EMBARGOED UNTIL 14 May 2015

SERIOUS CASE REVIEW

In respect of the death of Baby Eve

Born: 09/03/2013

Died: 30/03/2013

Presented to the Northumberland LSCB

10th April 2015

Report by: ORA1, Independent Overview Report Writer

Created: 17/10/2014
Modified: 17/04/2015

Contents

1. INTRODUCTION

1.1 Summary of Case:

Eve is the third child of her mother (M1) and her father (F1). She lived with both parents and her siblings S1 aged 14 years and S2 aged 6 years. F1 has an adult child who does not live with the family.

All three children were subject to child protection plans under the category of neglect, in the case of the older children, since November 2012 and for Eve from birth. The older children had previously been subject to child protection plans in 2006 under the same category.

Concerns for the children focused upon long standing maternal substance misuse, persistent and long standing parental failure to address the children's health and educational needs and non-cooperation with agencies attempting to help the children, and with adult addiction services, both prior to and since the implementation of the child protection plan. These concerns escalated until December 2012 when a letter before proceedings was issued, due to the family's persistent failure to engage with the plan.

Following that, the family increased their engagement with the plan and the letter was withdrawn, and a written agreement was put in place to clarify agencies expectations of the family. Eve was born on the 9th March with a dependence on methadone and began to exhibit withdrawal symptoms. Eve was prescribed Oramorph to address this. M1 and Eve were discharged home on the 14th March.

On 30th March an ambulance was called to the family home at 09.00am. S1 had found M1 asleep on the sofa with Eve in her arms. Eve appeared lifeless. M1 was roused and rang the emergency services and was advised on administering CPR. The baby was transferred to the Hospital by ambulance and Northumbria Police was alerted. Initially it was believed that there were no suspicious circumstances in relation to the baby's death, but subsequently, the pathology report identified a fractured skull, and another possible neurological injury.

The cause of death is unascertained at the time of writing. The Post Mortem revealed the following:

- Recent large bruise to the top of the head
- Skull fracture
- Haemorrhage to the lungs
- Entradural Haemorrhage around the spinal cord

Although the likelihood is that the fracture was the result of either a forcible blunt blow to the head or an injury caused from being dropped, crushing or symptoms relating to Sudden Unexplained Death in Infancy (SUDI) cannot be fully eliminated therefore and as a result causation cannot be established. Nevertheless Eve, a baby

identified as being at risk has died, whilst subject to a child protection plan, and with unexplained injuries.

M1 was charged with neglect of a child or young person on 24.1.14, and she pleaded guilty to two charges of neglect at Newcastle Crown Court. There was no trial, M1 was sentenced on the 23.10.14. M1 was given a six-month prison sentence, which was suspended for two years with a Supervision Order for two years.

1.2 The decision to carry out a review:

The LSCB Independent Chair has commissioned this Serious Case Review following a meeting of the Extended membership of the LSCB Case Review Committee on 05.04.13. The meeting was attended by senior representatives from each of the agencies involved. The meeting made a recommendation to the LSCB Independent Chair, that on the basis of the evidence available, the criteria for a Serious Case Review were met (ref Regulation 5 of the LSCB Regulations 2006 ref 2a and b1. that a) abuse or neglect of a child is known or suspected and b1) the child has died).

The decision to undertake this review was made under Working Together 2010 guidance. Working Together 2013, came into effect very soon after the decision was made. The terms of reference, will therefore take account of the new guidance.

A Core membership group of the Case Review Sub-Committee was convened as the Serious Case Review Panel to oversee the process. **The membership of the Serious Case Review Committee and Panel was as follows:**

Designated Nurse, Child Protection, (Northumberland Clinical Commissioning Group) Chair
Safeguarding Standards Manager, (Northumberland County Council Children's Services)
Children's Service Manager, (Northumberland County Council Children's Services)
Local Authority Designated Officer, (Northumberland County Council Children's Services)
Director, VoiCeS Network
Virtual Head Teacher, Early Years, (Northumberland County Council Children's Services Education)
Team Manager, (Probation Service)
Deputy Director of Nursing, Northumbria Healthcare NHS Foundation Trust
Detective Chief Inspector, (Northumbria Police)
Head of LAC & Safeguarding, (Northumberland County Council Children's Services)
Named G.P. Primary Care, (Northumberland Clinical Commissioning Group)
G.P. Locality Director, Northumberland Clinical Commissioning Group)
Head of Safeguarding, (Northumberland Tyne & Wear NHS Foundation Trust)
Principal Solicitor, (Northumberland County Council Legal Services)

The Serious Case Review Panel met on the following dates: 05.04.2013, 24.05.2013, 28.06.2013, 25.07.2013, 29.11.2013, 13.12.2013, 30.01.2014, 21.03.2014, 13.06.2014, 16.07.2014, 17.10.2014 & 08.01.2015.

The Overview Report was agreed by the Serious Case Review Panel on 27.03.2015 and formally signed off by Northumberland LSCB on 10th APRIL 2015.

1.3 Purpose of the review:

The Review was carried out in accordance with section 7 of the Local Authority Social Services Act 1970, section 11 and 16 of the Children Act 2004, regulation 5 of the Local Safeguarding Children Boards Regulations 2006 and the statutory guidance Working Together to Safeguard Children 2010, chapter 8.

Working Together to Safeguard Children (2010) states that a Safeguarding Children Board should undertake a Serious Case Review when a child dies **and** abuse or neglect is known or suspected to be a factor in the death. They should consider whether to conduct a SCR whenever;

- A child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- A child has been subjected to serious sexual abuse; or
- A parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or
- A child has been seriously harmed following a violent assault perpetrated by another child or an adult;

  and The case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

The purpose of the review is to

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what these lessons are, how they will be acted upon, and what is expected as a result.
- Improve inter-agency working, better safeguarding and promoting the welfare of children.

1.4 Terms of Reference:

1. The Serious Case Review (SCR) process will be Chaired independently

2. An Overview Report will be commissioned from an Independent Author.

3. Report Authors should provide a detailed chronology and analysis of their involvement with the family from January 2012 up to 30th March 2013.

Authors are also requested to produce a summary of any historical involvement with the family, with sufficient detail to provide the reader with an understanding of family dynamics and provide a context for the current circumstances. This should include relevant information about S1 and S2's earlier life including the circumstances of the previous child protection plan in 2006. Authors should consider throughout, as part of their analysis whether historical information was given appropriate consideration with regard to decision-making in the present circumstances.

4. Throughout the IMR's, authors are asked to consider any recurring themes from previous local or national case reviews. (The authors group will receive advice in relation to any thematic links emerging with local case reviews)

5. Were practitioners aware of and sensitive to the needs of the child and where appropriate, were the child's wishes and feelings ascertained and taken into account when making decisions about the provision of services?

6. Was practice sensitive to racial, cultural, linguistic and religious beliefs?

7. With regard to the circumstances prior to and during the 2012 Child Protection Plan: Did the agencies assessments include an appropriate assessment of risk? Authors should comment upon the impact of these assessments on the decision making in this case. Please consider the following:

    - Were robust ante-natal assessments undertaken and did they result in appropriate planning and decision making?
    - Was planning around the discharge of Eve made on a multi-agency basis and evidence based?
    - Was professional contact with the family following discharge adequate?
    - What assessment and analysis was undertaken to establish parental competence to administer oramorph and to provide appropriate care generally to Eve, in light of her needs at birth?
    - Did all of the agencies assessments give appropriate consideration to the potential impact of a new baby on this family, in the context of the long standing concerns about parenting capacity, the pre-existing concern for the children's safety and the evidence with regard to the vulnerability of babies?
    - Did assessments pay appropriate attention to the role of the father in this family?
    - Were the assessment processes undertaken as part of the 2012 child protection investigation thorough and robust?
    - Did all agencies that held information make an appropriate contribution to the child protection investigation? Were all agencies that may have held information asked to contribute to the child protection investigations?
    - Did all agencies involved with the family attend and contribute relevant information to the Initial case conference in November 2012?
    - Were decisions reached appropriate and justifiable at the time? Was there an analysis of risk in the context of neglect and a danger statement outlining the risk to the children and the unborn baby?

8. Core group meetings:

- Comment on the use made by the Core Group of the Written Agreement and if any changes to the Written Agreement were based upon sound assessment.
- Was there appropriate membership of and attendance at the Core Group meetings, and were meetings held within the required timescales?
- Is there evidence of appropriate, co-ordinated planning to implement the Child Protection Plan with identifiable desired outcomes for the children and the (then) unborn baby? Did the plan change following the birth of Eve and was this based on a reassessment of the family circumstances?
- How did Core group members feel about their contribution to the group, and did they feel able to challenge the views of other members?

9. When the family failed to engage with the child protection plan, did agencies respond appropriately? Please consider:

a. Had the practitioners in the core group attended NSCB training on working with families who are difficult to engage?
b. Were agencies aware of the NSCB guidance on working with hostile and resistant families? Was this guidance followed?
c. Were decisions made and actions taken concerning failure to engage, appropriate and justifiable at the time?
With regard to the Letter before Proceedings (both in terms of issuing it and withdrawing it):

- Were the decisions made appropriate and justifiable at the time and based on a current understanding of the family's circumstances?
- How were these decisions reached?
- Was the assessment process with regard to this (especially the withdrawal of the letter) robust and based upon sound evidence of change?

10. Was supervision provided to staff working with the family and if so, taken up in accordance with the agencies supervision policy? Describe the quality of the supervision and how it influenced the management of the case.

11. Were there organisational factors that had a bearing on how the work within the family was conducted by the agency? E.g. workload, staff sickness, vacancies, absence of supervisor, organisational change.

12. Was there sufficient Management accountability for decision-making and was information escalated to Senior Managers/supervisors as appropriate?

13. Each agency should consider what the key points of intervention were in this case, which may have influenced the outcome.

14. Agency recommendations should be concise and specific and enable the Board to be assured that the frameworks and agreements it puts in place are fit for purpose, fully understood and applied.

15. **For NHS Commissioning IMR only**

A NHS commissioning IMR should be completed by the Designated Nurse based upon relevant information and recommendations from individual Health Reports, but also to consider:

a. What does the review tell us about the safeguarding aspects of the health service offered to the family including: most significant learning, any significant gaps and missed opportunities in care or service delivery?
b. What were the most significant elements of notable practice in the commissioned health services provided?
c. Were there any relevant issues regarding how health organisations interacted together? If so how did they impact upon the progress with the case?
d. Are there lessons to be learned in relation to the interfaces between the health services?
e. Are there any proposed changes to the commissioning arrangements or process with provider organisations to ensure robust arrangements are in place?

NB-Authors should consider the events that occurred, why decisions were made, and the actions taken or not taken. Where judgments were made or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why something either did or did not happen. Particular reference should be made to the learning issues for the agency and any areas of good practice should be highlighted. Authors should also reference current research, as appropriate throughout their reports.

1.5 Individual Management Review Reports:

Agencies involved with Eve and from whom IMR reports were required were as follows:

1. Northumberland County Council Children's Services
2. Northumberland County Council Education Services
3. North East Ambulance Service
4. Northumbria Healthcare NHS Foundation Trust
5. Northumbria Probation Service (it should be noted that Northumbria Probation Service had no contact with the family either during M1's pregnancy with Eve, or following her birth. Within timescale for this review, there were only three months remaining of M1's last order. However, with the requirement to examine historical involvement with regard to S1 and S2's earlier life, the IMR considered contact with the family from July 2002
6. Northumberland Tyne & Wear NHS Foundation Trust
7. Newcastle Upon Tyne Hospitals NHS Foundation Trust
8. Primary Care (GP Service)

9. Northumbria Police
10. Northumbria Dental Service
11. Northumberland Clinical Commissioning Group
12. Northumberland County Council Legal Services

1.6 NHS Commissioning IMR:

An NHS commissioning IMR was also required for this review, in line with Working Together 2010.

1.7 Methodology:

For the IMR authors the methodology was set out as follows:

The transition between the current and previous guidance has been considered with regard to methodology. The LSCB has not yet made a final decision with regard to the future methodology for undertaking serious case reviews, and it has therefore decided that this review should not use the systems approach but would request a chronology and individual management reviews, and commission an overview report. In all other aspects however, the new guidance will be adhered to.

An author's group was convened, chaired by an Independent Chair. This included individual Report Authors, the LSCB Safeguarding and Quality Assurance Manager and the Overview and NHS commissioning IMR Authors.

Authors and senior managers with responsibility for quality assuring their agency reports were advised of the requirement to publish the overview report and to discuss with the Northumberland County Council Children's Services Safeguarding Standards Manager or the Designated Nurse (Chair of Case Review group) should any further advice be required.

The Safeguarding Standards Manager attended both the Panel and Authors Group meetings and oversaw the business process.

A standard format for the Management Review and Chronology was used and agencies were instructed to liaise with the LSCB Administrator regarding abbreviations in order to avoid duplication and conflict of information.

Individual agency authors briefed and interviewed their own staff in order to answer the areas identified in the terms of reference and explore, analyse and critically evaluate the issues in the case. It was stipulated that all individual interviews with staff were to be recorded with interviewees having the opportunity to comment on any factual inaccuracies and views expressed in the notes of interview.

All report authors must establish senior management scrutiny and sign off of reports within their own agencies

Final draft IMR reports were originally to be presented to the panel 4 months from the issuing of the finalised terms of reference with the exception of health reports,

which must be completed within 10 weeks in order that an NHS Commissioning IMR be undertaken.

- Date SCR initiated: 10.04.2013
- Date SCR to be completed: 07.10.2013 (6 months)
- Agreed Extension to finalise SCR and notification sent to the Department for Education: 06.09.2013
- SCR Overview Report completed: 18.12.2014
- SCR Panel Meeting sign off Overview Report: 27.03.2015
- Overview Report to be presented to the LSCB: 10.04.2015

Throughout this SCR process, some complicating issues were identified during the compilation of the Health Reports, regarding the prescribing arrangements for adults who are dependent on substances and the management of infants with post-natal abstinence syndrome, and, additional G.P records were also located which required further investigation and interviews with staff. The LSCB Independent Chair and Members of the Case Review Panel discussed these issues and agreed that an extension to the agreed timeframe was required, to ensure that all relevant information was considered and included in this SCR.

The panel also requested that the NHS Commissioning IMR Report Author should seek specialist, independent advice about the issue of Methadone reduction programmes in pregnancy. An independent Consultant Psychiatrist was contacted and was helpful in clarifying the issues.

During the review process there was also an additional meeting held between the overview authors and panel representatives of Northumberland Tyne & Wear NHS Foundation Trust and Northumberland County Council Children's Services. This was not an SCR panel meeting and was in order to reflect and provide advice on the quality of these specific IMR reports and their expected level and quality of analysis as had been set by the terms of reference.

Later in the review process additional information was also sought from Northumberland County Council Children's Services in order to seek further detail and clarify specific issues.

The Solicitor involved in the case was also interviewed by the overview author and an IMR report from Northumberland County Council Legal Department requested at panel, 21.3.14, in order to clarify the role of legal advice in this case.

- Parallel Processes:

There was a concurrent criminal investigation taking place with regard to this case. The Chair and each author continued to liaise with Northumbria Police to ensure appropriate coordination was in place in relation to any on-going Northumbria Police enquiries.

The timing of publication has taken account of any criminal proceedings.

The Child death review Process is running concurrently. The final Child Death Overview Panel (CDOP) discussion will not take place until completion of the SCR.

The Involvement of the Family in the Serious Case Review:

The Safeguarding Standards Manager wrote to the parents on 19.04.2013, to inform them of this review and ascertain how they wanted to contribute to the review and to seek consent for professionals to view family medical records.

Both parents were interviewed on the 8th January 2015 by the overview report author and the NHS commissioning IMR author. This was towards the end of the review process following the court proceedings in relation to Eve's death. The purpose of the meeting was to listen to the views of both parents regarding the help that was offered to them as a family and to understand their perspectives on the important learning that arises from Eve's death.

A decision was made not to interview the siblings S1 and S2. It was felt that on balance this would have been damaging to their emotional well-being.

The overview report will draw upon the work of the Agency IMRs and their conclusions. It has been agreed that the overview author will not interview staff (although an exception was agreed in relation to the Solicitor involved in the case).

This review was commissioned under the 2010 guidance, however, it will reflect on Eve's circumstances in light of the Social Care Institute for Excellence (SCIE) "Learning Together" methodology, allowed under the new 2013 guidance, in order to improve the usefulness of the analysis and the value of the lessons to be learnt. In particular the following questions will be held in mind to help frame the analysis and recommendations of the review:

- How did the issue manifest in the case?
- What makes it underlying (rather than an issue particular to the individuals involved)?
- What is known about how widespread or prevalent the issue is?
- What are the implications for the reliability of the multi-agency child protection system?

The review will also pay attention to Eileen Munro's caution about the "hindsight bias":

"It is important to be aware how much hindsight distorts our judgment about the predictability of an adverse outcome. Once we know that the outcome was tragic, we look backwards from it and it seems clear which assessments or actions were critical in leading to that outcome. It is then easy to say in amazement 'how could they not have seen x?' or 'how could they not have realised that x would lead to y?' Even when we know the evidence on the hindsight bias, it is difficult to shift it; we still look back and over-estimate how visible the signs of danger were. The hindsight bias: 'oversimplifies or trivialises the situation confronting the practitioners and masks the

processes affecting practitioner behaviour before-the-fact. Hindsight bias blocks our ability to see the deeper story of systematic factors that predictably shape human performance' (Woods, D., et al. (2010), Behind Human Error, 2nd Edition, pp15, Farnham, Ashgate.)" **Munro Review 2011**

The recent serious case review in relation to Daniel Pelka has been criticised in relation to not establishing "why" failures of practice occurred. This can often be very difficult to establish with any certainty, however, where possible explanation for why practice may have been the way it was will be considered.

This overview report is, however, clearly written with the benefit of reviewing all IMRs and so any analysis or discussion of additional issues will be done with the intention of building on the work of the individual reviews completed by individual agencies.

IMRs have addressed historical information in relation to Eve's family with different levels of detail, which occasionally makes it difficult to make definitive conclusions regarding practice, however, I believe enough information is available to, with some confidence, identify historical practice themes that have relevance for the period January 2012 up to 30th March 2013. It will be important for the Board to incorporate this learning into future terms of reference and ensure that individual agencies adopt a shared approach to historical information and analysis.

It is also true to say that this overview is challenging of IMR reports and once again this is done in order to improve the learning; in relation to Eve's circumstances specifically and the investigations undertaken in any future case reviews more generally.

- Overview Report Author details:
The overview report author has a professional background of over 20 years in the statutory social work sector including senior management of children's safeguarding services in Northumberland County Council until 2011. His final position was Safeguarding Standards Manager, which included the conference chairs team; however, this did not coincide with any period that the children were subject to child protection plans. In this capacity he also had no management responsibility for any of the operational teams subject to this serious case review for the time period under review.

As an independent social work consultant since 2011, he has authored several case and service reviews. He has also led improvement work for a range of Local Authorities, including as a safeguarding sector specialist on behalf of the Children's Improvement Board and as part of a safeguarding peer review team on behalf of the Local Government Association.

2. ANALYSIS OF AGENCY INVOLVEMENT

The IMRs completed for this review cover, in detail, a substantial amount of history, particularly in relation to M1 and F1, in order to provide a comprehensive context for later events. Although the main focus of the overview report will be as directed in the terms of reference, it is important, given the persistent patterns of difficulty faced by both M1 and F1 and the chronic nature of important aspects of their parenting and family life, that a longer perspective is considered. Multi-agency work with this family some time prior to Eve's birth will therefore be set out and the analysis will seek to give the proper weight to these events in light of the later tragic death of Eve.

For each chronological period key learning themes will be set out and in the final summary of key learning the underlying themes will be explored further as will the implications for the reliability of the local multi-agency child protection system.

2.1 January 1995 – October 2006

- 2.1.1 Chronology and analysis

In 1995 and again in 1997 M1 presented to her GP with backache. The GP prescribed a high dose of codeine phosphate. This was re-prescribed every few months for backache or falls.

Again in August 1997 M1 presented to her GP complaining of longstanding back pain. Co-codamol was recommended but declined. M1 continued to press for higher doses of codeine over the next 3 years. The GP noted that he felt that this was drug seeking behaviour. This is important as it marks the beginning, initially at age 17 years, of M1's drug seeking behavior and a pattern of disregarding the advice of medical practitioners. It is also the beginning of a long term relationship with her GP practice.

F1's pattern of criminality is noted in the Northumbria Police IMR as beginning in 1995. The following details are presented, F1 has been arrested a total of 7 times since January 1995 resulting in 5 convictions as follows:

- 12.01.1995 possess drugs with intent to supply, charged with 3 counts, convicted
- 11.10.1995 supply drugs, charged with 14 counts, convicted
- 12.11.2000 warrants fail to appear, warrant paid
- 04.12.2000 receiving stolen good, no further action
- 26.07.2001 taking vehicle without consent, also charged with 3 counts of possess drugs, convicted
- 27.10.2001 warrant fail to appear bailed to court
- 05.09.2009 harassment relating to a dispute with a former business partner, cautioned.

In the period preceding the death of Eve M1 has been arrested a total of 23 times since May 2000 resulting in 11 convictions and 1 caution:

- 12 arrests for theft, 9 convictions
- 7 arrests on warrant/fail to appear
- 1 arrest for use false instrument (altered a prescription), convicted
- 1 arrest for deception (attempted to obtain extra prescribed tablets), convicted
- 1 arrest for criminal damage, no further action
- 10.7.08 arrest for assault/ill treatment of a child after S1, 7 years was left alone while M1 went shopping. M1 received a caution and S1 and S2 were placed with F1 as result.

There are 128 pages of intelligence logs regarding M1 dating back to 1999. These mainly contain sightings and information about shoplifting and drug purchasing activities, along with her efforts to report lost or stolen prescriptions. There is also intelligence suggesting that M1 regularly purchased alcohol for local youths and the children's friends being located at the home address when their parents were not aware of their location.

S1 was born on the 7th January 1999. M1 had told the GP that she didn't wish to keep contact with S1's father and the GP noted that she relied upon her grandmother in terms of parenting skills.

In June 2000 M1 requested a higher dose of codeine, which the GP at that point described as "medication abuse".

In July 2000 M1 describes further difficulties to the GP regarding domestic abuse. It appears that M1 was sent to A&E but did not follow up with the GP.

The Primary Care (G.P Service) IMR rightly identifies these as missed opportunities that failed to consider M1's vulnerability and abusive experiences and equally the risks to S1 living in an environment that featured domestic abuse. No referral was made to Northumberland County Council Children's Services or safeguarding advice sought from any other source.

By October the same year (2000) The Primary Care (G.P Service) IMR summarises that:

"M1 was clinically drug dependent and difficult to manage. She was shoplifting, lying about scripts and showing significant drug seeking behaviour. She was referred to the substance abuse services (CSMT)".

In September 2001 M1 was referred again to the substance misuse clinic.

In December 2001 M1's father was killed in a road traffic accident for which she received bereavement counselling.

In 2002 (date not specified in the Northumberland County Council Children's Services IMR) the family is referred anonymously to Northumberland County Council

Children's Services regarding concerns about neglect of S1, aged 3 years. The Northumberland County Council Children's Services IMR continues that

"Between 2002 and 2006 there were periods of involvement to offer support on a 'child in need' basis regarding M1's substance misuse, housing and home conditions and S2's unkempt presentation and school attendance. Referrals received during this time were from Northumbria Police, anonymous sources, School and Education Welfare. Children's Social Care records describe M1 as 'uneasy' or 'highly anxious' about professional involvement and her failure to attend meetings or be available for professionals to visit is a feature of the recording by Social Workers and that the case continued to be managed on a child in need basis during this time."

At this early stage in professional work with M1 and her family there is already evidence of the GP not engaging in information sharing with all relevant services in a way that would focus on the children's welfare as well as any needs that M1 might have. This is important in that it was an early opportunity to address the risk to S1 and the very real support needs of M1.

Northumbria Probation service became involved with M1 on 5.7.02 when she was made subject to an 18 month Community Rehabilitation Order for one offence of 'Attempt to Obtain by Deception'. This was as a result of altering a prescription for Di-hydrocodeine. This order was revoked due to failure to attend appointments. The Northumbria Probation Service IMR briefly describes M1's background difficulties including substance addiction from the age of 19 years. However, it is not clear how this factored into multi-agency work during this period, given that Probation is not mentioned by the Northumberland County Council Children's Services IMR as a referral source during the 2002-06 period. Although the IMR addendum provided by Northumberland County Council Children's Services notes evidence of liaison between Northumberland County Council Children's Services and Northumbria Probation on 3.5.02, where a request for information was made by Northumbria Probation Service in preparation for a report.

Information held by F1's GP only came to light during the IMR research for the serious case review. It did not factor in any of the case analysis or intervention plans prior to Eve's death.

The Primary Care (G.P Service) IMR notes the following in this period:

"2000 F1 presented to the GP with poor sleep, panic and anxiety symptoms due to the Northumbria Police 'ransacking' his house.

2001 – 1 injury, F1 presented with a laceration of the lip after an assault, but he left Hospital 1 A&E before he was due to be seen.

2002 F1 presented to the GP often with back pain requesting analgesia 8 times. F1 presented to the GP surgery with stress. He told the GP that he had an amphetamine addiction and that he was out of prison for drug dealing. He took cannabis, ecstasy, amphetamines. He told the GP that his friend had been killed in a RTA and that he was worried about the Northumbria Police taking him away. The GP referred him to the addiction services stating that he had finished a 6-year prison

sentence 3 years ago and that he appeared to be paranoid that the Northumbria Police were after him. He was reportedly taking amphetamines to keep awake and denied dealing in drugs. The GP mentioned in the letter that he had spoken to the Community Psychiatric nurse and it was their view that F1 should first be managed within the addiction services rather than in the mental health team. The GP received a copy of a letter sent to F1 stating that F1 received an appointment for the addiction services 2 months later but there was no further information from the Ante natal substance misuse services (sic) to the GP to state whether F1 had engaged with the service."

The Probation Service IMR also notes that F1 has a criminal history, having served a period of imprisonment for supplying and intent to supply cannabis and ecstasy. However, the Probation Trust has no record of any contact with F1 as an offender. The dates of these offences and therefore any potential impact on M1 and children are not described, neither whether they led or should have led to a multi-agency response and a referral in relation to the welfare or risk to the children.

In December 2002 the Primary Care (G.P Service) IMR notes that M1's urine drug screen was positive for amphetamines, benzodiazepines, opiates and di-hydrocodeine. (DHC) and that M1 starts to attend the shared GP / substance misuse clinic. The Primary Care (G.P Service) IMR notes that GP rightly decided that specialist services intervention was needed and a decision was made not to further prescribe at the GP surgery. This was good practice and the appropriate services were then offered. It is impossible to draw any conclusion as to whether this affected the level of multi-agency concern at this stage, as there appears to be no information shared by the GP at this point.

On 28.9.03 there was a referral from A&E with concerns that M1 was in withdrawal and S1 had been left with grandmother. An initial assessment was carried out on 6.10.03 and noted the support, which M1 was to be referred to, this included the Addictions Service. A planning meeting was arranged and liaison took place between Northumberland County Council Children's Services and the Addictions Service. The decision at this time was to go forward on a 'child in need' basis, as the evidence was not felt to support child protection intervention.

In the meantime on 1.10.03 M1 had self-referred to the Addictions service, however, she was later discharged on 16.10.03 for non-engagement (this discharge, is referred to in the Northumberland County Council Children's Services IMR addendum, with reference to a letter received in November 2003). The Primary Care (G.P Service) IMR also notes that she was discharged from clinic on the 29.8.03 due to non-attendance.

On 2.12.03 M1 was made the subject of a new 18 month Community Rehabilitation Order to mark the original offence and breach of the previous Order (failure to keep appointments).

The Northumberland County Council Children's Services addendum notes that the case remained open at February 2004.

On 16.2.04 the first of a total of 18 Child Concern Notifications (CCNs) in relation to this family were completed (see section 2.3. for further detail, the majority relate to neglect issues regarding S1 and S2). It related to an incident where M1 had a seizure while taking S1 to school.

In the Northumbria Healthcare NHS Foundation Trust IMR this incident is described as follows:

"On the 17th February 2004, a Child Abuse notification form (CHAB) was received from…Northumbria Police (information held in S1's Continuous Child Health record). M1 had been seen to fall on her face and lie still whilst S1 screamed uncontrollably and ran away. An ambulance was called to provide medical help for facial injuries; M1 confirmed her addiction to Di-hydrocodeine and alcohol, which could have induced the attack."

A home visit by Northumberland County Council Children's Services took place and M1 was to follow up with the GP. The maternal Grandmother was noted to be accompanying M1 since the fit, although it is not clear whether this is the same Grandmother that M1 accused of alcoholism in the preceding September and the Northumberland County Council Children's Services addendum notes that:

"*The team manager discussed the case with SW in supervision and the 'collapse' is noted to have been confirmed as an 'epileptic fit'."*

It is clear that this episode did not lead to a safeguarding investigation response, rather involvement continued on a 'child in need' basis until it was agreed to close the case in July 2004. It's important to remind ourselves at this point what was known about this family by different services:

- An isolated young mother
- Substance misuse
- Criminal activity
- Historical vulnerability factors
- Potentially ineffective wider family support
- Domestic abuse
- Disengagement from therapeutic services
- Referral regarding neglect of S1

Services were offered to S1 as a 'child in need' however it is not clear how much of this information was shared and brought together into a coherent picture. As a consequence the threshold decisions at the time (2004) appear flawed. I believe it is important to consider cumulative professional practice failure in the same sense as "cumulative risk" is discussed in the Ages of Concern[1] document. It is this cumulative failure that can act to compound missed safeguarding opportunities and errors in determining the right level of interventions that should be put in place.

[1] Ages of concern: learning lessons from serious case reviews. 2011 Ofsted.

On 16.11.04 M1 informed her GP that she was prescribed diazepam for anxiety whilst in custody for shoplifting. The GP continued the prescribing of this, but with a reduction plan. The Primary Care (G.P Service) IMR once again correctly identifies this as a missed safeguarding opportunity for further discussion with M1 and exploration of the broader emotional needs of herself and her child.

Continuing vulnerability became apparent for M1 when on 16.3.05 she attended the GP surgery with acute bereavement, stating that her mother had died that week and saying that she needed 20mg Temazepam and 30mg diazepam to cope with her loss. This was prescribed and M1 remained on Temazepam, and Diazepam until January 2006. She was reported as happy after medication was issued.

Less than one month later on the 6.4.05 M1 attended the GP surgery with S1 (6 years old), with depression and suicidal ideation. She was clearly not coping and this made her very vulnerable. There is no evidence that the GP asked about the welfare of S1 and there was no information sharing with any other professionals at this point. S1 remained a child in need but critical information held by the GP did not influence any planning and the GP appears to be entirely disconnected from any system of support around this child and family. The Primary Care (G.P Service) IMR acknowledges that:

"The author did get the impression that the GP agreed that the children were vulnerable, but that the mother's vulnerability stood out more because the GP was dealing with her on a daily basis. The children were effectively hidden because they were not seen often."

On the 25.4.06 M1 presented to the GP with an unplanned pregnancy, unsure about dates and she informed the GP that she was getting extra Di-hydrocodeine (DHC) on top of what is prescribed (DHC, Temazepam and Diazepam). The GP documented that she was living with her partner and 7-year-old son (S1). It appears from the notes that M1 makes a self-referral to the antenatal clinic.

The Primary Care (G.P Service) IMR again notes that this was a missed safeguarding opportunity, both to refer M1 to the Addictions service and to share information about the new pregnancy and the fact that S1 was in the same household. There was no evidence to suggest that the presence of F1 was considered in the light of previous vulnerability to domestic abuse, either as a risk or a protective factor.

According to the Northumberland County Council Children's Services IMR on 3.5.06, a referral is received by Northumberland County Council Children's Services from the Community Midwife, reporting that M1 is pregnant, (approximately 12 weeks). The NHS Commissioning IMR states that a Child and Person Assessment Form was completed by Northumberland County Council Children's Services in relation to S1 (probably should read S2) on the 3rd May 2006, the recommendation from the assessment was a care package from a multi-disciplinary team in the antenatal period and following the birth. The precise pathway of the information is unclear; however, importantly information was clearly being shared at this point around the issue of risk. A joint home visit with the school nurse took place the next day on

4.5.06. This was when counselling for S1 was agreed and the unborn baby discussed; follow up contact was also discussed for two weeks later.

M1 describes having been in a relationship with F1 for 7 years at this point and they are living together. According to the Northumberland County Council Children's Services IMR the main issue of concern at this time is the effect of M1's substance misuse on unborn S2. She is misusing Di-hydrocodeine and reported to having been using up to 80 tablets per day. The Northumberland County Council Children's Services IMR notes that M1 accesses support from the Substance Misuse Midwife at this point and there is evidence of her engaging with this service and wanting to reduce her use of substances. There is a period of time during this pregnancy where she ends the relationship with F1 and moved with S1 into a friend's home, followed by homeless accommodation.

However, on 11.7.06 (4-5 months before the birth of S2) M1 presented at the GP surgery stating that she was *"not doing very well"* and had been asked to go into hospital for a week of drug titration. The GP reported that M1 was homeless and under a huge amount of stress. S1 was 8 years old and M1 was pregnant with S2. This was a further missed safeguarding opportunity to share information with other agencies about M1's drug usage, her homelessness and the very obvious risks to S1. Given the lack of engagement it is likely that the GP will also have been unaware of what information was known by other professionals at that time.

In August 2006, M1 is then offered a council property, which is the address the family have remained at since.

A pre-birth planning meeting was arranged for 5.9.06. Despite being requested to contribute to this meeting on the 31.8.06 the GP does not provide any information and does not receive minutes of the meeting. In effect the professional who had possibly had the most substantial and long term involvement with M1 is absent from the assessment and planning in relation to S1 and S2 at this point. Furthermore in September 2006, M1 again tested positive for benzodiazepine, opiate and DF118.

The Northumbria Healthcare NHS Foundation Trust IMR sets out the plan arising from the pre-birth planning meeting as:

> *"The plan was for the Community Midwife and Specialist Substance Misuse Midwife to undertake an antenatal home visit, to be followed up by an antenatal appointment for M to see a Consultant Obstetrician."*

An initial child protection conference (ICPC) is convened on the 10.10.06. This is a key point in work with the family, clearly the family's circumstances met the threshold for action under the child protection procedures and appropriately the decision of the conference was that both children were made subject to child protection plans, category neglect.

The definition of neglect in Working Together is:

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

Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment)*
- *protect a child from physical and emotional harm or danger*
- *ensure adequate supervision (including the use of inadequate care-givers)*
- *ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.*

The Northumbria Healthcare NHS Foundation Trust IMR notes some key aspects of the case as follows:

- *"M1 was offered titration to stabilise her drug misuse, but M1 refused as she felt that taking Methadone would be worse for the baby than taking Dihydrocodiene.*
- *F1 had been concerned about M1's substance misuse for a number of years and expressed his anger that some of the drugs were being prescribed for M1.*
- *M1 and F1's relationship had ended and M1 made it clear that she did not want F1 to be involved with the baby (S2), following the birth. M1 and F1 were a couple but had not lived together for most of their relationship. Since moving into her own tenancy, M1 had not spoken to F1.*
- *S1's attendance at school had been 91% over the previous month (September), however prior to that, it had been in the region of 70%.*
- *Physically he was well although he did have problems with his teeth. S1 has been seen by a paediatrician as concerns had been raised about him sometimes appearing to have a vacant expression although the school felt that this was S1 'day dreaming'.*
- *S1 received extra support in school and his social interaction was good with no signs of aggression.*
- *The social worker stated that she was worried about M1 meeting the baby's needs as well as S1's, especially if the baby was poorly."*

The GP was invited to the ICPC and contributes a report but 3 days late. The report sent to the meeting contains important information about M1's parenting capabilities, that she had relied upon her recently deceased Grandmother and that he did not have any concerns about M1's ability to look after her son. The Primary Care (GP Service) IMR concludes and I would agree that:

"The lack of and late contribution by the GP and the fact that GP doesn't receive minutes of the meeting held on the 5.9.2006 are missed opportunities to share important information to safeguard the children."

The view of the GP regarding M1 parenting capacity is also very difficult to understand in light of the historical evidence that should have been available to the

conference. It is difficult to assess any impact this view may have had on any subsequent case management or views regarding risk. It is also not possible to gauge what level of analysis is undertaken and available regarding the nature of the relationship between M1 and F1.

- 2.1.2 Key learning themes

During this period persistent failures of information sharing are present in terms of the practice of the GP. These are largely in terms of M1 and her parenting but there is also a failure to consider F1's distress in 2002 and any potential risks to S1.

What is most striking is the absence of a broader appreciation of the implications for the children of M1's own clear needs and substance misuse. In particular on the 6th April 2005 her distress and then less than 3 weeks later, when M1 presented with an unplanned pregnancy, how this distress may well have become more acute and the implications this could have in terms of her parenting capacity.

The GP does not provide any information to the pre-birth planning meeting in September 2006 and does not receive minutes of the meeting. Nor does the GP attend the ICPC. In effect the professional who has possibly had the most substantial and long term involvement with M1 is absent from the assessment and planning in relation to S1 and S2 at this point.

The view expressed by the GP that there were no concerns regarding M1's parenting capacity is also difficult to understand. It may be a function of the lack of opportunity taken by the GP to engage in the broader conversation with other professionals about the needs of the children and the very apparent concerns regarding neglect that the child protection process may have offered. There is no detail in the IMRs to make a judgment regarding the contacts made to the GP by Northumberland County Council Children's Services during the investigation, beyond the invitation to the ICPC.

The challenges faced by M1 were significant. Although services were offered and S1 allocated a social worker as a child in need, the threshold for action under the child protection procedures were likely to have been met long before action was taken in 2006, specifically in February 2004.

2.2 17/102006 to December 2008

- 2.2.1 Chronology and analysis

S2 is born on 30.11.06.

The 3-month Child Protection Review Conference (CPRC) is held on the 9.1.07.

Once again the GP did not contribute to the meeting even though the GP practice remained a critical source of information and care for M1. During January and February Hospital 5 had written to the GP (copied to the Health Visitor) querying S2's failed newborn hearing screening appointments. She failed to attend both

appointments and ENT voiced their concern about potential hearing problems and the need for further follow up when 8 months old. It is not clear precisely when this information was received or whom it was shared with beyond the GP or Health Visitor.

On 13.3.07 M1 saw the GP and requested a referral to the Addictions Service/substance misuse clinic. M1 informed the GP that she was buying drugs off the street. The GP wrote to the substance misuse service requesting only psychological help, which was declined.

Although the GP was experienced in dealing with drug misusing clients, M1 needed the psychological help and coordinated management, which may have been better coordinated in a specialist service rather than a GP practice where appointment slots were short and no psychological support available. S1 would have been 8 years old and S2 four months. The Primary Care (GP Service) IMR author rightly identifies the need for further support at this point but that another significant opportunity for information sharing, particularly given that the children were on the child protection register, is missed.

This is a safeguarding failure and beyond the previous reasons offered through the Primary Care (GP Service) IMR for such poor professional practice i.e. too great a focus on M1's needs, it is difficult to answer the question as to why the GP at this point appears to have entirely disregarded the child protection needs of both children, needs that had so recently been recognized at the ICPC. It is not possible to be sure whether the facts of M1's situation regarding substance misuse as understood by the GP were able to be considered at all by the core group at the time. Although given what we know about information sharing this seems highly unlikely. There is a significant breakdown in child protection practice at this point, in terms of the GP and the safeguarding system around the family.

On the 14th May the GP receives the written invitation to the child protection review due to occur on 22.5.07. The GP doesn't contribute to the meeting and also doesn't receive information from the meeting despite being on the distribution list. Although the Northumberland County Council Children's Services IMR addendum noted that the social work report to the review mentioned the GP's confirmation of ongoing consultation with M1 around her prescribed medication.

The Child Protection Review Conference took place on 22.5.07 and the Northumberland County Council Children's Services IMR notes that:

"…the review conference which agrees the end of the child protection plans notes that M1 has 'engaged extremely well' with the social worker, she is insightful into her own issues and difficulties, is engaging with substance misuse services and receives support from F1. S1's school attendance is much improved and S2 is 'thriving'. The relationship and strong bond between M1 and the children is noted throughout the records at this time and home conditions are consistently clean and tidy…It was acknowledged by the IRO that although (M1) is working positively and has made significant progress, it is still early days and the situation needs to be monitored. (M1) has continued to manage the children, work well with agencies and manage her medication. (M1) is also working positively with her GP and is in the process of being

referred to the Substance Misuse Team. (M1) is also attending a parenting class with S1 for six weeks and S1 now has additional support for his education. Although support will still be required, it is questionable whether this should be via Child Protection or if in fact it could be managed on a Child in Need basis'. The multi-agency conference decision was to remove S1 and S2's names from the child protection register."

Given the chronic, long lasting nature of concerns the question must arise as to whether this was the correct judgment and that only 7 months after registration the risks to both children had demonstrably reduced sufficiently to remove their names from the child protection register? The decision appears more flawed in hindsight when M1's consultation with the GP in March is taken into account, information not shared by the GP. It is not clear from the IMRs whether this consultation was shared with the review conference members via another professional though I think this would be highly unlikely.

M1 only started on her methadone programme in July and at this point her GP was wearing two hats given his role in the substance abuse clinic and on one occasion wrote to himself in this capacity to himself as the GP. The Primary Care (GP Service) IMR rightly points out that this may not have helped in including the risks to the children in the GP's thinking. The NHS commissioning IMR makes a recommendation in this regard.

In July, September and December 2007, S2 presented to the GP surgery with persistent nappy rash. Treatment and advice was offered. The health visitor was aware of at least one of the presentations, as she initiated the review.

M1 was assessed by the Addictions service on 24.7.07. The Primary Care (GP Service) IMR description of issues at this point is useful to set out in full:

"M1 then re-referred herself to addiction services on 24/07/2007, (some four years later) and was offered an assessment the following day. The following information was obtained. Within assessment M1 reported that following a back injury from going down a metal slide 8 years ago, she was prescribed Codeine Phosphate for analgesia (pain relief) by her GP. This medication was ineffective and following a review by her GP she was prescribed DF118's (Di-hydrocodeine). She stated she had continued to take this for the past 8 years. It was reported by M1 that over a period of time she started using illicit DF118's (using on top of her GP prescription) and her dependence increased. At the time of assessment M1 stated she was using 40-45 x DF118's per day. The author has not been able to establish whether this was a total number of tablets or the amount on 'top' of her prescription. M1 also stated that she was prescribed 20mgs of diazepam (Valium) daily again by her GP but was using a further 20mgs illicitly."

M1 stated she was experiencing withdrawals from the DF118's and did not want to take more than 45 tablets per day so was requesting substitute prescribing from addiction services. M1 reported and was assessed as having no problems with her mental health and was not prescribed any medication. M1 stated her main problems were her on-going back pain. Prior to this M1 reported she had only used illicit methadone once some time ago. The sample was positive for Methadone, other

Opiates, Benzodiazepines and Buprenorphine- (medication used to treat opiate withdrawals). The results were discussed with M1, who was not aware of what Buprenorphine was, this was explained to her. It would appear that M1 gave conflicting information within the initial assessment regarding her substance misuse. The risk assessment carried out indicated poly substance misuse.

M1 stated that she was living on her own with her 2 children, 8 year old son (S1) and 7-month-old daughter (S2) and that she had two brothers who lived nearby. Both parents and grandparents are deceased. She reported on-going Northumberland County Council Children's Services input on a child in need basis.

A 'parent initiative' course had recently been completed by M1, which she felt was successful. No other services were noted as involved by M1 who also described a small informal social network around her.

The Northumberland County Council Children's Services IMR notes communication between Northumberland Tyne & Wear NHS Foundation Trust and Northumberland County Council Children's Services, *"regarding the child/children either presenting as unkempt or M1's ability to parent due to on-going illicit substance misuse"* but no dates are given and it is not possible to conclude how soon after the Addictions services initial assessment this was shared.

The Northumberland Children's Services IMR states that:

"Following the removal of the child protection plans, M1's engagement with Children's Social Care is consistently good for a period of 12 months. The children are seen regularly by the Social Worker at home and there are no concerns reported."

Although the IMR does acknowledge persistent difficulties that substance misuse problems continue, that there are periods of instability in her treatment, her prescription is stopped at one point as a result and that M1 is also convicted of shoplifting and made subject to a 6 month Probation Order.

However, on 11.7.07, M1 is arrested for child neglect due to leaving S1 home alone for a period of 2 hours. Northumbria Police received a call from a member of the public to alert them. M1 said she had gone out to collect her prescription and S1 refused to go with her. M1 stated that she had intended to be back within 40 minutes, but had met a friend, become distracted, and went to the friend's home before returning. F1 was present, was very supportive and agreed to stay with M1 to offer support and care for the children. Northumberland County Council Children's Services do not have a record of this arrest and it is not clear what liaison was undertaken by Northumbria Police and Northumberland County Council Children's Services at this point although a social work visit to the home was undertaken on 13.7.07.

The conclusions of the conference are, in retrospect, much more open to challenge and I don't think that the comments of the Northumberland County Council Children's Services IMR regarding no concerns (see above) are sustainable. I do not think sustained change was apparent and within two months of de-registration there was

continued evidence of M1's lack of honesty regarding her drug use and evidence from Northumbria Police of how this was compromising the direct care given to her two children and the consequent risks that they were exposed to. It is difficult to detect any genuine change in circumstance from the period before the ICPC. The evidence base points to the need for caution in decision making in such circumstances. Cleaver et al[2] comment

"For those with the most difficult and complex alcohol and drug problems, it is likely that problematic use will continue over time. Treatment may well prolong periods of abstinence or controlled use but relapse, in many cases, should be expected. The nature of most community services is such that many clients drop in and out of services according to their own needs, attitudes and behaviour. It should not be assumed that simply because a parent is receiving services they are abstinent or even in control of their alcohol or drug use. Nor can it be assumed that if they have dropped out of treatment they are problematically using alcohol or drugs...It is the 'multiplicative' impact of combinations of factors that have been found to increase the risk of harm to children. For example, the risk of child abuse increased 14-fold when parents had themselves been abused in childhood, if the parent was under twenty-one, had been treated for mental health problems or had a partner with violent tendencies (Dixon et al. 2005a, 2005b)."

The only information from F1's GP (unsought and unknown at the time) is that in 2007 F1 saw his GP due to stress. His flat had been repossessed and his girlfriend (M1) and son had moved out. He was prescribed Temazepam and was seen fairly frequently for sick notes.

There follows a period in the chronology with very little recorded and this may relate to the comment in the Northumberland County Council Children's Services IMR regarding improvement. However, there is a further CCN from Northumbria Police on 29.01.08, when M1 was arrested for shoplifting when the children were with her, (she was made subject to a 12 month Community Order with a 12 month supervision requirement for offences of shop theft on 21.4.08). This incident was discussed with M1 at the care team meeting on 30.1.08 and it was noted that M1 needed professional help regarding kleptomania. By the time of the care team meeting on 6.3.08 the situation was felt to have improved, with M1 engaging with the Addictions Service, and Sure Start. Visits during this period by Northumberland County Council Children's Services are generally positive regarding the children.

There is a further CCN on 10.7.08 when M1 left S1 in the house alone aged 7 years (she later received a caution). A S47 investigation was undertaken, liaison with the Police and a risk assessment completed and an agreement reached that S1 could remain with M1. The Northumberland County Council Children's Services IMR addendum notes that M1 was contrite and that she thought this was normal to do and that parents left their children alone but now accepted this was not responsible parenting. It also notes that she showed evidence of an ability to reflect and put in place arrangements to ensure this did not happen again and care of the children was

[2] Children's Needs – Parenting Capacity. Child abuse: Parental mental illness, learning disability, substance misuse and domestic violence, 2nd Edition 2011. Hedy Cleaver, Ira Unell, Jane Aldgate. TSO

generally seen as good. It is difficult to reconcile this account of M1's explanation with her previous arrest in July 2007 again for leaving S1 home alone. M1 should have been well aware of the consequences of these parenting decisions and I would question the conclusions drawn at the time regarding her ability to reflect.

In retrospect the decision making at the time appears flawed. A further anonymous referral was received on 5.8.08 regarding the care of S1 and him being left alone for periods and being out late at night. M1 denied all of these allegations when discussed with the Social Worker. There do appear to be missed safeguarding opportunities at this point. Given the history, it is likely that these were indicators that the experience of the children had changed little from two years previously when concerns had escalated. It remains unclear in what sense any perspective on the chronological history in the case was being maintained. If it had it is difficult to see how the period from January to August 2008 should not have led to child protection concerns once again being addressed.

It is also difficult to get a sense of the voice of the children at this point and whether anyone had a relationship with them such that they could describe their experience of family life.

The importance of the views of children is graphically illustrated in the Office of the Children's Commissioner report[3]. Some of the comments from children and young people include:

- *Check back with the family before putting things in the report, get the family view.*
- *Don't be overly negative. Focus on the good bits as well as the not so good.*
- *Do the best you can, don't just go into a family and back out and not actually try and help them.*
- *Listen to what children have got to say and work with them.*

The report concludes that:

"Local authorities should recognise the importance of the child's relationship with the social worker and organise the work so that social workers can get to know children, and are not viewed as remote but powerful figures".

It can be difficult in cases with families resistant to meaningful work, to move beyond what appears from a distance and with the benefit of hindsight, to simply be the monitoring of events, however, it is essential. The voice of the child is central to this but is difficult to detect in case planning at this point.

[3] 'Don't make assumptions'. Children and young people's views of the child protection system and messages for change. Office of the Children's Commissioner and the Centre for Research on the Child and Family University of East Anglia (2011)

On 04/11/08, a referral was received from school regarding S1, which resulted in a Section 47 investigation (a child concern notification was also received from Northumbria Police). The outcome of the enquiries following a joint investigation with Northumbria Police was that the concerns were not substantiated and on-going support was offered on a 'child in need' basis.

Very soon after this the system of support and information sharing around the family is in certain regards weakened rather than made more robust. On the 12th November 2008 the School Health Advisor and social worker agreed that there was no longer any role for school health and that there was no need for the School Health Advisor to attend 'Children in Need' meetings and the GP, following a home visit described below, does not see S1 again for over two years.

On 27.11.2008 a GP visits the home and examined S1 for headache and temperature. The GP expresses concerns about the home environment and possible neglect and discusses these with the Health Visitor and is informed that they will visit with children services. The issues raised by the GP were followed up that day and were not substantiated other than that the house was cold. It was felt that the children's needs/health needs were being met and the Health Visitor felt the concerns raised by the GP were out of character for M1. M1 came to Northumberland County Council Children's Services the next day and support was given regarding fuel.

It is difficult to understand the Health Visitor comment regarding "out of character" and to what this is specifically referring. Nevertheless, coming so soon after the S.47 investigation regarding S1's behaviour at school and the events of 2008 more broadly, this is possibly a further missed safeguarding opportunity. Furthermore it is not clear what feedback the GP receives and, despite the value of the GP's initial expression of concern, this may be a further example of the incomplete engagement of the GP in the safeguarding system.

2.2.2 Key learning themes

In March 2007 there is another failure in child protection practice at this point, in terms of the GP and other professionals working with the family. Important information about M1's substance misuse is not shared by the GP despite the fact that the children have child protection plans. This reduced the ability of the professionals seeking to work with the family to reduce the risks to the children operating with a full understanding of the family's circumstances. The Primary Care (G.P Service) IMR comments and I would agree that:

"This family required support from multiple agencies. Child safeguarding is a team approach and it is only achieved through working together. At times it seemed as if the GP services was detached from the other services, partly due to at times not sharing information, and partly because general practice was not included in the distribution list. The GP felt the burden of the patient, but this could have been made lighter had the GP requested help from other services, in particular mental health team, children services, health visiting."

In fact the Primary Care (G.P Service) IMR author was surprised at how little information sharing there was between the GP and HV, and vice versa. It may well be that there was good communication between GPs and HVs in this practice at the time, but it was not documented in the GP notes.

The lack of contribution by the GP to the RCPC is a weakness in information sharing at that point; however, given the known needs of M1 I would have expected Northumberland County Council Children's Services to have been more persistent in seeking information.

The decision to remove the children from the child protection register at the RCPC on 22.5.07 was 2 months prior to M1's assessment with the Addictions service on 24.7.07 and before M1 started her methadone programme. This appears to have been over optimistic and unrelated to the facts of family life at that point or the evidence base. De-registration took place too soon and led unfortunately to a demonstrable reduction in multi-agency coordination around the family (in particular the SHA1 role being agreed as no longer required).

It is difficult to get a sense of the voice of the children by 2008 and whether anyone had a relationship with them such that they could describe their experience of family life.

It remains unclear in what sense any perspective on the chronological history of the family was being maintained. If it had it is difficult to see how the period from January to August 2008 should not have led to child protection concerns once again being addressed.

2.3 January 2009 – December 2011

- 2.3.1 Chronology and analysis

On 29.1.09 the GP received a letter from the Addictions Service stating that M1 had recent poor attendance and was found to have amphetamines, DHC and cannabis in her urine. The Primary Care (G.P Service) IMR author notes the likelihood of reduced support available to the family at the time due to M1's poor attendance. The pathway is unclear but the Primary Care (G.P Service) IMR states that this resulted in a re-referral to Northumberland County Council Children's Services, with the GP copied into the information. It is not clear who referred or what assessment and decision-making took place and the Northumberland County Council Children's Services IMR addendum notes that there is no evidence of a referral regarding poor attendance at the Addictions Service at this time. The IMR does note that:

"The case continues to remain open on a child in need basis throughout 2009 with regular visiting by Children's Social Care. During home visits, the children always present well and the home conditions are generally good with enough food and stimulation for the children."

On 15.6.09 a child concern notification is completed by Northumbria Police with respect to S1 and S2 being out of the home without M1's knowledge.

Consistent with the already long-term picture of chronic neglect, the Northumberland County Council Children's Services IMR notes the concern around the care of S2's physical development:

"The Social Worker is encouraging M1 to attend eye appointments for S2, as her squint is becoming very apparent. Towards the end of 2009, M1's substance misuse again becomes unstable. Information is received from treatment services to say that M1 is using illicitly and her substance misuse worker is concerned about her level of use and presentation."

The Northumberland County Council Children's Services IMR addendum notes a care team meeting on 2.10.09 which was attended by the Addictions Worker:

"The care team acknowledges the increase in substance use and what is required from mother and partner, with a further care team meeting in 4 weeks. There is note of the need for adherence to the working agreement."

The Social Worker contacted the Health Visitor on 5.10.09 who confirmed M1 was attending the clinic and no concerns were shared.

The letter from treatment services, likely to be the same as that received by the GP on 15.10.09, confirms that M1's attendance had been poor and her illicit usage of benzodiazepines has been of concern, to the extent that they are now sharing the information with Northumberland County Council Children's Services.

Social Work supervision followed on 26.10.09 and noted that the Health Visitor was seeing M1 weekly.

During the autumn of 2009 there continues to be information forwarded from Northumbria Police as follows:

- Northumbria Police referral is received following a Social Work visit where M1 was asleep and S2 was being cared for by a 15 year old who reported she cares for S2 every night.
- 16.09.2009, 16.12.2009, 27.12.2009, when S1 and S2 were out of the home without M1's knowledge.
- 1 incident (16.09.2009) when F1 was visited to warn him under the Harassment Act. F1 acted in an aggressive manner in the presence of S2.
- 1 incident (30.11.2009) when S1 was arrested for burglary.

A joint home visit with the Health Visitor followed on 17.9.09 in response to the CCN of the previous day. Following the CCN of the 16.12.09 the Social Worker attempted two unsuccessful home visits. Emergency Duty Team follow up took place again unsuccessfully.

A further care team meeting took place on 10.11.09, where no concerns were expressed about S2. The Northumberland County Council Children's Services IMR

addendum notes that health, immunisations were up to date, speech and language developing and S2 was attending Nursery.

Whatever view and/or actions were taken by the care team, now minus the input of the school health adviser, although the health visitor was involved, it's clear that there was no S.47 investigation or ICPC at this point in late 2009. Given the persistent pattern of poor supervision and the children being left alone and the concerns being shared regarding M1's substance misuse this was in retrospect an omission.

F1's last consultation with his GP was 26.11.09.

Throughout 2010 both Northumbria Police and Northumberland County Council Children's Services IMRs note the following child concern notifications from Northumbria Police:

- 5.6.10 when M1 reported an argument with another party. The house was noted to be dirty and untidy.
- 27.08.2010 and 28.08.2010 when S1 and S2 were out of the home without M1's knowledge.
- 20.10.10 when M1 reported an assault. When officers attended M1 was next door, leaving S1 and S2 in the house alone.
- 02.12.2010 when M1 was arrested for shoplifting when the children were with her.

On 29.6.10 M1 informs the GP that she was in big trouble and was not leaving the house. There is no further information available from the GP records, but the welfare of the two children is apparently not questioned and due to the disengagement of the GP from the 'child in need' process, there was therefore no possibility of considering M1's comment in the light of any other important information.

There was an opportunity again to correct this error on 5.8.10 when the Addictions service wrote to the GP with an update stating that M1's attendance with their service was very poor and she continued to take methadone and other illicit substances. It was mentioned that Northumberland County Council Children's Services were currently involved with the children (now aged 11 and 4 years) under a 'child in need' plan. However, there is no information in the GP notes about Northumberland County Council Children's Services seeking information and GP does not request further information from Children Services.

S1 was admitted into Year 7 of School 4, a non-maintained school, on 1.9.10. He had a statement of Special Educational Needs identifying learning needs in literacy and numeracy development (16 hours of support per week). The Northumberland County Council Education Service IMR notes that the transition between schools was robust and School 4 received SEN records and S1's 'Child Protection File' from the previous school. The school assigned a key worker to support S1 full time and attended regular care team meetings from the date of admission. Other interventions - such as homework, break and lunchtime club, were also introduced in order to support S1's needs.

On 18.10.10 a referral was made by S2's nursery, reporting a bruise to her cheek and scab on her ear. This led to a S.47 investigation and medical examination. The examining Doctor stated that the bruise was consistent with M1's account of S2's bouncing off the sofa and hitting her face on a coffee table. F1 was noted to be very angry at the nursery for making the referral. M1 is described as hurt, but understood the school's position; despite this M1 and F1 decide to remove S2 from the nursery at this point. SW2 felt in discussion with the Northumberland County Council Children's Services IMR author that this marked the point at which the family began to disengage from the relationship with her.

It is of concern that a broader view of vulnerability was not taken by the investigation at this stage. Even with the absence of information held by the GP (which should have been sought as part of the S.47 investigation), in terms of the recent intelligence from the Addictions service and the on-going series of notifications from Northumbria Police, there was ample information to point to the needs of the children being persistently neglected by the parents and the need to pursue child protection action. Instead involvement remained on a "child in need" basis and there were care team meetings held in March, May, June, August and November 2010.

On 22.10.10 M1 informed her GP that she was accused of harming her child, that she had been seen by Northumbria Police and Northumberland County Council Children's Services and a paediatrician had seen the children. The GP noted *"probably accident"* (this may have been mother's summary of events). M1 was upset and complained of insomnia, requesting Diazepam. M1 was told to attend Addictions service, and Zopiclone (a Z type dependency drug) was prescribed on a low dose. The Primary Care (G.P Service) IMR is right to conclude that:

"This was a missed opportunity to share information. The GP was not asked to contribute prior to this child protection medical and the GP didn't contact children services to find out what the outcome was of this assessment. The GP did however receive a copy of the paediatric report."

A Care Team Meeting was held on 17.11.10 (postponed from 5.11.10 due to S2's presence) and considered the concerns in relation to:

- S1 beginning to offend.
- M1's unstable substance misuse.
- Northumbria Police referrals regarding the children.
- The children's physical presentation.
- Lack of boundaries and supervision.

The meeting notes that professionals viewed F1 positively:

"… that F1 living in the house provides some safety for the children. F1 is described as a 'consistent support for the children regardless of whether he and M1 are together'. F1 is not known to use any substances since professionals have known him'. Since F1 has been living at the family home, things have improved."

The assertions regarding F1 and any possible substance misuse are not sustainable, the professional network simply didn't know enough about him as an individual. The history of events within this time period (2009-11) alone would be enough to legitimately question just how positive his influence was. If F1, as a positive influence, was a hypothesis worth considering then it should have been tested through evidence gathering and assessment. Instead what was actually known was that after a child protection investigation he removed S2 from the school that had reported the injury. This should have reduced confidence in his role rather than enhanced it.

S1's attendance had been poor since admission to school 4 in September 2010 and he was referred to the Educational Welfare Officer (EWO) on 7.12.10. The Northumberland County Council Education Service IMR notes that subsequently his attendance started to improve.

The social work service to both children is maintained throughout 2011 on a 'child in need' basis. The Northumberland County Council Children's Services IMR notes "variable" home conditions and provision of day care for S2 but attendance remains an issue. However, issues of criminality and the care and supervision offered to the children continue to make concerning reading not just on the merits of individual events but in the persistence of the evidence of parental neglect.

On 11.1.11 M1 was made subject to a 6 month Community Order with a 6-month supervision requirement for shop theft. This order was revoked in March 2011 due to the imposition of a new order following the commission of a further offence. This is likely to have been the arrest for shoplifting on 19.2.11, which was subject to a Northumbria Police child concern notification because she had her children with her at the time of the offence.

The Northumbria Probation Service IMR refers to a Signs of Safety Meeting on 12.1.11 where it was agreed that attendance at these sessions would count towards National Standards for appointments, and would be combined with a monthly home visit. This was very helpful flexibility and positive encouragement to guide M1 toward an intervention that could have led to a degree of positive change in her parenting.

M1 failed to attend a meeting regarding S1 at school on 17.2.11.

On 5.3.11 M1 was made subject to a 12 month Community Order with a 12-month supervision requirement for an offence of shop theft. This order was successfully completed in March 2012.

Northumbria Probation Service allocated a trainee officer to supervise M1 and the IMR comments:

"The Offender Manager for M1 from 11/01/11 was a trainee Probation Officer, who had received Probation Trust training in Safeguarding Children. Cases where there are safeguarding issues are not allocated to Probation Service Officers, but trainees are allowed to take on such cases with adequate supervision, and/or joint work with a colleague. The Offender Manager received regular supervision from her line manager, and had access to a mentor in the Team. As this was a Child in Need

case, it was felt appropriate for the Offender Manager to hold the case herself with support. This was unusual at an early stage in a trainee's career, but adequate measures were put in place to provide support. It is clear from the supervision notes that in-depth supervision was given, and the case was discussed monthly.

The risk management plan specified that home visits – both planned and unplanned – should take place, and that there should be regular liaison with Northumberland Northumberland County Council Children's Services and Addictions in relation to the children. Attendance at multi-agency meetings was seen as a priority."

I think this could be considered a reasonable approach given the level of intervention at the time i.e. 'child in need', notwithstanding my view that the threshold for child protection intervention had been met for some time. However, unfortunately the allocated worker did not pick up on some issues as acknowledged in the Northumbria Probation Service IMR:

"The allocation of a Child in Need case to such an inexperienced officer was unusual, but she did handle to (sic) case well. However, her inexperience was evident in three instances, none of which were picked up by her Team Manager or mentor. The failure of registering the case as medium risk to children, the lack of a formal letter to Northumberland County Council Children's Services at termination of the Order and, despite the concerns raised with the Team Manager, no Child Protection referral was made. However, the level of home visiting, the contact with other agencies and the detailed recording are well above average. Specific guidance should be given on the allocation of such cases, and be included in the forthcoming revision of the Child Protection Policy. It is also of concern that we have been unable to locate the letter written by the Team Manager to Northumberland County Council Children's Services. Copies of such letters should always be placed on file."

I would agree with the above and these conclusions are pulled through to the recommendations of the IMR.

One month later on 29.4.11 S1 presented at Hospital after falling from a tree. He sustained a deep laceration of the right calf and was referred to the paediatric trauma clinic. The GP received this A&E card and a summary of the admission mentioning that he required surgical debridement and suturing in May and then a letter in July stating that S1 failed to attend his review appointment in June and was discharged from the plastic surgery clinic.

Northumbria Police were already sharing regular notifications regarding the supervision of the children, and the injury to S1 coming 6 months after the injury to S2 should have raised further alarm regarding the level of parental care and to what degree it was compromising the children's safety and well-being.

The school attendance manager made a home visit on 14.4.11 with no response at the house. Again when S1 failed to return to school after Easter the school undertook a home visit with the EWO on 5.5.11. There was no response and Northumberland County Council Children's Services was informed.

This probably led directly to the visit on 9.5.11 by the Social Worker. During the home visit the member of staff observed that the bandage was *"hanging off and was dirty".* It was already apparent that the treatment for S2's squint was being neglected and in March, July and October, S1 was seen by 3 different GPs for gum swelling, dental abscess and toothache due to apparent inability to see a dentist.

The Northumberland County Council Children's Services IMR notes that:

"On 27/09/11, S1's school report a deterioration in attendance and lateness and that the Education Welfare Officer and school attendance staff were refused entry to the home by F1 and subject to 'a lot of abuse by him'. School also report that S1 presents as unkempt, uncared for, is frequently hungry and often does not want to talk. They have also struggled to contact M1 when they have needed to. Information received on 30/09/11 from Ante-natal substance misuse service (sic) was that M1 had tested positive for benzodiazepine and amphetamine and has missed the last two appointments."

During the June of 2011 (Year 7) and the Autumn of Year 8 (30.9.11) M1 demanded that the school did not allow Northumberland County Council Children's Services to talk to S1 without a parent present. This was triggered by a visit from the Social Worker on 20.9.11 after a conversation between F1 and school, which raised concerns about the level of pain (toothache) S1, was in and his uncertainty about whether he had taken painkillers. At the time there were concerns about the treatment S1 was receiving for severe toothache (during 2011 he was being seen by a private dentist). F1 was aggressive to the worker and staff when encouraged to take S1 to the dentist. The dental issue continued to October 2011 when M1 took S1 to the hospital. During the same period (September to December 2011) S2's attendance was 'very poor' at 66%.

Northumbria Probation Service maintained an approximately monthly visiting pattern between March 2011 and March 2012 and had concerns about the lack of meetings and information sharing. The Northumbria Probation Service IMR states that messages were left with Northumberland County Council Children's Services on 23/03/11, 31/03/11, 28/07/11, 08/09/11, 25/12/11 which received no response. An entry dated 17/08/11 on file states that a number of messages had been left over the past few weeks with no response. Northumberland County Council Children's Services has no evidence of any messages left by Northumbria Probation Service. On 25/08/11 the Offender Manager spoke to the duty officer concerned that there had been no care team meeting since June, (the planned July meeting had been cancelled due to the social worker's sickness absence) and she felt there needed to be discussions with regard to the family. Although it should also be noted that whilst the offender manager expressed concerns in relation to the children, conditions in the home were not seen by the Offender Manager as worsening.

As suggested earlier the threshold for more decisive action under the child protection procedures by this point was in my view clearly met. Even with the failures of information sharing practice enough was known to recognise the long-term and on-going risks to these children. The injuries to both children were likely to be in part caused by the poor supervision offered by the parents and this neglect was also being regularly evidenced by Northumbria Police CCNs. F1 was aggressive to staff

querying the medical oversight of the S1 and S2 and he and M1 were seeking to control professional access to the children.

There were further failed attempts by School 4 to engage M1 in November and December and the health visitor remained actively involved with the family until after the Care Team meeting held on the 17th December 2011, when she handed over to the School Nursing Service (SHA1). The handover included an update regarding the concerns in relation to the neglect of the children and the date and time of the next Care Team meeting (held on the 12th January 2012).

None of the IMRs consider the content of the 17.11.11 meeting, how much of the information relating to the last 12-24 months was considered as a whole, whether the hypothesis regarding the positive impact of F1 noted in November 2010 could be said to have been supported or contradicted. Simply put it is hard to see a realistic focus on the needs of the children guiding the assessment of events and actions taken to address the significant harm they were likely to be experiencing. Although outside of the terms of reference time period this is important because the delay in recognising thresholds for action in relation to S1 and S2 may well have played some role in the later view taken in November 2012 regarding legal planning for all the children, including unborn baby Eve. Essentially, if child protection action had been taken in 2009, 2010 or 2011 when it was clearly appropriate then it may be that by 2012 more decisive action would have been taken in relation to Eve.

- 2.3.2 Key learning themes

There was continued poor engagement by M1 with treatment services and unstable substance misuse. This coincided with further evidence of the children's needs not being met in significant respects, for example, S1's dental health (in March, July and October 2011, S1 was seen by 3 different GPs for gum swelling, dental abscess and toothache due to apparent inability to see a dentist) and S2's squint. This period also marked the beginning of S1's offending behaviour, burglary, in November 2009, aged 10. There was also the failure to follow up for S1's medical review in relation to a leg injury in June 2011.

If the pattern of CCNs were reviewed as a whole this could have prompted Northumbria Police to escalate concerns and seek further discussion with Northumberland County Council Children's Services regarding the welfare of the children and possibly led to a Northumbria Police request for a S.47 investigation. This applies in particular to the sequence in 2009 and 2010, which were focused in the main on the poor supervision of the children.

F1 and M1 also remained disengaged from the educational process and did not attend learning reviews, parents' evenings or statement reviews. Discussion of S1's progress was always part of Care Team meetings so F1 and M1 received feedback when they attended, however, for some time F1 refused to attend these meetings.

The children remained as 'children in need' throughout this period; however, there were points when the threshold for child protection action and S.47 investigation were in my view reached.

A S.47 investigation did take place in October 2010, in relation to S2 and facial bruising. Although the medical examination accepted the parental account as consistent with the injury a broader assessment of vulnerability should have been taken at this point. For example, considering the injury in terms of the recent intelligence from the Addictions service and the on-going series of notifications from Northumbria Police.

The Care Team Meeting held on 17.11.10 was a missed opportunity to consider whether the level of intervention with the children was correct and could have again reflected on the concerns in relation to:

- S1 beginning to offend.
- M1's unstable substance misuse.
- Northumbria Police referrals regarding the children.
- The children's physical presentation.
- Lack of boundaries and supervision.

F1 continued to be viewed positively whilst very little was actually known about him. This hypothesis should have been tested through evidence gathering and focused assessment.

Although the letter from the Probation Manager cannot be found by the agency and Northumberland County Council Children's Services have no record of receiving it, if it was sent then the Probation Manager should have followed up in the absence of any response from Northumberland County Council Children's Services.

A shared multi-agency understanding, put into practice, around thresholds is crucial in this case, as in others, and a key concept is the assessment of the issue of 'harm' and whether this is 'significant'. The Working Together 2010 guidance comments on significant harm as follows:

"*There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. In each case, it is necessary to consider any maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports, as well as an assessment of the likelihood and capacity for change and improvements in parenting and the care of children and young people."*

It is not clear during this period what child-focused assessment was taking place and there is a continued gap in relation to understanding the children's views of their own *'safety and welfare'*. Why this was the case is difficult to understand, nevertheless I think it is likely that the children were suffering significant harm throughout this period and that child protection action could and should have been instigated on a number of occasions. However, multi-agency safeguarding practice fell significantly short of the standards that should be expected.

2.4 January 2012 – 27th November 2012 (Initial Child Protection Conference)

- 2.4.1 Chronology and Analysis

On 9.1.12 SW1 undertook a home visit, no one was at home and a letter was left.

On 10.1.12 F1 met with attendance manager expressing anger at letters from the school regarding S1's poor attendance. F1 agreed to a strategy of sending S1 to school so that the school could decide if he was poorly and needed to go home.

On 11.1.12 SW1 had a supervision session with the Team Manager, no details are set out in the IMR.

On the 12.1.12 there was a care team meeting, the first since June 2011 (source Northumbria Probation Service although the Northumberland Tyne & Wear NHS Foundation Trust IMR refers to the last planning meeting having taken place on 17.11.10). This was held using the Signs of Safety format and it was the first involvement of the School Health Advisor (SHA1). The Northumbria Healthcare NHS Foundation Trust IMR notes the issues and that at this time M1 described F1 as being very supportive to the family.

No formal minutes are referenced in the IMR but SHA1 notes the plan as follows:

- *School to chase referral to speech and language.*
- *Referral to Family Recovery team.*
- *M to be spoken to about going on the parenting course.*
- *Addictions to meet up with M – support hopefully in terms of confidence.*
- *Referral for task centred care for S1.*
- *S/W to visit M and children weekly.*
- *If the children are ill or off school they are to be taken to the GP.*

The Addictions Service updated the GP in writing on 17.1.12, noted as follows:

"Update letter to GP, content includes current medication status and collection regime. Northumberland County Council Children's Services involvement and recent care team meeting and future care plan re medication reduction."

This was the same day as a visit to M1 by the Addictions Worker who assisted M1 in signing up to a 'parent factor' course and to seek financial help from Northumberland

County Council Children's Services regarding bills. M1 admitted to using Benzodiazepines on top of her prescription. No illicit opiate use was reported and methadone reduction was going well. Urinalysis was taken that day and confirmed this. There is no record presented that this was communicated to Northumberland County Council Children's Services. It is not possible to come to any conclusion as to whether this lack of report is in any way related to a sense of the normalization of M1's use of Benzodiazepines on top of her prescription.

On 20.1.12 there was a home visit from Northumbria Probation Service, who noted that the house was clean and tidy. M1 follows this up by attending an office appointment with Northumbria Probation Service on 26.1.12.

Also on 26.1.12 SW1 writes to arrange day care for S2 to allow M1 to attend the parenting group. There is also mention of referral to a Family Recovery Project. Clearly attempts were continuing to engage and provide a meaningful service to M1 and the family.

On 1.2.12 SW1 undertook a home visit, no one was at home. The Social Worker also undertook a visit to see S1 at school the same day and noted no concerns regarding S1's presentation.

On the 3.2.12 Northumberland County Council Children's Services received information from the Head Teacher regarding S2 and expressing concern about M1's presentation at school. Concerns about the pain she appears to be in and what she may 'do' or 'take', putting her children at risk. The School had also observed that M1 had been seen flagging down cars in road for a lift to nursery with S2. Although the school sent an email to this effect there is no evidence of this 'car flagging' behaviour held in Northumberland County Council Children's Services records. A further email was received from the school by Northumberland County Council Children's Services to inform that M1 has attended the GP and fed back that she has a prescription for painkillers and sleeping tablets. There is no record of a response from Northumberland County Council Children's Services. There should have been a more robust response at this stage given the known history, even with the lack of knowledge regarding the car flagging incident. However, the immediate assessment would also have been helped if the information from the Addictions worker visit on the 17.1.12, which confirmed M1's illicit Benzodiazepine use, had been shared with Northumberland County Council Children's Services. At least then there could have been consideration of whether there were immediate acute problems that required emergency action.

On 16th February 2012, a Family Worker, from the Local Authority Family Intervention Programme working into the Addictions service became involved and a letter was sent to M1 to inform her of an appointment / home visit with the Family Worker on 21.2.12.

Soon after there was a Northumbria Police child concern notification received by Northumberland County Council Children's Services on 20.2.12 (date in Northumberland County Council Children's Services IMR) in relation to the Ambulance service involvement with another child who was reported to have been drinking with his friend S1. Northumbria Police expressed concern about S1's

drinking and M1's inability to cope with the situation. The other child reported that he had been drinking spirits at S1's home. The Northumbria Police IMR cites the incident date and notification as 18.2.12 so if these relate to the same incident there may have been a significant delay by Northumbria Police in forwarding the CCN. It is not set out in either IMR why this delay might have occurred or how subsequent decision-making took place.

SW1 interviewed S1 at school the same day as receiving the CCN and the IMR notes:

"…there was a group of children drinking in a field near... S1 said he left with his friend to take him home as he was so drunk. S1 said he did not have much to drink, but had taken the alcohol from his house. S1 offered the information freely."

SW1 visited the home the same day unsuccessfully and again the following day when M1 and F1 denied that alcohol had been bought and drunk at their home and said that S1 never drank or smoked. The clear contradiction between S1's account and the parents is not explored further in the IMR. SW1 left the property as a result of F1's aggression. It is notable that a S.47 investigation is undertaken in relation to the other child, on account of injuries sustained from falling over, but not in relation to S1. The reasons for this, and how the decision was reached, are not analysed in the Northumberland County Council Children's Services IMR but I believe it's surprising, given the history, that a distinction between the two children was made. The decision fails to account for the obvious implication regarding parental care and supervision offered by M1 and F1 and the subsequent parental aggression and dishonesty in this regard. It was, however, to be commended that SW1 immediately informed the Addictions Service Family Worker of the events who subsequently visited M1 and F1 at home on the 23.2.12. The parents both appeared to confirm in discussion that S1 had been drinking, further compounding the evidence of parental dishonesty in their account to SW1.

Although undated the Northumberland Tyne & Wear NHS Foundation Trust IMR notes that during January and February there was no illicit opiate use reported and reduction was going well and that urinalysis confirmed this.

The care team meeting on 23.2.12 was cancelled presumably because of the work around the referral from Northumbria Police.

On the 28.2.12**,** S2's Head Teacher contacted SHA1 concerned about S2's absences from school due to reported illness. SHA1 was asked to visit the family to follow up. On the 5.3.12 SHA1 had a telephone conversation with F1 who agreed to meet with SHA1 and for her to undertake a Health Needs Assessment in relation to both the children. SHA1 emailed the social worker to update her on the conversation on the same date. F1 did not make contact again with SHA1 to arrange the appointment.

On the 6.3.12**,** a home visit was carried out by the Addictions Service Family Worker. During the session M1 discussed past criminal activity, boundaries and discipline for the 2 children.

On 12.3.12 the Probation worker visits following termination of M1's order (11.3.12).

The IMR concludes that:

"…there did genuinely seem to be an improvement and the Offender Manager, at the last appointment, continued to encourage M1 to engage with Addictions/Northumberland County Council Children's Services to access appropriate activities, not assuming that risk had been reduced. I am aware, however, that the children were again placed on Child Protection Plans for neglect some eight months later."

There were further visits by the Social Worker to the children at school on the 23rd and 27th March and a successful home visit with the appointed task-centered day carer also on the 27th March. This was the last successful home contact by a Social Worker with parents until 12.9.12, a gap of almost 6 months that will be discussed later in this report.

The Addictions Service Family Worker visited on the 28.3.12; however, M1 had left a note saying she had gone to the dentist for treatment of an abscess. The seeking of treatment contrasts markedly with the neglect of S1's dental needs (set out below in more detail) and echoes the comments of the Primary Care (GP Service) IMR regarding M1's apparent readiness to attend her GP for her own needs whilst the medical care and oversight of her children remained severely compromised. The Addictions worker rang SW1 the same day but no response is noted.

The care team meeting took place on the 29.3.12, neither parent attended and nor did the Addictions Worker, however, it was noted that:

"M1 has met with Family Recovery Project Worker…on 2 occasions and is also keeping a drugs diary to help with treatment plans. It is also reported that she is engaging well with the 'parenting factor' course."

Although SHA1 was unable to attend it is clear from the Northumbria Healthcare NHS Foundation Trust IMR that school staff reported that S2's attendance had improved since the last care team meeting (more than 2 months ago) and that there were a number of positives in relation to S2 and her progress. F1 had been to collect S2 twice from school and it was felt that F1 was starting to feel more comfortable with the staff. S2 was talking more in school about 'things' that she was enjoying with the family, homework had been completed that week and S2 had been reading more regularly. The contrast with the discussion between the school and the School Advisor on 28.2.12 is marked. There may well have been improvement; however, a much longer-term perspective was needed at this point in order to understand any improvements in family functioning. The care team should have corrected any short-term bias in relation to the evidence for progress.

I would agree with the conclusion of the Northumberland County Council Education Service IMR with respect to the school's understanding of the family's complexity and the potential lack of understanding regarding the levels of risk for S2.

The Northumbria Healthcare NHS Foundation Trust IMR helpfully describes a parallel area of concern that remained unknown at the time due to further failures of information sharing between the care team and dental services for S1. Given the likely impact on S1 the IMR will be quoted in some detail below:

"Unbeknown to the Care Team (including the school Health Advisor), S1 had missed a number of dental appointments despite him needing a number of teeth extracted which were retained roots that had been infected and swollen; he also needed a number of dental fillings (see chronology). In October 2004, when S1 was aged 5yrs 3 months, he had 6 teeth extracted due to dental caries.

On the 19th January 2012 S1 was seen by dentist at Northumbria Dental Service*. On examination S1 had halitosis, gross plaque deposit, florid gums, approaching ANUG (Acute Necrotising ulcerative gingivitis). ANUG is a severe gum infection. ANUG can be painful, result in gums being unable to support teeth, tooth loss, bad breath and ulcers.*

The consultation was very difficult with S1 refusing treatment; he was eventually persuaded to have a scale and polish. The dentist tried to remove sublingual calculus (calculus under the gums) from his bottom 4 teeth however S1 was grabbing at the scaler instrument. S1 was given Codesyl mouthwash. A new X-ray request was given as S1 had not been to have the X-ray as agreed on the 3rd October 2011(probably a miss-print and should read 2012).

<u>Treatment plan:</u>

- *X-ray to be undertaken at hospital.*
- *Arrange an appointment once X-ray has been received (it is policy that all patients must have oral cavity X-rayed before extraction of teeth).*
- *Remaining dental fillings to be completed and scale, polish and extraction of other teeth.*
- *S1 to come again for review of X-ray.*

The Care Team including SHA1 were unaware of the dental consultation."

The NHS commissioning IMR makes the point and I would agree that:

"… it does pose the question what was the focus of the care team at that time, if it was not to address the neglected health of the two children. If the information had been known then the threshold for a Child Protection plan may well have been considered and met earlier and more importantly the health needs addressed and met much earlier."

On 5.4.12 social work supervision took place, the Northumberland County Council Children's Services IMR notes as follows:

"Supervision….Discussed the verbal aggression experienced by the Social Worker…at the last visit. F1 is refusing to attend any meetings and M1 is now saying the same…continues to see the children alone at school. Discussed issues with both

children separately. S2 has had improved attendance over the last half term, but still tends to be sick 1 day per week. S1 still sometimes looks tired and disheveled (sic) at school and has admitted to drinking and smoking. M1's probation order has come to an end and her engagement with Ante-natal substance misuse service (sic) is 'hit and miss'. Team Managers analysis of the supervision note is that 'The situation does not appear unsafe as the children are being seen every day, however emotional needs may not be being met'."

A core assessment and chronology were actions identified by the Team Manager at this supervision discussion.

SW1 visited the home on the 27.4.12 after being informed that S2 was absent from school. There was no answer. S2 also failed to attend on the 30.4.12 and the SW1 noted that M1 is not adhering to the child in need plan *"appears not to have the capacity to meet the needs of the children"* and that there is a possible need to consider child protection procedures. There is no further note of any management consultation as a result of this.

M1 was seen by the Addictions Worker on the 30.4.12 and the discussion focuses on M1's needs to locate her mother's ashes. The Northumberland Tyne & Wear NHS Foundation Trust IMR correctly notes that as with other interactions with professionals M1's focus on her own needs appears to exclude more detailed assessment and intervention around the broader family's needs. In fact M1's engagement even on the level of her own needs was superficial and only 1 of 4 appointments were kept. Due to this lack of engagement the Family Worker was withdrawn.

On 2.5.12 the Northumberland Tyne & Wear NHS Foundation Trust 'Keeping Children Safe' document was completed after the visit on 30.4.12 (this is a document which is part of the Trust care co-ordination documentation).

On 8.5.12, SHA1 received supervision from NA1 (Nurse Advisor Northumbria Healthcare NHS Foundation Trust Safeguarding Children Team) and discussed her concern about the parents not engaging; they agreed that a care team meeting was required and an update from the Educational Welfare Officer and the Addictions service. It is not clear to whom this was subsequently communicated to.

On the 20.5.12 when S1 was arrested for theft, however, the Northumbria Police officer did not submit a child concern notification. The Northumbria Police IMR comments that:

"…the officer stated that it had been an opportunistic theft of a luxury item rather than Theft of items such as foodstuffs which would have caused concern. On speaking to F1 when S1 was arrested he was very supportive of the positive action taken by Northumbria Police, and informed the officer that S1 needed to understand the severity of the situation. In this case the author agrees with the decision not to submit a CCN."

I disagree with this view. The officer had no information regarding the context of S1's overall welfare, the lack of parental care evident to other agencies, the existing

instances of alleged drinking by S1 and the concern that any of the care team members would surely have had at that point of both the behaviour in itself but also of the possible use the re-sale value of the luxury item could be put to. Of course the Police Officer was not to know any of this, and so, on the precautionary principle, a notification should have been sent.

S2 was seen by SW1 at school on 21.5.12 and another failed home visit was undertaken on the 29.5.12. The latter was in order to pursue the core assessment work and M1 again refused (by text) to meet. M1 after another failed home visit the next day again refused (by text) to attend 'meetings'.

On 28.5.12 a home visit is also carried out by the Addictions Service Family Worker who is unable to gain access. The worker made a telephone call to SW1 and a message was left for her to ring back.

On 29.5.12 a further telephone call was made to SW1 by the Addictions Service Family Worker, again a message was left for her to return her call. The Family Worker also sent an email requesting SW1 to contact her as she wished to speak to her regarding the 'signs of safety meeting' to be held on 31.5.12. No response from SW1 is noted

The care team meeting took place on the 31.5.12 using the 'Signs of Safety' model to frame the discussion. The issues discussed (recorded in Northumbria Healthcare NHS Foundation Trust IMR) were as follows:

- School attendance.
- S2 significantly behind academically.
- M1 reported to be starting to reduce Methadone but it was not known if she was using illicit drugs, as she had not had a sample taken. The Addictions worker was visiting monthly and M1 was engaging with her.
- M1 and F1 were more involved with S2's schooling – reading and some homework being done (although by M as opposed to S2).
- Parents were not engaging with the Family Support Worker (FIP worker) and had missed 3 appointments.
- Parents were not engaging with SHA1 or the social worker.

The SHA1 view was that the concerns remained unchanged from when S1 was young with no significant sustained change since 2005.

It is not clear whether this was a planned meeting or convened in response to contact from SHA1. It also appears from the Northumberland Tyne & Wear NHS Foundation Trust IMR that the invitation letter was only received by the Addictions Worker on the 28.5.12. Although the invitation process did not support full attendance of critical professionals the possibility of the need for child protection action was at this point mentioned. However, it was not clear what measures were to be put in place to allow a view to be reached whether action should be taken. And if this was unclear for professionals then it is likely to have been unclear for the family. The plan documented by the SHA1 was:

"…that the social worker would contact the parents to discuss the concerns, required engagement and possible Child Protection procedures. The social worker would continue to attempt to complete the Core Assessment."

On 7.6.12 the Addictions Worker shared that M1 has informed her that she was getting a different social worker and that the Nursery School Head teacher was sorting this out. It is noteworthy that M1 is still clearly talking to some professionals but has refused to communicate with SW1. This management of professional input is a risk in itself and should have informed any further consideration of risk that was being undertaken at the time. At this point it should be remembered that the parents had not allowed/avoided a home visit by the Social worker for 3 months, effectively sabotaging meaningful assessment work and any management of risk.

On 13.6.12 social work supervision with the Team Manager (TM1) took place and the analysis is recorded as follows:

"'…Serious concerns that the family are refusing to engage…long standing concerns that the situation does not improve enough to change the outcomes…. However, the evidence of harm is very thin, although the poor school attendance will have a knock on effect in all areas of her development. Strengths are noted as:

- *No reports of Domestic Violence.*
- *No reports of disturbance in community.*
- *No evidence of illicit drug use.*
- *No alcohol abuse.*
- *No instances of S2 wandering unsupervised.*
- *No physical injuries.*
- *S2 wearing her glasses every day for school.*
- *M1 engages with Youth Offending Service for S1."*

The Northumberland County Council Children's Services IMR summarises as follows:

"It is the author's view that May 2012 was a point in the case where a decision could have been made to escalate the concerns and undertake a S.47 child protection enquiry. There was a lack of engagement with parents, no progress was being made with the plan and S1 and S2's needs were not consistently being met.

There is evidence of regular review of the risks in supervision and it is apparent that SW1 and TM1 have considered that the risks have not increased, but there is a lack of attention to the history of being unable to effect sustainable change and improvement for the children. There is a request from TM1 for SW1 to undertake a Core Assessment in April 2012. This could have provided an opportunity for a detailed exploration of the historical factors in this case, the risks to S1 and S2, how life was for them within this family and the likely impact on their future development. This core assessment was not completed by SW1. The next recorded core

assessment is in September 2012, when the case is reallocated to SW2. It is the author's view that from the supervision record and social work interventions at this point, the case planning did not take into sufficient account the persistence and cumulative effects of the neglect S1 and S2 had experienced over a period of years."

I would agree with this analysis, even so it is difficult to get beneath the reflection that did take place to understand the view that emerged regarding "thin" evidence. It may be that this is simply a misjudgment. It may also be an example of 'confirmatory bias' (Munro 2008), the tendency to form our views early and then unconsciously select and weigh the information emerging in a way that ensures our early beliefs will be confirmed.

Nevertheless in light of these judgments the plan from supervision was:

- Complete the Core Assessment.
- Check if eye hospital appointment has been followed up.
- Distribute and upload Care Team Meeting minutes.
- Write to parents outlining the fact that their lack of engagement worries us more.
- Convene further Care Team Meeting.

A further failed social work visit took place on the 15.6.12 and subsequently SW1 requested a joint visit with the Addictions Worker. M1, however, cancelled this proposed visit.

Despite the refusal of contact by the parents SW1 texts a reminder of the next care team meeting to M1 on 13.7.12.

The care team meeting, due to take place on the 17.7.12, is according to the Northumbria Healthcare NHS Foundation Trust IMR cancelled. In discussion SW1 informed SHA1 that the family have withdrawn from the task centered day care and that there is concern regarding access to and oversight of the children over the summer break. SHA1 expressed concerns that:

- S2's issues were also present for S1.
- S2 far behind at school.
- Non-engagement for too long.

The Northumbria Healthcare NHS Foundation Trust IMR goes on to note that:

"S/W informed SHA1 that she has discussed the case at supervision with her team manager who strongly feels that S/W should be going out to try to access the family with the Addictions worker to discuss their response to the concerns held by professionals.

SHA1 has written that she believes that this family should go to Child Protection Conference given that parents have failed to engage for such a long time now and not engaged with attempts to discuss concerns and the way forward for the children."

This was the first time that SHA1 had discussed chronic neglect with the social worker and the judgment regarding child protection action was, in my view, the correct one. It had been formed following 6 months involvement and prior to the knowledge of M1's pregnancy becoming available. SHA1's plan was to discuss her concerns with Northumbria Healthcare NHS Foundation Trust's Safeguarding Children Nurse Advisor, which she did on the 26.7.12.

On 25.7.12 the social worker informed the SHA1 that expectations had been set out in a letter to parents, that there had as yet been no response and that after 30.7.12 there will be unannounced visits on a daily basis until she manages to make contact with the family. A further action was outlined that the social worker will contact the Addictions Service to confirm M1 is still engaging with the service. The last report from the Addictions Service being that M1 is on a reducing Methadone prescription and is denying any illicit drug use. It must also be remembered that M1 very often denied illicit drug use even when this was taking place.

This conversation is not, however, in the Northumberland County Council Children's Services chronology. In any case the social worker was only able to visit the home on the 1st and 22nd August, both of which were unannounced and unsuccessful. The parents were only seen at home again on 12.9.12.

These two conversations on the 17th and 25th July clearly flag up a view regarding child protection and a significant plan of renewed activity in terms of attempted home contact by the social worker is part of the response. This home contact, as we can see above, did not in reality take place nor was there any further liaison between the social worker and the SHA1 until 10.9.12 when SHA1 made a referral to Northumberland County Council Children's Services about the children including for the first time unborn baby Eve. This is a significant gap in multi-agency liaison and is difficult to relate to the levels of concerns being expressed by both agencies. Timely and purposeful case management is difficult to detect at this point and it is not clear why both renewed social work visiting and more consistent professional communication were not achieved at this time.

On 25.7.12 a message is also left by S2's school, it contains no specific detail but requests contact. The Social Worker returned the call but was unable to speak to the relevant person. This was the call from school that had been prompted by the discovery of M1's pregnancy and is considered in more detail below.

On 26.7.12 SHA1 discussed her concerns with NA2. The plan agreed was to offer an appointment to the family and records to be requested from archive. It may be that at this point the concerns should have been escalated and a discussion with more senior managers sought and I would agree with the view expressed in the Northumbria Healthcare NHS Foundation Trust IMR that:

"In this case SHA1 was concerned but was not assisted by the nurse advisors in challenging the views of other professionals."

On 31.7.12 the GP received a copy of a letter from the SHA1 addressed to the parents of S2 and S1, requesting a meeting with the parents to discuss the health needs of both children following a recent care team meeting.

On 9.8.12 the Addictions Worker saw M1 at home and the IMR notes:

"M1 discussed death of her parents which was felt to be huge progress as she never discussed her feelings. S1 out at the cinema and S2 playing with friends - observation was S2 tatty hair and grubby face but looked well. Plan – methadone reduction to continue, M1 to re-engage with Escape. key worker to liaise with CSS re safeguarding."

On 12.8.12 Northumbria Police receive an intelligence report that S1 had been banned from the local shopping centre as a result of his behavior.

The Addictions Worker updated the FACE risk assessment on 16.8.12.

There were attempted but unanswered home visits undertaken by the social worker on the 1st and 22nd August and SW1 bumped into S1 on 14.8.12 whilst shopping, noting he looked well and was saying that everything at home was fine.

On 21.8.12 YOS Worker informed SW1 that S1 has successfully completed the Final Warning programme, that he had engaged well and M1's engagement is commented on positively and that she appears to be doing well on her Methadone reduction programme.

On the 22.8.12 a home visit was undertaken by SHA1 and her colleague SHA2, in order to complete an Initial Health Needs Assessment of S1 and S2. M1 stated that she was not aware that school health were visiting and had not received the appointment letter. After SHA1 explained the reason for the visit, M1 agreed for the assessment to go ahead. It was observed that in the garden S2 was using the family's trampoline, which had no safety net and some parts were not attached to the springs. M1 quickly took S2 off the trampoline. Both children were seen and S1 contributed to the discussion and as set out below also appeared to raise an issue of care regarding his eyesight which M1 was quick to disregard although later agreeing to make an appointment for an eye test.

The Northumbria Healthcare NHS Foundation Trust IMR sets out comprehensively that M1 essentially denied any significant problems with either S1 or S2 and that any necessary medical oversight i.e. dental and ophthalmic was being sought. Notes regarding the individual children's assessment are set out below:

"S1:

- *S1stated that he would like to have his eyes tested as 'things' sometimes appeared blurry. M reported that his eyes were perfect at his last vision check but agreed to make another appointment.*
- *M1 agreed to ensure that S1 was seen by his dentist as his 6 monthly check-up was overdue; M1 stated that his last dental appointment had been 7-8 months ago and that S1 brushed his teeth twice daily.*

- *M1 stated that S1's immunisations were up to date.*
- *M1 and S1 stated that S1 did not drink alcohol or smoke.*
- *S1's attendance at school had been poor at times and M1 stated S1 was only off school when he was poorly; M1 had no worries about his health.*
- *M1 described S1 as a loving, generous and very caring person.*

Both S1 and M1 sated they did not feel that they needed support from school health at that time and SHA1 agreed. SHA1 informed M1 that she could contact her if she changed her mind at any time.

S2:

S2 was not wearing her glasses at the time of visit but M1 produced them from on top of the fire and cleaned them. In relation to S2, M1 reported the following:

- *No concerns in relation to S2 general health.*
- *S2 had been reviewed at Hospital 2, in relation to her eyes 6 months prior and was due to be reviewed again.*
- *M1 did not feel that S2 had any more illnesses than other children.*
- *S2's Immunisations were up to date.*
- *S2 had 5 monthly checks at the dentist and had been reviewed 5 months previously.*
- *There were no concerns in relation to S2's behaviour."*

The lack of honesty and denial of the children's needs, which was quickly established following the visit, is striking and reinforces the difficulty of any realistic intervention with the family on a voluntary basis at this time.

On 31.8.12 further information from the Ophthalmology outpatients indicated that S2's eyes were not working together and this would:

"…impact on her school work unless she wore her spectacles all of the time; S2 needed to be regularly reviewed and if S2 was left unsupervised and struggling, her eye condition was likely to impede her learning."

The case is transferred to a new social worker (SW2) in supervision on 5.9.12. Issues in the case are noted and a home visit planned with a requirement for the core assessment to be completed by the previous Social Worker. Given the known history at the time it's surprising that the issue of engagement is not more specifically raised. By this point the parents had not been seen by a Social Worker since 27.3.12, S1 since the same date barring a chance encounter shopping and S2 since 21.5.12, at school.

On 6.9.12 SHA1 had supervision from NA3 (Nurse Advisor Northumbria Healthcare NHS Foundation Trust's Safeguarding Children Team). The plan of work was as follows:

- A letter to be sent to the family and if SHA1 had not heard back within a week, to re-refer to Northumberland County Council Children's Services.
- SHA1 to arrange an appointment for S2 to be seen by Ophthalmology and to continue to be part of the Care Team.

On 9.9.12 the GP received a copy of a letter from the SHA1 to both parents following the home visit on 22.8.2012. In the letter the SHA1 confirms that they had not been able to contact the parents since the meeting and also expresses concern regarding the lack of treatment sought for S2 (further detail set out below). The SHA1 also expresses the importance of S2 wearing glasses all the time and that S2's health needs should be met. The SHA1 asks the parents to get in touch so that S2's appointment can be booked with an optician.

Even with this significant information emerging regarding the parental neglect of S2's medical care there was no action taken by the GP or any liaison with the SHA1.

On the 10th September 2012, SHA1 was contacted by S2's Head teacher who informed her that S2 had been attending school on time and that M1 had informed her before the summer holidays that she was pregnant. SHA1 asked the Head teacher to pass this information on directly to Northumberland County Council Children's Services. The Northumbria Healthcare NHS Foundation Trust IMR also notes that:

"SHA1 on the same day then made a detailed referral via email to Northumberland County Council Children's Services regarding S1, S2 and unborn baby Eve. The referral included her concerns regarding what was in their view, a significant history of chronic neglect of the children, her concern that M1 was giving inaccurate and misleading information, was not engaging and was also pregnant (see chronology date 10th Sept 2012 details). Northumbria Healthcare NHS Foundation Trust's Safeguarding Children Team, Northumberland received a copy of the referral on the same day. SHA1 received telephone supervision from NA2 who agreed with SHA1's decision to make a referral to Northumberland County Council Children's Services NA2 did not give any other advice."

On the same day (10.9.12) the SHA1 sends an email update to the Social Worker. As part of her health assessment, M1 had stated that S2 was last seen at hospital for her eye check 6 months previously and was about due an appointment. When checked, however, S2 had not been seen for her eyes since the initial assessment visit 18 months previous, on 17.1.11. She had been diagnosed with:

- Left convergent squint.
- Amblyopic.
- Infantile Estropia.
- Long sighted.

SHA1's view was that untreated, this will really disadvantage her at school and that M1 has been untruthful about S2's eye care, has tried to mislead the SHA1 and has failed to attend 2 further appointments offered in March and April 2011. SHA1

confirmed that she had contacted family by letter but the parents had failed to respond.

The SHA1 also described that she has been told by Head teacher for S2, that M1 informed her prior to the summer holiday that she was pregnant. The Head Teacher had informed M1 at the time that she needed to let professionals know of the pregnancy, but M1 said she would prefer to wait until 12 weeks had passed. Subsequently it has been established that this information was the subject of the telephone message on 25.7.12. However, the message was not specific and no professional conversation followed. The failure of the school to clearly report M1's pregnancy to the social worker is a significant concern.

On the 12.9.12 the new social worker visits the family home and the IMR chronology notes:

"M1, S1 and S2 were present. M1 said she was happy to work with the new Social Worker and will attend future care team meetings. M1 gave SW a full tour of the home. Main areas of the house were clean, although cluttered. Children's beds were clean. Food observed in the cupboards. Recorded 'nice observations of interactions between the children and their mother'. SW arranged to visit S2 in school. S2 was happy with this arrangement. M1 did not deny she was pregnant and SW encouraged her to book in for antenatal care."

It was clearly important at this visit for SW2 to begin to establish a relationship with M1 given the difficulties faced by the previous social worker but I would have expected a much more open, robust and authoritative review of the circumstances at this point. For example, possible child protection procedures had been mentioned at the care team meeting on 31.5.12, M1's dishonesty regarding the medical care of S2, the rejection of social work intervention for almost 6 months and how in this context did M1 feel about her capacity to cope with a pregnancy and offer the right level of care to her unborn child? It must be considered that at this point 'start again syndrome' was clouding the nature of the intervention and the expectations placed on M1 and F1. There was also no sharing of the key information regarding the pregnancy with the Addictions Service.

A further visit by the Addictions Worker takes place on the 13.9.12 and an email update was afterwards sent to the social worker. A Urinalysis was taken for Benzodiazapines. M1 reported using Amphetamines and Benzodiazapines and a brief discussion took place about the new social worker. Both children were at school and, according to M1, both reported to be enjoying it. Methadone reduction was going well and the plan was Benzodiazapines levels to be checked and work towards a reducing prescription, M1 to continue to collect methadone as prescribed, reduction to continue. Later an email was sent from the addictions key worker to SW2 with a detailed update of the visit and plan from that day.

On the 18.9.12 the SHA1 again expressed their concerns to the Social Worker in particular that S2's health needs were being neglected and that the parents were not consistently engaging.

"The social worker stated that she had visited the family and that M1 and F1 had assured her that they would start to engage with the Child in Need Plan, would attend the next meeting on the 25.09.12 and would engage with services. SHA1 was advised by the social worker that if parents did not attend the next meeting, then she should raise her concerns again."

This discussion is not included in the Northumberland County Council Children's Services IMR but seems to be a wholly inadequate response to repeated and evidenced concerns expressed by SHA1. It acts to compound the relatively superficial discussion the Social Worker had with parents on 12.9.12 and the impression that a longer-term perspective and a focus on the evidence that was available was not part of the analysis.

With a longer-term perspective it is not surprising that three days later on 21.9.12 the Addictions Worker informed the Social Worker of high levels of Benzodiazepines evident in urinalysis, despite M1's denial of illicit use. The Addictions Worker said she was sharing the information due to it being a *'safeguarding concern'*.

It is also important to note that M1 did not share the fact of her pregnancy with the Addictions Worker at either of the home visits on 9th August and 13th September. The School had known since July and the SHA1 and the Social Worker since 10.9.12. None had informed the Addictions Worker. This is a significant failure in information sharing practice around such a critical issue as long-term chronic substance misuse and care during pregnancy. In fact it appears that the Addictions Worker did not become aware of the pregnancy until 3.10.12 within the minutes of the care team meeting.

On the 25th September 2012, SHA1 attended a Care Team meeting. The Addictions Worker was unaware of this meeting and does not appear to have been invited. M1 denied knowledge of the meeting and also did not attend. The details of the meeting are important and are set out below as in the Northumbria Healthcare NHS Foundation Trust IMR:

"Significant information:

- *M1 had failed to respond to the messages left by the social worker but had informed school that she would like a meeting to be arranged as she would like to attend.*
- *S2 had been off school that morning.*
- *S2 had been half an hour late the previous day for school and had also been late on Friday 21 September 2012.*
- *S2 had 100% attendance until that day and only 1 late (last year's attendance was 73%).*
- *S1 has made a good start to the year, occasionally late (2-3 time in the previous week). S1 looked clean and well kept, had friends although sometimes he played on his own.*
- *The social worker had accessed the home on the 12th September and saw M1, S1 and S2. The social worker felt the visit was positive as there was food*

in the house, the home conditions were cluttered but acceptable and there was clean bedding.

- *SHA1 shared her concern about M1 appearing to want to engage but not being honest, historic non- engagement and unmet health needs.*
- *A years' worth of chronic neglect was acknowledged. There needed to be a support plan with very tight timescales for change or case needed to go to CP Conference.*
- *M1's pregnancy was starting to show, however she had not informed the social worker and the Ante-natal substance misuse service had not mentioned it in their information.*
- *M1 was denying using illicit drugs however samples that had been taken recently showed illicit use of benzodiazepines.*

SHA1 called the community midwives during the meeting and they confirmed that M1 had not booked in for antenatal care, had not been seen and no appointment or scan had been arranged.

The plan agreed was as follows:

- *Update the chronology to share with all agencies, including GP attendances.*
- *SHA1 to discuss with Northumbria Healthcare NHS Foundations Trust's Safeguarding Nurse Advisors.*
- *The addictions worker and social worker to mention to parents that they need to contact SHA1 regarding S2's eyes.*
- *SHA1 to send another letter to the parents (this was sent on the 27th September 2012).*
- *A written agreement to be completed by the social worker.*
- *The social worker to share information regarding the pregnancy concerns with the addictions worker.*
- *The social worker to visit M1 and F1 to share concerns and ensure access to appropriate pre-natal care."*

SHA1 had supervision with NA3, the same day agreeing the plan, requesting that a midwife becomes part of the care team and observing that *"changes needed to be sustained for a substantial period to evidence change for the children."*

There was ample evidence at this point that a child protection threshold had been reached, two key agencies certainly thought so and an investigation should have followed. This was another missed opportunity to escalate concerns by NA3.

Two days after the meeting, on 27.9.12, there is a supervision discussion between SP1 and SW2. The supervision record reflects on the historical child protection concerns. It then clearly states the current concerns regarding both children separately, recognised 'chronic neglect' over a period of 7 years and agrees a further period of 4 weeks to assess engagement, concluding that if there is no change then child protection enquiries will be undertaken.

There is evidence of planning at this point with a timescale, although the threshold for action had, I believe, as stated above, already been reached. However, it wasn't until 13.11.12 that the S.47 investigation was undertaken without any further social work contact in the intervening period. I can find no record of the agreement reached by Northumberland County Council Children's Services in supervision, in relation to a further 4 week period, being communicated to any other agency and most importantly to the children's parents. This should have happened. The note above that *"M1 was denying using illicit drugs however samples that had been taken recently showed illicit use of benzodiazepines."* appears to directly contradict the Northumberland County Council Children's Services IMR which states that during this period *"There is no evidence at this stage that M1 is misusing substances."* This is potentially an important and worrying confusion and reflects I believe the evident problems in reaching a coherent and shared multi-agency view regarding the safety of these children.

On 1.10.12 following a conversation with S2's Head Teacher SHA1 conveyed the parental account of the reasons why they hadn't followed up her Ophthalmology appointment to the Social Worker. It is evident again that the parents had not been honest with the SHA1 on 22.8.12. There is no sense in the IMRs that this led to any heightened scepticism or challenge of the parents in their work with professionals and the care they were offering to their children. M1 continued to offer no reason for missing S2's review, other than to blame the post for non-delivered appointment letters and to state that her memory was bad. It is not clear from the Northumberland County Council Children's Services IMR how these issues were put to the parents or whether they formed part of the Section 47 Investigation that commenced on 13.11.12.

On 10.10.12 the GP received a copy of a letter (dated 2.10.12) from SHA1 to the Paediatric Orthoptic department expressing concerns re S2's school achievements and failed appointments at the eye clinic. SHA1 asked for S2 to be reviewed. No action was taken by, or further discussion sought by the GP, nor information shared with SHA1. Even when on the 7.11.12 the GP is informed by the ophthalmologist that S2 had been seen on the 19.10.12, her glasses were changed and a review arranged for 2 months hence.

On 15.10.12 the care team meeting was cancelled due to unplanned court work for social worker.

The Addictions Worker contacted M1 on the 17.10.12 and the IMR noted:

"M1 states she had no idea she was pregnant… said she is happy about it. M1 plans to 'book in' on 22.10.12 and is also to visit her GP. Methadone reduction discussed and the risks to the unborn and possible miscarriage, M1 stated she wanted to be off methadone asap. Addictions key worker also discussed use of benzodiazepines and amphetamine use while pregnant and the concerns professionals would have. Plan – key worker to continue to liaise with other services involved. M1 to abstaine (sic) from illicit substance use. Next app – 31.10.12 -10am."

On the 6.11.12 an email was received by SW2 from the Addictions Worker reporting concerns that M1 has not yet booked in with a midwife to access ante-natal care. Contact with Substance Misuse Midwife had confirmed this and the importance of confirmation as soon as possible was reinforced as *"she is deemed a high risk pregnancy".* M1 in fact only 'books in' on the 15.11.12, after the Section 47 investigation had started. The Addictions Worker also expressed a concern that M1 was reverting back to avoidance behaviours and was sending texts and cancelling appointments.

Between the 8.11.12 and 13.11.12 when the Section 47 investigation was commenced, there was liaison between the Social Worker, the SHA1, S2's school and the Addictions Worker. The following issues were apparent:

- M1 was not accessing midwifery services.
- M1 was not engaging with the Addictions Service.
- School continue to have concerns about S2.
- M1's last urinalysis was positive for DF118's.

The following day (14.11.12) the Addictions Worker informed the Social Worker and MW1 that there are *"very concerning levels of tamazepam and diazepam"* in urinalysis and there were concerns that M1 had not booked in. M1 had also cancelled the Addictions Worker home visit. On 15.11.12 SW2 replies stating that S.47 enquiries had been started.

On the same day, 15.11.12, M1 was booked–in by the Community Midwife (CMW1). The Midwifery Early Pregnancy Assessment form (level1) was completed and sent to HV1. The Level 1 assessment included the following:

- *"Late booking more than 20 weeks (EDD April 2013).*
- *Unplanned pregnancy but M happy now.*
- *Question regarding history of children being subject to a child protection or CIN plan – the form states "No".*
- *M1 informed CMW1 that she did have a history of Northumbria Police involvement for shoplifting 5 years ago.*
- *M1 admitted that she has used drugs and was on a Methadone programme.*
- *M1 answered 'yes' to feeling down, depressed or hopeless in the previous month and to having little interest or pleasure in doing things.*

<u>Personal Maternity record states the following:</u>

- *M1 did not have a partner during the booking-in assessment.*
- *M1 did not have any mental health problems.*
- *M1 was on Gabapentin and Methadone 30mls daily (prescribed by the GP).*
- *M1 smoked 10 cigarettes a day – M1 was referred to smoking cessation.*
- *M1 did not drink alcohol; 0 units per week.*
- *M1 had 2 previous pregnancies*

- *M1 had also miscarried before 12 weeks in her third pregnancy but had not clarified when exactly."*

The Northumbria Healthcare NHS Foundation Trust IMR deals well with the inadequacy of practice and information sharing at this point. Although a referral was made to the Northumbria Healthcare NHS Foundation Trust Ante-natal Substance Misuse Service, there was no referral to the GP or mental health services or of any further follow-up or support visits. Most importantly there was no referral to Northumberland County Council Children's Services. The IMR summarises:

"There were assumptions made that someone else would take the required action. For example, CMW1 stated that the booking-in assessment should have triggered a referral to Children's Social Care (CSC), however she did not refer because M1 was going to receive her ante-natal care from the consultant Obstetrician and the substance misuse midwife and she assumed M1 would be referred to CSC by them… SMW1 informed the author that whether or not a referral to Children's Social Care is made is dependent on the judgment of the community midwife undertaking the assessment, which may or may not be the named / allocated midwife. SMW1 stated that some community midwives prefer to hand over the responsibility of referring to the named / allocated midwife, whilst others are happy to make a referral if required. SMW1 stated there was no written Standard or procedure in relation to this."

There are also important failures in GP safeguarding practice highlighted at this point in the Primary Care (G.P Service) IMR. When the GP received a copy of the early pregnancy assessment no action was taken. This was important because:

"…of M1's drug abuse history, previous child protection concerns, maternal mental health state and the fact that she was now pregnant. This also would have meant that surgery to manage her neck pain (abnormal MRI) was also now not an option. S1 was a teenager and S2 would have been only 6 years old, both very vulnerable."

Further information is received from S2's school on the 15.11.12 regarding erratic attendance and lateness. The Head Teacher also shares that M1 has confirmed that she has booked in with the Midwife.

On the 16.11.12 the Social Worker undertook three unsuccessful home visits and a failed attempted telephone contact.

On the 19.11.12 the monthly communication meeting was held between the Community Midwives and the health visiting team. These meetings, at the time, were not recorded and so any discussion or actions agreed are not available for scrutiny.

In preparation for the Initial Child Protection Conference (ICPC) the Social Worker seeks the assistance of S2's Head Teacher to make contact with the parents, however, this doesn't happen before the conference and in fact the last social work contact with the parents appears to have been on the 12.9.12. This is a gap again of almost two and a half months and it is a significant detriment to engaging with the family on a new safeguarding footing. It undermines the quality of the Section 47

investigation and may at least in part explain M1's departure in distress from the conference.

The Local Safeguarding Children Board procedures are clear in this respect:

"6. Enabling Parental Participation

All parents and persons with ***Parental Responsibility*** *must be invited to conferences (unless exclusion is justified as described below). Parents will be encouraged to contribute to conferences; usually by attending, unless it is likely to prejudice the welfare of the child.*

See ***Section 7, Criteria for Excluding Parents or Restricting their Participation****.*
The social worker must facilitate the constructive involvement of the parents by ensuring in advance of the conference that they are given sufficient information and practical support to make a meaningful contribution, including providing them with a copy of the Conference report (see ***Section 11.2, Social Workers Report to Conference****).*

Invitations for the parent(s) to attend the conference should be conveyed verbally by the social worker and will be confirmed in writing by the Safeguarding Unit.
The social worker must explain to parents/carers the purpose of the meeting, who will attend, the way in which it will operate, the purpose and meaning if their child is deemed to require a ***Child Protection Plan*** *and the complaints process."*

On 21.11.12 the Addictions Worker carried out a home visit. This had been planned as a joint visit with the Social Worker who was unfortunately off sick. M1 denied illicit drug use and was currently only using 10mgs Diazepam. M1 also denied any Amphetamine use. M1 said that she was not aware of any child protection concerns, appeared to know nothing about them and had received no calls or correspondence from SW2.

There was contact between the Addictions Worker and SW2 (15.11.12 and on the 21.11.12 following the home visit) and the SMW1 (23.11.12), however, it falls away following this point and there is no further professional liaison with the Addictions Service until 3.1.13. This is a gap in multi-agency practice that should not have happened, coming at the critical period just after the children being placed on child protection plans and should have been corrected through supervision and management scrutiny.

The Social Worker made a further attempt to see the family on the 23.11.12 visiting twice. The Social Worker also engaged the support of the Head Teacher on the 23.11.12 who emailed the father to let him know that the Social Worker wanted to visit them urgently.

On the 26th November 2012, M1 attended for a Hospital ultrasound scan and was found to be 23 weeks and 6 days gestation. The GP also contacted M1 in response to letters from child health about not going to orthoptic reviews. M1 said that she had been a few weeks ago and that S2 received new glasses. The GP recorded that this was confirmed by the recent letter (7.11.12).

On the 27.11.12 the Initial Child Protection Conference (ICPC) was held. S1, S2 and unborn Eve were all made subject to Child Protection Plans, category Neglect.

I have already described the difficulties in terms of supporting the contribution of the parents, however, it is important to review the invitation process to this meeting and whether after such a long period of concern and lack of positive change under a 'child in need' plan this was adequate to ensure proper analysis and planning?

The Northumberland County Council Children's Services IMR states that:

"Attendees at the ICPC were from Social Care, the Local Authority Legal Advisor, both S1 and S2's schools, Northumbria Police and School Health. Apologies were received from the GP, CP Named Nurse, Midwifery Named Nurse, Community Midwife and Ante-natal substance misuse service."

The Addiction Worker's manager did not attend the meeting and I would have expected given the apologies of the front line worker, the lack of a written report, the concerns being expressed by the service and the duration of their involvement that a manager's attendance at the meeting was warranted and that a verbal report to the social worker was not sufficient. There should have been more assertive practice at this point and it is also true to say that this was another example of the poor arrangements for the meeting given that no recorded documentation can be found in addiction health records that the conference had been arranged or any written invite received. Nevertheless the report analysis by SW2, based on the verbal update from the Addictions Worker, did explore the impact of M1's substance misuse on unborn Eve and is explicit about the concerns regarding M1's lack of engagement with the Addictions Service. This will have compensated to some degree.

The Northumbria Healthcare NHS Foundation Trust IMR states that the Community Midwifes were not invited neither was the SMW1 or HV1, although as is acknowledged by the NHS Commissioning IMR author that the invitation to health visitors was not a procedural requirement and the overview report has therefore made a recommendation in this respect. As for the GP the Primary Care (G.P Service) IMR states that:

"The GP was contacted to share information for a child protection conference on the 27.11.2012. The letter was sent to the GP on 22.11.2012, but only scanned into the notes on the 27.11.2012. In this case there was very little time available for the GP to write a report (which was likely to be a fairly large document and which would have taken considerable time.) The GP could have contacted the social worker by phone (and vice versa) if time was precious. Unfortunately no report was provided and the GP also didn't receive the minutes from the meeting. This left the GP out of the loop and potentially increased the vulnerability of the children."

I don't think that in these circumstances the contention in the Northumberland County Council Children's Services IMR can be sustained, that:

"…the ICPC appropriately considered the issues, levels and imminence of risk to S1, S2 and unborn Eve giving good consideration of the previous involvement and

historical concerns...The outline plan which was drawn up at conference was in the author's view appropriate and gave due consideration of the children's individual needs."

Critical professional involvement was absent. The invitation process was flawed and contributed in major part to inadequate information sharing at the meeting. Not only in terms of F1 but also in ensuring that robust planning was put in place for Eve. This should have been challenged by the Chairperson of the meeting and serious consideration given to a speedy reconvening of the ICPC to allow for proper arrangements to be put in place.

The ICPC also failed in its responsibility to agree an outline child protection plan that would meet the needs of the children. It did recommend a core assessment that should consider the *"capacity to make and maintain positive changes"* and the recommendation regarding a Public Law Outline (PLO). In interview with the overview author the Local Authority Solicitor (L1) attending the conference recalled that he had considerable concern regarding the welfare of the children at the ICPC and that his advice to the meeting was that the threshold criteria were met for an interim care order application. He had not been consulted prior to the meeting, or provided with any background documentation and although this is not procedurally required, given a case of this complexity and the duration of involvement one might have expected prior consultation to have taken place. The ICPC invitation letter to L1 was dated 22.11.12 and confirmed by telephone on the 26th November and this lateness perhaps reflects the poor organisation of the conference.

The use of a Letter Before Proceedings rather than seeking an order, at this point, was understandable and as the Legal Services IMR states "proportionate", notwithstanding the argument to be made later that a legal framework could have been considered much earlier in the case.

However, the lack of consideration and planning around the birth and discharge of Eve is a serious omission. The minutes of the ICPC records the legal advice as:

"L1 Solicitor said that the threshold for initiating care proceedings is met. The major concern relates to the unborn baby. M1 is misusing substances, was late booking in for antenatal care. The family have failed to engage with services provided. Parents have failed to prioritise the needs of the children both in relation to their health and school attendance; given the concerns the proposal is that a letter before proceedings is issued under Public Law Outline in order to make clear to parents the expectations of them in relation to their children."

The points made by the Northumberland County Council Children's Services IMR about the future procedural underpinning are useful in terms of supporting practitioners but the outline plan should have included, simply in terms of good professional practice, some detail/indication regarding birth planning. This should have also set out the issues that should inform any future decision-making in relation to any necessary legal planning for Eve as distinct from the other two children given her specific vulnerabilities. It is an interesting contrast that despite not being in the procedures Northumberland County Council Children's Services had convened a

pre-birth planning meeting on 05.9.06 prior to the pre-birth ICPC regarding S2. Practice fell short of this standard for Eve.

There was procedural confusion with number of documents apparently guiding action regarding substance misusing pregnant women and with no consistent cross-referencing between them. Documents include:

- Maternity guidelines on 'Management of Women who Misuse Substances in Pregnancy' - The guidelines clarify that both the community midwife and the substance midwife should remain involved in the antenatal and postnatal period. The guidelines do not specify whose responsibility it is to make a referral to Northumberland County Council Children's Services when required. The guidelines are out of date and state that the document is no longer authorised for use after June 2012. The Head of Maternity has already arranged for the guidelines to be updated.
- Department of Obstetrics and Gynaecology Maternity Guidelines: Ante-natal Care, Guideline No: 14, Issue 3, Booking Appointments, do however clearly state that it is the responsibility of the community midwife who completes the assessment at the booking-in appointment to make the referral to Children's Social Care if required.
- Since July 2011, there has also been a North of Tyne Child Protection / Child in Need Birth Plan protocol in place which is agreed by all of the hospital Trusts and LSCBs North of the Tyne.

The Birth Plan form states the following:

*"This form is to be used for **all** unborn babies who become subject to complex child in need or child protection procedures. The information is required by parents, hospital staff and other relevant agency workers involved in the child protection procedures. **Immediately following** the conference/planning meeting a signed and dated birth plan **is to be completed by the midwife and social worker** (typed if possible). It is their responsibility to disseminate the birth plan to there (sic) own relevant agency links for information. **The Chairperson will ensure** that the conference provides the necessary information. The form should be faxed to the delivery suite of planned birth and placed in the **ALERT FILE.** Further copies are to be mailed to the hospital unit of planned delivery for the named nurse/midwife for child protection, hospital medical notes, and SCBU to be sent within 48 hours of the conference/planning meeting/core group/care team meeting. A copy is to be given to parents"*

The procedural requirement as set out in this last document is very clear, unfortunately this document was not referenced in the LSCB procedures. The Northumbria Healthcare NHS Foundation Trust IMR observes correctly that:

"If a community midwife had been in attendance at the child protection meetings, the midwife might have reminded the Core Group of the need for a formal Birth Plan and this may have led to discussions regarding a pre-discharge planning meeting. It is always the responsibility of the community midwife and the social worker to ensure this happens in cases when the substance misuse midwife is not involved."

Of course there were real difficulties in this particular case but these should not obscure the insufficient rigor of the ICPC and the lack of challenge provided by the Chairperson to the multi-disciplinary assessment and planning undertaken.

- 2.4.2 Key learning themes

In February 2012 concerns for S2's presentation at school should once again have led to a more robust reflection on the children's welfare and in all likelihood a child protection response from Northumberland County Council Children's Services. The main issues apparent included:

- M1 flagging down cars to get S2 to Nursery.
- M1 continued and evidenced use of illicit drugs.
- Northumbria Police CCN regarding S1's drinking and parental dishonesty in their account of his behaviour.

Care team meetings in retrospect can give the impression of being snapshots of current events rather than providing a longer-term perspective and analysis, for example, the meeting on the 29.3.12. Additionally there was certainly a failure to resolve the issue of dishonesty as a basis for future work and to increase professional confidence in the parents' ability to utilize the help being offered and achieve the identified changes within their family.

A parallel area of concern, unknown to the care team meeting was emerging with respect to S1's dental health and information was not shared in this regard.

Core assessment and a chronology were identified as required by the Northumberland County Council Children's Services Team Manager in April 2012 but were not completed by SW1. This should have assisted decision-making and more timely intervention. It is not possible to say what the demands on the Social Worker or team were at that point and whether there were any significant barriers to completion.

Northumbria Police should have submitted a CCN on 20.5.12 in relation to S1's arrest for theft.

The care team meeting on 31.5.12 should have been a point, where more decisive child protection action was agreed and implemented. The social work supervision that followed almost 2 weeks later does consider the detail of the case; however, I would agree with the Northumberland County Council Children's Services IMR that it is difficult to understand the view that emerged. It may be that this is simply a misjudgment. It may also be an example of 'confirmatory bias' (Munro 2008), the tendency to form our views early and then unconsciously select and weigh the information emerging in a way that ensures our early beliefs will be confirmed.

There were significant gaps in professional contact with the family that may reflect the impasse that appears to have been reached in work with the parents but that should have been challenged much more vigorously. The Addictions Service was

unable to see M1 between April and August and critically the Social Worker was unable to see the parents between 27.3.12 and 12.9.12 following the change of social worker. Northumberland County Council Children's Services procedural guidance states:

"It is expected that a Child subject to a Child in Need Plan (ICS Initial/Child's Plan) will be seen as a minimum on a monthly basis by the lead professional, ACW unless otherwise agreed by the Team Manager."

This was not adhered to and there should have been more authoritative work with the parents and potentially earlier legal planning. Within supervision, given the known history at the time, it's surprising that the issue of engagement and this worrying drift is not more specifically addressed.

At the school health needs assessment, 22.8.12, M1 was initially dismissive of S1's requests to get his eyesight checked. M1 again appears not to be focused on the health needs of the children and misrepresents the appointments attended regarding S2's eyesight.

The safeguarding supervision provided to the SHA1 and Social Workers did not facilitate further reflection and error correction in terms of case planning. Only with M1's pregnancy was child protection action taken whereas significant concerns regarding S1 and S2 were known well before this point. It may be that the nature of neglect and the lack of a significant 'event' may have continued to obscure the true level of the children's needs. It is also the case that SHA1's concerns should, through supervision, have been escalated to more senior management levels. For the Addictions Worker, Multi-Disciplinary Team (MDT) advice was on occasion sought but there was certainly no point at which more senior manager escalation took place and concern expressed formally at a senior level regarding the plan for these children.

There was a significant information sharing failure by S2's school in July 2012 in relation to informing Northumberland County Council Children's Services that M1 was pregnant. A connection was not made between the failure to clearly share this information and the potential level of risk to the unborn baby. The two other children were also without school as a protective factor during the 6-week holiday, which ensued. There then followed further delays in sharing this information with the Addictions Service who at that time had the responsibility for M1's prescription.

SW2's first visit on 12.9.12 was, in hindsight, not challenging enough of the parents and it is possible that there was an element of 'starting again' clouding the relationship and analysis at this point.

Midwifery practice fell short of the standards of information sharing you would expect following the early pregnancy assessment completed at booking in on 15.11.12. Although a referral was made to Northumbria Healthcare NHS Foundation Trust Ante-natal Substance Misuse Service there was no referral to the GP or mental health services or of any further follow-up or support visits. Most importantly there was no referral to Northumberland County Council Children's Services. There were also significant failures in GP safeguarding practice highlighted at this point in the

Primary Care (G.P Service) IMR. When the GP received a copy of the early pregnancy assessment no action was taken. There is also a pattern of concern raised by Probation, S2's school and the Addictions Service regarding a lack of responsiveness from Northumberland County Council Children's Services. It is difficult to explain the extent of the information sharing failure in this case.

The invitations issued and attendance at meetings was once again flawed during this period and seriously undermined the professional assessment of risk. For example:

- 25.9.12 care team meeting – Addiction Service were unaware of the meeting
- 27.11.12 ICPC – Addictions Worker, Community Midwife, Specialist Substance Misuse Midwife and the GP were all absent.

At the ICPC there should have been challenge by the Chairperson of the meeting and serious consideration given to re-convening the meeting to allow for proper arrangements to be put in place, including the completion of reports by key professional such as the Addictions Worker and GP. I would agree with the Legal Services IMR that ideally more notice for the ICPC should also have been given but that the legal advice was clear and despite the concerns expressed in interview by L1 regarding the welfare of the children the need for L1 to escalate his concerns at this point is not clear.

The poor use of chronologies is referred to by the Northumbria Healthcare NHS Foundation Trust IMR and is apparently not completed as requested by the Northumberland County Council Children's Services Team Manager, although one was presented to the ICPC. Furthermore the value an integrated chronology during this period would have been enormous in highlighting the longstanding chronic neglect and the persistence of M1's drug misuse. It would also have provided other professionals with the evidence required to reflect on and challenge decision-making. This may have resulted in earlier child protection action.

There was a significant delay in conducting a S.47 child protection investigation. This could have been legitimately agreed at any point from February 2012. When the S.47 investigation did start on 13.11.12 it fell short of the expected standards of safeguarding. Despite the efforts made the parents were not interviewed prior to the ICPC on the 27th and had not been seen by SW2 since 12.9.12. The children's views were also not gathered. The meeting was clearly not compliant with the NSCB safeguarding multi-agency safeguarding procedures and these practice failures were a significant detriment in engaging with the family on a new safeguarding footing and developing a meaningful child protection plan.

The ICPC critically failed to consider the appropriate guidance and protocols and to make clear recommendations for planning around the birth and discharge of Eve. There was procedural confusion with a number of documents apparently guiding action regarding substance misusing pregnant women and with no consistent cross-referencing between them, this was a critical omission that continued throughout the work of the core group. This set the context for the persistent absence of coordinated action by the professionals providing care to Eve. This echoes the closely related

issue of pre-birth assessment, which is an underlying theme of poor practice highlighted in the 'Ages of Concern' document.

2.5 28/11/2012 to 08/03/2012

- 2.5.1 Chronology and Analysis

On the 28.11.12, SHA1 contacted S2's Dental Centre and was informed that S2 had not been seen for more than a year. SHA2 was also informed by the GP practice that S2 had outstanding immunisations. This information had not been available to the ICPC and no professional had sought GP (other than through the invitation to the ICPC which did not lead to any information sharing) or dental information. SHA1 was also informed that S1 had not been seen by the dentist since September 2011 (14 months previously) and had failed to attend a hygienist appointment and Northumbria Healthcare NHS Foundation Trust's dental service for fillings.

SHA1 unsuccessfully tried to contact M1 by telephone and subsequently wrote a letter to M1, hand delivered on the same day. Later that day SHA1 and the Social Worker undertook an unannounced joint home visit to share the dental information with M1 and F1 but there was no reply.

The Addictions Worker visited M1 at home on the 29.11.12. M1 reported that she was upset about the ICPC and had felt picked upon. The Northumberland Tyne & Wear NHS Foundation Trust IMR notes that the worker expressed concerns about ongoing illicit drug use and the implications this placed on the unborn. The plan was for M1 to be discussed with medical staff and MDT once urine results were returned. This discussion took place on the 29th but it is not clear to what effect. It is also not recorded what M1's reaction to these concerns was, although she stated she felt picked upon the detailed views of M1 about the level of concern regarding her substance misuse is not present in the description of professional practice.

On 30.11.12 a supervision discussion between the Social Worker and Senior Practitioner took place. On the same day a statutory child protection visit took place. There was a discussion with F1 and M1 regarding the ICPC and F1 was described as supportive of the plan and of working with the local authority.

A further statutory child protection visit took place on the 4.12.12. Concerns were recorded by the Social Worker regarding M1's presentation. She was under the influence of substances and admitted to taking 3 Valium at teatime to help manage her low mood. F1 was present to care for S2 who was also present and the Social Worker recorded that *"it is of concern that S2 has been cared for by her mother who presents like this"*.

The Northumbria Healthcare NHS Foundation Trust IMR, however, notes more detail regarding this visit as a consequence of the Social Worker discussion with SHA1 the following day. In particular that during the visit M1 had attempted to put the household electricity key in a normal plug socket and her speech was slurred. S2 was downstairs with M1. F1 was reported as being upstairs throughout the visit and did not come down to see the Social Worker. SHA1 asked the Social Worker if the

Children's Support Team (CST) were involved yet and monitoring the situation in relation to the levels of care the children were receiving and the presentation of parents. The Social Worker stated they were not but that she was going to speak to the Team Manager that day. A written agreement was also to be put in place.

This is a very concerning incident so soon after the ICPC and reinforces the concerns that were already present regarding:

- The safety of the children.
- M1's capacity to care.
- M1's substance misuse.
- F1's ability to act as a protective factor.

The Northumberland County Council Children's Services IMR addendum notes that the basis of involvement was considered at this time and that it was agreed to issue the Letter Before Proceedings. There is no further comment regarding whether any consideration was given to the capacity of the parents to care for the children at this point. However, regarding the incident the SHA1 written comments express the concern well:

"It concerns me that (SW) visited the family on Friday and F1 appeared shocked to hear about the extent of M1's drug use and was clear that he would engage and be a party of providing care for the children – then (SW) visits a couple of days later and M1 is under the influence of substances and caring for S2 while F1 is upstairs and the social worker is unable to see and speak with him (unsure if F1 uses substances). (Social worker) is going to be visiting multiple times this week and will speak with (Team Manager) today re CST and PLO letter."

Also on the 5.12.12, M1 failed to attend her first appointment at Northumbria Healthcare NHS Foundation Trust's Ante-Natal Substance Misuse clinic. SMW1 informed the Social Worker at the core group the following day.

On 6.12.12 the first core group meeting took place. There were once again significant gaps in attendance, M1 and F1 failed to attend and it appears that the Addictions Worker may not have been invited although the Northumberland County Council Children's Services IMR states that they gave apologies.

Key information was as follows:

- Addictions recently profiled M1's sample and this indicated significant Benzodiazepine use.
- S2 School has also recently informed social worker that she thinks she could smell cannabis on M1.
- A written agreement was completed but as parents were not at the meeting social worker will have to take it out to them to sign.
- Both children continue to be late for school.

- CST referral to be made re routines and budgeting, announced and unannounced visits to ensure parents are not under the influence of substances and are safely able to care for the children.

It is, I believe, very significant that the parents did not attend the core group meeting. There was no written agreement agreed at this point and there appears in retrospect to be a sense of unreality regarding the professional view of parental engagement and the seriousness with which the parents were taking the concerns about their care of the children. There appears to be no further discussion of the incident of the 4th, no birth planning, no discussion regarding the Letter Before Proceedings or the role of F1. In fact S2's Head Teacher is of the view that it was never agreed as part of the Child Protection Plan that F1 would be in the family home 100% of the time and felt that his role and the expectations of him as a protective factor were not made clear in the plan.

Furthermore the likelihood of the written agreement commanding some acknowledgement, respect and commitment from both parents has to be seen in the context of the recent visits and I doubt whether the agreement would meet any of these tests. The Northumbria Healthcare NHS Foundation Trust IMR notes that none of the health staff can recall contributing to or seeing the written agreement. It has been established during the conduct of this review that there is no record of the written agreement having been shared with the core group.

There seems to be a fundamental error in judgment and over optimism regarding the parenting capacity of both parents at that time as well as a lack of analysis and planning regarding what this may mean for the care of the baby and long term potential for change. The lack of core group planning for Eve is well recognized by the Northumberland County Council Children's Services IMR and is even more difficult to understand when one considers that the CMW1 and SMW1 were present at the meeting on the 6.12.12.

Following the meeting, SHA1 had telephone supervision with NA3 and discussed the information made available to the core group. The Northumbria Healthcare NHS Foundation Trust IMR author's view, which I agree with, is as follows:

"…that the above information should have prompted the nurse advisor to escalate her concerns (initially by contacting the social worker's team manager), about the delay in instigating child protection proceedings with regard to the 25th September, and about the safety of S2 whilst in M1 and F1's care on the 6th December 2012.

The nurse advisors should have also provided guidance and advice directly to the community midwives and informed Northumbria Healthcare NHS Foundation Trust's Safeguarding Children team covering acute services (team provides supervision and advice to the community midwives).

There is no evidence that the delay in M1 booking-in, her drug use, or the suggestion that the family might move, raised the alarm for the nurse advisors or prompted them to alert any other service internally.

NA3 should have been challenging social worker's decision with Team Manager or above, ensuring a chronology was completed to evidence concerns of long-term neglect and risks to unborn baby following birth. Also informing named midwife of concerns."

On 8.12.12 S1's School Attendance Manager visited the family home, M1 was aggressive and denied access – this appears not to have been communicated to the social worker.

On 14.12.12 the Social Worker undertook a home visit, F1 and M1 were at home. According to the Northumberland County Council Children's Services IMR there was a lengthy discussion between SW2 and parents regarding the concerns about the children and the impact that a new baby will have on the family. M1 appeared to be minimising the concerns regarding unborn Eve due to the fact that S2 was fine when she was born and the situation is the same. F1 appeared to be accepting of the concerns on this visit and agrees to *"assume the primary caring role of the children and ensure that their needs are being met"*. A referral was agreed to CST.

14.12.12 SH1 emailed SW2 to inform S2 did not attend the clinic appointment scheduled that day.

On the 17.12.12 the Social Worker carried out a statutory child protection home visit. M1, F1, S1 and S2 were present. On the same day the SMW1 informed SW2 that M1 had not attended the antenatal appointments offered.

M1 also cancelled her appointment with the Addictions Worker on the 18.12.12 stating her son was poorly. I believe there should have been more scepticism at this point and a visit insisted upon. This information was not shared with the Social Worker

On the 19.12.12 M1 did not attend her appointment at the ante-natal substance misuse clinic. The 'DNA' is recorded on PAS; however, there is no indication that SW2 was informed.

It is important to review what was known about the continued lack of engagement by the family in the approximately 3 weeks since the ICPC about which there should have been more challenge. The parents had missed the following meetings:

- Substance misuse ante natal clinic 5.12.12.
- Core group 6.12.12.
- S2 clinic appointment 14.12.12.
- Substance misuse ante natal clinic 19.12.12.

This picture is worse when the 8th and 18th December appointments are taken into account. Of course other contacts were made with the family, however, none of these serve to lower the concerns nor provide evidence of an assessment or intervention taking place.

On 24.12.12 the GP received a letter from the Ophthalmologist dated 4.12.12 stating that S2 was seen on the 19.10.12 but that the parents failed to bring S2 to a follow up appointment on the 3.12.12. This was not shared by the GP. SHA1 was also informed regarding the failed appointment, telephoned the parents and wrote a letter to them outlining her concerns and the agreed plan of action. SHA1 emailed the social worker and the GP. This was good practice by SHA1 and again evidences S2's ongoing experience of neglect.

On 28.12.12 CST conducted a home visit. M1 was present. Areas of work to focus on in the New Year were discussed.

The final discussion of the case in supervision between the Team Manager and Service Manager took place in December 2012. The Service Manager's belief is that the plan continued to focus on assessment under the PLO framework and that the Team Manager did not challenge this, adding in interview, that this was based on the baby not being left in the sole care of the Mother.

On the 2.1.13, M1 attended, for the first time, the Northumbria Healthcare NHS Foundation Trust's Specialist Substance Misuse Ante-natal clinic. This was SMW1's first contact with M1 (7 weeks after Booking-in on the 15th November which was the last time M1 was seen by a midwife). M1 was assessed by SMW1 and the Obstetrician and was 29+1 week's gestation. The lack of support shown to M1 and poor professional practice underpinning this delay is described by the NHS commissioning IMR as follows:

"The IMR shows no evidence that the CMW was contacting M1 to remind her of the need to attend the clinic. The author believes that the CMW had a pivotal role in ensuring M1 attended the clinic as early as possible even if that meant transporting her to the clinic or asking a member of the core group to undertake that task. A gap of 7 weeks was unacceptable and meant that Eve was exposed to greater levels of drugs, a fact borne out by the 2nd January hospital appointment details."

At the 2.1.13 appointment M1 disclosed using Benzodiazepines, she was uncertain of quantities or dosage but stated she used on a daily basis. A urine sample confirmed M1 was using Benzodiazepines and Cannabinoids. M1 was advised by the Obstetrician not to reduce her methadone until she was off diazepam for at least 3 weeks. There is no evidence in the records of SMW1 or the Obstetrician informing the Social Worker or the Community Midwife of M1's position. Given the need for information sharing around a family where the children and the unborn baby were all subject to child protection plans the lack of information to Northumberland County Council Children's Services and others is a significant failing.

However, on 3.1.13 SMW1 contacts the Addictions Worker, stating she feels that M1's Methadone reduction should be stopped and her Diazepam use addressed. The Addictions Worker attempts to contact M1 by phone, unsuccessfully. The NHS Commissioning IMR author again highlights the fundamental multi-agency shortcoming at this point:

"As soon as the Addictions service were aware that M1's methadone reduction programme had been stopped on 02/01/13 by Obstetrics and that they were taking

over the prescribing they should have contacted Obstetrics to discuss this deviation from the pathway protocol. This discussion should have been at a senior level, either senior managers or senior clinicians. The NHS Commissioning IMR author's analysis is that whatever the foundation for this breakdown in communication between the two services it was fundamental and continued until Eve's death."

Prior to this date, in fact in February 2012, a new medication, Gabapentin, had been prescribed by the GP, and a prescription for this was last collected by M1 on 3.1.13. The Northumberland Tyne & Wear NHS Foundation Trust IMR notes that the Addictions Worker was not aware of this medication being prescribed and there is no record of the GP informing the Addictions Worker.

On the 3.1.13, M1 and both children also attended for a pre-arranged clinic appointment with SHA1 who went with M1 to the GP surgery to book the outstanding immunisations.

On 3.1.13 there was a further CST home visit to complete the case plan. No one was at the home. This may have clashed with the above and again raises the question of visit coordination.

On 4.1.13 SW2 telephones L1 to advise that the Letter Before Proceedings was ready.

On 8.1.13 L1 advising Northumberland County Council Children's Services raised concerns by email:

"As I stated before I am questioning the use of the letter before proceedings here. The letter should have been sent immediately after the conference on 27 November which would have allowed time for parents to attempt to make the necessary changes. With the EDD of the beginning of March 2013 now instead of mid March I do not see how the parents can convince the LA that they can keep the children, particularly the new born baby safe. The current situation is of very significant neglect and chronic drug misuse. The baby is likely to suffer from withdrawal symptoms aggravating the difficulties in parenting."

Northumberland County Council Children's Services state that they have no evidence on the child's record of this email and L1 did not receive a reply.

Clearly the view of L1 should have been discussed with the Team Manager and have given pause for reflection regarding the overall realism of the plan. The legal services IMR also acknowledges that L1's email was copied to his line manager which should have provided a further opportunity for escalation of concerns regarding the plan. Although on this occasion no further discussion took place. There is also no evidence that it was discussed in the Social Worker's supervision that followed on the 9.1.13 or at the PLO meeting on 14.1.13. In the addendum provided by Northumberland County Council Children's Services the Team Manager view is noted as follows:

"…that had the e mail been copied into her she would have taken the issue up immediately with the Social Worker. In such circumstances it would be appropriate

for the e mail to have gone directly to TM1 and SP1 as part of the escalation process."

This again throws into sharp relief the plausibility of the child protection plan in relation to Eve and the assessed level of safety likely to be available to her as a new born.

A statutory child protection home visit also took place on 8.1.13. There was no answer at the home.

On the 9.1.13 a supervision discussion took place between SW2 and SP1, the analysis of the supervision record states:

"Northumberland County Council Children's Services are significantly concerned about the long term neglect for these children and PLO letter has been completed, the meeting will take place on 14/1/13. Should there be no change, court proceedings will be initiated and consideration given to the removal of the children."

The Public Law Outline (PLO) Letter Before Proceedings was hand delivered to the family on 10.1.13.

Although living in a different household on 11.1.13 an incident occurred in relation to S3, described in the Northumbria Police IMR as follows:

"Call received from a security officer at a local power station reporting that S3 was there and he appeared to have been assaulted and his shoes were missing. Officers attended and an ambulance was called. S3 initially stated that he had been offered a lift by 2 males in a black car who then drove him out to the vicinity of the power station and assaulted him. As he ran off from them he lost his shoes. S3 refused medical treatment and therefore taken to Address 1. The area was searched with a negative result, there were no signs of tyre tracks although the area was muddy. There was no CCTV in the area that S3 states he was picked up from. S3's clothing was seized as evidence.

S3 was spoken to in the presence of F1. He became very evasive and vague and his account changed when asked to clarify some points. F1 stated that he did not believe S3 was being entirely truthful. He was left in the care of F1 for officers to speak with him further the following day.

When officers re-attended S3 stated that he had not been assaulted and had not called Northumbria Police, this had been done by others and he did not want to speak to Northumbria Police. S3 signed a pocket notebook entry to this effect which was countersigned by F1. As no offences had been disclosed, no further action was taken."

I do not agree with the assertion that no further action was warranted. Further action was warranted under the Children Act 1989, the incident clearly meets the criteria for the submission of a CCN and because this was not done there was also no opportunity to explore the incident with F1 and assess its relevance or not for the other children.

14.1.13 M1 and F1 attended a PLO legal meeting with representation and although agreeing to the conditions of the letter, refused to sign the written agreement for some time, due to a dispute regarding the 'danger statement' (Signs of Safety terminology). F1 thought the wording was too dramatic and that the risks were not as high as described. The Northumberland County Council Children's Services IMR authors view, and I would agree, is that F1's attitude may have indicated that he was minimising the risks to unborn Eve and this may have been evidence of resistance to engagement in the overall plan.

There is, however, no evidence that the written agreement was signed prior to Eve being born on 09/03/13 (the PLO was discontinued on 25.2.13). The Northumberland County Council Children's Services IMR addresses this important aspect of case management in some detail and is set out below:

"It is the author's view that the PLO was a recommendation of ICPC on 26/11/12 (sic) and therefore should have been initiated promptly and before 10/01/12. In addition, it is also the author's view that despite the progress being made against some elements of the PLO written agreement, the family were not fully cooperating with the process. Although progress was being made with attending appointments for S1 and S2 and improvements were seen M1 becoming more stable in treatment, assessments regarding the role of F1 and the sustainability of change had not been achieved. It is the author's view that had the PLO review considered co-operation and engagement with parents in a more robust way, it may have concluded that insufficient progress was being made and considered initiating legal proceedings."

It is important to remember that at this stage the family had not been seen at home by the Social Worker since 17.12.12 and by CST since 28.12.12.

This meeting is referred to as a core group meeting in the Northumberland County Council Children's Services IMR and there is further comment that:

"The meetings are well attended by the multi-agency core group members. Parents failed to attend the initial Core Group. Both M1 and F1 were in attendance at the meeting in January which discussed the PLO".

This meeting (14.1.13) is not in the Northumbria Healthcare NHS Foundation Trust or Northumberland Tyne & Wear NHS Foundation Trust chronology, there is no record of an invitation in service 6 files, and so it is difficult to sustain the above or that this was a multi-agency core group meeting in the accepted sense. If so then there was a gap in core group meetings between 6.12.12 and 26.2.13.

On 15 January 2013, SW2 sent the Solicitor an email with a revised Working Agreement. The email states: *"…it is the danger statement that I have amended as F1 and M1 refused to sign as it was".* There was no subsequent communication from Northumberland County Council Children's Services to L1 to indicate whether the revised Working Agreement had been signed by F1 and M1.

CST visited on the 15.1.13 and a statutory child protection home visit took place on the 16.1.13. At the latter the Social Worker discussed possible amendments to the

"danger statement" to facilitate parental signature. Later in the day the Social Worker also contacted the Addictions Worker to arrange a joint visit on the 24.1.13.

On 16.1.13 M1 attended Northumbria Healthcare NHS Foundation Trust's Ante-natal Substance Misuse clinic with F1; she was unwell and extremely distressed and angry with Northumberland County Council Children's Services. M1 admitted to increased illicit use of Temazepam and Diazepam. M1 was still reducing her methadone regardless of the Addictions Service being told to hold the present level. M1 was also *"pleading"* for help regarding hospital admission for stabilization. The Obstetrician documented the following:

"Amphetamine tablets regular, no codeine, Temazepam, Diazepam, Cannabis, Methadone 24mgs. Advised to come in. Wants to come in on Monday, gives her time to get things sorted. Advised re amphetamines increasing blood pressure, stroke, bleeds and still birth. For 30mg Methadone until admission. Must not use diazepam on top".

In interview the Obstetrician noted that:

"M1 was unkempt, undernourished and looked 'terrible'... M1 was extremely distressed and informed her that the Addictions service was still reducing her script despite her asking them not to, on the Obstetrician's advice."

There is no evidence in the records of the Social Worker, the Community Midwife or the Addictions Worker being informed by the Obstetrician of the above information, or that CST and SW2 had felt as concerned by M1's presentation as the Obstetrician. However, the Addictions Worker has recorded that SMW1 contacted her on 16.1.13 to inform her. The Addictions Worker also recorded that she queried why M1's Methadone was being increased. The Northumberland Tyne & Wear NHS Foundation Trust IMR notes that the decision by the Obstetrician had been made *"without consultation with addictions – long term service provider"*, and that these concerns were escalated to the clinical lead and MDT. The Addictions service emailed SMW1 confirming the reservations they have and questioning specific aspects of the plan for M1. There does, however, appear to be a more fundamental dysfunction between the two services at this point.

The Northumbria Healthcare NHS Foundation Trust IMR describes the position as follows:

"The Obstetrician stated that due to the Ante-natal substance misuse service's lack of understanding of the need to admit M1 and due to the fact that the addictions worker had continued to reduce M1's Methadone when it was medically unsafe to do so, she contacted the manager herself. The Obstetrician explained to him her concern that a doctor who had not even seen M1 was reducing her dose given her chaotic drug use and explained how serious this was to M1's health and that of her baby.

The Obstetrician stated that the manager agreed with her and was shocked to hear that no one from his team attended the clinic and had not done so for over a year. He said that he thought they were attending regularly.

The Obstetrician explained the difficulty she was having and he agreed that M1 should be admitted and reassured her that he would speak to the team. They both agreed on the importance of the joint clinic. M1 was successfully stabilised on the ward.

The Obstetrician stated that she contacted the Addictions team, GP and the chemist with the details of her new script and follow up, on discharge following titration, on the 28th January 2013."

It is extremely serious that communication had become so poor in general between the two services and professional opinion so polarised. How such a breakdown in joint working could have continued for such a long period is a serious safeguarding concern and will be addressed further in the lessons learnt. The NHS commissioning IMR deals with these matters in some detail and I would support the points made in particular the very helpful opinion provided through independent specialist advice about the use of Methadone reduction programmes in pregnancy. In particular:

"The view of the Psychiatrist is that methadone reduction programmes are acceptable practice as long as the team providing care for the mother is communicating effectively throughout the ante-natal and post-natal period."

Furthermore:

"The NHS Commissioning IMR author also asked the Psychiatrist if the increase in M1's methadone from 24mg to 30mg during and after the admission to hospital in January 2013 was significant. The Psychiatrist's view was that the increase was so small and the amount of medication M1 was taking was well below the accepted maintenance dose of 60-120mgs and therefore it was not hugely significant. It is not clear in the relevant IMR if the Obstetrician's concern was about the Methadone reduction itself or the fact that the consequences of it were that M1 was using illicitly. The most appropriate course of action the Obstetric service should have taken was to approach the Addictions service and seek an expert opinion on how to proceed with M1's care, taking a unilateral decision to admit M1 and take over the methadone prescription was unhelpful and led to a further erosion of the MDT approach to M1's care. Equally Addictions had a duty to contact the Obstetrics service to try to understand the rationale for the admission in terms of M1's health and Eve's health and try to resolve the problem."

On 16.1.13 there is email correspondence from SW2 asking the Addiction Worker to contact her as soon as possible.

On 17.1.13 S2 and S1 are brought to the surgery by F1, and the immunisation acceleration/update schedule is started.

On the 17.1.13 the Addictions service received a call from the Pharmacist querying M1's prescription (increased by 6mgs up to 30mgs and daily pick up, chemist closed on Sunday). The Addiction Worker spoke to SMW1 who agreed to discuss the issue with the Consultant Obstetrician. There is, however, no evidence in the maternity records of the call, nor how the queries of the Pharmacist were responded to.

On 17.1.13 M1 also attended the GP requesting sleeping tablets.

The Statutory Child Protection Home visit of 18.1.13 highlights a number of positives even though F1 was still not happy with the written agreement and was to instruct a new solicitor.

- M1 has chosen to go into hospital for 'detox'.
- S2's school attendance has significantly improved.
- Both children have had their outstanding immunisations.
- Finances are now under control.
- S1 has been for an x-ray and there is now a treatment plan in place for the dentist.

On 21.1.13 M1 was admitted to hospital for stabilization of her drug use (titration), she tested positive to a variety of illicit drugs.

On the 22.1.13 the Northumbria Healthcare NHS Foundation Trust's Dental service confirmed that both S1 and S2 had attended for their appointment. SHA1 emailed the Social Worker with an update with regard to the situation.

24.1.13 CST conducted a planned home visit. F1 was at home and discussed dental issues with the worker. M1 was likely to be in hospital for 10 days. Both children seen but were keen to get out to play with their friends.

On the same day the Addictions Worker contacts SMW1, to be informed that M1 is doing well, she remained an inpatient, the current Methadone dose is 36mgs and she had also been given a prescription for Benzodiazepines.

On 28.1.13 S1 attended an appointment with Northumbria Healthcare NHS Foundation Trust's Dental service for further assessment.

M1 was also discharged from hospital on this date following titration and stabilization of her drug use. She was given a prescription on discharge by the Obstetrician. The Pharmacist, GP and Addictions Service were informed of M1's discharge. M1's drug testing on the 28.1.13 showed that she was not using illicit drugs.

On 29.1.13 the Addictions Worker contacted the Pharmacy and is advised that M1 is being prescribed 40mgs methadone and 10mgs diazepam. The Pharmacist is concerned as the prescription does not appear correct and she was going to contact consultant to check. Lines of communication regarding the prescription still at this point appear confused and it isn't clear why the Pharmacist is not asking the responsible prescribing doctor directly or why this wasn't clearly advised by the Addictions Worker.

30.1.13 Following an Addictions Service MDT meeting there was agreement that the Addictions Worker would email SMW1 for confirmation that Obstetrics will be continuing with the prescribing of the Diazepam.

On the same day (30.1.13) M1 attended an appointment with the Consultant Obstetrician at Northumbria Healthcare NHS Foundation Trust's Ante-natal Substance Misuse clinic. She was taking methadone 40mgs as prescribed and was happy with the dose. She had pain in both her fore arms, which was worse at night. On this date M1's drug testing showed that she was not using illicit drugs.

On 31.1.13 SW2 informed SHA1 about M1's Hospital admission for titration.

On the 4.2.13 the Addictions Worker emails the Addictions Service Clinical Lead Nurse & Service Manager to update regarding M1 and the prescribing from Obstetric clinic. The Addictions Worker had been informed by the pharmacy that a discussion had taken place with Obstetric Consultant and that Obstetrics are to continue to prescribe for M1. The Addictions Worker had attempted to contact SMW1 to confirm this, as the Addictions Service had not been informed of any plans in respect of M1. The email reply from the Service Manager stated that there needed to be a discussion with Obstetrics as to what the addictions role is with M1. The email was also copied to the Lead Consultant Psychiatrist for North of Tyne Addictions, (reply received on 11.2.13 stating she agrees with the Service Manager and adds, it requires a discussion at the MDT to agree a plan). There is no further mention in the IMR of the advice from the service manager being actioned.

Also on 4.2.13 the Addictions Worker contacted SMW1 to discuss M1's prescription. SMW1 confirmed that the consultant would be seeing M1 fortnightly so would probably continue with prescribing. SMW1 was to discuss with consultant and report back to the Addictions Worker.

On the 5.2.13 email from Addictions Worker to SW2, giving apologies for the forthcoming conference as she is on leave. She adds she does not have anything to report as Obstetrics have continued to prescribe for M1 whilst returning to the community. Given the above this was an opportunity to raise the alarm as a service regarding the liaison between Obstetrics and the Addictions Service. There should have been management action at this point to resolve the situation but this seems to have been difficult to achieve given the state of the relationship between the two agencies.

Two days later on 6.2.13 SW2 undertook a Statutory Child Protection Home Visit recording that *"home conditions appropriate".*

On 7.2.13 SHA3 contacted M1 to offer an appointment to share reports prior to the Review Child Protection Conference (RCPC) on 12.02.13. M1 declined (and F1 declined the following day), however, SHA3 shared the information verbally over the telephone. M1 disagreed with SHA3's recommendation that S1 and S2 should remain subject to a Child Protection Plan and stated that the health needs of both children were now being met.

11.2.13 Home visit by CST. Discussed the RCPC to be held the next day. S1 has a dental appointment at the same time as the meeting so M1 is planning to take him rather than miss it. M1 reported her stay in hospital went well.

On the same day the Addictions Worker visits the home but there is no answer.

The RCPC took place on the 12.2.13. It is unfortunate that parents and professionals could not have ensured that appointments allowed for M1's attendance at this critical meeting. Although it is understandable that M1 wanted to get S1 to his dental appointment, particularly given previous criticism in this regard, it is difficult not to conclude that this probably represented further avoidance of issues to do with protection of the children and proper engagement with professionals. It also contravened the stipulation that M1 would not have sole care of the children.

It is not clear whether M1's views were gathered in preparation for the meeting in the same way that SHA3 did on the 7.2.13. This is an important issue of practice in all families and in particular where denial, dishonesty and minimisation of professional concerns are such a feature. I think it likely that if M1's views had been sought they would have been the same as expressed to SHA1: minimising of concerns and partial in their acknowledgement of the risks to the children. The Northumberland County Council Children's Services IMR author felt that although the contact with S1 and S2 could have been more focused on their views and experiences there is evidence of their involvement in the assessment process. For example, use of the 'three houses' tools from the Signs of Safety framework in order to gather their views and seeing the children at home and at school. It remains an open question, however, as to how meaningful this engagement had been. Both children had lived all their lives with M1 and substance misuse, the involvement of Northumbria Police and physical discomfort in terms of eyesight and dental health. S1 was relatively marginalized at school and S2 was significantly behind her peers. How the children felt about this, what they wanted to be different, how they wanted to be parented does not come through in the records considered as part of this review.

In terms of professional attendance at the RCPC, the Obstetrician and Community Midwife did not attend or submit reports (although the Specialist Registrar Obstetrician was present) and L1 had given his apologies. This meeting was understood to be in all likelihood the last child protection conference prior to Eve's birth and M1 had only two weeks previously been discharged from Hospital after titration. In these circumstances I find it difficult to justify the lack of formal input and this is likely to have been an impediment to reaching a properly evidenced assessment and updated Child Protection Plan. Once again the Addictions Worker was not present and did not submit a written report, although they do appear to have been on the invitation list no invitation could be found in the Addictions Service records. It appears that the Addictions Worker was asked to contribute to the RCPC conference but informed SW2 via a verbal report that "she had nothing to contribute" given that Obstetrics had taken over the care and treatment of M1. As with the ICPC critical professional involvement was absent.

The SHA1's involvement had ended in late January though they did provide a report to the RCPC. The SHA1 in interview stated that her understanding from the Social Worker was that Eve would not be returning home, a decision she agreed with based on the evidence available.

The information presented to RCPC by schools noted some improvement; CST continued their involvement and noted that F1's presence in the household was

having a positive impact specifically in relation to arrangements for health and dental appointments. M1 was described as being stable in treatment for 3-4 weeks. SMW1 stated the following:

"This is a very positive change after many years of illicit drug use, that M1 would continue to be reviewed fortnightly or weekly and that toxicology would be undertaken."

In interview the Chairperson of the RCPC described all conference members as positive about the progress made and the prospect for continued change.

However, SMW1's report did not make any reference to M1's missed appointments since the initial conference nor is there any reference in the IMRs to the RCPC discussing the presentation of M1 during the home visit of the 4.12.13. There was little evidence of any assessment that might inform confidence levels about sustained change nor why past parental dishonesty and denial of professional concerns, key to the effective provision of help, had become much less of an issue. There was almost no information assessed in relation to F1 regarding his safety and this omission (a common feature of case work recognised in Ofsted's 'Ages of Concern' report) does not appear to have been recognized by any professionals or the Chairperson of the RCPC. The meeting appears to have taken some very short-term practical compliance and confused this with the understanding you would expect to gain from a comprehensive assessment and an analysis that addressed the confidence levels regarding satisfactory parental care for the children.

In terms of unborn Eve there appears to be little added from the initial conference in that there is no further consideration of assessment or of planning in relation to the birth and the North of Tyne Child Protection/Child in Need Birth Plan protocol is not considered. No legal advice was sought prior to the meeting, which as with the ICPC I would have expected given the nature of the case and that L1 had given his apologies. L1's concerns regarding Eve's safety, expressed in his email of the 8th January, also do not appear to have been shared at the meeting. This was an important omission and it is not clear why this should have occurred.

The Chairperson did highlight that it was early days and all professionals agreed that the Child Protection Plan for all of the children should remain in place. The main concerns were Eve's health post-delivery, the health of M1 and the increased vulnerability of the baby, with a plan as follows (set out in Northumbria Healthcare NHS Foundation Trust's IMR):

- Children to remain subject to a Child Protection Plan.
- M1 to continue to work with SMW1.
- Public Law Outline letter to be reviewed on 25.02.13.
- SMW1 stated that F1 must inform health professionals or the Social Worker if he thinks M1 is using illicit substances.

The Northumberland Tyne & Wear NHS Foundation Trust IMR also notes that the plan recommends that M1 is to continue to engage with addictions re illicit substances, however, Midwife 1 was at the conference and there is nothing

documented in the minutes to inform the meeting that the prescribing and monitoring had been taken over by the Obstetric Service. Again there appear to be basic flaws in realistic multi-disciplinary planning. There was also no shared written agreement in place, which would have been likely to help address this omission, and this was also not challenged by the chairperson of the RCPC.

The Northumberland County Council Children's Services IMR summarises well the inadequacies of the meeting:

"It is the author's view that the RCPC failed to take full account of the progress made against the Child Protection Plan. It did not explore in any detail the previous recommendations which were for PLO and family assessments regarding parents and sustainability of change. If full consideration had been given to assessing progress against the PLO recommendation, there may have been a multi-agency view reached regarding engagement. It is the author's view that progress at this point was in relation to practical appointments and getting the children to school. This was indeed positive, but there was still outstanding assessment work to be completed in respect of F1. It is clear at this stage that there had been little success in engaging F1 in any assessment work, but the conference did not explore the lack of progress against this recommendation. In the absence of any detailed assessment of F1, it is the authors view that the RCPC did not sufficiently explore the risk assessment around why F1 was viewed as the protective factor in the plan for S1, S2 and unborn Eve…It is the authors view that the Review Child Protection Conference did not hold the multi-agency care team to account for the planning around Eve's birth and discharge from hospital. The conference took place approximately 4 weeks prior to Eve's birth and, at this point, the RCPC had an opportunity to identify that the multi-agency Core Group had given insufficient attention to birth and discharge planning."

On the 13.2.13 M1 attended an appointment with the Consultant Obstetrician at Northumbria Healthcare NHS Foundation Trust's Substance Misuse clinic. Drug testing was undertaken which indicated M1 was not using illicit drugs.

On the 18.2.13 a Statutory Child Protection Home Visit was undertaken, no one was at home. On the same day there was a CST home visit. M1 was on her way out to the hospital about her arm so asked that it be rescheduled.

The GP also received a copy letter on 18.2.13 addressed to parents (also copied to SW2) from SHA3, suggesting a home visit on March 6th as discussed in the core group meeting. There were no notes from the core group meeting in the GP notes. On the same day the GP received a letter from audiology informing GP that S1 may be suffering from glue ear (failed hearing test) and that the parents were advised to book an appointment. This was following a referral due to maternal concerns about S1's hearing.

23.2.13 CST home visit to the family. M1 and S2 were present. M1 reported things were going well and that she was feeling positive.

25.2.13 Statutory Child Protection Home Visit. Both children were seen, home conditions were noted as appropriate and M1 and F1 agreed to sign the written agreement once final amendments were made.

The PLO review took place the same day, included L1 and concluded that the core group would monitor the agreement and plan. There is a difference of view as to whether the Public Law Outline (Letter Before Proceedings) was in fact ended which will be dealt with below. Regarding the ending of the PLO, again from the Northumberland County Council Children's Services IMR:

"…there was insufficient evidence of the sustainability of change and the progress made had not been tested over a period of time. The written agreement accompanying the PLO clearly outlines the expectations for both parents and is focused on attending school, various medical appointments, engagement of M1 with substance misuse services and other services. It does clearly say that F1 was to supervise the care of the children at all times. M1 and F1 agreed to the conditions of the written agreement. The written agreement makes no mention of the requirement in the Child Protection Plan for parents to engage in an assessment of their abilities to make sustainable change. It is the author's view that this should have been included in the written agreement. If it had been included, it would have become apparent at the PLO review that progress had not been made against this element of the plan and a decision could have been made to either continue with the PLO or to consider a legal framework. It is the author's view that the multi-agency Core Group did not pursue the completion of this assessment to consider sustainability of change and were overly optimistic about the progress achieved."

The PLO review and decision appear to have been made solely by Northumberland County Council Children's Services and the Northumbria Healthcare NHS Foundation Trust's IMR notes that health staff were not involved in the decision. The procedural guidance does not require any multi-disciplinary input into this decision. In interview L1 noted that it was stated at the meeting that there had been significant improvement. Furthermore that 100% supervision of M1 by F1 was clearly required and that this formed part of the written agreement that was to remain in place until Eve was 6 weeks old when it would be reviewed by the core group. The Legal Services IMR notes that:

"Although L1 was given very short notice of the plan that compliance with the written agreement and progress would be reviewed by the Core Group, being informed a few minutes before the meeting commenced, L1 did not object to this as the expectations were made clear to F1 and were reflected in the plan."

The Team Manager, interviewed for the Northumberland County Council Children's Services addendum, is clear that the decision was for the PLO to continue, monitored by the core group. However the addendum notes:

"However SP1 reports that in her recollection the Social Worker was certainly under the impression that the PLO had indeed been stood down and this is supported to some extent by the Social Work recording, immediately following the PLO review meeting on 25th February 2013, which states 'PLO process to cease with core group to monitor the plan and should concern arise then PLO/Care proceedings to be

initiated'. Significantly ST was not involved in the meeting despite having the primary role in supervising the Social Worker. Notwithstanding this a case record dated 13 March 2013 of a supervision meeting between ST and the Social Worker states, 'following the second PLO meeting it was agreed that significant improvements have been made and the situation will be monitored under a CP plan with no further PLO meeting envisaged ***unless*** *there is a deterioration in the family circumstances'."*

The Service Manager points to the key role of the Team Manager in these decisions but that the Senior Practitioner should also have been present at meetings, this would have the benefit of incorporating their separate supervisory roles where this is in place.

Even with the apparent weight given to positive changes it is difficult with hindsight not to see the positive change noted by professionals at this point largely as a direct result of the prospect of legal action as described by the 'Letter Before Proceedings'. It was not in my view appropriate to remove the very framework that may have been supporting some positive changes in parental behaviour at this point and particularly so close to the birth of Eve. And the apparent confusion between members of the social work team will not have helped the clarity of the relationship with these parents, which was so important to Eve's welfare. The Northumberland County Council Children's Services addendum notes that the social worker was in discussion about the case with both of her managers, and so it is not possible to set out any further factors that may have been relevant.

On 25.2.13 the Addictions Worker recorded that she received an email from SMW1 regarding M1's treatment plan: that the Consultant was to prescribe Diazepam. Again there is no record in M1's maternity records of this email. The information was provided by the Addictions Service from their records.

The core group met on the 26.2.13 and was positive about improvements essentially endorsing the view that was agreed at the RCPC. Attendance at this meeting was once again poor; M1 did not attend, neither did the Community Midwife and the SMW1 gave apologies. The minutes concluded:

"At the current time the concerns that led to the Initial Child Protection Conference and subsequent PLO meetings being held have greatly reduced; this is in relation to M1's illicit substance misuse and her inability to ensure that the children's health and educational needs were being met.

During the assessment it became apparent that F1 was not fully aware of the outstanding needs of the children and the extent of M1's failure to meet the needs of the children. Since this time, F1 has been fully involved in overseeing the care of the children and has been a key in the change of situation. M1 has undertaken a detox programme in hospital and has stopped her illicit drug misuse.

M1 is completing weekly screening which will inform whether or not she is using illicit substances. At the time of the meeting the Local Authority felt that the children's needs were being met by parents and would like for this to continue."

Once again the multi-agency North of Tyne Child Protection / Child in Need Birth Plan was not completed. In terms of planning for Eve's birth and subsequent care this was briefly considered rather than ignored but led to the perverse decision not to convene a meeting. The Northumbria Healthcare NHS Foundation Trust's IMR notes:

"At this meeting it was agreed that SMW1 would inform the social worker should M1 test positive for illicit substances and should this be the case, then the Local Authority would need to convene a meeting to implement a safety plan for the discharge of the baby from hospital, as at the current time there are no issues of concern for parents caring for the baby following the birth."

However, SMW1 was not present at this meeting, which highlights the risk of allocating actions to a colleague without clear communication and follow up.

The Northumberland County Council Children's Services IMR comments further on the issue of a pre-discharge planning meeting for Eve:

"It is the author's view that a pre-discharge meeting should have happened in order to reiterate the plan for Eve's return home. It would have offered the opportunity to agree on a multi-agency basis what the visiting pattern and frequency would be to the family and to share information in relation to the care Eve required post–natally. Eve was born in withdrawal and prescribed Oramorph in order to manage this. Social Care was not at this point asked to contribute to an assessment of parent's capacity to administer this, or to manage Eve if she was poorly. A pre-discharge meeting would have offered the opportunity to discuss this in some detail."

It is also important to note that the designated person for child protection for S2 also felt that:

"…it was never agreed as part of the Child Protection Plan that F1 would be in the family home 100% of the time. His role and expectations of him as a protective factor were not made clear in the plan."

Despite this reservation there was no effective challenge to the expectations and assumptions being made about F1 and his role as part of the child protection plan.

The Addictions Service were also unaware of the expectations on F1 that M1 was not to be left alone, as they along with other Northumbria Healthcare NHS Foundation Trust health staff had not seen the written agreement. The Northumbria Healthcare NHS Foundation Trust IMR also concludes that there is no evidence in health records that health staff were aware that Eve should not be left in the sole care of M1. The service 6 IMR points out that there is no distribution list available to them to identify who received the written agreement and who then may have provided an opinion of F1's ability to undertake this role.

26.2.13 CST planned home visit. M1 is stating that she is unhappy with some of the things said to her by SW2 and discusses this with CST Worker.

On the 27.2.13 M1 attended an antenatal appointment with the Obstetrician at Northumbria Healthcare NHS Foundation Trust's Substance Misuse Clinic. M1 was well apart from neck pain. M1 had missed her appointment with Neurology and was waiting for another one. Methadone 40mgs and Diazepam 10mgs was prescribed for 2 weeks. Drug testing indicated that M1 was not using illicit drugs.

On the 28.2.13, HV1 undertook an arranged home visit, no reply.

There was a pre-arranged joint home visit by HV1 and SHA3 on 6.3.13. M1 was at home with all the family. M1 looked well and engaged in discussions about her health and impending birth. The ASST1 was completed and advice was given about a range of subjects including safe sleeping. However, the Northumbria Healthcare NHS Foundation Trust's IMR questions, and I would agree, why only routine HV contacts were planned following this visit given the family's vulnerability?

8.3.13 SW2 rang the Addictions Worker to inform her that M1 was doing well with no apparent illicit drug use. SW2 confirmed the next visit to see M1 on 15.3.13.

- 2.5.2 Key Learning Themes

There was a failure to respond to the risks apparent during the Social Work visit on the 4.12.12. SW2 should have ensured that a competent adult was available to the children and should have insisted on a discussion with F1, especially as he was seen as a critical protective factor. M1's confusion and intoxication seems neither to have been addressed as a short term risk that day or factored into thinking about the general standards of care within the home, long term, and as they might be experienced by a vulnerable new baby. Although Northumberland County Council Children's Services states that this led to the agreement to issue the Letter Before Proceedings, this had already been agreed at the ICPC and in any case was not formally agreed until 14.1.13.

Not enough weight was given to the non-attendance of M1 and F1 at appointments from the first core group onwards. M1 also began to miss health appointments almost immediately after the ICPC. The core group failed to share information about failed appointments and this weakened multi-agency understanding of the overall position.

There were missed opportunities for the Nurse Advisors, providing consultation and supervision, to ensure that concerns were escalated to a more senior management level.

It continues to be difficult to discern purposeful assessment work taking place regarding the relationships within the family and why neglect was present in relation to S1 and S2.

There is poor information sharing practice following M1's first attendance at the antenatal substance misuse clinic on the 2.1.13. This is symptomatic of the confusion and lack of coordination that was emerging regarding the management of M1's substance misuse and critically the deviation from the pathway protocol. This

also includes the fact that the GP had been prescribing Gabapentin for M1 but had not informed the Addictions Worker.

There are significant differences of opinion highlighted in the Northumberland County Council Children's Services addendum with respect to the views of what should be done and what had been agreed within the service.

i) Prior to ICPC

The Team Managers views are set out as follows:

"Prior to the ICPC TM1 states that she had a discussion with SM1, her senior manager regarding the most appropriate framework to manage the case within. TM1's view was that consideration should be made to removing the baby at birth given the risks. According to TM1, SM1 did not agree and made the decision to manage the legal framework through a PLO… SM1 is clear that she was concerned that there was insufficient time for the family to turn things around before the baby was born but according to TM1, SM1 still wanted to proceed on a PLO basis."

The Service Manager understood the situation as follows:

"SM1 informed that she believes that she had a discussion with TM1 prior to the ICPC and gave her agreement for the child protection plan and for the Letter before Proceedings to be issued… SM1 believes that her advice around the Letter before Proceedings was clear. SM1 states that she did not record this on ICS as she was confident that it was a recommendation from the ICPC and that the Social Worker, Senior Practitioner and Team Manager would be aware of this as the social worker and Senior Practitioner attended the ICPC. "

ii) Content of ICPC decision

The Senior Practitioner views are set out as follows:

"In interview, SP1 stated that she was under the impression that there was ongoing debate about the PLO between TM1 and SM1 from the ICPC to January 2013, although there is no case recording of any such discussions. Significantly, supervision between SP1 and the Social Worker took place on 30th November 2012 in which it is noted that 'should change not be effected quickly…Public outline will be initiated'. This would suggest that neither SP1 nor the SW were viewing the PLO as a decision of the ICPC."

In relation to the Social Worker:

"On 17th December 2012 the ICS case note completed by the Social Worker following a joint home visit indicates for the first time that the Social Worker knew the PLO letter was to be progressed… There is a difference of opinion between TM1 and SP1 regarding the PLO, however, the minutes from the ICPC and the child protection plan explicitly evidence what had been agreed and expected. In any event, it is clear that by 17th December 2012 the Social Worker knew she was to progress the PLO letter but oversight of the timeliness of this was clearly lacking

given the lapse in time from the ICPC and the letter finally being issued in January 2013."

There was an unexplained delay in issuing the Letter Before Proceedings. More fundamentally the whole issue of the appropriateness of legal action, throughout the entire period of the review, appears to have placed too much emphasis on short-term compliance by the parents rather than evidenced change.

The decision to discontinue the Letter Before Proceedings was misjudged, it was not appropriate to remove the framework that may have been supporting some positive changes in parental behaviour and particularly so close and prior to the birth of Eve. Consistent with L1's concerns on the 8th January the letter before proceedings was active for only 6 weeks, a substantially shorter period than usual (approximately 3 months on advice of L1 advising Northumberland County Council Children's Services). This is accepted by Northumberland County Council Children's Services. My judgement is that the fundamentals of family functioning had not significantly changed and so I believe discontinuing the Letter Before Proceedings at this point sent very mixed messages to M1 and F1 regarding what they needed to do and what changes they needed to make.

It was also not possible to evidence that the Core Group knew what the expectations were, outlined in the Letter Before Proceedings. In these circumstances it would have been impossible for a core group to assess compliance and progress with the plan if they had not had sight of it.

The Legal Services IMR agrees that L1 appropriately raised concerns about the delay in commencing the PLO procedure but that in retrospect this communication would have benefited from being copied to TM1 thereby providing an opportunity for escalating discussions about how the case was being progressed.

The incident involving S3 and an alleged assault on 11.1.13 was inadequately investigated. It is impossible to draw any conclusions regarding S3's welfare at this remove, however, it must be relevant to consider in relation to the overall view being formed regarding F1's parenting and by implication how this was being exercised in relation to S1, S2 and unborn baby Eve. Essentially, did F1 influence in any way the retraction of the harm initially alleged by S3? The lack of a Northumbria Police CCN prevented a more rounded assessment of S3's safety. It also prevented any implications for S1, S2 and unborn Eve being considered.

The PLO review, 14.1.13, appears to have been designated a core group meeting by Northumberland County Council Children's Services although it is not included at all in Service 6 or Northumbria Healthcare NHS Foundation Trust chronologies. There was therefore a gap in core group meetings from 6.12.12 – 26.2.13. Given the circumstances of the case this is a significant period when considered alongside parental non-attendance on the 6th December. Northumberland County Council Children's Services acknowledges that the PLO review meeting should have been in addition to the core group, not instead of, though not why this may have occurred. The addendum also notes a number of procedural improvements throughout 2014.

More generally core group meetings failed to implement adequate planning for the children and for unborn baby Eve. Professional attendance was inadequate, M1 never attended, the Addictions Worker never attended and on the 26.2.13 the core group meeting actively rejected the need for a birth plan, despite it being a procedural requirement. The use of a written agreement was inadequate as it was not shared with other agencies and was only dated 25.2.13. This was not challenged by core group members or the conference chairperson. Neither is there evidence that the core group had knowledge of the expectations set out in the Letter Before Proceedings. These were serious safeguarding failures.

There were no shared understandings of the stipulations in relation to F1 and lack of consultation/involvement with the Addictions Service given their anticipated on-going role.

The Northumbria Healthcare NHS Foundation Trust IMR describes the confused recording with respect to this critical issue:

"What is confusing from the author's perspective is that the minutes of the actual Child Protection Review meeting state: Following discussions it was agreed that F1 would move into the family home and take on some responsibilities for his children and support M1 in looking after the children" and the summary states: "F1 has moved into the family home and is taking responsibility for ensuring S1 and S2 are ready for school. He has taken over and organised medical and dental appointments for S1 and S2 either taking them to the appointments himself or assisting M1 to do so". There is no reference made to the expectation that M1 would not be left on her own with either of the children and the minutes also state that "M1 was unable to attend this meeting as S2 had an appointment at the dentist.

The Core group minutes of the 26th February 2013, only makes reference to F1 "overseeing the care of the children" and the minutes of the Core group held on the 28th March 2013 make no reference to M1 not be left on her own with either of the children.

Given the above, it does not seem surprising to the author that the health staff stated during interview that they were not aware that M1 was not to have sole care of the children. The author does believe that they should have given further consideration to the risks to Eve returning home and the robustness of the plan."

The Northumbria Healthcare NHS Foundation Trust IMR sets out health attendance as follows (although it should be noted that in fact the Named Nurse was invited to the ICPC):

"Northumbria Healthcare NHS Foundation Trust's Safeguarding Children team covering acute services (which includes community midwives), received the invite on the 28th November 2012 (date stamped when received) and therefore it was too late for them to inform the midwives prior to the meeting; they did however inform the allocated midwife that the meeting had taken place… Northumbria Healthcare NHS Foundation Trust's Safeguarding Children team covering Northumberland Community services received the invite on the 26th November 2012. The team do not routinely attend the meetings and do not routinely check to see who has been

invited. The health visitors do not routinely attend Pre-birth Initial Conferences for unborn babies as this not expected in the LSCB policies and procedures."

"The school health service regularly attended the meetings and in fact only missed one Care Team meeting on the 29th march 2012.

The community midwives did not attend the Initial Child Protection Conference held on the 15th November 2012 (as not invited), nor the CPR held on the 12th February 2013. The only meeting that was attended by the community midwives was the Core Group meeting held on the 6th December 2012 when the named / allocated midwife attended (she had not ever met M1).

SMW1 did not attend the Initial Child Protection Conference (as not invited) but attended the CPR held on the 12th February 2013 as did the Dr (SPR in obstetrics and maternity services but for experience only). SMW1 attended the Core group held on the 6th December 2012, as did the consultant obstetrician for Northumbria Healthcare NHS Foundation Trust's Substance Misuse service. SMW1 and the obstetrician did not attend the Core group meeting held on the 26th February 2013 or the 28th March 2013.

HV1 did not attend the Initial Child Protection Conference or the Child Protection Review conference held on the 12th February 2013 (as not invited to either). The only meetings HV1 attended were the Core Group meetings held on the 26th February 2013 and the 28th March 2013.

M1 only attended one meeting and that was the Initial Child Protection Conference held on the 15th November 2012.

F1 attended the Child Protection Review conference held on the 12th February 2013, and the Core Groups held on the 26th February 2013, and the 28th March 2013."

It also appears that the Addictions Service did not receive a copy of the outline plan and conference minutes, which are essential tools in child protection practice and will have compounded the difficulties in establishing proper multi-agency working arrangements.

There was also an LSCB procedural requirement regarding an unborn child with a Child Protection Plan:

"The ***Core Group*** must be established and meet if at all possible prior to the birth, and certainly prior to the babies return home after a hospital birth."

The core group did not, however, meet prior to Eve's return home from Hospital.

The confusion in medical care for M1 with respect to her substance misuse may have contributed in M1 *"pleading"* for help and stabilisation with the Obstetrician at her clinic appointment on 16.1.13. There was a fundamentally dysfunctional relationship between Obstetrics and the Addictions Service of which this is evidence, although it is right to say that the precise cause of M1's presentation is not known. The long standing non-attendance by addictions staff at the joint clinic had

apparently not been recognised as an issue or resolved by managers from either service and it is not clear why such important joint working arrangements were allowed to deteriorate to such a point. This was a serious safeguarding failure.

Even after the breakdown in liaison is recognised by the Obstetrician and the Addictions Service Manager there is still confusion over the responsibility and management of M1's prescription after she is discharged following titration on 28.1.13. Lines of communication still appear inadequate and this now includes the Pharmacist who is concerned that the prescription does not appear correct. The necessity of resolving this through management escalation was not recognised and no action was taken despite the fact that the Addictions Worker also raised the case with the Clinical Lead Nurse and the Consultant Psychiatrist.

Further evidence of confusion relates to the fact that the SMW1 also stated in interview that they would not have agreed to weekly drug screening as envisaged by the written agreement.

Critical professional involvement was once again absent at the RCPC. The Specialist Registrar Obstetrician did attend (but with no written report provided) though the Addictions Worker did not and this must have contributed in part to a meeting that failed to focus on the progress in relation to assessment, the children's needs and the birth plan for Eve. It is not only that 'optimism' appears overly present but also it is the lack of analysis and basic safeguarding practice which is so concerning. It is also concerning that SHA1 had the understanding sometime between late January and the RPCP that Eve would not be returning home after birth. Evidence for this view and it underpinning the plan and for any subsequent change in analysis is absent from documents reviewed by IMR authors.

The children's experience was not at the centre of planning generally and was not sufficiently apparent at the RCPC on the 12.2.13. Both children had lived all their lives with M1 and substance misuse, the involvement of the Northumbria Police and physical discomfort in terms of eyesight and dental health. S1 was relatively marginalised at school and S2 was significantly behind her peers. How the children felt about this, what they wanted to be different, how they wanted to be parented does not come through in the records considered as part of this review. I think it was unlikely that the social worker was able to spend enough time with the children to develop a relationship and as recognised by the Munro review.

"…if we take the perspective of children and their parents, the most important activity work takes place when social workers meet children and families, try to communicate with them, work with them, and help them to change." **Munro review 2011**

2.6 09/03/2013 to 02/04/2013

- 2.6.1 Chronology and analysis

Eve was born on the 9.3.13. A Neonatal Withdrawal Chart was commenced following birth at 04.30hrs and continued until the 13th March 2013. There was regular monitoring of her progress in line with Hospital protocol. The Hospital contacted

Northumberland County Council Children's Services Emergency Duty Team (EDT) to inform of Eve's birth and asked EDT if a pre-discharge meeting would be taking place. EDT agreed to pass this message on to the social worker.

It was apparent on the 10.3.13 that Eve was requiring medication to control withdrawal symptoms. She was admitted to the Special Care Baby Unit (SCBU) to commence oral morphine. The plan to start medication was agreed with the Neonatal Registrar.

On 11.3.13 Eve was more settled on Oramorph and was able to be discharged to postnatal ward; M1 has been providing care for Eve. SW2 also contacted the Hospital on the 11th and left a message requesting call back as no one was available.

It also appears that on the 11th the Addictions Worker undertook an abortive home visit being unaware of Eve's birth. The Addictions Service became aware of Eve's birth only on the 14th (described below). There is no record of this information being shared prior to this by any members of the core group with the Addictions Service.

13.3.13 SW2 receives supervision from SP1. The analysis states that the parents were now fully engaging with the child protection process and the written agreement had been signed. The discussion concluded that there was no suggestion that the baby cannot return home. However, M1 must be supervised at all times by F1 and it was felt that this was achievable due to the fact that F1 is no longer working.

This was a fundamental aspect of the plan for Eve's safe care at home; however, it appears flawed given that on the night of Eve's death F1 was out of the home working nights. What is not clear is whether the parents were again, at the time, being dishonest regarding their circumstances or whether F1's circumstances changed and he later gained employment. In either case the lack of knowledge regarding F1, through discussion and assessment, once again appears to have led to a naïve acceptance of the likelihood of this critical aspect of Eve's return home being in place. Furthermore, if M1's care was so compromised that she needed 24-hour supervision by F1 this should have led to deeper reflection on M1's true capacity to parent Eve.

On 13.3.13 CST visited the home. S1 and S2 were seen and were very excited about the birth of their baby sister. F1 was cleaning the house to prepare for M1 and Eve's return from hospital.

Also on the 13.3.13 M1 was given a demonstration by Hospital staff of drawing up medication and gave Eve medication. Safe storage was also discussed. The Discharge Summary Letter specifies medication required from pharmacy and states; *"…please give 60mls bottle of Oramorph"*.

14.3.13 M1 and Eve were discharged from hospital. M1 was prescribed Methadone and Diazepam and Eve was prescribed Oramorph. SW2 was informed of M1's planned discharge and informed the Midwife that she would be visiting M1 and Eve at home the following day. The maternal and baby transfer records state:

"Baby Eve is being discharged on Oramorph and has an appointment on Monday 18th at 11am to review and make a program for reducing the Oramorph. M1 will liaise with her GP re gabapentin and ? Methadone."

Further in relation to M1's prescription the 'Notification of maternal transfer from hospital to community midwives' form states:

"Social services are involved and will visit tomorrow morning at 10am. "GP (GP has been crossed out), will resume her prescription of Diazepam 10mgs and Methadone 40mgs daily. Prescription given for 1 week."

However, the Northumbria Healthcare NHS Foundation Trust IMR author on further discussion with the pharmacy manager was informed that M1 was given a prescription (written by the Consultant Obstetrician) for 14 days and had her first dose on the 15th March 2013; her last dose was therefore due on the 28th March 2013.

14.3.13 letter from Advanced Neonatal Nurse Practitioner and Consultant was sent to GP summarising the circumstances at discharge.

On 14.3.13 a telephone call was received by SW2 to inform that M1 and Eve are to be discharged from Hospital. Information was shared by the Hospital that *"…baby is fit for discharge"*. Discussion recorded regarding M1's presentation in hospital and SW2 is informed *"…no concerns notes over M1's care of the baby".* SW2 advises that she will visit the family the next day (15/3/13).

On the 14.3.13 the Addictions Service MDT were updated by the key worker. Information had been received from Midwife Sister on the postnatal ward; M1 had given birth and had been discharged from the ward. She was in receipt of a prescription for 40mgs Methadone daily, 10mgs Diazepam daily and 300mg Gabapentin TDS (1200mgs daily). Baby Eve was discharged on Oramorph. The post natal ward Sister expressed concerns about the amount of medication M1 was being discharged with and stated she had had a long conversation with M1 about harm reduction and safety regarding medications. This was also the first time the Addictions Key Worker had been made aware that M1 had been prescribed Gabapentin. Because there was no multi-disciplinary pre-discharge meeting these conversations took place in parallel and so it was not possible to weigh against the comment to the SW2 that Eve was fit for discharge.

There was no discharge plan in place and MDT was reminded that concerns had been previously raised regarding the care and treatment of M1. A Home visit was arranged for 15.03.13 and an email sent to Northumberland County Council Children's Services requesting a core group and raising concerns again that no discharge plan was in place.

15.3.13 The GP received a speech therapy review regarding S2 from an assessment undertaken in March 2013, suggesting further speech treatment plan at school.

On 15.3.13 a Statutory Child Protection Home Visit was undertaken. Eve seen by SW2 and the parent's report she is sleeping and feeding well. She is clean and

appropriately dressed. Moses basket is clean and appropriate. Both parents reported to be appropriate and affectionate towards the baby and M1 advises that she is not using illicit substances. SW2 reiterates the importance of keeping appointments for S1 and S2. On the same day the primary midwifery post-natal visit is undertaken by CMW1. M1 feels well, noted *"…baby lovely, alert, good colour. Checks as charted. Artificial feeding well. No concerns today."*

Again on the 15.3.13 there was a home visit from the Addictions Worker. She accompanied M1 upstairs to change Eve and checked the bedrooms, as M1 had been reluctant to allow SW2 to go upstairs, the bedrooms were described as crowded but clean.

M1 expressed concern as she was unsure what the plan was in respect of future prescriptions. The plan of care was for the Addictions Worker to liaise with SMW1, (a message was left and SMW1 made contact on 27.03.13, see below). It appears from the chronology that this was the first successful Addictions Service home visit since 29.11.12 and when this is seen in the context of Addictions staff absence from meetings and not being copied into letters from the Obstetrician there has to be a concern regarding the marginalisation of this service from the planning for M1 and Eve. This is even more crucial given the responsibility for prescribing which the Addictions Service was expected to resume two weeks following Eve and M1's discharge from Hospital.

Further difficulties that are symptomatic of the poor information sharing and planning around Eve's birth also occurred on the 15.3.13 when the GP received a standard letter about the discharge of M1 with Eve. The GP also received on the same date a notification of maternal transfer stating that Eve "remained on the delivery suite" and that social services were involved and visiting on the following day. The Primary Care (G.P Service) IMR rightly notes that:

"Given the complications of this case, there should have been communication prior to discharge particularly regarding the fact that the baby had been prescribed oral morphine. This would have been more protective for Eve. In the event this critical information was not supplied to the GP until 27 March even though the letter had been dictated on 14 March (delays in typing and post). This letter was also received by the Health Visitor on the same date. This important letter to the GP does not appear on the chronology because it was not entered on computer records (and therefore probably not seen by the GP) until 22 April (5 weeks after dictation), after the baby had died."

In terms of planning and coordination it is also striking that 3 separate visits took place on the 15th March. It is not apparent that there was any coordination of contact with the family at this point both to provide proper scrutiny of Eve's care but also to respect this time for them as a family.

On the 18.3.13 the Consultant Paediatrician for Eve wrote to M1, and recommended continuing the dose of Oramorph for another week then review. The letter was copied to the GP, Health Visitor and Social Worker but not to the Addictions Worker.

The following day on the 19.3.13 M1 did not attend the midwifery post-natal contact at clinic. This missed appointment and subsequent action is not recorded in M1's maternity records. There is no record in the CMW1 team diary of the Social Worker being informed of this missed appointment.

Similarly on the 21.3.13 for the health visitor primary visit appointment there was no reply at the home. The HV1 tried twice during the day without success. HV1 also left a message on M1's phone asking her to contact her. HV1 informed the SW2 of the failed visit. SW2 stated that she had been to the family home since Eve was born and reported they were both well. There had, however, been no midwifery handover, other than the form in parent-held child's record. This gave very little information and in the context of the case should have been expected to record in much more depth.

This is the second failed appointment in the week since Eve's discharge from Hospital.

The health visitor later made contact with M1 opportunistically at the health centre and went through the content of 'Primary visit' Standard. The Northumbria Healthcare NHS Foundation Trust IMR makes the point, and I would agree, that it is expected that this contact is a home visit and that the health visitor should have followed up with a home visit at the earliest opportunity, given the significant need for support and monitoring.

The Addictions Worker again e-mailed the SMW1 on the 21st March, 6 days after the home visit asking about the plan for prescribing.

Also on the 21.3.13 the Addictions Worker contacted SW2 seeking confirmation of the next core group as no communication had been received. The worker also informed SW2 by email that she had been out to do a home visit on 15 March 2013, she stated M1 looked well.

22.3.13 M1 attended a drop-in clinic for a repeat blood test for Eve. She was seen by a Midwife who had not had any contact with M1 before. M1 informed the Midwife that she had already been discharged and therefore the Midwife assumed that the discharge summary had been completed. At the clinic there was also an opportunistic primary contact by HV1: with the plan for 6-8 week assessment, attendance at core group meetings, and support for family as required. The Northumbria Healthcare NHS Foundation Trust IMR notes and I would agree that:

"Given M1's vulnerability, drug dependency, recent titration and history of low mood I would have expected weekly visits initially unless M1 was being seen by drug and alcohol worker regularly – no evidence in records of discussion with substance misuse workers regarding their level of involvement. Need for proactive offer of support and continuous assessment of need and parenting capacity. "

At this point there appears to be very little historical perspective regarding the potential fragility of the care offered to the children.

22.3.13 Statutory Child Protection Home Visit. Eve, S1 and S2 are seen. M1 was said to have presented well and there was no evidence according to SW2 that she was under the influence of substances.

On the 25.3.13 the Paediatric Neonatologist wrote again to M1:

"Eve has been managing nicely with missing out on some of her night time morphine doses so she is now getting 1ml 5 or 6 times a day depending. I examined Eve carefully and found her in good health. I think the best way forward would be to continue to give her 1ml for another 2 days and see how she manages on 0.9 (90mcgs) over the Easter weekend and we will see her again on Tuesday after Easter."

It is not clear when this information arrived with colleagues but the letter was copied to the GP, Health Visitor and the Social Worker but not to the Addictions Worker.

On 25.3.13 a telephone call was received by SW2 from SMW1 to notify that Eve has not been brought in for the baby clinic today. Although Northumbria Healthcare NHS Foundation Trust IMR notes that there was no baby clinic held on this day or substance misuse clinic and so it is not certain to which clinic SMW1 is referring.

27.3.13 SMW1 contacted the Addictions Worker (following her contact on the 15.3.13) to discuss M1's medication including Gabapentin. SMW1 informed the Addictions Worker that she was unable to make contact with M1 and had had no contact with her since the birth of baby. SMW1 asked the Addictions Worker to attempt to contact M1 and the GP. This was presumably in relation to the need to transfer responsibility for prescribing back to the Addictions Service but is wholly inadequate in terms of the quality of liaison and timing. It takes place only 1 day before M1's prescription runs out.

Also on the 27.3.13 the Addictions Worker telephoned the pharmacy regarding daily pick up and the GP. The Northumberland Tyne & Wear NHS Foundation Trust IMR notes:

"Telephone call to GP, regarding the prescribing of Gabapentin, she was prescribed this and her last prescription was 03/01/13. Addictions Key worker was informed that prescribing was taken over by Consultant in Obstetrics on 28/01/13, no other prescription by GP. Telephone call by addictions key worker to SW2 to inform of this information, SW2 made contact with F1 asking him to get M1 to ring the midwife1. Addictions key worker had a discussion with the team manager and was advised to refer the benzodiazepine prescription back to GP or addictions take back prescribing responsibility and reduce by 2mg's per week."

It is acknowledged by the Northumberland Tyne & Wear NHS Foundation Trust IMR, and I would agree, that further effort should have been made to make contact with a member of the team looking after M1 by the Addictions Worker given the lack of response between the 15th and 27th March.

The SMW1 contacts SW2 on the same day. The Northumberland County Council Children's Services IMR states:

"(SMW1) informing that she will be transferring M1's care back to Ante-natal substance misuse service. There appears to be some confusion around M1s prescriptions - Maternity services are prescribing a benzo for M1 with Addictions refusing to continue this.

I voiced my concern that given M1 is stable that there needs to be some continuity of care. It is apparent that SMW1 is to speak to the GP to ask if he will continue to prescribe should addictions refuse. This needs to be addressed as this would be catastrophic for M1 if her care is not consistent. She is stable and has been since January and is managing with her current prescription. Discussed with SMW1 that M1 is doing really well and SMW1 confirms this."

The point remains regarding the inadequacy of planning around the continuity of responsibility for M1's prescription and it is simply not tenable for SMW1 to comment on M1's progress or for this view to be used in any way to confirm any other professionals view given that SMW1, by her own account, had not seen M1 since the birth of Eve. The worry that M1's prescription was not being handled well enough should have been escalated for management action at this point, if indeed it was felt to have 'catastrophic' consequences, and urgent reassurance sought that a clear transition to the Addictions Service had been made.

Prior to the death of Eve, M1 last attended pharmacy on the 28th March (Northumberland Tyne & Wear NHS Foundation Trust IMR), although this date is set as 27th March by the Northumbria Healthcare NHS Foundation Trust IMR.

The core group met on the 28.3.13. M1 once again did not attend and neither did the Addictions Worker. In spite of the conversation on the 21.3.13 seeking confirmation of a core group meeting date the Northumberland Tyne & Wear NHS Foundation Trust IMR can find no record of an invite or request for information. No midwifery professional was present either, although they had discharged M1 by this time. The general tone of the meeting is positive, this was recalled by the educational representative for S2 and it was noted that all children's health appointments were up to date and that M1 continued to present well with no evidence of substances. Whether the presence of F1 made it more difficult for professionals to be more forthright regarding continuing difficulties is not clear, but it was the case that key issues do not seem to have been aired in order to assist evaluation of progress and planning. Some professional difficulty in contacting parents was noted but the failed appointments for M1 were not. In particular there appears to have been no recorded discussion with respect to M1's prescription and the management of the transition of responsibility to the Addictions Service. In this light the absence of the Addictions Worker is particularly critical. M1's prescription ran out on the 28th and the confusion apparent from telephone contact between the SMW1, Addictions Service and Northumberland County Council Children's Services on the 27th is a critical safeguarding failure.

The Northumberland Tyne & Wear NHS Foundation Trust IMR author describes the failure as follows:

"Once M1 became pregnant there appears to be no effective joint working between Ante-natal substance misuse services and Obstetrics/Midwifery services in the latter stages of pregnancy, delivery and discharge planning. It is the opinion of the author that the Obstetric/maternity and addictions pathway was not followed. The pathway refers to joint care planning, regular meetings with Obstetrics and addictions and addictions to continue to prescribe, this did not happen. The author had poor information from the obstetric service and there is evidence of several attempts from the addictions key worker to ascertain what the plan was for prescribing both ante and post natal. The Obstetric team took over the prescribing without formal discussion or any history of M1 from the Addiction service. The pharmacist was the conduit at times for the prescribing regime pre and post-delivery that is out with care pathway. The Ante-natal substance misuse service (sic) attempted to identify their role with Obstetrics in prescribing as the hospital consultant continued to prescribe medication when M1 was discharged back to the community following titration. The author can identify a fractured communication process between obstetrics and Ante-natal substance misuse service with a pharmacist attempting to clarify medication required. There was no formal handover of prescription from obstetrics back to Ante-natal substance misuse services (sic)… The author was informed that working relationships are at times difficult with the Obstetric team in the hospital trust M1 chose to have antenatal care. The addictions staff have attempted to work with the obstetric team but informed the author at interview they have been excluded from patient meetings and not included in any decision making. The addictions clinical team manager stated that this does not happen within other areas."

In interview the Obstetrician's view (set out in the Northumbria Healthcare NHS Foundation Trust IMR) was as follows:

"The Obstetrician has stated in her statement that SMW1 contacted the chemist regarding M1's prescription on Thursday 28th March 2013 and they confirmed that the addictions team were taking over the prescription. SMW1 spoke to the addictions worker and confirmed the dose. The worker stated they would be decreasing M1's prescription for Diazepam and when SMW1 queried this, the worker stated "that's our policy"."

The Northumbria Healthcare NHS Foundation Trust IMR author contacted the pharmacy and was informed by the manager that M1 was given a prescription (written by the Consultant Obstetrician) for 14 days and had her 1st dose on the 15th March 2013; her last dose (14th day) was due on the 28th March 2013. However, prior to the death of Eve, M1 last attended on the 27th March (the pharmacy has a record of when M1 attended). Although the Service 6 IMR states that M1 last collected on the 28th.

The pharmacy manager stated that she remembered contacting the Addictions Service to inform them that M1 needed a new prescription and that she had not attended on the 28th. She remembered as she also discussed the 29th as it was the Good Friday bank holiday and the pharmacy was closed. (It is not clear which conversation between the Pharmacist and the Addictions Service this relates to and the Northumberland Tyne & Wear NHS Foundation Trust IMR notes conversations between the services on 27.3.13 and 2.4.13).

Notwithstanding this further confusion regarding the date of M1's last pick up of her prescription, on the 28th the core group meeting was viewing circumstances positively without the attendance of either the previous prescribing service, Obstetrics, or the service taking on that responsibility from the 28th, Addictions (the Addictions service do not appear to have been informed of the core group meeting). The failure in particular of these two specific services and the core group function generally to scrutinise and challenge arrangements, in order to ensure that M1's continuity of prescription was considered as the highest priority and to ensure the resolution of whatever difficulties existed between Obstetrics and Addictions is a serious and fundamental failure of safeguarding practice in this case.

On 30.3.13, 9.05am M1 rang 999 stating her 2-week-old baby had stopped breathing. M1 stated that she woke and found Eve like this lying in her arms. The call taker experienced difficulty in gaining the address and postcode for this incident as M1 was not only distressed but also was clearly slurring her words. The cause of the slurring has not been established. The call taker talked M1 through cardio pulmonary resuscitation (CPR).

On arrival the paramedic found Eve on the floor in front of the fire (this followed advice from call taker to place baby on floor or hard surface), the fire was not switched on. One of the crew opened the curtains to let the daylight in and light up the room whilst the other attended to Eve. The property was described as 'messy' with limited floor space to be able to attend to Eve. CPR was continued and attempts were made to gain Intra venous (IV) access. This attempt failed, basic life support was continued en-route to Hospital.

The history given by M1 to Hospital staff was as follows:

"On the morning of the 30th of March 2013 M1 had fed her at approximately 5.00 am with a bottle (approximately 3 oz) along with Oramorph 1 ml (she had given the Oramorph first and then the bottle). M1 then changed her nappy and lay on the settee with Eve lying next to her on the inside. M1 then fell asleep and was woken up by her son (S2, 14 years), who said that Eve wasn't breathing. F1 was working at night…and he got a taxi and came to the hospital directly."

Unfortunately after leaving the property it was realised that S1 and S2 had been left at home unsupervised, Northumbria Police were contacted via ambulance control to attend the address to support the two other young children.

Whilst interviewing the paramedic to establish their reasons for leaving the children unattended they advised they genuinely forgot the children were present due to the resuscitation attempts. To ensure this does not happen again the North East Ambulance Service IMR notes that their training department has been reminded to advise staff to ensure the safety of vulnerable groups when taking main carers or parents to hospital. Guidance has also been provided to staff on a Patient Care Update.

Eve was subsequently diagnosed to be dead in the ER Department after 5 minutes of CPR. Parents were consulted and all the Resuscitation team, including the

Paediatric team, the A&E team and PICU team were in agreement. Death was confirmed at 09.50 am. Mother was present and fully informed.

Northumbria Police informed Northumberland County Council Children's Services (EDT) that Eve had died.

The report of the skeletal survey taken later on 30th March 2013 showed a parietal skull fracture.

On 02 April 2013, the Addictions Service were contacted by the Pharmacist to say M1 had not collected her prescription since 28.3.13 and again that M1 could not be contacted on her mobile phone. A text was sent to M1 asking her to make contact with the service and a telephone message was also left with SW2.

Later on the same day Addictions Worker was contacted by SW2 to be informed that Eve had died on the 30.3.13. Appropriate arrangements were made to carry out a home visit to offer support and plans to reinstate M1's prescriptions. Both M1 and F1 were seen and were both clearly upset. Support was offered and discussion regarding a Methadone prescription took place. Confirmation was obtained as to how M1 received Methadone over the weekend. F1 stated that a prescription was given by a local hospital. The Addictions Worker spoke to the Sister on A&E who confirmed that Methadone had been given on Saturday and a prescription given for Sunday 31st March 2013 by the Hospital GP.

- 2.6.2 Key Learning Themes

There continued to be a significant misjudgment in terms of the reliance to be placed on F1 and the safe discharge home of M1 and Eve. There was little information sought or known about F1 prior to Eve's death and it was unrealistic to expect F1 to supervise at all times. This error was not corrected in supervision between the Social Worker and SP1 on the 13.3.13. In fact the seriousness of this misjudgment was all too apparent on the night and morning of Eve's death when F1 was in fact out working.

There were conflicting messages being given by Hospital staff regarding the levels of concern shared at Eve's discharge. The Social Worker was told that there were no concerns regarding M1's care of Eve whilst the Addictions Worker in a separate conversation with the post-natal ward sister was told of the concern over the amount of medication M1 was being discharged with. Because there was no multi-disciplinary pre-discharge meeting or birth plan these conversations took place in parallel and so it was not possible to weigh against the comment to the SW2 that Eve was fit for discharge. As the NHS Commissioning IMR concludes:

"There is no evidence in the IMR (4) that in the consultation with the Consultant Paediatrician the full details of the social history of M1, F1 and their children was shared in order for a risk assessment to be made to assess the viability of Eve being discharged home with Eve's NAS being managed by M1. There is no evidence that the Consultant neonatologist sought clarification of the home situation before agreeing the plan for Out-patient management of Eve's NAS and there is no

evidence that there was any contact with the SW who held key worker responsibilities."

This was critical given research quoted in the NHS commissioning IMR which states that:

"drug-exposed new-borns have increased neonatal mortality from sudden death syndrome in the short term, particularly in the low birth weight infant."

There was a significant gap in the Addictions Service contact with M1 between 29.11.12 and 15.3.13. When considered alongside the absence from meetings and exclusion from information sharing by the Obstetrician there was a marginalization of this service from the planning for M1 and Eve. This remained unchallenged at a senior level by the Addictions Service.

Information sharing with the GP was also delayed and they and the Health Visitor were not aware that Eve had been prescribed Oramorph until 27.3.13. The Primary Care (G.P Service) IMR rightly argues that this should have been done prior to discharge and that it *"…would have been more protective for Eve."* There is no reason why communication could not be timelier for such important issues.

Other professional views were being expressed and recorded that attributed progress in an unsupportable way, for example, the SMW1 confirmed M1 was doing well in a conversation with SW2 when SMW1, by her own account, had not seen M1 since the birth of Eve. It is not tenable for SMW1 to comment on M1's progress or for this view to be used in any way to confirm any other professional's view. The NHS commissioning IMR also makes the point that one would expect community health staff to be aware of the need to do on-going assessment of M1's ability to administer Oramorph to Eve safely and effectively, given her own drug use. This did not happen.

The worry that formed the earlier part of the conversation between SMW1 and SW1 that M1's prescription was not being handled well enough should have been escalated for management action at this point, if indeed it was felt to have *"catastrophic"* consequences, and urgent reassurance sought that a clear transition to the Addictions Service had been made.

Missed appointments and lack of professional contact again begin to occur very soon after Eve returned home, two in the first week. There are again failures in information sharing given that the Social Worker was not informed and not enough weight was given to this by health professionals. As the NHS Commissioning IMR states:

"Given all that has been cited above about Eve's vulnerability, all of which was known by the CMW, it is not best practice that one home visit was viewed as acceptable. In fact it is directly in contravention of the trust's guidance which advices daily midwifery post natal visits because of the risks of drug withdrawal. (In fact the midwifery service can remain involved with a family up to the 28th post natal day). As M1 did not attend that drop-in clinic the formal discharge process never happened, further destabilising the already vulnerable discharge process."

The level of visiting identified by the Health Visitor at the primary contact on 22.3.13 did not reflect the level of vulnerability and risk for Eve. This may have been related to the general sense of progress and optimism that flowed from the analysis of the RCPC and core group meetings. It may also reflect the inadequate midwifery handover that took place in this case as identified by the Northumbria Healthcare NHS Foundation Trust IMR.

There was inadequate practice around the transfer of responsibility for M1's prescription. M1 had expressed confusion, as had the Addictions Service and the Pharmacist. Neither the Obstetrician nor the Addictions Service attended the core group meeting on the 28.3.13, the day M1's prescription ran out. There were no arrangements in place and she had to get a prescription from the local Hospital to maintain her medication over the weekend. The failure of these two services in particular and the core group generally to ensure continuity of M1's prescription and the lack of urgency and escalation of this issue is another serious and fundamental failure of safeguarding practice.

3. SUMMARY OF KEY LEARNING

3.1 Views of Eve's Parents:

Both parents were seen towards the end of the review process following the court proceedings in relation to Eve's death. The purpose of the meeting was to listen to the views of both parents regarding the help that was offered to them as a family and to understand their perspectives on the important learning that arises from Eve's death.

M1 recalls being very happy with the pregnancy and that she had gone to the Hospital to detox.

She was happy with the service provided by the substance misuse clinic and found the most positive professional to be the family health visitor, who both parents felt was genuine and down to earth. They also felt that the community support worker provided useful practical support.

In terms of the earlier concerns regarding Eve's sibling's dental health, F1 felt that there was unfair criticism of their parenting because you would have had to be a Dentist to see what was wrong and that one child would often run away when an appointment was due. M1 felt that she should have watched over the children when they were brushing their teeth.

M1's view was that she did not understand the reason for Eve's death but that M1 suffered from fits and when M1 had woken up on the morning of Eve's death, she found that Eve was not responding.

Both parents felt that they didn't receive information about the dangers of co-sleeping and that dad wasn't included in discussions regarding this type of advice.

They both felt that this information giving should be improved. M1 stated that, "I should not have been co-sleeping on the settee with her".

Both parents felt that they were not able to trust the social worker and that communication was poor. In particular they felt that evidence would be interpreted negatively by the social worker and this contributed to a lack of a good working relationship. For example, a camera and tripod in the living room was described as *"suspicious"* when it actually related to F1's work as a photographer. The parents stated: *"They have their agenda, they are not interested in what parents say"* and that *"They never wrote the positive things down".*

Both parents found multi-agency meetings very difficult and formal and that they were not really supported to get involved. They felt communication was poor and stated that sometimes they didn't know that meetings were taking place. Both parents felt that the child protection conferences were one sided against the family and, for M1, although the chair showed some understanding this was not enough. Meetings would be improved if the understanding was better and practical help offered. The parents felt that professionals *"looked down on them".*

Furthermore they only received professional's reports 1-2 days before the meeting, sometimes only on the day of the meeting and that there was too much to read and really understand.

Also when there were lots of people absent from meetings they felt this didn't reflect the supposed seriousness and were left with a feeling that people were not really concerned but were just doing their job.

Overall, they did not feel the assessment or written agreement was of any value, they did not agree that the children were at risk and from their point of view no aspect of the assessment was correct. M1 felt that they were painted as *"bad people".* F1 thought that the social worker was working from a template and did not have a specific understanding of their family and was not interested in their views as parents. Overall they felt that there was a fundamental lack of fairness.

3.2 Understanding and working with children's experiences

Throughout the entire period of this review and specifically between January 2012 and April 2013 it is difficult to see the children's experience being considered as central to professional practice. The needs and behaviour of both parents is crucial to the children and of course professionals were seeking to assess and deliver services that were helpful, however, there is a sense of the needs of M1 and understanding the risk she might present overwhelming the ability of professionals to view events through the eyes of the children.

Both children had lived all their lives with M1 and substance misuse, the involvement of the Northumbria Police and physical discomfort in terms of S2's eyesight and S1's dental health. S1 was relatively marginalised at school and S2 was significantly behind her peers. How the children felt about this, what they wanted to be different, how they wanted to be parented does not come through in the records considered as

part of this review. I think it was unlikely that the social worker was able to spend enough time with the children that would allow this relationship to develop. And to develop from this relationship a plan of intervention sensitive to their needs and detailed enough to address the sorts of issues raised by Cleaver et al:

"Children's ability to cope is related to their age, gender and individual personality. Children of the same gender as the parent experiencing difficulties may be at greater risk of developing emotional and behavioural problems. Children's ability to cope is related to a sense of self-esteem and self-confidence; feeling in control and capable of dealing with change; and having a range of approaches for solving problems. Such traits are fostered by secure, stable and affectionate relationships and experiences of success and achievement."

Very early on the well-being of the children appears not to have been considered by the GP. According to the Primary Care (G.P Service) IMR they were *"overlooked".* This may be a function of the lack of opportunity taken by the GP to engage in the broader conversation with other professionals about the needs of the children.

Many other decisions appear to have been taken without consideration of the children's wishes and feelings, for example:

- S1's and S2's de-registration from the Child Protection Register in 2007, 2 months prior to M1's assessment by the Addictions Service.
- Offending behaviour, medical and dental issues for the children were not properly integrated into the shared professional understanding of the family. For example, S1's dental health (in March, July and October 2011, S1 was seen by 3 different GPs for gum swelling, dental abscess and toothache due to apparent inability to see a dentist) and S2's squint. This period also marked the beginning of S1's offending behaviour, burglary, in November 2009, aged 10. There was also the failure to follow up for S1's medical review in relation to a leg injury in June 2011.

There was also a significant gap during 2012 when the children were not being seen at home by the social worker and their experience of home life was largely invisible. It is not clear what focused assessment took place and there is a persistent gap in relation to understanding the children's views of their own *'safety and welfare'*. Why this was the case is difficult to understand, nevertheless I think it is likely that the children were suffering significant harm throughout this period and that child protection action could and should have been instigated on a number of occasions from 2004 up to the Initial Child Protection Conference (ICPC) in 2012 (excluding the period in 2006-07 when they were placed on the Child Protection Register). In their analysis of serious case reviews Ofsted (2010) have noted how some children were only able to speak about their experiences once away from the home and suggest this underlines the importance of providing a safe and trusting environment, away from carers, for children to be able to speak about concerns. For S1 and S2 this opportunity was never realised and may explain why so little was understood about their feelings.

Multi-agency safeguarding practice in relation to Eve was inadequate in most respects and showed little sensitivity to her need for the right level of care and protection. This is evidenced throughout most of the IMRs in relation to the absence of acceptable standards of multi-agency planning around her birth and discharge from Hospital, poor levels of midwifery and health visitor oversight following discharge, the confusion and lack of management of M1's prescription and Eve's needs as set out in the joint pathway between health professionals and the failure of the core group to escalate this concern as one of critical and immediate risk.

Understanding the needs of children through a meaningful relationship with them features in both the Daniel Pelka and Keanu Williams serious case reviews and was highlighted as a key safeguarding practice issue by Eileen Munro. It is likely therefore that this issue is not going to be restricted to work with this particular family and potentially underlies and challenges safeguarding practice in Northumberland, as it will in many other Local Authorities. As will be clear from the above my view is that this could potentially have a serious and detrimental impact on the reliability of safeguarding practice and the safety of children. Establishing a relationship with children in families where the adults are rejecting concerns and the help offered is difficult, but should remain central to the social work task.

Eve and her family were of white British descent with English as their first language. The family members' religion is recorded as Church of England. The family lived in a relatively deprived area with high unemployment although F1 had been self-employed at times. There is no evidence in the IMRs that practice was insensitive to racial, cultural, linguistic and religious beliefs.

3.3 Assessment, thresholds for action and decision-making

There are major flaws in assessment practice in relation to S1 and S2's needs prior to 2012 and to the multi-agency work undertaken in relation to Eve from September 2012 onwards. In addition there are examples of flawed application of thresholds and decision-making apparent in this case. The children remained as "children in need" for too long and although there was a period of child protection registration this was not particularly distinguishable from any other period in terms of the risks they were likely to be exposed to. The removal of the children's names from the child protection register in 2007 was over optimistic and unrelated to the facts of family life at that point or the evidence. Further evidence of risk was clear in 2009, 2010, 2011 and much earlier in 2012 than November, when a Section 47 investigation took place. Care team meetings in retrospect can give the impression of being snapshots of current events rather than providing a longer-term perspective and analysis.

It appears that any evidence of parental engagement or improvement, however short term, led to professionals becoming reassured very quickly. This was not corrected by either multi-disciplinary conferences or care and core group meetings. Some professionals did raise concerns throughout 2012 but this did not as a rule lead to child protection action and when it did, in November, the investigation fell short of the expected standards of safeguarding. Although attempts were made the parents were not interviewed; in fact they had not been seen by SW2 since 12.9.12. The children's views were also not gathered. The Initial Child Protection Conference (ICPC)

meeting was clearly not compliant with the LSCB multi-agency safeguarding procedures and these practice failures were a significant detriment in engaging with the family on a new safeguarding footing and developing a meaningful child protection plan.

It may be that "confirmation bias" was undermining accurate assessment at this point and that practitioners were overwhelmed by the case:

"The capacity to understand the ways in which children are at risk of harm requires clear thinking. Practitioners who are overwhelmed, not just with the volume of work but by the nature of the work, may not be able to do even the simple things well." **(Cooper et al 2003, Cooper 2005 in A Biennial Analysis of Serious Case Reviews 2005-07).**

No evidence has been presented regarding specific caseloads for professionals at this time so how much this factor was present is difficult to assess.

As described in other reports (Pelka, Williams and the most recent management review "John" in Northumberland) there was no attempt to clarify the background history in relation to F1, which is basic social work practice and a procedural requirement. F1 continued to be viewed positively whilst very little was actually known about him. This hypothesis should have been tested through evidence gathering and focused assessment.

The GP assessments of M1's wellbeing and capacity almost never led to any further action in relation to the welfare of the children and this was compounded by the lack of contribution to the child protection conferences in 2006, 2007, 2012 and 2013. Critical information was as a result not available to inform any assessments being made and subsequent decision making.

The safeguarding practice by the Midwifery Service was inadequate both in terms of engaging with multi-agency assessment and recognising when thresholds for action had been reached, for example, the failure to refer to Northumberland County Council Children's Services by the CMW1 at the booking in appointment on 15.11.12. It must also be of concern that the CMW1 did not have any knowledge of withdrawal symptoms in babies or the risks in relation to the management of a baby suffering withdrawal including the risks associated with Oramorph. Perhaps in part as a consequence of this the Community Midwife did not discuss the issues with M1 and did not consider the risks for Eve, make appropriate referrals or seek support in relation to her practice. The findings, with which I agree, of the NHS commissioning IMR in this regard are important to note:

"The midwives involved in M1's care had a pivotal role, they are the experts in the care from ante-natal, through delivery to post-natal care and the core group would be relying on them to share their expertise in terms of the particular features of this case. Those features meant that there were two key midwives, the CMW for general care and the SMW for specialist care around substance misuse in pregnancy."

There was no multi-agency birth plan for Eve and no multi-agency pre-discharge meeting to ensure that the proper assessments had been completed to gauge her

potential impact on the caring capacity of the family and to establish her safe return home. Mixed messages were given in relation to concern regarding the amount of drugs M1 was leaving Hospital with and whether Eve was fit to go home. Advice was given by hospital staff regarding administration and safe storage of Oramorph; however, in light of the inadequate planning in relation to Eve's discharge home, I do not believe that parental competence to administer Oramorph was established to a high enough level of confidence. There was no clear and robust plan regarding the management of M1's prescription or care pathway followed. These were serious and fundamental failures of safeguarding practice. The care pathway, that was so inadequately applied to the care of Eve, and support offered to pregnant substance misusers, was of concern in Northumberland in a 2008 Case Review. This reinforces the importance of resolving the underlying dysfunctional organisational relationship between Obstetrics and the Addictions Service that was present at that time, which could have potentially affected the care of other vulnerable babies. I would strongly endorse the NHS commissioning IMR's conclusions and recommendation in this respect. It is also to be noted that the relevant agencies have, during the course of this review, recognised the need to improve their systems, practice, the pathway and the assurance to the LSCB that it is working satisfactorily.

Northumbria Police could have raised concerns in 2009-10 and sought further discussion with Northumberland County Council Children's Services regarding the welfare of the children, if the pattern of Child Concern Notifications (CCNs) had been reviewed as a whole. The CCNs were focused in the main on poor supervision of the children. The incident involving S3 and an alleged assault on 11.1.13 was inadequately investigated. The lack of a Police CCN prevented a more rounded assessment of S3's safety. It also prevented any implications for S1, S2 and unborn Eve being considered.

Both Northumberland County Council Children's Services and Northumbria Healthcare NHS Foundation Trust IMR authors note the absence of chronologies as a working tool in Eve's case. The value of an integrated chronology during this period would have been enormous in highlighting the longstanding chronic neglect and the persistence of M1's drug misuse. It would also have provided other professionals with the evidence required to reflect on their understanding of risk and, if necessary, challenge decision-making. This may have resulted in earlier child protection action.

On occasion the Signs of Safety framework was used to help organise the assessment and analysis being done in meetings. For example, the designated person for child protection from S1's school is noted in the Northumberland County Council Education Service IMR as commenting that "*There is agreement that S1 was a victim of neglect but not that he was in danger, for example there were no scores of 0 at the Signs of Safety event."*

Interestingly a previous SCR also undertaken by Coventry LSCB (child W) examined the use of the signs of safety tool and reported:

"The Review Team concluded that problems resulting from the use of the tool were likely to be due to its application when the scoring is not clear-cut rather than a fundamental problem with the tool itself… The 'signs of safety' tool has much to

commend it and is now in widespread use in Coventry and elsewhere. The case under review revealed the possibility of ambiguous interpretation of its findings and a lack of confidence in some staff regarding results in the mid-range of its scale where there was an indefinite indication of risk."

There is no evidence presented by the Agency IMRs in relation to Eve that the Signs of Safety framework was a barrier to proper assessment and the understanding of risk or whether a lack of confidence following mid-range scores was present in relation to work with Eve's family.

One aspect of the case management that may have changed if intervention levels had increased earlier was the likelihood of legal orders being sought and being in place for Eve at birth, setting a safe framework for assessment, as apparently understood to be the plan by the SHA1 prior to the end of her involvement in January 2013. These children were not invisible, they had an allocated Social Worker, M1 had an Addictions Worker for a considerable amount of time and at the time of Eve's death all the children were subject to child protection plans.

In my view, cumulative professional misjudgement over a considerable period of time resulted in thresholds of concern not being adequately recognized in particular the threshold of "significant harm". Although it is difficult to attribute any of the circumstances of the case as directly relevant to the cause of Eve's death it is possible that had legal orders been sought then, following her birth, Eve would not have returned home to the sole care of her parents, until proper assessment had taken place in circumstances where Eve's safety was guaranteed away from the family home.

3.4 Commitment and contribution to multi-agency safeguarding and information sharing practice

Information sharing in this case often failed to ensure accurate assessments and plans were in place for the children.

Information sharing by the GP practice was inadequate and they were peripheral to the work with the family and the management of any risk. They neither attended or provided reports to critical child protection conferences in clear breach of the guidance contained in the GP toolkit for General Practice[4]. They were also omitted from the report distribution list on occasions, which compounded their exclusion from the safeguarding system. They had important information in relation to M1 on a number of occasions following appointments and did not consider the need to share with Northumberland County Council Children's Services. The Keanu Williams serious case review referred to the importance of assessments including all relevant agency information and two previous management reviews in Northumberland have

[4] Safeguarding children and young people. A toolkit for General Practice (2011) Royal College of General Practitioners (RCGP) and the National Society for the Prevention of Cruelty to Children (NSPCC)

found serious deficiencies in GP information sharing and engagement in multi-agency safeguarding practice. The question asked in the previous review was whether this was evidence of a wider 'cultural' development in local safeguarding practice and of a growing professional gulf between GPs and the investigation of safeguarding concerns? This was subject to a previous recommendation and will be returned to in this report's recommendations.

The Northumbria Healthcare NHS Foundation Trust IMR provides a clear analysis of the failure of the dental service to share information in relation to S1 with other professionals. This included the diagnoses of severe dental caries; extremely poor oral hygiene and that S1 had missed a number of important appointments for treatment. This suggests that the dentists did not consider that these issues may have been an indicator of neglect or that they had clearly thought about the possible social impacts on S1 and what this may have meant in terms of the parental care he was receiving. The dentists acknowledged that for many reasons, they struggle with deciding when a case reaches the threshold for further intervention. The Northumbria Healthcare NHS Foundation Trust IMR addresses this in recommendation 4. The NHS Commissioning IMR author has also made a recommendation for NHS England to ensure that private dentists receive safeguarding training in particular with respect to the impact of neglect on children dental health.

There was a significant information sharing failure by S2's school, an independent school, in July 2012 in relation to informing Northumberland County Council Children's Services that M1 was pregnant. A connection was not made between the failure to share this information clearly and the potential level of risk to the unborn baby. The two other children were also without school as a protective factor during the 6-week holiday which ensued. There then followed further delays by others in sharing this information with the Addictions Service that at that time had the responsibility for M1's prescription.

The Northumberland County Council Education Service IMR identified a number of learning points in relation to independent schools:

- *"there is the potential for conflict of interest between promoting a community ethos and keeping children safe;*
- *professional boundaries are crucial if challenge is to be effective and relationships are to improve rather than threaten safeguarding procedures;*
- *training should emphasise the identification of indicators of risk and a holistic multi-agency approach to safeguarding;*
- *professionals should be aware of and supportive to those inexperienced in child protection procedures;*
- *appropriate representation on school/academy Governing bodies is vital if standards are to be monitored and met successfully, particularly if the Head teacher does not have a background in teaching;*
- *lines of accountability with regard to safeguarding standards for Head teachers of Independent schools should be clearly defined."*

I would endorse the importance of the areas highlighted above and the recommendation with respect to the application process.

Of course the IMR and this overview report are not suggesting that one can attribute the failure to clearly report M1's pregnancy to the fact that the school was an independent school. However, the duty to safeguard children and the complexity of multi-agency safeguarding practice challenges do not, in my view, appear prominently enough in any of the independent school application documents reviewed, these include the application forms and relevant DfE guidance.

There is reference to a 'child protection policy and procedures' as a required document but to get any detail regarding safeguarding, for example, from Working Together 2013 or the Governors Handbook (s.4.9 Safeguarding and promoting the welfare of pupils), this has to done through links from the main documents.

Legal advice to this serious case review notes that:

"Section 175 of the Education Act places a duty on local authorities in relation to their education functions, the governing bodies of maintained schools and the governing bodies of further education institutions (which include sixth-form colleges) to exercise their functions with a view of safeguarding and promoting the welfare of children who are either pupils at a school or who are students under 18 years of age attending further education institutions. The same duty applies to independent schools . . . by virtue of regulations made under Section 157 of this Act…all educational settings to whom the duty applies should have in place the arrangements that reflect the importance of safeguarding and promoting the welfare of children set out in 'Working Together' 2013."

For there to be professional and public confidence in the ability of all independent schools to fulfill their statutory duties in relation to protecting children the application process and documentation should address safeguarding issues much more robustly.

The invitations issued and attendance at child protection meetings was insufficient and a consistent theme of practice from 2006 onwards. Professional understanding and commitment to safeguarding, as an essentially multi-agency practice, is not evidenced nearly enough. In 2006, there was a pre-birth meeting in relation to S2, which was good practice, but there were significant gaps in information and attendance at the subsequent ICPC. These gaps were not addressed in the assessment work that followed. The attendance at the child protection conferences of 2012 and 2013 was flawed as was the distribution of the outline plan and minutes (as indicated by Northumberland Tyne & Wear NHS Foundation Trust IMR), and it is likely that both meetings, whilst going ahead to ensure minimum oversight, should have been quickly re convened to allow proper arrangements to be put in place. As described earlier both parents felt that they were not given reports prior to the meetings in order for them to properly read and understand the content and that this affected their ability to properly work with professionals. They also felt that with the number of apologies for some meetings that this left them confused regarding the seriousness with which the issues were being viewed.

Where there were clear gaps in communication more assertive engagement should have been sought and management escalation used to assist improvements in practice. This did not happen. The NHS commissioning IMR also notes that:

"Northumbria Healthcare NHS Foundation Trust IMR also identified that even when professionals knew that they had not attended for whatever reason they did not read the minutes of the conference to familiarise themselves with the CP plan. The SMW admitted that although a copy of the minutes were in M1's records she had not read them and neither, it seems, had the CMW. This suggests that the staff did not understand the importance of the minutes as a multi-agency record of the family's situation as well as an aide to help develop a package of care designed to protect the children."

M1 did not attend any Core Group meetings and neither did the Addictions Worker. The Core Group did not implement an adequate Child Protection Plan for Eve and was not challenged by the Review Child Protection Conference (RCPC) in terms of the lack of a birth plan or written agreement and did not question the lack of knowledge of the expectations set out in the Letter Before Proceedings. A professional blind spot appears to have been present in the core group of the 28.3.13 where the critical issue of M1's prescription is not addressed at all. The core group was not therefore involved in drawing up a written agreement or in agreeing critical aspects in relation to F1's supervision of M1, and the recording of F1's role, noted in various meetings, is confused. There was a serious and fundamental lack of clarity regarding the protection plan for Eve.

The Head Teacher for S2 felt that there was a shared view of risk amongst professionals in the Core Group. The Head Teacher confirmed however, that to their recollection, a birth plan was never discussed. The Head Teacher was also surprised at the decision that M1 would medicate the baby herself, and the Head Teacher knew that M1 slept on the sofa every night with her children S2 and Eve. There is no evidence that this important insight was shared with other Core Group members. If known, it should have reinforced the vulnerability of Eve to health professionals and given a more urgent focus to the work with M1 and the assessment of whether Eve could be safely cared for at home.

SHA1 did challenge and raise their concerns repeatedly in relation to the older children. All of the other health staff interviewed by Northumbria Healthcare NHS Foundation Trust stated that they felt able to challenge but did not feel any necessity to challenge the decisions.

There were discussions regarding the effectiveness of multi-agency liaison between the Obstetrician and the Addictions Service Manager but these did not lead to a demonstrable improvement in information sharing and joint action. The Core Group had a role in formally calling attention to these deficiencies but did not do so. Even with the benefit of hindsight the evident vulnerability for Eve was high and more leadership should have been given by those providing supervision to escalate concerns to more senior managers. The circumstances around the risks were evident and were known to the multi-agency team, which are summarised well in the NHS Commissioning IMR Report:

"Eve was 3 weeks old when she died, her vulnerability was profound:

- *She was unplanned,*
- *M1 had delayed seeking ante-natal care.*
- *M1 had abused a variety of drugs while pregnant.*
- *She was born into a household with a long history of neglectful parenting.*
- *She was the subject of a Child Protection plan for neglect.*
- *She was small at birth.*
- *She was suffering from withdrawal (NAS).*
- *She was on medication (morphine).*
- *She was co-sleeping with M1 on a settee.*
- *None of the information listed above has been obtained as a result of information gathered for this review, it was all known (SIC, bar the co-sleeping, which was known only by the Head Teacher), by the professionals working with the family at the time and if it had been used and acted upon, Eve's vulnerability would have had the recognition it needed. Eve's vulnerability was acknowledged in the Child Protection plan; there is "increased vulnerability of the baby": this statement should have translated into actions by all the professionals involved in her care in the form of a birth plan, hospital discharge meeting and a co-ordinated, intensive visiting plan once M1 and Eve returned home."*

It is difficult to explain the extent of the information sharing failure in this case and one can only consider whether Cooper et al comments regarding "overwhelm" is an unrecognised, but fundamental, feature of professional practice in relation to these children. If this is a legitimate theory as to "why" practice was the way it was, then this in itself requires further investigation and explanation.

3.5 Reflecting on practice: supervision, professional challenge and leadership

The supervision of practitioners working with Eve's family does not appear to have allowed for challenge and any error correction in thinking, analysis or planning. Although supervision with the School Health Advisor did log child protection concerns, it was only following the pregnancy of M1 that a S.47 investigation was undertaken. Escalation should have raised these concerns at a more senior level in Northumberland County Council Children's Services.

The ability of professionals and organisations to critically reflect on their practice is an essential component of a safeguarding system that is able to protect children. Burton's (2009)[5] key messages are worth reiterating in full:

- Assessments are fallible, and contexts constantly changing. Therefore, professionals need to keep their judgements under constant critical review (Munro 2008)

[5] C4EO Safeguarding Briefing 3, November 2009. The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?

- The single most important factor in minimising errors is to admit that you might be wrong (Munro 2008)
- Nonetheless there is a tendency to persist in initial judgements or assessments and to re-frame, minimise or dismiss discordant new evidence. Bias is inevitable and comes from the many ways our minds can distort, avoid or exaggerate information.
- On the other hand some practitioners can respond to new information, not by sticking to their preferred view, but by jumping around from one item or theory to the next, never reaching a coherent conclusion or coordinated response.
- Therefore, practitioners must be willing, encouraged and supported to challenge, and where necessary revise, their views throughout the period of any intervention.

She concludes that:

"Supervision should provide a safe but challenging space to oversee and review cases with the help of a fresh, experienced pair of eyes and to systematically guard against either rigid adherence to a particular view or the opposite tendency to jump from one theory to another without resolution."

The supervision of Social Workers does address important items of evidence but failed to recognise the extent of the lack of engagement by parents, the importance of the children's views and the absence of a relationship with them and appears in retrospect to adhere too rigidly for too long to the view that the threshold for child protection action was not reached or that evidence was "thin". A Northumberland management review in 2011 recommended that:

"Northumberland County Council Children's Services should review the supervision guidance and the training support in place to consider whether it is fit for purpose and making recommendations for improvement. This should include how best to support critical reflective thinking and deliver regular in-house consultation to reinforce the supervisory function."

Another management review in 2013 found supervision remained an issue and on the basis of this serious case review the above recommendation would still appear to be relevant.

As with another recent management review in Northumberland there was no evidence found that the GP Practice contacted the safeguarding team, designated nurse/ doctor or named GP for advice or support. Again I think it is likely that this is a widespread issue in Northumberland and one that reduces the ability of GPs to act in the best interests of children when their safety is at risk. It was the subject of a previous review recommendation and will be returned to in this report's recommendations.

CMW1 informed the Northumbria Healthcare NHS Foundation Trust IMR author that she had not received any safeguarding children supervision for more than two years and SMW1 had not received supervision since the 28th August 2012. It should also be recognised that there is an individual professional code of conduct duty to seek

appropriate support and supervision, however, in response Northumbria Healthcare NHS Foundation Trust have confirmed that they have already made plans to improve and monitor this situation.

The Addictions Worker received both management and clinical supervision for this case from their line manager, although this was not always recorded within health records. The children were on a 'child in need' plan during the majority of the time scale of the review so specific safeguarding supervision was not required. However, once subject to child protection plans safeguarding supervision did not take place.

Much more challenge should have been provided by the child protection conferences and in particular by the conference Chairperson. In terms of the assessment, information to and professionals attendance at, meetings, engagement with parents and the procedural guidance which should have been followed in relation to the planning for Eve's birth and hospital discharge.

3.6 Procedural guidance and recording

There was procedural confusion with a number of documents apparently guiding action regarding substance misusing pregnant women and with no consistent cross-referencing between them. Since July 2011, there has also been a Northumberland Child Protection/Child in Need Birth Plan protocol in place which is agreed by all of the hospital Trusts and LSCBs North of Tyne. The procedural requirement as set out in this last document is very clear; unfortunately this document was not referenced in the LSCB procedures. This lack of procedural clarity was a critical omission that continued throughout the work of the core group. This set the context for the persistent absence of coordinated action by the professionals providing care to Eve.

I believe that both the ICPC in November 2012 and the RCPC in February 2013 should have been re-convened and that they failed to scrutinise professional practice and compliance with procedural guidance.

As stated previously it is difficult to identify comprehensive assessment work and any that did take place did not consider information regarding F1 as central to an understanding of the family. Few practitioners involved in this case appear to have completed the LSCB training 'Working with Hostile and Un-Cooperative Parents'. Not all appeared to be aware of the guidance and this may have hindered professional confidence in working with the family.

Proper case recording is also fundamental to professional safeguarding practice. The Northumbria Healthcare NHS Foundation Trust IMR, however, notes serious weaknesses in relation to recording by midwives, and I would endorse the recommendations made by this report and the NHS Commissioning IMR Report. It should be noted that the Northumbria Healthcare NHS Foundation Trust has already taken steps to improve this issue.

The Northumberland, Tyne & Wear NHS Trust IMR is also clear that record-keeping policy was not always followed and very often telephone calls and emails were not recorded or uploaded onto the health records electronic system. The Northumberland, Tyne & Wear NHS Trust has taken immediate action to ensure all

emails etc and Multi-Disciplinary Team meetings are recorded in patient's health records.

3.7 Organisational factors

Whilst most of the IMR authors have not identified any major adverse impacts of any organisational factors on service delivery the general uncertainty that the change in the NHS produced is raised by the NHS Commissioning IMR author, who notes that some of the services in this review underwent a transfer of employment from Primary Care Trusts into acute Foundation Trusts. This resulted in changes of management personnel and structures.

There is a comment in the Northumbria Healthcare NHS Foundation Trust IMR with respect to the reduction in the capacity of the Substance Misuse Midwife and an increase in caseload, which may have affected service delivery. SMW1 cites this as negatively impacting on their ability to fulfil their role. Notwithstanding the constraints on this professional's practice, their role in this case has been examined in detail and the Northumbria Healthcare NHS Foundation Trust IMR author has addressed this issue in recommendation 7 of their report. It is to be noted that during the course of this Serious Case Review (SCR), Northumbria Healthcare NHS Foundation Trust has undertaken work around implementing improved ways of working around service delivery, procedural guidance and individual roles.

The Northumberland County Council Education Service IMR cites the lack of responsiveness to emails as a significant organisational factor and the lack of escalation early enough given the evidence provided by professionals. Further that there continues to be a concern about the overall poor professional attendance at care/core team meetings.

The Primary Care (G.P Service) IMR also notes that the GP practice does have a monthly child safeguarding meeting which is attended by all GPs. Health Visitors are also invited, but don't always attend. The IMR author accepts that this practice may have a disproportionate level of families with child protection concerns (given the geography of the GP Practice) and has offered some advice on how to manage the caseload more effectively. The GP at interview has also agreed to invite school nurses and midwives to this meeting. I would agree with the IMR author's view that:

"Had a full team been involved in a 'supporting families meeting', the author is certain that this family would have been discussed. This may have led to more support for the family and perhaps better protection for the children."

The Northumberland Tyne & Wear NHS Foundation Trust IMR doesn't highlight any organisational factors; this I feel is an omission. Although it is considered in detail elsewhere the organisational dysfunction that contributed to the rift with Obstetrics and the lack of senior management resolution is an extremely significant organisational element relevant to the findings of this review.

The Northumberland County Council Children's Services addendum describes different views regarding the demands on the Team and Team Manager. Clearly, capacity issues were recognised, given that there were conversations taking place

about increasing management capacity. This is borne out by some of the detail regarding caseloads noted by the Team Manager. The view of the Service Manager interviewed points to comparable capacity to other "neighbouring" teams. Of course this does not account for differences in demand and the fact that Senior Practitioners do not have the same formal roles and responsibilities as Team Managers, as acknowledged elsewhere in the addendum.

Northumberland County Council Children's Services has quickly put in place increased management capacity following the events of this review and this is to be noted. There is not enough performance and staffing data to make a confident judgement regarding the influence of organisational factors on the service offered to Eve, however, there is a significant possibility that such factors are relevant and did affect the quality of practice.

4. IMR QUALITY

During the review process there has been some difficulty in addressing the question 'why' events occurred the way they did or why individual practice was as documented. Although set out in the terms of reference this level of analysis has been uneven with some IMRs not addressing this as fully as others and this has been subject to scrutiny and challenge by the panel. Whilst on occasion preventing definitive explanations of why events occurred as they did, it has not prevented the areas of learning and the findings of this review from addressing the appropriate areas of systems and practice.

4.1 NHS Commissioning IMR

This has addressed the specific terms of reference well, provided a robust analysis and identified key learning. Its conclusions and recommendations are well thought through and are endorsed by this Oerview Report. I would also endorse the comments made in the NHS commissioning IMR regarding the quality of the other health organisations' IMRs and these are set out below:

- Newcastle upon Tyne Hospitals NHS Foundation Trust

This report was not an IMR as it was not required given the level of service provided by this Trust. The report is a factual account, describing the emergency care given to Eve when she arrived at the emergency department in an ambulance. It makes reference to the fact the Eve's father (F1) was not in the family home on the morning Eve was found lifeless on the settee with mother (M1). Sibling (S1) and sibling (S2) were both upstairs in bed. S1 had found M1 and Eve. The report was a useful adjunct to the North East Ambulance Service Report.

- North East Ambulance Service

This report did not require analysis of the Terms of Reference (TOR) as again the service was involved for a very short time. The report describes the care given to Eve and her family when the paramedics and ambulance responded to a 999 call from Eve's home. The report author rightly identifies one issue, where, in the heat of the moment (resuscitation of a very small, sick baby) the crew did not establish if there were any other children in the house before they left for the hospital. S1 and

S2 were upstairs and it was only established when, on the way to the hospital, M1 informed the crew. Unable to return to the house the crew summoned the police to attend the property and secure the children's safety. The recommendation in the report addressing this is appropriate. It is listed in Appendix 1.

- Northumbria Healthcare NHS Foundation Trust

The majority of the services which Eve and her family received were provided by Northumbria Healthcare NHS Foundation Trust. This IMR was therefore always going to be the largest of all three plus the most significant in terms of content. This IMR is an excellent piece of work. The author and the organisation should be congratulated on their open, transparent review and their willingness to acknowledge the gaps in service and implement the changes, some of them before the SCR process was completed.

Were the facts adequate?

The report is comprehensive and thorough and it is obvious that the author has gone to great lengths to investigate the facts and address the TOR. The report describes the services from the midwifery service, health visiting, the dental service, obstetrics and paediatrics. The level of detail included around the midwifery recording system, the attendance by health professionals at the child protection conference, the current evidence base for outpatient management of babies with withdrawal symptoms and the dental services' involvement is impressive.

There is no mention in this IMR of a crucial telephone call made by a hospital midwife to the Addictions worker on 14/03/13 (it is cited in the Northumberland Tyne & Wear NHS Foundation Trust IMR) prior to M1 and Eve's discharge, expressing concern that M1 was going home on large doses of medication (Methadone, Diazepam and Gabapentin) as well as Eve being on Oramorph. The overview author can only conclude that, along with several other communications between the midwifery service and others, it was not recorded as it should have been. M1's hospital records stated: "All relevant community healthcare professionals had been informed by the midwifery staff on Ward ** of Eve's discharge home". This is in contrast to the entry in the Northumberland Tyne & Wear NHS Foundation Trust IMR for the 14/03/13 which states: "Sister expressed concerns about the amount of medication M1 was being discharged with and they stated that they had had a long conversation with M1 about harm reduction and safety regarding medications".

This telephone call was an example of good practice by the midwife, but the NHS Commissioning IMR author is unable to expand any further because, as the recording in the Northumbria Healthcare NHS Foundation Trust IMR differs from the recording in the Northumberland Tyne & Wear NHS Foundation Trust IMR the Northumbria Healthcare NHS Foundation Trust IMR author did not credit the entry with the need for analysis. The Overview Author feels that had it been recorded in the same way as the Northumberland Tyne & Wear NHS Foundation Trust report the Northumbria Healthcare NHS Foundation Trust IMR author could have explored whether the midwife should have raised their concerns elsewhere as well as informing AW1. That said, this midwife appears to be the only professional to

express a concern about the impact of M1's medication alongside her responsibility to administer Eve's medication and the risk that may have posed.

Was the analysis robust?

The analysis was robust and the author has addressed all the shortfalls in the services and has also identified several examples of good practice from SHA1 and the recognition from the dental department, preceding this review, that they needed a communication pathway between their service and Community services such as School health. The section which concludes with the lessons to be learned is thorough, addressing each of the services and the shortfalls.

The overview author would wish to suggest however that wider analysis of the Terms of Reference would have enhanced the learning:

Were more senior managers, or other organisations and professionals involved at points where they should have been? Was there sufficient Management accountability for decision-making and was information escalated to Senior Managers/ supervisors as appropriate?

The overview author suggests that the level of dysfunction and failure to follow the agreed pathway for managing pregnant substance misusing women, between the Obstetric department and Addictions service should have led to an escalation of the concerns to more senior managers. The Obstetrician was concerned enough to raise the issue with a Manager in the Addictions service but a discussion with senior managers within the organisation would also have been appropriate. The author will explore this in more detail later in the report.

Are the recommendations appropriate?

This author feels that a 'golden thread' runs through this report from the facts through the analysis to the recommendations, they are logical and achievable and address the shortfalls in the service areas. The author has made 12 recommendations, all of which are appropriate and relevant to the issues identified in the review. They are listed in Appendix 1.

The overview author accepts all the recommendations and will make reference to them in the body of this report.

- Northumberland Tyne & Wear NHS Foundation Trust

This IMR sets out the review of the service afforded M1 from the Addictions service, a long standing commitment from the organisation which spanned 6 years from 2007 to date.

Were the facts adequate?

The report is detailed and contains enough detail for the overview author to gain an understanding of the extent and content of the service provision. That said the report would have benefited from more details around several key points:

- Whether a visit by AW1 which was planned actually took place, namely on the 31/10/12.
- Paragraph 4.2.18 in the IMR mentions two visits said to have taken place on 03/01/13 and 23/01/13. Neither of these dates are in the chronology or the summary section of the IMR and it remains unclear therefore, if they took place.
- Whether a joint visit with the CST took place on the 24/01/13; M1 was in hospital at the time but the IMR author could have commented on whether the staff knew and therefore the visit did not take place or they were unaware of the admission and attempted the visit.
- Whether there was any timely follow up to the e-mail sent on the 16/01/13 to the SMW about M1's planned admission; the IMR contains entries of communication between the AW and the SMW on 25/01/13 but this was after M1 had been admitted and discharged from hospital for titration.
- Did a Multi-Disciplinary Team (MDT) meeting take place after the recommendation from the Consultant Psychiatrist on 11/02/13 that one should be convened?
- Did AW1 contact the GP in January 2013 to clarify the prescribing arrangements following M1's discharge from hospital?
- Did AW1 follow the advice given by the manager in late March that Addictions should take action to "take back the prescribing responsibility and reduce by 2 mgs a week"?The overview author presumes this refers to Methadone.

  The report also lacks details about the number of meetings AW1 would have been expected to attend (conferences, core groups). The IMR comments on the absence in Northumberland Tyne & Wear NHS Foundation Trust records of any invitations to the meetings but as there could have been two explanations for this and correspondingly two solutions, it was important that the IMR author explored that in more detail. If the AW1 was invited, did not attend or discuss it with her manager then the issue lies with the AW1 and Northumberland Tyne & Wear NHS Foundation Trust. If the problem was that the AW1 was not invited and the process was flawed then the issue lies with Children's Social Care (CSC) and the Child Protection process. The author needed to establish the facts of the matter and make comments on the findings.

Was the analysis robust?

The analysis is not as robust as it could have been which, in part, is due to some facts not being included in the report. There are several areas which would have benefited from further analysis: the visiting pattern of the AW1 required more comment as to whether it was adequate; the report highlights that there were three gaps when the AW1 did not see M1, a 3 month period between January and April 2012, a 3 month period between April and August and a 4 month period between November 2012 and March 2013. These gaps should have been analysed, in terms of the appointments avoided by M1 and in particular the last one given that that was

the period of M1's third trimester of pregnancy, her admission to hospital for titration and a CP plan in place which had identified an action for M1 "to engage with Addictions Service". This will be explored further.

The IMR author has identified that AW's communication with other members of the core group namely the SW and CMW was very good and the overview author concurs with this. A particular aspect of this was the time after Eve's birth when it was clear that there was no birth plan or discharge plan in place. Whilst it was appropriate action from the AW1 to request a core group meeting, it is an action which the AW1 could have taken in the ante-natal period. If the AW1 had been fully engaged in the Child Protection process by attendance at the conferences and core groups as per the Trust's policies the issue could have been raised in a more timely and proactive way. It is not clear in the IMR where the problem about the AW's attendance at key meetings stemmed from and this is addressed elsewhere in this report in section 6.6.1.

There is a key point in the post-natal period when the AW1 was informed by a hospital midwife of M1's discharge home and her concerns at the amount of medication which M1 was being discharged home with, alongside the responsibility for administering Eve's Oramorph. The AW1 made a home visit the following day and requested a core group meeting but there is no evidence of any escalation of the issues to more senior managers. At that point it appeared that Obstetrics were still prescribing M1's methadone, which was contrary to the agreed pathway.

The IMR, similar to the Northumbria Healthcare NHS Foundation Trust IMR, would have benefited from a wider analysis of the Terms of Reference about management accountability:

Were more senior managers or other organisations and professionals involved at the points where they should have been? Was there sufficient management accountability for decision-making and was information escalated to senior managers/supervisors as appropriate?

The NHS Commissioning IMR author is of the opinion that AW1 and the internal MDT within the Addictions service should have raised the issues about the "gaps in care and treatment due to the maternity/addictions pathway not being followed". AW1 should have been asking her supervisor/ manager to intervene on behalf of the patients to address the problem. At that point in a sense it mattered not why the breakdown in the pathway had occurred, only that steps were taken to rectify the issue and provide M1 with the service as per the agreed protocol. It was compromising the care of M1 (and, given the long standing history of this problem, one has to conclude, potentially, the care of other patients) not least in terms of the prescribing but also in terms of the potential to undermine the Child Protection Plan for the three children. This will be explored in detail in the section on interfaces and interactions (section 7).

The IMR report made some observations about assumptions made around the Child Protection Plan. It is difficult to know from the IMR whether these assumptions were the IMR author's own or AW1's. The report was analysing if AW1's professional contact with the family following discharge was adequate. The IMR author concluded

that, subsequent to the home visit after Eve's birth, the plan for the AW1 to visit in "2 weeks which appears appropriate, given the amount of support the family had" (i.e. CMW, SMW, HV and SW) "and a Child Protection plan was in place" was adequate. The Child Protection Plan was in place and there was an assumption made that the plan would coordinate professionals' involvement and that there would be other professionals visiting the home.

This is a "common error of reasoning" (7) as well as a lesson from many reviews cited in the Biennial review of cases (8) and the Haringey paper (4), "just because another professional is involved with a child's case does not mean that they are proactively engaged with protecting the child". This was borne out on the 27/03/13 when the midwife, (it is not clear in the IMR chronology if it is the CMW or SMW, however the relevant IMR clarifies it was the SMW) telephoned AW1 and told her that she had not seen M1 since Eve's birth.

One further point which has not been analysed in the IMR is the role of the doctor and the MDT in the Addictions Service. In fact this doctor does not feature anywhere in the report. The individual is mentioned in the Northumbria Healthcare NHS Foundation Trust IMR which describes the interview the IMR author undertook with the Consultant Obstetrician which was followed up with a written statement from the Consultant. The Obstetrician had contacted the Team manager of the Addictions service (exact date unknown) after seeing M1 on the 16/01/13 in a distressed state due, M1 had said, to the Addictions service reducing her Methadone prescription. The Obstetrician stated her concern that: "a doctor who had not even seen M1 was reducing her dose given her chaotic drug use and explained how serious this was to M1's health and that of the baby". The Northumberland Tyne & Wear NHS Foundation Trust IMR offered no explanation about where or when this reducing plan was formulated and whether that had been shared with any member of the core group. At subsequent panel meetings the IMR author clarified that M1 had always been on a methadone reducing programme, this is explored further in this report. The fact that M1 was so distressed on 16/01/13 was not shared with the core group and therefore the effects on the children remained unknown by any member of the core group. This whole issue will be explored further in the section on interfaces (7.1).

Are the recommendations appropriate?

There are 4 recommendations which flow from the analysis; they address the pathway issue, the contribution to the Child Protection process, the record keeping and the need for supervision. One area which the author could have addressed in more detail was the lack of any evidence in the Northumberland Tyne & Wear NHS Foundation Trust health record of invitations to the initial child protection and review conferences or of any core groups. The report appears to suggest that AW1 was not invited, indeed AW1 told M1 that she was not invited, however the NHS Commissioning IMR author has seen written evidence that AW1 was on the distribution list. The NHS Commissioning IMR author has included a recommendation for Northumberland Tyne & Wear NHS Foundation Trust to review their internal administration systems to ensure that essential Safeguarding paperwork is processed effectively to ensure compliance with the Safeguarding process. It may well be that the internal administrative systems are robust but a

review of them would assure the organisation and the LSCB that the lack of attendance at meetings is not as a result of their own internal system. The overview author accepts all the recommendations with the addition of the recommendation above and will make reference to them in the body of the report. They are listed in Appendix 1.

Primary Care (G.P Service)

This IMR focusses on the primary care service provided to M1, S1, S2 and Eve from one GP practice and to F1 from a separate GP practice.

Were the facts adequate?

There is limited factual information around the actual GP consultations which the various family members had with the GPs. This may be to do with the way that GPs record the details of consultations which tend to be in short note form. The detail provided does give a picture of the service provided. F1 appears to have ceased attending his GP in 2009 but prior to that he attended for "multiple injuries" due, it seems, to assaults, an addiction to drugs and some acute mental health issues for which F1 was referred but did not appear to follow up. There is a gap in the knowledge of F1's health from 2009 onwards. M1, on the other hand was a very regular attender at the practice, seeking medications for back pain from the age of 17; this will be explored further in this report. S1 and S2 were not particularly regular users of the GP and considering their ages any attendance would have required parental involvement. It would seem that the two older children were not taken to the GP very often. Their immunisation history mirrors this as they were all delayed.

The facts which have proven to be very useful is the information provided in this IMR about the period before January 2012 which includes a period when the two children were Child in Need and the first period of Registration in 2006. This detail shows how the GP was being consulted regularly by M1 with on-going problems with her addiction and a neck problem. The IMR states that at the age of 22 years, M1 was "clinically drug dependent and difficult to manage".

Was the analysis robust?

The analysis is satisfactory however the IMR author could have explored in more depth the issue of how the GP viewed M1… "she had a traumatic past"… in comparison with the GP's limited view of S1 and S2, primarily because they were not brought to the GP practice a great deal. There is no evidence that the GP asked M1 about her children at any of her consultations, at which she sometimes presented in a distressed state. The Safeguarding toolkit for GPs developed by the Royal College of General Practitioners guards against the barrier to good practice of "not seeing the child" and allowing the parents' problems to overtake and overwhelm the consultation. There was at least one occasion when M1 used one of the children's appointments to address her own health needs.

The author has listed several incidents when the GP practice could have intervened in a child-focussed way to bring about a different outcome. Whilst eleven of these incidents were in the period before the timeframe of this review, they are useful to

illustrate the prevailing attitude of the practice to the problems which M1 presented with on a very regular basis, and the lack of an appreciation of the impact they may have had on her children.

The GP's lack of engagement in the Child Protection process (not attending either the Initial Conference or the Review conference despite invitations being received, and not submitting written reports in a timely way) is commented upon by the author. GP practices receive regular training and have access to a toolkit which recommends attendance at and/or written contribution to child protection conferences. The overview author understands that the NSCB are currently looking at the overall attendance data for Primary care in order to improve this performance. This is a national problem and the NHS Commissioning IMR author is aware that locally the Area Team located in NHS England are exploring ways of improving GP engagement in the Child Protection process.

The report would have benefited from more exploration of the prescribing issue, not just that it was difficult "to identify (from the GP electronic records) exactly which drugs were issued when" but also whether the GP could have taken a different approach to M1 when she first attended for medication for back pain at the age of 17. This will be explored further in this report.

M1 also had a neck problem which the IMR author analysed as an issue which could have impacted on M1's ability as the carer of 3 children.

Are the recommendations robust?

There are 4 recommendations all of which are connected to the facts and analysis within the body of the report. They suggest a template for Primary care to use with substance users which assists GPs to gather information and assess the Hidden Harm associated with the drug use. The second addresses the need for clear, unambiguous recording of the prescribed medications in GP practices. The third addresses the need for imaginative approaches to improving the engagement of GPs in the Child Protection process. And the last one is recommending that GP practices develop streamlined administrative processes to ensure timely actions when information is sought for the Child protection process.

The NHS Commissioning IMR author was concerned that the IMR author identified that one of the GPs was "writing to himself" as he provided a service to M1 when she attended the substance misuse clinic and as her GP. This highlights potential conflicts of interest and a recommendation will be made in this report to address this.

The overview author accepts all the recommendations and will reference them in the body of this report. They are listed in Appendix 1.

4.2 Northumbria Police

Were the facts adequate?

The report contains enough detail of Northumbria Police's involvement to understand the nature of contact with the family and the service provided. Intelligence logs were reviewed and relevant contacts set out.

Was the analysis robust?

The IMR sets out the involvement in a clear chronology although the analysis is not as robust as it could have been. For example, there could have been greater examination of the incident with S3 in January 2013 and my conclusions differ in this regard from the IMR.

There could have been more analysis of the pattern of Child Concern Notifications (CCNs) and whether this could have prompted Northumbria Police to escalate concerns and seek further discussion with Northumberland County Council Children's Services regarding the welfare of the children and possibly led to Northumbria Police's request for a Section 47 Investigation. This applies in particular to the sequences in 2009 and 2010, which were focused in the main on the poor supervision of the children.

The report would also have benefitted from a deeper analysis of why a CCN was not submitted on 20.5.12 in relation to S1's arrest for theft. Although the reasons are set out in the IMR that it was "opportunistic", this should have been explored further. Specifically that the officer had no information regarding the context of S1's overall welfare, the lack of parental care evident to other agencies, the existing instances of alleged drinking by S1 and the concern that any of the care team members would surely have had at that point of both the behaviour in itself but also of the possible use the re-sale value of the luxury item could be put to. It is this lack of joined up information that the analysis could have addressed.

Are the recommendations robust?

The IMR made no recommendations and the report would have benefitted from a recommendation with respect to the pattern of CCNs. The overview report has therefore made a recommendation for Northumbria Police and Northumberland County Council Children's Services focusing on CCNs.

4.3 Northumberland County Council Children's Services

Were the facts adequate?

The original IMR was supplemented by an addendum provided by Northumberland County Council Children's Services, which addressed additional areas of analysis highlighted by the overview author and NHS commissioning IMR and through discussion at panel. The IMR report together with the addendum sets out the facts adequately and is detailed enough for the overview author to gain an understanding of the extent and content of the services provided. Although there remain some discrepancies with other IMRs, for example, in relation to attendance at core groups

and the description of M1's substance misuse in late 2012, and these could have been explored in more detail.

Attendance at multi-agency meetings could also have been set out more clearly to assist understanding of the impact on assessment and case planning. For example, in relation to the:

- 25.9.12 care team meeting – Addictions Service were unaware of the meeting.
- 27.11.12 ICPC – Addictions Worker, Community Midwife, Specialist Substance Misuse Midwife and the GP were all absent.

Setting out the specific recommendations of the various multi-agency meetings would also have strengthened the report.

Was the analysis robust?

The analysis is adequate overall and the areas of the Review Child Protection Conference (RCPC) and the implementation of the Public Law Outline (PLO) are well dealt with. Although there are areas, which could have benefitted from more robust examination:

- Engagement of parents and their attendance at meetings and the consequent impact on the work with the family, including the impact of the new social worker allocated in September 2012. It was clearly important at this point for SW2 to begin to establish a relationship with M1 given the difficulties faced by the previous social worker, but I would have expected a much more open, robust and authoritative review of the circumstances at this point. It should have been considered that at this point 'start again syndrome' was clouding the nature of the intervention and the expectations placed on M1 and F1, and this could have been explored further in the IMR.

- The implementation of the written agreement and the impact on the work with the family.

- The reasons why the absence of birth planning remained largely unchallenged or escalated as a concern.

- It is also explored in the body of the overview report, that the contention in the Northumberland County Council Children's Services IMR that the Initial Child Protection Conference (ICPC) appropriately considered the issues and put an appropriate plan in place cannot be sustained. Critical professional involvement was absent. The invitation process was flawed and contributed in major part to inadequate information sharing at the meeting. Not only in terms of F1 but also in ensuring that robust planning was put in place for Eve. This could have been subject to further analysis in the IMR.

- The clear contradiction in February 2012 between S1's account of drinking and the parents is not explored further in the IMR. It is notable that a S.47 investigation is undertaken in relation to the other child, on account of injuries

sustained from falling over, but not in relation to S1. Neither the reasons for this or how the decision was reached are analysed.

- Issues of case management drift and the use of the PLO framework are considered within the IMR and addendum although there could have been more analysis of the gaps in contact in the 6 months prior to the ICPC in November 2012.

Are the recommendations robust?

The IMR and addendum have made 10 recommendations, all of which are appropriate and relevant to the issues identified in the review and are accepted. Further recommendations have been made in this overview report in relation to Service1 in order to strengthen the learning.

4.4 Northumbria Probation Service

Were the facts adequate?

Northumbria Probation Service had no contact with the family either during M1's pregnancy with Eve, or following her birth. Within the timescale for this review, there were only three months remaining of M1's last order. However, with the requirement to examine historical involvement with regard to S1 and S2's earlier life, the IMR considered contact with the family from July 2002.

The detailed chronology covers the last three months of Order 5 when M1 and F1 were living together with S1 and S2 and M1 was being offered support through the offender manager. The report adequately sets out the facts and provides enough detail to understand the extent and content of the service provision.

Was the analysis robust?

The analysis is satisfactory and identifies key learning in relation to the allocation of a Child in Need case to an inexperienced officer and three instances where the impact of this was evident: the failure of registering the case as medium risk to children, the lack of a formal letter to Northumberland County Council Children's Services at termination of the Order and no making of a child protection referral.

Although a letter from the Probation Manager questioning the absence of a multi-agency meeting in late 2011 cannot be found by the agency and Northumberland County Council Children's Services have no record of receiving it, if it was sent then the Probation Manager should have followed up in the absence of any response from Northumberland County Council Children's Services. The analysis was not as robust as it could have been in relation to why this was not the case.

The analysis identifies areas of good practice. For example, the IMR refers to a Signs of Safety Meeting on 12.1.11 where it was agreed that attendance at these sessions would count towards National Standards for appointments, and would be combined with a monthly home visit. This was positive encouragement to guide M1

towards an intervention that could have led to a degree of positive change in her parenting.

Are the recommendations robust?

The author has made 2 recommendations, both of which are appropriate and relevant to the issues identified in the review and are accepted.

4.5 Northumberland County Council Education Service

Were the facts adequate?

The report sets out the facts adequately and is detailed enough for the overview author to gain an understanding of the extent and content of the services provided. It provides details of the educational support needs of S1 and S2 and sets out referrals made. It also describes the fluctuating levels of engagement by both parents with the educational process.

Was the analysis robust?

The analysis is satisfactory and identifies key learning for the schools in question. In particular in relation to the lack of information regarding F1, the significance of M1's behaviour in relation to flagging down cars to get S2 to Nursery, and in relation to the failure to report M1's pregnancy. Regarding the latter there was no connection made by the school between the failure to share this information clearly and the potential level of risk to the unborn baby. The two other children were also without school as a protective factor during the following 6-week holiday. This was clearly and robustly analysed within the IMR.

There could have been further analysis of the views expressed by one of the schools about the effectiveness of Core Group meetings and the ability of the school to express this view and resolve any concerns. Also more exploration of the issue that, from the schools perspective wasn't discussed – birth planning.

The Northumberland County Education Service IMR identified a number of learning points in relation to independent schools, and I would endorse the importance of the areas highlighted.

Are the recommendations robust?

The author has made 4 recommendations, all of which are appropriate and relevant to the issues identified in the review and are accepted. An additional recommendation has been made by the overview author in relation to statutory guidance and is intended to strengthen the IMR recommendations made by the Northumberland County Council Education Service.

4.6 Northumberland County Council Legal Services

Were the facts adequate?

The IMR was commissioned after the completion of other IMRs as it became clear that there were relevant issues in relation to the planning by Northumberland County Council Children's Services and the legal advice offered. The chronology covers the period from 26 November 2012 when Legal Services first became involved until 5th April 2013 when a Strategy Meeting took place, following Eve's death. The report is clear, detailed and addresses the key points of planning in the case and provides an understanding of the service provided.

Was the analysis robust?

The analysis is good and reflects appropriately on aspects of practice that could have been improved, in particular the decision to close the Letter Before Proceedings/Public Law Outline (PLO) process and the need to escalate discussions between the Principal Lawyer and TM1's line manager in Northumberland County Council Children's Services. The report's conclusions that the Letter Before Proceedings should have been sent out immediately after the Initial Child Protection Conference on 27 November 2013 and that the period of monitoring of F1 and M1's engagement under the remit of the Letter Before Proceedings was too short are sound.

Are the recommendations robust?

The author has made 5 recommendations, all of which are appropriate and relevant to the issues identified in the review and are accepted. An additional recommendation has been made by the overview author in relation to ensuring that Northumberland County Council Children's Services, in making their decisions in legal meetings/discussions or in Letter Before Proceedings planning meetings, including later decisions to withdraw, have robust multi-disciplinary involvement. This is intended to strengthen the IMR recommendations made by Legal Services.

5. CONCLUSION

The cause of Eve's death is still unascertained and therefore no one factor could be said to have predicted this tragic event. However, there were significant safeguarding failures both in front line practice across agencies and in the management systems intended to check that practice was appropriate. As a result Eve was not afforded the protection that she deserved. These challenges are not unique to Northumberland; a number of the issues which have arisen in this serious case review are also familiar themes nationally, such as:

- Poor communications between and within agencies.
- A lack of analysis of information.
- A lack of professional curiosity in questioning the information.
- A lack of confidence among professionals in challenging parents and other professionals.
- Shortcomings in recording systems and practice.
- Professional over optimism rather than to '*respectfully disbelieve'* and dealing

with events as one off episodes often referred to as the '*start again syndrome*'[6]

Many of these failures relate to doing the simple things well: sharing information, seeing children, thinking and planning in relation to risk and persistence in challenging practice and decisions.

It is striking that none of the safeguarding shortfalls would have been the subject of focused investigation and reflection or come to the safeguarding board's attention had Eve not died. As a result of this review improved professional practice must be supported and the ability to reflect on the quality of assessment and planning for children strengthened.

6. RECOMMENDATIONS:

All recommendations identified in the NHS Commissioning IMR, IMRs and the Northumberland County Council Children's Services addendum are accepted with the following additions intended to strengthen existing recommendations or address additional issues (timescales are in relation to the period following the overview report being accepted and signed off by the LSCB).

- Understanding and working with children's experiences

1. Northumberland County Council Children's Services – In response to the gaps in contact with the family evident in this case, an audit of home visiting frequency and duration of time spent with children in need and those in need of protection should be undertaken to seek assurance that this is not a broader feature of practice. Quantitative and qualitative performance measures should be established in relation to the:

- Time spent with children by social workers.
- Quality of work undertaken including the voice of the child.

This will be assisted by Northumberland County Council Children's Services reviewing and clarifying the expectation for staff in relation to the purpose and activities undertaken with children that are considered most helpful in understanding their wishes and feelings. **Proposal to be presented to the Board within 3 months. Review and report to the Board within 6 months.**

[6] Building on the Learning from serious case reviews: 2007 – 2009 Brandon et al.

2. LSCB – The levels of professional contact with the family, including significant gaps in contact and missed appointments, was an issue for all agencies and the LSCB should investigate whether this is a broader feature of practice in other cases. This investigation will need to take into account the different levels of relationship that are expected to be established with children within the context of individual services' roles and purpose. This should inform a report to the LSCB with any further recommendations for improved guidance and practitioner support. **Proposal to be presented to the Board within 3 months. Review and report to the Board within 6 months.**

- Assessment, thresholds for action and decision-making

3. LSCB – A recent Management review in 2013 recommended that:

Building on lessons from 'Ages of Concern' the NSCB should take a strategic overview of the involvement of fathers in assessments of risk. Recommendations for improvement and reporting to the NSCB should follow.

The assessment of fathers remains an issue in this case; therefore this recommendation should be revisited. The LSCB should seek assurance in terms of the implementation of the previous recommendations, identify gaps and work yet to be completed, complete outstanding work and audit impact. **Review and Report to the LSCB within 9 months.**

4. LSCB - Few practitioners involved in this case appear to have completed the LSCB training 'Working with Hostile and Un-Cooperative Parents'. Not all appeared to be aware of the guidance and this may have hindered professional confidence in working with the family. The Board should audit awareness of the guidance and review the on-going training provision in this area of practice including the uptake of the current training course or any other method of practice support, by all partner agencies and establish targets for attendance. **Review and proposal to the Board within 3 months, agreed framework for practice support in this area in place by 6 months.**

5. LSCB – The findings of this review are that multi-agency assessment work in relation to the children was inadequate. Key areas of weakness relate to:

- Poor understanding and analysis of risk and the impact of chronic neglect.
- Over optimism in relation to assessed improvement.
- Lack of understanding regarding the history and role of the children's father.
- Poor understanding and analysis of the children's experiences and the impact of the care provided to them.
- Poor use of chronological information to support the analysis of risk.
- Poor understanding of the threshold for significant harm.

The LSCB should seek assurance that under the recently implemented new assessment framework the quality of assessments in relation to children is of an

acceptable standard. **Review and report to the Board within 6 months.**

- Commitment and contribution to multi-agency safeguarding and information sharing practice

6. LSCB and NHS England – A management review in 2011 and more recently in 2013 recommended that:

LSCB, Northumberland CCG and NHS England should commission a broad investigation/thematic review of the role and responsibilities of GPs in the safeguarding system, in order to answer for Northumberland the following questions:

- Is there sufficient understanding of safeguarding information sharing practice?
- How can any barriers to multi-agency safeguarding practice be reduced?
- What additional support is necessary?
- How can the specialist support via named and designated staff be made more accessible and utilised by GPs?

The responsibilities of GPs in the safeguarding system remain an issue in this case; therefore these recommendations should be re-visited. The LSCB should seek assurance in terms of the implementation of these previous recommendations, identify gaps and work yet to be completed, complete outstanding work and audit impact. This supports the related Primary Care (G.P Service) IMR recommendation. **Recommendations for improvement and report to the LSCB from NHS England should follow within 9 months.**

7. LSCB and Department for Education - For there to be professional and public confidence in the ability of independent schools to fulfill their statutory duties in relation to protecting children the application process and documentation should be reviewed in order to ensure that it addresses safeguarding standards much more robustly. **Report to the LSCB on agreed actions within 6 months.**

- Reflecting on practice: supervision, professional challenge and leadership

8. LSCB – The Board should review its multi-agency mechanisms for supporting practitioners' critical reflection in their work in the following ways:

- In relation to specific areas of practice to ensure that they are fit for purpose. The processes in place or to be developed should begin with the issues set out in this review in relation to the investigation and working with neglect, substance misuse, understanding and working with children's experience, legal planning and the risks to babies.

- The role of conference chairs and safeguarding nurses are critical in developing criteria for the need for additional reflection in specific cases. The LSCB should establish ways in which their challenge and reflection role can be strengthened in order to provide a fresh pair of eyes, identify and prevent drift and focus on the effectiveness of multi-agency working.

Review and Report to the LSCB within 9 months.

9. LSCB – As part of its responsibility to monitor the effectiveness of partners' implementation of their duties under S11 of the Children Act 2004, the Board should ensure that the learning from this review informs any future S11 review/audit. In particular that single agency supervision guidance and training is fit for purpose and that any recommendations for improvement are put in place. **Review and Report to the LSCB within 12 months.**

10. LSCB – A recent Management review in 2013 recommended that: LSCB to review the operation and use made of the "escalation and resolution of professional disagreements protocol", and to recommend any improvements to the Board for implementation.

The escalation of concerns remains an issue in this case; therefore this recommendation should be revisited. The LSCB should seek assurance in terms of the implementation of the previous recommendations, identify gaps and work yet to be completed, complete outstanding work and develop a process for understanding impact. **Report to the LSCB within 6 months.**

- Procedural guidance and recording

11. LSCB – The LSCB should implement local procedural change to ensure that integrated multi-agency chronologies are available to core group meetings, initial child protection conferences and review conferences. Chronologies should be proportionate and focus on improving the quality of analysis in individual cases. Procedural guidance should place the responsibility for maintenance of an up-to-date chronology with the core group. **Planning and preparation for this change within 6 months. Implementation by all partner agencies within 9 months.**

12. LSCB – Given the non-compliance with the Northumberland birth plan protocol the Board should ensure that the LSCB procedures do include the protocol and review its processes for agreement and dissemination of changes to procedures and guidance. In particular ensuring that changes as a result of this serious case review are communicated and accessible to all staff in relevant agencies. **Review and report to the Board within 3 months.**

13. LSCB and Northumberland County Council Children's Services – Given the absence of a shared written agreement for the core group, the LSCB multi-agency procedures in regard to core groups and working agreements should be reviewed to ensure that they are fit for purpose. This should include, but not be limited to, timescales for completion, factors in relation to parental agreement and specific scrutiny/review at core group meetings and conferences. The LSCB should

communicate the expectations to all partners and conduct a themed audit to give assurance regarding the quality of practice regarding core groups and working agreements. **Procedural review and LSCB communication immediately, themed audit within 3 months.**

14. Northumbria Police and Northumberland County Council Children's Services – Northumbria Police could have raised concerns in 2009-10 and sought further discussion with Northumberland County Council Children's Services regarding the welfare of the children, if the pattern of Child Care Notification's (CCNs) had been reviewed as a whole. In partnership with Northumbria Police, Northumberland County Council Children's Services and to link in with new practice in Northumbria Healthcare NHS Foundation Trust, there should be a review of procedural guidance around CCNs. In particular whether thresholds/trigger points should be put in place regarding patterns and numbers of CCNs that would trigger a specific procedural requirement for a case discussion between the agencies. **Review and report to the Board within 6 months.**

15. Northumberland County Council Children's Services and Legal Services - To revise procedural guidance in relation to the use of Letters Before Proceedings. To ensure that Northumberland County Council Children's Services in making their decisions in legal meetings/discussions or in Letter Before Proceedings planning meetings, including later decisions to withdraw, have robust multi-disciplinary involvement. This will support a focus on evidence and multi-disciplinary responsibility to assess improvement and the formal escalation of concerns where necessary. Any guidance should stipulate that escalation should be considered above the level of Team Manager and should include child protection chairpersons where they are involved. This endorses the IMR recommendations made by Northumberland County Council Children's Services and this should be additionally scrutinised by a themed audit of practice within 9 months. **Procedural change - review and report to the Board within 3 months. Audit to report to the Board within 10 months.**

- Organisational factors

16. LSCB – Given IMR statements that conference documentation was not always received and the expressed views of parents regarding the poor sharing of reports and attendance at meetings, a review of the conference process should be undertaken to ensure it is fit for purpose. This should include a review of the:

- Invitation process including standard attendees at unborn, initial and review conferences.
- Practice of the conference chairpersons in maintaining procedural standards in relation to attendance at and reporting to child protection conferences.
- Provision of reports to parents to ensure that they are fully informed and able to engage and contribute to the work of the conference.
- Subsequent distribution of minutes and plans.
- Chairperson's role in monitoring plans during the review period.

This will assist in assuring the safeguarding board that all agencies are fulfilling their statutory safeguarding responsibilities. **Review and report to the Board within 3 months.**

7. REFERENCES:

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14. Ofsted. Ages of Concern: learning lessons from serious case reviews (October 2011)

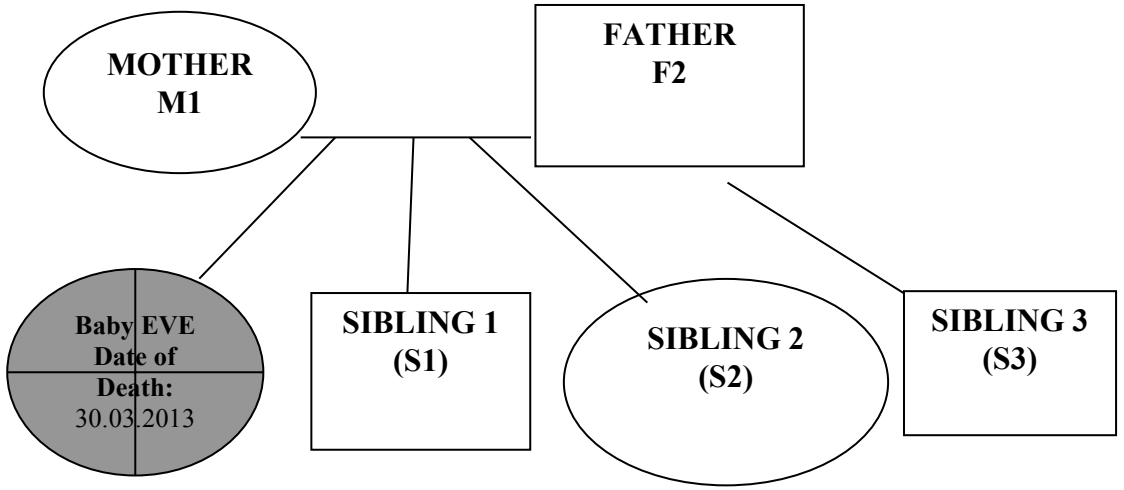
15. Royal College of General Practitioners (RCGP) and the National Society for the Prevention of Cruelty to Children (NSPCC) Safeguarding children and young people. A toolkit for General Practice (2011)

8.APPENDICES:

Appendix 1: Genogram as at April 2013

Family Name: XXXXX

Period of Review: January 2012 up to 30th March 2013.



A Genogram is a way of representing a family tree and relationships within the family.

Key:

○	□	△	X	⊕	▭	●	■	———	Enduring Relationship
								- - - -	Transitory relationship
Female	Male	Pregnancy	Abortion or Miscarriage	Deceased – Cross is placed inside gender symbol		Subject		/	Separation
								//	Divorce
…….	Family members who are part of the same household are indicated by a dotted line which is placed around the household members								

Created: 17/10/2014
Modified: 17/04/2015

Appendix 2: IMR lessons learnt from this case and recommendations:

NHS Commissioning IMR

Conclusion:

Eve and her siblings were known to all the services and had experienced neglectful parenting all of their lives. Health services knew of this neglect and had a significant role to play, working with partner agencies in protecting the children and promoting their welfare.

The contributions of the various parts of the health service were essential to a robust Child in Need plan initially and then to the most recent Child Protection plan. They had a statutory duty to cooperate in the process and a professional duty to advocate for 3 very vulnerable children.

The review of this case has shown that there were serious gaps in ***information sharing*** both within and out with the health service which meant that the whole picture of the family's functioning, dynamics and lifestyle remained unknown. This applied when the children were ***Children in Need*** and when they were subject to CP plans.

A care pathway for substance misusing pregnant women was uncoordinated and fragmented. Protocols developed when the pathway was set up several years before this review clarified how the multi-agency pathway would function, however one service acted unilaterally and contrary to the agreement. The role of ***Midwifery*/Obstetrics** and ***Addictions*** was pivotal to the functioning of that pathway.

The ***Primary Health Care Team*** was not functioning as a team with little or no evidence of a "Think Family" approach to the family.

Once the children's situation had been deemed to reach the Child Protection threshold the ***process was commenced concluding with a Child Protection conference, to which the contribution*** was patchy, not of an acceptable standard and not compliant with internal or external procedures. The contribution to other meetings was equally poor, including provision of written reports for conferences. Whilst some key health professionals were not invited to the conferences, the fact that Eve and her children were part of the child protection system was known by health agencies and should have instigated actions to ensure their contribution to the process. There is no evidence that health professionals challenged the decision-making in relation to the PLO proceedings, the legal advice or indeed sought supervision to reflect on these issues.

The **role of the GP** in the safeguarding process was less than robust and the review has highlighted many missed opportunities when the GP could have intervened to protect S1, S2 and Eve.

The vulnerability of Eve and her siblings was either not understood or not articulated to the core group members. The Child Protection plan, whilst

acknowledging Eve's vulnerability, did not identify actions which could have mitigated the risks e.g. intensive visiting post-natally.

The **midwifery service** did not provide the level of support which would have been expected, to a vulnerable family. The extent of this is listed in section 7.3. One of the areas which the Northumbria Healthcare NHS Foundation Trust IMR identified was the recording systems used by midwifery which was disjointed and numerous (8 separate places were identified where the midwives could have recorded information about patients). There was a view, expressed at one of the panel meetings, that the influence of the Choice agenda could have led to this situation.

In 2005 the Government underlined the importance of offering women a wide choice of type and place of maternity care and birth. There are 4 key choices:

- How to access maternity care.
- Type of antenatal care.
- Place of birth: at home, a midwifery-led unit or a medical-led unit.
- Place of postnatal care.

Women are provided with a record of their care in the form of a patient-held record, in which all their care should be recorded. Obviously some information should not be recorded in these records for example disclosure of domestic violence, as it may increase the risk to the woman.

The NHS commissioning IMR author has considered whether this agenda is compromising the governance of record keeping and Safeguarding practice. Discussions with midwifery staff suggest that the majority of women choose local services for antenatal care, delivery and postnatal care. M1 booked in locally and was known to the midwifery service. There is no evidence in the IMR that M1 changed her mind about her choice of antenatal, delivery and postnatal care so it is difficult to conclude that the Choice agenda was a major factor in the way that midwifery was recording information. It must, therefore, be an expectation that Northumbria Healthcare NHS Foundation Trust can develop a recording system which satisfies the principles of the Choice initiative as well as maintaining appropriate governance of the records.

The Northumbria Healthcare NHS Foundation Trust IMR has recommended that the organisation undertake a review of the maternity record system with the intention of improving the governance of the system, which includes an annual audit of the records. The NHS commissioning IMR author believes that this action should improve the system. In the event however, that the audit identifies on-going issues which can be attributed to the Choice agenda, then the Trust should formally raise this with NHS England as well as the CCG, Public Health and the national midwifery forums.

Each of the 3 main IMRs concluded quite rightly that there were significant gaps in the services which had been reviewed and they produced 21 recommendations in total (including one from Service 3) which when implemented will go some considerable way to addressing the shortfalls. This overview has added to that list with 11 recommendations designed to strengthen the learning.

The shortfalls in services were around the basic expectations of NHS trusts that they will be compliant with their section 11 responsibilities, and as each of those trusts commences its current section 11 self-assessment, it is timely for the Boards of those organisations to review their safeguarding arrangements, using the learning from this review to inform their self-assessment. These section 11 self-assessments from the providers, including Primary care, will need to be scrutinised by the commissioners of these services to provide assurance that the lessons have been learned.

- Recommendations

In developing the recommendations the author has been mindful of the finding of the authors of the DfE report: New learning from serious case reviews a two year report for 2009-2011(8). They commented on the sheer volume of recommendations (an average of 47 per review) and observed that "the recommendations which are easiest to translate into actions and implement may not be the ones which are most likely to foster safer reflective practice".
With this in mind, and being cognisant of the recommendations from IMRs (including Service 3), this overview's recommendations are an attempt to "foster safer, reflective practice" bearing in mind the authors' warning that "implementing (recommendations) should not be seen to imply that learning has taken place".

- Recommendation 1
The three IMRs have shone a light on **the care pathway**, which has been in place for several years, for managing substance misusing pregnant women. The care pathway relies on staff from two different trusts collaborating to provide a multi-disciplinary team approach to this vulnerable group of women and their babies. The level of dysfunction in the care pathway, not least around the responsibility for prescribing, was very concerning and as a result the overview author contacted the CCG to inform them of the situation, with the suggestion that urgent action should be taken to seek assurance about the current arrangements. This has been done.

The NHS Commissioning IMR Report author also contacted the Public Health commissioner in the Local Authority to gain an understanding about the commissioning arrangements. The commissioner informed the overview author that there has been a wholesale re-procurement of the Drug and Alcohol service in Northumberland, including the pathway for pregnant women. The contract and service specifications have been re-designed and the substance misuse midwife post de-commissioned. Given the findings of this review this whole development is a welcome one, however, it is information which is not contained in either of the IMRs whose services have been re-commissioned (Northumbria Healthcare NHS Foundation Trust or Northumberland Tyne & Wear NHS Foundation Trust).

It is important that the learning from this review is understood in full by the commissioners in Public Health and is used to inform the future contract monitoring of the new service.

Notwithstanding these developments the recommendation is:

1. **Northumberland CCG and NHS England, where relevant, should use the learning from this and other recent reviews to lead a root and branch review of the current care pathway for substance misusing pregnant women, using examples of good practice around the region as a comparator. It should include:**
    - **A detailed process map of the pathway to greater understand why this situation has developed.**
    - **A review of the respective roles of the Obstetrician and Psychiatrist including prescribing responsibilities.**
    - **A review of the role and current capacity of the substance misuse midwife.**
    - **A clarification of the role of Primary care to include prescribing responsibilities to encompass where a GP is a GP with Special Interest (GPwSI).**
    - **A clarification of the role of the prescribing doctor in the Addictions service.**
    - **The evidence base for reduction programmes in pregnancy.**
    - **A view of service users.**
    - **A review of the role of the pharmacist.**
    - **A process for auditing the pathway (to be agreed by the providers and commissioners and undertaken by the NSCB's appropriate sub-group).**

- Recommendation 2

Whilst there is no evidence that the Oramorph prescribed for Eve to manage her **Neonatal Abstinence Syndrome** symptoms was a contributory factor in her death, this review has highlighted some potential gaps in the procedure. The author is not qualified to comment on the prescribing of Oramorph but some basic research by the author has identified that there are different approaches to this both here and abroad. Guidelines suggest a need for the pathway to consider all the factors, including social factors, prior to the decision to manage NAS via an outpatient facility. An assessment of the risk factors is essential.

2a. Newcastle upon Tyne Hospitals NHS Foundation Trust should use the learning from this review to review the current guidelines on the management of NAS to ensure that the evidence base for the practice is robust.
The guidelines should reflect that the decision to discharge a baby home on Oramorph is based on a thorough risk assessment of all the circumstances including the current social factors.

2b The NSCB should seek assurance when Newcastle upon Tyne Hospitals NHS Foundation Trust has completed the review that the guidelines guarantee the robustness of the discharge plan and are then included in the LSCB safeguarding procedures.

- Recommendation 3

The health providers in this review are huge complex Foundation Trusts providing services across wide geographical areas as well as complex interfaces with other providers and other agencies.

The safeguarding responsibility rests with the Boards of these organisations, however the expertise for service delivery rests at the frontline and the supervision of these staff. The supervisors are primarily **Named professionals and nurse advisers**. The Named professionals are the cornerstones for the delivery of safe effective safeguarding practice and in order to do this they need the capacity, the time, the resources, the authority, the banding and associated status and, most importantly, the management support. These teams provide the knowledgeable leadership and are essential for quality assuring the service.

3a. The CCG should seek assurance from the Boards of Northumberland Tyne & Wear NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust that the Named professionals based in their organisations are assisted and empowered to provide:

- **Leadership.**
- **Quality assurance.**
- **Supervision and support to the frontline staff, including the promotion of evidence-based practice and the application of research in practice.**
- **Named professionals should, in turn, be provided with the quality supervision they require from the Designated Professionals as well as from their internal management structures.**

The Trusts should ensure that the Named Doctor's role is promoted amongst the medical staff so that they are aware that in difficult cases they should seek advice.
The Trusts should also review their internal supervision policies to ensure they reflect the learning from this review and in particular make reference to the importance of the production of detailed chronologies which can be shared with CSC in cases of neglect, and a consideration given to group supervision of the health professionals working with the same family in cases of protracted neglect.

3b. NHS England and the CCG should ensure that the GP practices in Northumberland know who the Named GP, Designated Doctor and Nurse and Caldicott Guardian are and how to contact them for Safeguarding advice.

- Recommendation 4
The IMR which reviewed the maternity services has highlighted some important gaps in the safeguarding practice of the **midwifery service;** the recommendations in the report will go some way to addressing the shortfalls. The recommendations focus on improving the record keeping system which was complex and confusing, the lack of a referral to CSC after the ante-natal assessment, the confusion around roles and responsibilities and the lack of safeguarding supervision for midwives.

Several of these shortfalls have been previously identified in local reviews. The NHS Commissioning IMR author is of the opinion that in order to address the shortfalls

there is a need for proactive midwifery leadership from the organisation. The named midwife is crucial to the promotion of safeguarding practice in midwifery but the post holder will need the time and capacity to deliver that agenda.

The author had intended to make a recommendation for Northumbria Healthcare NHS Foundation Trust to appoint to a full time Named midwife post, however the author has been made aware that the Trust, having recognised the learning from this review, have stated their intention to appoint a full time Named midwife. The NHS Commissioning IMR author would commend this pre-emptive action by the Trust. The recommendation therefore, will focus on measuring the impact of the appointment.

4. The CCG should receive evidence from Northumbria Healthcare NHS Foundation Trust that the appointment of the Named midwife has promoted, in conjunction with the Midwifery service and the Safeguarding team a learning culture within midwifery and improved the following: A robust record keeping system.

- **Improvement in the uptake and quality of supervision for midwives in line with trust policy.**
- **Improved attendance in the child protection process including attendance at conferences and provision of quality reports for conferences.**

It is important that supervision from the Designated nurse is part of the Named midwife's support.

- <u>Recommendation 5</u>

This overview has highlighted the issue of **missed health appointments** and the suggestion that a reconceptualization of the terminology will help staff to understand the relevance of the issue. The author understands that a review undertaken by NSCB (Matthew) recommended the same change in practice for all agencies. Whilst this will be a major undertaking involving changes to coding systems as well as awareness-raising amongst staff, the author feels that the fact that two reviews have identified it suggests that it is important.

5. Northumberland LSCB agencies should re-word their internal DNA policy for children to WNB to reflect the suggestion from Eileen Munro and undertake the appropriate awareness-raising with staff about the changes. The policy should be very clear what action is required if the Child not being brought to appointments is vulnerable.

<u>- Recommendation 6</u>

Evidence from the Child Death Process shows that **co-sleeping** represents a serious risk to young babies when their carers use drugs and alcohol. This Public health message does not appear to be having the same impact as the other parts of the advice package given to parents as there continue to be deaths where co-sleeping is an issue.

6a. Public Health in Northumberland Local Authority, in conjunction with the NSCB should undertake a campaign in conjunction with North Tyneside & Newcastle LSCBs to inform the public about this particular feature of risk in Sudden Unexpected Death of an Infant (SUDI), ensuring that the campaign uses the learning from other areas in the country to enhance the message.

Following a meeting with Eve's parents and discussion at a subsequent SCR panel meeting the author is also recommending strengthening the message around the dangers of co-sleeping.

6b. Children's social care should ensure that all Child Protection plans, Child in Need plans and the PLO "letter before proceedings" will include the risk of co-sleeping, in all cases where there is a baby under 1 year old.

- Recommendation 7

There is an accepted system in place nationally for GPs with a special interest (GPWSI) in a particular area of work to undertake sessions in those services whilst also maintaining their GP role. The IMR for Primary care highlighted the situation in which M1's **GP** "was writing to himself" as he worked on a **sessional basis at the Addictions clinic** whilst maintaining GP responsibility for M1 and her children. This arrangement did not leave any capacity for the medical practitioner to reflect on his practice, particularly as M1 was a regular attender at the GP practice was not always compliant with medical advice, was quite demanding at times and showed "significant drug seeking behaviour". It is important that the two strands of care are able to be kept separate so that in both roles the GP can "see the adult, see the child".

7a. Public Health as lead commissioners should seek assurance from Northumberland Tyne & Wear NHS Foundation Trust that where GPs are employed on a sessional basis in drug and alcohol services that they are aware of the possible conflict of interest if they were to see the same patients in both the substance misuse clinic and their own GP practice.

7b NHS England Area team should work with GPs with special interest (GPswSI) to consider objectively the potential risks and options in order to mitigate risk where the GPwSI is also the patient's GP.

- Recommendation 8

The role of commissioners as Robert Francis identified in his Inquiry into care provided by Mid Staffordshire NHS Foundation Trust published in 2010 (16) is to apply safety and quality standards to contract arrangements and have adequate resources to enable effective scrutiny of services. The changes in commissioning discussed in section 3 have shown that there is a danger of fragmentation of systems which have in the past been robust. There is a need for tighter systems of monitoring of safety and quality by commissioners.

8. The CCG needs to further develop its systems assurance processes around the whole commissioning of safe and quality safeguarding systems by a review of service specifications relevant to this review and an exploration of the use of:

- **Performance dashboards.**
- **The section 11 Children Act 2004 audits.**
- **The soft intelligence from the safeguarding network.**
- **Action plans from case reviews, including this one.**

- Recommendation 9

The review has highlighted the gap in the LSCB procedures which do not require the automatic attendance of health visitors at unborn baby conferences. This is a significant gap and it is not acceptable to wait until the LSCB amend the procedures.

1. Northumbria Healthcare NHS Foundation Trust should ensure that the HVs are attending pre-birth conferences as a matter of routine and good practice. In the event that a HV cannot attend it should be the duty of the MW to liaise with the HV after the conference to ensure that the outcome of the conference is shared.

- Recommendation 10

The recommendation in the Northumbria Healthcare NHS Foundation Trust IMR addresses the need for an internal dental pathway. The issue of whether Independent dental practices are recognising dental caries as a feature of neglect in children is another finding of this review. In order that this can be addressed there is a recommendation around this.

2. **NHS England Area team will seek assurance that Independent Dentists receive Safeguarding training in relation to their roles and responsibilities highlighting the features of dental presentations in neglected children and the requirement to refer to other services, including Children's Social Care. This assurance should be shared with the NSCB.**

- Recommendation 11

The IMRs identified learning around a range of administrative issues which need addressing in the 3 healthcare providers.

11a. Northumberland Tyne & Wear NHS Foundation Trust needs to assure itself and the NSCB that its internal administrative systems are robust, to ensure that external invitations to meetings, letters, minutes etc. are dealt with effectively.

11b. Northumbria Healthcare NHS Foundation Trust should review the timeliness of discharge letters to GPs.

11c. Northumbria Healthcare NHS Foundation Trust should ensure that a minute is kept of the monthly communication meetings between health visitors and midwives.

11d. Primary Care Single Agency Training must continue to stress the importance of regular "Supporting Families" meetings with key staff to discuss vulnerable families.

11e. Northumbria Healthcare NHS Foundation Trust should ensure that the staff who work in Primary Care Teams can attend the regular "Supporting Families" meetings (see recommendation 11d).

11f. Northumbria Healthcare NHS Foundation Trust and Service 6 should consider whether letters sent from their agency to other agencies should contain a section which includes actions to be taken by the receiving agency.

Appendix 3: Northumberland County Council Children's Services

Eve's life was short and the information about her life which was available to Social Care during her life was that she was being cared for appropriately and her withdrawal was being managed well. This information was gathered during visits to see the family by SW2 and also information given by other professionals such as Consultant Paediatrician and Specialist Midwife.

As a result of this review it has become apparent to Social Care that the multi-agency assessment and planning during the period Eve was an unborn baby could have been more robust and timely. The information regarding M1's pregnancy could have been brought to Northumberland County Council Children's Services attention at an earlier opportunity and child protection enquiries could have been initiated earlier in order to allow more time for assessment and planning around her birth.

Assessments did not fully consider the role of F1 in this case and it is important that all relevant adults are considered, with due attention given to gathering detailed and historical information to inform case planning.

The Child Protection Conference process where unborn babies are being considered needs to more explicitly hold the multi-agency Core Group to attention for the birth and discharge planning. A pre-discharge meeting would have given the opportunity to identify visiting patterns and frequency and share information regarding the care Eve required. Ages of Concern (2011) highlights lessons learned from previous Serious Case Reviews and highlighted 'the importance of good planning when babies are discharged from hospital'.

In this case, the review process has also highlighted that there were some issues with the transfer of care and prescription for M1 between midwifery services and also that Eve may have had a tendency for low birth weight, which could require a high level of monitoring. These issues may have been picked up at a pre-discharge meeting. A further theme identified in 'Ages of Concern' is relevant here and the report stated *'Where there were failings, this was often because of the need for better coordination between the different aspects of health provision involved with the safeguarding of babies. There is a particular emphasis on the transfer of care between Midwifery services, Health Visitors and GPs'.* (Ofsted 2011).

The Public Law Outline process in this case should have been more targeted in order to capture the need for a parenting assessment / risk assessment of F1 as a protective factor to keep Eve safe. In all cases where babies are subject to Child Protection Plans, pre-discharge meetings should be convened by Health and Social Care prior to leaving hospital.

In respect of Eve and her siblings, there is learning regarding the way supervision is used to take into account the child's journey through services, to understand the cumulative effects of neglect and capture what life is like for the children experiencing neglect. In addition, how supervision is used in order to analyse the impact of a parent's avoidant or hostile behaviour on planning for the children. Since Eve's death, 'NSCB Practice Guidance – Childhood Neglect' (July 2013) has been

issued to support practitioners and managers in their work. This was not available to the professionals working in this case at the time.

There is evidence of good practice in this case in relation to the relationship and communication between the Social Work Team and Ante-natal substance misuse service. Information sharing is good and especially so as the risks escalate and M1's substance misuse becomes unstable. It is apparent from the social care record and from the interviews with Social Workers 1 and 2 that the Addictions Worker was proactive in contacting Northumberland County Council Children's Services and on occasions undertaking joint visits to facilitate engagement. Communication regarding M1's substance misuse issues becomes considerably reduced from the point the treatment and care is transferred to the Substance Misuse Midwife (as part of ante-natal care).

In the light of the learning in this case it is essential that Supervision sessions and Core Groups are supported to function in a reflective way and to consider fully issues such as engagement, hostility and sustainability of progress against plans. They need to consider the 'here and now', but always in the light of the full history of the case.

Recommendations:

1. **Assessments need to consider the whole case history in detail when making conclusions regarding risks and protective factors in neglect cases.**

Updated assessments should contain a case summary at the outset in order to provide detail of the historical involvement.

This will improve the quality of assessments and give full weight to historical issues of neglect. Case file audits will be undertaken in order to evaluate the impact of this recommendation.

2. **Ensure that assessments fully consider all relevant adults connected to the child and give sufficient weight to fathers when assessing risks and protective factors.**

Case file audits will be undertaken in order to evaluate impact.

3. **Multi-agency procedures need to be revised and strengthened to ensure that Core Groups are required to undertake birth and discharge plans and Child Protection Conferences are required to be satisfied they are appropriate.**

Audits will be undertaken in order to ensure birth and discharge plans are in place and that they are explicitly referenced at conference.

4. **Ensure Senior Management oversight of all decisions to end a PLO.**

Case file audits will be undertaken in order to evaluate impact.

Northumberland County Council Children's Services Addendum

Summary and Conclusions

- The interviews with SP1, TM1 and SM1 have addressed the queries raised by the independent author. There is clear evidence that the PLO Letter before Proceedings was agreed prior to the ICPC and this was noted in the conference minutes and was a recommendation in the child protection plan.

- Significantly, the risk assessment of the father under the Letter before Proceedings was not completed by the SW. Furthermore, the Core Assessment under the child protection plan was not completed by the SW and the Core Group. The Core Assessment was a recommendation from the ICPC, RCPC and the working agreement. Had these assessments been undertaken, the overall plan for the child could have been revisited by the Core Group, SP1, TM1 and senior management.

- Whilst the risk assessment on the father did not feature as a clear recommendation in the child protection plan, the PLO Letter before Proceedings or the Working Agreement, the child protection plan did recommend a Core Assessment. This should have incorporated an element on parenting and parenting capacity which could have provided an assessment of the father. Additionally, it is a concern that the Working Agreement was not confirmed until the time of the first RCPC and is dated the 25th February 2013, the date of the PLO Letter before Proceedings review. The RCPC was on the 27th February 2013. I have not had sight of a signed Working Agreement.

- There has been a lack of management oversight by the social care team in ensuring that the PLO Letter before Proceedings was issued in a timely manner. There may have been some confusion in the team (note: we have not been able to confirm this with the Social Worker) with the Social Worker being supervised by the Senior Practitioner and seeking informal advice from the Team Manager. However, in my view, having access to two managers (in the same building and team) for advice and support should or could have provided additional guidance and management oversight to the Social Worker to ensure that the relevant safeguarding tasks were completed.

- There is a difference of opinion as to whether the PLO Letter before Proceedings ended. However, the evidence supports the view that it was brought to an end. This concurs with the view of the Senior Practitioner. The legal advisor who attended this meeting also supports this view. Furthermore, it would not be appropriate for the Core Group to have the responsibility to monitor the progress of the PLO Letter before Proceedings and TM1 should have set a review date for this to be formally reviewed by her.

- It is accepted that the team is a busy social care team. However, the team had the equivalent of two managers and arrangements were put in place as soon as practically possible to have two team managers in place, leaving the additional senior practitioner in place to add to the management capacity. In addition to this, the team were supported by the senior manager.

- To improve practice within Northumberland County Council Children's Services, in 2014, a number of important developments have taken place regarding pre–proceedings work: the timeliness of the PLO Letter before Proceedings being issued, the period of the Letter before Proceedings, the key review points, and the involvement of the senior manager in ending the Letter before Proceedings.

- The Care Proceedings Team now track all Immediate Issues and Letter before Proceedings cases and a 7-10 day timescale has been agreed for the actual issue of the Letter before Proceedings and a 14 day timescale for the paperwork to be with legal for Immediate Issues.

- In addition to this, the Department for Education have published 'Court orders and pre-proceedings for local authorities, April 2014'. This provides helpful guidance around pre-proceedings and more specifically around the timing of reviewing the Letter before Proceedings, advising a mid-way review no later than 6-8 weeks and a further review at no later than 12-16 weeks. This has been implemented in everyday practice.

- Furthermore, reference to the Letter before Proceedings has been incorporated into the new children and family statutory assessment with a guidance note on the assessment template advising of the above minimum timescales and that the senior manager should be involved in ending all Letter before Proceedings.

Recommendations

1. Senior Managers to ensure that all staff are aware of the pre-proceedings guidance: to ensure that the PLO Letter before Proceedings is issued within 7-10 days, has a midway review at 6-8 weeks and a further review at 12-16 weeks.

2. Where the Senior Practitioner is the allocated SW, they must also attend the initial and review PLO Letter before Proceedings meetings.

3. Team Managers to ensure that senior managers are involved in the decision making to end PLO Letter before Proceedings and that this is evidenced on ICS.

4. Senior Managers to ensure that the Team Manager is accountable for such cases and that they sign off the PLO Letter before Proceedings, the First Core Group and the Working Agreement and that these fully address the risks

identified and the work required to be undertaken by the Core Group, to include any specific assessments.

5. Following the PLO Letter before Proceedings 6 week review meeting, a new Working Agreement is drawn up and an updated children and family assessment is undertaken.

6. Senior Managers to ensure that the Senior Practitioners and Team Managers complete monthly workload profiles with staff to reassure themselves around workload capacity.

Appendix 4: Northumberland County Council Education Service IMR

Although both schools involved in this review are independent from the Local Authority they are distinct from each other in terms of their history and organisation and this is apparent in their separate safeguarding arrangements and standards and their involvement in this case.

It is the author's view that there is learning from this case for the way in which all independent schools, whatever their history and organisation, work to safeguard and promote the welfare of children. We can learn that:

- there is the potential for conflict of interest between promoting a community ethos and keeping children safe;
- professional boundaries are crucial if challenge is to be effective and relationships are to improve rather than threaten safeguarding procedures;
- training should emphasise the identification of indicators of risk and a holistic multi-agency approach to safeguarding;
- professionals should be aware of and supportive to those inexperienced in child protection procedures;
- appropriate representation on independent school Governing bodies is vital if standards are to be monitored and met successfully, particularly if the Head teacher does not have a background in teaching;
- lines of accountability with regard to safeguarding standards for Head teachers of independent schools should be clearly defined.

Recommendations:
On the basis of section 5 above:

1. Northumberland LSCB should consider developing a strategy on how to communicate and monitor safeguarding standards and expectations to all schools, to ensure that this is incorporated into the organisation from its inception;
2. The strategy should outline procedures for appropriate intervention by the LSCB, Local Authority or other agencies to hold education settings accountable if standards are not high enough or there is evidence of failure to recognise indicators of risk to children in the context of neglect;
3. Further consideration should be given to the developing relationship of independent schools with the Local Authority to ensure that responsibility for the safeguarding of children and duty of care is shared appropriately.

The LSCB and Local Authority should investigate further and then if appropriate seek to influence the DfE to review the application processes and guidance for independent schools with a view to ensuring that safeguarding is a priority.

Appendix 5: North East Ambulance Service (NEAS)

Prior to this incident the service had no previous involvement with the family. Due to the difficulty gaining information from M1 on the initial call there was limited information to hand for the arrival of the crew.

Incidents of this nature are quite emotional. Frontline staff become very focused in the resuscitation process as in this case and did not consider the wider safeguarding concerns of the other children. They were not able to gather information from the mother, due to her distress, regarding the family or the medical history of EVE; so they were unaware of Eve being on Oramorph or of M1's medical history.

Recommendations:

1. Reinforce with the paramedic involved in this incident the guidelines in respect of Intraosseous needle as a first line of drug administration in a paediatric cardiac arrest. This has been carried out when conducting the interviews, discussion took place around the decision making to 'load and go'.

2. Develop a procedure for staff in respect of leaving vulnerable children/adults at home when the main carer is taken to hospital. Discussion has taken place with the training department to include this on the safeguarding training on the Essential Annual Training Programme for 2014/15.

In the meantime to ensure all staff are aware of the procedure, a patient care update will be released electronically to staff and be displayed on the intranet which can be accessed by all staff.

Appendix 6: Northumbria Healthcare NHS Foundation Trust (NHCFT)

Conclusion: What Can We Learn From This Case?

NHCFT provides a range of services. This review has highlighted some good practice, areas for improvement and lessons to be learnt.

School Health Service

There were many examples of very good practice by the school health service particularly by SHA1 who was persistent and adopted the approach of checking out the parents' assertions (once SHA1 had realised they were being dishonest with SHA1).

SHA1 shared information in a timely fashion both with parents and professionals.

The assessment undertaken in August 2012 was holistic and in-depth and both S1 and S2 were present and spoken to.

SHA1 ensured the right people were informed of important information, for example by making a referral to Children's Social Care on the 10th September 2012, to inform the social worker that they were concerned in relation to the neglect of S1 and S2 and their concern that M1 was pregnant.

SHA1 confirmed in writing with the parents any actions they agreed to undertake, and ensured they had the required information to enable them to undertake those actions; for example contact numbers for ophthalmology department, dental surgery and GP appointments.

SHA1 made it clear to the social worker on a number of occasions dating back to July 2012, that SHA1 believed the children were suffering from chronic neglect and that a child protection plan should be in place.

The record keeping by the school health advisors was of a high standard.

The school health service attended all of the child protection meetings apart from the meeting held on the 29th March 2012.

The concerns that NHCFT can learn from are as follows:

The Care team did not become aware of the concerning serious condition of S1's teeth until after the Initial Conference held on the 27th November 2012. An area for improvement for all school health advisors and others would be to check-out as a matter of routine, where possible, the parents' assertions, for example, checking with the dentists the condition of the child / young person's teeth and compliance with attendance for appointments. In addition, checking with the GP whether or not the child / young person has any other health needs such as specialist services that might be involved e.g. ophthalmology.

Maternity Services

There are examples of good practice in that M1 was offered immediate admission

when she attended the antenatal substance misuse clinic pleading for help.

M1 and Eve were also provided with good service whist in hospital; Eve was monitored closely and provided with appropriate care and treatment.

The hospital midwife contacted the social worker following Eve's birth to inform Children's Social care and specifically asked if a pre-discharge meeting was required.

M1 was also referred to a specialist for her back pain and was given a physiotherapy assessment and advice on pain management whilst in hospital.

The hospital midwives gave M1 advice and instruction on administering Oramorph and M1 was assessed as competent to administer Oramorph to Eve. M1 was also given advice on safe storage.

The concerns that NHCFT can learn from are as follows:

- The ante – natal booking-in assessment undertaken was not in depth and the appropriate response / action was not taken. M1 disclosed during the Midwifery Early Pregnancy Assessment (level1), that she had been feeling down, depressed or hopeless and had little interest or pleasure in doing things over the previous month. There is no evidence that the midwife explored this with M1 or offered her any other support or a referral to any other service e.g. Peri-natal service or GP.
- There was some confusion regarding roles and responsibilities which led to assumptions that someone else was taking action when they were not. This resulted in policies and procedures not being followed. For example, crucially, a referral to Children's Social Care was not made following the Midwifery Early Pregnancy Assessment (level1) and a Birth Plan was not completed.
- There is no record of the communication meetings that were held with the health visiting team.
- Attendance at the Child Protection meetings by the midwifery staff was poor. The only meeting that was attended by the community midwives was the Core Group meeting held on the 6th December 2012 when the named / allocated midwife attended (she had not ever met M1). SMW1 did not attend the Initial Child Protection Conference (as not invited) but attended the CPR held on the 12th February 2013. SMW1 attended the Core Group held on the 6th December 2012, but did not attend the Core Group meeting held on the 26th February 2013 or the 28th March 2013.
  The obstetrician did not attend any meetings.
- There has also been a significant issue with regard to important information not being recorded in M1's records by SMW1 (see chronology for details of contacts):
  - 23/11/2012 – telephone call to addictions worker.
  - 17/12/12 –– telephone call to social worker.

- 03/01/13 – telephone call to addictions worker.
- 16/01/13 – telephone call to addictions worker.
- 17/01/13 – telephone call from addictions worker.
- 24/01/13 – telephone call from addictions worker.
- 04/02/13 – telephone call from addictions worker.
- 25/02/13 – email to addictions worker.
- 27/03/13 – telephone call to addictions worker.
- 27/03/13 – telephone call to social worker.

- There were significant concerns in relation to the lack of information sharing on a number of occasions as follows:

- The social worker was not informed that M1 had booked-in with maternity services on the 15/11/2012.

- The social worker was not informed that M1 missed her appointment at the Substance Misuse Clinic on the 19th December 2012 (despite missing previous appointment on the 5th December 2012).

- The Addictions Service were not informed of M1's discharge following the birth of Eve (on the 14th March 2013), until the 27th March 2013.

- The social worker was not informed of M1 failing to attend with Eve for her post-natal discharge on the 19th March 2013.

- The professional contact by the community midwifery service with M1 was not what it should have been either in the ante-natal or post natal period (particularly given that Eve was a small baby and M1 was administering Oramorph to her) and was not compliant with the Trust's guidelines.

- SMW1's report was overly optimistic and did not include missed appointments.

- CMW1 did not have any knowledge of withdrawal symptoms in babies or the risks in relation to the management of a baby suffering withdrawal including the risks associated with Oramorph. As a consequence the community midwife did not discuss the issues with M1 and did not consider the risks for Eve.

Health visiting service

There are examples of good practice in that during the antenatal period on the 6th March 2013, the health visitor completed an in-depth, holistic assessment and provided appropriate advice and education. The health visitor informed the social worker appropriately when M1 missed her Primary visit on the 21st March 2013 and made further attempts to contact M1 and F1 that day.

The concerns that NHCFT can learn from are as follows:

- Attendance at the Child Protection meetings by the health visiting service was poor. HV1 did not attend the Initial Child Protection Conference held on the 27th November 2012 or the Child Protection Review conference held on the 12th February 2013 (as not invited to either). The only meetings HV1 attended were the Core Group meetings held on the 26th February 2013 and the 28th March 2013.
- The health visitor recorded in their plan on the 22nd March 2013, following a Primary contact with M1 and Eve, that they would undertake a 6-8 week assessment, attend Core Groups and provide support to the family as required. This is not appropriate as M1 and Eve required regular pro-active contact given Eve's vulnerability and M1's problems with drug misuse. The health visitor stated this was a record keeping issue, however there is no evidence that a further contact was planned at the time of Eve's death on the 30th March 2013. This indicates that the health visitor did not understand the vulnerability of Eve.
- There is no record of the communication meetings that were held with the community midwives.

Northumbria Healthcare NHS Foundation Trust (NHCFT)'s Dental service

There are examples of good practice in that the dental service did attempt to engage S1 and his family.

The concerns that NHCFT can learn from are as follows:

- The dental service did not share with other professionals that S1 had severe dental caries and extremely poor oral hygiene and that S1 had missed a number of important appointments for treatment. This suggests that the dentists did not consider that his dental issues may have been an indicator of neglect.

  The dentists acknowledged that for many reasons, they struggle with deciding when a case reaches the threshold for further intervention. During interview it was clear that there are a number of barriers which hinder the dentists in terms of making judgements with regard to when a child or young person's dental needs are being neglected; these issues need to be overcome.

NHCFT's Safeguarding Children Team

There are examples of good practice in that the safeguarding children nurse advisors did provide SHA1 and HV1 with regular supervision. The concerns that NHCFT can learn from are as follows:

- The Safeguarding Children Nurse Advisors were not challenging enough in that concerns were not escalated and the views and decision–making of other professionals challenged.
- The nurse advisors did not appear to have the level of concern that the author

would expect in relation to M1's lack of ante-natal care and drug misuse and the risks to the children, particularly Eve.

- Information sharing internally was not as good as it should have been, in that the Safeguarding Children Team covering acute service (including midwifery staff) were not informed that M1 had not booked – in for ante-natal care.
- A chronology was not compiled which would have clarified the concerns and provided good evidence of the action required, i.e. CP proceedings much earlier and the safety of S2 whilst in M1's care reviewed.

General Comments

- There was evidence that some of the health staff did not have a good understanding of the history in this case and this appears to have led to the risks being minimised and an overly optimistic approach to the management of the case (this does not include SHA1).
- The working relationship between the Addictions Service and NHCF8T's Substance Misuse Service was compromised.

Recommendations

1. NHCFT to review and improve the maternity record keeping system used by the community midwives to minimise the number of records community midwives record in. NHCFT to review the system of pregnant mothers holding pre-natal and postnatal records when there is no other copy of the information documented in the records. This could present a difficulty for the Trust if the records were lost or damaged e.g. for reviews such as this one, responding to complaints etc.. It also means that the midwives do not have easy access to this information.

2. NHCFT to assure themselves that the assessments undertaken by the community midwives are of a high standard and that appropriate action is taken in response to the findings of the assessments.

3. NHCFT to ensure the Maternity Guidelines on the 'Management of Women who Misuse Substances in Pregnancy' are updated and include whether it is the Community Midwife's or Substance Misuse midwife's responsibility to ensure:

- The completion of the Birth plan.
- A referral to children's social care is made when required.

In addition, to ensure the role and responsibilities of the allocated/named midwife are clarified, particularly with regard to corporate teams.

4. NHCFT to ensure that a formal robust communication pathway/protocol is developed and implemented to ensure that NHCFT's Dental Service routinely inform HVs and PHSNs of children they see, the condition of their teeth and oral hygiene and of any missed appointments.

5. NHCFT's dentists to receive regular group supervision specifically in relation to safeguarding children.

6. NHCFT to ensure community midwives receive individual supervision specifically in relation to safeguarding children, from NHCFT's Safeguarding Children teams, on a 6 monthly basis as a minimum.

7. NHCFT to review the capacity and the role of the Substance Misuse Midwife and any required changes in relation to the capacity or the role itself to be implemented.

8. NHCFT to remind health visitors, school health advisors / public health school nurses and midwives of the Trust's policy that they must give attendance at child protection meetings the highest priority, and inform NHCFT's Safeguarding Children Team immediately they become aware that they will not be able to attend, and have been unable to arrange representation from a colleague. The importance of being there to share information, to be informed of the concerns and to participate in the decision-making and the plans for the children must be emphasised to the staff.

9. NHCFT's safeguarding teams to review all invitations to child protection meetings and inform any staff of the meeting who they believe need to participate and have not been invited.

10. All health visitors, school health advisors / public health school nurses and community midwives to be reminded of the importance of attempting to confirm the accuracy of information given to them by parents or children with regard to children in need or those for whom there are concerns regarding abuse or neglect.

11. NHCFT to ensure that the Safeguarding Team Nurse Advisors receive training to ensure they are aware of the learning from this case in relation to the following:

- Their role in terms of gaining a good understanding of the history via the use of chronologies.
- The importance of challenging the decisions of others both internally and externally when required.
- The importance of ensuring the appropriate staff are informed of concerns regarding risks to children.

12. All community midwives and health visitors understand the signs, indicators and possible consequences of an overdose of Oramorph and of withdrawal in babies suffering from Neonatal Abstinence Syndrome (NAS).

Appendix 7: Northumbria Probation Service

From the Offender Manager's account of life in this family, there are clear indicators of neglect. There were issues around the cleanliness of both the children and the house, and lack of food (drug abusers often do not feel hungry themselves and fail to recognise it in others). The Offender Manager had real concerns about the children - S1 taking on responsibility for S2 at a young age (particularly when playing out in a busy street), and S2 climbing dangerously over the furniture and being allowed to. S1 is described as being withdrawn and being very protective of M1, and S2 as being very clingy to M1. The house and garden were, however, full of toys but there was very little space in which to play with them. F1 was a shadowy figure, and did not appear to play any major role in the family or become involved in the social work intervention. This was becoming focused on M1, who was desperate to have her progress acknowledged, to the extent that she showed the Offender Manager around the newly cleaned house and the full food cupboards.

"Neglect is the persistent failure to meet a child's basic physical and or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance misuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment).
- Protect a child from physical and emotional harm or danger.
- Ensure adequate supervision (including the use of inadequate caregivers).
- Ensure access to appropriate medical care or treatment.
  It may also include neglect of, or unresponsiveness to, a child's basic emotional needs." (Working Together 2010)

The allocation of a Child in Need case to such an inexperienced officer was unusual, but she did handle the case well. However, her inexperience was evident in three instances, none of which were picked up by her Team Manager or mentor: the failure of registering the case as medium risk to children; the lack of a formal letter to Northumberland County Council Children's Services at termination of the Order; and the fact that no Child Protection referral was made. However, the level of home visiting, the contact with other agencies and the detailed recording are well above average. Specific guidance should be given on the allocation of such cases, and be included in the forthcoming revision of the Child Protection Policy.

It is also of concern that we have been unable to locate the letter written by the Team Manager to Northumberland County Council Children's Services. Copies of such letters should always be placed on file.

The use of home visits – both planned and unplanned – was good practice along with the detailed recording that followed. The Offender Manager encouraged and motivated attendance at parenting classes by using Probation appointments to facilitate this. Regular liaison with Northumberland County Council Children's Services/Addictions and attendance at Signs of Safety meetings ensured that the offender manager was fully involved in the case.

From the literature referred to above, it is clear that neglect is an issue perhaps not fully understood. Inter-agency training on indications of neglect and professional responses to it would seem to be a priority.

In terms of management and supervision, even though it was not an issue in this case, guidance should be issued to all Team managers on the allocation of such cases, and the provision of detailed supervision through the Child Protection Policy. Partnership working needs to be an integrated process, with all agencies taking responsibility for their work.

Recommendations:

1. (a) The Child Protection Policy should be updated to include:
    - Guidance on the allocation of cases to trainees
    - Team Manager supervision of such cases

    This would be undertaken by the Safeguarding Communities Manager – as has already been agreed – and will be completed by 30/09/13

   (b) Staff will be reminded of:
    - The importance of registration
    - Copies of all letters should be placed on file
    - Northumberland County Council Children's Services need to be informed when Probation withdraw from the case at termination of Order.

   These will also be included in the Child Protection Policy, but the Safeguarding Communities Manager will also issue a reminder to staff by 31/07/13.

2. This should ensure that all staff are aware of the issues raised by this SCR, and use the guidance to improve practice. Safeguarding cases are discussed monthly in supervision, and inspected both internally and externally on a regular basis. The Trust also has an internal process where a number of cases are subject to peer review on a monthly basis (DRIVE).

Appendix 8: Northumberland Tyne & Wear NHS Foundation Trust

Does a picture of the child's life emerge from the report that helps us to understand what it was like for him or her, what might have helped, whether s/he was the main focus of activity and did staff fulfil their responsibility to safeguard children.

A picture of the children's lives has emerged from the assessments and observations of the addictions key worker and information provided by other agencies. The children were living in an environment with a drug using mother, their general health needs were not addressed and many health appointments missed i.e. opticians, dentist. Work was ongoing with M1 to encourage her to address the effects her substance use was having on her ability to provide a safe, nurturing environment for the children. Due to regular absenteeism from school it could be assumed that both children were behind with basic educational skills and academic studies.

Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children?

Clinicians are aware of their responsibility in attending conferences, providing written reports and attendance at core groups. However during the review period there were high levels of verbal communication between addictions key worker and SW2 and only a verbal update was provided for the November and February conferences. The addictions key worker was unable to attend due to leave so was unable to challenge any decisions or offer any suggestions and contribution, for future care planning and safeguarding of the children. The importance of attending conferences and core groups for subsequent care planning needs to be part of everyday practice.

Clinical supervision was facilitated by an appropriate supervisor; however this was not recorded in the health records. Safeguarding supervision was not requested when the children were placed on a child protection plan, M1 had disengaged from addictions at this time and discussion was held within the multi-disciplinary team.

Ante-natal substance misuse service staff are aware of the importance in working in collaboration with other services to provide a full care package for all service users including pregnant women. During the review it has been evident that partnership working has been difficult in this situation. A further review of the pathway between addictions and obstetrics needs to take place to ensure women receive a seamless service during pregnancy, labour and discharge.

Addictions staff are fully aware and have a code of practice to follow regarding record keeping. It became evident during the review that communication had taken place but at times was not recorded in the patient's health records. The author was informed immediate action had taken place to ensure all emails etc. and MDT meetings are recorded in patients' health records.

Is there good practice to highlight as well as ways in which practice can be improved?

The author highlighted a number of areas of good practice during the review within the care and treatment that was provided to M1 and her family.
Initially back in 2007 when M1 re–referred herself to Ante-natal substance misuse services, she was offered an assessment appointment the following day. During the assessment details of the children were obtained and documented. Appropriate questions were asked to obtain information regarding external agencies involved with the family. Addictions later made contact with Northumberland County Council Children's Services to inform them of the referral and obtain further information. Following assessment a decision was made to offer M1 a substitute prescribing treatment programme.

During M1's ongoing involvement with addiction services she has remained with the same Key Worker, this has provided consistency and continuity to therapeutic intervention.

Ante-natal substance misuse services acknowledged that M1 had difficulty in attending and keeping appointments. The Addictions Key Worker used a number of strategies to engage and maintain M1 in treatment. Appointments were initially offered in clinic but these changed to home visits.

Addictions identified support staff to assist with and support M1 with ongoing parenting issues.

M1 was referred into the 'Parent Factor' course, which is a nationally recognised course which encourages 'substance using parents' to reflect on their own substance use, the effects on the child/children and the effects of their substance use on their parenting ability.

Addictions Key Worker escalated concerns regarding M1 and the children and followed Trust policy and procedure regarding safeguarding children, non attendance and difficult to engage service users.

Following the birth and discharge of Eve, Addictions Key Worker liaised with the Pharmacy and resolved prescription issues outside of her remit as this was the obstetric team's prescriptions at that time.

The Addictions Key Worker escalated and requested a Core Group Meeting following the discharge of M1 and Eve from hospital to discuss the lack of multi-agency working and future planning for this family.

Are there implications for ways of working; training (single and inter agency); management and supervision; working in partnership with other organisations; resources?

Since 2008 the Trust has in post a 'Named Nurse'/Head of Safeguarding Children and Domestic Abuse. The team has progressed and is now well established within the Trust and within all LSCBs within the geographical area the Trust covers. There are policies and procedures in place for all staff and clinicians to follow based on Working Together to Safeguard Children 2010 & 2013. There is a full and

comprehensive training strategy in place and the training is now part of the statutory and mandatory training which all employees have to undertake.

Clinicians have access to multi- agency training provided by the LSCBs which the Trust contributes towards. Partnership working is also well established and mental health staff are fully aware of the importance of informing and contributing to investigations by external agencies in order to safeguard children and young people.

Recommendations:

1. Northumberland Tyne & Wear NHS Foundation Trust to work in partnership with the Care Trust and obstetrics to review the care pathway for pregnant substance using women, to provide a stronger more integrated care package for women and their families and a more robust collaborative working relationship.
2. Northumberland Tyne & Wear NHS Foundation Trust staff working with families who are undergoing section 47 enquiries, to contribute to the assessment, discussion and planning in order to safeguard the child/ren (see Working Together 2013, pg 36 – 44). Providing a written report and attendance at the initial conference, core groups and reviews.
3. Northumberland Tyne & Wear NHS Foundation Trust addictions staff to ensure that all documentation regarding patient information is held within the electronic health records including emails and MDT discussions as per trust policy.
4. Northumberland Tyne & Wear NHS Foundation Trust staff to ensure that safeguarding supervision when involved with a family who are on a child protection plan is received within 6 months, and the recording of safeguarding supervision is documented within the health records as per policy.

Appendix 9: Primary Care (G.P Service)

The children were overlooked by the GP service. There was parental drug abuse, evidence of parental depression and the children therefore were vulnerable. GPs should remain child focussed during consultations with parents who are drug abusers.

When a GP has a consultation with a drug user, the GP should consider the following:

- Is the patient pregnant (if it is a woman)?
- Are there children in the household and how are they?
- Do I need to refer to any services (mental health team, children services)?
- Do I need to share information with any practitioners?
- Is there a father and what is his role and character?

There was evidence of poor coordination of services and lack of clarity in terms of who was leading as a service and who was supporting as a service in relation to substance misuse, especially when M1 was pregnant with Eve. A coordinated approach is needed by all agencies when a family member is a drug user. This is particularly important at critical times such as during antenatal and postnatal period and when there are children involved. This coordinated approach needs to be family centred, with the right balance, supporting the family and not overlooking the children. Services need to communicate effectively with one another.

Medication prescribed (repeat and acute prescriptions) to drug users should be clearly visible during each consultation in the electronic records in order to keep track of a patient's prescribing history. This should aid practitioners when medication reductions or changes are made for patients who are drug users. This should help practitioners to decide when to communicate with other agencies.

The GP Practice did not contribute effectively to child safeguarding meetings and sometimes was not included in the distribution list. This would have put the children at risk and needs to be improved. The written report needs to be on time and needs to contain relevant, proportionate information.

The discharge information following Eve's birth was delayed and did not contain crucial information. The GP was unaware that Eve was discharged with morphine. External letters need to be processed on time, relevant actions taken and computer coding added.

'Supporting families meetings' need to form part of general practice. This style of meeting needs to be advertised and discussed during single agency training for GPs.

Recommendations:

1. A "family template" should be developed for drug users in General Practice clinical records to include the following:

Current medication, parental status/contact with children, details of children, pregnancy, referrals to services, information shared with other practitioners, dates of meetings, contribution to meetings, mental health concerns, and Hidden Harm issues

Outcome:

This would enable the practice to have an overview of the family circumstances and an awareness of who else is involved and would promote good inter-agency working.

2. Medication prescribed to drug users needs to be clearly entered in computer notes. Clinicians may choose to insert them in the template used above or as part of every clinical encounter.

Outcome:

GPs and other prescribers in the practice will clearly see what has been prescribed, and when, to reduce the risk of inappropriate prescribing which may present a risk of harm to both the patient and their children.

3. The LSCB, Northumberland CCG and NHS England Area Team to work together to explore ways of promoting the engagement of primary care in all of the safeguarding children processes, including multi-agency meetings. This may involve investigating the obstacles to involvement, the use of technological solutions, inviting examples of good practice from other areas.

Outcome:

An improvement in GP and primary care staff involvement in safeguarding children, which can be demonstrated by increasing submission of information to multi-agency meetings and increasing attendance at all levels of decision making meetings.

4. Improved or restructured administrative arrangements within the practice to ensure timely provision of information.

Outcome:

To ensure GPs are aware of child protection concerns, meeting invitations, receipt of information requests should be dealt with in a timely way which enables them to make an effective contribution to the process.

Appendix 10: Northumbria Police

While there was no contact with Eve by Northumbria Police, over the years there was quite extensive contact with her family, especially M1, although there had only been one occasion in 2008 regarding neglect issues when S1 was left at home without supervision. S1 was also beginning to come to the attention of Northumbria Police, as he had been arrested on 2 occasions for theft/criminal damage and an occasion where he had been drinking alcohol. Officers were also aware that F1 had been banned from the local shopping centre as a result of his behaviour. The only incident that raised any safeguarding issues was the alcohol consumption. This was correctly dealt with via the CCN process. It was not possible for Northumbria Police to build a picture of Eve's life or comment as to whether she was the main focus of activity in regard to safeguarding issues.

There are no lessons to be learned by Northumbria Police.

There is no good practice to highlight.

There are no implications for ways of working for Northumbria Police.

Recommendations:

There are no recommendations for Northumbria Police

Appendix 11: Legal Services

4. Conclusion: What Can We Learn From This Case?

4.1 At the point of the decision to close the Letter Before Proceedings/PLO process and to move to oversight of the Working Agreement by the Core Group it is the author's view that L1 could usefully have been included in the discussions with TM1 and SW2.

4.2 Any disagreement about the exercise of the PLO process should have been escalated for discussions between the Principal Lawyer and TM1's line manager at Service1. The Letter Before Proceedings should have been sent out immediately after the Initial Child Protection Conference on 27 November 2013. The period of monitoring of F1 and M1's engagement under the remit of the Letter Before Proceedings was too short being for a period of 6 weeks.

4.3 The Letter Before Proceedings process would generally be expected to last 12 weeks.

4.4 The relevant points in the terms of reference have been covered throughout in this report.

It is important to recognise that during the conduct of this SCR continuing improvement work has been undertaken by the agencies involved. This overview report should therefore be read in conjunction with the LSCB response to the SCR.

Recommendations: Action by This Agency

5.1 **A checklist and guidance document for legal planning meetings including those where the PLO process is to be discussed, has been prepared by Northumberland County Council Children's Services and agreed with Service12.** The document needs to be incorporated into Northumberland County Council Children's Services' procedures and circulated to all Lawyers and Team Managers.

5.2 **There needs to be a standard format for legal advice at or following a legal planning/PLO meeting**. Advice should be given in this format where a request for a legal planning meeting has been dealt with by other means. Advice in writing should be sent to the Social Worker, Team Manager, Northumberland County Council Children's Services Manager and copied to the lawyers' manager within an agreed timescale. The Manager in Northumberland County Council Children's Services2 Legal Services Child Care Team should audit advice given for compliance.

5.3 **Requests for legal planning meetings must be accompanied by a proper referral and an agreed list of documents**. If the request for legal advice is dealt with as an emergency, as a general rule, lawyers do so without receiving the full background history. It would be beneficial for

Northumberland County Council Children's Services2 Lawyers to be provided with as much relevant information as possible including a chronology and any assessments if available at that stage. A legal checklist and guidance document for legal planning meetings has been drafted by Northumberland County Council Children's Services and deals with how referrals should be made to legal services, the information required and the format of such meetings. Requests for Legal Planning/PLO meetings should be monitored by Northumberland County Council Children's Services3 Child Care Team Manager for compliance.

5.4 **Lawyers and Social Workers should be clear about their respective roles in the decision making process around the issue of care proceedings. The role of the lawyer is to evaluate the evidence and advise on whether the threshold criteria are met and any other legal issues that arise.** The role of the Team Manager (in consultation with the Northumberland County Council Children's Services Manager) is to decide whether to issue proceedings, whether the child(ren) need immediate protection or whether there is time and opportunity to work with the parents in the pre- proceedings process with the aim of avoiding the need for care proceedings. There needs to be a clear understanding by Social Workers and Team Managers that a decision to pursue the pre proceedings/PLO process requires the threshold criteria to be met and an in principle decision to issue proceedings made by the Northumberland County Council Children's Services Manager in consultation with the Team Manager. This decision should normally be made following a legal planning/PLO meeting. Legal Services should be involved in checking the letter before proceedings by the team manager. A decision to stop the PLO process requires a similar structured decision making process. The Team Manager consults with the Northumberland County Council Children's Services Manager regarding the merits of stopping the PLO process once sufficient progress has been made. Advice from Northumberland County Council Children's Services2 is provided if required.
The decision making process needs to be fully documented and recorded in the minutes from such a review meeting.

5.5 **In the event of disagreement over a decision to cease the PLO process or if the lawyer is of the view that the process is in any way deficient there should be a mechanism for escalating those concerns to provide for a discussion between the Child Care Legal Services Manager and the Northumberland County Council Children's Services Manager**. This would enable a discussion between the senior managers of Northumberland County Council Children's Services2 and Northumberland County Council Children's Services regarding the merits of how the case was progressing, which they are not required to do within the current procedures.

Appendix 12: Summary of relevant evidence base

The IMR reports include references to the evidence base and research in relation to vulnerability as evidenced in the evaluation of other serious case reviews.

I would at this point refer briefly to issues from the evidence base, where I believe there are helpful lessons when reflecting on the circumstances of Eve's death. Given the brevity of involvement with Eve, due to her age, as with IMRs the evidence base has additional relevance when considering the history of M1 and F1.

Risk

Ages of Concern (2012)[7] is a thematic report covering the evaluations of 482 serious case reviews carried out between April 2007 and the end of March 2011. The focus of the report is on reviews that concerned children in two age groups: babies less than one year old and young people aged 14 or above 35% of the children were babies under the age of one year. In summary the report identified the following recurring themes

Shortcomings in the timeliness and quality of pre-birth assessments: Reviews identified the need for agencies to provide a very quick response to any concerns about the baby's welfare and development. While the speed of response is important for all age groups, the fragility of babies and their rate of development in the early months mean that agencies' swift response is even more essential.
The risks resulting from the parents' own needs were underestimated, particularly given the vulnerability of babies: whether these needs related to drug or alcohol misuse, a past history of being looked after, abuse suffered during childhood or being the victim of domestic violence as an adult.

- *There had been insufficient support for young parents: Findings from the reviews included concerns about teenage parents who had received inadequate support, or young parents who should have been considered as children in need in their own right. In most such cases the lessons learnt are not just about the challenges for young parents of bringing up a baby but also about the associated and cumulative risks arising from, for example, a troubled childhood, unsettled parental relationships and a lack of long-term accommodation.*
- *The role of the fathers had been marginalised: again and again, the reviews found that fathers had been marginalised, describing them as ignored, 'invisible' to practitioners or 'the ghost in the equation'.*
- *The need for improved assessment of, and support for, parenting capacity: The lessons about agency involvement with the parents are not just about risk factors arising from the parents' background and lifestyle; the lessons are also about the practitioners' assessment of parenting capacity. Findings included cases where there had been limited understanding by professionals of the impact of the parents' own experience of being parented; shortcomings in supporting parents both in preparing for parenthood and after the birth; and a failure to recognise that parenting can be a stressful process for which suitable materials and education programmes need to be provided.*

[7] Ages of concern: learning lessons from serious case reviews. 2011 Ofsted.

When considering the usefulness of research around parental problems a recent report by Cleaver et al[8] provides an update on the impact of problems, such as substance misuse, domestic violence, learning disability and mental illness, on children's welfare. When we recall M1's focus on her own medical needs and substance misuse the research by Cleaver et al contends that:

"When parents are preoccupied with their own feelings they may experience greater difficulty in responding to their child's needs, cues are missed and the parent appears withdrawn and disengaged (Martins and Gaffan 2000). Research suggests that the severity and chronicity of the issue affecting the parent is associated with its impact on parenting capacity…the known prevalence generally continues to rise with the seriousness of the child protection enquiry."

M1 and F1 both had historical difficulties that, in the terms of this research, would have been relevant and expected to have an impact on parenting capacity (see Table 1 below).

Table 1: Relationship between the rate of recorded parental problems and the level of social work intervention (Cleaver et al, 2011)

Parental problems	Referral stage	First enquiry or initial assessment	Child protection conference	Care proceedings	Serious injury or death
	%	%	%	%	%
Mental illness	10.4	16.8	25	42	63
Learning disability	0.8	2.6	N/K	22	15
Alcohol/drugs	5.8	11.4	25	23	33
Domestic violence	4.8	16.7	55	51	53

Brandon et al in their recent study of neglect and serious case reviews[9] comment in relation to neglect:

[8] Children's Needs – Parenting Capacity. Child abuse: Parental mental illness, learning disability, substance misuse and domestic violence, 2nd Edition 2011. Hedy Cleaver, Ira Unell, Jane Aldgate. TSO

[9] Neglect and Serious case reviews. A report from the University of East Anglia commissioned by NSPCC Marian Brandon, Sue Bailey, Pippa Belderson and Birgit Larsson University of East Anglia/NSPCC Jan uary 2013

"The possibility that in a very small minority of cases neglect will be fatal, or cause grave harm, should be part of a practitioner's mindset. This is not to be alarmist, nor to suggest predicting or presuming that where neglect is found the child is at risk of death. Rather, practitioners, managers, policy makers and decision makers should be discouraged from minimizing or downgrading the harm that can come from neglect and discouraged from allowing neglect cases to drift."
Also that:

"Lack of recognition by practitioners of the severity and impact of neglect emerged as a recurring concern in the early government commissioned analyses of serious case reviews in England and Wales (Brandon et al 1999; 2002; Rose and Barnes 2008). Rose and Barnes' study of 40 reviews from 2001–2003 emphasised the complexity and overwhelming range of problems in families where there was neglect and the erosion this had on parents' capacity to nurture their children safely."

In relation to one of their 6 themes, "maintaining a healthy, safe relationship" they comment as follows:

"Parents can wittingly and unwittingly be a source of danger rather than comfort to their child. Practitioners can miss the life-threatening risks that arise when relationships are so poor that care, nurture and supervision are almost non-existent. While every effort should be made to intervene early to prevent a parent–child relationship deteriorating in this way, once this has happened urgent action needs to be taken. Action is stalled when this danger is hidden, and when children, adolescents and families disappear from view.

Practitioners need to be sensitively attuned to the relationship between parents and children, even where parents present as loving but may be failing to cope, for example with the demands of their child's complex health needs or disability.

Older children carry the legacy of their experiences of neglect and rejection with them. As a consequence, threats to their own life can come from their own high-risk behaviour or from suicide. Adolescents need to maintain, or be helped to build, safe, healthy relationships with their peers and with caring adults."

Messages for policy makers, decision makers, practitioners and managers:
Routine contact between parents and professionals should be an opportunity to promote sensitive and attuned parenting. Early concerns should prompt targeted help from Children's Centre's, enhanced health visitor contact like the Nurse Family Partnerships, and other school or community-based help or services for example from Child and Adolescent Mental Health Services (CAMHS).

Missed appointments should be followed up and not considered a reason to withdraw a service. Children and young people who disappear from view may be at risk of severe or life-threatening harm from neglect. To be safe, children need to be seen and importantly, to be known. The fact that neglect is not only harmful but can also be fatal should be part of a practitioner's mindset as it would be with other kinds of maltreatment. Practitioners and managers should recognize how easily the harm that can come from neglect can be minimized, downgraded or allowed to drift. Practitioners should deal with neglect cases in a confident, systematic and

compassionate manner."

Relationship

The evidence base offers positive confirmation of the importance of creating constructive working relationships with parents and children. Munro cites Barlow and Scott (2010) reporting that:

'A recent overview of the evidence about effective interventions for complex families where there were concerns about (or evidence of) a child suffering significant harm, showed the importance of providing 'a dependable professional relationship' for parents and children, in particular with those families who conceal or minimise their difficulties' **Munro Review 2011**[10]

Turney et al (2011), however, make it clear from their research that this core task can be difficult;

"However, research continues to indicate that there are difficulties for many workers in making and sustaining relationships with children and with representing the child's voice in assessments. A number of personal and practical factors have been identified that affect the relationship between the practitioner and the child or young person. These include time constraints, insufficient skill or confidence in conducting direct work or undertaking child observations, and insufficient emotional support to ensure that workers do not become overwhelmed by such engagement. It is concerning to note that in some instances an opposite effect occurred, and lack of parental engagement led to less intervention, because parental obstructiveness effectively restricted access to evidence (Dickens, 2007; Farmer and Lutman, 2009)."

This is echoed in the Biennial analysis of Serious Case Reviews 2005-07[11] where 75% of families did not cooperate with services. This study also noted how fluid patterns of compliance and cooperation could be.

The reality is that working with families is very often working with people who are involuntary clients but who never the less are being assessed regarding their parenting. The professional relationship should be an authoritative understanding of developmental theory but also clear and purposeful regarding the parental capacity to change and clear about any change that does take place.

Analysis and Assessment

The ability of individual workers being able to carry out good quality assessments on behalf of their agencies in order to effectively plan for the safety and well-being of

[10] Munro, E. (2011) The Munro Review of Child Protection. Final Report – A child-centred system. London: Department for Education.

[11] Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. And Black, J (2009) Understanding Serious Case Reviews and their Impact. A Biennial Analysis of Serious Case Reviews 2005-07. Research Report DCSF-RR129.

children is a core competency when working with families. The Munro Review describes the uncertainty inherent in making predictions about children's future safety and how critical reflection and analysis are part of the minimum capabilities for social workers. The DFE 2011 research quoted opposite suggested that poor quality assessments typically feature:

- Gaps and inaccuracies in the information collected (or included in the file record).
- Description rather than analysis of the information presented.
- Little or no indication of service users' (including the child's) views.

Davies and Ward (2011) would also suggest how essential it is that, *"social work practitioners should understand the importance of finding out about and analysing historical information, particularly in cases of neglect."*

"Analysis" is rigorous, logical, systematic and methodical. Yet in work with families this still offers an incomplete understanding of the task. Critical thinking introduces the attitudes of reflection, interpretation and as Munroe would describe it, the constructive use of intuition:

"Gut feelings are neither stupid nor perfect. They take advantage of the evolved capacities of the brain and are based on rules of thumb that enable us to act fast and with astounding accuracy, shown, for example, in our ability to recognise faces. They are not infallible, as research shows, because intuitive judgments are vulnerable to predictable types of error. Critical challenge by others is needed to help social workers catch such biases and correct them – hence the importance of supervision." **Munro Review 2011**

Burton's (2009)[12] key messages are worth reiterating in full:

• Assessments are fallible, and contexts constantly changing. Therefore, professionals need to

Good assessment is a complex activity. It involves the systematic and purposeful gathering of information but is more than simply a process of collecting 'facts' (which may, themselves, be disputed). The practitioner needs to know why they are seeking the information in the first place, and then to be able to 'process' a mass of multi-faceted and sometimes contradictory material to come to a view about its meaning – including understanding its meaning to the child and to the parents - and to decide how to proceed. This requires a range of knowledge and skills, including the capacity to think analytically, critically and reflectively. Intuition also has a role to play and can, additionally, be helpful in establishing rapport and demonstrating empathy (Holland, 2010; Munro, 2008).

Social work assessment of children in need: what do we know? Messages from research DFE 2011

[12] C4EO Safeguarding Briefing 3, November 2009. The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?

keep their judgements under constant critical review (Munroe 2008).

• The single most important factor in minimising errors is to admit that you might be wrong (Munroe 2008).

• Nonetheless there is a tendency to persist in initial judgements or assessments and to re-frame, minimise or dismiss discordant new evidence. Bias is inevitable and comes from the many ways our minds can distort, avoid or exaggerate information.

• On the other hand some practitioners can respond to new information, not by sticking to their preferred view, but by jumping around from one item or theory to the next, never reaching a coherent conclusion or coordinated response.

• Therefore, practitioners must be willing, encouraged and supported to challenge, and where necessary revise, their views throughout the period of any intervention.

She concludes that practitioners and managers should; "...routinely play their own 'devil's advocate' in considering alternative actions, explanations or hypotheses". Specifically that:

"Supervision should provide a safe but challenging space to oversee and review cases with the help of a fresh, experienced pair of eyes and to systematically guard against either rigid adherence to a particular view or the opposite tendency to jump from one theory to another without resolution."

Relationship based practice and involuntary clients

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