Gloucestershire Safeguarding Children Board

Executive Summary

0109

SERIOUS CASE REVIEW CHAIR
Julia Oulton
INDEPENDENT OVERVIEW AUTHOR
Rosie White

1. Introduction

1.1 Jamie, aged 14 months at the time of her sudden and tragic death, lived with her mother and older brother Sam then aged 3. Her mother, Ms B had left the children's father, Mr C, prior to Jamie's birth and at the time of Jamie's death her mother was in a new relationship with Mr E.

1.2 Jamie's death was initially considered to be a result of haemolytic chickenpox, an extreme manifestation of the illness which is often fatal. Anal fissures were noted and specialist paediatric post-mortem investigated these and concluded they were not indicative of abuse. However, a later toxicology report indicated that Jamie had toxic levels of methadone in her body in sufficient quantity to cause death within 6 hours of it being ingested. This meant the child must have received the methadone whilst in the care of her mother and Mr E. Further tests had confirmed that both children had ingested methadone on an infrequent basis over a period of time. Ms B and Mr E were arrested and are currently serving prison sentences, having both been convicted in June 2010 for three counts of child cruelty. Two counts of cruelty to Jamie and one to Sam.

1.3 Initial enquiries identified that there had been reports of domestic violence in the family, perpetrated by the children's father Mr C and all three adults were known substance misusers. Ms B self reported suffering from depression on a number of occasions.

1.4 The significant adults and the two children referred to in this review are white-british. No cultural or religious issues have emerged that might have had bearing on events, however both Jamie's parents and the mother's new partner were known substance misusers and can be described as being aligned with the drugs culture.

2. The Review Process

2.1 A Serious Case Review follows the guidance set out in Chapter 8 of "Working Together" 2010. The decision to hold a Serious Case Review (SCR) was made by the Chair of the Gloucestershire Safeguarding Children's Board (GSCB), Jo Grills, on 17th February 2009 following a recommendation made by the SCR sub-committee on 12th February 2009.

2.2 A Serious Case Review panel made up of representatives from agencies providing services for children and families met to agree the terms of reference for the review and ensure that all of the agencies involved with Jamie and her brother were included. The panel members were as follows:-

SCR Panel

Chaired by Julia Oulton, Independent Consultant
Ruth Sinfield, Head of Children's Social Care, Gloucestershire CYPD (from February 2010)
Duncan Siret, GSCB Business Manager, Gloucestershire CYPD
Kate Hothersall, MAPPA Manager, Gloucestershire
DI Mark Little, Gloucestershire Constabulary, Child Abuse Investigation Team (CAIT)
Nuala Livesey, Designated Nurse, NHS Gloucestershire
Lynne Renton, Designated Nurse, NHS Herefordshire
Val Porter, Named Nurse CP, 2gether NHS Foundation Trust, Gloucestershire
Jane Bee, Safeguarding Children Development Officer (education)
Dr Imelda Bennett, Designated Doctor, NHS Gloucestershire
Linda Townley, GSCB Voluntary Community Services Representative
Hannah Malone, Minute Taker, Safeguarding Children Service

Lynne Renton also represented Herefordshire Safeguarding Children Board on the panel.

2.4 The review Terms of Reference can be found in appendix 1 on page 11 of this report. Each agency appointed a suitably independent person to review the agency's records and to review the actions taken and report back to the panel as to whether the actions of the agencies were appropriate, timely, child focused, and in line with their procedures that support the safe-guarding of children. The panel were required to identify and lessons to be learnt and make recommendations to the GSCB to improve multi-agency practice. The reports are known as Individual Management Reviews (IMRs). Each report is required to include a detailed factual chronology. There were specific terms of reference (ToR) to be addressed, relating to the circumstances of Jamie's and Sam's life, and additional terms of reference were added (relating to substance misuse) to the original ToR following evidence that emerged during the criminal trial. Additional reports were requested from agencies who were known to have had brief contact with the children and their family, for example housing services. The time-scale for the review covered the period from Sam's conception through to the strategy meeting that was convened when it became clear that prior to her death Jamie had been given a potentially lethal dose of methadone. Because of the criminal proceedings, the time frame for completing this SCR was extended. During the course of this review, "Working Together" was republished and in line with its revised guidance, two further independent reports from both counties were commissioned. These are known as Health Overview reports and they look at all of the health related issues identified in the IMRs written by the various health agencies involved.

2.5 Jamie's mother moved between two counties which meant that a significant number of agencies were required to produce IMRs and an additional consideration had to be addressed to establish whether there were any "cross border" issues that were problematic in this case.

2.6 An independent Overview Author (OA) was appointed to review all of the IMRs and any other written reports and also to report on the review process itself. The OA considers all of the actions and recommendations made in the individual IMRs and makes overarching recommendations which, along with all of the IMR reports, are submitted to the GSCB and to Ofsted for external examination.

3. The Involvement of the Family

3.1 It is now recognised that family members, including children, need to be given the opportunity to make a contribution to the SCR process and to contribute to any lessons to be learnt. The children's mother, Ms B and her partner could not be offered an interview until after the criminal trial was over. However, the maternal and paternal grandmothers and father were offered interviews. The children's father did not feel able to respond although a second opportunity was offered to him. The paternal grandmother and Ms B agreed to be interviewed and Mr E expressed his views through a letter. Sam was considered too young to be interviewed. The adults' experience of some of the services they received was very positive. However this was not universal and although some of their factual accounts can be disputed their negative experiences should not be dismissed.

4. Reports submitted

Children's Social Care (CSC) – Gloucestershire CYPD & Herefordshire Children's Services, Social Care. (N.B. the IMR author for Gloucestershire CYPD undertook to include relevant information into the IMR from the Broadwell & Coalway Playgroup, Coleford Children's Centre and Rose Day Nursery in Gloucestershire)
Probation Service - Gloucestershire Probation Trust and West Mercia Probation Trust
Police - Gloucestershire Constabulary and West Mercia Police
Health - In Gloucestershire –
Gloucestershire Hospitals NHS Foundation Trust

NHS Gloucestershire (Health Visiting and GP)
2gether Gloucestershire NHS Foundation Trust
Great Western Ambulance NHS Trust
Gloucestershire Health Overview Report

Health - In Herefordshire - Herefordshire Hospitals NHS Trust,
Herefordshire PCT Provider Services, Drug Services DASH
Herefordshire PCT Provider Services, Health Visiting
Herefordshire Health Overview Report

The following agencies submitted short reports

- Women's Refuge
- Gloucestershire Domestic Violence Service Advocacy Project (GDVSAP)
- 2 Rivers Housing Association
- Herefordshire Housing
- The Independence Trust (formally GDAS)
- Herefordshire Early Years and Extended Services

5. Factual Information

5.1 When Ms B became pregnant with Sam, she re-referred herself to the local Drugs Service seeking help with her substance misuse. She remained under the care of the service until Sam was 6 months old and underwent a methadone reduction programme; Mr C had also been known to the same service on two previous occasions. Ms B disclosed to her drugs worker and her midwife that she had a history of depression and was a drug user from a young age. The Midwifery Service and the Drugs service considered making a referral to Children's Social Care about Ms B and her child but decided against this. Sam was a healthy baby with no signs of opiate withdrawal. Ms B's methadone use had incrementally reduced throughout her pregnancy. The Midwifery Service transferred the care of Sam to the Health Visiting Service but the HV was unaware at the time that Ms B had a history of substance misuse. None of the available records make any detailed reference or assessment of Mr C's role or impact upon the children. Sam appeared to be developing well.

5.2 Shortly after becoming pregnant with Jamie, Ms B re-referred herself to the drugs service. Ms B was re-prescribed methadone. During the period of this review West Mercia Probation Service were involved with Mr C. During her pregnancy Ms B made several complaints to the police about domestic abuse and although referrals was made to Children's Social Care (CSC), decisions taken not to progress the concerns to an initial assessment, despite them having earlier notification of domestic violence concerns from the police.

5.3 Jamie was born on October 2007. She was healthy and was assessed as having no opiate withdrawal symptoms. Professional contact with Ms B and the children continued. The police made further referrals to CSC following reports of domestic violence and the Health Visitor (HV) at the time sought supervision about her concerns but was not encouraged to follow up the referral made to CSC.

5.4 When Jamie was 6 weeks old 2007 Ms B took the children to live with her mother in Gloucestershire to get away from Mr C. She advised her HV about domestic abuse and written information was transferred to the new HV that identified Ms B's substance misuse, the history of domestic violence and maternal depression.

5.5 During this period Mr C referred himself to his local drugs service requesting help for his heroin addiction and seeking anger management. Workers had concerns about the threats he made toward Ms B over her denying him access to the children. CSC in Herefordshire received professional concerns about Ms B but Ms B's actions in protecting herself and the children by moving out of area were seen as sufficiently protective and no assessment of needs in relation to the children was initiated.

5.6 During the following year Ms B and her children received health visiting services from four different HV's, two drugs workers, women's refuge staff and the police. The police made 9 Domestic Abuse referrals to CSC. Mr C's also made counter allegations against Ms B for poor care of the children and demanding money from him.

5.7 Ms B began a relationship with Mr E, who was also a substance misuser and was receiving services for addiction and was subject to a post custodial Probation Order. The reports suggest the relationship between them was poor. There were three reported concerns from Sam's nursery in the two months before Jamie's death stating that her mother was stressed and that Ms B had been drinking when she collected Sam from nursery. No referral was made to CSC. The last visit to the family home by the HV, to follow up these concerns, occurred five days before Jamie died. The home was described as "immaculate".

5.8 Following Jamie's death, appropriate support was offered to the family whilst post-mortem tests were completed. Following the arrest of Ms B and Mr E, Sam was placed with his extended family who continue to care for her.

6. Comment and key themes:

6.1 The lack of clear and accurate multi-agency information sharing was a significant factor in this case. It is clear that information on the histories and lifestyles of the three significant adults in this case was available to a range of services. No professionally directed assessment was undertaken in respect of the children's needs. Given the history of maternal depression, the known substance misuse and domestic abuse this was a repeated error. None of the referrals to CSC progressed to either a home visit or an assessment. Key indicators have been identified as directing professional decision making away from the needs for an initial assessment (by CSC). These were:-

- The adults concerned were never assessed as being "chaotic drug users" by the drug agencies working with them and there were periods when all three adults were compliant in working to reduce the substance misuse.
- Neither Sam nor Jamie showed signs of opiate withdrawal at birth, which was seen as confirmation that Ms B's substance misuse was not at an excessive level.
- Ms B was seen to act appropriately to protect her children following continuing actual and verbal threats of domestic violence from Mr C toward her.
- Both children appeared to be physically well cared for and home conditions were reported to be clean. Neither child showed any worrying developmental issues, nor did the pattern of attendance and compliance with health appointments cause excessive concern.
- Information from the extended family supported the view that Ms B was a good mother.

6.2 However, the picture that emerges from the various agency records indicate that additional information was available and should, if properly shared and analysed, have led to an initial assessment of the children's needs whilst living with parents/carers whose own histories and lifestyles had the potential to be detrimental to the children's welfare. No sense emerges from reading the IMRs of what it might have been like to be either Jamie or Sam

being parented by the adults in their lives. It was known that all the adults had been involved in criminal activity and served prison sentences and both males had committed violent crimes. Their drug usage was a continuing concern.

6.3 IMR reports identify occasions when an initial assessment or an assessment under the common assessment framework should have been completed. An initial assessment would have addressed the potentially detrimental impact of the adults' behaviour upon the children, and, whether the adults were really capable of understanding the children's needs and able to put them before their own. All three adults had been imprisoned for criminal offences and the two male adults were involved with the criminal justice system at different times during the period under review, as was Ms B but less so. Both males had committed violent offences. The link between criminality and substance misuse is widely researched and a more rigorous assessment of this area of concern would have added to the overall knowledge of the environment factors that might impact upon the children.

7. Practice issues arising from this case

7.1 With the benefit of hindsight, it is clear that there are a significant number of occasions when the concerns of professionals about these children should have triggered the acceptance of a referral by CSC (in both counties) and that an initial assessment, or possibly one occasion, a Section 47 Child Protection Enquiry should have been instigated. The failure of CSC in Gloucestershire in particular to aggregate the repeated concerns they received, mainly from the police but also from other sources, has been fully acknowledged in the relevant IMRs and recommendations made to ensure that referral patterns are considered when making decisions and that all possible sources of information are considered and analysed to enable an appropriate decision to be made.

7.2 The IMRs make detailed recommendations to redress the gaps in procedure, practice and knowledge that led to professionals not sharing fully the information they held about the family or keeping their focus on the impact of parental circumstances, lifestyle choices and recurring behaviour, that were likely to have an increasing impact upon Jamie's and Sam's well-being over time.

7.3 No agency or worker can be held solely accountable for failings in practice that would have changed the course of events. However, the errors made are of particular concern because they are errors that are repeatedly identified in other SCRs. They are:

1. The professional focus was all too often on the immediate needs of the adults and not on the impact the adults' behaviour was having on the children, or might have in the future if continued.

2. There were three known factors that when they occur together can have an increasingly negative effect on a child's development and are known to significantly increase the risk of abuse. They are:- maternal/parental depression, substance misusing parents and domestic violence.

3. There were repeated occasions at key points when professionals either were unaware of all three factors or failed to consider what these might mean for the well-being of the children.

4. The drugs services, particularly DASH in Herefordshire who knew the mother over a period of four years, never seriously engaged her in an assessment of her parenting capacity if she remained a substance misuser, or looked at how the additional factors of depression and domestic violence might affect her and her children.

5. Whilst there is some evidence that confirms information was shared with the mother about the safe storage of methadone, it has become clear that more robust procedures in relation to this issue need to be developed by drugs services and disseminated to other agencies. This needs to include information about toxicity.

6. Both CSC in Herefordshire and Gloucestershire failed to respond adequately to referrals. This error was repeated in Gloucestershire despite there being nine separate referrals from the police about domestic violence. Both the police and CSC IMRs have made recommendations to address these failings but the concerns about clarity of referral processes and thresholds for intervention by CSC have been recurring themes in SCRs and suggest there is a systematic problem that needs to be resolved.

7. There were a number of significant but more peripheral professionals involved with this family who raised concerns with CSC, the relevant HV or their own supervisors.

8. Because no formal assessment of these children's needs was made, and there should have been several, over the period under review, no one professional or agency "owned" the responsibility for co-ordinating information sharing, assessment or decision making.

9. The Overview Author is satisfied that no professional had the opportunity to observe whether these children showed symptoms of methadone ingestion (although there is some concern as to whether they would have known what these were) and there was no occasion when a professional had cause to consider that methadone may have been given to either child, presumably to soothe or pacify them.

8. Lessons Learnt

8.1 The Overview Author has concluded that although there were gaps in professionals' interventions and responses to these children, it is unlikely that Jamie's death could have been avoided. However, this SCR has identified issues that need to be addressed. They are concerns that have parallels in other SCRs, both local and national.

8.2 In total, the IMRs and Health Over-view Reports have made over 70 recommendations, most of which have already been acted upon. All of the recommendations are endorsed by the Overview Author. The thoroughness of the combined IMRs has left little for this Overview Author to add. The recommendations below are about emphasis rather than additional insights and are predicated upon the assumption that the GSCB accepts the recommendations made by the IMR authors and requires agencies to report on the recommendations yet to be completed within a reasonable time-frame.

8.3 Lesson 1

The child needs and voice must take precedence over those of adults when assessing their circumstances. Assessing parental issues *and* parental history is very important but the focus throughout needs to be on the impact this has, or might have, on the child's welfare. This does not discount the needs of vulnerable adults in anyway. These also have to be addressed.

8.3.1 Evidence 1

The professionals involved with Jamie and her brother repeatedly focused on the needs of Ms B, her substance misuse and the impact domestic violence was having on her. The impact on the children of her lifestyle and that of her new partner, and the impact of the father's behaviour were never properly considered. None of the IMRs are able to provide an account of what life might have been like for these children living in these circumstances which reflects the lack of a focus on the children in the work undertaken during the period under review. Following his sister's death Sam gave a graphic account of his response to his father behaving in a threatening manner. This was clearly not a one-off occasion.

8.3.2 Recommendation 1

Agencies must ensure their processes are pro-active and child centred. Adult behaviour should be assessed to ascertain the impact on children in their care and appropriate safeguarding action taken.

GSCB and HSCB must ensure this recommendation is disseminated to all agencies whether they are child or adult focused, particularly to front line staff and require service leads, within an agreed time-scale, to confirm that this has been done and that it is included and reinforced in all single agency and multi-agency training programmes.

8.4 Lesson 2

There is a need to ensure that all professionals working with substance misusing parents are aware of the potential dangers to children where their parents and carers are substance misusers, and in particular of the storage and toxicity issues in relation to methadone and other drugs where children are also involved. Drugs Services need to take the lead on sharing information on a need-to-know basis with agencies working with their clients to ensure information and any concerns are shared and assessed. Compliance with safe storage arrangements needs to be part of any methadone reduction care plan *and* where children are known to be present it is reasonable for a professional to monitor compliance by asking to see the storage arrangements. Gloucestershire and Herefordshire have made progress in this area.

8.4.1 Evidence 2

There is evidence in this report that information between agencies about substance misuse was not shared and that professionals were not suitably informed of the potential risks to children as to make this issue a priority when assessing the children's circumstances. Ms B reported when interviewed that she had never been given information about the storage and risk issues in relation to methadone and she also indicated that she believed the practice of administering methadone to small children was not uncommon amongst some substance-misusing parents.

Some progress has already been made in this area. Herefordshire have already done a considerable amount of work in implementing the messages from "Hidden Harm". A strategy has been developed to ensure that the risks of methadone to children are widely known across the client group and by the range of multi-agency professionals providing services. Multi-agency training now incorporates this strategy. Gloucestershire has also completed a Hidden Harm Protocol that has not been formally adopted.

8.4.2 Recommendation 2

Both HCSB and GCSB should implement (and monitor) locally written "Hidden Harm" protocols now in place to set out how all agencies will share information and work together when there are families where the adults are misusing substances *and* that the protocol is explicit about ensuring that adults are made aware of the risks to children who might have access to drugs, associated paraphernalia, alcohol and other medicines. Specific recorded reference should be made on all case-notes about the toxicity and possible fatal consequences of administering methadone to babies and small children in particular to confirm that this has been discussed with the client(s). The provision of free, lockable storage boxes for methadone should be available for all methadone users in treatment.

8.5 Lesson 3

Poor communication is a reoccurring theme as is multi agency assessments. What this review demonstrates is that poor communication can build upon itself and lead to repeated mistakes and inadequate assessments being made. No one agency or professional owned the responsibility for the safeguarding issues in this case. The Common Assessment Framework and an identified lead professional would have assisted in ensuring information sharing and a multi-agency approach to assessment.

8.5.1 Evidence 3

The professionals missed opportunities to share information on many occasions and where information was shared it was not acted upon appropriately or analysed with sufficient professional rigour. This is evident in poor supervision practices for HV, the failure of both CSC services and police authorities to cumulatively assess referral patterns and concerns, and in drugs workers either not passing on information or focussing too pointedly on the needs of their adult clients

8.5.2 Recommendation 3

When working with families where there are complex issues and/or many agencies are involved, it is important that information is shared within a clearly understood framework and there is a lead professional is responsible for bringing all involved professionals together and maintaining the focus on the needs of the child.

CSC in Gloucestershire is in the process of setting up Locality Teams. This is an excellent opportunity to embed the concept of a lead professional in cases where there are child welfare concerns and where a CAF is appropriate but that have not yet reached the threshold for intervention by CSC. GSCB should require that there is a clear multi-agency protocol in place that supports the appropriate use of lead professionals. This should strengthen and support the CAF process. It should be mandatory to appoint a lead professional for the children where parents are known to be problem drug users where their drug use is impacting on the care of their children. This does not assume that substance-misusing parents will be poor parents but it does presume that both the immediate and long term needs of their children will need to be always considered. HSCB should also consider how the concept of lead professional can be embedded within Herefordshire.

8.6 Lesson 4

Involving families and children directly in the SCR process is relatively new. Service providers need to receive feedback from service users. The views that Ms B and the grandmother had of the services they received need to be shared with professionals. Whilst

their reported experience of the facts may be disputed their reported experiences as service users are too familiar to ignore. In addition direct service-user feedback is a powerful driver in improving practice, and should also provide an addition avenue whereby the voice of the child is heard. Therefore this lesson has implications for the way all service user feedback is collated and used to improve practice.

8.6.1 Evidence 4

Whilst the adults interviewed identified positive responses from agencies involved with them both Ms B and Mr C's mother identified a poor response from both CSC services and Ms B found the number of HV's she who visited her in Gloucestershire to be a problem. She also felt they were always "rushed". Ms B expressed a view that sometimes the police response in Gloucestershire had been too slow and Mr E expressed the view that the children's mother had frequently asked for help that was not forth-coming as she only wanted what was best for her children.

The is increasing evidence from organisations like the Voice of the Child in Care, the NSPCC, Young Minds and Bodies and The CAMHS Outcomes Research Consortium (CORC) show how important service user feedback is to service improvement and development. Safeguarding Boards are now required to undertake Section II (Children Act 2004) annual audits which include how agencies are obtaining service user feedback.

8.6.2 Recommendation 4

Both the HSCB and the GSCB should consider how to feedback to all agencies the views of family members following a Serious Case Review. This can be done as part of the dissemination and learning process adopted by all agencies who should be required to add a section on "Family Feedback" to their processes. In addition both single and mutli-agency training should incorporate "Family Feedback" as part of professional learning.

In addition both LSCBs should look at the use of the annual Section 11 audit and seek to learn how service user feedback is impacting upon practice.

8.7 What happens next?

Gloucestershire Safeguarding Children Board and Herefordshire Safeguarding Children Board have accepted these recommendations and plans to put them into action are in place. Progress will be monitored by both Boards. The action plans can be found on the GSCB website.

9 Action completed so far

Much has been done already as a result of this serious case review:

- It has been a big driver in children's social care reorganising front door services for social work.
- A new multi agency project has been established at the Gloucestershire Public Protection Bureau to review all domestic abuse incidents in families where there are children
- The Gloucestershire drug services have carried out an audit/risk assessment of all parents/carers who are substance misusing.
- Two new policies have been agreed by the SW Safeguarding and Child Protection Procedures group on resolving professional disagreements and children crossing borders that are now available to all staff working with children, and their carers.

- The GSCB has spoken to over 500 staff through a serious of Road Shows and addressing team meetings to disseminate lessons from this and other reviews.
- The GSCB have commissioned multi agency training around the impact of parental substance misuse on children.

22nd September 2010

Appendix One

Gloucestershire Safeguarding Children Board

Serious Case Review

0109

TERMS OF REFERENCE – Anonymised (Updated May 2010)

Child (Subject)	**Jamie**	**Died aged 14 months**
Child (Subject)	**Sam**	**Aged 3**
Mother	**Ms B**	
Address	**Gloucestershire**	
Mother's Partner	**Mr E**	
Address	**Gloucestershire**	
Father	**Mr C**	
Address	**Herefordshire**	

The decision to hold this review was made by the Chairperson of the Gloucestershire Safeguarding Children Board in the 17th February following a recommendation by the Serious Case Review Sub Committee, held on the 12th February 2009. The conclusion of the review has had to be postponed until now to include information from criminal proceedings. The decision to hold the review was made as soon as it was established that Jamie died after ingesting methadone. Jamie died while in the care of her mother, Ms B, and her partner, Mr E. Information we have received indicates that the parents (and mother's partner) are known drug users and there is now evidence that both children had ingested methadone on an infrequent basis over a prolonged period of time. This is thought to have been a contributory factor in the death of Jamie. Further there have been incidents of domestic abuse highlighted between the parents. Working Together to Safeguard Children, 2010 states that: "When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family." Para 8.9. On this basis it has been decided that the criteria for a serious case review have been met.

The review will need to carried out under guidance from Working Together to Safeguard Children, 2010, Chapter 8. In particular individual management review (IMR) authors are to be independent of line management responsibility for the work of the agency in respect of

this family. Further guidance on how to complete IMRs is available through the Gloucestershire Safeguarding Children Service.

The aim of individual management reviews is to look openly and critically at individual and organisational practice, to establish whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about. Any significant concerns identified relating to practice should be responded to as soon as possible to ensure that all children receiving a service are safeguarded.

It is the responsibility of senior management from each agency involved to ensure the IMR is of sufficient standard and addresses all aspects of the terms of reference. The completed IMR should be agreed and signed off by the Senior Manager in the organisation who has commissioned the report and who will be responsible for ensuring that the recommendations are acted upon in a timely manner.

It may be that contact with certain agencies has been limited and that it may not be necessary for those agencies to complete a full IMR, please contact the Safeguarding Children Service (see contact details below) to discuss whether a full IMR is required.

A criminal investigation is about to be concluded with a criminal trial due to take place between the 9th and 18th June 2010. Ms B and Mr E are both facing charges of manslaughter, allowing a child to die and neglect. As yet there has been no conviction. The Police have undertaken to ensure any interviews with staff are carried out early on in the investigation to insure there is no impact on the Serious Case Review or the criminal investigation.

Aims of the Review

To establish:

- Which agencies have worked with Jamie, Sam, Ms B, Mr E and Mr C.
- Whether the practice was sensitive to the racial, cultural, linguistic and religious identity of the children and their family.
- The impact of any substance misuse culture on the family.
- The nature of the services offered to the children and adults and identify any gaps in provision.
- Separate factual chronologies of the actions taken by each agency within the agreed time scale and a combined chronology of actions taken by all involved agencies.
- If the decisions and actions taken in this matter were/are in line with the policies and procedures of individual agencies and the Gloucestershire Safeguarding Children Board and the Herefordshire Safeguarding Children Board.
- Whether appropriate services were provided in relation to the needs of the children and in line with the decisions and actions taken in this matter.
- Whether the services provided were child-centred and whether the voice of the child was listened to.
- How interagency communication and working together impacted on the provision of services and the welfare of the children in this matter.
- Whether there were any cross boarder issues relating to communication and the provision of services.
- The level of cooperation of significant adults with the services provided (Ms B, Mr E and Mr C).
- To recommend appropriate single or inter-agency action in light of the findings
- To assess whether other action is needed by any agency.

In addition it is the panel's view that:

- In this case there is no need for individual management reviews (IMRs) to be carried out by 'independent' management reviewers (external to your agency).
- The review should include, where possible, the views of the parents and grandparents. How this is carried out will be dependant on the impact of any criminal investigation and will be revisited during the review process.
- All contributing agencies will need to complete an IMR in accordance to Working Together to Safeguard Children, 2006 (Chapter 8) and Gloucestershire Safeguarding Children Board guidelines. The IMR to cover the following issues:-

    - Was communication within the organization and between the organisations, timely and effective?
    - Has there been appropriate interface between adult and children's services?
    - Did the organisation refer concerns appropriately to other organisations (according to inter–agency and/or internal procedures)?
    - Was the depth of information provided in the referrals appropriate?
    - Did the organisation make appropriate and timely assessments of the parents/children, in line with internal organisational procedures?
    - Did assessments of parents take into account possible risk to the children?
    - Was there any opportunity to recognise the administration of Methadone to either child was taking place?
    - If the administration of Methadone to either child was recognised was appropriate action taken?
    - Was action taken in a timely manner and in accordance with agreed policy and procedures?
    - Is there any evidence to suggest that there were missed opportunities for sharing information about the adult's drug misuse and domestic violence?
    - What would have made a difference to the outcome?
    - State what improvements/actions have been implemented within your agency to address concerns raised your agency's initial IMR.

Scope of the Review

This Serious Case Review is to include the records of siblings, Jamie and Sam, and the three adult carers, Ms B, Mr E and Mr C.

IMR authors must consider their agency's records and compile a chronology from the beginning of Ms B's pregnancy with Sam (i.e. 9 months prior to his birth in 2004) up until the second Child Protection Strategy Meeting. The review is to include the immediate events and the particular circumstances following Jamie's death and any action taken by agencies at this time (to establish whether there are any lessons to be learned through the implementation of the child death review process) and any welfare issues that come out of criminal proceedings.

IMR authors must identify any other significant adults in the children's life during the completion of their report. This information should be shared with the SCR Panel where a decision will be made as to whether they should be included in the Review.

IMR authors must notify the Serious Case Review Panel of any additional significant adults to that all agency records can be checked.

IMR authors must identify where possible if any of the three adults had any significant relationships with any other children. If so, this information should be shared with the SCR

Panel, in order to satisfy the SCR Panel that any safeguarding issues are appropriately addressed.

To include information held by the following Agencies (if they have had involvement with the family):

Agency	**Contributed:**
Gloucestershire CYPD, Social Care	IMR
Herefordshire CYPD, Social Care	IMR
Broadwell & Coalway Playgroup, Coleford Children's Centre	Report
Rose Day Nursery in Gloucestershire	No information
Mucky Pups Nursery in Herefordshire	No information
Gloucestershire Hospitals Foundation Trust	IMR
Gloucestershire Primary Care Trust (including GP records)	IMR
2gether Gloucestershire NHS Fountain Trust	IMR
Great Western Ambulance NHS Trust	IMR
Gloucestershire Health Overview Report	Overview report
Herefordshire Primary Care Trust (including GP records)	IMR
Hereford Hospital Trust	IMR
Herefordshire Drug Services (DASH)	IMR
West Mercia Ambulance Trust	No information
Herefordshire Overview Report	Overview Report
Coleford Women's Refuge	Report
West Mercia Women's Aid	No information
Gloucestershire housing (2 Rivers Housing Association)	Report
Herefordshire Housing	IMR
Domestic abuse services in Gloucestershire (DVSAP & CARP)	Report
Gloucestershire and Herefordshire Crown Prosecution Services	No information
Dentists and Opticians	No information
CAFCASS	No information
NSPCC	No information
Family Members	
Paternal Grandmother	Notes of meeting
Father	Meeting offered
Mother	Meeting offered
Mother's Partner	Meeting offered

Revised Timescales

- Revised Review agreed 27th May 2010
- Letters and terms of reference to Chief Execs sent by 4th June 2010
- IMRs updated and returned to SCS by 2nd July 2010
- Health Overview Report to be returned to SCS by 19 July 2010
- SCR panel meeting 2pm, Wednesday 21st July 2010 at GPPB.
- Overview report completed and approved for GSCB by 2nd September 2010
- Presented to GSCB meeting, 17th September 2010
- Submitted to Ofsted, DCFS and GOSW end September 2010

Lead officers for internal management reports

To be confirmed by each agency and details sent to the Safeguarding Children Manager at the Safeguarding Children Service by 10th June 2010 to:

Safeguarding Children Service

Children and Young People's Directorate
3rd Floor Eastgate House
121 – 131 Eastgate Street
Gloucester, GL1 1PX

Tel: 01452 583636
Fax: 01452 546922

SCR Panel

Chaired by Julia Oulton, Independent Consultant
Ruth Sinfield, Head of Service, Gloucestershire CYPD
Duncan Siret, GSCB Business Manager, Gloucestershire CYPD
Kate Reynolds, MAPPA Co-ordinator, Gloucestershire
DI Mark Little, Gloucestershire Constabulary, Police CPU,
Nuala Livesey, Designated Nurse, Gloucestershire PCT
Lynne Renton, Designated Nurse, Herefordshire PCT
Val Porter, Named Nurse CP, ^{2}gether NHS Foundation Trust, Gloucestershire
Jane Bee, Safeguarding Children Development Officer (education)
Dr Imelda Bennett, Designated Doctor, Gloucestershire Hospitals Trust
Linda Townley, VCS Rep, County Community Project
Maria Costello, Minute Taker, Safeguarding Children Service

Overview Author

To be confirmed, Independent Consultant

The role of the Overview Author is to analyse critically the Individual Management Reports from Agencies and to provide a multi Agency overview report in accordance with Working Together to Safeguard Children guidance. The report must contain high quality analysis, lessons to be learned and, based on these, clear recommendations for future multi-agency working to improve the safeguarding of children and young people in Gloucestershire. The report will draw upon research and current best practice advice.

Duncan Siret
2nd March 2009
Revised 27th May 2010