LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD

SCR G

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Note: This Overview Report has been anonymised throughout.

1.Introduction

1.1 This Serious Case Review (SCR) concerns four children:

- Matthew and Sarah
- Catherine
- Andrew

There are two other siblings who are adults living independently and therefore not subject to this review. The four children were living with their mother until 23rd November 2016, the day after Matthew was admitted to hospital with a head injury which was subsequently diagnosed as a fractured skull.

1.2 The family have been known to Childrens Social Care since 1997 when mother was pregnant with her oldest child and there were concerns about her drug use and related issues. Both of the older siblings were subject of CP Plans under the category of neglect and by 2002 were living with their respective fathers.
There were a number of referrals to Childrens Social Care between 2006, when mother was pregnant with Catherine, and 2013 which were mainly in respect of concerns about parental drug use and domestic abuse. While some assessments were completed, the children did not remain an open case for any substantial periods of time. The family, at that time mother, her partner (father of Andrew), Catherine and Andrew, lived outside of Lincolnshire from 2013 where the two children were made subject to Child Protection (CP) Plans on 4th July 2014. Mother and the two children returned to Lincolnshire in September 2015 informing workers that she had left father of Andrew and her property. A transfer in conference was held on 9th October 2015 and the children remained on CP plans under the category of Neglect. An Initial Child Protection Conference (ICPC) was held on 5th May 2016 to consider the unborn twins resulting in a decision that they be made subject to CP plans at birth. The first CP Review Conference for the twins (and third in respect of Catherine and Andrew) was held on 24th June 2016 at which the decision was made to remove the CP plans and manage all four children as Children in Need.

1.3 The Lincolnshire Safeguarding Children Board (LSCB) commissioned a SCR in accordance with 'Working Together to Safeguard Children' 2015 and the 'Local Safeguarding Children Board Regulations' 2006. The Terms of Reference (TOR) for this review are set out in S1.5 below. The SCR was commissioned in June 2017 and the delay is due to a change in the Independent Author.

1.4 The LSCB appointed Sue Gregory as independent overview report author of this review. Ms Gregory is a HCPC registered social worker with over 30 years experience, predominantly in childrens services, and in particular safeguarding as a front line worker, child protection co-ordinator, head of safeguarding and a director. She has worked independently as Matthew Thomas Associates since 2009 and has experience of undertaking reviews in childrens and adult services.

1.5 This review seeks to provide an analysis of what happened, what could be done differently and what has already changed. The LSCB identified 7 key factors to be addressed:

- transfer in to Lincolnshire
- move to a different Lincolnshire town

- agency understanding and impact of mothers problematic drug use on her parenting ability
- pre-birth assessment
- immediate post natal period
- Review Conference and decision to step down to Children in Need
- delivery of the Discharge Plan and Children in Need plan

1.6 The review also gives consideration to:
- management oversight and accountability
- policy and procedures
- domestic abuse
- overarching safeguarding issues
- the role and involvement of the fathers
- voice of the child

2. Methodology

2.1 All agencies to whom one or more children and their family were known have participated in the review. Agency submissions were provided by:

Lincolnshire County Council
GP's
United Lincolnshire Hospital Trusts (ULHT)
Lincolnshire Community Health Services NHS Trust (LCHS)
Addaction
National Probation Service (NPS)
Schools

2.2 All agencies provided a chronology of involvement during the scoping period of the review along with a precis of knowledge/involvement at the time of transfer conference. They also provided an analysis of their involvement during the scoping period of October 2015 to Matthew's hospital admission on 22/11/16 using an agreed template addressing the key factors identified in para.1.5.

2.3 Summary reports were also provided by East Midlands Ambulance Service (EMAS), North Lincs and Goole (Scunthorpe) A&E, and Lincolnshire Police.

2.4 Each agency has identified relevant actions taken as a result of examining this case and the action plans can be found in Appendix 1.

2.5 The childrens fathers have been written to twice and mothers' sister, all were invited to participate in the SCR. Mothers' sister met with the Independent Author and was able to make valuable contributions to this review which have been incorporated into this report. There was an inquest into mothers death on 11th April 2018 and the coroner conclusion was open verdict.

3.Parallel processes and Investigations

3.1 Determination for completion of this SCR has been mindful of other processes.

3.2 Lincolnshire Police conducted an investigation following the injury to Matthew. While medical opinion is clear that the injury was as a result of significant trauma there was no forensic evidence or witnesses to assist the investigation. A decision was made that there was unlikely to be a realistic prospect of securing a conviction against any of the potential suspects and did not meet the threshold for submission to the Crown Prosecution Service. A decision to not proceed was made within the Force and the investigation closed.

3.3 The details of mother's death were notified to the Lincolnshire Police Professional Standards Unit and the Independent Police Complaints Commission under the category of ‘death or serious injury of a person after police contact’. The case has been finalised with no further action.

4. Narrative Summary

4.1 The childrens mother has been known to social care since 1997 when 17 years old, homeless and expecting her first child. It is known that she was already using heroin at that time. Her first child was born in September 1997 with her second in November 1998. There were concerns about drug use, lifestyle and offending behavior including a short prison sentence for theft in 2001. Both children were subject to CP plans under the category of neglect and by 2002 were living with their respective fathers.

4.2 In 2004 she was in a relationship with father of Andrew who had a child (with one of mothers' sisters) who was in care and subsequently placed for adoption. During this year and again in 2006 concerns were also raised with social care about the safety of the mothers' two children during contact due to the drug and alcohol use of both mother and father of Andrew.

4.3 The midwife made a referral to social care when mother was pregnant with her third child, Catherine, due to concerns the history of drug use by mother and father of Andrew. Whilst there is evidence of an assessment the case was closed. A further referral was made in 2008 by a drug agency concerned about standards of parenting by both mother and father of Andrew. Catherine was known to have been taken to A and E on 5 occasions with bumps and bruises believed to be as a result of poor parental supervision. Again there was an assessment and the case was closed by the end of December 2008.

4.4 The next contact was in 2010 when a midwife raised concerns about mothers heroin use and she was pregnant with her fourth child. At the time it was believed that mother was engaging with services and it was initially agreed that the case could be managed by Team Around the Child (TAC) rather than being open to Social Care, however following additional concerns with respect to mothers heroin use a Core Assessment was started in respect of Catherine and the unborn baby. Andrew was born on 7/8/10, remaining in the neo-natal unit until 23/9/10 as showing symptoms of drug withdrawal. The case remained open as Children in Need under s17 of the Children Act until 9/6/11 by which time mother was believed to have reduced her drug use and ended her relationship with father of Andrew.

4.5 In July 2011 father of Andrew told a worker at Lincoln Prison that the mother of his children injects heroin and that a male, later confirmed to be her brother, was visiting the house. The case was again closed after an initial assessment. Further concerns were raised in August 2011 when the police attended an incident of violence between father of

Andrew and mother. Two days later Addaction called social care to advise that mother had missed her last two appointments and that they had been informed that she had recently taken an overdose and tried to cut her wrists. Again an initial assessment was completed that resulted in the case being closed less than a month later. A further Initial Assessment was carried out in August 2012 after an anonymous referral via the RSPCA and evidence of drug paraphernalia found in the house. Again the case was closed within a few weeks.

4.6 It is believed that the family, at that time consisting of mother, father of Andrew, Catherine and Andrew, moved outside of Lincolnshire in 2013. The children were made subject to CP plans due to concerns about parental drug use and domestic abuse in July 2014.

4.7 The period in scope for this SCR starts when the family became known to Lincolnshire again after mother presented herself to a Social Care office in September 2015 advising that she had left father of Andrew and her property outside of Lincolnshire to stay with her family in Lincolnshire. This was followed by a notification from outside of Lincolnshire that the family had moved and that the children were subject to CP plans. A transferring in ICPC was held on 9/10/15 by which time mother was known to be in a relationship with her cousin, father of Matthew and Sarah. The decision was made that Catherine and Andrew should remain on CP plans under the category of Neglect. In November 2015 mothers oldest daughter, who was 17years old at the time, accused her of physical assault and Catherine and Andrew, who had been present, were placed with family friends while the police investigated the allegation. Mother, who at this point was known to be 12 weeks pregnant with the twins, was released without charge. By December 2015, mother and children had moved to a different Lincolnshire town and she had informed Addaction that she had been injecting heroin for the previous 3 weeks and was pregnant. In January 2016, mother made an allegation that she had been abused as a child by her stepfather who continued to provide support for her by caring for the children including assisting in transporting the older two to school.

4.8 During the pregnancy mother was informed that there was a high probability that one of the twins (Matthew) would be born with significant disabilities resulting in mother facing a real challenge about whether to terminate the one twin. The prognosis improved and mother made the decision to continue with the pregnancy for both twins. An ICPC was held in respect of the unborn twins on 5th May 2016 where the decision was made to make them subject to CP plans under the category of Neglect at birth.

4.9 The twins were born prematurely on 31st May 2016 and were diagnosed as having Neo Natal Abstinence Syndrome, described as a group of problems that occur in a newborn exposed to addictive opiates while in the womb. They received appropriate treatment, including use of morphine. Mother had discharged herself from hospital the day after the birth and continued to visit the twins on the ward. During this period the first Review CP Conference on 24th June 2016 made the decision to remove all four childrens names from CP plans and step down to Children in Need.

4.10 On 11th July 2016 the twins were discharged to the family home to live with mother and their two siblings. The discharge plan outlined the required pattern of visiting by agencies including an Early Help worker to support mother in the home and with practical tasks. Mother's brother and her adult son were regarded as playing a significant role in supporting mother in caring for 4 children. In August the family were found to have

temporarily left their home due to problems with drug dealers in the area. Mother and the twins stayed with one of her sisters while Catherine and Andrew stayed with father of Andrew at his father's house. In September 2016, and again in October 2016, concerns were raised when mother left the twins in the care of others who were regarded by agencies as unsuitable carers. It also became known in October 2016 that mother was again using heroin and had been taken to hospital on one occasion with an infected injection site in her groin. She was accompanied to the minor injuries unit by her stepfather, and it is unknown who was caring for the children. She subsequently visited the hospital on advice. Around the same time, mothers' brother and her adult daughter raised concerns about her drug use and shared information about one of the twins falling from her knee while she was injecting. The descriptions of mothers' wound fitted with that seen by the health professionals.

4.11 On 22nd November 2016 Matthew was taken to hospital with a wound to his head. It is known that 5 people had or potentially had care of him in the previous 24 hours. The other children were removed following medical opinion that the injury was a Non Accidental Injury. Subsequently, following Matthew discharge from hospital, he joined his 3 siblings who have remained in the care of a family member.

5.The Experience of the Children

5.1 Catherine, Andrew, Matthew and Sarah are the younger children of mother with their two older siblings living with their respective fathers from a young age. The nature of the relationship between these four and the older siblings, particularly relevant for Catherine and Andrew, is unclear although it is known that there was contact as the daughter raised concerns about her mother's drug use and the son was included as part of the support package for mother when the twins were discharged from hospital.

5.2 The four children remained in the care of mother until November 2016. It would appear that father of Andrew lived with Catherine and Andrew for the majority of their life until mother and the children returned to live in Lincolnshire in 2015. It is clear that father of Andrew remained a significant part of their lives, even after it emerged that he wasn’t the father of Catherine, for instance they stayed with him when the family had to temporarily move out of their house due to problems with neighbours. The nature of any relationship or contact between Catherine and her father, father of Catherine, is unclear. The relationship between mother and the twins father, father of Matthew and Sarah, had ended before their birth. It is unclear as to whether he ever lived in the same house as mother, Catherine and Andrew.

5.3 Catherine and Andrew are described very positively by their teachers who have known them since February 2016. Both children have been clearly effected by the death of their mother though are making good progress socially and academically.

5.4 Whilst it is hard to know what life at home really looked like for these children, it is known that during the time within the scope of this SCR they experienced significant change both in terms of where they lived and who was living with them. They changed school and had a significant periods of time out of school due to mother moving house. It is known that they had been exposed to domestic abuse and had lived with adults, including their mother, with problematic drug use. There is information to suggest that they had seen their mother injecting.

5.5 Matthew and Sarah spent the first 6 weeks of their lives in the neonatal unit where it was clear that they were suffering from the effects of mother's drug use while pregnant. During the four months they lived with their mother there were at least 2 occasions when they were left with unsuitable carers and significant evidence that mother was injecting heroin. It is unclear who was in the home throughout this period of time.

5.6 There is much information to suggest that mother loved her children and intended to provide a warm, caring environment for the four children subject to this review. Although unable to care for her two older children she had clearly managed to maintain contact and establish a relationship with them both. However, she had a long history of drug and alcohol abuse and had a history of self harm. She had experience of life in a large family with complicated networks of relationships and, as an adult, disclosed childhood sexual abuse by her stepfather who she continued to be dependent on for support. Mother had experienced a number of abusive relationships, including physical assaults, with a number of those significant to her being involved in drugs and/or criminality. Mother herself had a long criminal record, with her first recorded offence at the age of 15 years, including offences against the person and property. From 2000 until her death her pattern of offending included thefts, fraud and breaches of police and court orders all clearly linked to the need to provide herself with drugs.

5.7 All three of the fathers of the children have a history of criminal behaviour and drug use, although only father of Andrew appearing to have played a significant role in their lives.
father of Matthew and Sarah is in prison at the time of this review. Mother's brother, and his partner, were also part of the childrens lives including the provision of support and care, during the scoping period of this review. Both have a history of drug abuse with mother's brother having a significant criminal record which included violent offences.

5.8 Information available to this review indicates that mother, along with other adults who at times had responsibility for the care of Catherine, Andrew, Matthew and Sarah, found it difficult and at times impossible to prioritise the needs of the children.

6. Analysis

6.1 This section of the report seeks to analyse the evidence gathered to address each of the key factors identified in the ToR and is therefore structured accordingly.

6.2 **October 2015 and transfer to Lincolnshire**

6.2.1 Childrens Social Care had initially been informed that the family had returned to Lincolnshire when mother visited the social work area office. At the time she was staying with family and was seeking help to find accommodation and settle in the county. This was followed by an appropriate notification from another Local Authority Social Care that children subject to CP plans had moved into the area. A transfer in conference was arranged within the required timescales where the decision made was that Catherine and Andrew would remain subject to CP plans and that this would be under the category of Neglect. All of this activity was in accordance with Child Protection Procedures.

6.2.2 The report presented to the conference from another Local Authority Social Care indicated that there had been little progress in the case since the children were made subject to CP plans and that consideration was given to progressing to Public Law Outline before the family decided to move. There was however some incongruity between the report and information shared by the presenting Social Worker who had only known the case for 2 weeks and attention appeared to be focused on how well mother was doing and that she had left a violent relationship. There is no evidence that this was challenged within the meeting. Neither mother or father of Andrew were at the meeting and there is little evidence of curiosity about the causation, circumstances or timing of the ending of their relationship. There was a decision that contact between father of Andrew and the children should be supervised until an assessment of him had been completed although it is not clear how this was to be arranged with the responsibility for supervising contact left with mother. There is no evidence of consideration of the impact on the children of this assessment or the move to Lincolnshire. It was subsequently discovered that mother would have already been pregnant with the twins as a result of a relationship with her cousin.

6.2.3 Although mother did not attend the conference there is evidence of professionals contact with her prior to the meeting. There is no evidence that professionals sought the views of father of Andrew who the children had lived with all their life and who, it is now clear, continues to play a significant role in their lives. It is important for professionals to retain an open minded curiosity when conducting assessments and they should include fathers even where there is a concern that they are perpetrators of Domestic Abuse.

6.3 **Move to Lincolnshire Town**

6.3.1 By November 2015 mother had found a property in a Lincolnshire Town and was planning to move there with Catherine and Andrew. By this time the children had moved home 3 times in 3 years. They were not enrolled in a local school until late December 2015. In the same month mother referred herself to Addaction and informed them that she had been injecting heroin for the previous 3 weeks. There is no clear picture of who was living in the house with mother during this period. At times she indicated she was again in a relationship with father of Matthew and Sarah and he would be moving in. She had also informed workers that she had resumed her relationship with father of Andrew. There is no real clarity regarding her relationships during this period.

6.3.2 There is evidence that Core Groups met within procedural expectations and that required CP visits did happen. Information was appropriately transferred between health professionals when the family moved towns and there is evidence of managerial oversight and in particular, case supervision in Childrens Social Care. A significant outcome of the move was that two children already subject to CP plans were out of school for a number of weeks with their educational needs not being met and the opportunity to monitor their safety on a daily basis also missed. There were already indicators that mother was struggling to put her childrens needs first e.g. knowledge that she was injecting heroin.

6.3.3 Even more concerning is an incident in November 2015, when mother, who was drunk at the time, was alleged to have physically assaulted her 17 year old daughter. Whilst the alleged crime was investigated by the police and a notification of a domestic abuse incident was sent to social care there is no evidence that consideration, either by police or social care, was given to fulfilling the requirements of s47 of The Children Act i.e.

to make enquiries where there are concerns that a child under 18 years may be experiencing abuse or neglect. There were a number of children in the household at the time including two who were already subject to CP plans. It is also unclear as to whether consideration was given to the sufficiency of these CP plans, in light of this insight into mothers alcohol use following this incident, and resulting behaviour.

6.4 **Agency understanding and impact of mothers problematic drug use on her parenting ability**

6.4.1 Mother's history of drug use since at least 17 years old was well known to all agencies. However, there continued to be an optimistic view by some professionals at the times mother stated her intention to stop and on the basis of her achieving short periods of apparent abstinence. This positive view by professionals significantly impacted on decisions and planning for the children. Whilst she sought help including self- referral to Addaction following her move to a different Lincolnshire town, it should be noted that she failed to engage with work to support sustainable change. She attended only 50% of Break the Cycle sessions, 1 of 5 psychosocial counselling sessions and failed to keep any outreach appointments compared to attending 22 of 23 appointments for drug testing. Many of the significant people in her life also continued to use drugs and therefore it is hard to see where she would find the necessary support to put her intent into action.

6.4.2 There is no doubt that mother stated her intent to act in the best interests of her children and did in the main continue to meet their basic needs. However, her need for drugs and the lifestyle that was associated with their acquisition continued to get in the way of her meeting her children's needs e.g. 3 house moves plus temporary stays in 3 years, 3 partners (including one whose identity appears not to be known to agencies though for a short time she stated her intent to move to another Lincolnshire town with him), children not being enrolled at school for an unacceptable period of time. There is evidence that at times it placed the children at risk of harm e.g known violence sometimes from partners but on at least one occasion by mother, leaving the twins with unsuitable carers, one twin falling off her knee while she was injecting.

6.4.3 On the basis of information available to this review it appears that mothers periods of 'being clean' were 'blips' rather than evidence of sustainable change. Apart from the opportunity to engage in sessions with Addaction there is little evidence of support for mother to remain drug free or to recognise the impact of stress, e.g worries about one twin being born with significant health needs, being in a position of choosing whether to abort one of the twins, caring for four children etc, or her ability to do so.

6.4.4 Mother was described as likable and it is clear that she was able to engage with staff. It is admirable that workers were able to establish a relationship with her and wanted her to do well, however, it is suggested that this resulted in an overly optimistic view of her ability to change and to prioritise the needs of her children. Consideration should have been given as to the real level of mother's ability and/ or willingness to engage with professionals and the plans in a meaningful way. It is suggested that mother was complying with plans when she was able but that there is little evidence of engagement in interventions which were aimed at achieving change in her drug and alcohol use and, therefore, the level of care and protection afforded to her children.

6.5 **Pre birth assessments**

6.5.1 A Protective Carers and pre Birth Assessment was commenced by childrens Social Care although mother did not attend all of the planned sessions. This appears to have been mainly concerned about her ability to care for a child with disabilities in light of the concerns at the time about one of the twins. Whilst there is no question that this was a difficult situation it is suggested that this and the resulting sympathy for mother distracted the attention from the wider concerns about her ability to care for, let alone, protect 4 children. There is little evidence of focus on the risks and yet by that time Catherine and Andrew had been subject to CP plans for almost two years with very little evidence of change in their circumstances, apart from their address, since being identified as at risk in 2014.

6.5.2 During this period mother had made the disclosure of child sexual abuse by her stepfather resulting in her being asked to sign a written agreement not to allow Catherine and Andrew to have unsupervised contact with him until a risk assessment was completed. There is no evidence of consideration of the impact of the abuse on her emotional and psychological wellbeing or her ability to protect herself and her children from her abuser. Furthermore, she continued to depend on him to support her in transporting the children to school. There is no evidence that a risk assessment in respect of her stepfather was ever completed.

6.5.3 There is no evidence that the pre- birth assessment included any consideration as to the risks that other adults may present for example father of Andrew and mothers brother.

6.5.4 The proposal to arrange a Family Group Conference as part of clarifying and establishing support for mother was positive, however mother did not attend appointments and the referral was closed. There always seemed to be a good reason for none attendance with no evidence of appropriate challenge by workers. It is suggested that this is an example of disguised compliance and potentially of avoidant behaviour.

6.5.5 Mother attended the ICPC on 5th May 2016 with her brother mother's brother and it was well attended by relevant professionals. The discussions appear to have focused on the medical issues relating to the unborn twins and the difficult decisions that mother had faced. It is noted that the chair of the conference stated to mother that “the issues around her seem to be shrinking and professionals are so proud of you for it” although little evidence was provided to support this perceived progress. It is suggested that this over optimistic view and lack of focus on the actual risks led to what was initially a split decision as to whether the twins should be made subject to a CP plan. Any doubt as to the need for CP plans is hard to understand given the circumstances already set out in paragraph 6.5.1

6.6 **Immediate post natal period**

6.6.1 The twins were born at Queens Medical Centre on 31st May 2016 and transferred to Lincoln County Hospital on 2nd June 2016. There is no evidence of exploration with mother of why she discharged herself from hospital on 1st June 2016 although staff at the QMC did inform ULHT of her discharge and her need for a Community Midwife.

6.6.2 It was good practice for the nursing staff to arrange a pre discharge meeting in respect of the twins which took place on 13th June 2016 although it is suggested that

meeting could have also served as a Core Group meeting which would have provided a focus on the potential risks as well as the health needs of the twins. The twins remained on oral morphine and it was noted that mother was not staying overnight. Two days later the Consultant Paediatrician expressed concern about twin's additional needs and questions the adequacy of the discharge plan. There is some evidence of concerns about mother's behaviour on the ward but no real evidence of appropriate challenge or recognition of this as part of the ongoing assessment. Further discharge meetings take place on 17th and 21st June 2016 where the frequency of visiting post discharge were increased to address the concerns about the level of care the twins would need. A decision had already been made within social care to provide Early Help support as soon as the twins were discharged.

6.6.3 There is evidence of managerial oversight and case supervision however there is no evidence of appropriate challenge of the social worker's view that the threshold of significant harm was no longer met. It is difficult to see how this position could be reached when the parenting assessment had not yet been completed, risk assessments in respect of significant other adults remained outstanding and the ability of mother to care for four children had not yet been tested, particularly in light of the Paediatrician's concerns about the additional needs of the twins.

6.7**. Review Conference**

6.7.1The Review conference held on 24th June 2016 was the first in respect of the twins and third for Catherine and Andrew since the transfer in conference. Mother attended the conference and was supported her brother, mother's brother and her 19 year old son. Father of Andrew was not at the conference. The meeting was also well attended by those agencies who would have ongoing involvement but it is of concern that there was no representative from the neo natal team in light of the level of the concerns expressed to the social worker prior to the conference.

6.7.2 The Social workers report to conference appropriately outlined the difficulties the twins had faced since birth as a result of Neo Natal Abstinence Syndrome and yet the safety goal was for them to continue to make progress rather than address the issues that had caused them to be in that situation. The report also recognised the pressures that mother would face in caring for two babies but indicated that support would be provided through the Discharge Plan and recommended that the CP plans be removed and that all 4 children are stepped down to Children in Need. Minutes of the meeting indicate that the discussions focused on how well mother had engaged with agencies and the evidence of some negative drugs tests. The concerns of the Paediatrician and ward staff which were expressed to the social worker do not appear to have been acknowledged or discussed.

6.7.3 Mother's brother was accepted as suitable to provide support based on a belief that he had stopped using drugs. There is no evidence of discussion about his history of violence or previous decisions about his own child.

6.7.4 It appears that the focus of the meeting was on mother's support needs and not on whether the risks to all 4 children had been reduced or their vulnerabilities. There is no evidence of consideration of the impact of the twins return home, and resulting demands on mother, or the safety and well- being of Catherine and Andrew.

6.7.5 The decision of the conference appears to have been solely based on the use of the Scaling Tool with all but one participant scaling the risks to the twins as low. It can only be assumed that this was based on an over optimisitic view of mothers ability and on the twins at that moment in time which was safe on the neo natal unit. Mother's capacity to care for all four children and the efficacy of the support identified should have been tested before removal of CP plans was considered.

6.7.6 It is therefore suggested that the evidence available at the meeting did not support the decision to remove the CP plans and step down to CinN at that stage.

6.8. **Delivery of the Discharge Plan and Children in Need Plan.**

6.8.1There were indicators that the plan may not be sufficiently robust prior to discharge with concerns about mothers lack of contact with the twins and her behaviour when she did visit the hospital. There is no evidence of questioning whether she was using drugs or challenging her behaviour. It is suggested that the plan should have been reviewed prior the twins being discharged on 11th July 2016.

6.8.2 There appeared to be lack of clarity about which discharge plan was being followed and it is of concern that the twins went home without social care being informed before the day of discharge. There is evidence of good practice by the Early Help worker who made a visit within the hour when informed by mother that the twins were home. Appropriate practical and material support was provided by the Early Help worker. There is evidence that the Discharge Plan, which was part of the Children in Need Plan, was not implemented and home visits by agencies did not happen in accordance with the plan leaving the twins unseen by professionals for a number of days. The plan was also heavily dependent on support from mother's brother and her son, neither of which materialised. Mother's sister described how mother would telephone her describing how tired she felt and believes that mother needed more support than she received.

6.8.3 Subsequently, there were a series of events between July and November that indicated that plan was not effective:

- Mother had left the twins with a neighbour. The Early Help worker was concerned that the neighbour smelled of alcohol and disclosed that she did not have care of her own children.
- Mother presented at the hospital with Matthew who she could not stop crying. She left before he could be seen. It is of concern that Childrens Social Care were not informed.
- Mother and twins were found at her sisters. She explained that she had gone there to get away from trouble in the street thought to be linked with drug dealers. Mother disclosed that she was using her sister’s methadone which she was topping up with street heroin. Catherine and Andrew were found to be staying with father of Andrew and his father.
- Mother was talking about moving to another Lincolnshire town with a new partner
- It was known that the twins were left with neighbours.
- Mother presented at the minor injuries unit with an infected wound in her groin. She was accompanied by her stepfather who was present throughout the investigation
- Further concerns about the twins being left with carers whose own children are on CP plans
- Sarah was in hospital with a viral infection

- Information is passed to Social Care that mothers adult daughter has voiced concern about the safety of the children as a result of mother injecting drugs.
- Mother informs the Early Help worker that she is having difficulty walking
- Mother's brother informs social care that he saw one of the twins roll off her knee while she was injecting heroin

6.8.4 It is suggested that the information in respect of the twins being left with unsuitable carers on at least 3 occasions and one of the twins falling while mother was injecting met the criteria for enquiries to be made under s47 of The Children Act. There is no evidence that this was considered or that the totality of this information was addressed in management supervision or the Children in Need meetings held on 21st July and 17th November.

6.8.5 The Children in Need meeting on 17th November was attended by mother, Catherine, Andrew, social worker and professionals working with the older children. Despite mother talking about her infected wound and drug use while at her sisters the meeting appeared to view this as a blip and minutes indicate that consideration would be given to step down to TAC if both mother and father of Andrew continued to be drug free. It was also noted Catherine and Andrew enjoyed visiting father of Andrew and sometimes stayed overnight. It is of concern that the risk assessment in respect father of Andrew, identified as necessary at the transfer in conference, had not been completed and it is unclear when the position changed about the need for contact to be supervised.

6.8.6 On 22nd November 2016 Matthew was taken by his mother to the A&E department at Scunthorpe General Hospital and later transferred to Sheffield Children's hospital. Information shared by mother with the hospital staff indicated that her brother, his partner and a neighbour had also had care of Matthew during that day.

7. Changes in Practice and Actions

7.1 Section 2 of this report sets out how agencies have examined their own practice as part of this Serious Case Review. Appendix 1 provides a table of actions identified and changes made as a result of this activity.

8. Summary and Conclusions

8.1 It is clear that Catherine, Andrew, Matthew and Sarah had experienced living in a family where there was a significant amount of problematic drug use, offending behaviour and on occasions violence. The potential impact of this had been recognised when Catherine and Andrew were made subject to CP plans in another county in 2014, and subsequently continued when they moved to Lincolnshire. Matthew and Sarah were made subject to CP plans at birth.

8.2 There is evidence that mother, who was believed to be their sole carer throughout the time within scope of this review, was committed to caring for her children and intended to do her best. It appears that for the majority of the time she was able to provide for their basic needs with no concerns about their appearance or the behaviour of the older children. However, she had a history of problematic drug use that had led to her first two children being brought up by their respective fathers, and which continued to get in the way of her being able to afford the level and consistency of care that these four children

needed. She also had a complicated set of relationships with partners and some family members who themselves had problematic drug use and/or offending behaviour. Information gathered through consultation with the family supports this conclusion.

8.3 It appears that professionals did not have an understanding of the family history, relationships and functioning and, as a consequence, there was no clear picture about what daily life was like for these children.

8.4 Although outside of the scoping period for this review it remains hard to understand why assessments concerning Catherine and Andrew had not resulted in more robust action prior to their move to outside of the Local Authority.

8.5 There was an opportunity to manage the case more effectively on the family's return to Lincolnshire. However, it is of concern that significant decisions were made without key assessments being completed, including the pre- birth parenting assessment and risk assessments of father of Andrew and mother's stepfather. It is suggested that the removal of the CP plans prior to the twins being discharged from hospital was not evidence based.

8.6 It is evident that the Discharge plan and Children in Need plan were not implemented and there were a number of incidents between the decision to remove the CP plans and the injury to Matthew that should have prompted a review of the plans and, on some occasions, enquiries being made under s 47 of The Children Act. There is no evidence that the professional resolution and escalation procedure was used by any agency.

8.7 In conclusion, the information available to this review suggests that there were missed opportunities to intervene which may have impacted on the level of care afforded to these children and which may have prevented the injury to Matthew.

8.8 It should be noted that all four children are now doing well and Matthew has recovered from his injury.

9. Recommendations

9.1 It is recommended that the LSCB:

- seeks assurance that the model used in assessing risk within conferences is being used effectively and in particular that:
    - the Scaling tool is used as part of a wider assessment of perceived future risks.
    - 'Danger statements' and 'safety goals' are translated into effective plans that seek to both effect necessary change to protect children and to monitor their safety and well -being.

- Seeks assurance in the practice of Independent Child Protection Chairs and their management of conferences.
- consider establishing a practice by which CP plans should not be removed at the first review unless there are evidenced circumstances
- seeks assurance that the professional resolution and escalation procedure is understood and effectively applied in all partner organisations.

- Assures itself that the actions and recommendations in section 7 and Appendix 1 are completed.
- Produces a practice learning brief for circulation to all partners.