Plymouth Area Child Protection Committee

Serious Case Review for ‘LB’
Executive Summary
January 2006

Public Document

Introduction

The purpose of this document is to provide an overview of the outcomes and recommendations of the ‘part 8’ serious case review commissioned by Plymouth’s Area Child Protection Committee (ACPC) into the death of a child.

The aim of a part 8 review is not to assign blame, but to ensure that lessons are learned and recommendations are made to the agencies involved in order to avoid similar situations reoccurring in the future.

In the interest of public immunity names will not be used in this document. Instead an individual’s title or the position they held will be sited, for example, mother, child or social services, police.

If you would like further information about part 8 reviews and how they are conducted, please refer to the ‘Working Together to Safeguard Children’ document published by the Department of Health (ISBN 011 322309 9).

Brief case history

The child at the centre of this case was admitted to hospital with Methadone in his system in September 2002. He was unconscious and suffered renal failure, liver failure, brain damage, muscular breakdown, eye abrasion and bruising. He was expected to suffer from long-term neurological damage, but did not die.

A part 8 serious case review was instigated in April 2005 by Plymouth's ACPC (Area Child Protection Committee) and an independent consultant undertook the review which was agreed at Plymouth's ACPC in December 2005.

In the full part 8 review report a write-up regarding family history was included in order to provide the background leading up to the death. A chronology of events from November 1999 to September 2002 was also included in order to provide an account of the work and interactions of the professional agencies involved with the child. Written reports from the following agencies were also used to carry out the review:

- Plymouth Hospitals NHS Trust
- Plymouth PCT
- Social Services Department
- Plymouth Probation
- Devon and Cornwall Constabulary

It was from this evidence that the recommendations and lessons to be learned highlighted in the part 8 review were identified. Those recommendations form the content for this summary.

Lessons learned and recommendations

This case highlighted some fundamental practice issues that all agencies need to learn from. In the investigator's view there were serious gaps in the conceptual understanding of working with drug abusing parents.

The recommendations below highlight the key areas for improvement identified in the part 8 review report:

Individual agency recommendations

Recommendations for Social Services

- Service Managers should read and sign off all Section 47 enquiries (a section 47 means that social services must carry out an investigation when they have reasonable cause to believe that a child living in their area has suffered or is likely to suffer significant harm). Monitoring/tracking of Section 47 enquiries to be sent to Assistant Director on a monthly basis, to improve case accountability and track threshold criteria.
- Set timescales for replying to families' concerns and train staff in dealing sensitively with family concerns, to ensure information is proactively shared with families.
- Deal effectively and within timescales any disciplinary issues for staff.

Recommendations for Drug and Alcohol Team

- Drug and alcohol agencies should recognise that they have a responsibility towards the dependent children of their clients and should set up good links with other relevant agencies to improve safety of children.

Recommendations for Police

- Meetings with senior police officers and senior social services staff to be established to enable effective joint working to improve information sharing.
- Make clear that officers regard the protection of children as paramount to ensure officers become more child focused.

- Adopt a proactive approach to the completion of child protection reports following incidents.

Recommendations to all agencies involved

- Priority is given to training in the area of direct work with drug abusing parents to improve practice standards.
- Documentation on the assessment of parenting and of risks to be standardised and focussed on the child, with particular regard to substance misuse.
- All staff receive updated training in Assessment Framework to improve multi-agency assessments and improve standards.
- Supervision of staff in all agencies to be assessed in the context of management responsibility, to improve quality of supervision.
- All staff that undertake direct contact with families to have basic child protection training to improve knowledge and practice.
- Any professional working with children and families is accountable for their child protection practice.
- Any child/young person with an unexplained, possibly non-accidental injury must be seen urgently by a paediatrician.
- Sufficient notice must be taken of family/neighbour concerns about a child. Concerns should not be dismissed as malicious until they have been investigated.

Conclusion

The part 8 review questions whether the child's intake of Methadone could have been avoided. The agencies involved were aware for some years of the nature of both parents drug misuse. Extended family and neighbours regularly voiced their concerns about both parents and their inability to safeguard the child.

The investigator concludes that 'It is difficult to comprehend why this child was not protected by the agencies charged to do so...I have made my recommendations, which I hope will prevent a similar incident occurring again.'