WORCESTERSHIRE SAFEGUARDING CHILDREN BOARD

Independent Overview Report of the Serious Case Review concerning

The death of baby Isaac

This report has been commissioned and prepared on behalf of the Worcestershire Safeguarding Children Board.

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1 Introduction

1.1. In July 2017 the Worcestershire Safeguarding Children Board (WSCB) decided to undertake a Serious Case Review in respect of a baby who will be referred to as Baby Isaac. It was agreed that the criteria for carrying out a Serious Case Review as defined by Working Together to Safeguard Children 2015[1] had been met.

Baby Isaac was 12 weeks old when Mother found him to be unresponsive and called an ambulance. Despite medical attempts Baby Isaac did not survive and the initial assessment was that the death was resultant from a co-sleeping incident. Evidence collected by the Police found that Mother and Father were drunk the previous evening and Baby Isaac had been placed on Mother's bed by a relative. Parents were arrested and following further investigation by the Police no charges were made. The siblings of Baby Isaac had been subject to a Child in Need Plan (CiN)[2] which was closed when Baby Isaac was 17 days old.

Summary of learning

Learning Point 1 (Assessment)

This review found that whilst there were initial concerns about the alcohol consumption of Mother and Father these were not fully explored by professionals from any agency. Over time, parental minimisation of alcohol use was accepted by professionals and a serious incident was perceived as an isolated occurrence. Therefore the impact of parental alcohol use on the capacity to parent was not recognised and the lived experience of the children was unknown.

Learning Point 2 (Voice of the Child)

When children and young people speak directly to Practitioners it is not sufficient to just record what has been said. If the voices of young people do not inform assessments and subsequent interventions, it is likely that they will not feel listened to, intervention may not be appropriate and concerns could escalate.

Learning Point 3 (Early Help Support)

Early Help Support lacked coordination and therefore had limited impact. There was a lack of clarity about the role and purpose of Early Help which contributed to a limited understanding among partners about Early Help and the responsibility of relevant agencies to support delivery of the Early Help offer through Universal services.

[1] Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children, HM Government 2015

[2] A child in need is defined under the Children Act 1989 (Section 17) as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled

Learning Point 4 (CiN process – the Plan)

A Child in Need Plan should focus on the assessed needs of children and families. Intervention or support to meet these needs should be explicit about expectations, outcomes and available resources to support the implementation of a Plan. Without this focus and clarity practitioners may develop a false reassurance about the effectiveness of support provided to children, young people and families, the issues of concern may be lost and the needs of the children may be overlooked.

Learning Point 5 (CiN process – joint working)

Effective partnership between agencies is essential when implementing a Child in Need Plan. Without the engagement and contribution of all relevant professionals it may be difficult to understand the significance of some events or disclosures by children, important opportunities for intervention may be lost and the Plan will have limited impact.

Learning Point 6 (CiN Process- following change in family dynamics and closure of the Plan)

When the siblings of an unborn baby (UBB) are subject to a Child in Need Plan it is important that there is an opportunity within multi-agency CiN meetings to;

- discuss the impact of a new baby on the family circumstances
- include the UBB on the Plan with specific reference to risks and vulnerabilities
- ensure there is multi agency agreement prior to closure of the Plan.

Learning Point 7

Given the prevalence and acceptance of alcohol use in society it is possible that practitioners may normalise periodic excessive drinking and fail to recognise the serious consequences that non-dependent drinking can have on parenting capacity.

2 Methodology

2.1 This review has followed the Government guidance outlined in Working Together 2015 which states that SCRs should be conducted in a way that;

- Recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did

- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight

- Is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings[3].

[3]Working Together to Safeguard Children was updated and published in July 2018. Arrangements for reviews following the death of a child have now changed; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf

2.2 The purpose of this review was to identify whether improvements are needed in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice. Lessons learned both within and between agencies have been clearly identified and informed a programme of action for improvement which is sustainable and explicit about what is expected to change and within what timescale (Appendix i).

2.3 It was agreed that the review would consider the professional involvement with the family from an incident in May 2016 until March 2017 when Baby Isaac died. The incident was prior to the birth of Baby Isaac and resulted in the siblings being subject to a Child in Need Plan.

2.4 Information provided to the review included Individual Management Reports (IMR) from relevant agencies and an interagency chronology. Key practitioners, managers and agency safeguarding leads were invited to a Learning Event to explore issues relating to multi-agency practice during the timeline considered by this review. Participants involved in the initial Learning Event were invited to a Recall Event to study and debate the initial findings and lessons learned. The SCR Steering Group contributed to the findings and recommendations to ensure that actions resulting from this review complemented the improvement activities of the WSCB and Partner Agencies and avoided duplication. The contribution of all those involved enabled a greater understanding of the context in which practitioners and managers worked and maximized opportunities for organizational learning.

2.5 Relevant information prior to these dates was also considered and included a referral to Police by a neighbour who was concerned about the welfare of the children in December 2014.

2.6 The detailed Terms of Reference considered throughout this Review and addressed within the IMR's are included at Appendix ii. In summary, the review focussed on two overarching questions which broadened the opportunity for learning whilst retaining focus on the presenting issues;

- What can we learn about the effectiveness of practice in Worcestershire to identify substance misuse in parents/carers and how this impacts on actions to safeguard children and babies?

- What can we learn from this case about the assessment of risks and vulnerabilities (known at the time) and how these influenced decision making and intervention?

2.7 Much consideration was given to obtaining the wishes and feelings of the children in a way that was meaningful, child-focused and least likely to cause additional distress. Children's Services remain involved with the family and following significant reflection it was decided not to involve the two younger children directly in the review process. On balance it was thought that participating in the review would risk further trauma at what was known to be a difficult time. Sibling 4 was offered the opportunity to engage with the Review and chose to speak with a social worker about the support provided to the family during the period of relevance to this Review. The social worker shared the views of Sibling 4 with the author and these are reflected in this Review Report.

2.8 The parents agreed to speak with a social worker about their experience of support and intervention during the timeline considered by this Review. The views of Mother[4] are reflected in this Review Report.

3 The Family

3.1 Baby Isaac lived with Mother, Father and three half Siblings. A third half Sibling had left the family home and lived with their birth father.

3.2 For the purpose of this report the following family members are relevant;

Family member	Known as
Baby **Isaac**	Baby **Isaac**
Mother of Baby Isaac (and Half Siblings 1, 2 and 3)	Mother
Father of Baby Isaac (and Sibling 4)	Father
Half Sibling 1	Sibling 1[5]
Half Sibling 2	Sibling 2
Eldest Half Sibling, living with birth father	Sibling 3[6]
Half Sibling 4	Sibling 4
Mother of Father	Maternal Grandmother
Father of Father	Paternal Grandfather
Mother's Previous partner and father of Half Siblings 1,2 and 3	Mother's Previous Partner

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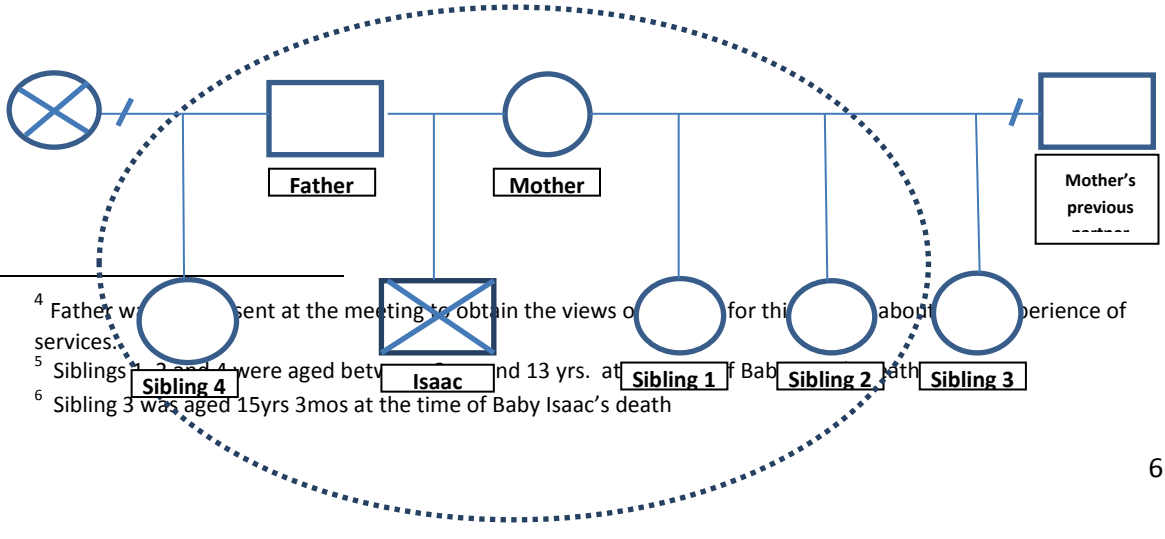

[4] Father w sent at the meeting to obtain the views o for thi about perience of services.

[5] Siblings 1, 2 and 4 were aged betv nd 13 yrs. at f Bab ath

[6] Sibling 3 was aged 15yrs 3mos at the time of Baby Isaac's death

4 Background Information

4.1 Police records indicated that Father was involved in three incidents in 1998, 2013 and 2014 and was intoxicated on each occasion. Police attended the family home over the Christmas period in 2014, following reports of a domestic dispute by a neighbour. Father stayed at Paternal Grandmothers house overnight to prevent further problems. Sibling 1, 2 and 4 were present at the time, a Police Referral was made to Children's Services and alcohol was recorded as a contributory factor.

4.2 Sibling 4 had been known to School Nursing Services since 2010 due to concerns around her emotional wellbeing. Following the incident at Christmas 2014 it was recorded that School Nurse 1 (SN1) planned to discuss the referral at a vulnerability meeting[7]. The outcome of this was not known.

4.3 Sibling 4 started at School 1 in September 2015 and in December made a disclosure to the class teacher that she had been self harming as a result of *bullying and things going on at home.* Sibling 4 was very tearful at the time and said that father had told her not to say anything because she was seeing a doctor at home. A referral was made to the School Nurse.

4.4 Sibling 4 repeated to SN1 that she was being bullied at school and was self harming. Sibling 4 said; *I don't like it when parents drink alcohol at the weekends as they end up arguing. I can go to Nan's (Paternal Grandmother) if I feel unsafe or unhappy.*

SN1 shared this information with Children's Services the following day.

4.5 In October 2015 SW1 informed School 2 that following an anonymous referral[8] a Social Work assessment was going to be completed. SW1 did not attend school to meet with Sibling 2 as had been arranged.

4.6 In February 2016 Sibling 4 made a further disclosure at school (to the School Nurse) about self-harming and bullying. Sibling 4 said that Father did not know about the self harm. A meeting took place with the Head of Year and Father who was advised to seek help from the GP for Sibling 4.

4.7 Immediately prior to the timeline for this review Mother and Father were caring for two nephews of Mother's due to safeguarding issues within their own family home. These children were subject to a Child Protection Plan[9] and had an allocated Social Worker.

[7] Vulnerability meetings are held in schools as a way of highlighting concerns and sharing information between school staff and school nurses.

[8] This referral was in fact made by Paternal Grandmother

[9] Children are subject to Child Protection Plans when assessed to be suffering from or at risk of significant harm, Children Act 1989.

5 Agency Involvement between May 2016 and March 2017

Various agencies were involved with the family during the timescale considered by this review. The support and intervention provided by key agencies is detailed below.

Warwickshire and West Mercia Police

5.1 Police attended the family home in May 2016 following an allegation that Mother and Father had assaulted Sibling 4. Mother and Father were intoxicated at the time and arrested on suspicion of common assault. Both were released after interview with no charge following consultation with Children's Services. Mother and Father declined a referral to drug and alcohol services for support. The Police made a written referral to Children's Services and records indicate that the children were placed on a CiN Plan. The Police had no further involvement with the family prior to the death of Baby Isaac.

Worcestershire Children's Services

5.2 A Strategy Discussion was held with the Police in May 2016. Professionals from Heath and Education were not consulted. Mother's nephews were accommodated by the Local Authority and moved to foster placements. Sibling 4 moved to stay with Paternal Grandmother.

5.3 A working agreement was put in place which outlined that Mother and Father were not to physically chastise the children, be intoxicated in front of the children or expose them to domestic abuse. Sibling 4 returned to the family home after a few days. At this time Siblings 2 and 4 were accessing direct support from Early Help Practitioners following a previous referral. Mother informed the Review that she could not recollect a working agreement.

5.4 Following Section 47 Enquiries[10] and a Social Work Assessment it was concluded that the children were to be supported by a Child in Need Plan which included the provision of support for Mother and Father in managing what was described as the challenging behaviours of the children as well as accessing support regarding their own alcohol use. It was recognised that parental alcohol misuse was an aggravating factor.

5.5 In July 2016 prior to conclusion of the Social Work assessment an Early Help Action plan was implemented and Sibling 4 had ten sessions with an Early Help Worker which concluded in October 2016.

5.6 The first CiN meeting took place in June 2016 and the second in September. Mother and Father did not attend the September meeting as the date clashed with the 20 week scan for Baby Isaac. SW1 informed the meeting that Sibling 4 was receiving bereavement counselling and support from an Early Help Worker. It was recorded that there was ongoing tension in family relationships and that Mother and Father were expecting a baby in January 2017. There had been no further reported incidents involving alcohol consumption and it was reported that Children's Services were planning to close the case.

5.7 SW1 left the authority in September 2016 and SW2[11] was allocated to work with the family. It was recorded that SW2 would remain involved until a Family Group

[10] A Section 47 Enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

[11] Social Worker in training

Meeting[12] had taken place. The referral for the Family Group Meeting noted that the purpose was to specifically address safety arrangements around the times when Mother and Father drank alcohol. The supervision record for SW2 noted that; *family plan to be developed to identify how the extended family can prevent family breakdown and support Sibling 4.*

5.8 SW2 completed the parenting support work with mother and Father[13] and at the request of the family continued to offer support until after the birth of Baby Isaac. A final Child in Need Meeting took place in January 2017.

5.9 Mother, Father, Health Visitor 1, Baby Isaac, SW2 and a representative from School 1 attended the final CiN meeting. It was recorded that there was agreement from all agencies to close the CiN Plan as it was assessed that the threshold for ongoing intervention and support was not met. Baby Isaac was 17 days old at this time.

Worcestershire Acute Hospital NHS Trust

5.10 Mother informed Community Midwife 1 (CMW1) of Children's Services involvement with the family during a home visit to complete the Pregnancy Booking History. CMW1 referred the family to Specialist Midwife 1 (SMW1) who made a home visit to establish safeguarding concerns and noted that a social worker was involved due to difficulties with the children within the family. Mother was asked about alcohol consumption at two ante natal appointments and stated that she was not drinking alcohol whilst pregnant.

5.11 Baby Isaac was born at WAHT and records indicate that cot death was discussed with Mother and a leaflet provided prior to discharge. Hospital midwives informed Children's Services about the birth of Isaac and were advised that the case was closed.

Worcestershire Health and Care NHS Trust

5.12 In December 2015 Sibling 4 told SN1 that things weren't good at home and said that she wasn't getting on well with her Step-Mum and to a lesser extent her Dad and felt her Step Mum has turned Paternal Grandmother against her.

5.13 In June 2016 SW1 informed SN1 about the incident in March and advised that a CiN meeting would take place. SN1 recorded that Parents were under the influence of alcohol, it was a Bank Holiday Monday. Alcohol use and verbal arguments were noted as a concern as parents struggled to manage the behaviours of Sibling 4. SN1 attended the initial CiN meeting.

5.14 In July 2016 SN2 met with Sibling 1 who reported that things at home had improved a little since the social worker had become involved. Sibling 1 shared that Mother and Father sometimes argued and became violent when they were drunk and said that when this happened all the siblings went into a different room to phone Paternal Grandmother.

5.15 Sibling 4 had two further appointments in September and October with SN1 and reported that things were good at home and they were excited that Mother was expecting a baby.

[12] A family group meeting is an opportunity for family members to get together to make a plan for their child which addresses the problems identified by professionals who know the child (like a teacher or social worker), with extra help being given by the agencies involved.

[13] Mother said she was unable to attend parenting classes due to work commitments. It was agreed that SW2 (a student with experience in family support work) had the capacity and skills to deliver this work which was completed at the family home.

5.16 The Health Visiting Service was informed of Mothers Pregnancy in autumn 2016[14] and an antenatal appointment was planned. Baby Isaac was born 4 weeks preterm and the antenatal visit did not take place. SW2 informed Health Visitor 1 that the CiN plan was soon to close and alcohol consumption by Mother and Father was not identified as a significant concern.

5.17 Health Visitor 1 (HV1) completed a New Birth home visit and it was recorded that routine health promotion topics were discussed which included Safe Sleep. HV1 recalled that she spoke about safe sleep in relation to alcohol although she had no information at that time that alcohol consumption was a problem. HV1 did not view the bedroom where Baby Isaac slept but saw the Moses basket where he slept which was downstairs at the time. HV1 advised Mother and Father to be cautious when carrying the Moses Basket upstairs as this was a known risk.

5.18 In January 2017 SW2 informed SN1 that Sibling 4 had been unsettled over Christmas as it was the anniversary of her Mother's death. SN1 met with Sibling 4 on two occasions and she said that things were generally good at home since baby Isaac had been born.

5.19 The final CiN meeting took place in January 2017 this was recorded by the HV but not by the SN as she did not attend the meeting. SW2 reported that she had completed parenting work. The final CiN Plan was to be updated and circulated to professionals however this was not received by School 1, School 2, the HV or SN.

Worcestershire Clinical Commissioning Group

5.20 Mother, Father, Sibling1, Sibling 2 and Sibling 4 were registered with GP1 however there was no link to show that they lived in the same household. There was no record about the CiN Plan or notification of concern regarding the alcohol consumption of Mother and Father as this information had not been shared with the GP.

5.21 Father and Paternal Grandmother took Sibling 4 to see GP1 following the incident in May 2016 which resulted in the arrest of Mother and Father. The GP was informed that Sibling 4 had anger management issues, Children's Services were involved and counselling was being sought.

5.22 At the eight week check for Baby Isaac GP1 noticed a smell of alcohol, Mother and Father stated they had drunk a couple of cans the previous night. GP1 shared this information with HV2 who recorded that there were no safeguarding concerns and the GP had shared the information in the best interests of Baby Isaac. HV2 planned to inform HV1 when she returned from unplanned leave.

Secondary School (School 1)

5.23 The Head of Year attended the three CiN meetings in June and September 2016 and January 2017. It was noted in the IMR for School 1 that there was little information on school records to evidence what had been discussed.

5.24 In late November 2016 School 1 received a letter from Children's Services to confirm that SW2 was the new SW allocated to Sibling 4. School 1 received an invite to the final CiN meeting in January which was attended by the Head of Year.

[14] The ante natal sheet was signed by midwife on completion and health visitor on receipt but not dated.

5.25 Sibling 4 was visited in school by professionals from an Early Help Provider (5 occasions in September/October 2016) and Footsteps[15] (fortnightly from September 2016). There is no school record about the content of these meetings. On one occasion three professionals from different agencies attempted to meet with Sibling 4 on the same day.

Primary School (School 2)

5.26 In June 2016 School 2 was informed by email from SW1 that there had been an incident at the family home and a CiN meeting had been planned. Concern about the use of alcohol by Mother and Father was noted in the email. The Head Teacher (HT1) attended the initial CiN meeting.

5.27 There was no record of involvement between School 2 and Children's Social Care between the first CiN meeting in June 2016 until January 2017 when an invitation to attend the final CiN meeting was received. HT1 was aware that a CiN meeting had been held in the summer holidays, this was not attended by a representative from School 2.

5.28 In March 2017 Sibling 2 told the class teacher and a student on placement about being worried because *mum and step-dad were drinking and having arguments*. This information was passed to HT1 who invited Mother into school to discuss the concerns.

5.29 Mother informed HT1 that they were experiencing challenges with Sibling 4 at home and the arguments were between Sibling 4 and Father. Mother said that there was no excessive drinking. The following morning HT1 spoke to Mother and Father on the school playground and had no concerns about their presentation.

Women's Aid

5.30 A referral was made for Mother to attend the Freedom Programme (A Domestic Abuse 12-week awareness raising and support programme for Women). Domestic abuse had been identified as a contributory risk factor following the arrest of parents in May 2016 and provision of support with domestic abuse was included as an action in the CiN Plan. Mother attended three sessions[16] and declined to attend further sessions stating that she had not experienced domestic abuse.

6 Analysis

6.1 Identification of themes within this analysis was influenced by the overarching questions central to this review;

- What can we learn about the effectiveness of practice in Worcestershire to identify substance misuse in parents/carers and how this impacts on actions to safeguard children and babies?

- What can we learn from this case about the assessment of risks and vulnerabilities (known at the time) and how these influenced decision making and intervention?

[15] FOOTSTEPS, supporting bereaved children, young people and their families in Worcestershire.

[16] An introductory session and two further sessions

6.2 Information provided by practitioners and managers who attended the Learning Event and Recall Event and information contained in IMR's was considered throughout. The views of Sibling 4 and Mother are reflected in the analysis.

6.3 Specific themes emerged following systematic analysis of all the available information. Exploration of each theme enabled rigorous examination of practice and identification of opportunities to improve the systems to safeguard children in Worcestershire.

6.4 Whilst the analysis of each theme is presented separately it is important to note that each theme impacted on the others in a systematic and dynamic way. For example, omission to fully explore alcohol consumption by Mother and Father within the Social Work Assessment influenced the type of intervention and support offered to the family. In addition, limited information sharing impacted on the ability of practitioners to appreciate and understand the potential importance of isolated incidents relating to the alcohol consumption by Mother and Father.

6.5 The themes identified were;

- Information sharing, inter and intra agency communication
- Effectiveness of the CiN process and multi-agency working
- Effectiveness of assessment - parental alcohol use and the impact on parenting
- Professional understanding of the Children's lived experience
- Escalation of professional concerns

Each theme will be considered in turn.

<u>Information Sharing, inter and intra agency communication</u>

6.6 It was acknowledged within the agency reports that information sharing between agencies during the timeline considered for this review was very limited and impacted on the ability of professionals to fully understand the issues of concern.

6.7 The strategy discussion between Police and Children's Services in May 2016 did not involve representatives from Health or Education and there was a delay in informing partner agencies about the Section 47 Enquiry and Social Work Assessment. This mirrors a finding noted in the 2017 Ofsted Report;

> *Many child protection strategy meetings do not involve all relevant agencies, to inform a thorough 'live' discussion of the presenting risks to children (p12)*

6.8 Six months before the Strategy discussion in May 2016 Sibling 4 had disclosed to the School Nurse that *she didn't like it when parents drank alcohol at the weekends as they end up arguing*.

6.9 This information was not considered at the Strategy discussion. Had the disclosure about alcohol consumption been shared it may have been more difficult for Mother and Father to minimise or deflect concerns. Professionals would also have had a greater understanding about the emotional wellbeing of Sibling 4 to inform subsequent enquiries.

6.10 It was noted within the IMR from Children's Services that, during the timeline for this review, there was a recurrent theme of Sibling 4 being at the centre of family

dysfunction and a scapegoat for problems within the family[17]. Mother informed this Review that Sibling 4 was not a scapegoat and said that she strongly believed that Sibling 4 had additional needs which the family needed help to manage. Lack of effective information sharing contributed to the view expressed by professionals and family members that Sibling 4 was the cause of much family dysfunction.

6.11 This view served to deflect attention from the incident in May 2016 in which it was known that Mother and Father had been intoxicated following excessive alcohol consumption and arrested due to an alleged assault on Sibling 4. The impact of Parental alcohol consumption on the children was not addressed. Sibling 4 informed the Review that *we had a little bit of a bust up, I got pinned down on the floor and it all kicked off*[18].

6.12 Children's Social Care had been aware of Mothers pregnancy from 16 weeks gestation however there was limited communication between Children's Services and Midwifery Services until the birth of Baby Isaac. Mother had informed the Specialist Midwife (SMW) that that a social worker was involved with the family due to difficulties with the children and there was no reference to concerns about parental alcohol use. SW1 advised Midwifery Services that Children's Social Care were involved due to complex family dynamics.

6.13 The detail within maternity records about the reason for the involvement of Children's Services was very sparse. The IMR for WHAT noted that SW1 had advised that assessment findings and plans would be communicated however no further information was provided. Midwifery services were unaware that a CiN Plan had been initiated and there was no documentation on file to confirm that the CiN Plan had been closed.

6.14 When hospital midwives informed Children's Services about the birth of Baby Isaac they were advised that the case was closed. In fact, Baby Isaac had not been considered within the CiN Plan and a pre-birth assessment had not been completed. Siblings 1, 2 and 4 remained subject to a CiN plan at this time and it was unclear which record had been closed.

6.15 SW2 informed HV1 about the birth of Baby Isaac and advised that a CiN Plan had been in place but was soon to close. It was explained that parenting support had been provided to address complex family dynamics. Information about the incident which involved excessive alcohol consumption by Mother and Father and resulted in the referral to Children's Social Care was not shared.

6.16 Concerns over alcohol consumption and related violence were minimised by Mother and Father. Mother said that Sibling 4 had lied about being assaulted by Father and herself and this was supported by PGM. The decision by Police to refer to Children's Services and not take further action appeared to be appropriate given the available information. However, due to lack of information sharing and inadequate assessment, Health practitioners were unaware of the presenting concerns regarding excessive

[17] Examples of when Sibling 4 was scapegoated include; Father and Grandmother informed the GP that Sibling 4 had 'anger management issues', the FGM focussed on support for Sibling 4 and Mother and Father informed the HT at School 2 that they were experiencing difficulties with Sibling 4 when discussing the disclosure by Sibling 2 regarding parental alcohol consumption.

[18] Sibling 4 phoned a friend and said that she was being assaulted and the friend's parents contacted the police.

Parental alcohol consumption, and were unable to address this in their involvement with the family.

6.17 Information regarding safe sleeping and Cot Death is given to mothers on four occasions but only recorded in the Personal Child Health Record (PCHR) on the first postnatal home visit by the Midwife and Health Visitor. A single agency recommendation has been made to ensure that recording regarding the provision of information regarding cot death to parents is more robust at the 6 week review.

6.18 It was evident that information was not appropriately shared with the GP Practice by Children's Social Care. There was no record within the GP practice about parental alcohol use or that the children were subject to a CiN Plan. This is poor practice and does not effectively safeguard children. The IMR for Worcestershire Clinical Commissioning Groups noted that there was a culture within Worcestershire County Council in which CiN records were not shared with GP Practices particularly if they had not attended the CiN meeting. This has emerged as a finding within a previous Serious Case Review and is being addressed by the WSCB and partner agencies.

6.19 Information was not appropriately shared between Women's Aid and Children's Social Care. The referral form for Women's Aid specifically asks for information about safeguarding concerns and involvement of Children's Services with the family. SW1 omitted to inform Women's Aid about the incident in May 2016 or the fact that the children were subject to a CiN Plan. In addition, Women's Aid omitted to inform Children's Services when Mother withdrew from the Freedom programme. Inadequate information sharing impacted on the ability of both agencies to work effectively with Mother.

6.20 When Mother's pregnancy was confirmed, information about the CiN Plan should have been shared with the GP Practice by Midwifery Services. However, this was not possible, as Midwifery Services were not aware that a CiN Plan was in place or that that there had been concerns about Parental alcohol consumption. A single agency recommendation has been made to ensure that copies of all CiN or Child Protection Conference minutes are shared with the relevant GP Practice. This improved practice of sharing information should be evidenced as part of WSCB's multi-agency audit programme in 2018/2019. In addition, the GP Practice was not aware that a code was available to flag that a child is subject to a CiN Plan and will review their system to align with other Practices across Worcestershire.

6.21 As the GP had not been informed of the incident which resulted in the arrest of parents in May 2016 it was easier for Father and Paternal Grandmother to deflect attention away from the fact that both Mother and Father had been intoxicated and present Sibling 4 as a young person with 'anger issues'. It would have been good practice for the GP to see Sibling 4 alone to explore the underlying cause of the alleged 'anger issues' however this did not happen.

6.22 It is not possible to state with confidence what Sibling 4 was attempting to communicate by her behaviour and this was not considered within the social work assessment. Learning points from previous SCRs have highlighted the importance of recognising behaviour as a means of communication and the implications of doing so for practice. (Ofsted (2011) p18[19], Sidebotham P. Brandon M. (2016) p118[20]).

[19] The voice of the child: learning lessons from serious case reviews Ofsted 2011

[20] Sidebotham P., Brandon M. et al Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011- 2014 London: Department for Education 2016

Omission to understand the child's lived experience is discussed further under the heading Voice of the Child.

6.23 The GP was not aware of previous concerns with regard to the alcohol consumption of Mother and Father. When parents presented for the 8 week check smelling of alcohol with Baby Isaac there was lack of critical questioning to elicit the amount of alcohol that had been drunk. The potential impact on Isaac and their capacity to parent was not discussed. Whilst the GP shared this information with HV2 this was not followed up and there was limited consideration about what it was like for an 8 week old baby living with parents who had consumed enough alcohol that the GP could smell it on them the following morning.

6.24 HV2 was new to the GP Practice, did not know the family and planned to wait for HV1 to return to work following unplanned leave. There was no evidence that the GP and HV2 discussed the best way to respond to the concern about Mother and Father smelling of alcohol at the 8 Week check for Baby Isaac. It would have been appropriate for GP1 to exercise healthy scepticism and challenge Mother and Father further as the information provided did not correlate with their presentation[21].

6.25 School 1 and School 2 received letters from Children's Social Care in November 2016 which acknowledged the challenges within the service and advised that SW1 left the authority in September and SW2 had been allocated to work with the family. The change in SW impacted on communication with the family and agencies. Both Mother and Sibling 4 spoke positively about SW2 and said that prior to this they had not felt understood and had been chasing for things to be followed up. Omission to share information effectively within and between agencies impacted on all the other themes identified within this Review as highlighted below.

<u>Effectiveness of the CiN process and multi-agency working</u>

6.26 The Child in Need process did not meet expected guidelines[22]. Visits by the social worker to the children and review meetings did not take place within six and eight weeks respectively which was the minimum requirement. There was a lack of communication between agencies and practitioners did not have a shared understanding of the key issues and concerns. The serious incident which triggered the CiN plan was not fully explored and the impact on the children of parents being arrested whilst intoxicated was not considered by any agency.

6.27 There were a series of failed CiN meetings which resulted in drift of the case and will have impacted on the effectiveness of interventions. There was a lack of coordination and School 1 informed the review that on one occasion three professionals from different agencies attempted to meet with Sibling 4 in school on the same day. Sibling 4 informed the Review that she did not like meeting people at school and said; *the teacher would always moan if I had to see someone and I would have to see them at break or lunch. I didn't like that because it's my time.*

6.28 It was acknowledged in the IMR submitted by School 1 that implementation of the CiN Plan lacked a holistic approach. It was noted that the involvement of multiple professionals from different agencies was at times overwhelming for Sibling 4 and had limited impact.

[21] It would be unlikely that the GP would be able to smell alcohol on Mother and Father if they had only consumed two cans of alcohol the previous evening.

[22] http://worcestershirecs.proceduresonline.com/chapters/p_cin_plans_rev.html#cin_plans

6.29 It was a significant omission that the CiN Plan was not shared with relevant agencies. From information provided to this review the actions and interventions within the plan focussed on the improvement of family relationships. Domestic Abuse and Alcohol consumption by Mother and Father was not considered to be a significant concern and the incident which resulted in the S47 Enquiry in May 2016 became increasingly understood, described and accepted as an isolated occurrence.

6.30 There was limited involvement of partner agencies, Mother and Father in the CiN process. There also appears to have been no consideration given to the children attending the CiN meeting which is both expected procedure and good practice. It appears that the children were not aware of the CiN plan and when asked about the support received Sibling 4 made no reference to the CiN process.

6.31 In contrast, Mother said that she did understand the purpose of the CiN Plan and stated that it helped her particularly and supported the family to do what they needed to for everyone to be happier at home. Mother said that she contributed to the CiN Plan, felt listened to and received copies of the paperwork. This view was not supported by Sibling 4 and there was limited evidence of parental contribution to and involvement in the CiN process. Given the omission to hold regular CiN meetings, the fact that Mother only attended two of these (one being the closure meeting in January 2017) and the limited communication with partner agencies, it is reasonable to conclude that the effectiveness of the CiN process in this case was limited. This was acknowledged by various agencies in the IMR's submitted to the Review and by Practitioners during the Learning Event. The WSCB are currently undertaking a review of Child in Need Processes as a result of findings from a previous Review.

6.32 It was not appropriate for agencies to be invited to a 'final' CiN meeting, as this implied that a decision had already been made by Children's Services to close the case. Supervision records for SW2 included a reference to closure of the case which evidenced management oversight of the decision. This practice was contrary to that outlined in the procedures for closure of a Child In Need Plan which states;

> *A decision to discontinue a Child in Need Plan should be taken at a Review Meeting and agreed by the Team Manager, to allow full consideration of the issues by all agencies and family member involved*[23]*.*

The IMR submitted to this Review by School 2 noted that the decision to close the case to Children's Social Care was based on evidence gathered by SW2 between November 30th 2016 and January 17th 2017. It was argued that this was insufficient time to ensure that all identified concerns had been resolved and plan appropriate support for the family to manage the impact of a new baby.

6.33 It was acknowledged in the IMR for Children's Social Care that there was lack of clarity about the role and remit of the involvement of Early Help Services following escalation of the case to the Children's Safeguarding Team. An Early Help action plan[24] was formulated in July 2016 prior to conclusion of the social work assessment. The 2017 Ofsted report noted that the delivery of Early Help was not well understood by partners and that more work was required to ensure consistent application of thresholds at every stage of the child's journey.

[23] http://worcestershirecs.proceduresonline.com/chapters/p_cin_plans_rev.html#close

[24] Sibling 4 received 10 sessions of support from Early Help services which concluded in October 2016.

6.34 Practitioners at the Learning Event noted that the provision of support initially to Sibling 4 by the Early Help practitioner[25] and subsequently to Mother and Father by SW2[26] contributed to the view that it was Sibling 4 that needed to change rather than the behaviour and responses of Mother and Father. It is possible that this enabled Mother and Father to further minimise their actions and there were continued examples of Sibling 4 being blamed for difficulties within the family whilst the alcohol consumption by Parents was overlooked.

6.35 Social Worker 2 delivered the parenting support sessions to Mother and Father and undertook what was described within Children's Social Care records as, *an intensive piece of parenting work*. This work concluded in January 2017 however it was unclear what, if any work was completed to explore parental alcohol consumption and the impact of this on parenting. From information provided to this review it seems that a pattern emerged of Mother and Father minimising the impact of their alcohol consumption and this being accepted without challenge or robust exploration by professionals.

6.36 The Family Group Meeting (FGM) was part of the CiN Plan and the focus of the initial referral for the FGM was to develop a support plan for when Mother and Father had been drinking. Supervision records for SW2 in September 2016 recorded that *a family plan to be developed to identify how the extended family can prevent breakdown and support Sibling 4.* Identification of Sibling 4 as in need of specific support was a further example of how attention was deflected from parental alcohol consumption by practitioners, Mother and Father.

6.37 When the FGM took place in November 2016 Mother's previous partner was not invited to the meeting because it was argued that the issue to be resolved related to family dynamics within the family home. It is not clear how this decision was made. Mother's previous partner was involved in the care of the Siblings 1 and 2, it is likely that he could have provided support and there was no clear rationale for his exclusion**.** Omission to assess the contribution that Fathers can make to safeguard children has been a consistent finding within Serious Case Reviews[27].

6.38 It was recorded that the children's voices were heard at the Family Group Meeting however as the focus was on family dynamics it was unlikely that the children would have said anything about how they felt when Mother and Father drank alcohol. Sibling 4 said, *I had to stay in my room when it (Family Group Meeting) happened. No one told me what it was about or asked me anything.*

6.39 The statement by Sibling 4 is in contrast with the principles of good practice which often underpin family group meetings[28]. These include hearing the voice of the child and involving the whole family in development of the family plan. Mother could not clearly recall the FGM.

6.40 It was unclear how or whether the FGM plan was communicated to other professionals or linked to the CiN plan. At a review of the FGM plan in December 2016 the family requested that SW2 continued to support the family until Isaac was born. It is unclear what additional support was required and the needs of Isaac were not considered

[25] 10 sessions between July and October 2016

[26] Parenting support during home visits in November 2016 until closure of the case in January 2017

[27] Hidden Men: Learning from Serious Case reviews. NSPCC, 2015

[28] Also referred to as Family Group Conferences, for more information see; https://www.frg.org.uk/the-family-group-conference-process

within the FGM plan or any other assessment. It was acknowledged by practitioners during this review that Baby Isaac should have been subject to a CiN plan in his own right.

6.41 Practice standards have subsequently changed and it was noted at the Recall Event that all children in the family including an unborn baby would be included in an assessment. Team managers now have access to robust monitoring procedures and if practice does not meet the recommended standards this would be identified at an early stage. Any drift in practice including visits by the social worker and frequency of CiN meetings which underpinned this case should be avoided in future.

Effectiveness of assessments - parental alcohol use and the impact on parenting

6.42 Practitioners at the Learning Event spoke about the normalisation and acceptance of alcohol consumption in society. It was noted in the IMR from Children's Services that referrals received prior to May 2016 and direct work undertaken since that time also indicated that there was a normalisation of alcohol consumption by Mother and Father. Practitioners acknowledged that this could have influenced the minimisation of concerns by professionals about the incidents which involved parental alcohol consumption and occurred over Christmas and a Bank Holiday, accepted times for celebration.

6.43 Initially domestic abuse had been identified as the main area of concern and was linked to excessive alcohol use. Mother and Father refuted that there was a problem with domestic abuse and it was acknowledged in the supervision notes of SW2 that referral to a domestic abuse programme had been disproportionate. Mother said that when she told SW2 that there was no domestic abuse in her relationship she was advised that she did not need to attend the Freedom Programme. Alcohol consumption was however clearly indicated as a risk factor within assessments, referrals and plans.

6.44 There was little evidence that domestic abuse and alcohol consumption had been assessed effectively. The Social Work assessment contained limited exploration of the insights of Mother and Father into the impact of alcohol use on their parenting. The IMR submitted by Children's Services acknowledged that Sibling 4 had insight into the impact of alcohol consumption on the mood and responses of Mother and Father. Whilst there was some discussion with Mother and Father (following the incident in May 2016) about the impact of their alcohol use on the children they were caring for, there was no record to evidence professional inquisitiveness and challenge. It appeared that the information provided by parents was accepted and prioritised over information provided by the children.

6.45 There was no evidence provided to this Review that consideration was given to the cause of the behaviour of Sibling 4[29]. Mother said that she believed Sibling 4 hated her and this was a natural reaction to the death of her own mother. Mother stated that she really did not believe that the alcohol consumption by herself and Father was the cause of family problems and explained that the outbursts by Sibling 4 were very difficult to manage. Mother and Father had requested to attend a parenting course for support to manage the difficult behaviour of teenagers but none were available at the time.

[29] There appears to have been an assumption by professionals that this was due to the death of Mother and bereavement support was required.

6.46 Deflecting attention from alcohol consumption by Mother and Father resulted in family dynamics, particularly the relationship between Sibling 4 and Mother becoming the primary area of concern. The report from Children's Services noted that the professionals involved with the family were more concerned with the relationship dynamics than the incidents triggered by the excessive alcohol consumption by Mother and Father. There was no consideration given to the underlying reasons for the behaviour of the children, particularly Sibling 4. There was a missed opportunity to explore the impact of alcohol consumption on the parenting ability of Mother and Father within the Social Work Assessment (SWA). Sibling 4 informed the Review that she did not think the drinking of Mother and Father was a problem which contrasts with information provided by the children to professionals during the timeline for this review.

6.47 The perspective of the children in relation to the alcohol consumption of Mother and Father was not adequately reflected within the SWA. Whilst there were occasions when the children told School Nurses and a teacher about how they felt when Mother and Father drank alcohol these views were not evidenced within Children's Services records. At the Learning Event Health Practitioners were clear that this information had been shared and was evidenced in records made by the School Nurse. Absence of a coordinated response to information provided by the children contributed to a lack of targeted work to understand the lived experience of the children, the extent of alcohol consumption by Mother and Father and the impact on their parenting.

6.48 There was a missed opportunity to include the views of Mothers Previous Partner within the SWA. At the Learning Event it was noted by Participants that Sibling 3 should have been involved in the assessment process. The circumstances which caused Sibling 3 to leave the family home to live with birth father were not explored. This is significant as Sibling 1 expressed a concern about having to live with dad when worried about the drinking of Mother and Father. It is possible that alcohol consumption by Mother and Father had been a trigger for Sibling 3 leaving the family home however this is not known.

6.49 The social work assessment, in this case, mirrored findings within the 2017 Ofsted Report[30] which noted that *Parents who are not living at the family home are not always adequately consulted, and their involvement and impact on children's lives are unexplored.* The Social Work Assessment was not holistic and there were some significant gaps in information. Omission to involve Mothers Previous Partner, Sibling 3, Maternal and Paternal Grandparents in the assessment process resulted in a partial understanding of the lived experience of the children and over reliance by social workers and managers on information provided by Mother and Father.

6.50 Mother and Father requested that SW2 remained involved with the family until after the birth of Baby Isaac. There were no concerns about home conditions and as noted within the IMR for Children's Services there was an understanding that it was occasional binge drinking that took place in the home which did not impact on the care provided to the children on a day to day basis.

6.51 A briefing by the NSPCC[31] highlighted that professionals have too often trusted parents' self reporting of their alcohol consumption. Substance misuse was known

[30] Worcestershire County Council, Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board Ofsted, January 2017 p12.

[31] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances/

32 http://westmidlands.procedures.org.uk/ykpzl/statutory-child-protection-procedures/additional-guidance#s537

about but not seen as excessive or problematic. The briefing noted that some reviews talk about tidy and clean homes and happy and healthy children. In this review Practitioners reported at the Learning and Recall Events that Mother and Father engaged well with professionals and it appeared that the views of Mother and Father of Baby Isaac were accepted without question. There was an absence of critical reflection and little evidence of professional curiosity by practitioners and managers involved with this case.

6.52 During the CiN process there was very little multiagency working and little consideration was given to the impact on family dynamics following the birth of Baby Isaac. There was no record of analysis of risks or vulnerabilities or how these may be reduced and monitored. The absence of a comprehensive social work assessment of Baby Isaac resulted in his needs not being explicitly considered should the parents be under the influence of alcohol. Whilst procedures were clear that a Pre-Birth assessment should be conducted when siblings are subject to a Child Protection plan[32] there was no such requirement at the time for when a Child in Need Plan was in place.

6.53 Assessments conducted during the timeline of consideration for this review were limited. The NSPCC briefing stressed the importance of thorough, timely and child focussed assessments with regards to all the children cared for by people who are misusing alcohol. Assessments should contain a clear picture of the alcohol consumption and usage and behaviour must be properly analysed to understand the risks that this poses to the children.

6.54 Key factors which had a negative influence on the assessment process included, normalisation of drinking excessive amounts of alcohol at holiday periods, acceptance of parental accounts without further exploration, omission to identify the impact of parental drinking on the child, inadequate focus on the voice of the child, and lack of professional curiosity. There was limited understanding about the extent of parental alcohol consumption by Mother and Father.

6.55 Mother and Father consistently minimised concerns and denied that there was a problem with their alcohol consumption. It was evident from disclosures by the children before and during the timeline for this review that parental alcohol use caused persistent problems within the family. The anxiety and distress experienced by the children as a result of Parental alcohol consumption was not explored or assessed.

6.56 Findings of a report published in 2017[33] on the effect of non-dependent parental drinking on children and families are of significant relevance to this review. The Report found that;

- *A permissive pro-alcohol environment has led to normalisation of drinking in a range of settings and 'culture blindness' to alcohol harm, masking issues which may affect children p4.*

- *Too much attention is paid to the amount and pattern of parental drinking, frequently neglecting the actual impact of parental drinking on children*

[33] "Like sugar for adults "the effect of non-dependent parental drinking on children and families. Alcohol Focus, Scotland, Institute of Alcohol Alliance, Alcohol and Families Alliance, October 2017

- *Parental drinking across a range of levels can affect children and it may be wrong to assume that lower levels of consumption are associated with no negative impacts for children*

- *Isolated incidents where children witness their parents to be tipsy or drunk may have a lasting effect.*

6.57 Undertaking a thorough assessment regarding parental alcohol consumption when there is no evidence of alcohol dependency is a significant challenge. Practitioners at the Learning Event spoke about the risk of moralising as there was general recognition of a cultural acceptance regarding excessive alcohol consumption at holiday times. It is essential that practitioners are equipped with the skills, knowledge and confidence to assess the impact of parental alcohol consumption on children regardless of the level of use. The SW assessment template has been amended to include information about the amount of alcohol consumed, frequency of drinking episodes and the impact on the children when parental alcohol use is a concern.

Professional understanding of the Children's lived experience

6.58 It was acknowledged in the IMR submitted by School 2 that more could have been done following the disclosure about Mother and Father drinking and having arguments to ensure that the lived experience of Sibling 2 was fully understood. A single agency recommendation has been made to improve practice. Lack of involvement with the Child in Need Process together with limited information sharing about previous concerns regarding parental alcohol consumption impacted on the significance that School 2 gave to the disclosure by Sibling 2.

6.59 At the Recall Event practitioners noted that their previous experience regarding the threshold of referrals to Children's Social Care impacted on decisions made following the disclosure by Sibling 2. It is a matter of concern that the professional response to the disclosure by Sibling 2 was influenced by perceptions of high thresholds which resulted from previous experience of making referrals to the Family Front Door[34]**.** Given the recent closure of the CiN Plan it would have been appropriate to refer back to Children's Social Care for further enquiries to be made however there was no procedure to enable this.

6.60 There was no evidence that Sibling 4 was spoken to alone when taken to the GP by her Father and Paternal Grandmother and therefore her voice was not ascertained or considered in the decision-making process. The GP appeared to accept what Father and Paternal Grandmother said without questioning and did not appear to value or explore the lived experience of Sibling 4. It was acknowledged in the IMR submitted by School 2 that none of the professionals involved understood the lived experience of Sibling 4 at home.

6.61 Sibling 1, Sibling 2 and Sibling 4 all disclosed concerns relating to the alcohol consumption of Mother and Father either during the timeline of consideration for this review or immediately before. There was evidence of good practice from teachers and School Nurses in listening to the children and sharing the information with Children's Services however this in itself was insufficient to impact on the provision of support for the children or professional challenge to parents.

[34] First point of contact with children's social care for professionals and members of the public to report concerns about a child.

6.62 The disclosures about the alcohol consumption of Mother and Father to three different professionals on separate occasions by Sibling 1, Sibling 2 and Sibling 4 were very significant. Professionals involved with the family did not appreciate the importance of what the children were saying and opportunities to respond appropriately were missed. The disclosures could be considered as an indication that the children lived with a consistent level of worry and significant concern. This is in contrast to the views of Mother, Father and subsequently professionals which emerged during this review, that the event in May 2016 was an isolated occurrence. Persistence of this view resulted in the impact of alcohol consumption by Mother and Father on the children not being sufficiently considered by any agency.

6.63 The opportunity for children to influence decisions which impact on their lives was highlighted in the Multi Agency Case File Audits undertaken by the Worcestershire Safeguarding Children Board. Themes and learning from 2015 – 16 highlighted;

> *Whilst the words of the child are being recorded in case files, the child's voice is not routinely influencing the decisions and actions taken to safeguard them*

6.64 When practice does not systematically enable the voice of the child to influence assessments and intervention this can have a significant impact on the quality of work undertaken to safeguard children. This was reflected in the Annual Report of Worcestershire Safeguarding Children's Board 2016-2017 with reference to the Ofsted inspection;

> *The inspectors identified lack of challenge, chronic drift and delay; which could be indicative of practitioners failing to consider the child's lived experience and promoting the voice of the child p28.*

6.65 It is important to note that listening to the voice of the child is a current priority for the WSCB and central to the eight-point improvement plan of Worcestershire Children's Social Care. Processes are in place to ensure that the child's lived experience is more effectively considered within assessments by Children's Social Care and partner agencies. It is important that learning from this review contributes to the ongoing improvement of multi-agency practice to listen to the voice of the child in a way that is meaningful and has a tangible impact on the practice of relevant Practitioners within all partner agencies.

<u>Escalation of concern</u>

6.66 It was acknowledged in many of the IMR's submitted for this Review that there were concerns about closing the CiN Plan so soon after the birth of Baby Isaac. The reports submitted by School 1 and School 2 were particularly critical as, from their perspective, there was insufficient information to ensure that identified needs within the CiN Plan had been met. The IMR submitted to this Review by School 2 reflected that there had been key points when the case could have been escalated using local procedures. This had not happened as due to limited safeguarding supervision, the drift with CiN processes had not been clearly understood.

6.67 There was a culture of acceptance amongst agencies that CiN plans were not routinely shared with partners. In addition, both School 1 and School 2 acknowledged the challenging context in which social workers were operating at the time. It is likely that historical omission to circulate plans and sensitivity to the challenges facing Children's Social Care impacted on the ability of schools to escalate concerns regarding the drift in CiN processes.

6.68 There was very limited challenge to CSC from partner agencies in Education and Health about the lack of minutes from CiN meetings, absence of a CiN Plan, drift between meetings and what was perceived by some to be premature closure of the CiN Plan.

6.69 It was noted in the IMR that Midwives did not demonstrate curiosity or understanding about the involvement of Children's Social Care and the issues of concern. There was little consideration of the impact a new born baby may have on the family and insufficient professional curiosity.

6.70 The case was not discussed in safeguarding supervision by either the School Nurse or Health Visitor as neither had information to increase their concerns. It was acknowledged by the School Nurse that this was less worrying than other cases and not considered to be a priority. Limited information sharing impacted on the ability of practitioners to assess concerns and consider whether escalation would have been appropriate.

6.71 The responsibility of relevant partner agencies to work alongside Children's Social Care to implement the CiN plan was acknowledged by Practitioners at the Learning Event. Single agency recommendations have been identified to ensure implementation of the escalation procedure when required.

7 Good Practice

7.1 It was significant that agencies struggled to identify good practice during the Learning and Recall Events. It was evident that practitioners were working within their specific agency to meet the needs of the children. The process of this review has provided an opportunity for practitioners to reflect on their practice and single agency action plans are included at Appendix (iii).

7.2 School Nurse 1 developed a good relationship with Sibling 4 and obtained the voice of the child, explored the lived experience and this was recorded in detail. The School Nurse kept Sibling 4 fully informed of relevant discussions with other professionals.

7.3 School Nurse 2 demonstrated good use of quizzes and a child friendly effective approach to explore the true feelings of Sibling 2.

7.4 Information was shared by the School Nurses with Social Worker 1 in a timely way.

7.5 The Health Visitor provided a good level of service and communicated well with the Social Worker despite challenging circumstances within the work environment.

7.6 Safe sleep guidance and assessment is embedded into Health Visiting practice and staff have confidence to deliver the information.

7.7 Midwifery practitioners were proactive and contacted Children's Social Care following the birth of Baby Isaac and prior to discharge.

8 Organisational Context

Worcestershire Health and Care NHS Trust

8.1 The Health Visiting and School Nursing services underwent a service redesign in autumn 2016 and teams were integrated into a combined 0-19 service. This was an unsettling time with low morale particularly for the health visiting teams who

experienced major change. HV2 had little or no induction as one HV left giving three weeks' notice and HV1 had to take unplanned leave. HV2 was an experienced practitioner and had worked for the Trust elsewhere. It was noted in the IMR that there was no evidence that staffing constraints impacted on the quality of care received during this time.

Worcestershire Acute Hospital NHS Trust

8.2 During the period considered by this Review two out of four Specialist Midwives were absent from their roles[35]. The High-Risk Vulnerable Women and Safeguarding Cases held by SMW1 were redistributed to Community MW and may have contributed to the delay in communication between Midwifery to Children's Services.

Worcestershire Children's Services

8.3 Children's Services in Worcestershire were assessed as inadequate by Ofsted in January 2017. Systemic failures were identified which resulted in children not being effectively protected and vulnerable children remaining at risk of significant harm[36]. The morale of staff was very low during this period and there was a high turnover of social workers and managers which contributed to drift and delay in decision making and management of cases.

8.4 There was a change of strategic leadership within Children's Services to direct the improvement journey for Children's Services and improve the quality of practice. Over the past eighteen months positive progress has been noted following three monitoring visits by Ofsted.

9 Conclusion, Learning and recommendations

9.1 The 2017 Ofsted report identified systemic weaknesses in the process and procedures to safeguard children in Worcestershire. Many of the issues highlighted by Ofsted have been reflected in this review. Whilst it is important to acknowledge the organisational context which impacted on the work of practitioners involved with the family of Baby Isaac it is essential that the single and multi-agency action plans evidence significant improvements in practice.

9.2 The Ofsted report noted that children were not effectively protected, and vulnerable children remained at risk of significant harm[37]. It was noted by the 2016 Triennial Review of Serious Case Reviews that; *breakdown in communication can happen where there is an absence of local safeguarding systems, barriers to effective co-working or failure to recognise or act upon safeguarding opportunities[38].* All these factors were identified by this Review.

9.3 The Review focussed on two overarching questions;

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[35] One due to long term sickness absence and the other was working on non-clinical work streams

[36] Worcestershire County Council, Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. Ofsted, January 2017 p2.

[37] Worcestershire County Council, Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board Ofsted, January 2017 p2.

[38] Sidebotham P., Brandon M. et al Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011- 2014 London: Department for Education 2016 p15

- What can we learn about the effectiveness of practice in Worcestershire to identify substance misuse in parents/carers and how this impacts on actions to safeguard children and babies?

- What can we learn from this case about the assessment of risks and vulnerabilities (known at the time) and how this influenced decision making and intervention?

9.4 With regard to the effectiveness of practice to identify substance misuse the review highlighted the complexity of practice particularly when parents were considered to be non-dependent on alcohol. There was limited evidence that practitioners considered the impact of alcohol consumption by parents on parenting ability or the emotional and physical wellbeing of the children. There was limited assessment of risks and vulnerabilities which impacted on decision making by professionals and resulted in inadequate and ineffective plans to support the family.

9.5 This review has benefited from the generous participation and reflection of practitioners and managers at the Learning and Recall Events. Whilst practitioners worked to support the children and family within their respective agencies there were systemic issues which had a significant impact on the practice of all. These included communication, multi-agency working, and limited appreciation of the impact on children when parents consume alcohol to excess and absence of an effective response to the voice of the child.

9.6 The importance of undertaking a holistic assessment of children and families was a central finding of this Review. The vulnerabilities of the children including unborn Baby Isaac were not understood and the lived experience of the children was not explored. Completion of a thorough assessment in this case would have included the views of the children and extended family members.

9.7 In the absence of a comprehensive updated assessment there was an overreliance by professionals on the explanations provided by the Parents. Critically, the significance of a serious incident when the parents were intoxicated and unable to care for the children was overlooked

9.8 Lack of clarity about the role and remit of Early Help Services (6.33) and overlap between the Early Help Action plan and the CiN Plan further served to focus attention on Sibling 4 and deflect concerns about parental alcohol consumption. There was lack of understanding among professionals about the role of Early Help Services and the purpose of involvement was unclear.

9.9 Serious Case Reviews have involved a significantly high number of babies less than one year of age[39]. In addition, parental alcohol misuse has been found to be a significant risk factor in many Reviews[40]. Whilst the alcohol consumption of Mother and Father was not identified as alcohol misuse it could be argued that lack of robust assessment regarding alcohol consumption contributed to the exposure of Baby Isaac to additional vulnerabilities.

9.10 Practitioners at the Learning Event acknowledged that there was normalisation and acceptance of excessive alcohol consumption in society, particularly at holiday times.

[39] Sidebotham P., Brandon M. et al Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011- 2014 London: Department for Education 2016 *(41%) were aged under one year at the time of their death, or incident of serious harm; and nearly half of these babies (43%) were under 3 months old p35.*

[40] Ibid p 75

It was likely that this normalisation contributed to the professional acceptance of excessive alcohol consumption by the parents. This a National issue and not specific to Worcestershire. It is important however (in response to the tragic death of Baby Isaac and the findings from this review) that the WSCB and all partner agencies work together to challenge excessive drinking by parents and increase awareness about the potential impact of alcohol consumption on parenting capacity.

9.11 It is important to acknowledge that the findings within this Review are similar to those identified in previous national SCR's. In addition, information sharing, the importance of remaining child focussed and adoption of a critical questioning approach to Parents are relevant to the safeguarding responsibilities of each agency involved in this review.

9.12 Effort has been made within this Review Report to build on similar findings from local and regional serious case reviews with reference to relevant research. Consideration has been given to the current work plan of the WSCB to ensure that recommendations complement and enhance work in progress and avoid duplication. The voice of the child/child's lived experience is a WSCB priority. In addition, there was a similar finding within a previous review and actions to address this are ongoing therefore there is no recommendation for Learning Point 2.

9.13 The findings within this review provide an opportunity for the WSCB to evidence how practice has changed since the tragic death of Baby Isaac and what additional work needs to take place to ensure that lessons are learned, and practice improved. There are 7 Learning Points which focus on findings relating to assessment processes, understanding the lived experience of the child, provision of Early Help Services, Child in Need Procedures and cultural acceptance of excessive alcohol consumption.

Learning Point 1 (Assessment)

This review found that whilst there were initial concerns about the alcohol consumption of Mother and Father these were not fully explored by professionals from any agency. Over time, parental minimisation of alcohol use was accepted by professionals and a serious incident was perceived as an isolated occurrence. Therefore the impact of parental alcohol use on the capacity to parent was not recognised and the lived experience of the children was unknown.

Recommendation 1

When there are concerns about the alcohol consumption of parents assessments undertaken by professionals should focus on the impact of alcohol use on parenting skills and the lived experience of the children.

Recommendation 2

The WSCB to remind partners about the importance of demonstrating professional curiosity and challenge and reduce the acceptance by practitioners of information provided by parents/carers without appropriate questioning.

Learning Point 2 (Voice of the Child)

When children and young people speak directly to Practitioners it is not sufficient to just record what has been said. If the voices of young people do not inform assessments and subsequent interventions, it is likely that they will not feel listened to, intervention may not be appropriate and concerns could escalate.

No recommendation required as Worcestershire Safeguarding Children Board have published a Learning and Improvement Briefing on Voice of the Child. Multi-agency case file audits (MACFA) will monitor how the voice of children and young people inform assessments and interventions.

Learning Point 3 (Early Help Support)

Early Help Support lacked coordination and therefore had limited impact. There was a lack of clarity about the role and purpose of Early Help which contributed to a limited understanding among partners about Early Help and the responsibility of relevant agencies to support delivery of the Early Help offer through Universal services.

Recommendation 3

The WSCB to seek assurance from the Health and Wellbeing Board regarding the effectiveness of the provision of Early Help and satisfy itself that;

- **There is clear communication with and between all partner agencies about the shared roles and responsibilities regarding the provision of Early Help support for children and families in Worcestershire.**

Learning Point 4 (CiN process – the Plan)

A Child in Need Plan should focus on the assessed needs of children and families. Intervention or support to meet these needs should be explicit about expectations, outcomes and available resources to support the implementation of a Plan. Without this focus and clarity practitioners may develop a false reassurance about the effectiveness of support provided to children, young people and families, the issues of concern may be lost and the needs of the children may be overlooked.

Learning Point 5 (CiN process – joint working)

Effective partnership between agencies is essential when implementing a Child in Need Plan. Without the engagement and contribution of all relevant professionals it may be difficult to understand the significance of some events or disclosures by children, important opportunities for intervention may be lost and the Plan will have limited impact.

Learning Point 6 (CiN Process following change in family dynamics and closure of the Plan)

When the siblings of an unborn baby (UBB) are subject to a Child in Need Plan it is important that there is an opportunity within the multi-agency CiN meetings to;

- discuss the impact of a new baby on the family circumstances
- include the UBB on the Plan with specific reference to risks and vulnerabilities
- ensure there is multi agency agreement prior to closure of the Plan.

Recommendation 4

The WSCB to satisfy itself that appropriate action is taken to address learning from this review specifically with regard to;

- **The quality of assessment and ensure there is a clear link between assessed need and the CiN Plan**
- **Clarification of the role and responsibilities of partner agencies, specifically with regard to implementation of a CiN Plan**
- **The process of re referral should additional concerns arise within a specific time period**
- **Explicit consideration of unborn babies when children in the family are subject to a CiN Plan**

Learning Point 7

Given the prevalence and acceptance of alcohol use in society it is possible that practitioners may normalise periodic excessive drinking and fail to recognise the serious consequences that non-dependent drinking can have on parenting capacity.

Recommendation 5

- **The WSCB request that Public Health, Worcestershire considers the development of resources to increase awareness of the public and professionals about the risks associated with non-dependent alcohol use (including binge drinking) and the impact on parenting capacity**

- **The WSCB and Public Health, Worcestershire jointly contact relevant national agencies with findings from this review and request that consideration is given to the development of resources as described above**

Recommendation 6

The WSCB to ensure that learning from this Review is:

- **Disseminated and included as part of the Learning and Improvement Framework. This should include the development of a Learning and Improvement briefing which signposts practitioners to a toolkit regarding alcohol use**

- **Included in future relevant multi-agency training**