Division(s):

CABINET– 25 NOVEMBER

Action Plan in Relation to a Recent Serious Case Review Overview Report

Report by Director for Children's Services

Introduction

1. At its meeting on 13 May 2014, Cabinet endorsed the recommendations of the Cabinet Advisory Group on the Strategic Assurance Framework for safeguarding children and young people. One of those recommendations was that Cabinet (among others) should be alerted to the outcome of all Serious Case Reviews and actions flowing from them. This is the first such report, and concerns "Child H". An overview report of that Serious Case Review is available on the Oxfordshire Safeguarding Children Board's website Case Reviews | Oxfordshire Safeguarding Children Board

Key issues

2. On 15 September 2014, Oxfordshire Safeguarding Children Board (OSCB) published the report of a serious case review following an incident in which Child H (then aged 21 months) ingested a prescribed opiate-based medication.

3. Emergency services were called to the home of Child H in September 2013. Child H had reportedly taken the prescribed opiate-based medication out of the mother's bag and appeared to have drunk from it. The mother delayed calling the emergency services for approximately 1.5 hours.

4. In the ambulance, Child H stopped breathing and needed resuscitating. Upon arrival at hospital, the child was admitted, required intensive care treatment and subsequently made a full recovery. The child was placed with a foster carer on discharge from hospital and is currently the subject of court proceedings with a view to adoption.

5. The mother of Child H was convicted of neglect and served a prison sentence.

6. The report details the extensive contact that the mother had with agencies before and after the birth of Child H in an attempt to mitigate the impact of her substance abuse on her child.

7. The report highlights the difficulties agencies face when dealing with children living in families with substance abuse and concludes:

8. “Though accidents such as ingestion of methadone were to some very limited extent ‘predictable’, it cannot reasonably be claimed to have been ‘preventable’ by decisions or actions available to the professionals working with the family.”

9. Although a great deal of work was done to try to support the mother and safeguard the child, drug dependency was not in itself regarded as grounds for removing Child H, who was initially the subject of a child protection plan.

10. Numerous attempts were made to provide support to mother and baby, and the report provides an account of offers of advice and support frequently being turned down, with many missed appointments with agencies involved. These include appointments with drugs workers, health services and social workers, and a failure to attend court appearances.

11. Issues raised in the serious case review include:
    - Reluctance of some agencies to share information that could have improved understanding of the risks to Child H
    - There was a widespread tendency to focus narrowly on a particular or central role of each agency
    - There were a number of examples where professionals made unjustified presumptions about what colleagues in other agencies would / should do
    - There was insufficient exploration or appreciation of the day to day experiences of Child H and the likely impact of those experiences on the child’s development and life chances.

12. The report makes a number of recommendations for all agencies involved. Those relating to Oxfordshire County Council are given in the table below.

Recommendation	Directorate	Progress at 31.10.14
1. The independent chair of the Board should propose to Children’s Social Care that a well-informed and sensitively worded letter is drafted and retained in records so that when child H is of sufficient age to do so, s/he can establish why, when and how alternative care became necessary and that a serious case review was completed.	Children, Education and Families	The letter is being prepared and will travel with Child H into his/her permanent placement to be kept by the carers until the appropriate time.
2. The Board should recommend that pharmacists in the county be reminded of the expectation that	Public Health	All pharmacists have been informed of the recommendations of the report

Children's Social Care or Police should be informed if they are concerned a drug-dependent person might pose a risk to their own or another child.		through the electronic contract management system notifications. This will now be followed up by letter to each pharmacy. The Local Pharmaceutical Committee have been informed of the recommendations of the report.
3. The Board should recommend that the Commissioners of GP Services and Public Health Commissioners review their monitoring processes to ensure collaborative management of contracted services provided in General Practice in particular drug and alcohol services.	Public Health	Independent Chair of the Safeguarding Board (OSCB) has written to Chief Executive Office (CEO) NHS England, Local Area Team and OCC Director of Public Health. Public Health held an initial meeting with the Local Area Team safeguarding lead. NHS England internal discussions regarding GP practice performance management or safeguarding have yet to take place, but agreement is in place to ensure coherence with OCC's quality assurance monitoring of drug/alcohol services and prescribing. Child Safe Lock Boxes were available at the time of the incident but it is unclear whether this was made available by Oxford Health to the mother. Child Safe boxes are now produced locally by Aspire and provided freely throughout the county.
4. Pre-birth assessment practice procedures should be reviewed and amended to ensure that assessments start at latest by 28 weeks of gestation where previous Care Proceedings	Children, Education and Families	Fully implemented, with agreed escalation to senior manager should any relevant case be at risk of starting later than 28 weeks.
5. Pre-birth conferences should be held at least 1 month before	Children, Education	Fully implemented, with agreed escalation to senior manager

the child's estimated date of delivery (EDD).	and Families	should any relevant case be at risk of coming to conference later than 1 month before the Estimated Date of Delivery.
6. Training and guidance in relation to working with drug misusing parents should be developed and highlight the importance of maintaining a close working relationship with wider family and friends to assist with ongoing risk assessments	Children, Education and Families	Training in working with drug misusing parents is provided to staff by Learning & Skills. The Principal Social Worker has run parental substance misuse training sessions in all children's social care teams introducing evidence-based practice guidance. He has ensured the roles of wider family and friends are understood and encouraged by social workers undertaking assessments and plans with children.
7. When a professional provides information on a closed case a decision as to whether to respond to it as a 'contact' or new 'referral' should be made within 24 hours by a team manager and confirmed with the professional providing the information	Children, Education and Families	The process of decisions re contacts and referrals has now changed and contacts have been replaced with an enquiry to the Multi-Agency Safeguarding Hub. When a Multi-Agency Safeguarding Hub enquiry is received the information-gathering and decision-making process takes place within 24 hours as to whether or not to share information across agencies and to progress to an assessment. The referrer is involved in the process and is also notified of the outcome.

RECOMMENDATION

13. **The Cabinet is RECOMMENDED** to note the action being taken in response to the Serious Case Review.

JIM LEIVERS
Director for Children's Services

Background paper: Child H overview report

Contact Officer: Hannah Farncombe, Safeguarding Manager , 01865 815273

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