Child D

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

Two children have parents who both receive support from Substance Misuse Service (SMS).

Children's hair samples tested positive for opiates. It was believed that the children were deliberately given opiates and/or methadone whilst the children were on the child protection register. They were subject to an Interim Care Order (which was placed in spring 2014). During the autumn of 2014, both children were removed from their parent's care.

Circumstances of, and challenges faced by the individual

Following birth, the second child showed symptoms of drug withdrawal due to mother's substance misuse in pregnancy.

The parents did not engage with agencies regularly and their children's needs were not always a priority.

At the end of December 2013, developmental delays in the children were noted, which prompted an investigation into the potential causes. It was later shown to be likely cause by opiates/methadone.

A clinical psychologist suspected that opiates/methadone was used to reduce difficult behaviours or preventing withdrawal symptoms.

What happened?

- In October 2012 social services received a referral from the Substance Misuse Service, when mother was 26 weeks pregnant. A decision was made to complete an initial assessment to obtain further details as the referral was so vague. The referrer intended for this to be opened as a child protection case, however this case was opened as a 'child in need' case.

- Not all social care departments accept pre-birth referrals from partner agencies, some only accept referrals after 24 weeks of pregnancy. Some will accept early referrals to try and support parents in making necessary changes and decisions.

- Pre-birth assessments were not consistent across the region.

- The Substance Misuse Service identified the risk of lone working when meeting the father. Despite this assessment, the correlation was missed regarding possible risks to the children as they were still living in the household.

- Professionals had been slow to pick up lack of parental compliance.
- Very few police intelligence logs were shared with partner agencies. Whilst the reasons for this may be rational, it was felt that the police needed to check that there were no gaps in the sharing intelligence relevant to safeguarding.
- The police had attended the family home as a result of a pre-planned warrant under the Misuse of Drugs Act 1971. There were two opportunities missed for joined up working between agencies.
- The children were asleep whilst the police visit to were at the family home, and subsequently the police made a child protection referral outlining safeguarding concerns. However, this referral was delayed and not timely enough.
- At key safeguarding meetings, there were missed opportunities where safeguarding information was not shared and as result any strategic decisions were not made with firm foundations.
- Due to staff's increasing workload, formal multi-agency meetings are not being seen as 'golden opportunity' to create a multi-agency, co-ordinated and informed plan based on current and relevant information.
- Urine test results from Substance Misuse Service were not shared at multi-agency and there was one occasion where the result was shared but without any context relevant to safeguarding.
- Mother refused to allow youngest child to provide sample for analysis. This should have triggered concern that parent not prioritising child's safeguarding needs and should have set alarm bells ringing and activate escalation.
- Health professionals not getting timely access to safeguarding documents and had to rely on verbal briefing from Substance Misuse Service's worker.
- Not all professionals use the same terms around misuse substances – this led to decisions made based on assumptions and misunderstandings.

Why it happened?

- The initial assessment was weak as it lacked checks with all statutory agencies including the police – Safeguarding Children: Working Together under the Children Act required all information should be considered. It's possible that with more information a more informed risk assessment could have been completed and future behaviour identified at an early stage.
- Team manager flagged up that the children were at risk of harm as their parent's capacity to care for them had deteriorated due to substance misuse. The manager stated that further assessment and child in need planning would be needed. It is not clear if the assessment had taken place.
- The social care manager understands that felt it was not a reasonable expectation to have a chronology for all child in need cases. However, this approach is a key tool to support with reflection and analysis, in real time and after the event. Research also shows that chronologies can identify early patterns in behaviour, which is a key part in this case.

- The social services professional was not clear at all times when a pre-birth assessment should take place. (It was more suitable as the initial assessment has to see the child to assess.)

- The manager involved in the case had a gut feeling that the social worker's decision wasn't correct (the social worker was persuaded that the children should stay with parents). It was highlighted by the reviewer that it is helpful in this type of case to consider what this gut feeling is and how to look for evidence to support or discount the manager's professional instincts. This should be done by supervision and reflective practice.

- This case shows the importance of fresh eyes and objective supervision as there were two occasions where new workers met the family and immediately flagged up concerns. This could be an indication of collusive relations or another issue such as workers being groomed by parents. These should be explored and challenged.

- Professionals were not always consistent in challenging the parents about their actions.

- Not all professionals are comfortable challenging decisions and there is no culture where professional challenge acts as an effective check and balance to unilateral decision making.

- It was felt that the children's safeguarding needs were not given precedence. No evidence that the Supporting Children, Supporting Parents: A North Wales Multi-Agency Protocol was followed.

- The professionals did not 'think the unthinkable' that it was possible that a parent had given the children opiates and/or methadone.

Report recommendations

The serious case review makes 10 recommendations:

1. Professionals involved in potential child abuse cases must have their awareness raised to enable them to think the unthinkable. They must consider that children may have deliberately been given illegal substances such as methadone and should be trained in the signs and symptoms arising from this.

2. Substance Misuse Service to receive training and clarification about when and how to share information appropriately.

3. For social services, the strategy meeting at the point of discharge was a key opportunity and internal mechanisms must be reviewed to ensure that appropriate and sufficient challenge is in place when chairing these meetings.

4. Dealing with complex and often challenging parents is difficult for many professionals and in this case there was an over optimism in relation to the parents willingness and ability to change. Further training is required to adequately equip professionals to manage complex parents.

5. The police must review its processes for the timely sharing of information which may impact on safeguarding.

6. It is recommended that the 'Supporting Children, Supporting Parents: A North Wales Multi Agency Protocol' is reviewed and updated to include specific signs and symptoms to help workers identify when parents are deliberately doping their children.

7. 'Supporting Children, Supporting Parents: A North Wales Multi Agency Protocol' consideration should be given to agencies reviewing their processes and providing reassurances to the Regional Safeguarding Children's Board about how they have disseminated and implemented the protocol.

8. This case has also highlighted the value of chronologies in considering families in the context of their history in order to predict future behaviours.

9. Multi-agency substance misuse training needs to include information on what urine test results in such cases actually mean.

10. It is recommended that health examine their internal processes to ensure that key professionals receive safeguarding information in a timely way.

Citation

Williams S. and Salem F.(2016)
re:ECPR Gwynedd 1 2015

www.safeguardingboard.wales/2018/06/17/case-reference-north-wales-gwynedd/