Executive Summary of

The SERIOUS CASE REVIEW relating to

‘Sarah’
1. Introduction
1.1 Sarah and her mother, F2, died in a house fire at their home. A Rapid Response meeting was held under the Child Death Review and Response processes where it was felt that there were some aspects of the deaths that might warrant further review. At this stage the death was being investigated by the police as a possible arson and the definitive cause of the fire was unclear. It was agreed that any decision as to whether the case should be referred to the Wandsworth Safeguarding Children Board (WSCB) Serious Case Review (SCR) Sub-Committee would await the findings of the Fire Brigade investigation into the cause of the fire, and the outcome of the toxicology tests which were not available for three months.

1.2 The SCR Sub-Committee held a meeting to discuss the case in the light of the fire and police investigations, including the toxicology tests (F2 had 241mg of alcohol per 100mls of blood – over three times the drink-drive limit – and there had been recent use of opiates). The investigation by the Fire Brigade into the cause of the fire showed that this had been the second fire at this address within fifteen months and issues regarding fire safety had been noted. It was also reported at the meeting that the health visitor had difficulty in maintaining contact with the family.

1.3 The SCR Sub-Committee therefore recommended that a SCR be undertaken and this recommendation was accepted by Paul Robinson, the Chair of the Wandsworth Safeguarding Children Board. On balance, in light of the concluded investigations, the SCR Sub-Committee agreed that neglect was suspected to be a factor in Sarah’s death [Working Together, Chapter 8, paragraph 8.9 (2010)].

2 The Review Group
2.1 The review group membership was as follows:
Jane Wonnacott, Independent Chair
Assistant Director, Children’s Specialist Services Division
Assistant Director, Standards and Schools Division
Designated Doctor, NHS Wandsworth / St George’s Hospital NHS Trust
Designated Nurse, NHS Wandsworth
Detective Chief Inspector, Metropolitan Police
Senior Manager, Housing Department
General Manager, South West London and St George’s Mental Health NHS Trust
Designated CP Lead, London Probation Service
Designated Officer, London Fire Brigade
Designated Officer, South London and Maudsley NHS Foundation Trust
Safeguarding Standards Unit Manager, Policy & Development Division
Development Manager, WSCB

Additionally Fiona Johnson, the Independent Overview Writer attended review group meetings.

2.2 The independent overview writer is Fiona Johnson, an independent social work consultant. She qualified as a social worker in 1982 and has been a senior manager in children’s services since 1997 contributing to the development of strategy and operational services with a particular focus on safeguarding and child protection. She is GCCC registered and has previously written overview reports for East Sussex, Brighton & Hove, Portsmouth, Southampton, Kent and West Sussex LSCBs.
Review Process

3.1 Individual Management Review (IMR) reports were received from the following sources:
- Wandsworth Children’s Services Department
  - Children’s Specialist Services
  - Standards & Schools Division
- Wandsworth Housing Department
- London Fire Brigade
- Metropolitan Police
- NHS Wandsworth (including London Ambulance Service, Pharmacies, NHS Direct)
- SWL and St George’s Mental Health Trust
- St George’s NHS Trust
- South London and Maudsley NHS Foundation Trust

Family Input to the Review

Consideration was given to involving family in the review process and it was agreed that the overview writer would meet with maternal grandmother. The father was also offered this opportunity but did not wish to be involved. The family will be offered feedback at the end of the review process and the opportunity to see the executive summary.

The facts

5.1 Sarah’s mother was one of three children. Sarah’s mother was previously known to social services because of difficult behaviour in her teens associated with alcohol abuse and drug-taking.

5.2 Sarah’s father had a significant criminal record, mostly for dishonesty, probably to fund his drug addiction. Very little is known about the childhood of the father and the first major contact with him by any specialist agency seems to have been when he was the subject of a drug treatment order and was referred to the drug treatment agency for support in resolving his substance misuse difficulties.

5.3 Sarah had an older half-sister and whilst it was clear that mother had abused drugs in her teens there is no evidence that during that pregnancy she was misusing drugs or alcohol. Later however mother was noted to be abusing alcohol as well as taking heroin and was on a waiting list for inpatient treatment. At this time maternal grandmother was providing much of the child care. Mother was admitted to hospital for assessment stabilisation and detoxification as she was eleven weeks pregnant. At this time her husband was said to be depressed and abusing alcohol and the couple’s relationship was in difficulty. Maternal grandmother was looking after Sarah’s half-sister.

5.4 A son was born six weeks prematurely and with drug withdrawal symptoms that required treatment with morphine. Mother admitted to heroin use during the pregnancy and a multi-agency plan was put in place to support the family and monitor the care provided to the children. The family situation then deteriorated and the parents separated, father moving to Ireland where he later died. The children were the subject of child protection plans and moved to live with maternal grandparents who obtained residence orders on them. Mother was then sentenced to a nine-month prison sentence for robbery. The children remained with the maternal grandparents while their mother was in prison and they were provided financial support from children’s social services. At this time concerns were raised about maternal grandfather’s use of alcohol and he agreed not to drink while in sole care of the children.

5.5 The older children remained in the care of the maternal grandparents. Mother continued to access drug treatment including residential rehabilitation. She stabilised on a methadone
prescription and moved into a council flat. Mother was in a new relationship and was pregnant again. When the couple self-referred themselves to the children’s social work team for support they said that they had been in a relationship for about eighteen months and that the pregnancy although unplanned was welcomed.

5.6 Both parents were open and forthcoming about their previous drug use and requested assessment and support from all professionals. A comprehensive core assessment that included contact with both parents and the maternal grandparents was undertaken. There was also consultation with probation, health visitors, midwife and the community drug teams. The core assessment was detailed and full. It covered the drug history of both parents and their criminal histories. Following this assessment there was a pre-birth child protection conference that unanimously decided the unborn child should not be the subject of a child protection plan but that the family should be supported via a network meeting and child in need plan.

5.7 Sarah was born and despite some communication between the hospital social work team and the ward staff immediately after her birth there was no pre-discharge planning meeting and a network meeting was cancelled and was not reconvened. The reasons for this are unclear however the positive progress made by the parents was maintained and at this time both parents were doing well on their methadone programmes.

5.8 During the first six months of Sarah’s life there was regular monitoring by a range of agencies. There was also consistent contact with the drug treatment agencies and maternal grandparents were actively involved and providing support. There was ongoing contact between mother and her two older children facilitated by the maternal grandmother. There were at this time concerns raised by mother about maternal grandfather’s alcohol use but this was not fully substantiated.

5.9 Mother expressed concerns about her father’s alcohol use and the effect this could have on her older children and made a referral about a specific incident where Sarah’s father had returned the two older children to the grandparents care. Following this a formal child protection investigation was initiated. Welfare checks were undertaken on the children and the brother was interviewed at the school. Maternal grandparents were also interviewed and a core assessment was completed. The outcome from this assessment was that there should be consideration given to convening a family group conference, however this was not initiated, and the maternal grandfather then died of pneumonia. One impact of this incident was that relations between Sarah’s mother and the maternal grandmother were significantly strained and from this point there is little direct contact between maternal grandmother and Sarah although the older children continued to have regular contact with their mother.

5.10 In the next year there was no contact with Sarah by the health visiting service. The health visitor changed and the new health visitor attempted contact on five occasions during the next two months before eventually completing the 8-month check on Sarah when she was fourteen months old. No concerns about Sarah’s development were noted and the health visitor provided relevant information about playgroups and nursery involvement. The next contact with Sarah was five months later when another new health visitor made contact and did a home visit. At this visit again all was seen to be well and similar advice was given to mother about dental treatment and attendance at playgroups. In the next nine months there was limited contact with Sarah by any agency and there was nothing significant noted at any of these contacts although her poor teeth were noted by the GP.

5.11 There was then a chip-pan fire at the flat where Sarah and her mother lived. This was caused by mother falling asleep after having put food on the stove to cook. Fire officers and medical personnel involved after the fire indicated that Sarah’s mother smelt strongly of alcohol and that Sarah was wearing nothing but swimming pants. The fire was reported at
9.30pm. Mother’s explanation was that she fell asleep watching TV. The fire was noted by a neighbour who had put it out. Neither Sarah nor her mother was hurt in the fire although they both suffered from smoke inhalation. It is unclear if the father was present at the fire but he was seen at the hospital after the event.

5.12 Following receipt of a referral from the ambulance service after the fire, the children’s social work team initiated an assessment. The status of this assessment is unclear but there is no evidence however of contact with the police and they do not appear to have contributed to the assessment process so it is unclear whether it was a formal child protection investigation. The assessment that was undertaken did not include any contact with the maternal grandmother and focussed solely on recent events. A joint visit was undertaken with the health visitor and Sarah was seen to have decayed teeth, be drinking cola and had matted hair. Sarah’s mother said that she took her to the ‘one-o’clock club’ but this was not checked with the organisers. The risks of possible neglect and the social isolation of the family were not identified and there was no record that issues of fire safety were discussed. There was no clarification of father’s whereabouts at the time of the fire and no discussion about support systems available for the family. Three months later the team manager reviewed the case and agreed closure as the care being provided was deemed to be ‘good enough’.

5.13 The health visitor visited twice in the three months after the fire. She identified a ‘parent play’ class for mother to attend and made a referral to it however mother did not attend and there was no communication between the professionals about this. Mother again said to the health visitor that she took Sarah to playgroup but there was no follow-up to check if this was true; it was not. Father was not present at either of the visits and his role did not appear to be considered.

5.14 Six weeks after the first fire at 7.00pm the ambulance service was called out to the home address because of a possible overdose. On attendance by ambulance staff it became apparent that mother had taken methadone on top of alcohol and was comatose however there was no immediate risk to her health. The ambulance was called by father and the ambulance team have no record of Sarah being present at the visit however it is possible that she was in a separate room in the flat. The information about this call-out was not shared with any other agency as there was no evidence of child protection concerns and there was no way that the ambulance staff could connect this incident with the chip-pan fire six weeks earlier.

5.15 The fire service made three unsuccessful visits to the property to undertake a fire assessment that would have ensured that smoke alarms were fitted in the flat. These were unproductive as the family were always out and after three attempts the fire service ceased visiting as their policy is to stop calling after three abortive visits.

5.16 In the following year there was limited contact with Sarah by professionals. The health visitor undertook a home visit and advised mother about accessing a nursery place. Sarah was noted to have been seen at the eye clinic with regard to a squint and was seen by the GP for a viral illness; her mother maintained her regular contact with the surgery for her methadone prescription. Nothing of note was identified at any of these contacts. Father was also attending his drug treatment appointments regularly and was reporting that he was working.

5.17 In the summer before the second fire the father was interviewed by the police in connection with a stolen vehicle. The police were concerned about the cluttered nature of the flat and the possibility of this being a hazard if there were a fire. They passed these concerns to social care. Contact was made by social workers with the health visitor who was requested to visit; as she was about to go on leave she requested that a colleague contact the family to check if conditions had deteriorated. An unsuccessful attempt was made to visit in August.
During August father’s attendance at the drug clinic became more erratic. In September father was assaulted in the street and he attended the Accident and Emergency Unit at the St George’s Hospital. He was accompanied by Sarah and her mother; Sarah was noted to look pale, thin and unkempt. This information was passed to the health visitor who attempted to contact the family unsuccessfully. The housing department had difficulty in gaining access to the property in order to undertake the annual gas servicing and had to issue a notice for forced entry. They were eventually able to gain access and the house was noted to be cluttered and messy but not dirty. Sarah was seen and appeared to be clean, healthy and appropriately dressed.

5.18 During the autumn both parents’ attendance at drug clinic appointments was a little erratic but the explanation given was that paternal grandmother was ill which required them visiting her in Scotland. The health visitor had telephone contact with mother and father at this time but Sarah was not seen. Information from the coroner’s report indicates that at the time of her death mother had in the recent past been using heroin, methadone, cannabis and cocaine as well as having a blood alcohol level of 241mg of alcohol per 100mls of blood which is about three times the prescribed limit of 80mg of alcohol per 100mls of blood above which it is an offence to drive a motor vehicle. The expectation of the drug treatment service is that mother should have been screened approximately every three months for drugs but was not tested for alcohol. In the last year of her life mother was tested twice; once when she tested positive for methadone only and once when she showed positive for cannabis and methadone; there was a six month interval between these tests. The caseworker stated that mother was always well presented, dressed well and showed good self care. She never appeared intoxicated or smelt of alcohol or appeared to be using illicit substances.

5.19 Both Sarah and her mother died in a house fire probably caused by a candle. At the time of the fire there was no electricity in the house as the pre-payment meter had been automatically disconnected because the £6.00 emergency supply had been used and the pre-payment key had not been credited. Communication with EDF, the energy providers for the flat has indicated that the pre-payment meter was installed at the request of Sarah’s mother. The meter was regularly charged with money until just before the fire when Sarah’s mother had difficulties charging the key. An emergency call-out was made to the property and £10.00 credit was added to the meter and she was issued with a new key. No attempt was made to add further credit to that key and there was no contact made with EDF to say that there were further problems being experienced. EDF electricity pre-payment meters have a £6.00 emergency credit facility for the customer to access if required until the key is credited again. Should this emergency facility be used and no credit is put on the key a £6.00 debt will show on the meter and at this point the meter will automatically disconnect.

6. Views of family members

6.1 The Overview Writer met with the maternal grandmother. The maternal grandmother had comparatively little direct contact with Sarah and her mother in the last two years of their life following the allegations being made about maternal grandfather’s alcohol use but had indirect contact as the older children were seeing their mother regularly.

6.2 The maternal grandmother was surprised that there seemed to have been relatively little oversight of Sarah by professional agencies in the recent past as she had assumed that Sarah would have been monitored by social workers or health visitors. She did however acknowledge that after Sarah’s birth her mother had appeared to have improved significantly and admitted that she was not directly aware of any failings in the care provided to Sarah.

6.3 The maternal grandmother was also surprised to hear from the overview author that Sarah was not attending playschool or nursery at the time of her death. She expressed concern
that this had not been a cause for intervention by professional agencies and felt that they should have known that Sarah was not enrolled and to have done something about this.

6.4 The maternal grandmother also expressed concern about the response by agencies after the first fire and indicated that she felt that this should have triggered a more formal assessment. She was particularly surprised that no contact had been made with her to involve her in the assessment as she felt that if she had been aware of the issue of possible alcohol abuse she would have been available to provide additional support.

7 Key themes identified by the review process

7.1 Assessment of neglect in the context of substance misusing parents
There were indicators that the parents were neglecting aspects of Sarah’s care however Sarah’s height and weight was checked periodically and was always found to be within normal parameters. None of the missed health appointments were crucial and she did attend ophthalmology appointments regularly and was receiving appropriate treatment for her eye condition. Furthermore despite not attending pre-school provision Sarah was noted by the professionals who had contact to be chatty and friendly and was developing normally. Whilst it is now usual for children to attend pre-school provision it is not a requirement and non-attendance alone cannot be used as a neglect indicator. The real issue with regard to neglect was a failure to identify the pattern that was emerging which was similar to that experienced by her older children. The degree of neglect experienced by Sarah as observed by professionals was not sufficient to warrant legal intervention however if it had been viewed in the context of substance misusing parents who had previously failed to care for children adequately it should have raised more concerns. The child care professionals needed to think about the parenting being provided within the context of adults with drug and alcohol problems and the specialist drug and alcohol treatment staff needed to consider Sarah’s experience and the impact of substance misuse on her.

7.2 The importance of challenging assumptions and the role of evidence
Both of Sarah’s parents were very likeable and appealing individuals. This is particularly true of her mother and it is apparent that all the professionals involved found it difficult to challenge what she told them. The health visitor and social worker accepted at face value mother’s assertions about participation in playgroups and parenting groups and did not check that it was actually happening. In part this may have been because there were no obvious indicators that Sarah was failing to develop in these areas but it is also possibly because there was a ‘desire’ to believe mother.

7.3 The need for effective inter-agency communication and challenge
Whilst there was evidence of some good communication between agencies in supporting Sarah and her family particularly around the pre-birth assessment there were however some difficulties. A significant communication failing was the absence of a network meeting after Sarah’s birth which meant that there was no clear lead professional or inter-agency plan and this undermined communication between adult and children’s services. The request from the social worker to the health visitor to visit the family in response to the police referral was another example where there was a need for more effective inter-agency communication and challenge. The request should have been resisted by the health visitor who knew that she was unable to make the visit because of her imminent leave. Workload pressures are known to detrimentally affect the capacity of workers to undertake their work effectively and to provide adequate challenge to each other. The health visitors working with the family presented as being overwhelmed by the quantity of the work but also by the nature of the work particularly in the absence of good supportive supervision to enable an objective overview of the casework.
7.4 The need for agencies not providing services to children to consider safeguarding children in all aspects of their work

There were a number of agencies where a lack of child focus could be identified. Firstly both drug treatment agencies where there was nominal acknowledgement that their service users were parents and limited attempts by them to work in co-operation with child care agencies; secondly the Ambulance Service who despite identifying child protection concerns when they first visited the address, on the second occasion failed to link the incidents and see that their input could have been significant in safeguarding Sarah; thirdly the Fire Brigade had a policy of only three attempted fire safety visits regardless of vulnerability or whether children are present; and finally EDF energy’s policy to cease to supply electricity when the meter is £6.00 in deficit regardless of the risks to or vulnerability of the customer.

8 Lessons learned from the review

8.1 The importance of effective assessment by professionals that fully involves all aspects of families lives. This must ensure that there is sufficient information available about fathers and their personal history. It should also involve the wider family who often have a greater knowledge of what is happening within families and are able to offer greater support than professionals. Such assessment must be ongoing and must be regularly updated to incorporate new information as there are changes in family’s lives.

8.2 That when working with parents who abuse alcohol and drugs there needs to be a healthy scepticism about self-reported progress and workers should ensure triangulation of evidence to confirm or deny any improvements. All professionals when working with parents who substance misuse (alcohol and/or drugs) need to be aware of the individual’s history of substance misuse and correlate that with current behaviours. This must concentrate on the child’s experience and should consider parenting capacity in the context of the substance abuse.

8.3 The importance of effective communication between agencies which must include all professionals having the confidence to challenge appropriately. This confidence will only be present when services are appropriately resourced and staff are receiving the necessary support and supervision to allow thorough and considered professional analysis of the safeguarding risks and strengths of families.

8.4 The need for effective systems to be in place that act as fail-safe monitoring in case of individual error or incompetence. The most significant example of this was that the inter-agency planning meeting after Sarah’s birth was not held. A system of review of the implementation of conference decisions would have identified this omission which could have resulted in different outcomes for Sarah, although not necessarily prevented her tragic death. Similarly if there had been suitable follow-up of the social work action by the manager following the referral from the police it is possible that this would have led to an assessment being undertaken rather than a request for the health visitor to undertake a visit.

8.5 Regular, effective and challenging supervision and management is essential if staff are to be able to protect children adequately. This needs to enable workers to review and evaluate their actions with the assistance of an objective and sceptical mindset. As stated previously this is particularly important when working with parents who misuse alcohol and drugs and they are often very plausible and deceptive and frequently present as victims themselves. Without the benefit of robust and informed challenge by a manager it is too easy for the worker to accept a version of reality that is skewed and fails to protect the child.

8.6 Finally it is essential that all agencies ensure a consistent focus on the child. It is key that this applies fully to those agencies whose primary client is an adult and it is crucial that those agencies consider whether their service users are parents or care for children when designing
and delivering their services. The responsibility for protecting children lies with everyone and agencies cannot presume that parents will raise the issue themselves.

9 Recommendations

9.1 That Wandsworth LSCB establish a multi-agency file audit process to review multi-agency working to safeguard children. The first area of auditing should focus on the quality of inter-agency assessment with specific reference to working with parents who misuse alcohol and or drugs. The audit should explore whether the difficulties identified in this review are common to work with other families. This audit should review a range of children including some where there is no child protection plan in place.

9.2 That the Wandsworth LSCB training programme should be reviewed to ensure that all courses include reference to the need for staff in all agencies to be able to constructively challenge each other. This review should identify opportunities where existing training courses can be modified to strengthen the areas around sceptical consideration of mutual agency intervention and empowerment of individuals to question each other’s practice.

9.3 That Wandsworth LSCB should develop training for all staff around the messages from the research ‘Hidden Harm – Responding to the needs of children of problem drug users’. (Advisory Council on the Misuse of Drugs, 2003) and ‘Bottling it up the effects of alcohol misuse on children, parents and families’ (Turning Point 2006). This training to focus in particular on the importance of all agencies considering the effects of alcohol and drug abuse on the individual capacity to parent effectively and the implications of this on children.

9.4 That Wandsworth LSCB should develop a system for checking whether the recommendations from child protection conferences where there are no continuing child protection plans are implemented.

9.5 That Wandsworth LSCB should work with the Children’s Trust to instigate a review of supervision across the agencies. This review should examine frequency and quality of supervision provided within all member agencies of the LSCB.

9.6 That Wandsworth LSCB should request that the London Ambulance Service further review the potential for adapting their recording systems to ensure that there can be cross-referencing of information when there are repeat call-outs to addresses where a child protection referral has been made.