SOMERSET LOCAL SAFEGUARDING BOARD

Serious Case Review

Child D: DoB 12.9.06, female

Author: Christine Hindle

1 INTRODUCTION

1.1 Child D was born at Yeovil District Hospital, and spent four weeks in SCBU withdrawing from an opiate, as her mother is a drug user who, at the time of Child D's birth, was known to be receiving methadone on prescription from Somerset Drugs Service.

13 months later, on 17 October 2007, GP records indicate that mother and father presented Child D to their GP late in the afternoon with facial bruising in the form of a mark on one cheek and significant bruising to her back. The explanation for the facial bruise was that Child D's sister (Sibling 1, age 3 years) had thrown a toy which hit Child D on the cheek. Father (Parent 1) explained that Child D and her sister had been in his care that morning, and he had been in another room when he heard a thump from the living room. He had entered the room and found Child D on the floor, later saying that she fell from the sofa. He reports that Child D vomited, so he had put her to bed. She had vomited again later, at which point he and his partner (Parent 2) had taken Child D to see the GP. The GP was immediately concerned about child protection issues, and referred the family directly to Yeovil District Hospital.

On the following day, Child D was transferred to Bristol Children's Hospital due to a suspected perforated duodenum and liver. Surgery was performed, during which it was found that Child D had sustained a tear in her bowel and bleeding to the mesentery (connective tissue between bowel and abdominal wall). A later CT scan and skeletal survey showed that Child D had a vertical fracture to the occipital bone on the right (skull), but no brain or retinal injuries. This led to a diagnosis of 'impact injury' as the level of trauma was similar to that received in a road traffic accident. This diagnosis was not compatible with a fall from the sofa.

1.2 Terms of Reference

1.2.1 A meeting was held on 16 November 2007 to consider whether or not to undertake a Serious Case Review using the criteria set out in paragraphs 8.6 to 8.9 in Working Together 2006. The meeting concluded that it was not possible, on the information held at that time, to answer 'yes' to any of the criteria questions. However, there were significant questions which needed addressing to clarify whether a risk of harm to Child D could have been recognised by any organisation working with the family prior to the incident, and whether information was appropriately shared and/or acted on appropriately.

Once these questions had been adequately addressed it would be possible to consider if there are implications for a range of agencies and/or whether the Local Safeguarding Children Board (LSCB) should develop further local protocols, or amend or disseminate existing protocols more widely. The meeting decided that the most effective means of managing this process would be to call a Serious Case Review, which would consider events from nine months before Child D's birth until the diagnosis of her injuries on 19 October 2007.

1.2.2 In accordance with Working Together to Safeguard Children (HM Gov 2006), the overall objectives of a serious case review are to:

(a) establish a factual chronology of the action which has been taken within agencies
(b) assess whether decisions and actions taken in the case appear to have been in line with the policy and procedure within the agency
(c) consider what services were provided in relation to the decisions and actions in the case
(d) recommend appropriate action in the light of the review's findings.

1.2.3 The Serious Case Review Panel was convened and agencies with knowledge of and involvement with, the case were asked by the Chair of Somerset LSCB to undertake internal management reviews in accordance with the requirements of Working Together to Safeguard Children (HM Gov 2006) as set out in the South West Procedures, in order to establish the following:

- Does Somerset Drug Service (SDS) make adequate on-going risk assessments (in terms of content and frequency) of clients assessed as 'low risk' where they are also parents?
- Is multi-agency risk assessment of parents who use drugs or alcohol appropriate in terms of addressing the impact of substance misuse on parenting capacity?
- Are health agency and SDS thresholds appropriate for referral to Children's Social Care (CSC), where parents have known drug/ alcohol issues?
- Are CSC thresholds appropriate for receiving referrals where parents have drug/alcohol issues?
- In this case are there cultural issues in relation to the father's nationality (he is believed to be of Chilean origin) which have not been recognised or addressed?
- Did the professional status of either the mother, maternal grandmother or maternal step-grandfather adversely affect appropriate information sharing and/or risk assessment?
- To what extent has SDS addressed the guidelines and recommendations set out in the DOH response to Hidden Harm?

1.3 Contributors

1.3.1 Internal Management Reviews were submitted by:

Somerset Primary Care Trust
Avon & Somerset Constabulary
Yeovil District Hospital NHS Foundation Trust
United Bristol Health Trust (Bristol Children's Hospital)
Misterton Pre School (where Sibling 1 attended)
Somerset Partnership NHS & Social Care Trust (providers of Somerset Drug Service)

1.3.2 The members of the review team were:

Linda Barnett, Chair, Head of Service, Children's Social Care, and Chair of Somerset Local Safeguarding Children Board
Martyn Triggol, DCI, Avon & Somerset Constabulary
Anne Allen, Designated Nurse for Safeguarding
Tony May, Policy Development Manager, Somerset County Council
Claire Winter, LSCB Coordinator
Michele Rose, Group Manager SEN, Children & Young People's Directorate, Somerset County Council
Deborah Stalker, Named Doctor and Consultant Paediatrician, Musgrove Park Hospital
Christine Hindle, Commissioning Manager for Young People's Substance Misuse, Somerset County Council, and Independent Author

2 THE FACTS

2.1 The family genogram is in Appendix 1.

2.2 Background

Prior to Child D's conception and birth, her parents and elder sister moved from Liverpool to Somerset in September 2005. Child D's father, Parent 1, was receiving a methadone prescription of 120 mls/day at the time of the move, prescribed by Merseyside Drug Service (MDS), because he had previously been a heroin user. Following the move to Somerset, Parent 1's case was referred to Somerset Drug Service (SDS) where his case was managed in the GPwSI (General Practitioner with a Special Interest) programme (shared care) as part of which he also received regular support from an SDS caseworker. MDS reported on transfer that Parent 1's urine screens were clear and there were no issues for concern.

2.3 Integrated Chronology

The multi-agency chronology template is attached at Appendix 2. It includes a column indicating the occasions on which Child D was seen by professionals.

2.4 Overview of Relevant Information Known to Agencies and Professionals

(A) Integrated Chronology for the nine months before Child D's birth

2.4.1 On 16 December 2005 it was noted by SDS that (Parent 1) was the main carer for Sibling 1.

On 18 January 2006 (Parent 1) sees the GPwSI and says that Parent 2 had just started work [as a Social Worker] and was pregnant with their second child. The GP discusses with Parent 1 his possible need for extra support as he was at home on his own with Sibling 1. It is believed this conversation took place because Parent 1 could appear anxious at times.

2.4.2 On 23 January 2006, during a telephone conversation concerning the immunisation of Sibling 1, Parent 2 herself informs the Health Visitor that she is pregnant.

2.4.3 Parent 1's SDS caseworker meets with him on 10 March 2006, having last seen him on 6 January. Parent 1's relationship with his daughter is explored and more support offered if required. Parent 1 expresses concern about Parent 2's bouts of depression. It is agreed Parent 1 will meet with his caseworker monthly in future, as well as meeting with the GPwSI regarding his prescription for methadone.

2.4.4 On 7 April Parent 2 is diagnosed as having a recurring depressive disorder by Somerset Partnership. A letter is sent to Parent 2's GP confirming the diagnosis and saying that she is on a waiting list for cognitive behavioural therapy.

2.4.5 (Parent 1) misses an appointment with his caseworker on 28 April. He contacts SDS himself on 2 May and a new appointment is made for the 26th. He telephones before that appointment to say he cannot attend, and tells his caseworker that he is feeling anxious, is suffering with chest pains and starting to drink. He requests an increase in his methadone prescription because of the stress on him of his partner's pregnancy.

His caseworker arranges this with the GPwSI and, by the time of her next meeting with (Parent 1) on 9 June, he reports that his alcohol use is under control because the increase in methadone has taken effect. (Parent 1) says he uses alcohol when he is anxious, and that he is finding his partner's moods and sensitivity difficult to cope with.

2.4.6 On 14 June, five days after seeing his SDS caseworker and confirming that his alcohol use is under control, (Parent 1) tells the GPwSI that he is worried about his partner's pregnancy and moving [house] and needs additional methadone. On 12 July (Parent 1)'s methadone prescription is recorded as having risen to 130 mls.

2.4.7 Parent 2 attends a psychiatric review with Somerset Partnership on 16 June, at which no mention of drug use is made.

2.4.8 (Parent 1) is due to meet with his SDS caseworker on 30 June, but rings to rearrange. They next meet on 3 July (less than a month since their previous

meeting). (Parent 1) again reports that his alcohol consumption is much reduced and a reference is made to Sibling 1. He continues to report that he is very anxious and stressed. He misses his next appointment on 12 July with the GPwSI, saying he missed the bus.

2.4.9 (Parent 1) meets with his SDS caseworker on 21 July (again, less than a month since their previous meeting). Alcohol is discussed and (Parent 1) reports still being anxious. No mention is recorded of any conversation regarding his ability to care for Sibling 1, despite knowing that he is her main carer when Parent 2 is at work.

2.4.10 On 25 July Parent 2 discloses to her GP for the first time that she has been using 'street' methadone, and has a two-year history of heroin use. She is 32 weeks pregnant at this time. A urine screen proves positive for methadone. It is noted that there are no concerns about Parent 2's ability to work, nor for Sibling 1. Referrals are made by the GP on the following day to SDS and the Obstetrician. Parent 2 requests a referral to SDS in Taunton, rather than Yeovil which is closer, because her stepfather works for SDS in Yeovil and she does not want him to know.

2.4.11 On 31 July Parent 2 is visited at home by the Health Visitor. Parent 2 shares with her that she has been seeing a psychiatrist and is awaiting cognitive behavioural therapy, but does not mention her drug use. Parent 2's mother is known to the Health Visitor as they had been colleagues. The Health Visitor is alerted to the fact that Parent 2 suffered post-natal depression after Sibling 1's birth. The family are due to move house in two weeks' time, when Parent 2 will also start her maternity leave from work. Sibling 1's development is assessed by the Health Visitor as being appropriate for her age and it is noted that she attends a childminder once a week and a crèche twice a week.

2.4.12 Parent 2 receives an initial assessment with her SDS caseworker on 1 August 2006.

2.4.13 On 2 August, (Parent 1) meets with the GPwSI and appears more relaxed. They discuss Parent 2's pregnancy. On the same day, Parent 2's SDS caseworker calls the Psychiatrist at Somerset Partnership, and the family connection to the Yeovil team is mentioned.

2.4.14 At her antenatal appointment at Yeovil District Hospital on 3 August Parent 2 discloses to the Community Midwife that she has been using 'street' methadone. The actions note that she is already being seen by SDS and that her GP is aware. A Maternity Department Risk Identification form is completed and copies are sent to the Labour Ward, Freya Ward, Special Care Baby Unit (SCBU), the Paediatrician, Anaesthetist, Pain Control Team, Risk Manager and Child Protection Team (all within Yeovil District Hospital). The form also goes externally to "GP/Community Midwife" but to neither the Health Visitor nor Children's Social Care.

2.4.15 On 8 August, Parent 2's SDS caseworker speaks to the midwife to discuss Parent 2's methadone dosage and the size of the baby. The same SDS worker receives a call on 15 August from the Pain Relief Nurse at Yeovil Hospital and again Parent 2's methadone levels are discussed.

2.4.16 On 16 August Parent 2 sees her SDS caseworker in Taunton, after which the caseworker e-mails the Psychiatrist who has been seeing Parent 2 to advise that Parent 2 is 'self-medicating' on opiates.

2.4.17 Two days later, (Parent 1) sees his SDS caseworker and it is noted that things are going well.

2.4.18 The Psychiatrist records in her notes on 22 August that she considers Parent 2 hard to assess and that she had previously denied using Class A drugs. She had rejected Fluoxitine in favour of 'street' methadone.
She queried whether CSC needed to be informed. A letter is sent to the GP informing him that Parent 2 had missed an appointment and has declined any further contact and chosen to wait for cognitive behavioural therapy.

2.4.19 On 23 August, Parent 2 is seen in Yeovil District Hospital by the Paediatric Consultant pre-natally for counselling about the forthcoming delivery. A plan is put in place to admit the baby to SCBU after birth for at least one week. The reason for this will not be disclosed to extended family members at the request of the parents, thus remaining confidential to the staff group.

2.4.20 Sibling 1 starts pre-school on 4 September 2006, on Mondays, Wednesdays and Fridays. Over the next ten months, she is late on 18 occasions.

2.4.21 Parent 2 tells her SDS caseworker on 5 September that she is using extra methadone because she is sleeping badly. They discuss the baby and the fact that it is small. The care of Sibling 1 is not mentioned. Three days later Parent 2's methadone is increased to 20 mls/day.

(B) <u>Integrated Chronology from Child D's birth to the time of the injury</u>

2.4.22 Child D is born in Yeovil District Hospital on 12 September 2006 and weighs 5 lbs. She is reported in the medical notes to be "in good condition" after delivery and is transferred to SCBU for observation. A Multidisciplinary Concern Diary is started, and the Named Nurse for Child Protection is informed of the birth. GP notes on the same day record that the delivery was induced (at 38 weeks), and reports intrauterine growth retardation and opiate withdrawal.

2.4.23 The day after Child D's birth, Parent 2 visits her in SCBU and stresses to staff the importance of confidentiality surrounding the reason for Child D being there (because Parent 2's stepfather is a drugs worker and her mother a health visitor and neither of them are aware of Parent 2's drug use). The Paediatric consultant advises Parent 2 to be open with her own mother about Child D's reason for being on SCBU.

Both SDS caseworkers contact their own clients, ie both parents, on 13 September. Parent 2's caseworker also speaks to the Acute Pain Sister concerning an unlabelled bottle of methadone brought into the hospital by Parent 2.

2.4.24 n 14 September, (Parent 1) and Sibling 1 visit Child D in SCBU. (Parent 1) is noted to be sweating profusely and to smell of alcohol. This is logged in the Concern Diary. On the same day, the Named Nurse, updated by SCBU nursing staff, notes there are 'no child protection concerns'.

2.4.25 On 18 September, the Midwife contacts the Health Visitor to make her aware of Parent 2's disclosure of using heroin and crack cocaine until she was nine weeks pregnant, street methadone until 33 weeks pregnant, following which she received methadone on prescription from Somerset Drugs Service. Parent 2 has given her consent for this information, and also that (Parent 1) is a drug user, to be shared with the Health Visitor.

On the same day, Child D starts to display increased signs of opiate withdrawal and Oramorph treatment is commenced. Also, a phone call is made by the SCBU Staff Nurse to the Locality Safeguarding Nurse for South Somerset (who was covering for the Named Nurse for Child Protection at Yeovil District Hospital) to ask if a referral should be made to Children's Social Care. Concerns are shared that Parent 2 might lose her job as a Social Worker if the referral is made and her drug problem revealed to her Child Dployers. They refer to 'Guidelines for Inter Agency Working in Somerset' relating to substance misusing parents, and come to the conclusion that the threshold for referring Child D to CSC has not been met.

Parent 2 asks to be discharged and the Pain Relief Nurse telephones the SDS caseworker. The Nurse voices concerns over (Parent 1) drinking unlabelled methadone on the ward, and appearing to be under the influence of drugs. The caseworker says she will talk to (Parent 1)'s caseworker, but no contact between them is recorded

2.4.26 In 19 September, a discharge plan is made for Parent 2 and she later self-discharges saying (Parent 1) is struggling to cope at home. The Pain Nurse notes that Parent 2 is showing severe withdrawal on the prescribed methadone, raising the likelihood of using considerably more than prescribed. She shares these concerns with the Consultant at SDS who advises her to speak to the midwife and refer to CSC if necessary. Child D stays in SCBU and is seen to be suffering severe withdrawal.

2.4.27 On 20 September, the Pain Nurse contacts Parent 2's SDS caseworker, sharing concerns about the degree of the baby's withdrawal.

2.4.28 On the following day, the Health Visitor phones SCBU for an update on Parent 2 and Child D's condition and she is informed that Parent 2 was discharged from midwifery care on the previous day. The Health Visitor meets with Parent 2 when she visits the baby in SCBU. It is recorded that Parent 2 is "open" about her drug use. Parent 2 reports that (Parent 1) is

stressed about the situation, and the Health Visitor offers to visit and thus give him an opportunity to discuss his concerns.

2.4.29 On 22 September, Parent 2 phones the Health Visitor saying she is tired, tearful and out of control. She has found Sibling 1's needs difficult to meet and has argued with (Parent 1). Child D's Oramorph has been increased due to irritability. The Health Visitor reiterates avenues of support (including visiting her GP for an assessment for antidepressant medication) and suggests Parent 2 makes more use of them. There is no record confirming any liaison by the Health Visitor with SCBU or the GP concerning Parent 2's mental health. However, it is recorded that she speaks to SCBU and shares her concerns that Parent 2 is not coping very well. There is no mention of a referral to CSC being considered at this point.

When Parent 2 visits SCBU that day, she discloses to nursing staff that she is finding managing home and hospital too much to cope with and agrees to visit once a day only. It is documented that she does not want to see her GP about antidepressant medication.

(Parent 1) speaks to his SDS caseworker by telephone, saying that he cannot keep appointments because of child care arrangements. He had not attended their previous meeting on 8 September, and had last been seen by his caseworker on 18 August. They discuss his "worries" over the telephone.

2.4.30 On 24 September, Parent 2 is noted to be sweaty, jittery, confused, disorganised and excessively anxious when she visits SCBU. She is also requesting meals for herself during her visits. This is noted in the Concern Diary. There is no record of urine screens being carried out by SDS or the GPwSI on either of the parents during this period.

2.4.31 Yeovil District Hospital medical records on 25 September record that CSC had been consulted, although subsequently this has proved to be a mistake. At this time the Paediatric Consultant considers that Child D is nearly ready to be discharged and documents plans to discuss the case with the Designated Doctor for Child Protection and then to contact CSC to arrange a pre-discharge planning meeting if there are plans for Child D to be discharged into foster care, thus indicating that he thought CSC were already involved in the case. His notes also show that CSC were "happy with the drug using mother's home situation", which was not the case as they had not been consulted.

The Designated Doctor for Child Protection has a conversation with the Named Nurse for Child Protection, and recalls that the Named Nurse had informed her that a decision had been taken that no professionals' meeting would be held prior to the discharge of Child D because there were no concerns about the family's social situation or ability to care for Child D. The Designated Doctor mistakenly believes that CSC was involved in this decision and had agreed there were no concerns that merited intervention pre-discharge.

2.4.32 On 27 September, the Health Visitor makes a visit to (Parent 1) at home. The family situation is deemed calmer now that Parent 2 is spending less time at SCBU. The parents' drug use is discussed but no details recorded. On the same day, Child D is registered with a GP and her health problems noted.

2.4.33 Parent 2 is visited in Yeovil Hospital on the following day by her SDS caseworker to discuss child protection concerns. The caseworker also speaks to the Pain Nurse, but it is not recorded whether the concerns of the Pain Nurse previously noted on 19 September were shared. Parent 2's relationships with (Parent 1) and her own mother (who is still unaware of Parent 2's drug use) are discussed, as well as Parent 2's concerns that she would lose her job if her drug use becomes known. Parent 2 is described as being very open and honest "as she always had been". The SDS caseworker says she has no child protection concerns, but if the midwives are concerned, they should refer to CSC. It is not clear whether or not the SDS caseworker has been made aware of SCBU staff's concerns about Parent 2's appearance and behaviour on 24 September.

2.4.34 On 29 September, the Named Doctor and Named Nurse at Yeovil District Hospital discuss Child D's case and are concerned that Child D's social situation must be assured as safe to protect her wellbeing. The Named Nurse is to contact SCBU to discuss their concerns. This happens on 2 October and SCBU inform her that the Health Visitor is aware of the concerns, and that a decision not to hold a professionals' meeting has been taken. It is unclear who is taking responsibility for the decision not to call a meeting.

On the same day, the Health Visitor telephones SCBU saying she will work closely with the family and does not have any concerns. She does not feel that it is appropriate to involve CSC.

2.4.35 On 3 October, (Parent 1) contacts his SDS caseworker to say his telephone number has changed. She had recorded her inability to contact him by phone on 29 September.

2.4.36 On 4 October Child D is discharged home to the care of her parents. Parent 2 alerts her SDS caseworker to this herself by telephone.

2.4.37 On 5 October, the day after Child D's discharge from hospital, the Health Visitor visits and observes that Parent 2 is coping well with the demands of Child D and Sibling 1. Contact is made again two days later and Child D is noted to be well. However, on the same day (Parent 1) tells his SDS keyworker over the telephone that he is very anxious and has not bonded with Child D as he did with Sibling 1. He is advised that he should not put himself in a position where he is alone with Child D until he feels more able to cope. There is no record of the caseworker discussing the case with a supervisor at this time.

2.4.38 On 9 October, the Health Visitor sees the family at home and observes all to be calm. She is unaware of the content of the telephone call made only four days before between (Parent 1) and SDS.

2.4.39 Two days later, the Health Visitor visits the home again, and Parent 2 admits to becoming tearful when she is over-tired. Child D is weighed and the gain noted as "excellent".

2.4.40 (Parent 1) meets with his SDS caseworker on 13 October and appears pale and tired. He says Child D's crying "winds him up". He is trying not to be alone with her, but this is not always possible. He says that the Health Visitor is seeing them regularly and is aware of his anxiety. No contact is made between SDS and the Health Visitor to verify this. On 19 October the Health Visitor again records Child D's weight gain as "excellent".

On the same day, the two SDS caseworkers have a telephone conversation about the concerns regarding (Parent 1) and Child D. Parent 2's caseworker advises that there are not enough concerns to go to CSC but she will find out who the Health Visitor is and speak to her. There is no record to show that she did this.

2.4.41 On 20 October SDS staff visit the family at home (unclear if both attended). (Parent 1) is said to be showing warmth towards the baby. It is suggested to Parent 2 and (Parent 1) that they both talk to the Health Visitor. Again, no direct contact is made between the Health Visitor and SDS.

2.4.42 Parent 2 takes Child D for her six-week postnatal assessment on 24 October 2006, and no concerns are noted, although weight gain is described as minimal. This appears to be the first time contact has been made between the GP and Health Visitor. Parent 2 is concerned about the requirement to advise the Driver Vehicle Licensing Agency (DVLA) of her methadone prescription, as she thinks this could result in her driving licence being withdrawn and the loss of her job.

2.4.43 (Parent 1) meets with the GPwSI and produces a drug screen that proves positive for methadone and benzodiazepines (not prescribed). He later says that he used them on three occasions to aid sleep.

2.4.44 On 31 October Child D is seen in the Paediatric Clinic and no concerns are noted. An appointment is made for 3 months' time.

2.4.45 On 2 November the Health Visitor discusses the DVLA issue with Parent 2. Parent 2 tells her that she has discussed a rapid methadone reduction with SDS and is feeling under pressure, although there is no record of this planned reduction on SDS files.

2.4.46 On 9 November the Health Visitor visits the home. The Edinburgh Postnatal Depression Questionnaire is completed by Parent 2 and she scores seven. This score is within acceptable limits. Parent 2 discloses that the family has financial difficulties, but there is no record of the Health Visitor signposting

her to a supportive agency. On 13 November Parent 2 fails to attend an appointment with SDS.

2.4.47 (Parent 1) is seen by the GPwSI on 16 November and reports feeling low in mood. The drug screen again shows he is using benzodiazepines. There is no record to indicate that they discussed his care of the children.

2.4.48 The Health Visitor visits the home again on 17 November. Child D has been crying a lot and Parent 2 is advised to take her to the GP, which she does on the same day. The GP prescribes Gaviscon and gives 1st immunisations.

2.4.49 In December 2006 the Health Visitor sees Child D twice, observing the family and Child D to be well, although a little stressed with preparations for Christmas. (Parent 1) misses an appointment with his SDS caseworker, although he attends Parent 2's SDS appointment with her, along with Sibling 1 and Child D. The SDS Consultant notes that Parent 2 and (Parent 1) interact appropriately with the children, and confirms this in a letter to the GP. (Parent 1) also sees the GPwSI twice this month. The Health Visitor does not see Child D again until 4 June 2007.

2.4.50 In January 2007 (Parent 1)'s SDS caseworker reports he is looking well and a small reduction in his methadone prescription is discussed. On 11 January, his methadone is reduced by the GPwSI to 120 mls/day, and on 25 January it is reduced again to 115 mls/day.

2.4.51 Parent 2 is seen by SDS on 12 January at which time she reports feeling stressed and says (Parent 1) is "not pulling his weight". Parent 2 requests an increase to her methadone, which takes place from 18 January. A drug screen is taken on the 12th, which shows positive for opiates (codeine, apparently for pain relief). The family are planning to move house.

2.4.52 On 19 January Child D is taken to the GP for her 2nd immunisations.

2.4.53 On 6 February Child D is reviewed in the paediatric baby clinic at Yeovil District Hospital, and a further appointment is made for six months' time.

2.4.54 The following day, Child D is taken to the GP with conjunctivitis.

2.4.55 On 8 February, (Parent 1) is seen by the GPwSI and his methadone is reduced to 110 mls. He misses an appointment with his SDS caseworker on the 9th, but when he is contacted apologises saying the family is moving house.

2.4.56 Parent 2 cancels an appointment with SDS on 13 February. She is sterilised on 16 February and an e-mail from the Pain Nurse indicates that Parent 2 did not tell the hospital about her methadone usage, which caused problems.

2.4.57 (Parent 1) sees his SDS caseworker on 28 February. He reports that the move has been stressful. Also, Parent 2 has been sterilised and he had sole care of the children during this period. He says he believes that Child D does

not like him. His alcohol intake is increasing and he is going to the pub five nights a week and reports consuming approximately 12 units of alcohol on each occasion.

2.4.58 Parent 2 cancels a second appointment with SDS on 1 March. She has returned to work by 8 March.

2.4.59 Child D is taken to the GP on 16 March and receives her 3rd immunisations.

2.4.60 On 23 March, Parent 2's SDS caseworker sees that Child D has bruising on her cheek (no description of the bruise is recorded). This is accounted for by the parents saying Child D fell out of her bouncy chair when being looked after by (Parent 1). The caseworker concludes from the information provided that (Parent 1) acted appropriately after the accident. The two SDS caseworkers discuss the family later that day, and agree that (Parent 1)'s methadone use "should not affect his parenting capacity" (no mention is made of his alcohol intake). The workers believe that Child D's maternal grandmother (a Health Visitor) visits often and "would be alerted to any concerns". The Health Visitor is not contacted.

On the same day, (Parent 1) is seen by his SDS caseworker in a pre-arranged appointment. It is reported that he has bonded well with Child D. No mention is made of the bruise to the baby.

2.4.61 On 26 March, Parent 2's SDS caseworker discusses the case in a team meeting, and it is agreed that no further action is required. Parent 2's methadone prescription is 'altered' (presumably increased). On 16 April it is increased again to 40 mls.

2.4.62 (Parent 1), Parent 2 and both children are seen by SDS on 23 April.

2.4.63 (Parent 1) misses appointments with his caseworker on 27 April and 11 May. He does, however, see the GPwSI on 3 May. His SDS caseworker discusses his failure to attend appointments with the GP. He eventually keeps an appointment with his caseworker on 18 May at which he reports his alcohol use is down and a reduction to his methadone is discussed. He sees the GPwSI again on 24 May.

2.4.64 After a gap of over five months, the Health Visitor makes a home visit to the family on 4 June. Issues of finance and the DVLA are unresolved. There is no record of discussion concerning drug use. Both children are seen and "observed to be developing appropriately", although Child D is "very petite" and the weight chart shows her to have drifted off centiles and to be below 0.4th centile.

2.4.65 (Parent 1) sees his SDS caseworker on 6 July and an oral drug screen is taken (identifies a positive for benzodiazepines). He has changed GP. It is mentioned that the children are staying with a grandparent for the weekend. "All going well." On 12 July (Parent 1)'s methadone is reduced by a further 10 mls by the GPwSI.

2.4.66 On 24 July, Parent 2 produces an “acceptable” drug screen. No progress has been made with the DVLA/driving issue.

2.4.67 The Health Visitor sees Child D and Sibling 1 during a home visit on 27 July, and both children are assessed to be developing appropriately, although the Health Visitor records that Child D is still eating poorly and losing weight.

2.4.68 (Parent 1) sees his SDS caseworker on 27 July and the drug screen showing a positive result for benzodiazepines is discussed. He states he took one only. He reports feeling insecure, and fed up with his routine. There is no discussion recorded about how this might be affecting the children.

2.4.69 Parent 2 is assessed for cognitive behavioural therapy. She tells the Psychologist that she has good support from her mother, sister and colleagues, but does not mention her partner. This is the first time any mention of a sister has been made.

2.4.70 An entry made by (Parent 1)’s SDS caseworker on 22 August indicates that (Parent 1) and Parent 2 had been considering parting. However, their relationship is now improving.

2.4.71 In September 2007, the family transfer to a different GP. It is unclear why.

2.4.72 Child D is seen at the paediatric clinic at Yeovil District Hospital, and unsatisfactory weight gain is noted. She is referred to the paediatric dietician and an appointment made to review her case in the clinic in two months’ time.

2.4.73 (Parent 1) misses an appointment with SDS on 7 September, because “he forgot”. He is next seen by SDS on the 14th when concerns are voiced about confidentiality within SDS and a potential change of caseworker discussed. He sees the GPwSI on the 19 September and 3 October.

2.4.74 It is recorded on 13 September that Sibling 1 is now taken to pre-school by a friend.

2.4.75 On 21 September, Somerset Partnership records (SDS) note that there have been problems in the relationship between Parent 2 and (Parent 1), and Parent 2 had asked (Parent 1) to leave the home. However, this is now apparently resolved. Parent 2’s care plan is to remain on methadone until both children are at school. Driving is not mentioned in the notes.

2.4.76 On 16 October 2007 Child D is taken to her GP having suffered “a fall from the sofa” whilst she was in the care of (Parent 1). She is referred to the paediatric team at Yeovil District Hospital with bruising to the left cheek and back. She is drowsy and distressed, with episodes of vomiting. The explanation for the bruising to the cheek is that Sibling 1 had thrown a toy at her. Both parents are noted to be methadone users. The Child Protection Register is checked, and no record is found of the family.

3 ANALYSIS

The analysis is provided in five sections: Information Sharing (including staff supervision and leadership), Missed Opportunities for Referral to CSC, Impact of Professional Status on Confidentiality, Ethnicity, and Issues for Clinical Practice.

3.1 Information Sharing

3.1.1 The level of information sharing between professionals, both within their own agencies and between different agencies, is a key issue in the case of Child D. In particular, record keeping and information sharing by both the SDS caseworkers, especially within their own organisation, was hindered by the fear of disclosing confidential information to Child D's maternal stepfather who is an SDS colleague (and team member to (Parent 1)'s caseholder). The confidentiality issue in this case also had an effect on the frequency and type of supervision (Parent 1)'s caseworker thought was available to her, resulting in reduced input from colleagues and managers about the case.

3.1.2 No professional in any agency informed the Police about the availability of 'street' methadone. At the point when (Parent 1) was requesting an increase in methadone, there should have been suspicions raised that Parent 2 was using (Parent 1)'s methadone, but SDS did not investigate this or challenge the couple about it.

3.1.3 On 21 September 2006, the Health Visitor records that Parent 2 is "open" about her drug use after she meets with her in SCBU. At this point, the Health Visitor is unaware of the concerns of the Pain Nurse about the degree of withdrawal of both mother and baby. She is aware, however, that Parent 2 continues to choose not to tell her mother about her drug use, despite this potentially providing extra support to the family. If the Health Visitor had been made aware at this time of the concerns surrounding the intensity of Child D's withdrawal symptoms, and that Parent 2 was struggling to cope on her prescribed methadone only, perhaps she would have been less trusting of what Parent 2 was telling her. This may have led to a different outcome when the Health Visitor decides whether or not CSC should be involved in the case.

3.1.4 The GPwSI is not part of the liaison at any time regarding a referral to CSC.

3.1.5 It has been disappointing that the Panel has not been given access to full GP records (paper documents from the surgery have not been provided).

3.2 Missed Opportunities for Referral to Children's Social Care

3.2.1 There are four key periods in time when it would have been advisable for professionals to involve CSC.

3.2.2 The first is ante-natally at the beginning of August 2006. On 3 August Parent 2 discloses her use of 'street' methadone and two-year history of heroin use

to the Midwife at Yeovil District Hospital. A Maternity Department Risk Identification Form is completed; with only one copy going outside the Hospital to the GP/Community Midwife as noted previously (the Health Visitor is not included).

At this point in time, however, Parent 2 had already been assessed by SDS (on 1 August), making them the only agency to hold the complete picture about the family, ie that (Parent 1) also misuses substances, and had a history of anxiety during Parent 2's previous pregnancy, which resulted in increased alcohol consumption. A discussion between SDS and Parent 2's GP would have been beneficial at this time and the opportunity to refer to CSC is missed.

No Lead Professional is identified.

3.2.3 The second opportunity is when Child D is in SCBU, and relates not only to the future care of Child D when she goes home, but to what was, at the time, the current care of Sibling 1.

On 14 September 2006, an entry in the SCBU Concern Diary notes that (Parent 1) is sweating profusely and smells of alcohol. There is a further entry on 18 September when he is seen to be "swigging" methadone from a bottle and appears to be under the influence of drugs. At this point contact is made with SDS when this information is shared. On the same day, a decision is taken by the Named Nurse for Child Protection and a SCBU Staff Nurse not to refer the case to CSC.

An influencing factor appears to be that Parent 2 may lose her job as a Social Worker if the referral is made and her drug problem revealed to her Child Dployers. It is also recorded that the multi-agency document 'Substance Misusing Parents – Guidelines for Inter-agency Working in Somerset' has been consulted and the threshold for referral to CSC not met. These guidelines do not provide criteria from which referral should be made, but give general guidance about the issues to consider when working with parents who misuse substances, ie the general duty for agencies to refer to CSC when there is the likelihood of a child suffering significant harm. The decision is reached, using this document, that CSC would not have accepted a referral if one had been made.

Whilst Parent 2 remains in hospital, (Parent 1) is the sole carer of Sibling 1 and his appearance and behaviour in SCBU is reported to Parent 2's SDS caseworker by the Pain Nurse as she is appropriately concerned. There is no apparent follow-up to this telephone discussion by SDS. On the information provided, it would have been a good time to contact CSC about risk of significant harm to Sibling 1. At the very least a pre-discharge multi-agency meeting surrounding the potential risks to Child D should have been called. Parent 2 is obviously concerned and self-discharges on 19 September because (Parent 1) is "struggling to cope".

When, on 19 September 2006, the Pain Nurse observes (pre discharge) that Parent 2 is suffering severe withdrawal on her prescribed methadone, and also that Child D is suffering severe withdrawal, she raises her concerns with SDS, this time with the Consultant. This is a very positive piece of inter-agency liaison, and aims to minimise future risk to Child D. The SDS Consultant advises the Pain Nurse to speak to the midwife and refer to CSC if necessary. No referral is made, and the Health Visitor is not advised. It does not appear that the Consultant at SDS supports the Pain Nurse in making enquiries, nor checks that that this process has been undertaken.

Three days later, on 22 September, Parent 2 contacts the Health Visitor saying she feels "out of control". The Health Visitor advises Parent 2 about avenues of support, and the Health Visitor speaks to SCBU. Despite the problems Parent 2 is suffering with her mental health, no mention is made of a referral to CSC.

The mistaken belief held by the Paediatric Consultant and Designated Doctor for Child Protection documented on 25 September, that CSC were aware of the case, indicates that they considered it at an appropriate level for referral to have been made.

3.2.4 Child D was seen in the paediatric baby clinic on 6 February 2007. The third period in time when it would have been prudent to refer the case to CSC is shortly after this. In February and March 2007 there are numerous stressful factors at play within the family. On 23 March SDS notes there is bruising to Child D's cheek and takes no action on this.

These stress factors on the family include moving house, Parent 2's spell in hospital for sterilisation (during which time (Parent 1) looks after both children), followed by Parent 2's return to work, Also this period sees Parent 2 sharing her concerns about having to report her methadone intake to the DVLA. It is recorded by SDS that (Parent 1) says Child D does not like him. Furthermore, (Parent 1)'s methadone prescription is reduced, whilst he is reporting that his alcohol intake is increasing due to stress.

3.2.5 The two SDS caseworkers have a telephone discussion together on 23 March 2007 about the parenting capacity of Parent 2 and (Parent 1), when mention is made of the involvement of Child D's maternal grandmother with the family. This indicates that they are relying on the assessment and intervention of a family member rather than solely on their own professional judgement. In light of the known stress factors on the family and the bruising to Child D, this was the fourth time that referral to CSC was missed, and there is no record to indicate that it was discussed. Neither worker informs the Health Visitor of their concerns.

3.3 <u>Impact of Professional Status on Confidentiality</u>

3.3.1 A factor for consideration in this case was the professional Health Visitor status of Child D's maternal grandmother, who was known personally to the Health Visitor in Child D's case. It is hard to gauge the exact influence this

had on decisions about the safety of Child D, but examples such as that on 23 March 2007 in 3.2.5 above, where records indicate that professionals at SDS are assuming the maternal grandmother is keeping a watchful eye over the family, suggest that it had an influence on the way the family was perceived.

3.3.2 Similarly, the professional status of Parent 2 is a potential influencing factor in decision making (see 3.2.3 above). She influenced a number of professionals to maintain a culture of secrecy. Comments about negative consequences for Parent 2 should her Child Dployers or the DVLA learn about her methadone use are recorded in Sibling 1Rs on 18 September, 28 September and 24 October 2006. There is one mention, however, on 13 November 2006 of the SDS Consultant confirming that Parent 2 "would not be treated differently" when she fails to attend an appointment with him.

3.3.3 The presence of Child D's maternal stepfather in the SDS Yeovil team had a profound effect on the availability of team support for (Parent 1)'s caseholder.

3.4 Ethnicity

(Parent 1)'s ethnicity is currently recorded with CSC as White British as requested by (Parent 1), and we know he has moved to Somerset from Liverpool. There is no note in any of the records supplied for the SCR that conversations took place with him about any potential effect his paternal family background and culture (believed to be either Spanish or Chilean, but not defined) affected his attitude and decisions regarding his family.

It had been hoped to explore the ethnicity issue further with (Parent 1) at a meeting with the author of this report. Letters were sent to both (Parent 1) and Parent 2 offering them the opportunity to meet, but they declined (due to a hospital admission for Parent 2 and also the timing coinciding with care proceedings).

3.5 Issues for Clinical Practice

3.5.1 SDS did not take a detailed case history for Parent 2 in relation to previous alcohol and drug use.

3.5.2 The midwife did not share information about Parent 2's drug use with the Health Visitor, because of a request from Parent 2 not to do so, on the basis that her mother was a Health Visitor.

3.5.3 Following Parent 2's meeting with her SDS caseworker on 16 August 2006, an e-mail is sent by the caseworker to the Psychiatrist advising that Parent 2 is 'self-medicating' on opiates. The Psychiatrist's notes of 22 August indicate that Parent 2 had rejected a prescription for Fluoxitine in favour of 'street' methadone. Both these entries seem to indicate that Parent 2 was using heroin and methadone as a way of coping with her depression. These should have been considered risk factors for child protection.

3.5.4 On 12 July 2007, (Parent 1)'s already reducing methadone prescription is reduced again by a further 10 mls at the same time as his latest drug screen identified a positive for benzodiazepines (another depressant drug).

3.5.5 It would have been advisable for SDS to contact the General Social Care Council about Parent 2's drug use in order to be transparent in their practice.

3.5.6 Research conducted on the GMC website and in telephone conversation with the DVLA suggests that the Consultant at SDS who was prescribing for Parent 2 should have informed the DVLA about Parent 2's methadone prescription.

4 RECOMMENDATIONS

1 All agencies should have clear procedures in place as to how highly confidential cases are managed, to include those cases where staff and/or members of staff families are involved, as well as other professionals (see recommendation 1 in Part 5 of Somerset Partnership NHS and Social Care Trust's Sibling 1R).

2 A multi agency model of safe working practice for families where either parent misuses substances should be developed to replace the red book.

3 In the future, Health Visitors in Somerset are moving into Children's Centres and will have even fewer links with GPs than at present. Processes need to be developed to ensure there is liaison between the GP and Health Visitor in all substance misuse cases, and with the GPwSI where applicable. The Maternity Department Risk Identification form should be altered to include the Health Visitor on its list for distribution.

4 It is recommended that a process is put in place whereby CSC is made aware of all cases where Class A drug users present to maternity (potentially by their inclusion on the Maternity Department Risk Identification form mentioned in 4.6). The Paediatric Consultant should check that this has been done

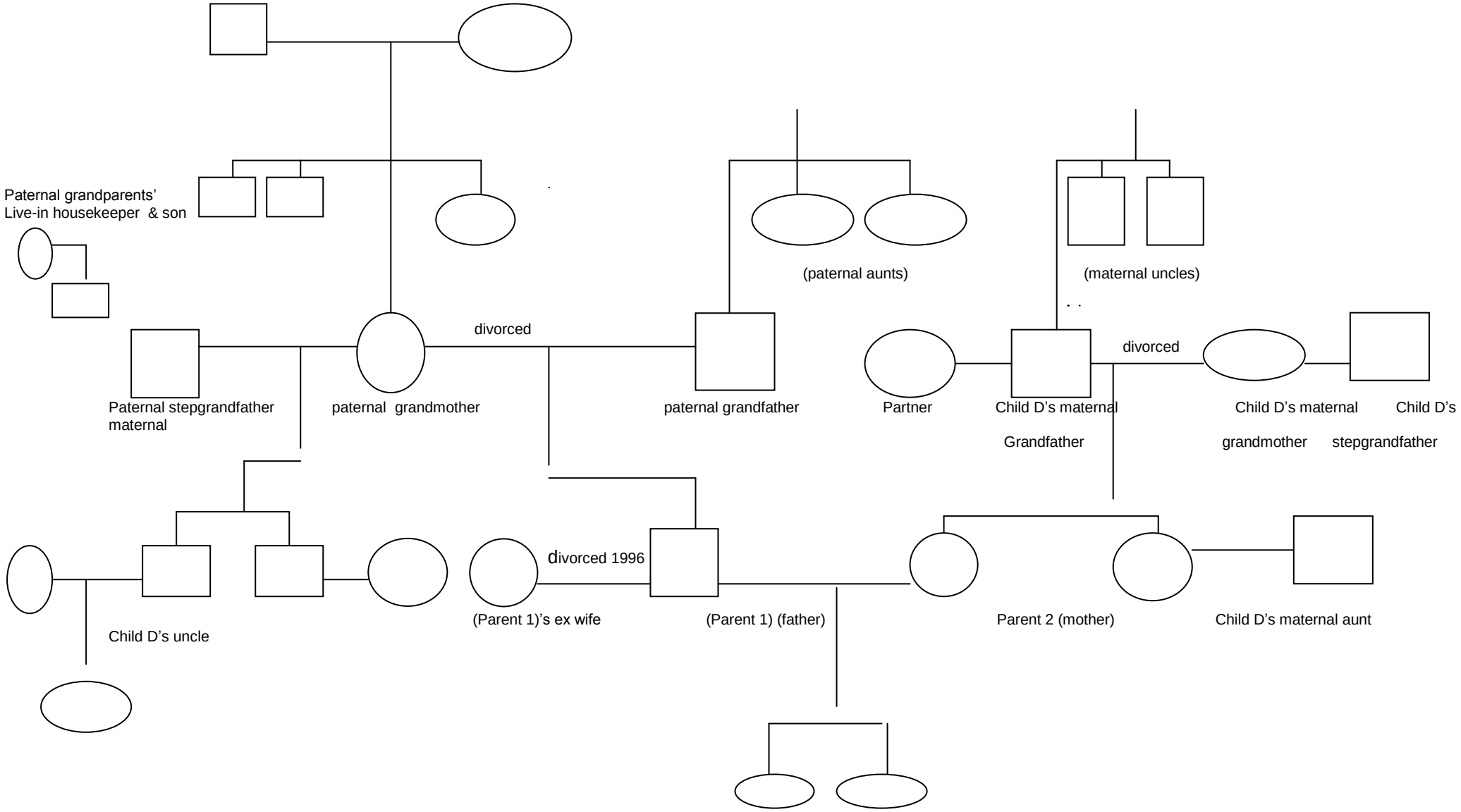
5 The LCSB should develop a clearer understanding with agencies about the difference between consultation and referral, with the aim of encouraging the former in preference to being kept outside of the information sharing process.

6 Turning Point Somerset (who take over the provision of the adult drug service in Somerset from 1 April 2008) should adopt the South West Child Protection Procedures (www.swcpp.org.uk) and ensure their internal child protection processes are aligned with it. They must have a prioritisation system that includes substance misusers who have children, and to ensure supervision is available to staff that reflects the risk to children. They should also provide training (or access to it) for all staff on child protection and the impact of parental substance misuse (Hidden Harm). Recording procedures should include noting when children are seen in the course of appointments as part of the adult record (see Somerset Partnership NHS and Social Care Trust's recommendation number 2).

7 Turning Point Somerset should have a Code of Conduct in place advising staff about what to do when an individual who regularly drives a car refuses to tell the DVLA about their methadone prescription.

Appendix 1

Child D FAMILY – GENOGRAM



Integrated Chronology

Appendix 2

Incorporating Single Agency Chronologies from:

Somerset PCT, Somerset Partnership, Bristol Children's Hospital,
Yeovil District Hospital, Avon & Somerset Police, Misterton Pre-School

Date dd/mm/yy	Agency and source of information e.g. member of staff or other agency	**Agency**	**Details of the contact (including whether the child/ren were seen)**	**Child seen**	**Action taken**	**Additional observations /comments**
1992	Police, British Transport Police	Avon & Somerset Police	Intelligence held on BTP intell. system. This information is limited to (Parent 1)'s name only. There is no other information held at all. It is likely this refers to 1992 Bylaws – Public Order. No trace on crimes or custody record.			Held on BTP Intell. system, Attempts have been made to glean further information but this is all that is held.
08/09/04	GP Re Sibling 1	Previous GP	1st Immunisations	Sibling 1 seen		Family engaged with Child Health Surveillance (although declined MMR)

06/10/04	GP Re Sibling 1	Previous GP	2nd Immunisations	Sibling 1 seen		
10/11/04	GP Re Sibling 1	Previous GP	3rd immunisations	Sibling 1 seen		
29/09/05	Family Health Visiting Record (FHVR)	Health Visitor (HV), Somerset PCT (SPCT)	Visit by health visitor to family home as family had just moved into Somerset 10 days ago from other area. Not yet registered at surgery. Sibling 1 noted to be developing appropriately and that her diet is adequate. HV observed that family need more furniture. Parents stated they are hoping to get part-time work and enrol Sibling 1 in a local nursery.	Sibling 1 seen	Parent Held Child Health Record, (PHCHR) completed. Well Baby Clinic venue and dates given. HV to provide introduction letter to Furnicare, (local furniture charity).	Important core contact to assess health needs of families recently moved into area. No formal Health Needs assessment tool was in use in SSPCT at time. Such an assessment may have revealed substance misuse.
30/09/05	GP Re (Parent 1)	C Health Centre	Registered with GP			
30/09/05	GP Re Parent 2	C Health Centre	Registered with GP			Notes summarised.
03/10/05	GP Re Parent 2	GP C Health Centre	Insomnia. Saw GP, not depressed but known past history depression.		Documented discussion about family, stress etc. Prescribed zopiclone for 2 weeks, given information leaflet.	Appropriate discussion and advice.
04/10/05	GP Re Sibling 1	C Health Centre	Registered			

10/10/05	Family Health Visiting Record (FHVR)	Health Visitor Assistant, (HVA), Somerset PCT (SPCT)	Family's previous Health Visiting records requested from Child Health Department, Wellsprings Road, Taunton.		Records requested.	Procedure to review previous family engagement with health services, including any child protection issues.

17/10/05	MDS	Somerset Partnership	(Parent 1): Referral letter			Details drug usage and identifies (Parent 1) drinking 10 units a day 6 months ago
18/10/05	GP Re (Parent 1)	C Health Centre	1st seen, moved from other area, gave details of heroin use, now methadone 120mls. Referred by drug service in other area to SDS and waiting for appointment with SDS in Yeovil.			Clear from his computer summary that he is a methadone user, under care of SDS, but practice has no letters from SDS about him.
27/10/05	FHVR	HV, SPCT	Telephone call regarding Sibling 1's outstanding MMR immunisation appointment. HV ascertained that Parent 2 is taking Sibling 1 to a local crèche once a week and other local activities.		HV contacted Somerset Child Health Department and discovered that they had not yet received Sibling 1's previous immunisation status from other area.	Client initiated contact with family. Involvement in local community activities would provide good opportunities for socialisation with peers and also possible early detection of adverse effects of any problems at home Therefore HV enquiry re this is protective to child.
06/12/05	GP Re Parent 2	GP C Health Centre	Depression.		Referred to Community Mental Health Team.	

06/12/05	Letter from GP to Psychiatrist	Somerset Partnership	Parent 2: History of depression			
09/12/05	GP Re (Parent 1)	C Health Centre	Appointment, Liverpool Clinic now stopping prescribing.		GP confirmed history with drug clinic in other area, who reported no problems with him, drug screens clear. Wrote to Somerset Drug Service, prescribed methadone to see him through.	Good continuity between MDS, SDS, and GP. Details checked. GP appropriately helped with prescribing.
16/12/05	GP Re Parent 2	GP C Health Centre	History of depression applying for job, medical information requested by Occupational Health.		Letter to Occupational Health.	
16/12/05	RIO: Progress Note SG	Somerset Partnership	(Parent 1): R seen by SG & Dr D – 120 mg Methadone Parent 2 & Sibling 1. 17 months mentioned. Parent 2 has SW Post in Chard **NB:** R caring for Sibling 1. SG to do ICPA on 6 January 2006. Dr D to do prescribing + drugs screen ** need these explained			Factual information recorded
28/12/05	GP Re (Parent 1)	C Health Centre	For methadone script			
03/01/06	Dr D, GP	Somerset	(Parent 1):			Topic raised but no

	Progress Note	Partnership	For prescribing GP discussed Possible difficulties for R being alone with Sibling 1			comment as to why it was raised
06/01/06	SG Progress Note	Somerset Partnership	(Parent 1): **(Parent 1), Parent 2 & Sibling 1 seen**. R needs very little from Key Worker: Dr D to do maintenance prescribing	Sibling 1 seen		No comment on interaction between family members
11/01/06	Psychiatrist, responds by letter reporting on her interview	Somerset Partnership	Parent 2: Moderate depression. Parent 2 denies ever using Class A drugs. Review in 3 months. Refer to CBT Clinic			
18/01/06	Dr D Progress Note	Somerset Partnership	(Parent 1): Partner started work 2 days ago – pregnant, not planned but happy. Chat re possible extra support needed as father on own with Sibling 1 whilst Mum at work			Discussion with Dr D indicated he was checking out what R needed as R could appear anxious
19/01/06	GP Re (Parent 1)	C Health Centre GP	Hurt foot, seen in A & E yesterday.		SDS taking over prescribing, 115mis methadone.	
20/01/06	GP Re Parent 2	GP C HC	Pregnant LMP 14.12.05 EDD 21.09.06 Saw GP		Booked with midwife. Routine antenatal care started.	Presented appropriately early in pregnancy.
23/01/06	FHVR	HVA, SPCT	Telephone call from Parent 2 in response to telephone message left by HV, informing HV that		Parent 2 given the contact number for the Somerset Child Health Department	Follow up contact with family.

			she has decided that Sibling 1 can have an MMR immunisation but not at the present time. Parent 2 also informs the HVA that she is currently pregnant.		and requested to contact them when she wants Sibling 1 immunised.	HV records do not record whether a reason was discussed for Parent 2's decision not to have Sibling 1 immunised at that time and whether it was an informed decision.
01/02/06	Dr D Progress Note	Somerset Partnership	(Parent 1): Routine appointment – "looking after Sibling 1"			Nothing to raise concerns
15/02/06	Dr D Progress Note	Somerset Partnership	(Parent 1): 2 hrs before, appointment cancelled (D&V) (Methadone script reduction)			
17/02/06	Psychiatry review Progress Note	Somerset Partnership	Parent 2: Parent 2 (Parent 2) 7/8 weeks pregnant			
24/02/06	Maternity Notes (Parent 2)	YDH	Home booking appointment with community midwife. Maternal depression and refusal of antidepressant treatment during pregnancy noted. Both parents noted as non-smokers		Plan to review after antenatal USS	6 further antenatal appointments with community midwife between 09/03/06 and 20/07/06 – normal progress and no problems identified
10/03/06	SG Progress Note	Somerset Partnership	(Parent 1): Relationship explored. Needs of dependent children referenced R concerned about Parent 2			Father comments that his relationship with his daughter is good

			and bouts of depression. More support offered if required Monthly visiting established			
27/03/06	GP Re Sibling 1	GP C Health Centre	Seen with conjunctivitis		Prescribed chloramphenicol eye drops	
29/03/06	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script given. Script management discussed. Mum and Aunt visiting from Chile			
07/04/06	Further Psychiatric Review Progress Note	Somerset Partnership	Parent 2: Diagnosed as having a recurring depressive disorder			
26/04/06	Dr D Progress Notes	Somerset Partnership	(Parent 1): Some problems with Mum but coping well			
28/04/06	SG Progress Notes	Somerset Partnership	(Parent 1): Did not attend; no reason given			
02/05/06	SG and R: telephone call Progress Notes	Somerset Partnership	(Parent 1): R sorry he missed appointment; negotiated a new one			
10/05/06	Dr D Progress notes	Somerset Partnership	(Parent 1): Methadone script			
26/05/06	SG and R: telephone call	Somerset Partnership	(Parent 1): R: telephone call: cannot keep appointment. (40 minute telephone conversation.) R			SG agrees to discuss this with Dr D

	Progress Notes		anxious: started to drink. R seeing pattern in pregnancy R struggling/chest pains; anticipates drinking levels will increase. Wants increase in Methadone script because of stress of pregnancy			It is difficult to know from the notes if R's problems are more to do with his dependency problems or what is happening. Either way, he is laying down a marker
09/06/06	SG and R Progress Notes	Somerset Partnership	(Parent 1): R says alcohol under control because of Methadone increase. R says, when he is anxious, he turns to drink – like first pregnancy. Needs of dependent children referenced Mother tired and this is affecting daughter. R finding Parent 2's moods difficult to cope with. Parent 2 very sensitive			There is a good description of the problems as defined by R. I would have thought it appropriate to explore with R if his drinking impinged upon his ability to care for his daughter
13/06/06	GP Re Parent 2	Saw Psychiatrist from Somerset Partnership	Letter received by practice, depression, waiting for CBT, investigations for facial rash.			
14/06/06	Dr D & R Progress Notes	Somerset Partnership	(Parent 1): R is full of negative thinking; worried about partner's pregnancy and moving. Needs additional Methadone			GP firm with R about his need to address the underlying problems There is a sense that R is using

						triggers to increase his Methadone script
16/06/06	Further Psychiatric review Progress Note	Somerset Partnership	Parent 2: No mention of drugs			
30/06/06	SG: telephone call with R Progress Notes	Somerset Partnership	(Parent 1): R rings because he is late. SG rearranges day			
30/06/06	Police	Avon & Somerset Police	Assist – Non endorsable fixed penalty ticket issued to Nissan – offender Parent 2			Paid for
03/07/06	SG Progress notes	Somerset Partnership	(Parent 1): Alcohol consumption much reduced because of increase in Methadone. Still saying he is very anxious and stressed			Sibling 1 is referred to but the entry is almost identical to the one on the 9 June 2006. This is a description of the situation, not an assessment of the child's needs
07/07/06	GP Re Sibling 1	GP C Health Centre	Seen with viral illness			
07/07/06	GP Re (Parent 1)	C Health Centre GP	Diarrhoea		Advice	
07/07/06	GP	GP	Vomiting		Advice	

	Re Parent 2	C HC				
12/07/06	Dr D: telephone call with R Progress Notes	Somerset Partnership	(Parent 1): R rang to say he missed bus. Methadone script now 130 mgs			
20/07/06	GP Re Parent 2	Yeovil District Hospital	Had USS			
21/07/06	SG and R Progress Notes	Somerset Partnership	(Parent 1): Alcohol discussed – OK R still anxious			As above. There is no plan of work, only a visiting pattern.
25/07/06	GP Re Parent 2	GP C HC	32 weeks pregnant. Disclosed she was using methadone, and 2 year history of heroin use. Asking for referral to SDS but Taunton as stepfather work s in Yeovil SDS.		Referred to Turning Point Taunton, noted no concerns about Sibling 1 or ability to work. Did urine drug screen – positive for methadone. Letter to obstetricians.	First knowledge of Parent 2's drug use. Speedy and detailed referrals next day to SDS and Obstetrician.
26/07/06	Maternity Notes (Parent 2)	YDH	Disclosure to GP (Dr S. Merrifield) by Parent 2 that she had been using street methadone for a heroin habit that had become 'out of control' since Christmas 2005. Parent 2 had stopped smoking heroin in February 2006 when she had commenced suing street methadone. Parent 2 happy to for information to be shared with consultant obstetrician –		Letter sent to Consultant Obstetrician	

			letter written. Parent 2 admits needing help with her drug use.			
31/07/06	FHVR	HV, SPCT	Home visit to Parent 2 to begin an ante-natal health needs assessment. HV noted that family are moving house in two weeks time and that Parent 2's maternity leave will also commence at this time. Parent 2 volunteered that she has been seeing a psychiatrist and is awaiting Cognitive Behavioural Therapy. Parent 2 admitted to suffering with post-natal depression after Sibling 1's birth. Sibling 1's development assessed as being appropriate for her age. HV informed that Sibling 1 attends a childminder once a week and a crèche twice a week.	Sibling 1 seen	Appropriate advice given to Parent 2 regarding current immunisation programme, new born audiological screening, changes to weaning guidelines. Parent 2 was also strongly recommended to reconsider her decision to allow Sibling 1 to have her MMR immunisation.	Important core contact to reassess family's current health needs given the information that a new baby is expected. Protective to both child and unborn baby. Appropriate information given to mother regarding her unborn baby. Discussion about postnatal depression would allow HV to prioritise the family's health needs after the birth. No record of in depth discussion about mother' Appropriate action taken by HV in recommending that Sibling 1 is given the MMR

						immunisation. Protective to child.
01/08/06	FH - SDS Progress Note	Somerset Partnership	Parent 2: Initial assessment			No info as to how she came to be referred
02/08/06	FH: telephone call - Dr Q re Parent 2	Somerset Partnership	Parent 2: Yeovil Family Connection mentioned			
02/08/06	Dr D Progress Notes	Somerset Partnership	(Parent 1): R more relaxed; long discussion about pregnancy			
03/08/06	Yeovil District Hospital (Medical Notes)	YDH	Revealed at 33 week antenatal appointment that Parent 2 using street methadone.	•	• Parent 2 seen by Taunton Drug Service • GP aware • Referral sent to paediatric consultant • Child Protection Team informed verbally	
07/08/06	FHVR	HV, SPCT	Health Visitor records received from Liverpool via Somerset Child Health Department. These are recorded as showing no significant information.		Records read and reviewed by HV.	Reviewing records received from another area ensures that the current HV is appraised of the family's history and involvement with services at their previous address.

						This allows reassessment of current needs for the family in light of any new significant information and is protective to child. Notable practice that reading of records has been recorded
07/08/06	FH: telephone call to Midwife	Somerset Partnership	Parent 2: Message left			
08/08/06	FH: telephone call - Midwife	Somerset Partnership	Parent 2: Methadone dosage and size of baby discussed Midwife to notify hospital			
14/08/06	Maternity Notes (Parent 2)	YDH	Antenatal admission for reduced foetal movements – methadone 15mls a day documented		Discharged home	
15/08/06	FH: telephone call from DW, Yeovil Hospital	Somerset Partnership	Parent 2: Methadone levels discussed			
16/08/06	FH sees Parent 2 at Taunton Progress	Somerset Partnership	Parent 2: Focus is on Parent 2			No mention of the child

	Note					
16/08/06	E-mail from FH – Dr Q	Somerset Partnership	Parent 2 Parent 2 self-medicating on opiates			
18/08/06	SG Progress Notes	Somerset Partnership	(Parent 1): Things going well – Parent 2 at home. R less anxious			There is an assumption that Parent 2 copes with child
22/08/06	Dr Q Progress Note	Somerset Partnership	Parent 2: Concerned this lady is difficult to assess and had denied using Class A drugs. She had rejected Fluoxitine in favour of 'street' Methadone. Care Co-ordinator not accepted by Dr Q. Queried whether CSC needed to be informed			
23/08/06	GP Re Parent 2	Letter received from Psychiatrist	Missed appointment with Psychiatrist, then phoned to say would wait for CBT, declined further appointment.			
23/08/06	Yeovil District Hospital (YDH) (Medical Notes)	YDH	Parent 2 seen by paediatric consultant pre-natally for counselling about forthcoming delivery		Plan agreed to: 1. Admit baby to SCBU after birth for at least 1 week 2. To vaccinate baby against Hepatitis B 3. To check mothers Hepatitis B and C status 4. To ensure that whilst on SCBU staff respect parents' wishes that	Antenatal notes document that Parent 2 was participating in a methadone programme, having smoked heroin until 7-8 weeks of pregnancy and then using street heroin. Antenatal notes also document that Parent 2 suffers

					the baby's reason for admission to remain confidential SCBU unit informed to expect baby's admission after delivery	with depression requiring anti-depressant medication, but that the medication was not being taken during pregnancy
23/08/06	Admin Adult Psychiatry Progress Note	Somerset Partnership	Parent 2: Parent 2 only wanting CBT			
26/08/06	Maternity Notes (Parent 2)	YDH	Antenatal admission for CTG in view of decreased liquor (amniotic fluid volume)		Discharged home	3 x further routine antenatal admissions for monitoring on 29/08/06, 04/09/06 and 09/09/06
04/09/06	Local Pre-school, Chair & Supervisor	Local Pre-School	Sibling 1 started pre-school	Sibling 1 seen		Child's registration form completed. No allergies etc. Request a place for Mon, Wed & Fridays
05/09/06	Parent 2 attends appointment Progress Note	Somerset Partnership	Parent 2: Using extra Methadone because she is sleeping badly**.** FH says it is better to have discussed the need with her. Info re baby discussed - small, some problems			No evidence that problems with baby attributable to drug use. Sibling 1 not mentioned
06/09/06 - July 07	Local Pre-	Local Pre-School	Sibling 1 late for pre-school 18 times	Sibling 1 seen		Records show late as after 9.30 am.

	school, Chair & Supervisor					No pattern to days of week.
06/09/06	GP Re Parent 2	Paediatrician YDH	Letter received about hepatitis immunity.			Was there review with Social Services at this time?
06/09/06 - July 07	Local Pre-School - Supervisor	Local Pre-School	Sibling 1 off sick 4 separate days			Reason given – mum not well for 2 days. Sibling 1 not well 2 days (bugs)

08/09/06	FH Progress Note	Somerset Partnership	Parent 2: Methadone. Increased to 20mgs a day			
08/09/06	SG Progress Notes	Somerset Partnership	(Parent 1): DNA			
12/09/06	Yeovil District Hospital (Medical Notes)	YDH	Child D () born (38 + 5 gestation). Baby in good condition after delivery.	Child D seen	• Child D transferred to SCBU for observation • Multidisciplinary Concern Diary commenced • Named Nurse for Child Protection informed of Child D's birth (already aware –informed whilst Parent 2 in labour)	
12/09/06	GP Re Parent 2	Yeovil District Hospital	Induced delivery at 38 weeks, intrauterine growth retardation, and opiate withdrawal.	Child D seen		
12/09/06	FH: telephone call to Yeovil Hospital	Somerset Partnership	Parent 2: Parent 2 off Labour Ward. Child D born	Child D seen		
13/09/06 0130	Yeovil District Hospital (Medical Notes)	YDH	Parent 2 visited Child D in SCBU. She stressed the importance of Child D's reason for admission to SCBU remaining confidential. It was suggested to her that as Parent	Child D seen		

			2's step-father is a drugs worker, and her mother a health visitor they may realise Child D's diagnosis. Parent 2 acknowledged this, but remained adamant that she did not wish any information to be made available to others.			
13/09/06	YDH (Medical Notes)	YDH	Parent 2 and Child D seen by paediatric consultant . Parent 2 advised by consultant to be open with Child D's maternal grandmother about Child D's reason for being on SCBU	Child D seen		
13/09/06	YDH (Medical Notes)	YDH	Parents noted to be '*very up-front and honest regarding their use of methadone*' in nursing entry into medical notes			
13/09/06	FH: telephone call with Parent 2 in hospital	Somerset Partnership	Parent 2: Small baby, mother fine	Child D seen		
13/09/06	FH: telephone call to Acute Pain Sister	Somerset Partnership	Parent 2: Concerned that Parent 2 brought in unlabelled bottle of Methadone in with her. Seems to have been a breakdown in communication and confidentiality issues			FH had made contact
13/09/06	SG: telephon	Somerset Partnership	Parent 2: Baby born. Baby on SCBU –			SG told me that she knew the baby had

	e call with R Progress Notes		5lbs (stopped growing)			withdrawal problems. Did this warrant a conversation between SG and FH?
14/09/06	YDH Named Nurse records	YDH	Named Nurse updated by SCBU nursing staff – '*no child protection concerns*'			
14/09/06	YDH (Multidisciplinary Concern Diary held within Medical Notes)	YDH	Child D's father and sibling visited Child D in SCBU. Father noted to be sweating profusely and to smell of alcohol	Child D and Sibling 1 seen	Logged in Concern Diary	
18/09/06	FHVR	HV, SPCT Midwife, Yeovil District Hospital NHS Foundation Trust, (YDH).	HV contacted by Midwife from SCBU. Parent 2 disclosed that she had been using heroin and crack cocaine until she was 9 weeks pregnant. She had then used street methadone until she was 33 weeks pregnant. At this time Parent 2 disclosed that she became involved with Taunton Drugs Team and was prescribed methadone. Baby Child D is now experiencing withdrawal and being given Oramorph. She is likely to be in SCBU for 4-5 weeks.	Child D seen	Midwife gained consent from Parent 2 to share this information with HV and HV planned to discuss this with Parent 2.	Important information sharing contact to update other involved professionals. Opportunity for HV to update her professional assessment of the family's current situation and level of risk to the children. Protective to children.

18/09/06	YDH (Medical Notes)	YDH	Child D displaying increased signs of opiate withdrawal	Child D seen	Oramorph treatment commenced	

18/09/06 13:15	Named Nurse records and interview with Named Nurse's deputy	YDH	Phone call to Named Nurse's deputy from SCBU staff nurse. Asked if staff should make a referral to CSC re. Child D. SN concerned that Parent 2 might lose her job as a social worker if the referral was made and her drug problem was revealed to her Child Dployers. SN advised Named Nurse that SCBU staff had no concerns about Child D, and that the multi-agency document 'Substance Misusing Parents – Guidelines for Inter-agency Working in Somerset' (held on SCBU) had been consulted and the threshold for referring Child D to CSC had not been met.		Referral to CSC not made. Advised to discuss case with all relevant professionals / agencies prior to Child D's discharge.	
18/09/06	FH: telephone call from DW	Somerset Partnership	Parent 2: Parent 2 asking to be discharged tomorrow. DW voiced concerns over partner who was 'swigging' Methadone from bottle and appeared to be under the influence of drugs			FH says that she will talk to partner's Key Worker. No contact is recorded
19/09/06	YDH (Medical Notes)	YDH	Discharge plan for Parent 2 made: Discussion between Staff Nurse & midwife. Further discussion between		Decision not to refer Child D to Children's Social Care '*as no concerns*'	From 12/09/06 to 04/10/06 it is documented on a number of occasions that Parent 2 has been providing all 'cares'

			RGN, Parent 2 , pain relief nurses (DW and AL) and C S (YDH) Concerns raised by SCBU nursing staff that Parent 2 is a little rough when handling Child D.		Advice on handling techniques given	for Child D (ie changing nappies, dressing etc)
19/09/06	Dr A: telephone call from DW	Somerset Partnership	Parent 2: Parent 2 self-discharged as partner struggling to cope. Baby in SCBU. Baby suffering severe withdrawal. Patient also showing severe withdrawal on prescribed Methadone, 'raising likelihood of using considerably more than prescribed'. Advised DW to speak to midwife and refer to CSC if necessary	Child D seen		
20/09/06	FH – re phone call from AL	Somerset Partnership	Parent 2: Re hospital concerns: baby suffering severe withdrawal			
21/09/06 09:50hrs	FHVR	HV, SPCT	Telephone call to staff on SCBU to get update on Parent 2 and Child D's condition. Informed that Parent 2 was discharged from midwifery care on 20.09.06. Child D breastfeeding on demand.		HV arranged to visit Parent 2 and Child D later that day.	Follow up call to update HV information and arrange visit to family.
21/09/06 15:30hrs	FHVR	HV, SPCT	Parent 2 seen by HV in SCBU. Reported to HV that labour was good in spite of induction.		HV obtained Hospital car parking permit for the family.	Important contact to offer support to Parent 2 during a

			Open about drug use, stated that she intends to tell her mother "when the time is right". Had been concerned about Sibling 1 whilst she was in hospital but reported that she is more settled now that Parent 2 is home at night. Parent 2 also worried about cost of daily trips to hospital to see Child D. Reported that (Parent 1) is also stressed about this situation.		HV offered to visit (Parent 1) to give him an opportunity to talk if he wished.	stressful time and give practical advice regarding the management of the current situation. Example of notable practice as not all HVs visit families in SCBU. Notable HV practice to offer support to father. Further assessment opportunity to add to family health needs assessment. All of above protective to children.
21/09/06	Dr Westonray Progress Note	Somerset Partnership	Parent 2: Parent 2 discussed re possible CBT			
22/09/06	FHVR	HV, SPCT	Parent 2 telephoned HV as she was feeling tired, tearful and out of control. Informed HV that she had struggled to meet Sibling 1's needs the previous evening due to her tiredness and had argued with (Parent 1). Discussed with HV the need to inform her mother about her drug use but not at present		HV reiterated avenues of support for Parent 2 – Drugs service, GP, Community Mental Health Unit and HV and suggested Parent 2 makes more use of them. Specifically suggested Parent 2 see GP for	Opportunity for HV to support Parent 2 and give practical suggestions for managing current situation and utilise available avenues of support. Protective to

			time. Parent 2 requests that HV talks to (Parent 1) too. Parent 2 also worried about Child D's irritability yesterday. Child D's Oramorph has now been increased as a result.		assessment and possible antidepressant prescription. HV offered to discuss Parent 2's difficulties with both Parent 2's GP and staff on SCBU to ensure that they are aware of Parent 2's current Child Dotional state.	children. Importance of sharing information with other professionals involved with the family. No record however of whether the HV achieved her plan to liaise with SCBU and GP regarding Parent 2's mental health.
22/09/06 11:00	YDH (Medical Notes)	YDH	Phone call to SCBU from Health Visitor – concerns that Parent 2 '*not coping very well'*. Aware of previous history of post-natal depression.		Parent 2 to see her GP	
22/09/06	YDH (Medical Notes)	YDH	Parent 2 visited SCBU and disclosed to nursing staff that she was finding managing home and hospital 'too much to cope with' and felt that if she spent more time at home she would be able to cope better	Child D seen	Mum to visit SCBU once a day only	Documentation that Parent 2 does not want to visit GP as she does not want to be on antidepressant medication and feels she will cope if she is less tired.
22/09/06	SG, (Parent 1) 's	Somerset Partnership	Parent 2: (Parent 1) says no longer concerns about Parent 2 using			It is unclear why this entry is on this record

	Drugs Worker Progress Note		extra and no concerns by hospital, no referral to Social Services. Baby's medication being reduced.			
22/09/06	SG: telephone call with R Progress Notes	Somerset Partnership	(Parent 1): R cannot keep appointment because of child care arrangements. R stressed and anxious and better now Parent 2 is home. Parent 2 discharged herself. Sibling 1 missing her and R not coping "Long conversation about R's worries"			No reference to any other professional, HV or to Family Support
24/09/06 14:00	YDH (Multidisciplinary Concern Diary held within Medical Notes)	YDH	Parent 2 visited Child D on SCBU and noted to be sweaty and jittery. She appeared confused, disorganised and excessively anxious. Parent 2 was also noted to be requesting meals for herself when coming in to visit Child D	Child D seen	Logged in concern diary	
25/09/06	YDH (Medical Notes) and interview with Named Doctor for Child Protection	YDH	Child D seen by paediatric consultant on SCBU ward round and felt to be nearly ready to be discharged. Paediatric Consultant documents plans to discuss case with Named Doctor and then to contact CSC to arrange a pre-discharge planning meeting if social services have	Child D seen	Discharge plans for Child D discussed between Paediatric Consultant and Designated Doctor for Child Protection; Consultant advised by Designated Doctor that Social Services are '*happy with drug using mother's home situation, and Child D would go home to*	Designated Doctor recalls her conversation with Paediatric Consultant. She recalls that she had previously discussed Child D with Named Nurse for Child Protection and had been

			made plans for Child D to be discharged into foster care, where the possibility of weaning Child D off oramorph as an outpatient could be considered		*mum*'. (documented by Paediatric Consultant in Medical Notes) Decision made that Child D not to be discharged home until weaned off oramorph treatment	informed that a decision had been made that a professionals meeting would not be arranged prior to the discharge of Child D as there were no concerns about the family's social situation or ability to care for Child D. Named Doctor understood that CSC were also aware of Child D and agreed that there were no concerns that merited intervention pre-discharge.
25/09/06	FH: telephone call with Parent 2	Somerset Partnership	Parent 2: Parent 2 concerned that she is not being told about baby's meds; baby's withdrawal symptoms are distressing but at least she is breastfeeding well (how are they getting there?) The plan is "I will visit Parent 2 at hospital ….to discuss CP concerns"			Really odd, moving off areas of own responsibility. Is this avoidance? as had been discussed in the team and the possible CP issues needed addressing
27/09/06	FHVR	HV, SPCT	HV made planned visit to (Parent 1) at family's home address. (Parent 1) informed		Opportunity for (Parent 1) to talk about the stressors within his life currently.	Correct HV intervention given family's current

			HV that the family's situation is calmer since Parent 2 reduced the amount of time she spends at SCBU with Child D. HV discussed with (Parent 1) the couple's drug use and how they managed this.			stressful situation. No record however of the details of discussion on family's management of drug issues. This would be useful information to record for any other professionals working with the family.
27/09/06	GP Re Child D	C Health Centre	Child D was registered at the Health Centre with GP.			Clear from the computer summary that there was a serious problem – good practice.
28/09/06	FH visits Parent 2 in Yeovil Hospital	Somerset Partnership	Parent 2: Also spoke with DW re Midwives' concerns. No objective signs of withdrawal. Issue re partner and relationship with her mother was discussed. Parent 2 had told staff she would lose her job if a referral was made to CSC; FH said she had no concerns but if midwives did, they should refer to SS, even informally. Parent 2 was immediately very open. Adamant that she had only used prescribed Methadone. Being honest 'as	Child D seen		Whilst this was a competent interview and professionals were encouraged to exercise options, is there the possibility that Parent 2 is saying the right things? It all feels very "pat"

			she always had been'. Not a good relationship with Mum, but now much improved. Wants to tell Mum about drug use, not right time. Conclusion: no need to refer to SSD			
29/09/06	YDH Named Nurse Records	YDH	Discussion between Named Nurse and Named Doctor. Named Doctor concerned that Child D's social situation must be assured as safe to protect Child D's wellbeing prior to Child D's discharge		Named Nurse to contact SCBU to discuss concerns	
29/09/06	SG Progress Notes	Somerset Partnership	(Parent 1): Telephone calls to R failed			
01/10/06	YDH (Medical Notes)	YDH	Child D well on very small amount of oramorph		Oramorph treatment stopped	
02/10/06 08:45	YDH (Medical Notes and Named Nurse Records)	YDH	Named Nurse for Child Protection informed by SCBU nursing staff that Health Visitor is aware of hospital concerns about Parent 2 's ability to cope once Child D discharged. Named Nurse aware that a decision not to hold a professionals meeting has been taken		To check with HV to see whether she feels Social Services need to be involved at this stage.	
02/10/06 16:00	YDH (Medical Notes)	YDH	Phone call from Health Visitor to SCBU – she does not have any concerns about the family and does not feel that it is appropriate to involve social		HV to work closely with family and will '*check Parent 2 regularly for signs of depression*'	

			services			
03/10/06	SG: telephone call from R Progress Notes	Somerset Partnership	(Parent 1): Phone number changed			

04/10/06	GP Re Child D	Discharged from Yeovil District Hospital				
04/10/06	YDH (Medical Notes)	YDH	Child D discharged home to care of parents	Child D seen		
04/10/06	FH: Telephone call from Parent 2	Somerset Partnership	Parent 2: All well, according to Parent 2, and nurses are not going to refer to SSD. Baby going home			I would have anticipated that professionals would have clarified what the health visiting arrangements would be
05/10/06	FHVR	HV, SPCT	Planned home visit by HV following Child D's discharge from hospital on 04.10.06. Parent 2 observed to be coping well with demands of both Child D and Isabella. (Parent 1) noted to be helpful.	Child D and Sibling 1 seen	Information given to the couple regarding Sudden Infant Death Syndrome.	Postnatal visit giving HV an opportunity to assess the parents' ability to manage the needs of the children appropriately and to give important health promotion information and advice. Protective to children.
05/10/06	Dr D: telephone call Progress Notes	Somerset Partnership	(Parent 1): Baby back home			

6/10/06	PHCR	HV, SPCT	Child D noted to be well	Child D seen		Site of contact not entered
06/10/06	SG: telephone call Progress Notes	Somerset Partnership	(Parent 1): R very anxious. He has not bonded with baby as he did with first; also discussed the need for R to ensure he is not put in a position where he is alone with baby at present until he feels more able to cope			I think a telephone conversation with the HV and FH would have been wise
09/10/06	FHVR	HV, SPCT	Planned home visit by HV. HV observed the family situation to be calm. Noted breastfeeding to be well established and Parent 2 to be well, not tired but worried that "everything is going so well". Child D was asleep during this visit so not weighed.	Child D seen (asleep)	Parent 2 reassured about her progress and given advice about eating well, relaxing and believing in her capabilities as a mother.	Postnatal visit to assess both Child D and her parents' progress. Unclear from records whether Child D was seen by the HV. Incomplete records are a potential risk to the children if other professionals cannot access accurate information about the family in the absence of the named HV.
11/10/06	FHVR	HV, SPCT	Planned home visit by HV. Parent 2 admitted to HV that she gets tearful if she gets overtired and when the	Child D seen	Parent 2 advised by HV to get additional sleep whenever she can.	Postnatal visit to monitor Child D's progress. No record of

			methadone starts to wear off.			whether HV discussed whether Parent 2 should have drug management reassessed or whether there was liaison with SDS. If Parent 2 having problems with Methadone cover, this would be a risk to the child.
	PHCR	HV, SPCT	Child D was weighed and the gain said to be “excellent”.			
13/10/06	GP Re Child D	Discharge summary from Yeovil District Hospital received by practice	First information about Child D’s opiate withdrawal syndrome.			
13/10/06	SG:	Somerset Partnership	(Parent 1): R – pale and tired. When baby cries ‘it winds him up’. Parent 2 is aware – R tried not to be alone - sometimes not possible. HV visiting regularly and aware of R’s anxiety			This would have been an opportunity to speak with the HV
19/10/06	FHVR	HV, SPCT	Planned home visit by HV. Parent 2 noted to be tired but coping.	Child D seen	Not recorded.	Postnatal visit to support Parent 2’s parenting role. No detail in record of how HV assessed that

	PHCR	HV, SPCT	Child D was weighed and the gain said to be “excellent”.			Parent 2 was coping.
19/10/06	FH: telephone call from SG	Somerset Partnership	Parent 2: SG was worried about R’s coping skills; he was shouting at the baby. FH says there are not enough concerns to go to CSC but she will find out who the HV is and speak to her			**This call is not on SG client record for (Parent 1)** Definitely should have been discussed in supervision by both workers
20/10/06	Home visit 14.30 Progress Note	Somerset Partnership	Parent 2: R in bed, catching up on sleep. Discussed concerns with both. R felt bonding would improve and showed ‘genuine warmth towards baby’ – suggested they both talk to HV. DVLA issues raised very clearly by FH. Made clear by SG that Parent 2 was driving. Parent 2 feeling stronger – ‘do I now need CBT?’ Unsure if her depression will return	Child D seen		A clear and direct interview A call to the HV was indicated. I feel both parents can change the ‘goal post’
24/10/06	FHVR	HV. SPCT	HV informed that Parent 2 was induced at 38 weeks gestation due to Intrauterine Growth Retardation. Birth weight 2.340 Kg. Baby currently in Special Care Baby Unit, (SCBU), and being partially tube fed.		For information only.	Information sharing between professionals important to ensure all involved remains appraised of family’s current

						situation. Records do not state where information came from therefore professionals would have difficulties in attempting future liaison. Date of entry is clearly inaccurate given records are completed contemporaneously.
24/10/06	FHVR PHCHR	HV, SPCT	Planned contact with HV and GP at the Health Centre for 6 week postnatal assessment. No concerns re Child D's health although weight gain described as minimal. Parent 2 informed HV that she has had a bad week because she is being encouraged by her drugs mentor to inform the DVLA about her methadone use. Parent 2 is concerned that her licence will be withdrawn and she will lose her job.	Child D seen	HV advised Parent 2 to contact her drugs worker and discuss her concerns.	Planned contact as part of the universal Child Health Promotion programme. Joint contact with GP. An opportunity for Child D's health and development to be assessed by HV. Protective to child.

24/10/06	GP Re Child D	C Health Centre	Had 6 week check done at Health Centre, Dr not identified.	Child D seen		The practice is using both paper and computer notes, paper notes have been sent to Child D's new GP. It would have been appropriate for the GP to have discussed and recorded how Child D was, and how her parents were managing, but this may be in the paper record. The practice is in the process of going paperless.
26/10/06	Dr. D	Somerset Partnership	(Parent 1): Screened. Baby crying. R anxious – too anxious to reduce Screen positive for Methadone and Benzodiazepines			
30/10/06	GP Re Parent 2	C Health Centre GP	Emergency contraception.		Advise and prescription.	
31/10/06	GP Re Child D	Yeovil District Hospital	Seen in Paediatric Clinic, no concerns, for review in 3 months.	Child D seen		
31/10/06	YDH (Medical Notes)	YDH	Child D reviewed in paediatric baby clinic. Well and developing normally	Child D seen	Appointment to review Child D again in 3 months made	

31/10/06	FH: telephone call from Parent 2	Somerset Partnership	Parent 2: Re DVLA: Parent 2 says she would lose her job if licence revoked.			
02/11/06	FHVR	HV, SPCT	Parent 2 contacted HV to discuss current situation regarding the DVLA. Parent 2's key worker states Parent 2 has an obligation to inform the DVLA about her methadone usage. As Parent 2 is worried that she may lose her licence and job she has discussed with the drugs worker rapid reduction in her methadone prescription. Parent 2 admits to feeling forced into this situation as she had not planned to reduce for a year. Parent 2's drug worker will discuss Parent 2's proposal of reduction with Parent 2's consultant. Parent 2 informed HV that (Parent 1) has taken this news badly.		HV plans to visit the family in one week.	Opportunity for Parent 2 to talk over her concerns calmly with a third party with the objective of alleviating stress between the couple at home. Protective to children; tensions between parents can have an adverse effect on children, particularly their Child Dotional wellbeing.
03/11/06	SG	Somerset Partnership	(Parent 1): Challenged re Benzodiazepines screen – so little sleep, used 3 times (old script) Bonding better with Child D. Less anxious - Methadone reduction discussed			One has a sense that having been 'caught out ', R is identifying the positives and wanting to reduce
09/11/06	FHVR	HV, SPCT	Planned home visit by HV. Edinburgh Postnatal Depression Questionnaire		HV encouraged Parent 2's with identification of the positives of Parent 2's	Postnatal depression screening carried

	PHCR	HV, SPCT	completed by Parent 2. Score is 7. Parent 2 admitted that the family have some financial difficulties. Child D reported as now fully bottle fed but unsettled at times.		progress and discussed how to access help and support should she feel depressed in the future.	out appropriately as per SPCT protocol. Score was within acceptable limits and no further action would have been taken. Not recorded in record whether advice or signposting was given regarding the family's financial difficulties. Worries about money could adversely effect the family's functioning and negatively impact on Parent 2's mental health and therefore the Child Dotional wellbeing of her children.
13/11/06	FH re DVLA: discussion with Dr A Progress Note	Somerset Partnership	Parent 2: Parent 2 DNA. Dr A clear Parent 2 would not be treated differently			

16/11/06	Dr D	Somerset Partnership	(Parent 1): R low – feels he has 'post-natal depression' Drug screen – benzodiazepine positive again			Again this was an opportunity to talk with the HV
17/11/06	FHVR, PHCR	HV, SPCT	Planned home visit by HV. Parent 2 reports that Child D has been crying before and during feeds for two days. Parent 2 admits to finding the noise difficult to cope with.		HV advised Parent 2 to take Child D to the GP.	Appropriate response to Parent 2's concerns. A constantly crying baby can be a cause of stress for parents and adversely affect their ability to parent her safely. The need to rule out underlying medical cause for her symptoms would also be paramount. No record of follow up or liaison between HV and GP following the suggested consultation. HV records do not illustrate if problem was resolved.
17/11/06	GP Re Child D	Somerset PCT	Attended for 1st immunisations and given prescription for Infant Gaviscon	Child D seen	HV spoke to GP who prescribed gaviscon.	

24/11/06	GP Re Parent 2	C Health Centre GP	Saw GP, request for sterilisation.		Counselling, referral.	
27/11/06	GP Re Parent 2	SDS Letter	Letter received.			
01/12/06	SG	Somerset Partnership	(Parent 1): DNA – heavy cold			No mention of benzodiazepines
04/12/06	GP Re Parent 2	C Health Centre	Saw GP, diarrhoea and vomiting		Advice.	
05/12/06	PHCR	HV, SPCT	Child D reported as feeding well and more settled Prescribed aqueous cream for rough skin on face	Child D seen		Follow up contact, site not specified
06/12/06	Parent 2 at Clinic with R & two kids Progress Note	Somerset Partnership	Parent 2: DVLA discussed	Child D and Sibling 1 seen		
11/12/06	Dr A – letter to GP RIO	Somerset Partnership	Parent 2: Partner and two children seen. Interacted appropriately with children. DVLA about previous Heroin use and current Methadone use	Child D seen		This refers to the above office visit
14/12/06	AD	Somerset Partnership	(Parent 1): Doing well – moving house			
20/12/06	FHVR	HV, SPCT	Opportunistic home visit by HV. Observed family to be well albeit a little stressed with preparations for Christmas.		Not recorded.	Appropriate visit to a family that had previously struggled to cope with their problems. The length of time between this and the next contact 6

						months later appears a little long given the family's previous problems. However this length of time may be appropriate if HV assessment is that family are coping and well supported by family and other agencies.
27/12/06	AD Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
05/01/07	SG Progress Notes	Somerset Partnership	(Parent 1): R looking well; planning to move. R said: "E and I doing well" – small Methadone script reduction discussed			
11/01/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): R: well Med: 120mls			
12/01/07	Home visit Progress Note	Somerset Partnership	Parent 2: Parent 2 stressed. R Not pulling his weight. Things getting better and they are moving. Can't reduce, actually wants increase. Other options discussed. Child D **seen**			No mention of whether HV is visiting and supporting family
12/01/07	Drug screen Progress Note	Somerset Partnership	Parent 2: Codeine. Positive for opiates for pain relief			

18/01/07	Reviewed at Clinic Progress Note	Somerset Partnership	Parent 2; Methadone increased			
19/01/07	GP Re Child D	Somerset PCT	2nd Immunisations	Child D seen		
24/01/07	GP Re Sibling 1	C Health Centre	Seen with chickenpox		Calamine lotion	No entry on Sibling 1's notes to indicate parent's drug misuse.
25/01/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Med: 115mls			
06/02/07	YDH (Medical Notes)	YDH	Child D reviewed in paediatric baby clinic. Well and developing normally.	Child D seen	Appointment to review Child D in 6 months made	
07/02/07	GP Re Child D	Somerset PCT	Saw GP with conjunctivitis	Child D seen	Sticky right eye	
08/02/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Med: 110mls			
09/02/07	SG Progress Notes	Somerset Partnership	(Parent 1): DNA (no contact)			
13/02/07	Parent 2 cancels visits Progress Note	Somerset Partnership	Parent 2:			
13/02/07	SG Progress Notes	Somerset Partnership	(Parent 1): R contacted and apologised – moving house			

16/02/07	GP Re Parent 2	Yeovil District Hospital	Laparoscopic sterilisation			
19/02/07	GP Re (Parent 1)	C Health Centre	Otitis media		Prescribed Gentisone drops	
21/02/07	E-mail from DW, RIO	Somerset Partnership	Parent 2: Parent 2 sterilized; did not tell them about Methadone usage which caused problems			Should this not have been in her hospital notes anyway?
23/02/07	GP Re Parent 2	GP C Health Centre	Gastroenteritis		Advice and prescription	
28/02/07	SG Progress Notes	Somerset Partnership	(Parent 1): Moving stressful; Parent 2 Sterilised. R Had children alone. Felt Child D did not like him – worked through this and she did settle – Parent 2 going back to work. Drinking more and going to pub 5 nights a week and drinking 4/6 pints. Recognised link with alcohol and stress.			Is he open and honest or is he asking for help? Is he projecting his feelings onto the child?
01/03/07	FH Progress Note	Somerset Partnership	Parent 2: Cancels home visit			
08/03/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): No further reduction as Parent 2 back at work			
16/03/07	GP Re Child D	Somerset PCT	3rd Immunisations	Child D seen		

23/03/07	PH Progress Note	Somerset Partnership	Parent 2: Parent 2 has bruising on cheek (no description of bruise). Fell out of bouncy chair when R was looking after her. FH says R behaved appropriately after the accident and also talked about when he dropped Sibling 1 on her head when she was a baby. Parent 2 not wanting to reduce her Methadone because of the way she was feeling	Child D seen		This is short on specifics. What did R do that was right after the baby was injured? Did he take her to the GP or HV? Where was the bruise? Location can be very important in small babies. I feel this was taken too much on face value, not with the wisdom of hindsight, but in view of what went on before
23/03/07	FH: telephone call to SG to discuss R's parenting capacity Progress Note	Somerset Partnership	Parent 2: SG says R's Methadone use should not affect his parenting capacity. He was used to high opiate use. Also maternal grandmother, who is a HV, visits often 'and would be alerted to any concerns…'.			FH does right thing in ringing Sharon. They do not discuss the quality of the relationship between Parent 2 and her Mum which, 6 months ago, was considered to be poor Child's HV should have been notified
23/03/07	SG Progress Notes	Somerset Partnership	(Parent 1): R: telephone call to say half hour late for appointment			

23/03/07	SG Progress Notes	Somerset Partnership	(Parent 1): Routine visit. Parent 2 back at work. R and girls OK. Bonded well with Child D. Sibling 1 testing boundaries. Not stressed. Alopecia patch growing. One or two beers every evening. Would like to reduce Methadone script, but not yet	Child D and Sibling 1 seen		Very positive interview **This was the same day FH visited the family and discovered the bruise to Parent 2. Her Rio record makes it clear that this was discussed with SG. There is no mention of this being discussed with R**
26/03/07	FH and Team Discussion Progress Note	Somerset Partnership	Parent 2: Methadone script altered. Discussed baby's accident. Agreed no need to take further action			I disagree, HV at the very least needed to be notified
30/03/07	Telephone call: Parent 2	Somerset Partnership	Parent 2: Methadone usage discussed			
02/04/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
09/04/07	Police	Avon & Somerset Police	Assist – Parent 2 called 999 reporting at 0101hrs. Report of drunken youths in the car park opposite her house causing noise and being anti-social			Police unit dispatched and log closed with no further action
13/04/07	Telephone call: Parent 2	Somerset Partnership	Parent 2: Discussed Methadone usage and 'seeing a client of our Service, but not for long'			

16/04/07	Dr A & FH Progress Note	Somerset Partnership	Parent 2: Increase to 40mgs . R reducing			Are they sharing?
16/04/07	PH cancels home visit Progress Note	Somerset Partnership	Parent 2:			
23/04/07	GP Re Parent 2	Somerset Drug Service letter	Letter received from SDS, seen there with children and husband. Methadone increased to 40mg.			
23/04/07	FH Progress Note	Somerset Partnership	Parent 2: Parent 2 increasing. R decreasing. DVLA discussed. **Children seen with both parents**	Child D and Sibling 1 seen		Are they sharing?
27/04/07	SG Progress Notes	Somerset Partnership	(Parent 1): DNA			
30/04/07	SG Progress Notes	Somerset Partnership	(Parent 1): R telephoned. Apologised for DNA; celebrating birthday and hung over			
03/05/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
11/05/07	SG Progress Notes	Somerset Partnership	(Parent 1): DNA – discuss DNA rate with Dr D. Concerned (Parent 1) (telephone call) - has new address			
17/05/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			

18/05/07	SG Progress Notes	Somerset Partnership	(Parent 1): (Parent 1) sorry for DNA. Alcohol use down. Reduction discussed			Not seen for nearly 8 weeks because of DNA. Girls referred to in passing. Rather superficial
24/05/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
04/06/07	FHVR	HV, SPCT	Planned visit to family in their new home. Reported to HV that finances remain a concern and that (Parent 1) is considering returning to work. Both children seen and observed to be developing appropriately. The DVLA issue has not been resolved and Parent 2 continues to drive for her job.	Child D and Sibling 1 seen	Not recorded.	Appropriate visit to monitor the family's ongoing ability to manage their difficulties whilst ensuring the children's needs are met as a priority. No record of any assessment of current drug status.
	PHCR	HV, SPCT	Child D reported as on 3 meals of solids a day but no lumps. Also described as being very petite. Weight chart shows her to have drifted off centiles and to be now below 0.4th centile		Not recorded.	No action recorded re Child D's poor weight gain. Non protective to child.
19/06/07	GP Re Child D	Somerset PCT	Saw GP with spot in hair, not feeding so well.	Child D seen	Impetigo.	
28/06/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
29/06/07	GP Re Parent 2	GP C Health	Hearing problem		Referred to audiology.	

		Centre				
06/07/07	SG Progress Notes	Somerset Partnership	(Parent 1): R late. Oral drug screen done. Changed GP. Kids with GP for weekend. All going well.			Passing reference to children
12/07/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): 110mls. 10mls reduction			
13/07/07	Home visit Progress Note	Somerset Partnership	Parent 2: **Child D in bed; Sibling 1 seen**	Sibling 1 seen		
18/07/07	GP RE Parent 2	C Health Centre GP	Review of methadone – stable. Keen to avoid her mother knowing about it. Dental abcess.		Prescription.	
20/07/07	Home visit Progress Note	Somerset Partnership	Parent 2: Parent 2 about to go to pre-school in car she was driving. FH had checked with GSCC re the need to inform her Child Dployers	?? Child D seen		
23/07/07	FH: discussion re driving to Clinic	Somerset Partnership	Parent 2: Driving to be treated as a one-off			
24/07/07	Progress Note	Somerset Partnership	Parent 2: Drug screen OK			
27/07/07	FHVR	HV, SPCT	Planned home visit by HV to carry out 9-15 month assessment of Child D. Both Child D and Sibling 1 seen and assessed to be developing appropriately. EPDS score is seven. Parent 2 informs HV	Child D and Sibling 1 seen	Advice given to Parent 2 regarding diet, dental hygiene and home safety.	Planned contact as part of the universal Child Health Promotion programme. Postnatal

	PHCR	HV, SPCT	that she finds juggling work and home stressful at times but she is glad she is working. Child D's poor eating discussed and drop in weight		No action recorded other than to be seen at hospital follow up in September	depression screening carried out appropriately as per SPCT protocol. Advice given appropriately due to Child D's developmental stage, particularly as she is becoming more mobile. Protective to child.
27/07/07	SG Progress Notes	Somerset Partnership	(Parent 1): Drug screen. Last one positive for Benzodiazepines. Took one on drinking night with friend. R & Parent 2 having problems. R feeling insecure. R feeling fed up with routine			No discussion as to how this will affect the children
31/07/07	GP Re Parent 2	GP C Health Centre, telephone calls	(Parent 1) rang concerned about confidentiality regarding Parent 2's work at SS. FH rang from SDS – she would see her ASAP.			
09/08/07	Psychologist Progress Note	Somerset Partnership	Parent 2: Assesses Parent 2 for CBT. She tells him she has good support from her mother, sister and colleagues (does not mention partner)			First time sister and any support network have been mentioned
09/08/07	Dr D Progress	Somerset Partnership	(Parent 1): Methadone script – 110mls			

	Notes					

15/08/07	J W Progress Notes	Somerset Partnership	(Parent 1): R wanted temporary change of prescription arrangements			
16/08/07	GP Re Parent 2	C Health Centre GP	Discussed possible transfer to Shared Care Service.			
22/08/07	SG Progress Notes	Somerset Partnership	(Parent 1): Telephone call: relationship with Parent 2 improving. Had decided to part but working on it. R wants to work. Fluent in Spanish and German		No mention of the children	
23/08/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
23/08/07	AD Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
24/08/07	SG: telephone call Progress Notes	Somerset Partnership	(Parent 1): Wanted to change Methadone script			
30/08/07	GP Re (Parent 1)	C Health Centre GP	Musculoskeletal chest pain, methadone now 110mls a day			
Sept 07	Family transferred to GP	Somerset PCT				Unclear why they chose to transfer to GP's list – no disagreement with GP, no loss of continuity.

04/09/07	GP Re Child D	Paediatric clinic YDH appointment	Poor weight gain.	Child D seen		
04/09/07	YDH (Medical Notes)	YDH	Child D reviewed in paediatric baby clinic. Found to have an unsatisfactory weight gain. Weight << 0.4th centile (prev 9th centile aged 4.5 months), length 0.4 – 2nd centile.	Child D seen	Child D referred to the paediatric dietician and an appointment made to review Child D in clinic in 2 months	
06/09/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
07/09/07	SG Progress Notes	Somerset Partnership	(Parent 1): R: DNA because he forgot			
13/09/07	FH: telephone call to rearrange appointment	Somerset Partnership	Parent 2: Sibling 1 is now taken to pre-school by friend			
14/09/07	SG Progress Notes	Somerset Partnership	(Parent 1): R coping – possible change in worker discussed. R wants confidentiality maintained.		No mention of the children	
19/09/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
21/09/07	Home visit Progress Note	Somerset Partnership	Parent 2: Goes to crèche with Child D. R in bed. Problems in relationship. She had asked him to leave – all now resolved. Care Plan: remain on	Child D seen		Needs of the children not discussed

			Methadone until both children are at school			
28/09/07	J W: telephone call Progress Notes	Somerset Partnership	(Parent 1): R wanted change of script arrangement: is going way			
28/09/07	T S Progress Notes	Somerset Partnership	(Parent 1): Trying to contact Ralph			
03/10/07	Dr D Progress Notes	Somerset Partnership	(Parent 1): Methadone script			
04/10/07	Nursing RIO	Somerset Partnership	Parent 2: Re CBT appointment			
15/10/07	Nursing RIO	Somerset Partnership	Parent 2: As above			
16/10/07	GP Re Child D	C Health Centre	Presented with history of a fall from sofa.	Child D seen	Referred to paediatricians.	Excellent practice – immediate action based on suspicious findings and history, even though severity of injuries not apparent.
16/10/07 to 20/10/07	Chair & Supervisor	Local Pre-School	Sibling 1 late everyday			Supervisor aware there were issues in the family but not details
16/10/07	YDH (GP letter held within Hospital Notes)	YDH	Child D seen by GP and referred to the paediatric team at Yeovil District Hospital with bruising to left cheek and back, drowsy, distressed and with	Child D seen	Admitted to YDH (arrival on ward 19:30)	

			episodes of vomiting. GP letter documents that the explanation given for the bruising to Child D's cheek was that Child D's older sister (Sibling 1) had pushed her into a door, and that the bruising on Child D's back was from a fall from a sofa on the morning of 16/10/07.			
16/10/07	YDH (Medical notes)	YDH	Child D examined by paediatric team on ward 10, YDH. Child D accompanied to hospital by Parent 2. History by Parent 2 given that whilst in the care of (Parent 1), at approx 1200 on 16/10/07, Child D fell from a sofa and subsequently became unwell, vomited and developed bruising to her back. Bruising to Child D's cheek attributed to being hit on the face by a toy thrown by her older sister. Both parents noted to be methadone users.	Child D seen	1. Full history and examination performed 2. Injuries documented on body maps (held within Child D's medical notes) 3. Blood tests performed (FBC, U&E, CRP, blood film, clotting studies, Liver function tests) – liver function abnormal 4. CT head – initially reported as normal 5. Chest and Abdominal Xrays – air seen below diaphragm 6. Skeletal Survey booked for	

					17/10/07 – after transfer rearranged to be performed in Bristol 7. Consultant informed of admission 8. Ward Sister (informed of admission 9. Child Protection form (CP2) commenced (and completed at discharge) 10. Concern Diary Commenced 11. Child Protection Register checked (2030) – not on register 12. Named Nurse informed of admission (0800) – she will contact Health Visitor	
17/10/07	FH: telephone call from Parent 2 Progress Note	Somerset Partnership	Parent 2: Parent 2 fallen off sofa and perforated bowel			No alarm bells are raised for FH. Accepts Mother's account
17/10/07 04:20	YDH (Medical	YDH	Child D's clinical condition deteriorated with grunting	Child D seen	Bristol Children's Hospital contacted re. urgent	

	Notes)		respiration and abdominal distension. Examination confirmed an acute abdominal problem and Xray's suggested the presence of a perforation to Child D's bowel		transfer Consultant contacted to attend Child D	
17/10/07 06:20	YDH (Medical Notes)	YDH	Child D examined by consultant and full history taken from Parent 2	Child D seen	• Child D to be transferred to Bristol – discussed with surgical registrar • Suspicion of NAI discussed with Parent 2 • Clinical Photographs of Child D's injuries taken	
17/10/07	YDH (personal recall consultant paediatrician & Named Doctor)	YDH	Consultant off-duty and on annual leave from 0900 17/10/07.		Comprehensive verbal handover given to consultant paediatrician and Named Doctor for Child Protection before going off-duty	
17/10/07 10:00	YDH (Medical Records)	YDH	Interview by consultant paediatrician of Parent 2. Parent 2 informed by consultant paediatrician that it was unlikely that a short fall from a sofa could have caused such a significant injury, and that non-accidental injury must be		Parent 2 told that CSC and police to be informed and given a written leaflet explaining what happens when hospital staff have concerns a child may have been non-accidentally	

			considered as a possible cause.		harmed. Parent 2 requested that as she works for Chard Social Services as a social worker she would prefer another area team to deal with the referral	
17/10/07 10:21	YDH (Copy of faxed Multiagency Referral Request in Medical Notes)	YDH	Multiagency referral request form faxed following telephone discussion between Somerset Direct Team Leader and consultant paediatrician – '*Bruising and Major Abdominal Trauna without adequate explanation ? NAI'*		Telephone referral and multiagency referral request followed up immediately with typed report by consultant paediatrician sent to CSC by post on 17/10/07 Somerset Direct Team Leader (CSC) to liaise with CSC in Bristol	
17/10/07 10:40	YDH (Medical Notes)	YDH	Child D Transferred to ward 31 Bristol Children's Hospital	Child D seen		
17/10/07	YDH (Medical Notes)	YDH	Dr L M (community paediatrician and on-call for child protection (Bristol)) informed by Dr K (telephone) of Child D's transfer to Bristol		Copy of medical report and clinical photographs e-mailed to Dr Mackintosh Ward 31 contacted by Dr Kane and requested to contact Dr Mackintosh when Child D arrives on the ward	Child D is underweight (well below 0.4th Centile). Will need skeletal survey, ophthalmology R/V, further bloods, when stable.
17/10/07	YDH	YDH	Dr K contacted CAIT by		CAIT will discuss	

	(Medical Notes)		telephone		strategy and CSC area allocation with CSC Medical report faxed and photographs e-mailed to CAIT.	
17/10/07	YDH (Medical Notes)	YDH	Dr K contacted Bristol Surgical registrar by telephone to inform her of Child D's transfer and to ensure the accepting team aware of Child Protection concerns		Surgical registrar confirmed knowledge of CP concerns – will contact Dr L M when Child D seen.	
17/10/07	YDH (Medical Notes)	YDH	Phone call to Dr K from CSC Bristol		History and Child Protection concerns discussed.	
17/10/07	FHVR (HV, SPCT, Named Nurse YDH)	HV, SPCT Named Nurse, YDH	HV informed by Named Nurse, Yeovil District Hospital NHS Foundation Trust, that Child D had been admitted to the hospital the previous evening and being transferred to Bristol Children's Hospital later that today with a probable perforated duodenum and liver.		HV gave information on her previous involvement with the family.	Important and necessary information sharing to ensure correct information is known by all agencies involved.
17/10/07	FHVR	Somerset Children's Social Care, (SCSC); Avon and Somerset Police Child Protection Unit; SPCT Designated Nurse;	FHVR records that HV liaised with all the agencies listed verifying known information about the family and the extent of HV involvement. Maternal Grandmother voiced concerns regarding (Parent 1) often being "spaced out". She raises concerns about a lack of supervision for both children;		HV passed on information received from Maternal Grandmother to Children's Social Care.	Important and necessary information sharing to ensure accurate assessment of the family can be made. Protective to children. Possible conflict of

		Maternal Grandmother	that both parents “give in” to the children and that there are few behaviour boundaries in place. She also informs HV that Sibling 1 has been known to jump on Child D in the past.			interest as Maternal Grandmother known to HV as previous colleague.
17/10/07 12:39	Paed Surgical Reg. UBHT A&E notes	Bristol Children’s Hospital	Child D transferred from Yeovil, Seen in A&E, BCH? Perforated bowel. Large bruise noted to back and left side face	Child D seen		H/O fall from sofa whilst in c/o Dad yesterday. Started vomiting, took to GP. Noted concerns about bruising, Child protection procedures started. Parents noted to be methadone users. Child D looks underweight
17/10/07 13:00	Cons Paed Surgeon. UBHT hospital notes	Bristol Children’s Hospital	S/B Surgical team	Child D seen	Admitted to ward 31, for observation, CT scan, and surgical review.	
17/10/07 16:40	Dr L M. UBHT, hospital notes	Bristol Children’s Hospital	S/B Consultant Community Paediatrician. ? NAI. All visits to be supervised.	Child D seen	Full examination and history taken. Body map	Child D is underweight (well below 0.4th Centile). Will need skeletal survey, ophthalmology R/V, further bloods, when stable.
17/10/07 19:30	Nursing Notes UBHT	Bristol Children’s Hospital	Message from CAIT, Dad has been arrested and is being questioned			

17/10/07 22:20	Dr W UBHT, hospital notes	Bristol Children's Hospital	Laparotomy and closure of jejunal perforation under GA. Signs of peritonitis	Child D seen		Large haemorrhage found at root of bowel mesentery, small perforation in proximal jejunum. Findings consistent with injuries from RTA
18/10/07 11:30	Nursing notes, UBHT	Bristol Children's Hospital	Mum interviewed by CIAT on ward.			
18/10/07 13:30	Dr L M UBHT, hospital notes	Bristol Children's Hospital	Strategy discussion held, Social Work dept, BCH		Medical/ police investigations to continue. Supervision of parents to continue	Multi –agency plan prior to discharge.
19/10/07	Dr L M UBHT, hospital records	Bristol Children's Hospital	Community Paed R/V		Blood results would be compatible with liver trauma, to repeat some to confirm.	Explained current situation to Mum. Mum asked if Child D's small size would make her more at risk. Mum informed this unlikely. Confirmed injuries were result of severe trauma.
19/10/07 14:10	Mr Z. UBHT, hospital notes	Bristol Children's Hospital	Ophthalmology R/V	Child D seen		No sign of retinal haemorrhages
19/10/07	Dr L M. UBHT, hospital notes	Bristol Children's Hospital	CT scan shows? Right occipital skull fracture. TBC	Child D seen	For skeletal survey when well enough	
22/10/07	Dr L M.	Bristol	Skeletal Survey performed	Child D		Confirmed vertical

	UBHT, hospital notes	Children's Hospital		seen		fracture right occipital bone.
23/10/07	YDH (Medical Notes – Sibling 1)	YDH	Sibling 1 (Sibling 1 - sibling) examined by Named Doctor at the request of CSC. Sibling 1 seen with maternal grandmother and father. Sibling 1 medically well with no evidence of injury, though abnormally upset by the examination. (Parent 1) noted to be aggressive at times, and staff voiced concerns about his interactions with Sibling 1. (Parent 1) had a marked tremor, which caused him marked difficulty when dressing Sibling 1.	Sibling 1 seen	Report sent to CSC, Named Doctor for Child Protection, Health Visitor, and GP	
24/10/07	T S TC. SG Progress Notes	Somerset Partnership	(Parent 1): Telephone call from SG (who is off sick) re family developments			This is when Child D was injured
25/10/07	Nursing notes, UBHT	Bristol Children's Hospital	Call from SW informing ward that Child D is not to be discharged to C/O parents			? to be discharged to Yeovil Hospital of foster parents.
30/10/07	X-ray report in UBHT hospital notes	Bristol Children's Hospital	Chest X-ray, Normal			
31/10/07	Dr L M. Confidential Medical report.	Bristol Children's Hospital	Copy of Confidential Medical report, summarising treatment and investigations at BCH. Acknowledges plan to			

	UBHT notes		discharge to foster parents on 1.11.07. Copy to Health and Social Services partners.			
01/11/07		Bristol Children's Hospital	Child D discharged into foster care.			

02/11/07	YDH (Medical Notes – Sibling 1)	YDH	Letter from Royal Liverpool Children's NHS Trust received after a request for information from Named Doctor re Child D's sibling Sibling 1. Two episodes when Sibling 1 taken to A&E in Liverpool in August 2004 detailed. On both occasions Sibling 1 found to be well, with appropriate attendance and no concerns re. NAI			
20/11/07	Local Pre-School Supervisor	Local Pre-School	Sibling 1 left pre-school			No issues or concerns about Sibling 1 during her time at pre school. She made good progress and described as a happy child with a good relationship with mum. Gran or mum took / collected Sibling 1 – Child D seen on one occasion as usually left in the car. Dad never went to pre-school, so not known by pre-school
10/12/07	Police / Inter-pol	Avon & Somerset Police	Information suggested that (Parent 1) lived in Germany for a time in or around 1980. Inter-			Information received through HQ SPOC

			pol check shows that he was registered with Hamburg aliens authority having entered Germany on 16.05.1980			
10/12/2007	Police / Inter-pol	Avon & Somerset Police	Checks re possible criminal conviction and intelligence held by Germany. These are negative i.e. no information held on R. apart from that mentioned above.			Information received through HQ SPOC
10/12/07	Police	Avon & Somerset Police	Police National Computer check on (Parent 1) shows no arrests or convictions apart from that for this matter.			
10/12/07	Police	Avon & Somerset Police	Police National Computer check on Parent 2 shows nothing, ie no record held.			
10/12/07	Police	Avon & Somerset Police	Impact Nominal Index (INI) check on (Parent 1) only shows BTP information as previous disclosed			Information received through HQ SPOC.
10/12/07	Police	Avon & Somerset Police	Impact Nominal Index (INI) check on surname only shows BTP information as previous disclosed.			Information received through HQ SPOC
11/12/07	YDH (Medical Notes)	YDH	Child D review in general paediatric outpatient clinic	Child D seen	Good recovery from injuries noted 16/10/07. Weight, length and head circumference all on 0.4th centile – probably a normal small child	

					Appointment to review Child D in clinic in 3 months arranged.	

Glossary of Abbreviations in the Document

AL	Named Pain Relief Nurse
BCH	Bristol Children's Hospital
BTP	British Transport Police
CSC	Children's Social Care
DNA	Did Not Attend
Dr A	Drug Service Psychiatrist
Dr D	General Practitioner with Special Interest
Dr K	Named Doctor for Child Protection, YDH
Dr L M	Community Paediatrician, BCH
DVLA	Driver Vehicle Licensing Agency
DW	Named Pain Relief Nurse
Child D	Subject
Parent 2	Mother
FH	SDS Social Worker
FHVR	Family Health Visiting Record
GMC	General Medical Council
GP	General Practitioner
GPwSI	General Practitioner with Special Interest
GSCC	General Social Care Council
HV	Health Visitor
Sibling 1	Sibling
Sibling 1R	Internal Management Review
JW	Team Leader, SDS
LSCB	Local Safeguarding Children Board
MDS	Other Area Drug Service
MMR	Measles, Mumps, Rubella vaccination
PHCR	Parent Held Child Health Record
R/(Parent 1)	Father
SCBU	Special Care Baby Unit
SDS	Somerset Drugs Service
SG	Named LDS Worker
Sompar	Somerset NHS & Social Care Partnership
SPCT	Somerset PCT
TS	Primary Care Substance Misuse Nurse
UBHT	United Bristol Healthcare Trust
YDH	Yeovil District Hospital