SOLIHULL LOCAL SAFEGUARDING CHILDREN BOARD

Serious Case Review 2 concerning child A

Born May 2014

Significant Event: December 2014

Independent Author: Dr Russell Wate QPM

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1.0 Introduction

1.1 CHILD A was born on 5th May 2014 at Heartlands Hospital. He was the fourth child of ADULT A.

1.2 ADULT B is the father of CHILD B and was in an on/off unsettled relationship with ADULT A, they denied living together and so it cannot be determined to what extent he was involved in a parental capacity with his own child CHILD B and his other siblings, including CHILD A. The father of CHILD A was absent and uninvolved with his upbringing.

1.3 On the 19th September 2013 at 1:30pm ADULT A took CHILD B to the Emergency Department at Hospital and it was reported by her that he had accidentally swallowed a tablet belonging to his Aunt at 08:00am that morning. The tablet ingested was 45mg of Mirtazipine which is an antidepressant medication for adults and is available only on prescription. ADULT A stated that the tablet had been in his Aunt's bag and must have fallen out and CHILD B found it. She said she had seen him chewing on something which she thought was a tablet, but only became concerned when he complained of back pain and seemed drowsy. The delay in bringing him to Hospital was apparently accepted. After assessment and advice CHILD B was put under observation for 4 hours and no other treatment was recommended at the time. He made a good recovery.

1.4 According to ADULT A's initial account, this is what occurred on Wednesday 24th December 2014. ADULT A put her children to bed at 5:00pm and she followed them to bed at 6:00 pm having taken a 7.5g Zopiclone sleeping tablet which she said was given to her by her father. At the time that she went to bed her brother and his friends were downstairs in the house but apparently they left whilst she was in bed. ADULT A stated that she woke twice in the night to feed CHILD A before getting up at 5:00am on the 25th December (Christmas Day) to open presents with her children.

1.5 She further stated that during the morning of Christmas Day, CHILD A was standing holding onto a "jumperoo" (a sit in activity station) when he fell over and bumped his head. Shortly afterwards he was sick and the vomit contained wrapping paper. CHILD D told her that she saw CHILD A eating wrapping paper although ADULT A herself did not witness this. CHILD A became grizzly and when she picked him up he stiffened and threw his head back. She panicked and ran the short distance to her mother's address. Her father then called an ambulance.

1.6 The ambulance service responded and saw CHILD A at 08:20am observing that he was "floppy and unresponsive", with noisy breathing and a rapid heart. He was admitted to the Emergency Department at Heartlands Hospital. En-route to hospital he suffered cardiac arrest and had to be resuscitated four times.

1.7 Police Public Protection officers attended CHILD A's home address on the morning of 25th December 2014. The general condition of the property was described as untidy but with sufficient food, toys and bedding available. A small amount of vomit containing wrapping paper was recovered and taken to Heartlands Hospital for further tests.

1.8 ADULT A gave a history to staff similar to the account above and denied that CHILD A could have ingested a drug. However, when seen later in the day with her mother, she elaborated that there had been lots of people at her house on Christmas Eve and maybe CHILD A had picked a tablet up from the floor and swallowed it.

1.9 At 10:00am CHILD A's condition was recorded as stable and the doctor in attendance recorded that the most likely reason for CHILD A's seizure was thought to be either ingestion of a toxin or intracranial trauma. A paediatric intensive care bed was sought for him and he was transferred to Stoke Paediatric Hospital. A skull CT had been completed prior to this transfer and it was clear.

1.10 ADULT A told a different doctor that although she had previously used cocaine, she had been "clean" since March 2014. Another record says that she said since August 2014 she has been "clean". She denied

having cocaine in her home and stated that the only drugs in her house were the sleeping tablets Zoplicone, stored in her bedside drawer. She added that Children's Social Care (CSC) had been involved with her family because of her drug taking.

1.11 CHILD A was transferred back to Heartlands Hospital on 28th December 2014. It is noted that he was well, alert and eating sat in a high chair.

1.12 At 11:10 hours on 30th December 2014 toxicology tests were received and it showed that CHILD A's blood and urine samples showed positive for a high level of cocaine and 2 cutting agents, Levamisole which is a drug for dog worming and Etilefrine which is a banned sports drug. An emergency strategy meeting was convened and ADULT A was arrested at 4:45 pm for wilful neglect. A search of her home address revealed drug paraphernalia such as drug wrap/seal bags as well as a Zopiclone tablet found within a Moses basket in ADULT A's bedroom.

1.13 ADULT A was interviewed and gave a further account of events but maintained her innocence around drugs in her home and her own drug abuse. In a further interview she changed her account.

1.14 ADULT A's children were placed in foster care, as was CHILD A when he was released from Hospital on 1st January 2015. He had made a good recovery.

1.15 After further enquiries ADULT B was arrested on 11th January 2015 and interviewed, giving a similar account to ADULT A but with inconsistencies.

1.16 Both ADULT A and ADULT B were released on Police bail pending Crown Prosecution Service advice and the result of further investigations. At the time of writing, Bail conditions are still on going and take account of the safeguarding concerns of this child and his sibling.

1.17 Where abuse or neglect of a child is either known or suspected and the child has been seriously harmed and there is cause for concern as to the way in which the Local Authority, their Board Partners or other relevant persons have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) should undertake a Serious Case Review (SCR). The Independent Chair of the Solihull Local Safeguarding Children Board (SSCB) has commissioned the review and asked Russell Wate to undertake the SCR. Edwina Grant (Independent SSCB chair) chaired a Serious Case Review Panel meeting on 12th May 2015 and the Panel agreed the scope of the review and identified key lines of enquiry, timescales and identified the agencies that would be required to provide a chronology of their involvement and an Individual Management Report (IMR).

1.18 The timescale for the review was agreed to start from the time when ADULT A, the mother of CHILD A, booked for ante-natal care at the start of her pregnancy with him and the end date of the review was agreed as the date when CHILD A was discharged from Hospital to the care of the Local Authority. Significant events dating back to 2007 have been considered as relevant.

The review involves CHILD A.

Child A: Born May 2014. Father absent for the purposes of this review.

The fathers of Child C & D are both absent and have played no part in this review.

Relationship to Child A	Name	Date of Birth
Mother	Adult A	August 1986
Estranged partner of Mother and father of CHILD B	Adult B	December 1989
Sibling	CHILD B	October 2010
Sibling	CHILD C	June 2009
Sibling	CHILD D	March 2007

2.0 Terms of Reference

2.1 The purpose of this review is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are both within and between agencies and how they will be acted upon and why any failings leading to these lessons occurred.
- Improve multi-agency working by ensuring lessons impact positively on practice whilst understanding the root cause of the problems.

2.2 Particular focus will be made towards:

- The decision made in July 2014 to step down from the Child in Need plan (CiN)
- Communications between professionals and agencies following the relevant incident on 25th December 2014 up until CHILD A's discharge from Hospital.

2.3 The Key Lines of Enquiry for the review will be:

- Were there any communications failures between professionals working with children and/or adult's services and why did these failures occur?
- Are there improvements to be made in the way that disagreements are managed and dealt with?
- Were the risks clearly understood and was the risk level to ADULT A appropriately identified?

- Was the "step down" procedure appropriately applied?
- Is the escalation procedure for professionals fit for purpose and was it instigated and if not, why not?
- Were any of the communications failures due to misunderstandings about cover in the Holiday period and why did these occur?
- Were there any cross boundary communications failures?
- Was the multi-agency response to CHILD B's ingestion of a tablet on 19th September 2013 robust enough? Were the risks understood and was available information acted upon?
- Would the proposed new children's information sharing system have made a difference?
- Are there any specific issues around ethnicity, religion, diversity or equality that may require consideration?

2.4 Contributors to the review

A number of agencies have contributed to this review as follows:

- Heart of England NHS Foundation Trust (HEFT)
- West Midlands Police (WMP)
- Solihull Clinical Commissioning Group (SCCG)
- Birmingham and Solihull Mental Health Foundations Trust (BSMHFT) which includes Solihull Integrated Addiction Services (SIAS) which incorporates the services of Aquarius, Welcome, The Bridge (A summary of key agencies roles is provided in appendix a)
- Solihull Local Safeguarding Children Board (SLSCB)
- Solihull Metropolitan Borough Council (SMBC) Children's Social Work Services (CSC)
- Solihull Metropolitan Borough Council (SMBC) Education Welfare
- Solihull Community Housing (SCH)

2.5 Independent author

Solihull LSCB made a decision to appoint an independent author to carry out the review. The review is supplied by RJW Associates and the lead reviewer is Dr Russell Wate QPM MSc. He is independent of any agency within the Solihull area. He is a retired senior police detective, who is very experienced in the investigation of homicide and in particular child death and child neglect issues. He has contributed to a number of national reviews, inspections and inquiries, as well as being nationally experienced in all aspects of safeguarding children and public protection. He has carried out a large number of SCR's and is also an independent chair of an LSCB.

2.6 Methodology

The review took the format of the LSCB inviting all appropriate agencies to submit a chronology of significant events and an Individual Management Report. After these were collated and considered the management report authors and key practitioners attended a meeting on 3rd June 2015 chaired by Russell Wate. This meeting had a good multi-agency attendance and valuable and honest contributions were made by all agencies. Analysis then took place of the findings and after requests for further information from certain agencies; a report was completed for sharing and presenting to the SCR subcommittee for comment, prior to submission to the Safeguarding Board.

3.0 Summary of the facts and initial analysis.

3.1 The following section aims to provide a picture and the voice of the lives of ADULT A, her partner ADULT B and the children CHILD A, and his siblings as seen through their interactions with professionals from various agencies.

Pre-ante natal period for CHILD A

3.2 The timeframe set for the review focuses from 8th November 2013 when ADULT A attended an antenatal appointment being 13 weeks pregnant with CHILD A. However, to view and contextualise the whole picture, other occurrences before this date are needed.

3.3 On the 17th January 2011 a referral to Children's Social Care (CSC) was received from the Police. A verbal dispute took place between ADULT A and ADULT B and the Police were called**.** ADULT B had minor bruising/reddening to the right side of his face, which he said was self-inflicted by head butting the wall out of frustration. Both ADULT A and ADULT B said there had been a domestic incident but refused to give further details. None of the children were present during this incident. ADULT B was taken to his parent's address to prevent a further Breach of the Peace. ADULT A stated that ADULT B used cocaine regularly and has a tendency to lash out when he is wound up.

3.4 On the 17th November 2011 ADULT A was seen at home by a Health Visitor. She disclosed she had recently terminated a pregnancy which she now regretted and she had considered self-harm. She stated that there were some behavioural issues with Child B. There is no record of any Health Visitor follow up plan concerning the mental health concerns. There is no evidence of any Health Visitor liaison with ADULT A's GP.

3.5 On the 16th February 2012 ADULT A was seen at her new and current address by a Health Visitor. She stated that CHILD C was displaying aggressive behaviour and temper tantrums. A two year nursery funding application was discussed.

3.6 On the 24th July 2013 ADULT A saw a GP and stated that she had a 12 month alcohol addiction, drinking 4 cans of Strong bow cider and 1 litre of vodka daily and also using £280 worth of cocaine a week and this was due to her low mood. The GP made no referrals to CSC.

3.7 On the 31st July a referral was received by 'The Bridge', which provides a specialist substitute prescribing Service within SIAS Solihull. At the point of referral ADULT A was completing a detoxification programme which was completed on 27th August 2013.

3.8 It is reported that ADULT A came into contact with the Solihull detoxification service following a referral from her GP due to alcohol dependence and cocaine use 5 days out of 7. Home detoxification was planned, and commenced on 19th August 2013, when ADULT A was seen at home, and was successfully completed on the 27th August 2013, when ADULT A provided a negative alcohol reading. Prior to the alcohol detoxification starting, ADULT A reported her cocaine use only occurred when she was drinking, however at the end of the detoxification she disclosed that she had used 5g of cocaine on one occasion during the detoxification. An oral swab drug test was taken and results awaited. An Initial Assessment was started by a Social Worker as a result of this referral.

3.9 On the 2nd September 2013 the drug test results confirmed positive for cocaine. There were also concerns that ADULT A maybe using Class A drugs whilst in sole charge of her children. It is noted that during the detoxification programme only one child CHILD B was present at home and he appeared well kept. ADULT A agreed to referrals to SIAS Welcome for support with her drug use and SIAS Aquarius for relapse prevention (Both agencies are part of SIAS.)

3.10 On 2nd September 2013 CSC received a referral from a Community Psychiatric Nurse (CPN) from the Bridge Alcohol Detoxification Team based at the Solihull Integrated Addiction Service (SIAS) The Bridge. (SIAS is a partnership of addiction services , which include the Bridge, Welcome and Aquarius) commissioned by Public Health to work in an integrated way to provide a range of addiction treatment approaches to the Solihull Metropolitan Borough residents. Responsibility and the safeguarding

governance of SIAS is arranged through the Birmingham and Solihull Mental Health Foundations Trust's (BSMHFT).)

3.11 On the 3rd September 2013, a referral received by Welcome services from The Bridge (BSMHFT). This service, and Aquarius are further 3rd sector providers working with BSMHFT under the "umbrella" of SIAS. This was a week after the alcohol detoxification and she was referred because of her cocaine use. At the same time she was referred to Aquarius for her alcohol relapse prevention treatment.

3.12 On the 3rd September 2013 a Health Visitor visited ADULT A at home and ADULT A stated that CHILD B's behaviour was getting worse. He was extremely boisterous and swore a lot. Reasons were discussed and it was evident he copied the language used by visitors to the house. It is not known whether domestic abuse was discussed as a cause for his aggressive behaviour.

3.13 On the 4th September 2013 ADULT A told CSC that she had been using alcohol and cocaine. ADULT A stated that she had stopped using alcohol and the last test was clear for alcohol but she did use approximately 5g of cocaine during the detoxification period and the test was positive for cocaine. ADULT A stated that she wanted to stop using cocaine as well as alcohol and she was seeking support from SIAS, Aquarius and Welcome. ADULT A stated that she had terminated a pregnancy and now found this very difficult to cope with and believed this had triggered her addiction.

3.14 On the 4th or 9th September 2013 (records differ) a Health Visitor attended ADULT A's address to visit another client who was living there and saw ADULT A and CHILD B there. The Health Visitor was confronted by CHILD B who went to swear at her and then hit her. ADULT A told the Health Visitor about her alcohol detoxification programme and this was the first time the Health Visitor had been made aware of it. ADULT A also said that CSC was involved. There appears to have been no professional liaison about this, between SIAS, CSC and the HV. The risk of relapse following detoxification is known to be high and as the Health Visitor was aware that ADULT A was not coping with CHILD B's behaviour, added with coping with her other children, this also heightened the risk of relapse.

3.15 On the 19th September 2013 at 1:30pm ADULT A took CHILD B to the Emergency Department at Hospital and it was reported by ADULT A that he had accidentally swallowed a tablet belonging to his aunt at 08:00am that morning. The tablet ingested was 45mg of Mirtazipine which is an antidepressant medication for adults and is available only on prescription. ADULT A stated that the tablet had been in his Aunt's bag and must have fallen out and CHILD B found it. Another recorded account given by ADULT A is that CHILD B took it out of his Aunt's handbag. She said she had seen him chewing on something which she thought was a tablet, but only became concerned when he complained of back pain and seemed drowsy. The explanation for the time delay provided to the clinical team was considered feasible/plausible. After assessment and advice CHILD B was put under observation for 4 hours and no other treatment was recommended at the time. He made a good recovery.

Ante-natal period CHILD A

3.16 On the 23rd September 2013, CSC record that a referral is discussed with ADULT A due to the ingestion of the tablet by CHILD B. It stated, that ADULT A said she was pregnant, but not in a relationship with the father. She was having an ante natal appointment with the Substance Misuse Midwife. She also reported that she had a lodger and the lodgers baby staying with ADULT A for a short while and there were concerns for the lodger too through mental health issues, alcohol and cannabis use and self-harm. On this date the Social Worker that visited ADULT A's address also recorded that an adult seen at the property may have been dealing or buying drugs as he was seen leaving ADULT A's home and meeting the occupants of a car that pulled up and handed something over. This information was not shared with the Police.

3.17 On the 24th September 2013 a Health Visitor made a home visit to ADULT A and discussed CHILD B's behaviour. He was seen jumping off the settee and it was noticed that there was a lack of toys. ADULT A stated that he broke them and he preferred guns. She went onto say that he was defiant, aggressive, swears a lot and head bangs. She also said he was a fussy eater. The Health Visitor referred CHILD B for a two year nursery funding which appears to have been the third time such an application had been been discussed with ADULT A and it is not known why this was never progressed by her. No information sharing is evident from this visit, even though it was an open case to CSC.

3.18 On the 25th September 2013 SIAS shared information with CSC that they had been unable to engage ADULT A back into treatment.

3.19 On the 2nd October 2013 ADULT A visited her GP and stated she was depressed and always feeling sad. This had been occurring for 2 months and she repeated that she had been misusing drugs and alcohol for a year. She said she didn't feel like going to work and that crucially she had 3 children and was 8 weeks pregnant and not in a relationship with the father. No referral to CSC was made and the flagging system is not used for CiN

3.20 On the 3rd October 2013 ADULT A repeated the same information that she had told the GP to a Social Worker.

3.21 On the 5th October 2013 the Initial Assessment ended and CSC recommended that the case was transferred to the long term team for support and coordination of multi-agency support. The case transferred on as a Child in Need (CiN) case. In view of the information on the 3rd of October and the information known by other professionals, the review author is of the opinion that this was another opportunity to go back and have a strategy discussion and consider a section 47 interventions.

3.22 On the 8th October 2013 a Community Midwife referred ADULT A for Specialist Maternity Care noting her drug and alcohol addiction, depression, ongoing treatment and Social Services involvement as the rationale. This was highly appropriate and risk was recognised. There is, however, no evidence of CSC being contacted nor an Assessment made. The Midwife has since said that she did not contact CSC as she was going to refer to specialist midwife. A referral is not made to CSC in cases of pregnancy until it is a 'visible pregnancy' (18 weeks).

3.23 On the 11th October 2013 a home visit was made by a Health Visitor and ADULT A again was reporting CHILD B's difficult behaviour. ADULT A had not, nor wanted, to engage in the "understanding your children's behaviour" course which had been previously recommended and denied that her drinking was affecting CHILD B. She claimed she was alcohol free, was under the care of a Substance Abuse Midwife as she was 9 weeks into an unwanted pregnancy, the father not being her current partner. It is noted that the record for this meeting is brief and lacking in detail. The Health Visitor's concerns, if any, are not documented nor is/was there a a follow plan.

3.24 On the 23rd October 2013 West Midlands Police advised CSC to make a referral to Multi Agency Risk Assessment Conference (MARAC) to discuss some safeguarding concerns. This centred on the Police being called to ADULT A's home at 04:30am in June 2013 for a party where the buying and selling of drugs was suspected. It is not sure why this was done as the police can do it themselves, and wouldn't have met the criteria in any case.

3.25 On the 11th November 2013 ADULT A attended a booked appointment with the Perinatal Mental Health Service within the Maternity Unit at Hospital. She said she was no longer on any medication for depression and felt better. She said she was receiving 2 weekly counselling for her addictions from The Welcome and from Aquarius, and did not need pre-natal mental health midwife.

3.26 On the 13th November 2013 ADULT A attended a booked appointment with a Specialist Midwife for substance abuse and disclosed her history of cocaine use which she said she had last taken 6 weeks

previously. She said she was drinking a bottle of vodka a day. She was advised about the risks to her unborn child and the Midwife correctly made lateral checks with Social Care colleagues, initiated blood tests and shared this information with the relevant agencies.

3.27 On the 2nd December 2013 an update was received by CSC that ADULT A had failed to engage consistently with SIAS.

3.28 On the 3rd December 2013 Health Visitors received a notification of concern from the Maternity Service reporting that ADULT A had maternal alcohol misuse as she was drinking a litre of vodka a day and she had suffered previous depression. There is no documented response to this or evidence of a plan to visit the family or liaise with other agencies. A risk appropriate response is not evident. It is noted by the review author that the information about alcohol misuse on the 13th November and 3rd of December is not shared with SIAS.

3.29 On the 24th December 2013 ADULT A is advised that her case was being transferred to the CiN team following an Initial Assessment and the recommendation for a CiN plan. There is no knowledge why this took 2 months to complete, from the date of the recorded decision on CSC systems. As stated earlier it is felt by the review author that this was not the best decision and consideration should have been for a section 47 discussion. The review panel felt there was and is still some confusion with thresholds and the application of them. The new threshold procedures and accompying leaflet was approved by Solihull LSCB in March 2015.

3.30 On the 9th January 2014 a Social Worker visited ADULT A at home. ADULT A reported that CHILD B's behaviour was challenging and she couldn't be bothered to cook meals. She said she was stressed and that triggered her alcohol and drug use. She said she was engaging with other agencies and attending her appointments.

3.31 On the 13th January 2014 ADULT A attended an appointment with the Specialist Midwife. She reported no further alcohol intake or cocaine use since she realised that she was pregnant. A urine sample was requested from her but she was unable to provide one. The review panel felt that this was ADULT A demonstrating disguised compliance.

3.32 On the 16th January 2014 ADULT A attended a routine antenatal appointment with a Midwife. She was now 23 weeks pregnant. ADULT A provided a urine sample for a drug misuse screening and the result of this test on 22nd January 2014 revealed no illicit substances. The Specialist Midwife contacted the allocated Social Worker who advised her that a Team around the Family (TAF) was being considered.

3.33 On the 27th January 2014 the Social Worker contacted the Health Visitor advising on ADULT A's past alcohol and drug misuse and that a meeting would be set up. The Health Visitor recorded that she had been informed of ADULT A's spirits and cocaine use but no recorded action is evident after the receipt of this information. There is no evidence of lateral checks or liaison with other professionals ahead of the meeting.

3.34 On 6th February 2014 the first TAF meeting took place and ADULT A attended. The meeting was chaired by the allocated SW. Present were a Midwife and a student Midwife, a Health Visitor, the Designated Member of Staff for Child Protection (DMS) from the children's primary school and a support worker from Midland Heart, who was assisting her with her housing circumstances.The meeting was updated on matters from November 2013 that ADULT A was 13 weeks pregnant and under the care of Aquarius and Welcome and a Substance Misuse Midwife for her alcohol and drugs abuse. ADULT A told the meeting that she was now drug free. This meeting is also called a CiN meeting by other practitioners; this does lead to slight confusion and the potential for duplication. No apparent safeguarding plan appears to have resulted from this meeting other than the Community Midwife would provide feedback after her next visit. The CiN procedures for Solihull have been examined by this review. They do not include any detailed

guidance on how CiN meetings and the process should be managed. There is no mention of TAF in the procedures. This has clearly had an impact in this case.

3.35 On the 7th February 2014 at 04:20am the Police were called to ADULT A's home as a neighbour described it as "kicking off" and shouting could be heard. ADULT B was found at the address and was very angry and drunk. There had been a heated argument between him and another man at the address and ADULT A had got involved. ADULT B was asked to leave but refused to do so. He would not leave when the Police asked him to, so he was arrested. This was treated by the Police as a DA incident, because the other man was a past partner of ADULT A. The children were at the address at the time. A child protection referral was correctly made as CHILD B had witnessed some of the incident.

3.36 On the 18th February 2014 ADULT A was seen by the Specialist Midwife for her substance misuse. She was 28 weeks pregnant. She was asked some routine questions about domestic abuse but she made no disclosures. She provided a urine sample for a drug misuse screening.

3.37 On the 21st February 2014 the result of this sample was received and it showed positive for cocaine. The Specialist Midwife correctly identified clear risk and contacted and updated the Social Worker, the Community Midwife and the Health Visitor. It is not known whether ADULT A's GP was made aware of this information.

3.38 On the 24th February 2014 the Specialist Midwife records that she was notified by SIAS that ADULT A's case would be closed due to her non engagement. The positive cocaine result was shared. Despite this, ADULT A had been told that she had to re-present herself if she was to continue with the programme. It is not clear who told her this information.

3.39 On 26th February 2014 the Social Worker and Specialist Midwife spoke about the domestic abuse incident and the Midwife expressed a need to proceed to an Initial Child Protection Conference (ICPC) in view of the recent positive test for cocaine and the domestic violence. This was an attempt to escalate the case beyond a CiN/TAF approach and was responsive to the level of risk emerging in the case. The LSCB escalation process needs to be clearly understood and applied by professionals.

3.40 On 18th March 2014 a TAF meeting took place nearly a month after the positive drug result and ADULT A attended with her mother. Present was a Social Worker, Midwife and the DMS from the children's primary school, SIAS were not present. It is unknown whether this was because they were not invited. It is unclear from any notes recorded whether there were any increased risks highlighted for ADULT A and her children or what progress had been made. The meeting was updated about the domestic violence incident on 7th February when ADULT B was arrested. CHILD B had been present during the incident. ADULT A stated that she was being made redundant at the end of March and would be applying for benefits. What is known is that ADULT A was unhappy at the meeting as concerns were raised and the potential for an Initial Child Protection Conference (ICPC) was discussed. The Specialist Midwife was particularly vocal about this. The positive drug test result from 18th February was discussed and ADULT A stated she was using cocaine again as she was feeling stressed. She had mentioned previously that the recent death of her Aunt had added to her stress levels. SIAS had reported in the past, that ADULT A had completed her detoxification but had declined participation in relapse prevention work saying she was too busy at work to attend.

3.41 Over the next few days the escalation to a Child Protection Case and Case Conference is mooted but it did not happen and records do not assist to see why as this consideration for escalation was highly appropriate. The minutes of this meeting were not shared with attendees and more importantly non attendees so what was captured within the meeting was not properly shared. There is a process in place for the sharing of minutes, but clearly not followed on this occasion.

3.42 On the 26th March 2014 a Social Worker visited ADULT A's home and reported that the family and the CiN plan were progressing well. There has not been however any CiN plan for this case seen as in

existence. She stated that ADULT A was engaging well with both her midwives and there were no concerns raised by any professionals working with the family. She reported that ADULT A was providing regular samples for drug testing and they had been negative. This of course is wrong. ADULT A's last drug test sample was provided on 18th February, some 6 weeks ago and it was positive for cocaine. The TAF meeting resulted in a CiN plan (not known what is in the plan, or in fact who it was shared with). The recording of this visit makes no reference to the recent TAF meeting and the concerns there and wanting to escalate to a CP conference. The review panel raised a point that there is a need for training for SWs and other relevant professionals in relation to chairing and recording of meetings.

3.43 On the 10th April 2014 the Social Worker informed the Midwife, that the Team Manager for the Social Worker made a decision that the plan would continue as a CiN. There is no record of this in the Social Work file, however there is in the Midwifery records. As the Specialist Midwife and Community Midwife were voicing concerns that it needed escalating due to the recent domestic abuse and ADULT A's positive cocaine results. These concerns were highly appropriate but would have carried more weight if they had been brought to the attention of a more senior manager in CSC or the Heart of England NHS Foundation Trust (HEFT) in an attempt to escalate it. This didn't happen and can be considered as a missed opportunity. The review has learned that a promotion of the escalation procedures and a focus on supervision has already been commenced by the LSCB and this is noted.

3.44 Further discussions between the Specialist Midwife and the Social Worker took place on 14th April 2014 with regards escalating the plan. It was decided that another drug misuse screening would take place soon and the Team Managers decision would not currently change. This sample proved negative.

3.45 On 1st May 2014 a TAF meeting took place and ADULT A attended with her mother. Present were the Designated Member of Staff for Child Protection (DMS) from the children's primary school, a Social Worker, a Community Midwife and a Drug Practitioner. The meeting was told that ADULT A had attended 3 appointments for her relapse prevention work and future dates had been set.

Post-natal period CHILD A

3.46 On the 5th May 2014 ADULT A gave birth to CHILD A. There was no pre-birth assessment made by CSC.

3.47 On the 8th May 2014 ADULT A and CHILD A both provided urine samples that were clear of drugs and alcohol. It is noted that this drug testing by the midwives was good practice but it is concerning that the review has learned that they are the only agency who provide this service. It must be noted that this is a voluntary test by the client. Welcome (SIAS) are not commissioned to carry out this drug testing, hence the midwife carried out the test. It is the Bridge (SIAS) that do drug testing.

3.48 On the 11th May 2014 ADULT A and CHILD A were discharged. The Hospital notes still recorded that CHILD A had a Child Protection plan in place. This was never challenged. The responses to CHILD A and his discharge were appropriate and information was shared, including liaising with CSC. A safe discharge planning meeting is best practice where there are substance misuse issues and not holding one was another missed opportunity to escalate any safety concerns.

3.49 On the 29th May 2014 a Social Worker made a home visit two and a half weeks after CHILD A's discharge from Hospital and it is reported as a positive visit with the CiN plan progressing well. ADULT A was trying to move houses and this was being supported by a Support Worker from Midland Heart.

3.50 On the 3rd June 2014 a report of anti-social behaviour was made by a neighbour that ADULT As children were " running riot and throwing plant pots". Solihull Housing was updated by the police but no further action was documented, although the Police IMR refers to a communication with Housing.

3.51 On 5th June 2014 at 9:20 pm a neighbour called the Police as a female had been seen wielding a kitchen knife and chasing after a man from ADULT A's home address. ADULT A was found in nearby woods but no

knife was found. She stated she had had an argument with ADULT B who was not at the scene anymore. ADULT B was spoken to on the telephone later that evening and he made no complaint. Nothing further is recorded. The incident was referred to Social Services. No checks were made by the Police on the children's welfare. This is seen as a missed opportunity to check on the children, but was followed up the next day by the SW.

3.52 On the 6th June 2014 a Social Worker made a home visit and no concerns were raised as the children were seen and reported as being ok.

3.53 On the 9th June 2014 a student Health Visitor made a visit to ADULT A's home. All was reported as normal with no parental concerns.

3.54 Also on the 9th June 2014 ADULT A was interviewed by Solihull Community Housing (SCH) claiming she was homeless. This came about because she had fallen into rent arrears and the landlord had served a notice seeking possession on the basis of unpaid rent. She denied the arrears claiming an agreement had been made not to pay rent pending the completion of repairs to the property. The landlord denied this. Her application was considered and was investigated.

3.55 On the 27th June 2014 a student Health Visitor made a home visit to ADULT A. All was recorded as normal with no parental concerns.

3.56 On 2nd July 2014 a student Health Visitor made a home visit to ADULT A. ADULT A said she was participating in regular TAF meetings; there had actually only been two within six months. Three other people were present in the house but there is no record of who they were or why they were there. CHILD A and CHILD B were not seen but it is not recorded why. Subsequent enquiries made by the review found with a degree of certainty that the student Health Visitor had been accompanied, but whether this was the case on all three occasions is unknown.

3.57 On the 3rd July 2014 at 9:40pm Police were called to ADULT A's home address after a neighbour had complained about the noise there and ADULT A and ADULT B were being aggressive to the neighbour and other people present. The Police update is that the occupants of ADULT A's address had been drinking all day and an argument broke out. No further action was taken was not noted by police as a neighbour dispute.

3.58 On the 10th July 2014, Solihull Community Housing completed a housing affordability report from information provided by ADULT A. The Midland Heart support worker disclosed that she spent money on alcohol and drugs (This was by telephone on the 18th July 2014).

3.59 On the 21st July 2014 the fourth and what turned out to be the final TAF meeting took place and ADULT A attended. There were only 3 involved professionals present with ADULT A, that being a Health Visitor, a Social Worker and the DMS from the children's primary school. A support Worker from Midland Heart supporting ADULT A with a housing application was also present. SIAS sent their apologies, they did not provide a report yet the main concerns about ADULT A stemmed from substance abuse (It must be noted that this meeting was called at extremely short notice). ADULT A stated that she was drug free and had completed her relapse prevention work. She updated the meeting that she was engaging with Solihull Housing to progress her homeless application. She also said she was no longer having contact with ADULT B because of the domestic violence incidents. There is no clear recording of any concerns or progress made and nothing of significance is recorded as being discussed. The meeting continued without ADULT A. The Social Worker stated that contact with her manager would take place to close down from the CiN plan and to liaise with all professionals about the decision. It is presumed the two other professionals who were present agreed with this. There is no rationale recorded as to why the plan would be closed down. Again minutes of the meeting are not shared, some agencies state they did not know that a record existed and have still not seen them.

3.60 On the 25th July 2014 a Social Worker made a home visit and it is reported that ADULT A had made positive progress and had worked well with all the professionals assisting her. ADULT A stated that she no longer used drugs or alcohol and that she had been discharged from SIAS as she had successfully completed the programme. ADULT A also stated that she was no longer in a relationship with ADULT B. The review panel did note that this is ADULT A self-reporting that she is free of drugs and alcohol, and not a professional view.

3.61 On the 19th September 2014 a decision was reached on ADULT A's homeless application and she was informed. The decision was that she had made herself intentionally homeless and she had sufficient funds to pay her rent but had failed to do so. She did appeal this decision but it was upheld, that there was no duty to accommodate.

3.62 On the 10th October 2014 at 11:49pm ADULT A called the Police as ADULT B had "kicked the front door through". Police attended and found ADULT A and CHILD D distressed and crying. ADULT B had been to the address and had been asked to leave. He became aggressive towards ADULT A and was abusive to CHILD D shouting in her face and scaring her. ADULT B pushed ADULT A onto CHILD A's crib as he was asleep in it which caused some slight injury to ADULT A. He then punched the door and kicked it causing damage. ADULT B was located and arrested but no further action was taken by the Police, due to the evidential threshold not being met. ADULT A said that her relationship with ADULT B had ended in March 2014 but his clothes and belongings were found at her address suggesting this was not true. They were also due to go on holiday together. The report on this incident was joint screened by the internal police referral desk and no further action is taken.

3.63 On the 16th October 2014 the Social Worker and Health Visitor spoke and it is recorded that no further meetings would take place and the case was closed. This was the first time the Health Visitor had been informed that the CiN had concluded. It had been 3 months since the last TAF meeting. No rationale is recorded for the decision and no concerns are recorded nor does the Health Visitor challenge the decision.

Post serious harm period

3.64 On 25th December 2014 at 08:20am the Ambulance Service responded to a 999 call to ADULT A's parents' home address and saw CHILD A, observing that he was "floppy and unresponsive", with noisy breathing and a rapid heart. He was admitted to the Emergency Department at Heartlands Hospital. En route to Hospital he suffered cardiac arrest and had to be resuscitated four times. At 09:07am Ambulance Control notified the Police of this serious child incident.

3.65 By 10:00am that day CHILD A was stable and plans were made to move him to a paediatric care bed. The attending Doctor recorded the following notes. "The most likely reason for the seizure/status epilepticus was thought to be ingestion of a toxin or intracranial trauma." Electronic records showed that CHILD A had had toxicology testing completed at birth.

3.66 The Emergency Duty Team (EDT) were contacted and a message left to see if CHILD A was known to them and to update them on his condition. EDT did not call the Hospital back until 26th December 2014. They did state, however, that they had been liaising with the Police. No written copy of the referral was sent to CSC.

3.67 At 12:37pm on the 26th December 2014 CHILD A was transferred to the Stoke Paediatric Intensive Care Unit. A skull CT had been completed and it was clear.

3.68 On the 29th December 2014 at a time unknown, a Strategy Discussion took place between the Police and CSC. Information was exchanged and the Police officer stated that the Hospital had indicated there were two potential options for CHILD A's condition. One was overheating whilst the other was ingestion of a substance. The officer said that the Police were not planning to interview ADULT A formally until

toxicology results were received. This does suggest that by now the police may have had some knowledge of the drug ingestion possibility.

3.69 On the 30th December 2014 at 11:10 am the toxicology results were received at the Hospital which showed positive for cocaine and two cutting agents. The nurse taking the call immediately contacted the Social Worker and another nurse contacted the Police. This was an excellent response to the information received. The Social Worker responded by informing the nurse that CSC were liaising with the Police and a Strategy Meeting was being arranged as soon as possible. The nurse was advised not to tell ADULT A about the results or the plan.

3.70 At some time after this on 30th December 2014 the Strategy Meeting was held. The toxicology results were discussed and a Section 47 Child Protection enquiry was decided for all four children. The plan made included:

- The Police to arrest ADULT A immediately after the Strategy Meeting
- CSC to arrange for Child Protection Medicals for the three siblings
- The Social Worker was to ask for maternal consent to place all children in foster care (CHILD A was not medically fit at this point and so this would not apply to him until he was well enough to be discharged) and if she did not agree then an application for an Emergency Order would be made. ADULT A did provide her consent and CHILD D, CHILD B and CHILD C were placed in foster care on 30th December 2014.

3.71 At 4:45 pm on 30th December 2014 ADULT A was arrested by the Police for wilful neglect and interviewed. Her home address was searched. She was released on Police bail.

3.72 On 1st January 2015 at 3:40 pm CHILD A was taken away from Hospital into the care of foster parents.

3.73 On 11th January 2015 ADULT B was arrested by the Police and interviewed. He was released on Police bail.

3.74 On 30th January 2015 the results of hair strand tests were received for ADULT B. They showed positive for cocaine throughout October, November and December 2014. He accepted this result.

3.75 On 3rd February 2015 the results of hair strand tests were received for ADULT A. They showed positive for cocaine throughout October, November and December 2014. ADULT A initially denied this result but on 13th February 2015 accepted that they were accurate and admitted that she had been using cocaine during this time period.

3.76 On 14th February 2015 an incident took place between ADULT A and ADULT B. All that is known is that ADULT B was charged with common assault and criminal damage and was due at court in June 2015. CSC was notified of this.

4.0 Further analysis of significant safeguarding events

4.1 This review was helped greatly by the IMR authors, firstly by their reports and chronologies, but also the practitioners at the workshop. The review also really benefited from the work of the SCR panel.

4.2 This analysis covers three significant periods, namely before the antenatal period for CHILD A, the antenatal period and post serious incident period.

4.3 ADULT A has no criminal convictions. Her on/off partner ADULT B has four convictions from six offences which include common assault, threatening behaviour and battery between 2008 and 2012.The review panel were concerned that not enough attention was taken by professionals to ADULT B who although not the father of Child 2 he was a constant in this household (As part of an assessment there could be

consideration given to who is reguarly having an influential role in the household). This was also a theme recognised by Brandon et al (2009) in one of the Biennial Analysis Reports of Serious Case Reviews:

"The failure to know about or take account of men in the household was a theme in a number of serious case reviews. Assessments and support plans tended to focus on the mother's problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence or allegations of or convictions for sexual abuse." (Brandon et al, 2009). Although not a formal recommendation it is a clear point of learning resulting from this review, for professionals to be aware of the impact of the males in or visiting the household.

4.4 In relation to CHILD B's attendance at Hospital on 19th September 2013. This is when he ingested a prescribed drug, it is noted that Emergency Department staff were positive in recognising that ADULT A and her family had had previous Social Care involvement and that ADULT A had been involved in an Alcohol Detoxification Programme. They considered safeguarding and the incident was referred to CSC, albeit no immediate verbal referral was made which goes against their policy. They also notified ADULT A's GP and her Health Visitor. The referral was not concise and it did not mention the time delay between the ingestion and the delay of five and a half hours later, when ADULT A brought him to Hospital. This is a significant fact which should have been included.

4.5 There is no evidence that any consideration was given to the possibility that CHILD B could have swallowed anything else and knowledge of the family would make this an appropriate enquiry. It appears that ADULT A's report that it was one tablet of Mirtazapine was accepted, despite the fact that she claims to have not actually seen him take it. Routine toxicology is not completed if a parent reports what has been taken and brings in proof, ie packaging. It is accepted by the review author that mum did provide a plausible explanation.

4.6 There has been no evidence why actions did not take place provided to the review. It is the review author's opinion, that the multi-agency response to this could have been enhanced if there had been a multi-agency meeting to share information and agree a joint plan. There appears to be no consideration given for the need for a Strategy Discussion. The incident has not been explored sufficiently. A Health Visitor liaised with CSC and established that an assessment was taking place and did complete a home visit to discuss the management of medical items and home safety issues with ADULT A. There is no evidence that the Social Worker shared the assessment with the Health Visitor or that the Health Visitor in return updated the Social Worker with what she found on the home visit. Both practitioners worked in isolation of each other. This Initial Assessment recommended that further Social Work Assessment be undertaken, but there is no record evidencing that such an Assessment was completed.

4.7 There is no evidence of any management oversight on the day of the incident, or why this didn't take place, until 1st October 2013 when an Assistant Team Manager comments that, "Mum acted appropriately and took her child to Hospital". Which although is true but delayed and without urgency.

4.8 The review author believes that the Police should have been made aware of this incident. The review panel debated this point, as knowledge of it may have changed their initial response to the incident with CHILD A on Christmas Day 2014. However, it should have placed some part of the initial assessment that was taking place.

4.9 Following the initial assessments it was felt that this case was best managed by a long term team and the case should be transferred to a CiN case. As part of the CiN plan, four Team around the Family (TAF) meetings were held involving ADULT A and an attendance by the Community Midwife, the Health Visitor,

DMS from the older children's primary school, a Drug Practitioner and a Support Worker helping with a housing application. There was not consistent attendance of all partners for various reasons. What is evident for this paragraph and subsequent few paragraphs, is that the lack of a clear plan for all professionals (no one knew what this was) with a lead professional was missing from this whole period of CiN(TAF) meetings and hampered any focussed work with ADULT A.

4.10 On the 6th February 2014 the first TAF meeting took place and the meeting was updated on matters from November 2013, and that ADULT A was 13 weeks pregnant and under the care of Aquarius, Welcome and a Substance Misuse Midwife for her alcohol and drugs misuse. ADULT A told the meeting that she was now drug free. This meeting is also called a CiN meeting by other practitioners this does lead to confusion and the potential for duplication. As already said no apparent CiN plan appears to have resulted from this meeting other than the Community Midwife providing feedback after her next visit.

4.11 On 18th March 2014 a TAF meeting took place nearly a month after ADULT A provided a positive drug result. The review author suggests a strategy meeting should have been convened in the circumstances. It is unclear from any notes recorded whether there were any increased risks for ADULT A and her children, or what progress had been made with ADULT A and her family. The meeting was updated about a domestic violence incident on 7th February when ADULT B was arrested. CHILD B had been present during the incident.

4.12 What is known is that ADULT A was unhappy at the meeting as concerns were raised and the potential for an Initial Child Protection Conference (ICPC) was discussed. The Specialist Midwife was particularly vocal about this. The positive drug test result from 18th February was discussed and ADULT A stated she was using cocaine again as she was feeling stressed. She had mentioned previously that the recent death of her Aunt had added to her stress levels. An update was provided by the Drug Practitioner present for SIAS which added that ADULT A had completed her alcohol detoxification but had declined participation in relapse prevention work saying she was too busy at work to attend. It appeared a volatile meeting. Over the next few days the escalation to a Child Protection Case Conference is suggested but it did not happen and records do not assist to see why this was. This consideration for escalation was highly appropriate. An observation by the review author is that the minutes of this meeting were not shared with attendees and more importantly non attendees, so what was captured within the meeting is not properly shared, which it should have been.

4.13 On 21st July 2014 the final TAF meeting took place. Welcome SIAS sent their apologies which were unfortunate, as they did not provide a report, yet the main concerns stemmed from substance abuse. ADULT A stated that she was drug free and had completed her relapse prevention work. She updated the meeting that she was engaging with Solihull Housing to progress her homeless application. She also said she was no longer having contact with ADULT B because of the domestic violence incidents. There is no clear recording of any concerns or progress made. It is accepted that 'Signs of Safety was discussed but it was just not effectively recorded. The meeting continued without ADULT A and the Social Worker stated that contact with her manager would take place to close down from the CiN plan and to liaise with all professionals about the decision. It is presumed the two other professionals who were present agreed with this. There is no rationale recorded as to why the plan would be closed down. Again minutes of the meeting are not shared, some agencies state they did not know that a record existed and have still not seen them.

4.14 This case was "stepped down" despite the history of concerns including, ADULT A's substance misuse in her pregnancy, domestic abuse in her pregnancy, ADULT A's previous mental health issues, evidence that ADULT A could not cope with CHILD B's behaviour and CHILD A being only 2 months old. There was no documentation in the Health Visiting record of any indicators that the family required additional support and monitoring. It would appear that the Health Visitor closed the active intervention in October 2014, when they found out that CiN had been stepped down. There does not seem to have been any agreement about what the step down plan would consist of or who would be providing future support to ADULT A

and her family. Making more clear the expectations for additional support and monitoring on the Health Service when a case is stepped down is required.

4.15 The decision to step down from CiN in July 2014 has been analysed. It is felt that why this happened, is due to the fact that there is no clear recording of any concerns or progress made at the July CiN meeting, and nothing of significance is recorded as being discussed. This is despite the information of the domestic abuse concern from 5th June 2014. The meeting continued without ADULT A and the Social Worker stated that contact with her manager would take place to close down from the CiN plan and to liaise with all professionals about the decision. There is no rationale recorded as to why the plan would be closed down. A record exists that the Social Worker discussed closure with a Team Manager on 23rd September 2014, some two months later, but no clear decision for closure is recorded. During this meeting it was stated that the view of the meeting was closure but other practitioners disagree with this. Again minutes of the meeting are not shared or distributed, some agencies state they did not know that a record existed and have still not seen them.

4.16 The escalation process regarding professional disagreement was not used. The escalation process should have been followed in the antenatal period by the Midwife, and could have been more sustained. The Health Visitor did not see a reason to escalate in July 2014 when discussions were held about stepping down whilst other professionals apparently disagreed. There is conflict here as other agencies records state there was no disagreement. The process appears to be in place but in this case not correctly considered. It can only be presumed why this didn't happen is due to the lack of knowledge of the escalation procedures by practitioners.

4.17 The Designated Member of Staff for Child Protection (DMS) for the school attended all the TAF meetings and was unaware that a decision was made to step down from CiN in July 2014. The DMS was present at the 21st July 2014 meeting and was part of the Signs of Safety exercise that was completed by the professionals who were present. The DMS understood that at the end of the meeting a decision regarding the case was to be made by the Social Worker and their manager based on the information shared in this exercise. The DMS was not informed of the decision to step down from CiN and never received any minutes of the meeting. The DMS believed that the case remained open. Why this lack of communication happened regarding the decision made could be attributed to the fact that 21st July 2014 was the last day of the academic year. There was no early help or co-ordinated support put in place by the school as they were under the impression the Social Worker was the lead person and that the CiN plan was still in place. This was a break down in the flow of very important information. Also there was no contact between CSC and the school between the 9th September 2013 to 6th September 2014. The school was completely unaware that the case was open and not aware of any concerns about adult behaviours and possible risks to the children attending the school.

4.18 Communication between the agencies was varied. Although there were good examples of information being shared in a timely and appropriate way, there were also times where communication between professionals could have greatly been improved and at times was non-existent.

4.19 ADULT A latterly failed to engage with Welcome and Aquarius and so their involvement in later decisions was limited. The possibility of a joint visit with Social Care to explore the needs of ADULT A and her family is an option that could have been considered and may be useful in future cases. Children Social Care's stance that there was no obvious or immediate risk to ADULT A and her children despite the drug and alcohol misuse and evidence of potential drug dealing in her home should have been challenged due to the impact of hidden harm. It is presumed that lack of knowledge about hidden harm is the reason why this didn't happen. Raising the level of multi-agency working and carrying out joint visits with assessments would have been beneficial. Safeguarding training and the impact of hidden harm requires addressing with staff to ensure that it is addressed at the point of assessment and throughout the treatment time. Professional development post training required to develop practice.

4.20 Risks were not clearly understood and the CSC records suggest various areas for concern were not fully considered. This includes domestic abuse risk from ADULT B, (very little seems to have been considered about him or any risks he posed), and the violent incidents, the risk of eviction, the ingestion of the tablet by CHILD B, the presence of another vulnerable mother and her child within ADULT A's home and the chaotic lifestyle of ADULT A through her drug and alcohol abuse. Risks should have been formally discussed within a strategy meeting at a much earlier stage.

4.21 BSMHFT as part of SIAS provided a very short intervention with ADULT A to conduct a Community Alcohol Detoxification Intervention. ADULT A was drinking heavily each day and her admissions should have triggered her allocated worker to discuss with either early help or other safeguarding professionals the concerns. The reason why this didn't maybe because ADULT A disguised her failings and issues well enough to lead her worker to believe all was well as she was portraying, and therefore misses the vulnerability of her family. Her detoxification was successful but she used cocaine during the treatment period and the worker correctly made a Child Protection referral. The review considers that the lack of communication with CSC at the instigation of the detoxification period and the failure to consider the effect of excessive alcohol consumption or what a relapse could do on safe parenting is a lesson for learning.

4.22 SIAS partners did work together during the first phase of ADULT A's treatment and at her first discharge. At the point of discharge there was insufficient information passed to the Health Visitor but some information was passed to other agencies (CSC, GP) relating to the risk of her relapse and how this might increase the risk to her children. It is suggested that SIAS can review their safeguarding policies and consider where there are opportunities for closer working and liaison within partners. Drug testing of clients where children are involved in CiNs or CP should be strongly considered. As highlighted earlier it is acknowledged that Welcome SIAS are not commissioned to do this drug testing.

4.23 During the initial strategy discussion (This communication between police and social care, (EDT) is referred to in the police records as a strategy discussion. This does not concur with the social care record which does not describe this communication in these formal terms.) The discussion took place on the 25th December 2014 the police officer who attended this strategy discussion felt that the Hospital staff didn't adequately disclose the Doctors recorded thoughts on causation, that being ingestion of a toxin or intracranial trauma. The implications of ventricular fibrillation, ie ingestion of a toxin, that this was highly suggestive of cocaine and/or methamphetamine use, were in her opinion not conveyed to the police at this time. The review panel were of the view that the message had been conveyed. Had the hospital been invited to take part in this strategy discussion, the clinicians could have had an opportunity to explain the the clinical picture in lay terms. Had this occurred the police may have responded differently at this point in time. The medical assessment also documented the fact that CHILD A had been subject to urine toxicology at birth and that ADULT A had disclosed her previous substance misuse. It appears that Emergency Department staff was thinking that drug ingestion was a possibility. The wraps and seals recovered from ADULT A's home on 30th December 2014 were analysed and were found to contain traces of cocaine, Methylmethcathinole, Benzocaine, Levamisole, Tetrahydrocannabinol, Caffeine and Paracetamol.

4.24 The reason why this didn't happen is because the police have stated that they were not clear at the time of the incident that it was a possibility that CHILD A had ingested an illicit drug. There appears to be some confusion over the word "toxin" with the police not understanding that this could have meant an illicit drug. It is hard to establish from records what actual information was shared. Social Worker (EDT) input on 25th December 2014 or a formal meeting with the police would have resolved any misunderstandings or lack of knowledge about this. Being told something doesn't meant to say it has been understood.

4.25 It is also not clear whether ADULT A's later recorded disclosure to Emergency Department staff that she could not rule out friends having brought drugs to her home on Christmas Eve was shared with the Police and CSC.

4.26 A strategy discussion took place on 29th and a strategy meeting on 30th December 2014 but records of these meeting are incomplete. An earlier strategy discussion would have assisted, given the delay in awaiting the outcome of toxicology results due to the holiday period. This coupled with ADULT A's history gave more weight to the possibility of an ingestion of a drug by CHILD A, which of course a Doctor has recorded but apparently not shared. The lack of an earlier strategy discussion does suggest that potential risk may not have been fully identified and explored and safeguarding could have been put in place earlier. There is no evidence to suggest the remaining three children were risk assessed for their safety between 25th and the meeting on 29th December. As the case was open to CSC they could have made direct contact with health professionals to establish vital information that hadn't been shared with the police.

4.27 One of the actions from the strategy meeting was for a named Doctor to follow up and locate a sample of vomit that the Police reported giving to the Emergency Department staff on CHILD A's admission on Christmas Day. It is not even recorded in the Emergency Department notes that the police were in attendance with CHILD A when he was admitted and no mention made that they provided a sample of vomit. This sample was an exhibit and was never located. With hindsight the police could have taken two samples from ADULT A's home providing one to the hospital and retaining one for analysis. The police acted in the best interests of CHILD A by handing it to Emergency Department staff.

4.28 There is no evidence that the GP was made aware of safeguarding concerns related to the family. Records do not suggest that the GP was asked to contribute to either the TAF meetings or the CiN process. Although it could be presumed why this didn't occur, it is inappropriate to presume that the GP would not have attended these meetings and the opportunity should have been provided for engagement. Had the GP been fully engaged in safeguarding processes, primary care information and input could have formed part of the plan.

4.29 The review author has looked at a number of domestic violence incidents that have a bearing on the subsequent issue of neglect. Limited investigations to establish the welfare of ADULT A's children took place. Most incidents were dealt with in isolation and reports were generally filed after some brief enquiries. The cumulative effect of a number of incidents does not appear to have been recognised and not acted upon. Information was sent for joint screening and to the Child Abuse Investigation Unit (CAIU) but there is no evidence of this leading to any further police investigation. The police, although taking action, were, in some/most? Cases slow to recognise signs of child abuse caused by some of the domestic violence incidents and the information provided by other neighbours who witnessed ADULT A's disorderly lifestyle. Risk could have been identified earlier if a more holistic approach had been taken and other agencies information shared better. The police did not adequately share the information in relation to the DA effectively.

4.30 Between February 2014 and December 2015 West Midlands Police responded to ADULT A's home address 4 times to issues of domestic abuse and one of anti-Social behaviour. Instances of domestic abuse are also recorded outside the timescales for of this review. ADULT B was arrested twice and no further action taken (NFA). ADULT A was herself the offender on one occasion but she was not arrested nor any action taken. The officers attending and dealing with the incidents do not appear to have acknowledged the risks to the children from such domestic abuse, nor appreciated the concept that parental drug and alcohol abuse would have an effect on the children's welfare. The incident on 10th October 2014 saw a more holistic approach and information was correctly shared. On the other occasions the attending officers seemed focussed on establishing whether an offence had occurred without considering the children's safety

4.31 In her 'Review of Child Protection' (2010) Professor Eileen Munro reminded professionals of the need to have a degree of caution when working with families and to maintain what Lord Laming called "respectful uncertainty" and "healthy scepticism". Opportunities were missed when ADULT A gave inconsistent reports related to her own health, in particular her depression and drug abuse. The review panel stated

that “respectful uncertainty” and “healthy Scepticism” is in local training, but up until recently not explicitly in training across Solihull. They advised that this is a specific section included in LSCB Level 2 training (since summer 2014) and built into new LSCB training model going forward.

4.32 The system that engages the GP in safeguarding processes requires review. GPs are routinely informed when a child registered with their practice becomes subject to a child protection plan. A similar process should be implemented to ensure that a GP is informed of a child supported by a CiN plan or a TAF process. The GP should be routinely invited to any safeguarding meetings and a report requested if attendance is not possible. A member of the CiN should be identified to liaise with the GP practice to ensure that pertinent information is communicated.

4.33 Within the timeframe of this review 14 different GPs saw ADULT A and her family and so the potential for one or two GPs getting to know ADULT A and her family were lost. The reason why this happened is that the review has been told that there were instabilities within the GP practice which was virtually disbanded overnight at one point and set up again. Many locum GPs were brought in to cover during this period that had a lack of knowledge of the complexity of the practice and its patients. When ADULT A told a GP on 24th July 2013 about her level of alcohol abuse (4 cans of Strongbow cider and 1 litre of vodka daily) and cocaine use (a £280 week habit which she took through her nose, never injected) going back 12 months plus depression, no referral was made to CSC bearing in mind the obvious risks to her children. Information was not shared with the Health Visitor. This was a missed opportunity and the GP missed the chance to “identify and assess the impact on children of parental substance abuse and to ensure they are given opportunities to access normal childhood activities and education,” as promoted by the Royal College of General Practitioners (RCGP) Safeguarding Children Toolkit (2011) This has now been updated in 2015. It is noted that the practice managerial structure changed four times during the period of September 2013 to April 2015.

4.34 ADULT A visited a GP on 2nd October 2013 saying she was depressed and struggling to cope, as well as still misusing drugs and alcohol. She was also 8 weeks pregnant. No referral to CSC was made.There was no use made of the flagging system on the SystmOne parent record. While not all health professionals are on SystemOne, This flagging would have alerted those who areADULT A and to the key issues of concern by using markers such as , “ maternal drug use “ and “maternal alcohol use”. This was not in isolation as the flagging system was never used after ADULT A’s many contacts with GPs. An audit carried out at this GP practice revealed that staff were not familiar with the flagging process. This was another missed opportunity as it would have prompted inquisitiveness and raised concern for the family and especially the children upon future contact. It is the opinion of the review that the inconsistency of permanent staff and the capacity and lack of continuity of the service of the practice has impacted on the way information relating to safeguarding policy and procedures including the flagging of records have not been delivered. An audit carried out in February 2015 revealed that staff at the practice was not familiar with this flagging process.

4.35 Staff should feel confident to appropriately challenge service users. Professional curiosity and healthy scepticism should be included in all levels of safeguarding training to give staff confidence and the skills to challenge and check information provided by service users.

4.36 The case recording by Children Social Care is not good in this case and misleading with dates recorded for events recorded differently to other agencies. All case recording must be in line with procedures and be accurate to ensure safe decision making and correct information is known. Procedures need to be referred to and in particular, thresholds, as this could prompt different actions.

4.37 No issues relating to ethnicity, religion, diversity or equalities has been identified by the review.

5.0 Family perspective.

CHILD A is too young to verbalise his wishes and views. Observations of CHILD A suggest that he is happy and content and thriving in the care of his maternal grandmother. CHILD A is learning to walk and is curious and enthusiastic to explore his environment. CHILD A maintains eye contact with his close family members and will seek them out if they leave the room.

His older siblings love to spend time with him and he is always really excited to see them. When they are playing games in contact CHILD A likes to watch and he will crawl around to try to join in. He also laughs and smiles whilst watching them. When CHILD B dances CHILD A tries to copy him and was seen trying to stand in the sofa and dance.

The health visitor has just completed a developmental check and CHILD A is meeting all his developmental milestones. The Health Visitor for the family will continue to monitor CHILD A's health and developmental progress as he grows.

6.0 Conclusion

6.1 The above commentary and analysis shows what happened in the build up to the significant event involving CHILD A on 25th December 2014, and at times why it is thought actions were taken or not taken.

6.2 The review process has revealed the below key themes that have arisen from this review..

- Parental Drug and Alcohol abuse
- Parental mental health (depression)
- Domestic abuse
- CiN/TAF meeting process and procedures
- Escalation processes including Step down processes
- Early help provision- Focus on mother
- Voice of the child missing

6.3 The review looked at the questions asked at the start of the process; these did change emphasis as the review process progressed. The questions have been adequately answered during the analysis sections.

6.4 The review has recognised a number of missed opportunities that could have been seized upon which may have assisted in CHILD A and his sibling's life and welfare. Interventions could and should have occurred earlier. As an example there were requests by a Midwife that the case move to an ICPC. The concerns were highly appropriate but would have carried more weight if they had been brought to the attention of a more senior manager in CSC or HEFT in an attempt to escalate it. This didn't happen and can be considered as a missed opportunity. The review has learned that a promotion of the escalation procedures and a focus on supervision has already been commenced by the SSCB and this is needed.

6.5 There were a number of concerns about systems and practice found by the review. The key one, that there was not in place a robust plan that all professionals were aware of and could work to. ADULT A abused drugs and alcohol and was a parent of four small children and who allowed other adults to use drugs within her home, who suffered from mild mental health issues and who had a number of partners, one whom subjected her to domestic abuse. These issues were recognised across the agencies. Initial responses to her domestic abuse and its effects on her children were not fully considered.

6.6 It has also been noted that issues still exist with information sharing and that these barriers must be overcome. The vital information about CHILD B's ingestion of a tablet on 19th September 2013 was never brought to the attention of the Police until 25th December 2014. Agencies must adequately share routine information and work together with it and this is a key issue. Information sharing protocols are not effective enough and information is not regularly being shared. A free flow of information must exist and agencies need to ensure incorrect fears of releasing information are resolved. Much better clarity about information sharing is required. The review noted a comment made by one of the professionals involved who said that, "we weren't talking to each other."

6.7 Professionals allowed the rule of optimism to affect their judgement. Warning signs were missed which may have assisted in the safeguarding of ADULT A's children. ADULT A's various statements to professionals indicated that she was no longer abusing drugs and alcohol and this led to misinterpretations of the actual truth as it filtered out areas of concern. A pattern of this disguised compliance was not spotted. One professional said that ADULT A was "very good at sharing her issues", but as is seen, she put little effort into resolving those issues by making changes.

6.8 The Solihull Integrated Addiction Service (SIAS) The Bridge is highlighted by the review for their work and perseverance with ADULT A and her detoxification treatment which was initially successful. They made correct referrals when concerns were noted for ADULT A's children through her cocaine abuse and correctly used partners Welcome for drug use support and Aquarius when she needed support for abusing alcohol.

6. 9 The review considers that supervision and proper management oversight were not always evident and considers this to be vital in the effective safeguarding of children. Staff need support and reassurance and the case management across the agencies requires closer supervision. It was observed that professionals were not completely aware of hidden harm and that the voice of the child was not the priority. The review suggests some training to remedy this situation.

6.10 ADULT A and her children lived in rented accommodation with a private landlord but SCH became involved with ADULT A in June 2014 when she made a homeless application to them as her landlord was seeking repossession of her home due to rent arrears. As part of this process, ADULT A had to complete an affordability assessment. At a later stage her Midlands Heart supporter stated to SCH that ADULT A was spending money on drink and drugs. This admission was at a key stage when professionals were on the verge of stepping down from a CiN and knowledge of this information may have changed their mind set. SCH have expressed a view that they should be more involved in safeguarding and this has now been recognised by CSC.

6.11 Escalation and step down lacked a lead professional. SCH was not involved in the CiN however ADULT A indicated several times that housing was a factor in her CiN status. SCH could have been involved and have made it known that they wish to participate in CiN plans and meetings decisions.

6.12 The review has not found any clear evidence that would lead to any conclusions that what actually happened to CHILD A on the morning of 25th December 2014 could have been avoided. Until the legal process is concluded this cannot be commented on further. Both ADULT A and ADULT B in their initial Police interviews denied causing CHILD A any harm and sought to blame others.

6.13 The review praises the swiftness of the Police's Public Protection Unit (PPU) who was involved and dealing with the incident within 25 minutes of it being first reported via the Ambulance Service. Social Care was soon informed and there was instant attendance at the Hospital and the scene by police from the Unit. The rapid response protocol was also instigated very quickly.

6.14 EDT did not attend Heartlands Hospital on the day of the incident on Christmas Day. No senior CSC was contacted. The review has questioned whether this was because procedures are different as it was a

Public Holiday but have been reassured that on call procedures are always in place. The failing is viewed as an oversight.

6.15 This Serious Case Review concerning CHILD A has made a number of recommendations as detailed below and the implementation of these will assist the partnership to deal more effectively with children and vulnerable young people in the Solihull area.

7.0 Recommendations

It is hoped that the following recommendations that have been developed from this review will help the SSCB to improve the effectiveness of the partnership in safeguarding and promoting the welfare of children in the Solihull area.

7.1 **Recommendation 1**

a) Solihull LSCB, Child in Need (CiN) process needs to be much more robust, which can be achieved by becoming more in line with the current CP process. This needs to be circulated and marketed effectively to relevant professionals to allow proper consistency and commitment of all partners.

b) A process for the distributing of the minutes of the meetings and ensuring actions are swiftly forwarded to the correct agency with a follow up plan is also essential. The development of a meeting template may assist this.

7.2 **Recommendation 2**

The Solihull LSCB should put in place a process, which takes into account the regional approach, that enables the effective use of escalation and professional challenge procedures to take place. With particular focus on when step down or step up considerations are being made, and there is professional disagreement.

7.3 **Recommendation 3**

a) The Solihull LSCB should enquire with the Director for Public Health about the launch of a prevention campaign aimed at parents of safe handling and storage of drugs. This should include the dangers of taking them whilst they have care for children.

b) The Solihull LSCB should contact the Director of Public Health to consider the commissioning arrangements for drug testing in Solihull.

7.4 **Recommendation 4**

In order to improve safeguarding in primary care, the Solihull LSCB should approach the Director of Commissioning for Primary Care (and or successor organisation) to make arrangements to ensure that the services they contract out to others, are provided having regard to the need to safeguard and promote the welfare of children (Children Act 2004, Section 11 (2) (b)). These statutory duties continue to apply in circumstances where there are changes in providers/ service contracts.

7.5 **Recommendation 5**

Solihull LSCB should accelerate their multi-agency training programme that it includes

a) The risks associated with the complex needs which were present in this case (ADULT A abused drugs and alcohol and was a parent of four small children and who allowed other adults to use drugs within her home, who suffered from mild mental health issues and who had a number of partners, one whom

subjected her to domestic abuse.) This is for all professionals and not just those that work in specialist services.

b) How to deal with resistant parents who make use of 'disguised compliance'.

c) Ensure that as part of their learning and developing the workforce in Solihull it includes how to effectively either chair or contribute to safeguarding meetings.

Appendix A: Roles of Agencies

1.1 Whilst local authorities play a lead role, safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play.

1.2 Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

1.3 Local agencies, including the police and health services, also have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.

1.4 Under section 10 of the same Act, a similar range of agencies are required to cooperate with local authorities to promote the well-being of children in each local authority area. This cooperation should exist and be effective at all levels of the organisation, from strategic level through to operational delivery.

1.5 Professionals working in agencies with these duties are responsible for ensuring that they fulfil their role and responsibilities in a manner consistent with the statutory duties of their employer.

Solihull Local Authority Children's Services

1.6 Local authorities have overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions under the 1989 and 2004 Children Acts which make this clear, and this guidance sets these out in detail. This includes specific duties in relation to children in need and children suffering, or likely to suffer, significant harm, regardless of where they are found, under sections 17 and 47 of the Children Act 1989. The Director of Children's Services and Lead Member for Children's Services in local authorities are the key points of professional and political accountability, with responsibility for the effective delivery of these functions.

1.7 Solihull Borough has a resident population of approximately 50,200 children and young people aged 0 to 19, representing 24.4% of the total population of the area.

1.8 An initial response to service users is provided by the Duty, Assessment, and Referral Team (DART). When cases are deemed to require longer term interventions they are moved onto other teams such as the Child in Need Team.

Heart of England Foundation Trust (HEFT)

1.9 HEFT is a large, multi-site, NHS Trust providing acute and community care to an ethnically diverse and predominantly urban population of approximately one million. Heart of England NHS Foundation Trust has maternity units across three sites; Birmingham Heartlands Hospital (BHH), Good Hope Hospital (GHH) and Solihull Hospital (SH).

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)

1.10 The Trust was established on 1 April 2003. The function of the Trust is to provide secondary mental health care to the population of Birmingham and Solihull. It provides both in-patient and community mental health services to adults (All those over the age of 18). In Solihull, Solihull Integrated Addiction Service or "SIAS" provides the addiction provision. This is a partnership of both statutory and third sector addiction services commissioned by Solihull MBC. It offers a range of drug and alcohol interventions via different providers. Within SIAS, BSMHFT provide a specialist prescribing service, known as The Bridge.

Welcome

1.11 Welcome is a small local charity with the function of providing drug and alcohol treatment services and family support services in the borough of Solihull. Welcome is commissioned by Solihull MBC to deliver services in partnership with BSMHFT and other partners in the umbrella body, Solihull Integrated Addiction Service (SIAS). The Welcome service provides a single point of contact for those wishing to access treatment services and provides a drop in facility, psychosocial interventions, counselling service, employment support and a structured day care programme. A prison through care and after-care programme is also provided.

Solihull Clinical Commissioning Group

1.12 Solihull Clinical Commissioning Group (Solihull CCG) was authorised to lead the local NHS by commissioning (planning, buying and monitoring) high quality healthcare services for the people of Solihull from April 2013. It is also responsible for improving the quality of primary care services but it is not responsible for the commissioning of primary care, this lies with NHS England.

1.13 It is comprised of GPs from every practice in Solihull, and Church Road practice in Sheldon, and has a governing body of GPs, CCG executives and lay members. Prior to authorisation, services in Solihull were commissioned by Solihull Primary Care Trust. The designated nurse for safeguarding is employed by Solihull CCG and the CCG has supported the practice involved in this case with its individual management review.

West Midlands Police

1.14 West Midlands Police is the second largest police force in the country.

1.15 The region sits at the very heart of the country and covers the three major centres of Birmingham, Coventry and Wolverhampton. It also includes the busy and thriving districts of Sandwell, Walsall, Solihull and Dudley.

1.16 The force deals with more than 2,000 emergency calls for help every day, as well as patrolling the streets and responding to incidents 24-hours-a-day, seven days a week.