BSCB
Bristol Safeguarding Children Board
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BRISTOL SAFEGUARDING CHILDREN BOARD BRIEFING

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CHILD PROTECTION INCIDENT REVIEW BRIEFING – FAMILY L

What is a CPIR?

A CPIR (Child Protection Incident Review) is undertaken by BSCB when a case is referred that does not meet the criteria for a Serious Case Review, but can still provide learning at a local level in respect of:

- How agencies are working together
- Improvements that might be required in local services

In Bristol the decision to undertake a CPIR is made by the Serious Case Review Sub-group. A CPIR is completed by local reviewers appointed by the Serious Case Review Sub-group, using the same 'systems' based approach that is used for Serious Case Reviews.

CPIR's are not published, but their learning needs to be shared within the professional community, both what to do differently, and where best practice is identified.

To help embed this learning with all professionals involved in safeguarding children we have decided to issue briefing notes for Bristol CPIR's that can be used to inform practice, and for training purposes across the city.

WHAT WE KNOW ABOUT THE FAMILY AND WHAT HAPPENED

Family L is: Mother, Father, two year old F and six year old C. Both parents have a history of substance misuse and Father has spent a number of periods in prison. A social worker had been involved when Mother was pregnant with F but this involvement was closed in August 2012 following reports of successful engagement with Mother.

In September 2013 two referrals were received by children's social care. The second referral expressed concerns that F was being given substances, including methadone. Following a number of meetings between professionals, including S47 strategies, S47 enquiries and assessments and MARAC meetings, both children were made subject to a Child Protection Plan in May 2014. In July 2014 an Interim Care Order was granted and both F and C were placed in the care of the local authority.

OUR FOCUS IN THIS REVIEW: HOW AGENCIES WORKED TOGETHER AND WHAT INFLUENCED DECISION MAKING

The review looked at delays throughout the period from receiving the referrals in September 2013 until the removal of the children 10 months later to understand what influenced decision making and what we can learn from this case.

The reviewers found that throughout this case there was a concern from all professionals regarding whether

the children were exposed to substances in the environment or had actually ingested them. This concern caused significant delays waiting for additional tests to be completed before action was taken to protect the children.

There were also delays in actions taken in both social care and the police due to staffing issues and staff sickness.

Initial urine tests were inconclusive due to a dilute sample, but this was recorded as a 'negative' result and this inaccuracy was then repeated by other agencies, including during the MARAC in May 2014.

Information provided to children's social care in January 2014 was not shared with other professionals until the Child Protection Conference in May 2014. This information changed the view of all professionals involved regarding the risk to the children.

Towards the end of the period under review a safety plan was put in place, which was not followed by all agencies. There was no information recorded about what the school support worker should do if during visits concerns about the children escalated, or they could not see the children during visits.

The Father was not included until late in the process, and this can impact significantly on the analysis of risk in the family.

THE GOOD PRACTICE THAT WE IDENTIFIED

- The initial referral was highlighted and responded to effectively, and children's social care took into consideration the past history of family L
- The second referral was initially responded to quickly, sharing information with health and police and immediately organising urine tests of both children.
- A clear safety plan was also put in place until the urine test results were known.
- All professionals involved worked hard to engage the family and build relationships.
- Once the BDP worker was aware of the risk they immediately followed protocol and placed Mother on 7 day supervised prescribing of her methadone.

WHAT WE HAVE LEARNT

- We need to be certain that we record test results accurately.
- Holding parents in high regard can mean that the 'rule of optimism' interferes with robust risk assessment regarding information that demonstrates risk to the children.
- Holding a parent in high regard can lead to a focus on their issues, instead of the impact on the children.
- Information regarding families where there are concerns about risk to children must be shared promptly with everyone who is involved in the plan, or has involvement with the family.
- It doesn't matter how a child is exposed to harmful substances – the risk to their health and life is still a significant child protection concern.
- Staff sickness and staffing issues can impact on risk to children if managers don't review cases promptly and ensure that outstanding actions are completed.

WHAT WE CAN DO DIFFERENTLY IN THE FUTURE

- Make sure that the voice of the child is present, and prioritised in all our records. This will remind us about the impact on the child, and help us to stay focussed on the child's needs.

- Record facts accurately – "we don't know" is exactly that and is less likely to be influenced by the 'rule of optimism'.
- Attempt to involve all parents in assessments from the very beginning, even if they are absent through being in prison, or not currently having contact.
- Work openly and collaboratively with each other across agencies. Sharing information can act as a check that our own views are not being influenced too heavily by one factor.
- Make sure everyone involved with the family is working together – if you know about someone then share this information with the lead professional. Don't forget professionals working with the adults in the family.
- Managers can review cases promptly when staff are absent, or when they have staffing issues in their teams, and escalate concerns if these issues are impacting on the risk to children.

GOOD PRACTICE GUIDANCE RELATED TO THIS REVIEW

- Bristol now has a Multi Agency Safeguarding Hub (MASH) to improve sharing and analysing information across agencies. First Response sends appropriate referrals to the MASH.
- Exposure to substances, including methadone has been an issue in previous Bristol Serious Case Reviews, Child K, Baby Z – read more about them: https://bristolsafeguarding.org/children-home/serious-case-reviews/bristol-scrs/archive/
- BSCB Escalation of professional disagreements: https://bristolsafeguarding.org/media/1176/escalation-procedure.pdf
- BSCB guidance note on sharing information: https://bristolsafeguarding.org/media/1280/92info-sharing-2013-new-link.pdf
- BSCB and Safer Bristol joint practice guidance on substance misuse: https://bristolsafeguarding.org/media/1194/bscb-safer-bristol-substance-misuse-guidance.pdf
- BSCB Protocol to prevent childhood exposure to opiod substitution medication 2017: https://bristolsafeguarding.org/media/1174/prevent-opioid-exposure.pdf

FEEDBACK, SUGGESTIONS AND IDEAS

Tell the BSCB how you have used this briefing to improve practice at:

- Email: bscb@bristol.gov.uk
- Twitter: @BristolLSCB
- Website: www.bristolsafeguarding/children/contact/contact-the-bscb

Let us know if you identify work that the BSCB could complete to support professionals learning and development in relation the findings from this review.