



# Case Review Executive Summary

November 2008

## INTRODUCTION

This is a summary of a Serious Case Review undertaken by Staffordshire Safeguarding Children Board (SSCB) following the presentation in May 2008 of a child, then aged 3 years 9 months, to a county Accident and Emergency Department in a life threatening condition which was potentially as a result of abuse or neglect. Therefore, in accordance with Working Together to Safeguard Children 2006, Para 8.2, it was agreed that a Serious Case Review would be undertaken in order to examine interagency practice and information sharing and to learn lessons.

This Executive Summary provides an overview of:

- the Case Review process
- the circumstances of the child and their family
- lessons learnt from the Case Review
- recommendations for action by Staffordshire Safeguarding Children Board.

Findings of the review have been reported to the Office for Standards in Education (OFSTED) as is required. The review timescales were extended as additional information was received from another agency. This extension received the agreement of the Government Office, West Midlands (GOWM).

Information in this report has been anonymised including references to the gender of the children.

## REVIEW PROCESS

The process of the Review was managed by the Serious Case Review Panel which is made up of members from SSCB. SSCB is made up of all public agencies working with children and families in the county and some voluntary

organisations. This includes Children and Lifelong Learning Services, Staffordshire Police, Health Agencies and Education.

Each agency which provided a service to the child and their family were asked to undertake a review of their involvement called an Individual Management Review (IMR). This involves producing a report and chronology of involvement. Independent Authors were appointed by the Panel to produce an Overview Report pulling together all information from the IMRs. The child's parents were contacted by the Independent Authors in an attempt to involve them in the process. The author met with the child's mother but has not received a response from the child's father. The Overview Report analysed all the information including information from the parents and produced lessons to be learnt and recommendations for action. A clear focus on the needs of the child and their siblings was maintained throughout the process.

## **FAMILY BACKGROUND**

The child's parents are married and also have two other school-age children. The parents moved into the county from another neighbouring Local Authority and have lived in rented accommodation. The parents are now separated.

The child's mother was previously Looked After and has been the subject of childhood abuse. The father has a history of violence and is known to criminal justice agencies. Both parents have a history of substance and alcohol abuse. The father also has three children from a previous marriage but little is known of this relationship.

The father had been previously prosecuted for Child Neglect as a result of being found drunk in charge of his two school aged children. An Initial Child Protection Conference was convened as a result of this incident. The children were not made subject of a Child Protection Plan but the Conference did recommend that a Core Assessment should be completed and a plan devised to offer services to the family.

A number of referrals made to the Vulnerable Children Division did raise concerns about the welfare of the child and the two siblings but this did not lead to any legal protective action or the convening of a further multi agency meeting under the auspices of the Child Protection Procedures.

The family have been receiving services and support from a number of key statutory Adult, Health and Social Care agencies for a number of years. These services have particularly focused on the continued substance abuse by the parents, periodic alcohol abuse and domestic abuse. Episodes of domestic abuse led to Police investigations and the temporary separation of the father from the family.

## **OUTLINE OF EVENTS LEADING TO THE SERIOUS CASE REVIEW**

The mother contacted the Emergency Services as the child was unconscious and needed immediate intervention to support their breathing. The child was taken by ambulance to an Accident and Emergency (A&E) department. The paramedic initially reported that the child had consumed a mixture of bubble bath and germolene. The intervention of the ambulance staff and the A&E staff at the hospital saved the life of this child when the Doctor recognised the symptoms and diagnosed that the child had taken their mother's methadone.

A referral was made under the "Child Protection Procedures" to the Vulnerable Children Division (VCD) and the Emergency Duty Team was contacted.

The child's siblings initially stayed with the maternal grandmother but were subsequently placed in Foster Care by the Local Authority whilst enquiries continued. The mother is subject to a criminal investigation by the Police which is ongoing.

## **ISSUES ARISING FROM THE REVIEW PROCESS**

The issues that emerge as areas of concern in relation to interagency working and safeguarding children are:

- Key background information on this family was not transferred speedily from the previous Local Authority where the family resided and between schools within the county.
- The lack of understanding across all agencies of the impact that continued substance misuse would have had on the capacity of both parents to meet the needs of their children.
- Both the physical and emotional impact of domestic abuse on the children had not been fully explored by the agencies involved in this family.
- Although there were a number of opportunities to undertake a Core Assessment of this family, including one that arose as a recommendation of the Initial Child Protection Conference, no Core Assessment was completed.
- Communication and information sharing between agencies proved problematic, in particular between the Police and the Vulnerable Children Division during three key stages of contact with this family.
- The children had limited contact with key agencies and in total there was only five recorded times over a six year period when the two school aged children were specifically seen by Social Workers or Family Support Workers from the Vulnerable Children's Division.

## LESSONS TO BE LEARNT

- The findings from this Serious Case Review and the recommendations that follow demonstrate that there are several lessons to be learnt in order to improve multi agency communication and information sharing. Further, lessons should improve agencies understanding of the impact substance misuse and domestic abuse has on children and young people. Lessons that are taken forward should reinforce the importance of undertaking a holistic assessment of vulnerable families. This would help to analyse past and current events to ensure children and young people are the focus of any intervention.
- The children appeared to be barely visible to the professionals and, despite the level of family contact from the agencies in this case, their focus was primarily on the mother and the welfare of the children was secondary. One of the lessons to be learnt is the need to maintain a clear focus on the children when working with vulnerable families. The importance of communicating and listening to children to establish their wishes and feelings should be central to any planned work and this should be reflected in all Initial and Core Assessments.

*"Some of the worst failures of the system have occurred when professionals have lost sight of the child and concentrated instead on their relationship with adults. The child should be seen by the practitioner and kept in focus throughout work with the child and family. The child's voice should be heard and account taken of their wishes and feelings".<sup>1</sup> (HM Government 2006)*

- Safeguarding children and young people is everyone's responsibility but this was clearly not demonstrated in this case. The messages that emerged from the Laming Report 2003 are still relevant today and further work by Staffordshire Safeguarding Children Board is required to promote that safeguarding children and young people should be the priority of all agencies.<sup>2</sup>
- Individual agencies seemed to have a fixed view of this family and failed to recognise that these were children at risk and that they were subjects of potential child neglect due to parental substance abuse, alcohol misuse and domestic abuse. It is important that all agencies work closely together when dealing with complex families so that a holistic assessment can be achieved.

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<sup>1</sup> HM Government (2006) *Working Together to Safeguard Children : a guide to inter-agency working to safeguard and promote the welfare of children*, London: The Stationery Office.

<sup>2</sup> Laming, Lord H. (2003). *The Victoria Climbié Inquiry*. London: The Stationery Office.

- The need for all agencies to collate, analyse and share known information in respect of all family members. This case highlighted that very little information was known about the father and there was no evidence that anyone had explored with him his previous parenting experience.
- Agencies need to consider the vulnerability of adults and children when there is a family history of childhood abuse. The mother had previously alleged sexual abuse by family members but the impact of this on her was not considered nor was the extended family's contact with the children assessed.
- Individual referrals about this family were viewed in isolation of each other. Their impact on the welfare of the child and the two siblings was not fully considered or linked to information already known about the family. Agencies therefore need to be mindful that the "Start again Syndrome", identified by Brandon et al, 2008, evident in this case, does not lead to unsafe practice and that some evaluation is made of the progress of any longer term intervention or support offered to vulnerable families.
- The current Multi Agency Risk Assessment Conferencing (MARAC) process needs to be strengthened to ensure that the participating agencies do not lose sight of the needs of children and young people who are also the victims of domestic abuse.
- The importance of providing regular, good quality supervision to professionals who deliver services to vulnerable families in often very challenging circumstances.

### **KEY RECOMMENDATIONS FROM THE REVIEW**

- The members of Staffordshire Safeguarding Children Board ensure that all staff working with children and families are aware of the need for compliance with the interagency Child Protection Procedures and that the principles underpinning the work to safeguard and promote the welfare of children and young people are embraced. Working Together to Safeguard Children 2006, Chapter 5 (Paragraph 5.4).
- The members of Staffordshire Safeguarding Children Board ensure that identified managers and staff attend the Interagency Foundation Course on Working Together to Safeguard Children and Young People. This compliance is overseen by Professional Development and Training Sub group.
- The members of Staffordshire Safeguarding Children Board ensures that designated staff from Adult Health Services, Vulnerable Children's Division and Police have access to relevant, targeted training on Domestic Abuse and Substance Misuse and the safeguarding

consequences for children, as this case demonstrated a lack of practice knowledge in these areas.

- Staffordshire Safeguarding Children Board to provide training on information sharing to be targeted at managers and supervisors from member agencies and representatives from Staffordshire's Vulnerable Adults Board.
- Staffordshire Safeguarding Children Board to co-ordinate and deliver training to designated managers from key agencies that have to undertake the compilation of IMRs for Serious Case Reviews.
- Staffordshire Safeguarding Children Board undertakes a sample audit of multi-agency cases to establish if staff within statutory agencies, are receiving appropriate supervision when dealing with complex child care cases. (Working Together 2006 – Paragraphs 5.154 – 156).
- Staffordshire Police and the Vulnerable Children's Division (VCD) review their current communication and information sharing protocol to ensure that information relating to the welfare of children is shared effectively.
- Staffordshire Police ensures that an Appropriate Adult is present when children and young people are interviewed as witnesses or potential victims in accordance with 'Achieving Best Evidence' guidance.
- Staffordshire Police should ensure a more robust application of the MARAC referral criteria so that cases defined as High Risk, where children have also been victims of domestic abuse, are forwarded for discussion at these meetings.
- The needs of children and young people who are victims of domestic abuse are actively addressed by MARAC in any agreed action plan and this is reflected in the minutes.
- Staffordshire Safeguarding Children Board to issue guidance to all agencies to assist them to review their recording practice and procedures to consider the appropriateness in complex Children in Need and Child Protection cases of maintaining a chronology of key events.
- Staffordshire Vulnerable Children's Division (VCD) ensures that a chronology of significant information available is maintained when Children in Need cases are subject to multi-agency Service Plan reviews.
- North Staffordshire Combined Health Care NHS Trust should devise a Safety Plan when parents are administering prescribed methadone at home which should be reviewed every three months. A written copy of

this should be retained by the service user and a copy given to other agencies involved with them.

- NHS North Staffordshire, formerly North Staffordshire Primary Care Trust, should ensure that upon receipt of patient records from another area that these are reviewed so that all health professionals involved with the family are aware of the significant information.

#### **By Serious Case Review Panel**

- Overview Report and Executive Summary to be provided to Derbyshire LSCB Chair and Business Manager. Local lessons to be learnt and necessary actions to be addressed.

#### **By Staffordshire Safeguarding Children Board**

- All Board Member agencies to evidence how their own training strategy complies with the Staffordshire Safeguarding Children Board training strategy.
- The Staffordshire Safeguarding Children Board recommends that all Board Member agencies consider how safeguarding principals (as per Section 11, Children's Act) will be applied to all commissioning arrangements and provides evidence to the Board of how this has been enacted.
- Each agency has a responsibility to ensure that training is available for all applicable staff so that they can deal with families where there are complex needs, including domestic violence, substance misuse and mental health issues.

**Staffordshire Safeguarding Children Board provide a range  
of Inter-Agency  
Training opportunities**

**For details go to:**

**[www.staffsscb.org.uk](http://www.staffsscb.org.uk)**

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