Serious Case Review Learning Briefing

Child U

What is a Serious Case Review?

A Serious Case Review (SCR) is a local multi-agency review, conducted in circumstances where a child has been abused or neglected, resulting in serious harm or death, and there is cause for concern in relation to how the relevant agency or agencies have worked together to safeguard the child. Since October 2019, these reviews are now called Child Safeguarding Practice Reviews (CSPR).

The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals/agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

Background

Child U was a three-month-old child who died in 2017. He lived with both of his parents and his older siblings. Child U died following a reported fall from his parent's bed to the floor. His mother had a dependence on Tramadol, a prescribed strong painkiller. There were no other known predisposing risk factors, and there had been no concerns about the care or parenting of any of the older children.

Serious Case Review Findings

The local review found that there was evidence of good practice and areas for improvement and the review made recommendations for practice improvement. Please take time to read the Serious Case Review, which is on the partnership website:

Good Practice:

- ✓ Positive information sharing between the GP surgery and health visitor during their regular multi-agency meetings.
- ✓ The provision of a midwife counsellor following Mother being unable to have a termination.
- ✓ The timely notifications of the incident from the ambulance service.
- ✓ Evidence of commitment of professionals over the weekend to keep the children safe including; two well attended strategy meetings despite them being held over the

weekend. This included the health visitor who provided the information about Mother's Tramadol misuse. In addition, there was evidence of positive challenge and debate over the weekend between the police and Children & Young People's Services (CYPS) manager to find a way forward.

- ✓ Sensitive supervision of contact with Child U in hospital.
- ✓ The early involvement of a Home Office pathologist to consider the fracture.
- ✓ Information sharing from Children's Social Care (CSC) and from the regional children's hospital to community health professionals following the incident.

Areas to strengthen:

- Many prescription and some over the counter drugs are highly addictive and may have an impact on parenting. This is not widely acknowledged and understood.
- Professionals need to ask detailed questions about the use of prescribed or over the counter medication and consider the impact of any dependence on parenting. This includes the impact of withdrawal. This questioning should also consider the other parent, in this case Father.
- Information sharing about a parent's misuse of prescribed drugs is as important as with any other drug dependence. Don't assume other professionals (or family members) will be aware or that a parent will disclose the information. This learning will be included in WSSCP substance misuse training.
- All professionals should be aware of significant information on their agency's records for example a letter from a GP and incorporate that information into their assessment of risk.

Take the Learning into your Practice:

Take the issues raised in this SCR into your supervision, team meeting and group supervision.

Consider the following:

1. Am I adequately aware of the potential impact of the misuse of prescribed or over the counter medication?
2. Do I ask enough questions of parents who are prescribed medication that may be addictive?
3. Do I understand the impact of withdrawal from prescribed or some over the counter medication on a parent?
4. Do I recognise the importance of sharing information about a parent's use of prescription medication? If consent is not given, am I aware this may be a child protection issue?

5. Do I understand how important it is to speak to a parent's GP when undertaking any assessment?
6. Do I maintain professional curiosity and ensure I do not make assumptions about risk based on a lack of previous concerns or incidents?
7. Do I adequately challenge other professionals and escalate my concerns if there is lack of progress, uncertainty or no clear plan for a child?

Resources:

The Government published a report on prescribed medication dependence: https://www.gov.uk/government/publications/prescribed-medicines-review-report

This report identified that 25% of adults in England in the year 2017 - 2018, were prescribed benzodiazepines, z-drugs, gabapentinoids, opioids for chronic non-cancer pain, or antidepressants. There is a higher rate of prescribing to women and both the rate of prescribing and the time receiving a prescription increase with deprivation.

The report highlights that some prescription medicines like benzodiazepines and z-drugs, gabapentin and pregabalin, and opioid pain medicines, can be addictive and could cause problems for people taking them or trying to come off them, especially if someone has been taking them for a long time. Withdrawal effects can include impact on well-being, personal, social and occupational functioning. These effects and symptoms could last many months and can have an impact on parenting capacity. It is important that both reduction of the dosage and ceasing of these prescription medicines is under medical supervision.

Adfam: Opioid Substance Treatment (OST) and risks to Children: https://adfam.org.uk/files/docs/OST-Good-Practice-Guide-September-18.pdf