positive as well as Opiates positive. Sibling 4 was discharged home ten days after readmission.

41. On 24th February 2010, an anonymous caller contacted SCS regarding 4 children. The caller did not know the names, but stated that the children "do not see the light of day" and that there was dog mess all over the garden. An Initial Assessment was completed on 29th March 2010. The children presented as happy and the home conditions appeared good enough, although cramped. There were no concerns identified so the case was closed.

42. A referral was received by SCS from Kent Police on 3rd December 2010 following the mother contacting them on 1st December 2010 reporting a Domestic Abuse incident in which she had been injured by her partner. The 3 younger children were present at the address when this happened. The mother stated at the time that this had been the first time he had been violent towards her, (*although this was not the case as SCS had received a referral regarding domestic abuse in December 2007*).

43. A Social Worker contacted the mother on 8th December 2010 to discuss this domestic abuse incident. The mother informed the Social Worker that she had already been contacted by the Domestic Violence Unit (Police) and had told them that everything was "okay". The mother stated that she had good support from her parents. The case was closed.

44. On 9th December 2010, the ambulance services contacted SCS expressing concerns about the family's home environment. They had been called to the home to see Sibling 4, who was said by the parents, to have had blue extremities, breathing problems and a reduced level of response. Ambulance staff stated that they were concerned with the environment that the children were living in, describing the house as being cold with no furniture, carpets or wallpaper. All the children were said to have been in the same bed and the house was described as being very run down. When the ambulance staff attended, the mother and father informed them that two of the other children had chest infections.

45. An Initial Assessment was completed on 4th January 2011 by a Social Worker who considered "that mother and father are conscientious parents and they are moving forward in providing a better home environment for their children". "The walls had been painted, new furniture had been bought and much of the groundwork had been prepared for laying of new carpets, for wallpaper to be bought and new bedding".

46. Siblings 2, 3 and 4 were observed in their parents' company during a social work visit and were described as being "gentle and caring towards each other and appeared to have a warm and loving relationship with both parents, evidenced by appropriate eye contact, cuddles and a relaxed demeanor in the presence of both parents". The mother and father were described as being attentive towards the children and encouraging each child in their individual and group activity. They were described as a "loving and caring couple".

47. The assessment concluded that there was no need to progress the referral in to a Child in Need meeting as it was felt the best course of action was to support the parents in providing a warm and safe home for the children by applying for financial support to expedite the situation.

48. The case was closed on 10th May 2011, but at this time it was noted by health professionals from the hospital and Health Visiting, that there were concerns about poor attendance at hospital appointments, (Sibling 3 and Sibling 4 were attending the Orthoptist and Audiology), non- attendance at Playschool, 'no access' visits, and on the occasion that home contacts were made, the parents were willing to engage, but this rarely happened.

49. During 2011, Sibling 1 completed a behavioural intervention programme and pastoral support was put in place for anger management support.

3.4 Key Practice Episode 2012 - 2015

50. On 1st March 2012, the Police were called to an incident where it was reported that three children were left in a car crying and screaming. The Police undertook a welfare check and spoke to the mother. The children were seen and there were no injuries. Information and advice was given. The Police made a referral to the SCS Out of Hours Team. The children were described as being "all in order, well fed with no visible injuries". The Out of Hours Team notified the day team of the incident. It was agreed that no further action was needed.

51. On 9th March 2012, Sibling 1 received a 5 days fixed term exclusion from School for bullying.

52. On 11th May 2012, Sibling 3 was subject of a Common Assessment Framework assessment which was requested by early years in preparation for a school placement. Sibling 3 was known to have speech and language difficulties, visual problems, required toilet training and general developmental delay. At the assessment, no other children within the family were considered.

53. On 31st May 2012 the family were discussed at a Single Point of Access meeting as the school expressed concerns regarding all children, but specifically Sibling 3, (development needs, significant behavior issues and bedwetting); and Sibling 2, (lateness to school and poor attendance at times). Support was put in place for the family from the Pre- School Family Liaison Officer.

54. On 10th August 2012, the Police were informed by a local resident that Sibling 2 was at their house late. The resident had taken Sibling 2 back home and had to bang on the door for 40 minutes before the father answered. The house was in darkness. When the father answered the door, there was a strong smell of cannabis. The resident reported that the children are often left on their own. Police took no further action themselves, but made a referral to SCS.

55. On 20th August 2012, it was recorded in the Health Visitor's notes that Sibling 3 had been re-referred to the Orthoptist but did not attend.

56. On 20th and 21st August 2012, two incidents occurred. It was reported to the Police that a child was heard screaming and sounded in distress, plus an adult could be heard screaming and swearing. In addition, Police Officers were called to a supermarket car park regarding a domestic abuse incident between the mother and father. The mother said she did not want to go into detail, but that an incident had been brewing for a couple years. The mother was not in fear for her safety. A DASH Risk Assessment[4] was carried out and deemed to be 'standard risk'. SCS made three attempts to contact the family. Health Visiting services were contacted for their views, as was KCA.

57. The case was closed by the Central Duty Team on 24th August 2012. The rationale being that six of the previous referrals/professional contacts were considered and that there was a Team Around the Family in place which included the children's school, children's centre and health visitor and the plan was for KCA

[4] DASH Domestic Violence Risk Assessment

The introduction of the Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was first developed by the Police in 2009 and meant that for the first time all police services and a large number of partner agencies across the UK would use a common checklist for identifying and assessing risk, which would save lives. ACPO Council accredited the DASH (2009) Model to be implemented across all police services in the UK from March 2009.

to join. The rationale stated that although the matter was concerning, from "agency information" it was not a repeating concern and neither was the drug use as the parents were being tested within KCA with no concerns evident.

58. On 28th August 2012, the decision by SCS to close the case was reviewed and agreed as part of management sign off.

59. On 29th August 2012, a letter was sent to the mother and father by the Social Worker informing them that a referral had been received and advising them to continue to engage with the Team Around the Family process.

60. On 24th October 2012, the Health Visitor undertook a home visit to review medical appointments and the children's health needs. The parents reported that they are doing "ok and did not need any additional help at this time". They agreed to ensure that the children attend all future appointments. The parents' drug use was discussed.

61. On 18th November 2012, the father, together with others, was involved in a serious assault. The father was initially bailed. As part of the Court bail conditions, the father was not allowed to enter the home town whilst on bail. He was later charged and convicted in May 2013, receiving a 9 year prison sentence.

62. The mother was taking care of the children on her own and it was recorded by the Health Visitor that she may have needed additional help. The mother disclosed on 4th December 2012, that she was pregnant, but did not want the baby, so had not booked with the Midwife. She planned a termination in London but was not able to attend. The Health Visitor offered support.

63. The Health Visitor visited the home on 13th December 2012. The mother and father had agreed to keep the baby. The mother was encouraged to book an appointment with the Midwife as matter of urgency. The Health Visitor agreed to contact the Midwife.

64. On 29th December 2012, the mother booked a Midwifery appointment at 32 weeks gestation (late booking).

65. On 18th January 2013, the Health Visitor undertook a home visit. The father visited the family briefly. The children were upset when he left and the Health Visitor reported that Sibling 3 had a major tantrum. The other children were feeling insecure and emotional. The Health Visitor suggested that a pre-birth plan would need to be put in place and agreed to contact the Midwife. The Health Visitor was also planning to attend a Team Around the Family meeting on 22nd January 2013.

66. The Health Visitor also considered a referral to SCS as she believed the family difficulties were beyond a Team Around the Family plan. Professionals at the meeting did in fact agree with this and the Health Visitor agreed to make a referral under the category of Children In Need.

67. A referral was received at SCS stating that the children were showing signs of emotional distress and the family was at crisis with the potential for neglect. The case was allocated to a Social Worker for an Initial Assessment.

68. The Social Worker visited the family home on 31st January 2013. The mother and Sibling 4 were present and the mother accepted that she would likely struggle following the arrival of the new baby, given that the father was not allowed in the family home. The mother stated that she wanted the father home as

soon as possible as he was staying at his parents' home. She explained that she received significant support from her mother and mother–in-law and expressed an interest in receiving support with Sibling 4 who she described as being "clingy". The Social Worker's notes stated that Sibling 4 was observed playing with toys and demonstrated appropriate stranger awareness. The house was described as being clean and tidy and the children's bedrooms were of an appropriate standard.

69. The fridge was described as being sparse and the mother informed the Social Worker that she intended to go shopping; she showed the Social Worker waffles and baked beans which she intended to feed the children later for tea.

70. The Social Worker discussed the situation with the Health Visitor who stated that the family had not engaged with the Team Around the Family and she felt that this was due to them being overwhelmed and disorganised. She added that the mother was over optimistic as to how well she would cope with the care of the new baby and "talks the talk".

71. The Initial Assessment was completed on 6th February 2013. It identified the following:

- The mother was a recovering heroin addict and she was using 60mls of Methadone
- All children were seen as part of the assessment, the Social Worker spending time with each child
- The mother was described as preparing well for the birth and planning to remain in hospital, if necessary, after the birth. She refuted the claim that the pregnancy was concealed and stated that she had received the contraception injection prior to getting pregnant
- Sibling 4 was said to have presented as being fit and healthy and up to date with her immunisations. She was attending nursery and had slight speech and language delay which the Social Worker felt would benefit from speech and language support. The mother was observed to understand what her child was saying and respond appropriately
- Sibling 2 presented as fit and healthy and the assessment informed that she had recently lost her front milk teeth. She was attending school and although there were no concerns about her academic attainment there were some issues around lateness
- Sibling 3 also had lateness for school. She was reported to have a "lazy eye" and recently had suffered with an infection in her hip. She was described as a 'happy and smiley child'
- Sibling 1 was seen outside the family home at school and stated that she was initially angry with her mother for getting pregnant again. She was attending school regularly and although there were some concerns that she was involved in some bullying behaviour, she had a firm group of friends
- School staff had reported that Sibling 1 was a bright child who had the potential to be one of the highest achieving pupils in her year; this was not the case at the time and it was noted that she could try harder
- The house was considered to be clean and tidy and all the children were having regular contact with the father at his parents' home

72. The analysis of the assessment considered the risks on the baby of withdrawal from Methadone, he father being involved in a serious assault and the mother struggling to manage the care of the children. Worries about the children being late for school were also considered. The protective factors at the time included, the children being of the age where they could voice their wishes and feelings and that they were regularly seen in their respective schools. Although often late, the children's school attendance was at a good level and the children were having regular contact with their father, spending the night with him at his parents' home. Both sets of grandparents indicated that they could offer a high level of support to mother, including sharing the care of the older girls while she stayed in hospital with the baby following its

birth. The mother had accepted support from a Social Work Assistant to address some boundaries and routines to help her for when the baby is born during the assessment.

73. Summing up the assessment, the Social Worker stated "in light of the above I do not feel that SCS intervention is proportionate or warranted at this time; mother has a wide range of support who have all stated their intention to help the family during this time and in the longer term should father be sentenced. The children's schools will continue to monitor the children, as will the Team Around the Family. I feel the family would benefit from a family support worker joining the Common Assessment Framework (CAF) process also with support from KCA. A Social Work Assistant is undertaking a short piece of work in the interim".

74. KCA advised that they had worked with the family for five to six years. The mother was doing really well; she was on a shared care scheme with a GP commissioned through KCA, who was seeing the mother monthly, although the sessions had increased due to being pregnant. The worker had attended the home on a number of occasions and the children presented 'beautifully' and been seen to engage well with parents.

75. **Child C (subject) was born on 13th February 2013.** As with previous pregnancies, Child C was born unattended at home. An ambulance attended, shortly followed by the Midwife on call. Child C was transferred to the Labour Ward at the local hospital. Child C was observed to have a cleft lip, noted to have a tremor and a raised temperature. There was a plan to observe for Neonatal Abstinence Syndrome.

76. On 18th February 2013, Child C's condition deteriorated and she required admission to Neonatal Intensive Care Unit.

77. On 20th February 2013, it was noted that Child C had a high pitched cry, poor sleep, tremors, increased tone, poor feeding, vomiting and loose stools. Records indicate that it was considered that Child C was likely to be in pain due to Methadone withdrawal and Oramorph medication was increased.

78. The Health Visitor informed staff on the Neonatal Intensive Care Unit that she had notified Social Services of the current position and had asked for extra support for the family. There was already a Team Around the Family in place. The Health Visitor commented that the mother and father did not live together and that the father was not allowed to visit the family home and that he was a "devoted father".

79. It was noted that the Health Visitor said that although the parents were chaotic in their management of the children, both were very loving and not a danger to each other or the children. It was also recorded that the Health Visitor confirmed that the children were considered Child in Need two years ago, but were not now, and some of the children have complex needs.

80. On 25th February 2013, there are records of various calls made to the Hospital Safeguarding team, the Social Worker, KCA and Health Visitor by the Neonatal Intensive Care Unit. The Social Worker was contacted by the team who confirmed the case was closed to SCS and bail conditions prevented the father residing at the family home. The Nurse highlighted that the mother would have five children with her on her own. It was stated that although maternal and paternal grandparents give a lot of support, they are reported to be unaware that mother is on a Drug Treatment Programme (Methadone). (*This is a change from previous pregnancies when the grandparents were noted to be aware of issues and supportive*). A conversation with the Health Visitor was recorded and she stated that she had known the family for some time. She felt that the case had escalated and stated that she referred recently and the Social Worker was to reassess, but she felt that the case should remain as a CAF.

81. On 23rd April 2013, Child C was discharged from Hospital and taken home by the mother. It is noted that all relevant professionals were informed of the discharge and that the Health Visitor was to visit on the 25th April 2013. Child C spent 65 days in hospital withdrawing from methadone, requiring a day in Intensive Care and 56 days in High Dependency Unit. The neonatal discharge summary noted there was Neonatal Abstinence Syndrome. The baby started withdrawing and needed high doses of oramorph for this for a substantial period of time. She was clinically well at discharge. She has an incomplete cleft lip. She was seen by the Cleft Lip and Palate Specialist Team, for a follow up. A discharge summary was sent to the GP and Health Visitor.

82. Following discharge, Child C had several follow up appointments, a referral to Orthoptist for visual problems and received an enhanced service from Health Visiting.

83. On one Health Visitor visit to the home, it was recorded that Child C had her hair shaved, although there is no explanation for this, or indeed any enquiry into why her hair was cut so short.

84. A Team Around the Family meeting was held in March 2013, which the mother attended. Discussions focused on ensuring a regular attendance at school as it was reported that there were low level concerns about lateness and attendance, the general developmental delay of Sibling 3, speech delay for Sibling 4 and planned cleft lip surgery for Child C.

85. On 12th April 2013, concerns were raised regarding Sibling 4 non-attendance at nursery. This was apparently due to arrears in fees.

86. In May 2013, the Health Visitor identified at a home visit, that the mother had no money. She had borrowed money from her mother to buy food for the children, but this wouldn't last for the weekend. The Health Visitor approached a charity regarding a food parcel.

87. On the 10th June 2013, a telephone call was made by the Cleft Lip and Palate Specialist Nurse to the Health Visitor to notify her that Child C had not attended for her pre-operative assessment (for cleft lip surgery). Surgery was eventually undertaken in October 2013. Sibling 3 was noted by the Health Visitor to have immature behaviour, tantrums and demanding of adult attention.

88. Also on 10th June 2013, the mother contacted Turning Point (who were awarded the contract to provide drug treatment services in April 2013, previously delivered by KCA) to say that three bottles of Methadone had fallen from the safe storage box in the home as she was putting them away after collection. There were no concerns regarding the mother's ability for safe storage. The Shared Care GP (a GP with Special Interests who works with Turning Point to monitor the prescribing of Methadone and undertakes medical reviews) accepted the incident as accidental and doses were replaced.

89. On the 25th June 2013, the School recorded that Sibling 1 was having difficulties at School, had friends who were a bad influence and had an 'exclusion' due to poor attendance and violent behaviour. She had been staying with her grandparents, but was spending more time at home again.

90. Over the next few months, a number of Team Around the Family meetings took place. The mother attended some and contributed. All appeared to be well, with the family receiving additional support. There was some mention of consideration being given for the mother to begin reducing her Methadone.

91. In January 2014, the mother notified the Local Authority in writing of her decision for Sibling 1 to have Elective Home Education and that Sibling 1's maternal grandmother would undertake this.

92. On 25th January 2014, Child C had her 1 year developmental review. She was reported as developing age appropriately, sociable, engaging and inquisitive. It was observed that she may have a possible squint in one eye.

93. In August 2014, it was documented by the Health Visitor that the family situation appeared stable; however, there remained some issues that the mother was failing to ensure all Child C's health needs were being met. These included non-attendance at Orthoptist and that she was overdue for her immunisations.

94. Housing reported an incident on 1st September 2014. A Housing Manager, along with a Neighborhood Manager, witnessed a couple of small children running around the communal grass area near to their home and one of them running across the car park next to the communal area as a large van was reversing.

95. The children were seen to bang on their family house door and call through the letter box. After 10 minutes, the Manager banged on the door and then the window. The mother eventually opened the door and reported that there was an older child looking after the younger ones. There was no evidence of an older child supervising them. A referral was made to SCS expressing concerns about the safety of the children. A call was also made by Housing to the Police to notify them of the incident. The mother was spoken to by a Social Worker, but seemed unconcerned. Agency checks were undertaken but no significant concerns were raised.

96. On 13th May 2015 when the mother attended to collect a prescription, it was reported by Turning Point that the mother had 'continued' use of illicit Methadone and that her current prescription was not sufficient. They were not able to action this without a review by the Doctor, so a medical review appointment was booked for 10th June 2015. It was also reported that the mother had not attended for her fifth consecutive medical review. It was agreed that any prescriptions were to be collected from the hub to ensure that the client was seen.

97. On 20th May 2015, the Health Visitor attempted a home visit, but there was no reply. A text message was sent to the mother and a note put through the door to offer a visit on 26th June 2015.

98. On 5th June 2015, at shortly before 09.50hrs, a 999 call was made by a friend of the mother, who reported that Child C was unresponsive and had stopped breathing. An ambulance attended the home address within 3 minutes and on arrival, paramedics were informed by the mother that Child C had ingested Methadone at 07.30 hrs.

99. The ambulance crew transferred Child C to Hospital and resuscitation attempts were made until 11.50hrs when she was certified as deceased.

100. The Police control room was notified of the incident, as was SCS. The mother was arrested and an investigation commenced.

101. Hospital records state that the mother reported at the time, that Child C had been taken down stairs to play at around 06.30hrs. The mother fell asleep for around 10 minutes and found Child C lying on the floor. Her mother picked her up and realised that her dose of Methadone, measured out the night before, was missing. Her mother panicked and attempted to make Child C vomit. She was under the impression that if she waited 30 minutes and Child C was 'OK' then perhaps she would be fine.

102. A Police investigation was commenced.

4. Thematic Analysis, Learning and Recommendations

103. Thematic analysis is described as 'A method of identifying, analysing and reporting patterns (Braun and Clarke 2006)'. It is helpful when there is important information, when there are large amounts of text (agency reports), and where the views and experiences of people are gained in focus groups (practitioners learning event).

104. Para 11, p74 of 'Working Together' guidance (HM Government 2015) states that SCRs should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- is transparent about the way data is collected and analysed
- makes use of relevant research and case evidence to inform the findings

105. The integrated agencies chronology allowed an overview of the involvement of different agencies with Child C and her family.

106. There was a significant range of information available to the agencies who were involved with the family, with a range of meetings taking place where agencies and practitioners met (the Team Around the Family, Professionals meetings and Child In Need meetings).

107. The analysis below evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioners' efforts to safeguard.

108. 'All agencies' within the recommendations refer directly to those agencies who provided IMR's and contributed directly to this SCR; however, the principles behind each recommendation can be applied to all agencies.

4.1 What was life like for these children in this family?

Findings

109. All professionals recognised that the family is usually the best place for bringing up a child and strived to support mother and father to adequately and safely care for their children.

110. There is some documentary evidence, and at the Practitioners Learning Event, professionals agreed that attempts were made to review, monitor and support the family.

111. There were a high number of professionals providing care/services to the family. There was significant Health Visiting involvement and possibly they were the service that had the most contact within the home.

112. There is evidence that the Health Visitor reported on a number of occasions that the children were reaching their milestones (recognising the significant developmental needs of each of the children), were sociable, happy children and having a good relationship with their parents, with secure attachments.

113. In contrast to these positive observations, there are reports of siblings having episodes of tantrums, attention seeking behaviours and being clingy (on occasions, one Health Visitor thought there was not enough stimulation); the mother did not take the children to groups offered; the home was not toddler proof and there were a high number of missed health appointments.

114. In early 2013, prior to the birth of Child C, one Health Visitor stated that "the children are already insecure and emotional and emotional needs will increase, having a new baby will be a challenge".
Sibling 1 struggled with transition to Senior School, became involved in criminal activity and had a period of exclusion from school due to poor attendance and violent behaviour. She also had one report of going missing from the family home.

115. Behaviour support was put in place for Sibling 1 along with encouragement to take part in positive school activities.

116. On 5 separate occasions, anonymous callers (to the Police and SCS) stated that the children "didn't see the light of day", that there was "screaming and shouting in the house by an adult" and the children seemed "distressed". The children were allegedly left in a car and were distressed, and on one occasion, a neighbour was not able to return Sibling 2 to the care of her parents[5].

117. Housing reported on two occasions, concerns about young children running around in the street away from the family home and had difficulty contacting the parents to discuss their concerns.

118. The Health Visitor was concerned enough to offer enhanced services to the family. Enhanced services are offered over and above the universal services when a professional perceives a family to have significant vulnerabilities, safety or child protection concerns.

119. It was recorded that Sibling 1 took on a 'mature role' within the family, however, no consideration was given to whether she was a Young Carer or exploration of what a 'mature role' meant within the family[6]. The Big Lottery Fund and The Children's Society[7] launched a four year programme: The Young Carers In Focus. Many young carers come from hidden and marginalised groups, including children caring for family members with mental illness and parental substance dependency.

Kent Young Carers service may have been a helpful resource at this time particularly for Sibling 1, but the other siblings would also have been eligible to receive Kent Young Care Services.

120. The children lived in a household which must have given them inconsistency in their lives, from a happy household with loving parents, periods of stability, grandparents who had a positive impact set against a number of challenges that were more worrying, which include:

[5] The NSPCC (2010) suggest that "there can be a tendency to prioritise contacts and referrals from professionals, lending insufficient weight to information from family, friends and neighbours in the early stage of both referral and assessment". From these 5 referrals of concern, only one led to an assessment by Specialist Children's Services

[6] Kent Young Carers describe young carers as 'often take on practical and/or emotional caring responsibilities that would normally be expected of an adult' (www.kentyoungcarers.org.uk).

[7] Hidden from View: The experience of young carers in England (Children's Society 2013)

- Both parents having long standing illicit and prescribed drug use and the apparent inability to change their lifestyle
- Three episodes of domestic incidents[8]. In fact, the mother minimises the events a short time afterwards
- A household that was described on occasions as cold, damp, poorly decorated and all children sleeping in one bed
- Lack of money, on occasions resulting in lack of food
- Health needs not being responded to in a timely manner and consistent failure to attend appointments
- Late presentation of pregnancies and unplanned home births
- A father who was in prison and his association with violent males possibly putting the children at risk, also dangerous adults had visited the mother at the home
- Both parents were prescribed medication by the GP for anxiety and father also for depression

Learning

121. Although the children were seen on a number of occasions and by a number of professionals, there was no documentary evidence of views from the children in seeking what their life was like. Apart from one assessment by a Social Worker, there was no other evidence that any of the children were seen alone and directly asked 'what was their life like?' This may have been particularly significant for the elder sibling in her caring role.

122. Equally, there was no documentary evidence of recording the children's views in any consultations.

It would seem that professionals may have been focusing the needs of the parents rather than the children.

It would have been helpful if one professional had taken time to draw together all information and undertake a critical analysis of professional issues/concerns and decisions made. There was no evidence that at any one time, professionals clearly considered:

- Impact of the parents' behaviour on the family as a whole
- Impact on the children, specifically the emotional impact of drug abuse and domestic incidents
- Impact on professionals working with a family with significant vulnerabilities, chaotic lifestyle and parenting capacity/capability.

123. Chronologies enable a study of events in the order in which they happened (a timetable of what happened when). It enables the organisation and professionals to review care over the time period.

124. The mother seemed unable to prioritise the needs of her children. On only two occasions, once by a Health Visitor and once by an Ambulance Crew member, was neglect[9] considered to be a risk to the children.

[8] Refuge UK suggest that only 35% of domestic violence incidents are reported to the Police and on average, a woman is assaulted 35 times before her first call to the police (www.refuge.org.uk), therefore it could be assumed that there may have been more incidents of abuse that mother did not contact the Police to report which the children may have witnessed.

There were numerous occasions when neglect could have been considered such as:

- The mother frequently not attending to children's physical/medical needs
- On at least two occasions, the children, when very young, being left unsupervised in the street near to their home and on one occasion being left unsupervised in a car
- Prior to the birth of Child C, the other children were beginning to show signs of emotional instability

Recommendations

Recommendation 1 - All agencies
All agencies are to provide evidence that children are given an opportunity to give their views, that the views have been recorded, and how their views are used to inform and influence actions.

Recommendation 2 - KSCB
KSCB are to undertake a multi-agency awareness raising programme of Young Carers and Hidden Young Carers, including how to identify them, how to work with them and support them, including referring to Kent Young Carers Services.

Recommendation 3 - KSCB
KSCB is to review and update its training programme on 'Dealing with Hostile and Resistant Families' to include enhancing awareness of disguised compliance and professional curiosity and working with complex families. KSCB are to undertake targeted impact audits.

4.2 Multi- agency working

Findings

125. There is a mixed picture of how well agencies worked together. The agency reports and practitioners' comments at the Practitioner Learning Event identified many episodes of excellent communication, good information sharing and working jointly.

126. Due to the family having a rather chaotic and transient lifestyle, poor attendance for appointments, late bookings for pregnancies, regular users of Methadone and a number of referrals, both to the Police and SCS, it appears that agencies became reactive rather than proactive; some protection plans were not clear, there was a lack of historic information about the adults and this was a family with high support needs balanced with high challenges. This resulted on occasions, multi-agency working being disrupted.

127. There were a number of opportunities for agencies and professionals to come together through the various meetings and agree a long term plan for the children, however, at the Practitioner Learning Event it was reported that the majority of these meetings were task focussed.

128. In addition, a number of agencies reported that minutes and agreed action plans from these meetings were not always shared.

[9] Neglect is "the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development".

129. It was also evident that not every agency had a full picture of the needs of the children, for example the Elective Home Education Team had no idea that the parents were drug users, and equally when Child C was discharged from Hospital, the GP was only notified of the medical situation and no report of the social circumstances or vulnerabilities of the family.

130. This resulted in agencies (either single or jointly) not being clear about the expected outcomes for the children or the parents.

Learning

131. Information sharing is vital to safeguarding and promoting the welfare of children and young people. A key factor identified in many serious case reviews has been a failure by practitioners to record information, to share it, to understand its significance and then take appropriate action.

132. At each pregnancy, the Midwife adhered to local policy in regard to the mother being a known drug user, and notified SCS, however, it appears that this may have been seen as a 'notification tool' rather than an 'assessment and referral tool' giving detailed history of events or a full assessment of current position/concerns/vulnerabilities, this resulted in information shared being inadequate.

133. It is also important to encourage professionals to take time to review all available information to support their professional judgements and decision making. It is recognised that this can pose a challenge when professionals have heavy caseloads and limited time available.

134. When professionals become reactive to each incident separately, it can disguise long term neglect. All Professionals must take equal responsibility at multi-agency meetings to ensure they are fully signed up to the action plan, challenge any aspects they do not agree with and leave the meetings knowing exactly what aspects of the plan they are responsible for.

Recommendations

Recommendation 4 - SCS
SCS will provide the Board a biannual report outlining multi-agency participation in Child Protection Conferences. The report will include attendance levels, analysis of the quality of reports submitted, any escalation of disagreements and compliance with agreed plans.

4.3 Risk Assessments

Findings

135. A number of assessments were carried out in single agencies, for example, SCS carried out seven Initial Assessments and one Core Assessment, Health Visiting undertook a number of Family Health Needs Assessments and the Police undertook a domestic incident assessment.

136. There was no documentary evidence that a formal systematic safeguarding risk assessment was undertaken.

137. There was evidence of professionals considering risks in relation to home safety, Methadone storage safety, domestic abuse risks and parental drug misuse being identified as a vulnerability factor. In fact, when one Health Visitor began to challenge the mother about her lifestyle and the impact on the children, the mother asked to be moved to another Health Visitor.

138. The grandparents were seen as a protective factor as there was evidence that they did, in fact, have a positive impact for the children.

139. One Hospital Manager considered the effects of Methadone on a child at birth and explored whether the degree of withdrawal correlates to the quantity of Methadone being taken on a daily basis by the Mother[10]. Having spoken to a Neonatologist and looked at some research, there appears to be mixed views on this and each baby metabolises the Methadone in different ways and time scales[11].

140. It is important to have as much background information as possible to ensure that assessments are fully informed and enable effective decision making.

141. When supporting families, professionals can make efforts not to be 'too judgemental' resulting in a failure to exercise professional judgement and/or professional challenge.

142. Overall, there was evidence within SCS and across the health services, of an absence of safeguarding supervision and case management oversight.

143. There was no single agency or cross agency chronology of events undertaken, this prevented collective information being fully analysed.

144. The Health Visitor was concerned enough to offer enhanced services, but did not consider compiling a chronology. Midwifery services had the mother and baby history, but this was not considered as part of the ongoing risk assessments during subsequent pregnancies.

145. It was unclear through the agency reports and in discussion with professionals at the Practitioners Learning Event, what the 'safeguarding risk assessment' process was within KCA and Turning Point. There was evidence that Turning Point provided regular support and stability for the mother and father, had shared care with a commissioned GP and gave the mother and father adequate information about Methadone and safe storage. However, it is unclear what the arrangements were for sharing information with the family GP or seeking out the family history.

[10] The research on the impact of Methadone on the prenatal child is not conclusive but there is evidence it may impact on their cognitive ability as well as gross motor skills in early development. Researcher Carolien Konijnenberg has studied a group of children born throughout Norway in 2005 and 2006, to Methadone using mothers. Many of the children exhibited difficulty with gross motor skills in their early years. Some of the children in the study exhibited attention problems and/or had difficulty drawing figures or tracking fast-moving objects such as a ball.

"Disorders of behavioural and emotional regulation can be particularly challenging when a child is learning to read and write,"

Beth Logan, a doctoral student from the University of Maine, USA conducted some research on mothers taking Methadone in pregnancy. Her findings suggested that with very young children the greatest concern is delay in motor development. There are several studies suggesting a link to children having visual problems linked to Methadone intake by mother during pregnancy. One study by Tove S. Rosen, M.D, and Helen L. Johnson, Ph.D. identified a consistently higher incidence of head circumferences below the third percentile

146. Turning Point did attend the Team Around the Family meetings, however, at the Practitioner Learning Event, often other professionals appeared to not fully understand how the service works.

147. It was unclear from the evidence what system existed within agencies to quality assure assessments, or if sufficient agency checks were undertaken.

Learning

148. Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others.

149. Assessment and Risk Assessment are pivotal in child protection work for professionals. The Kent SCS Child and Family Assessment procedure (2013) states that "an assessment should establish:

- The nature of the concern and the impact this has had on the child;
- An analysis of their needs and/or the nature and level of any risk and harm being suffered by the child;
- How and why the concerns have arisen;
- What the child's and the family's needs appear to be and whether the child is a Child in Need;
- Whether the concern involves abuse or Neglect; and
- Whether there is any need for any urgent action to protect the child, or any other children in the household or community" (www.kentproceduresonline.com)".

150. A systematic approach to review the case, such as in supervision and multi-agency meetings, would have identified the impact on professionals, the impact on the family and the impact on the children. There are a range of tools that can assist professionals that look beyond the individuals concerned and seek to understand the underlying causes and environmental/home context in which incidents happen. It might be argued that had this been done professionals, may have reacted differently.

151. There was a lack of in-depth assessment of the parenting capacity of drug misuse (prescribed or illegal) by parents.

152. Kent SCS have introduced Signs of Safety[12], training for which is being rolled out to practitioners. Other agencies are also engaged in this new approach. This will have a positive impact on assessments and a holistic review of the family. It supports professionals to focus on child safety, partnership with parents, identifying strengths that lead to safety and safety planning and development of safety networks.

153. Ultimately the learning must place emphasis on improving outcomes for children and not on getting the processes right.

154. Practitioners in hindsight, recognised their over dependence and over optimism on the Team Around the Family, CAF, the additional support services given and parents often attending the meetings. They were seen as a protective factor.

[12] A safety and solution orientated approach to child protection case work (Andrew Turnell and Steve Edwards 1999)

155. Practitioners in hindsight also acknowledged that they had experienced disguised compliance[13] from the family.

156. Neither of these meant that the children were safe and such factors needed to be balanced against the evidence and actual risks.

157. Safeguarding supervision would have offered robust challenge, critical reflection, looked at evidence and risks and provided support to professionals.

Recommendations

Recommendation 5 – All agencies who undertake or contribute to assessments
All agencies are to ensure that the use of chronologies is accepted practice and that it is evidenced that they are used to inform assessments.

Recommendation 6 – All agencies
All agencies are to audit and evidence how their risk assessment tools are used to improve outcomes for children.

Recommendation 7 - All agencies
All agencies to review their internal safeguarding supervision practices to ensure that it provides and evidences critical reflection, robust challenge, risk review and support to staff when dealing with families.

4.4 Parental drug abuse and domestic abuse and its impact on agencies' responses to the family

Findings

158. From initial contact with the family in 1998, all agencies and professionals were made aware that both mother and father were drug users. The mother and father were always open with professionals.

159. Very early on, mother and father signed up to Methadone Maintenance Plan with KCA and subsequently a Drug Treatment Programme (Methadone) with Turning Point[14].

160. It is well recognised that the misuse of drugs (prescribed or illicit) can have an adverse impact on parenting capacity because parents often find it difficult to maintain a focus on the needs of their children.

161. The links between the misuse of drugs (prescribed or illicit) and neglect are strong, as is denial, chaotic lifestyle, manipulation of professionals and involvement in criminal activity.

[13] Disguised compliance is described as 'Parent giving the appearance of cooperating with the child welfare to avoid raising suspicion, to allay professional concerns and ultimately to diffuse intervention. This can result in professionals missing opportunities to make interventions, remove focus from the child and over optimism about progress.

[14] KCA were the initial providers of drug and alcohol services and a commissioned transfer occurred in early 2013 to Turning Point. As part of the overarching transfer of one service to another there was a Project Board to ensure smooth transfer for clients and staff. All essential paperwork, which included assessment forms, risk assessments, triage and comprehensive assessments, was reviewed. Briefing events were held for partners.

162. There is little evidence in this case that the parents had a full understanding or acceptance that there were specific requirements for them to significantly change their behaviour or their parenting style, or indeed, whether motivation or capacity to change was present.

163. The mother often responded positively to suggestions, but there was evidence that this was not carried through on many occasions.

Throughout this report there is evidence of this, with the most worrying signs being:

- Late booking for 4 of 5 pregnancies and unplanned births at home
- Missing health appointments and not always responding to health needs
- Occasions of absence from school and lateness
- Social isolation at times
- Poor housing at times
- Non-attendance at groups, for example Children's Centre
- Co-existing domestic abuse
- Possible parental mental health

164. The current Kent Safeguarding Children's Board Pre-Birth Procedures suggest that a referral must be made when there is knowledge that there are parental risk factors. These include that domestic abuse, mental illness/impairment or substance misuse may impact on the unborn baby or child's safety or development and/or there are maternal risk factors with potentially detrimental effects for the unborn baby, e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-co-operation with necessary services and non-compliance with treatment.

165. KCA/Turning Point and Midwifery services provided high levels of support to mother during her pregnancies and following the birth of each child.

166. Midwives were faced with a challenge to prepare adequately for the birth of the children due to continuous late booking and deliveries at home. This limited the opportunity for earlier identification and preparation for the possibility of neo-natal addiction in the unborn children.

167. A number of agencies provided enhanced services to the family striving to ensure that the mother and father were able to care for their children safely. There were examples of tenacity by some professionals.

168. Professional curiosity and challenge is extremely important in assessing risk to young children and unfortunately there is evidence to suggest that in this case this happened on very few occasions.

169. There was limited evidence to show what the relationship, information sharing and planned care was between the Turning Point special interest GP and the family GP, and whether their prescribing practice considered the risks and benefits of take home Opioid Substitution Treatment versus mandatory supervised consumption on pharmacy premises, safe storage or any concerns regarding any inappropriate use were ever being raised. Current practice is for medical review letters to be sent to the family GP as standard, a safe storage agreement is signed by each client and supervised consumption is assessed at each medical review.

Learning

170. The Families, Drugs and Alcohol Report - Medication in Drug Treatment: Tackling the Risks to Children (Adfam 2014) considers the impact of Opioid Substance Treatment (OST) medicines prescribed to help people overcome drug addiction.

171. Substantial research has been undertaken and the Report identified that there had been 17 Serious Case Reviews in the previous 5 years involving ingestion of OST by children, plus potentially more incident that didn't reach that level in inquiry. The mean age of the children was two years.

172. Further studies and national guidance has been supported by the NSPCC, Social Care Institute for Excellence, the Department of Health and the National Institute for Care Excellence.

173. It is well recognised across the world that OST can be a protective factor for children, allowing parents to gain or regain control and stability in their lives; and improve their relationships with family and friends. It can also improve the financial situation when money is not being spent on illegal drugs.

174. Professionals at the Practitioner Learning Event identified their lack of knowledge, experience or full understanding of the impact of drug use on children both physically and emotionally despite Kent Safeguarding Children Board offering a multi-agency training programme 'Substance Misusing Parents: The impact from pre-birth to adolescence.

175. Turning point, through their work, have recognised the risk of over-familiarity by their staff with clients and have introduced practice changes to ensure that service users do not stay with the same worker for more than 12 months.

176. Toxic Trio - In an analysis of 139 serious case reviews, between 2009-2011 (Brandon et al 2012), – investigations showed that in over three quarters incidents (86%) where children were seriously harmed or died, one or more of a "toxic trio" – mental illness, substance misuse and domestic abuse, played a significant part. Not only are children at risk in such situations, living in such conditions means that children and young people's life chances are also affected, with an impact on their future learning, behaviour and health.

177. No one professional appears to have considered the Toxic Trio or drawn together information that would assist agencies to understand the impact of this on the mother's and father's parenting capacity or capabilities, the impact on the lives of the children or indeed the impact on professional practice.

Recommendations

Recommendation 8 - **KSCB**

KSCB to review and update the training programme, 'Substance Misusing Parents: The Impact from Pre-Birth to Adolescence', to ensure that the programme is publicised and marketed across partner agencies and raise awareness of the role, availability and accessibility of drug treatment services.

5. Conclusion

178. The death of Child C could not have been predicted by any agency or individual who knew her. However, from the information provided to the review, there were missed opportunities when

professionals could or should have better identified the risks of the significant harm that the children may have been exposed to, particularly in respect of neglect. The mother had been prescribed and taking Methadone for a number of years without any specific concerns ever being raised regarding safe storage or misuse of the drug.

179. There was limited challenge to the mother to change her lifestyle, and her ongoing engagement with a Drug Treatment Programme (Methadone) was seen as a positive. This resulted in professionals being over optimistic. It did not necessarily mean that the children were safe.

180. It is evident that through all five pregnancies, where at each pregnancy, the mother booked late for maternity care and had unplanned births at home, the mother did not put the needs of her children before her own needs. Whether that was because she did not have the capacity or the capability is difficult to know.

181. All Professionals wanted the best for this family and worked to support them, however, this sometimes resulted in the focus being on the parents and not sufficient focus on targeting and supporting the needs of the children.

182. There are examples of good joint working within agencies and individual professionals themselves. Sibling 1 was offered excellent support to divert her from criminal activity and help improve her anger management. One Social Worker also spent time with her to understand her needs.

183. Midwifery Services and Health Visiting Services had significant input with the family and provided enhanced services, demonstrating tenacity.

184. Turning Point did offer stability and continuous support to the mother, although it has been recognised that this can, on occasions, lead to over-familiarity. Turning Point have put measures in place to address this and ensuring that service users do not have the same worker for more than 12 months.

185. Professionals demonstrated a level of optimism and, as previously stated, over optimism because they saw small positive changes such as; the mother stating that she was determined to come off drugs, would stay clean and access counselling and would work to reduce her Methadone, though that was not reflected in significant positive changes in the family situation or for the children.

186. There was a lack of recognition of the negative impact on the children of non-attendance at health appointments and the mother not seeking appropriate medical assistance. This lack of concern distracted professionals from the risks to the children's health and welfare through neglect in the longer term.

187. Insufficient weight was given to concerns expressed by neighbours.

188. There was a lack of focus or understanding of the daily lives of the children, particularly in relation to the consistent non-attendance for health appointments, which should have been seen as neglect as the children had late diagnosis of developmental needs and receiving early appropriate treatment.

189. There was not enough challenge for non-attendance at medical appointments or robust follow up of missed appointments. These are consistent features in cases on long term neglect.

190. Some of the indicators and health issues in the children are possibly linked to family history, but others could be linked to the impact of methadone.

191. At times, the supervision and management of staff was ineffective. Safeguarding supervision would have offered robust challenge, critical reflection, looked at evidence and risks and provided support to professionals. Supervision may also have recommended undertaking a detailed chronology.

192. Professionals placed a considerable reliance on the protective influence of the involvement of Turning Point, the Team Around the Family and the positive influence of the grandparents.

193. It is not unusual for parents who use substances to be suspicious of services, be resistant to and avoidance of engagement. This was evident with health services.

194. Had professionals undertaken a systematic risk assessment and drawn together all the separate information that was available for each incident, professionals may have reacted differently. Kent SCS have introduced the Signs of Safety approach. This will have a positive impact on assessments and a holistic review of the family. It supports professionals to focus on child safety, partnership with parents, identifying strengths that lead to safety and safety planning and development of safety networks.

6. Summary of Recommendations

195. The recommendations made within this report and summarised below, add value to both single agency and multi-agency learning.

196. 'All agencies' within these recommendations refer directly to those agencies who provided IMRs; however, the principles behind each recommendation can be applied to all agencies.

Recommendation 1 - All agencies
All agencies are to provide evidence that children are given an opportunity to give their views, that the views have been recorded, and how their views are used to inform and influence actions.

Recommendation 2 - KSCB
KSCB are to undertake a multi-agency awareness raising programme of Young Carers and Hidden Young Carers, including how to identify them, how to work with them and support them, including referring to Kent Young Carers Services.

Recommendation 3 - KSCB
KSCB is to review and update its training programme on 'Dealing with Hostile and Resistant Families' to include enhancing awareness of disguised compliance and professional curiosity and working with complex families. KSCB are to undertake targeted impact audits.

Recommendation 4 - SCS
SCS will provide the Board a biannual report outlining multi-agency participation in Child Protection Conferences. The report will include attendance levels, analysis of the quality of reports submitted, any escalation of disagreements and compliance with agreed plans.

Recommendation 5 – All agencies who undertake or contribute to assessments
All agencies are to ensure that the use of chronologies is accepted practice and that it is evidenced that they are used to inform assessments.

Recommendation 6 – All agencies

All agencies are to audit and evidence how their risk assessment tools are used to improve outcomes for children.

Recommendation 7 - All agencies
All agencies to review their internal safeguarding supervision practices to ensure that it provides and evidences critical reflection, robust challenge, risk review and support to staff when dealing with families.

Recommendation 8 - KSCB
KSCB to review and update the training programme, 'Substance Misusing Parents: The Impact from Pre-Birth to Adolescence', to ensure that the programme is publicised and marketed across partner agencies and raise awareness of the role, availability and accessibility of drug treatment services.

197. All agencies involved with this family undertook management reviews of their engagement to provide an independent, open and critical analysis of individual and organisational practice. These reports include single agency recommendations and action plans. Updates on agencies' action plans will be monitored by KSCB.

7. References

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (HM Government 2015)

The Families, Drugs and Alcohol Report - Medication in Drug Treatment: Tackling the Risks to Children (Adfam 2014)

DASH Domestic Violence Risk Assessment (ACPO 2009)

Getting It Right For Children and Families Affected by Parental Alcohol and Drug Use (Edinburgh and The Lothians 2013)

Signs of Safety- A safety and solution orientated approach to child protection case work (Andrew Turnell and Steve Edwards 1999)

Hidden from View: The experience of young carers in England (Children's Society 2013)

Appendix A

Scope and style of the Serious Case Review

The main purpose and focus of the review is to identify key learning points; and as such, the style of the review has been a facilitative approach following the lines of the Welsh Model for Serious Case Reviews – Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews (2012).

Terms of Reference:

Although agencies have been involved with the family since 1998, the scope of the review relates to Child C and therefore the key focus was agreed from 1 January 2012.

Agencies involvement with the family prior to this date should be summarised with significant events (those with similarities to those raised post 2012) highlighted.

Key Practice themes were identified as:

A. What was life like for these children in this family?
How was this captured?
How was it acted upon?

B. What was the impact of Multi-Agency working?
Information sharing
What was known by agencies?
How was this shared?
When shared, how was this acted upon?
How did providers of adult services link with children's service providers?
How did any partners' organisational changes impact on the service provision?

C. How were risk assessments undertaken?
What single agency risk assessments, including 'pre-birth', were undertaken?
How was the family history used to influence the assessments? (Including previous involvement of agencies and likeliness of re-occurrence)
How was everything that was happening for the parents taken into account around their parenting capacity and how was this considered in the assessments?
How was the children's resilience considered?
How were single agency risk assessments joined up in to multi-agency risk assessment?
Did home visits take place as part of the assessment process?
What was the understanding of role of other adults who associated with the family and the impact on the children?

D. How effective was the multi-agency and single agency decision making?
How was the risk assessment used in decision making around this family?
How were thresholds used in decision making?
Was there appropriate professional challenge where necessary?
Were all relevant partners invited to multi-agency meetings, (Strategy Discussions, Child Protection Conferences, and Child in Need meetings)?
Did partners attend?
Were minutes of meetings circulated to all attendees and invitees?

E. How did parental drug abuse and domestic abuse impact on agencies' responses to this family?

How was ongoing service provision monitored and joined up?
Was anything known that might have suggested things were worsening?
How were the parent's issues supported by agencies?
What support was provided to the children?

F. General

Are there any areas of good practice to highlight?
Are there any implications for training (single or multi-agency)?
Are there implications for partnership working between organisations?
Are there any similarities between this case and others serious cases, locally or nationally?
Are there implications for service provision?
Is there any relevant research which can be taken into consideration?

Serious Case Review Panel:

A Serious Case Review Panel was formed consisting of Senior Managers and professional experts from statutory agencies and chaired by the Principal Social Worker SCS. No panel members had direct contact or management responsibility for the family.

Agency Reports:

Individual Management Reviews and Chronologies were submitted from the following agencies:

- General Practitioner Services – Local Clinical Commissioning Group
- Kent County Council SCS
- Kent Police
- Kent County Council Education and Young Persons Services (Education, Early Help and Youth Justice)
- Kent and Medway Partnership Trust (KMPT)
- Kent Community Health Foundation Trust (KCHFT)
- Local Acute Hospital Trust
- South East Coastal Ambulance Service (SECAmb)
- National Probation Service
- Turning Point (Drug User Support Services)

Individual Management Reviews (IMR) enable agencies to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so how those changes will be bought about.

Chronologies enable a study of events in the order in which they happened (a timetable of what happened when). It enables the organisation and professionals to review care over the time period set out in the terms of reference.

Practitioners Learning Event:

In line with the Welsh Model approach to this SCR, a Practitioners' Learning Event was held. The purpose of the learning event is to bring together key staff to reflect and learn from what happened in order to improve practice in the future. It enables Managers and Practitioners to be in a place where listening and learning can be supported by curiosity, ownership, learning and changes for the future.