Executive Summary

SIGNIFICANT CASE REVIEW

Undertaken on behalf of
Glasgow CPC

On

Child A

JANUARY 2017

CONTENT

Introduction

This Significant Case Review (SCR) was commissioned by the Glasgow Child Protection Committee in the context of the Scottish Governments National Guidance for Child Protection Committees on Conducting a Significant Case Review.

This SCR relates to the death of child A. Child A was aged fourteen weeks when she died in March 2015. At the time of death child A was known to health and social work services. An elder sibling was subject to a statutory supervision order and pre-birth procedures had been instigated as a result of historical concerns which included neglect, non-engagement and addiction concerns.

On the date of her death in March 2015 emergency services were called and attended at the family home. Child A was taken to the local children's hospital where she subsequently died. The cause of death was Sudden and Unexplained Death in Infancy (SUDI).

Following the death of child A Police attended the family home and noted concern in respect of the home conditions and evidence of drug misuse within the property. Police noted further concerns during the course of their investigation. Police submitted an Initial Case Review (ICR) and requested consideration be given to a full Significant Case Review.

The SCR panel was convened on 8th June 2015. At this time there was some question as to whether the case warranted a SCR. Further information was provided at the subsequent SCR panel on 6th August, where it was agreed to proceed to a full SCR. The panel agreed the Initial Terms of Reference. These were later revised and amended and agreed by the Review Team and Panel. The review would take account of historical agency involvement however would focus on the time frame from identification of the pregnancy until the child's death.

From the outset there was discussion and debate as to whether this case should be reviewed under the SCR protocol. The decision was taken to formally review and undertake a full SCR as agencies believed this case would allow greater examination and learning around the complexity of managing and intervening in cases of chronic or long term neglect.

As the report will go on to highlight there is a continuing need for all agencies to be alert to, and understand the impact of neglect. This is an ongoing conversation within Glasgow and requires to be an area of priority for practice development and improvement. Consideration needs to be given to the different levels of communication and supervision that are necessary to ensure that practitioners are given the opportunity to critically evaluate practice in cases of long term neglect and in working with resistant and non-engaging families.

Significant Case Review Terms of Reference

1. Review the nature of multi-agency discussion on pre-birth. Clarify which agencies were aware of the pregnancy.

2. Consider issues around the child being discharged whilst prescribed controlled drugs. As Mum had drug addiction issues but was responsible for administering controlled drugs to the child without supervision.

3. Consider issues with post birth discussion. Mum was non-engaging, - why did the case not proceed to a Post Birth Case Conference.

4. Consider issues around the nature of the social work and health assessment. The risks were not highlighted. i.e. mum's smoking, non-engaging, no evidence of workers examining the condition of the physical environment, no reference to alcohol use, or co-sleeping issues.

5. Review the assessment and involvement of the Addictions Team.

6. The timeframe for the investigation was pre-birth to post birth

7. Other circumstances to be reviewed:

    - Mum's parenting ability for the 3 older siblings, was she able to parent a fourth child.
    - Review the quality of assessment to see if accumulation of concerns were linked;
    - Consider questions around how workers interpret 'protective' factors i.e. close bonds between families are not necessarily protective if children's needs are not being met.

Historical Involvement

The family had a significant history of involvement prior to the birth of child A. Agencies that had direct involvement with the child and the family were requested to undertake a single agency review and to provide a report and chronology of their involvement with the family to the review panel.

The following agencies provided reports and chronologies:

- Social Work Services
- NHS Greater Glasgow & Clyde
- Police Scotland
- Education Services
- SCRA

In addition, a report and chronology was requested from Housing however this provided little detail to assist in the review.

A multi –agency chronology of historical concerns was compiled to offer a context of agency concern.

This highlighted

- Generational neglect and substance misuse
- Lack of meaningful engagement with addiction services
- Mother, grandmother and partner involved in drug dealing and criminality
- Community and domestic violence. Children exposed to violence
- Concealment of partners involvement and contact with children
- Mental health issues for mother with little engagement with services in respect of this
- Themes covering hostile and un-cooperative behaviour: resistant behaviour from : breakdown in relationship with Health Visitor, request for new SW
- Issues noted in respect of co-sleeping with two of the older siblings in hospital

The review identified critical practice episodes which it explored in sequence, examining each episode in terms of agency involvement, assessment, analysis, intervention and decision making.

The critical episodes were:

- Pre-birth/antenatal period
- Post birth prior to hospital discharge
- Post birth following child's return home

Process

Agency representatives completed a chronology based on case records. Following this individual interviews and discussions took place with Health, Social Work and Education staff. Information gained was brought together into single agency reports. The reports and findings were shared with those involved and single agency reports finalised. Agency reports throughout the process were shared with the review team and SCR panel and analysis findings and learning points discussed and debated.

The Independent Chair drafted an initial composite chronology and report In April 2016 however the review team had insufficient time to consider the report in full and were of the view the report required further discussion before it could be finalised, agreed, signed off and presented to the SCR panel.

The Independent Chair's contract came to a close at the end of April and reviewing officers from Health and Social Work services were tasked with progressing the final review report. This was concluded in June 2016. The review team met on the 23rd June 2016, a number of changes and amendments were agreed and the report was signed off to be submitted to the SCR panel.

The Facts

Child A was born in November 2014. She was diagnosed and treated for Neonatal Abstinence Syndrome (NAS) and discharged home into the care of her mother in December 2014. In March 2015 emergency services were called and attended at the family home. Child A was taken to the local children's hospital where she subsequently died. The cause of death was Sudden and Unexplained Death in Infancy (SUDI).

Social Work Services (SWS) were actively involved with the family prior to this time as a result of child A's elder sibling being subject to a statutory Supervision Order and also as a result of Vulnerable Women in Pregnancy Procedures (Pre-birth procedures). A pre-birth conference was held prior to child A's birth. The conference concluded there was no need for a post-birth case conference or meeting prior to the discharge of child A from hospital.

Police attended the family home after child A's death and noted concerns regarding the conditions they found: they reported the home being in a state of disarray, dirty soiled clothing and nappies observed in rooms throughout the home, the bedroom occupied by two of the older siblings was stated to be uninhabitable with broken beds, no mattresses or bed clothes. Police further noted evidence of drug misuse within the property: scorched tinfoil on the floor and remnants of a plastic wrap believed to have contained heroin.

During the course of the police investigation they also noted the history of non-engagement with services. Police noted this pattern of behaviour throughout their investigation both in terms of child A's mother, and the immediate family members. They also noted a number of inconsistencies in their account of movement and events on the day child A died. There was conflicting information with regards to access the children's fathers may or may not have had with their respective children.

Further to the above, police noted statements obtained from witnesses who raised concern about the welfare and safety of the children in respect of adult supervision of the three older children. This and CCTV footage noted the children being out at midnight within the flats and at the play park at the bottom of the flats with no adult present.

Police noted mothers version conflicted with statements provided by witnesses and CCTV footage. She declined to engage further with police and was obstructive in the planned joint investigative interview (J.I.I.) of her other children which resulted in the children not being spoken to about their experiences prior to and during the night in question.

The information gained via witnesses regarding the lack of supervision of the children was not shared or known by services prior to this time and this along with concerns regarding the condition of the home heightened concern for the remaining children. In response the children were placed in the care of their maternal great grandmother on a voluntary basis with the proviso that their mother had no un-supervised contact with them.

Following the conclusion of the police investigation and the post mortem no suspicious circumstances were found and the cause of death was recorded as a SUDI. However, given concerns regarding neglect child A's mother was charged with an offence under S12 Children and Young People Act 1937. A report was submitted to the Procurator Fiscal in relation to her treatment and neglect of her four children.

Conclusion

Reviewers were impressed through discussions held with staff involved in the review, in terms of their preparedness and ability to reflect on their role and the role of others in this case.

It is important to note the context in which the teams involved were working. This was a busy locality in Glasgow with high caseloads and competing demands and priorities. This should be noted both in terms of the complexity of other case work and level of risk being managed, and raises some concern regarding the thresholds that teams in Glasgow are working with. Some social work staff interviewed highlighted issues regarding caseloads and morale within their team.

The practitioners involved with the family were all experienced, competent and able, skilled in working with hostile and non-engaging families and able to get alongside families while challenging issues openly and effectively. However, the reviewers questioned whether this translated into changes being made, and if so at what level and whether they were sustained. In addition the point was made that the team around the child was fragmented by child A's mother who had a more positive relationship with some professionals and did not engage with others.

Of note was the positive dynamic professional relationship described between the Health Visitor - HV1 and the original allocated Social Worker. They had worked together for a number of years within this complex family and often visited jointly.

The rationale for proceeding with a full SCR was noted above and focussed on the very real challenge of:

- Long term work with families where neglect is a concern
- Practice around non-engaging families
- Practice and assessment re neglect and working with hostile and uncooperative families

The review of this case has allowed for critical reflection which will be pertinent to practice with many other such cases in the city. The findings identify key practice episodes which highlight deficits in information sharing, within and across agencies which impacted on assessment, decision making, care planning and intervention with child A and her family.

The review additionally identified that these factors were further impacted by changes of personnel at key practice times and were influenced by the time of year when the families circumstances further declined. The subsequent absence of assigned workers and periods of leave reduced the opportunities to re-assess the child and families circumstances.

It is important however to note that the cause of child A's death was a SUDI and to acknowledge that had there not been any issues in single or multi-agency practice the outcome may have been the same for her whether she remained at home or in foster care.

Learning Outcome Findings

FINDING 1

At critical points in the management of this case the assessment processes, including professional practice, were not consistently effective. In particular tools which assist with assessment, analysis, care planning, risk assessment and risk management were not always deployed.

ISSUES FOR THE CHILD PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER

- **Is this inconsistent and fragmented approach to assessing the needs and risks of vulnerable infants an issue the Committee is aware of and has previously considered?**
- **Is the Committee confident that single and interagency assessment tools for neglect are fit for purpose and are appropriately deployed?**
- **Does Committee accept that the practice highlighted by this finding requires further investigation to ascertain whether it is unique to this case or more prevalent in the wider systems?**
- **How will Committee be assured that any improvement in assessment systems and practice is working well enough?**

Finding 1 in detail

- Although an acknowledgement of historical factors and history was recorded, there was no review or bringing together of information held which viewed the whole family unit and assessed the risk and needs of all children.

- The view that circumstances had improved in comparison to the previous pregnancy was not borne out with the benefit of hindsight, and all the information that has become available during this review.

- The view that the extended family was a protective factor for the children was not borne out by the review.

- There were issues around assessment, the gathering of information, the sharing of information and analysis including chronologies between and across sections and agencies. Information was fragmented and not always known to all agencies.

- There were issues with the use or lack of use of assessment tools which assist assessment, analysis and care planning, risk assessment and risk management as well as verification of assessed need and risk. There was limited assessment within all agency records. Attempts were made by addiction staff to complete IPSUs on child As mother and partners but due to non-engagement they were never completed. Given the lengthy involvement would an assessment based on available information have helped the analysis of the perceived risk?

- There were issues about the assessment and knowledge across agencies re Neo-natal Abstinence Syndrome (NAS) that NAS is not linked solely to the

level of parental drug misuse. There is a need to review capacity and support to manage babies with additional health needs. Pre-birth assessments should consider this in all known women with substance misuse difficulties.

- There were issues about the assessment of need for the Special Care Baby Unit (SCBU) and how this translated into the assessment by other partner agencies. This needs to be fully understood in post-birth assessments.

- The assessment and education re SUDI was highlighted given the noted historical issues re co-sleeping and what would appear to have been known risk factors i.e. on-going addiction, smoking and leather couches. Failure to subsequently gain access meant this was not addressed or explored. Safe sleeping requires to be highlighted within and across agencies.

- An addiction chronology which reviewed mothers attendance at a clinic or the pharmacist, given the pattern of missed or late presentations, would have been invaluable in compiling a full assessment.

FINDING 2

Single and inter-agency systems designed to meet needs and protect vulnerable infants at risk of harm did not operate correctly. This was particularly relevant regarding escalation of concerns in response to lack of engagement.

ISSUES FOR CHILD PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER

- **Are the issues identified in the operation of single and inter-agency systems which are designed to protect vulnerable infants an issue the Committee is aware of and has previously considered?**
- **Does Committee accept that the systems issues highlighted by this finding requires further investigation to ascertain whether it is unique to this case or more prevalent in the wider systems?**
- **How will Committee be assured that any improvement in assessment systems and practice is working well enough?**

Finding 2 in detail

- It was noted that pre-birth liaison processes changed shortly before chid P's birth and this may have had an impact on communication, information sharing and subsequent assessment.

- SNIPS system deals with vulnerable women in pregnancy however it does not undertake urine testing. This contrasts with community where this is done. SNIPS system has been in existence for some time and all services may benefit from review to ensure all assessment process are similar

- An issue of concern was regarding relationships and joint working between SNIPS/Ward/Medical staff and in particular the system for sharing and bringing all information together to form an assessment and ensure information is not missed.
- Inter-agency communication re child A having NAS and discharged on medication was not adequate: the addiction team was not aware of this.

- Transfer process and handover from community midwife to Health Visitor was not robust.

- Linked to above, was the process for handover for children and families and addiction robust? As formal meeting(s) between addiction and children and families at times of transfer were not evident.

- The Health Visitor was unaware of the co-sleeping issue in hospital so did not raise this post discharge or enquire where baby would sleep.

- Systems for transfer of cases, management of un-allocated cases where services are aware of the need for new workers was an issue of concern.

- The response from Addiction re continued non-engagement should have resulted in a formal meeting.

- There was a lack of escalation in terms of the need to progress a post discharge meeting or to instigate further child protection procedures in response to renewed resistance and lack of engagement.

Finding 3

Procedures designed to address a number of circumstances including disagreement at case conferences, harmony between health discharge protocols and child protection procedures, instigating the "unseen child policy" and pharmacy protocols did not function effectively

ISSUES FOR CHILD PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER

- **Are the issues identified in the effectiveness and application of key procedures and protocols something the Committee is aware of and has previously considered?**
- **Does Committee accept that the procedures and protocol issues highlighted by this finding require further investigation to ascertain whether it is unique to this case or more prevalent in the wider systems?**
- **How will Committee be assured that any improvement in assessment systems and practice is working well enough?**

Finding 3 in detail

- Case conferences and dissent, roles and responsibilities were an issue in this case.

- There was a lack of awareness and harmony in respect of the health discharge protocol re NAS discharges and how they fit or not with CP procedures.

- The case highlights a need to re-visit and consider the implications of a baby being discharged with medication and the need to consider both supports and the process of review in such cases.

- The response from Health re instigating the unseen child policy following child A's discharge was not adequate and should have resulted in a multi-agency meeting.

- There were issues re the storage of controlled drugs.

- The protocol for Pharmacists reporting on missed attendance would benefit from review.

FINDING 4

Single and inter-agency communication, joint working and decision making was not always effective. In particular case recording, the transfer of information between teams and agencies, especially during holiday periods, were significant issues in this case.

ISSUES FOR CHILD PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER

- **Is the lack of effectiveness in communication, joint working and decision making identified in this case an issue the Committee is aware of and has previously considered?**
- **Does Committee accept that the practice highlighted by this finding requires further investigation to ascertain whether it is unique to this case or more prevalent in the wider systems?**
- **How will Committee be assured that any improvement in assessment systems and practice is working well enough?**

Finding 4 in detail

- There is a need to re-visit and consider systems which bring children and family services, addiction services and other agencies together when working with cases of long-term addiction to look at neglect, impact, thresholds, disengaged and/or avoidant parents and carers.

- The report identified issues around joint working across addiction and children and families in relation to the assessment of current addiction, impact on parenting and the need for a more robust response which translates into more effective joint working, care planning and intervention including in the pre-birth process.

- The report found deficits in information sharing and conflicting information at time of child A being discharged.

- Opportunities for refreshed assessment, decision-making, and the need for further CP processes were missed.

- The list of concerns submitted in the Notification of Concern (NOC) was not reviewed by the Team Leader as it was assumed they were all dealt with.

- Intra and inter-agency working was not always effective and although there was evidence of some joint visits it is questionable whether this translated into joint work and shared assessments and knowledge of others disciplines and processes.

- Escalation of concerns from partner agencies following concern being shared post discharge didn't translate into action.

- It was noted that the Children & Family worker, the Addiction Worker and the Medical Officer changed at a crucial time. This should have been considered at the pre-birth meeting.

- In this case, the festive period was a more vulnerable time of year due to reduced staffing and this needs to be recognised.

- Opportunities were missed to review and re-visit decision making, given the deterioration over and following festive period.

- There was a lack of an up to date Impact of Parental Substance Use (IPSU) assessment for mother due to her non-engagement.

- There were concerns regarding the role of duty team leaders and managers involved in assigned cases and their potential role in looking beyond the presenting issue.

- There is a need to consider the role of Cordia, its value and function in this and other similar cases.

- It is necessary for Social Workers to recognise their role and responsibility to have a clear assessment and recommendation and to communicate this with conviction at a Children's Hearing.

- Recording was identified as an issue for staff involved, however this was more notable and extensive for addiction staff.

- There was a lack of communication and joined up practice between different pharmacists/prescribers - Hospital and Community.

Glossary of Terms

C&F	Children & Families
CAT	Community Addiction Team
CC	Case Conference
CMA	Child Medical Assessment
CP	Child Protection
GIRFEC	Getting it Right for Every Child
HV	Health Visitor
ICR	Initial Case Review
IPSU	Impact of Parental Substance Use
JII	Joint Investigative Interview
NAS	Neonatal Abstinence Syndrome
SCBU	Special Care Baby Unit
SCRA	Scottish Children's Reporter Administration
SCR	Significant Case Review
SNIPS	Special Needs In Pregnancy Service
SUDI	Sudden and Unexplained Death in Infancy
SW	Social Worker
SWS	Social Work Services