Kirklees Safeguarding Children Partnership

# SAFEGUARDING PRACTICE REVIEW (COMPLEMENTARY LEARNING)

CHILD E

Version 7 February 2020

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# Contents

# Introduction

## Family composition

| | |
|---|---|
| Child | Steven |
| Mother | Joanne |
| Father | Mark |
| Mother's ex-husband, father of older children | Robert |
| Friend of mother | Liz |

## Reason for this review

On 30th August 2018, KSCB were informed of the death of Steven, a 4 month old baby, on 23rd August 2018. The death was initially suspected to be an overlay. The inquest has concluded a verdict of accidental death due to co-sleeping. A historic bruise on Steven's chest was also noted which was thought may be innocuous or may have been indicative of a broken rib[1]. Steven had been subject of a pre-birth assessment as Joanne's previous children had been "removed"[2] and were in the care of their father. Both of Steven's parents were known to have mental health difficulties and there were concerns in relation to current and previous alcohol misuse. The pre-birth assessment concluded that the family should be supported on a Child in Need plan. This plan ended on the 9th July 2018.

## Purpose of the review

At the time of writing the review it was not known whether any police action was being taken in respect of Steven's death. The pathologist has ultimately determined Steven's death as unascertained and the police have now confirmed that they are not pursuing a criminal investigation in relation to Steven's death.

In any event, Safeguarding Practice Reviews are not written to determine causes of death or to assign blame to either family members or practitioners involved with or previously involved with the family, but to seek to understand the child's life, experience of services and whether anything can be learnt to improve practice and prevent future harm to other children.

In 2018, KSCB commissioned 3 Safeguarding Practice Reviews, all on children aged 2 and under. When the notification of Steven's death was received it was clear that there were many similarities to these 3 cases and the emerging learning coming from it. As such the specific purpose of this review is as follows:

1. To act as complementary learning to those other reviews and to identify learning that mirrors that of the Kirklees Cases Child A, Children B+C and Child D and whether Steven's life and death can deepen our understanding and response to that learning.
2. To understand the multi-agency response to Steven, Joanne and Mark to ascertain if any learning can be gained to strengthen future practice
3. To identify learning that differs from those other 3 reviews and highlight this for the agencies involved.

## Style of review

This review differs from those usually commissioned by KSCB for a number of reasons. Firstly, its similarity to other reviews already in the process of being written meant that much of the learning

[1] The Post mortem ultimately did not find any evidence of a broken rib, the bruise appears to be in the process of healing and was not considered significant by the pathologist.

[2] This author can find no evidence of Joanne's older children being legally removed, they appear to have been living with her ex-husband, the children's father, by mutual agreement.

and the context of safeguarding practice in Kirklees has been identified and, as such, it was felt that commissioning another "full" review would be repetitious. Further it would take longer for a full review to be completed and any action needed from additional learning would be delayed.

This review has not arranged Practice Learning Events which seek to engage first the practitioners involved in the case and then the senior managers of the involved agencies. Again though highly valued parts of most reviews these learning events take time to organise and it was felt would not add much more to the understanding than had already been gleaned from previous Practice Learning Events on the other cases. This author has however had the option to contact agencies to clarify events where necessary.

The structure of this review has therefore been as follows:

1. Initial information gathering from all involved agencies
2. Compilation of a full detailed multi-agency chronology
3. Analysis of written information including additional information (CIN minutes, pre-birth assessment)
4. Review of the learning arising from Child A, Children B+C and Child D for comparative purposes

This review is therefore written in three parts:

1. Overview of the case
2. Findings and analysis linked to recent reviews
3. Additional findings and analysis linked to this particular case

Parts 2 and 3 will both provide evidence from this case to support the finding and also provide excerpts from relevant research to inform future practice.

Although this review is conducted with a lighter touch, it is a thorough and comprehensive review at the case, with a focus on Steven and his needs. This reflects the national move to conduct more agile reviews which draws out learning quickly for agencies

## Overview of this case

In February 2017, Robert (Joanne's ex-husband and father of her 3 eldest children) contacted Kirklees Children's Social Care with numerous concerns for his children. These included Joanne's excessive drinking and deteriorating mental health, poor home conditions, allegations by the children of being physically abused by their mother and violent and aggressive behaviour between Joanne and her friend Liz which was being witnessed by the children. A single assessment was conducted but no further action was taken as Robert assumed full time care of the 3 children out of the Kirklees area with only supervised contact allowed[3] between the children and Joanne.

In July 2017, Joanne attempted suicide by overdose (prescription medication and alcohol).

In August 2017, Joanne attended an antenatal booking appointment at 8 weeks pregnant. She did not disclose her alcohol and mental health issues, including the overdose she had taken the previous month. Nor did she mention that her 3 older children no longer resided with her as a result of her issues. In November 2017, however, Joanne's midwife became aware of Joanne's older children and that CAFCASS were currently assessing those children. The midwife made a referral to Children's social care at this point but was told no further action would be taken. Shortly after this referral that was closed CAFCASS contacted Children's Social Care to ascertain the progress of the pre-birth assessment and were told that they were awaiting the outcome of the CAFCASS section 7 report. CAFCASS

[3] Again the contact arrangements appear to have been by mutual arrangement between Joanne and her ex-husband.

informed Children's Social Care that they were only completing a report on the 3 older children not the unborn and highlighted the concerns they currently had regarding Joanne's care of them, they also highlighted that they did not have any information about Mark apart from the fact that he had a previous child who was under a Special Guardianship Order. Following this a pre-birth assessment was commenced.

This pre-birth assessment concluded that a Child in Need plan would help support the family and manage any risks to the unborn child. Referrals were made for Joanne to access support for her mental health through the single point of access but South West Yorkshire Mental Health Trust (SWYMHT) records note that Joanne did not feel she required the support of mental health services, she felt her support network around her was enough. On 20th October 2017 Joanne asks her GP for a report for court regarding her mental state.

On the 19th December 2017 the court hearing was held regarding the custody arrangements for the older children, the CAFCASS recommendations were followed and Robert was awarded full custody of the children with Joanne allowed fortnightly supervised contact.

For the duration of her pregnancy Joanne appears to engage fully with all antenatal, Child in Need and health appointments. There is however, very little reference to Mark, Steven's father, with whom Joanne is still in a relationship. Steven is born on 7th April 2018 and Joanne and Steven are discharged from hospital the same day.

Following Steven's birth Joanne continues to engage with all agencies, including self-referring to IAPT services. South West Yorkshire Mental Health Trust are very active with Joanne at this time assessing her for the most appropriate service. Psychology liaised with the Perinatal Mental Health Specialist and it was agreed that the perinatal period was not the right time to engage in a course of therapy sessions, however, the nature of her case indicated longer term support was needed, therefore she was referred to and accepted by the Core Mental Health Team.

There are no concerns noted regarding Steven's health, development or care and though there is little detail in any agencies records in relation to Mark it is clear they are still in a relationship and caring for Steven together with no apparent issues.

On 28th May 2018, there is a domestic dispute as Mark attends Joanne's home wanting to stay but Joanne's refuses as he is under the influence of drink and drugs and she has her older 3 children with her on their first overnight unsupervised stay. The police are called to Joanne's home by Robert, who is not present but who has presumably been contacted by one of the children and informed of what is happening. When the police attend Mark has already left. He appears to have gone to Dewsbury District Hospital from Joanne's house to present himself to the A+E department for his mental health issues, he is advised to attend local substance misuse agency CHART, which he does late the next day. At the subsequent Child in Need meeting it is noted that Joanne "acted protectively" by calling the police. She was not the person who contacted the police, though by refusing Mark entry in the home was clearly prioritising the needs of her 4 children.

Mark is present at the Child in Need meeting on 7th June and recommendations are made for him in relation to addressing his mental health difficulties, alcohol misuse and unstable housing. It is made clear he is not have unsupervised access to Steven. At this stage the status of Joanne and Mark's relationship is not clear, nor is Mark's place of residence.

On 12th June Mark is again assessed by the crisis mental health team following police detention under sec.136 of the Mental Health Act. This is due to the police being contacted by a member of the public who was concerned that Mark was on a bridge threatening suicide.

During the mental health assessment it is noted that Mark's partner, Joanne, informed the team that Mark could not return to the family home due to Social care assessing him as not being safe around their new-born son due to his substance misuse. This would seem to indicate that the relationship was continuing.

The mental health assessment concludes that Mark may have been trying to get a hospital bed in order to have somewhere to stay and "prove" to Children's Social Care that his issues were mental health in origin not alcohol and therefore "not his fault"[4]. Mark did not meet criteria for detention or informal admission under the Mental Health Act so he was allocated to the Intensive Home Based Treatment Team, support was given by this team and the Emergency Duty Team to expedite his housing needs with the council housing department. In the interim, it was agreed he would attend appointments at Folly Hall.

The mental health assessment was sent to housing and to Children's Social Care, though neither were contacted as part of the assessment therefore clear information regarding the unsupervised access to Steven and the direction not to reside at Joanne's address was not gained. As neither the Housing Department or Children's Social Care contacted mental health services upon receipt of the mental health assessment to clarify information contained within clarity was not gained regarding contact and living arrangements for Mark.

Joanne also discusses with her Community Psychiatric Nurse (CPN) that the domestic incident with Mark which was witnessed by her children has strained her relationship with the children's father who has stopped contact and this was "negatively impacting her mental health". Joanne's CPN discussed her emotional wellbeing and available support networks with her but does not appear to have fully explored with her the possible coping mechanisms she may employ or how this might impact on her care of Steven.

Joanne continues to engage with her CPN, her Community Care Officer (working in a specialist council service supporting families with mental health issues) and her Health Visitor though she raised the limited contact she had with her Social Worker to her Health Visitor. Mark is engaging with his mental health team though not with CHART who close his case following his repeated failure to attend for the completion of his initial assessment.

There is no apparent liaison between the parents' mental health team despite Joanne and Mark still being in contact with each other at this time.

On 4th July, the Health Visitor is contacted by a newly allocated Social Worker who asks what the date of the next Child in Need meeting is and for a telephone contact number for Joanne. It is subsequently recorded in Children's Social Care's records that a Child in Need meeting is held at Joanne's home on the 6th July, however as only the social worker and Joanne were present this would more accurately be called a Child in Need visit. Joanne is informed by the new Social Worker that the Child in Need plan is closing and it is noted in the social care records that "parents are caring for the child well and addressing mental health concerns". Children's Social Care appear to have made this decision unilaterally and neither the Health Visitor nor the mental health team appear to be clear about any plan going forward. As the Social Worker closed the plan, it would be expected that they would notify the other professionals involved, including the rationale given it was done in isolation. Both the managers who compiled the agency chronologies note that it would have been prudent for the practitioners to clarify what the closure plan was with the Social Worker.

Between 15th and 26th July Joanne reports to her Health Visitor, mental health team and GP on separate occasions that her mood was low and that she was emotionally distressed due to the

[4] Chronology record from SWYMHT on 13th June 2018

restricted access to her older children, Mark's deteriorating mental health and ongoing housing issues. Although not alcohol specific, Joanne's CPN discussed her wellbeing, support network and coping strategies. However, again, a possible relapse into alcohol use and the impact of her ability to care for Steven does not appear to have been discussed.

On 23rd July, Joanne contacts the mental health crisis team stating that Mark was angry, in drink and banging his head against a wall. Mark can be heard swearing in the background of this call but refuses to talk to them. There is no indication of where this incident is taking place, whether Steven is present, whether Joanne is safe herself and no liaison with either the Police or Children's Social Care. Joanne is advised to contact the Police herself if she does not feel safe without consideration of whether she *could* safely do so.

On 26th July, Mark contacts the Intensive Home Based Treatment Team to cancel an appointment as he is looking after his son. This was not explored or challenged though the mental health team were aware that he should not have unsupervised contact with Steven. Later that night Joanne contacts the Police to state that Mark is present at her home, in drink, being physically aggressive towards her and demanding her bank card.

This incident is discussed in the Daily Risk Assessment Management Meeting (DRAMM) the following day and it is clear from the Police and Social Care records on the incident that Joanne stated Mark was at the property to have supervised contact with Steven. However, despite this clarity in the records, the police representative at the DRAMM, GP and Health visitors records from the DRAMM at which this incident was discussed state that it is not clear whether Steven was present and that Children's Social Care must ascertain whether he was or not and to assess if he was. It is unclear where this confusion has arisen.

Further to this, no agency appears to have noticed that the incident was called into the Police at 10.30pm which would be an unusual time for a supervised contact visit to a 4 month old baby, especially as the attending Police Officer records that Steven was asleep upstairs at the time.

Mark was arrested at this incident and given bail conditions not to go within 100m of Joanne's house and not to contact her, directly or indirectly, except via services to arrange child contact.

On 3rd August at 11.15pm Joanne contacts the Police to say she is concerned about Mark's welfare as he may be suicidal and she has not heard from him for 18 hours. This would seem to indicate firstly that she had had contact with him in the early hours of the morning (around 5am) despite the bail conditions in place and that it was out of the ordinary for Joanne to not have contact with Mark for that length of time.

On 5th August, Mark is again detained by the police under section 136 of the Mental Health Act after he again threatened to jump from a bridge. During his assessment he states that he attempted suicide by overdose 3 days earlier too. He is discharged the same day and following this Joanne contacts the police reporting that Mark is breaching his bail conditions by contacting her directly and indirectly (via a friend) including threats to cause criminal damage.

On the 7th August Joanne's CPN visits her and discusses domestic abuse, Joanne informs her that she has been allocated a Domestic Abuse worker, it is not clear who Joanne is referring to. On the 9th and 16th August Joanne's Community Care Officer visits her and acknowledges the domestic violence incidents and her low mood. Again neither worker appears to have discussed coping mechanisms including, a possible relapse into alcohol misuse and the impact of her stressful current situation and low mood on her parenting capacity.

On 23rd August, in the early hours of the morning the police are notified by the ambulance service of the sudden death of Steven. Joanne reports that she had been drinking wine with her friend Liz at Liz's

home until 3pm then had returned home with Steven who had fallen asleep in the pram. She had got home about 7pm and continued to let Steven sleep in the pram until 11pm when she took him into bed with her.

# Findings and analysis linked to recent reviews

## Finding 1 – Workforce understanding of the risks of domestic abuse, particularly the risks associated with post separation are poorly understood

Victims of domestic abuse are given the responsibility of keeping their children safe from the perpetrators of abuse without an assessment of their capacity to do so

Perpetrators of violence, though identified as the source of risk to children, are not directly worked with to address concerns

Relationships characterised by domestic abuse and between people with alcohol, substance and mental health issues rarely end without periods of reconciliation and contact.[5]

### Link to recent reviews (found in Appendix 1)

Child A learning points 8, 20, 23, 33 and 34

Child D Finding 5

### Illustrative evidence from this case for Finding 1

Following the 1st recorded domestic abuse incident between Joanne and Mark on 28th May 2018 there is a Child in Need meeting on 7th June where recommendations for Mark to address his mental health, alcohol and housing issues are discussed. There is no formal record of this meeting, nor a written Child in Need plan so it is not clear what support was offered to Mark to achieve this. Further it is at this meeting that Mark is told he is not allowed unsupervised access to Steven but there is no detail about how this contact should be supervised so presumably this fell to Joanne to organise despite the history of abuse and the fact that they have only recently separated.[6]

During one of the supervised visits on the 26th July Mark arrives under the influence of alcohol refuses to leave when asked by Joanne, assaults her and demands her bank card.

Discussions with Joanne about this incident and the safety plan put in place are centred around what Joanne can do, not what agencies are doing or what Mark is expected to do (other than comply with his bail conditions of no contact).

Though Joanne did "act protectively" by contacting the police when assaulted there is no explanation of why the supervised contact with Steven was taking place so late at night.

No worker appears to have discussed with Joanne how she could facilitate safe contact between father and son, if the responsibility for doing so was to rest with her, for example, in a public place not her

[5] Some women with abusive partners may not end relationships because they have been threatened with increased violence if they leave. Others fear for the safety of their children, family, or friends. Although some women stay in relationships because they believe their partners will change, others stay for fear that the violence will escalate against themselves or their loved ones should they leave. (Fleury et al, 2000)

[6] It is to the credit of the last social worker involved in the case that she did have a discussion with Joanne about facilitating contact and different support options available to her.

home, in the day, with another adult, for a set period of time, with agreement for a support worker (from any organisation with whom Joanne was engaging) to check on her at an agreed time to check that there had been no issues.

This incident and the following call from Joanne to the police on the 3rd August concerned that she had not heard from Mark for 18 hours, despite the no contact bail conditions, indicate that they were in more than daily contact with each other, if not, had actually resumed their relationship fully.

## Research supporting Finding 1

*Relying too much on mothers for essential information*

Professionals sometimes rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children.

Professionals do not always talk enough to other people involved in a child's life, such as the mother's estranged partner(s), siblings, extended family and friends. This can result in them missing crucial information and failing to spot inconsistencies in the mother's account.

NSPCC Hidden men: Learning from Case Reviews

Domestic abuse often relies on isolating the victim: the perpetrator works to weaken her connections with family and friends, making it extremely difficult to seek support. Perpetrators will often try and reduce a woman's contact with the outside world to prevent her from recognising that his behaviour is abusive and wrong. Isolation leads women to become extremely dependent on their controlling partner.

Women's Aid: Why don't women leave abusive relationships?

Research suggests practitioners initially related to women as victims, however, as time progressed and abuse continued workers made increasing demands of women to ensure child safety (Jenney and colleagues, 2014). The construction of mothers as being primarily responsible for childcare sets women up for blame for the perpetrator's abusive actions, and renders the abusive partner's behaviour invisible to social services (Mandel, 2010).

The Institute for Research and Innovation in Social Services (2017)

## Finding 2 – Clear, up-to-date records and effective, comprehensive information sharing are the foundations on which effective child safeguarding practice are built

## Link to recent reviews

Child A – Learning points 1 and 17

Children B and C – Finding 5

Child D – Findings 5, 7 and 9

## Illustrative evidence from this case for Finding 2

This case notes concerns regarding record keeping across all partner agencies.

Children's Social Care records submitted for the chronology for this review are incomplete for example;

- No record of when the pre-birth assessment was completed
- No record indicating when the Child in Need starts (Locala notes that it was Joanne, not Children's Social Care, that informed them that there was a Child in Need in place)
- Not clear which agencies were involved in the Child in Need
- No Child in Need plan on file and this was not shared with any agency
- No minutes from the Child in Need meeting on 7th June 2018

Difficulties in Children's Social Care regarding effective record keeping at this time are well documented and an extensive programme of improvement to address this issue has been in place through the Strengthening Practice Programme which has focused on Recording, Assessment and Planning (RAP).

The information presented to DRAMM on 27th July 2018 is contradictory and confusing. The police callout information is clear that Steven is present at the DV incident on 26th July 2018 yet at the DRAMM the police representative questions this and task Children's Social Care with finding out.

Children's Social Care do have a conversation with Joanne about this incident where she clarifies that Mark was there for his supervised contact. This information does not appear to have been shared back with the DRAM / other agencies who may then have picked up on the issues highlighted in the previous finding regarding the unusual timing for a contact visit.

Further the Child in Need plan appears to have been closed without prior discussion with the other involved agencies and the decision to close was only communicated to the other professionals by Joanne.

The South West Yorkshire Partnership Foundation Trusts records provided to this author in the first instance were difficult to follow with a lack of clarity regarding which team from their service a record related to and a lack of richness in the entries in relation to what a worker had specifically discussed, in particular with Joanne. Further work was done to clarify this and the report has been amended accordingly.

Though they respond to requests for information from Children's Social Care when asked, SWYPFT appear to have had little pro-active contact with them or any other agencies working with the family including the sharing of information that would indicate increasing risk of harm to Steven. This is detailed further in under Additional findings: Finding 4

Examples illustrating this finding include at Joanne's first contact with the service when she informs SWYPFT that she is subject to a pre-birth assessment but no contact is made with Children's Social Care to confirm the reasons for this or to notify CSC of their involvement with Joanne.

On 14th June, Joanne discloses the Domestic incident between herself and Mark on 28th May when she had overnight care of her 3 older children as well as Steven. There is no follow up with Children's Social Care but perhaps more noteworthy is that there is no contact with the crisis mental health team who also had contact with him on the same day.

The records relating to Marks care under SWYPFT have little information related to him as a father. On 26th July Mark calls his Mental Health Nurse to cancel his appointment due to looking after his son. This is not explored or checked to see whether this is supervised contact or not and it is not shared with CSC.

In total there are 21 instances this author can find where information is not shared either with CSC, between Joanne's and Mark's MH workers or with other agencies. SWYMHT may wish to assure themselves that this case is an aberration rather than indicative of wider practice.

The GP's involved in Joanne's care also have instances of poor information sharing which are linked to the additional finding discussed later in this report regarding adult facing agencies.

In relation to information sharing and record keeping specifically, on 20th October 2017 Joanne asks her GP for a report for court regarding her mental state. She gives information regarding her previous alcohol use, recent overdose, the fact that she is no longer taking anti-depressants and her current status as 17 weeks pregnant. There is no record of the response to this request or what safeguarding checks or action was taken (if any).

On 3rd May 2018 an Answer machine message is left by the GP to the Social worker regarding a request made for Joanne's medical records, the message asks whether these records are still needed. The request was made by Children's Social Care on 11th January 2018 in order to complete Steven's pre-birth assessment. This request was clearly not actioned, or followed up and at this stage the pre-birth assessment had already been completed and Steven born.

The unclear or incomplete records of agencies and the instances of a failure to share information impacted on the risk assessment for Steven in the following ways:

- Incomplete Pre-birth assessment that did not have a complete picture of the mental health difficulties or alcohol misuse of either parent or how these might therefore impact on Steven when he was born.
- Failure to recognise when there might be a live safeguarding concern for a child due to a lack of flagging of concerns
- Failure to challenge parents when they give information that actually indicates they are breaching bail conditions, increasing the risk that Steven may be exposed to further incidents of domestic abuse
- Lack of consistency in the approach to parents from partner agencies, even within an organisation, decreasing the likelihood of effective interventions. For example; some agencies were responding to Joanne and Mark as a separated couple where other agencies clearly had information that they were still in regular contact, if not, still in a relationship.
- An overall lack of clarity and consistency to interventions that gives a poor impression to parents about the seriousness of concerns raised, the reason for intervention and the need to make change and reduce risks to Steven

## Research supporting Finding 2

Good quality case recording is essential in ensuring:

•Continuity of service to children and families when staff are unavailable or change, or when a service resumes after a period of time

•Effective risk management practices to safeguard the well-being of children, especially in emergency situations;

•Effective partnerships between staff, children, their families, their carers, other agencies and service providers;

•Clarity of information for everyone involved in the planning and delivery of services, and in the event of investigations, inquiries, or audits;

•Adequate information for staff and managers to ensure the best possible utilisation of available resources;

•As a means by which to ensure accountability and adherence to procedures and statutory responsibilities

West Yorkshire Consortium Procedures [accessed 12.3.19]

## Finding 3 – The support arrangements post Child in Need are not clear and co-ordinated and the circumstances under which Children's Social Care may want to consider re-opening a Child in Need case after the closure are not specified to the agencies who remained in contact with the family

### Link to recent reviews

Child A – Learning Point 7

Children B and C – Finding 3

Child D – Finding 4

### Illustrative evidence from this case

On 6th July, the newly allocated Social Worker visited Joanne for the first time and decided to close the Child in Need plan. The case closure summary outlines the reasons for this as being Joanne's good care of Steven, the fact that she had separated from Mark, Joanne's good understanding of the risks posed to Steven by Mark and the need for ongoing supervised contact. No discussion had taken place with the other agencies prior to the decision to close the case being made and only appears to have been communicated to Joanne's Mental Health Core worker afterwards. SWYPFT's chronology compiler noted that the forward plan was not recorded by their staff including what action to take should there be any further domestic incidents. Joanne's CPN received a telephone call from her social worker and was informed that the CIN was being closed, no plan received. Joanne reported to her CPN that she was not clear on the future contact between Mark and Steven, social worker told CPN that Joanne was fully aware and understood all her options etc. regarding options for Mark to see

baby. This lack of contingency planning for when risks may re-appear or worsen is mirrored in other recent local reviews.

Joanne contacted her Health Visitor to inform her of the Social Worker visit and decision to close the Child in Need. She reports that she informed the Social Worker that she was disappointed by the poor service provided by CSC (records indicate that this was dealt with appropriately by the social worker who listened, apologised and gave information regarding the complaints procedure). The chronology compiler for Locala notes the lack of challenge by the Health Visitor regarding the decision to close in light of the recent domestic abuse incidents and Marks deteriorating mental health.

Joanne had engaged well with mental health services, appeared to have ended her relationship with Mark, the Health Visitor had no concerns about Joanne's bonding with or care of Steven. In light of this the closure of the Child in Need at this point is understandable, however, it would have perhaps been prudent to have a multi-agency Child in Need meeting to enable all involved professionals to have the opportunity to discuss any remaining concerns they had and develop a clear, co-ordinated plan for ongoing support for Steven and his parents following closure. In particular, this plan could have specified the remaining risks and a contingency plan which specified under what circumstances Children's Social Care might be concerned and feel that a Child in Need may need to be re-commenced.

As no Child In Need plan appears to have been written it is hard to judge whether it met its original objectives and if objectives remained for other agencies to continue to address.

Following the closure of the Child in Need plan, both Joanne's and Mark's mental health deteriorates, this is evidenced by a number of entries from Joanne's MH team stating that she is "lower in mood" in "increasing emotional distress" etc. and started to take antidepressants. Whilst it is accepted that Mark had a lifestyle characterised by increasing use of substances which led to risk taking behaviour and crises requiring intervention from the Police and Mental Health services at this point he has made threats of suicide and is self-harming (banging head against wall) which indicates both that he is struggling and that there may be an increased risk for those around him, included Steven. Added to this there is a lack of clarity about the status of his relationship with Joanne and the contact arrangements for Steven and there is an increasing frequency and severity of domestic abuse incidents. These do not appear to have been assessed holistically by any agency which may have then been enabled to make a robust referral back into Children's Social Care.

## Research supporting Finding 3

> "… it is apparent that many of these children's cases had either been closed too soon or lacked the ongoing support services and monitoring the children and families needed."
>
> Pathways to harm, Pathways to protection: a triennial analysis of serious case reviews 2011 to 2014
>
> Department for Education May 2016

> 23. Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe. Serious case reviews have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children.
>
> 24. Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care (e.g. they are being supported as a child in need or have a child protection plan). Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child's safety or welfare.
>
> Working Together to Safeguard Children 2018

# Additional findings and analysis particular to this case

## Finding 4– For those agencies primarily addressing parental issues, child safeguarding does not appear to feature in their assessments, decisions or direct work.

### Illustrative evidence

As previously mentioned this case has raised concerns regarding information sharing between SWYPFT and other agencies. This is evident in some of the GP contacts too and there is no evidence that Mark was asked about children or contact with children in his initial contact with CHART though it is acknowledged that Mark never completed his full initial assessment with CHART.

On 3rd July Joanne discloses to her CPN that she is struggling with sleep, breastfeeding, finances to visit her children and concerns about Mark who is still under the mental health crisis team. There is no signposting to or liaising with other agencies who could have offered further support and no liaison with Mark's mental health team in particular to try to ascertain whether their relationship has resumed.

On 23rd July, Joanne contacts Marks Intensive Home Based Treatment Team (IHBTT) concerned that he is angry, in drink and banging his head against a wall. Joanne is not asked whether she is safe, needs police to attend, whether Steven is present, where they are. This incident is later discussed in a multi-

disciplinary team meeting but still not shared or referred to any other organisation. The IHBTT registered mental health nurse contacted Joanne the following day, she informed them that Mark was sleeping and a lot calmer, Mark agreed to be seen by IHBTT the following day. SWYPFT have acknowledged that the IHBTT could have made enquiries regarding the welfare of the child at the time and at the contact the next day and will be following this up with them.

On 5th August, Mark is admitted to the 136 suite (for the second time) following a further suicide attempt and is discharged. Mark is signposted to CHART as his issues were related to illicit substance misuse. Clear (Community Links) was also discussed for anger management[7]. The suicide attempt, admittance to the 136 suite and subsequent discharge are not shared with any other agency (the police are aware as they bought him to the suite). Mark's children are identified in the case records for this assessment and the document for the MHA assessment although this further suicide attempt and admittance to the 136 suite does not appear to have been passed on to Children's Social Care.

An example of the GP (s) having a similar approach is evident in Joanne's contact on 24th July with her GP where she reports her dipping mood. She is prescribed anti-depressants but this information is not shared with any other agency. No consideration appears to have been given to the potential safeguarding issue this represents.

[7] The appropriateness of this referral needs to be explored with SWYPFT, anger management is not the same as domestic abuse and there are concerns that treating perpetrators of domestic abuse for anger management issues can raise the risk to their partner.

## Research supporting additional Finding 4

To safeguard and promote the welfare of children, assess their needs (including their role as young carers) and fully understand the family's circumstances, children's services practitioners should seek the expertise of adult services. Collaboration should be given greater priority because practitioners in domestic violence units, alcohol and drug services, mental health and learning disability services will have a better understanding than those working in children's services of how these issues impact on adult family members and family functioning.

Collaboration between children's and adults' services will allow the expertise of practitioners in these specialist services to inform assessments, judgements and plans. Joint working is likely to result in a more proactive and integrated approach to the delivery of relevant and timely services for both children and parents. To ensure joined-up service provision, specific attention should be given to creating robust professional links between children's and adults' services.

(*Children's Needs – Parenting Capacity, Cleaver et al)*

Lack of information sharing between adults' and children's services

Professionals involved with men who are fathers (such as substance misuse workers and probation officers) do not tend to share information about potential risks with other professionals supporting the children and partners of those men. This may be because they are unaware the men have contact with their children. Consequently, practitioners depend entirely on parents to share this information, which they may or may not do.

NSPCC briefing: Hidden men: learning from case reviews

Providers of adult services, such as adult psychiatrists, other mental health professionals and substance abuse workers, can be reluctant to refer because they focus on adults and often do not appreciate how, for example, parents' mental health problems are impacting on their children.

Safeguarding Children Across Services: Messages from Research

Carolyn Davies and Harriet Ward

## Finding 5 – The safe sleeping advice, given consistently to mother, was not effective in reducing the risks to Steven

It is not within the remit of this review to ascertain a cause of death for Steven, however, it would be remiss not to comment on the fact that the chronology details safe and co-sleeping advice on 3 separate occasions by Locala (19th February, 24th May and 16th July) and on 8th April by the community midwife and that Steven was reported to be found dead by his mother in her bed in the early hours. The post-mortem report details that though the exact sleeping position of Steven and his mother are not known he was "placed in an adult bed with a sleeping and quite possibly intoxicated adult – a

sleeping arrangement that could be considered as unsafe for an infant". The pathologist has ultimately determined Steven's death as unascertained.

Emerging research indicates that whilst the safe sleeping message appears to have effectively reduced deaths in the general population it appears to be less effective with parents with complex needs.

The Lullaby Trust has recently changed its message regarding co-sleeping to acknowledge that 76% of parents have co-slept with their baby at some point[8]. They have acknowledged that by giving out blanket advice about not co-sleeping at all, information about how to do so safely, or avoid unplanned co-sleeping situations is not given to parents or sought by them. Critically information about what the high risk factors in co-sleeping are, should be imparted to new parents.

In Kirklees information given to new parents regarding safe sleeping is in accordance with the Lullaby Trust advice. The following section is especially emphasised:

"Things to avoid

- Never sleep on a sofa or in an armchair with your baby
- Don't sleep in the same bed as your baby if you smoke, drink or take drugs or are extremely tired, if your baby was born prematurely or was of low birth-weight
- Avoid letting your baby get too hot
- Don't cover your baby's face or head while sleeping or use loose bedding"

Given the detail of information that is given by the midwife both during the antenatal period and after the birth of the baby and by the health visitor during the antenatal contact between 28 and 36 weeks (if there is one) and at the birth visit, the effectiveness of the method of imparting this information, or what other interventions might be needed, perhaps, for parents who could be considered high risk may need to be explored.

[8] A survey of over 8,500 parents carried out by The Lullaby Trust has shown that 76% have co-slept with their baby at some point. However, over 40% of parents admitted to having done so in dangerous circumstances such as on a sofa, having drunk alcohol or as a smoker. All of these circumstances greatly increase the risk of sudden infant death syndrome (also known as cot death or SIDS). (Lullaby Trust, 2019).

## Research supporting additional Finding 5

Around half of SIDS babies die while co-sleeping. However, 90% of these babies died in hazardous situations which are largely preventable

Co-sleeping and SIDS

Unicef

When categorised by co-sleeping environment, the multivariable risk of co-sleeping with an adult on a sofa or chair, or with an adult who had consumed more than two units of alcohol was 18 times greater than those who did not co-sleep; and four times greater for those who slept next to a parent who smoked.

Notably, the risk associated with infants co-sleeping on a sofa or sleeping next to an adult in the parental bed who had consumed more than two units of alcohol was a magnitude higher than most risk factors associated with SIDS. Both of these environments pose a risk to the infant regardless of infant age. The reasons as to why infants are at increased risk when sleeping next to a smoker are not clear, but this risk seems to be far greater in the younger infants.

An important implication of our findings is that to give blanket advice to all parents never to bed-share with their infant does not reflect the evidence.

Bed-Sharing in the Absence of Hazardous Circumstances: Is There a Risk of Sudden Infant Death Syndrome? An Analysis from Two Case-Control Studies Conducted in the UK

Blair, P., Sidebotham, P., Pease,A., and Fleming, P

## Finding 6 – The risk of a return to problematic alcohol use by mother was not understood, assessed or managed.

Prior to July 2017, when Joanne took an overdose and then subsequently found out she was pregnant with Steven, she had been drinking heavily. It is not clear from what point she started to drink heavily and this does not appear to have been assessed by any agency during the period of this review (though this may have taken place prior). It is recognised that, as Joanne asserts, finding out that she was pregnant was motivation for her to stop drinking. However, there does not appear to be a full assessment of her alcohol use before Steven's birth through the pre-birth assessment, or by any of the health professionals, or afterwards when, not being pregnant, Joanne no longer had the direct protection of her unborn child as motivation for her abstinence.

The potential for a return to alcohol use and the risk of harm to Steven this represented was not assessed. It appears that Joanne simply she stated that she had stopped drinking in July 2017, this was accepted and although questions were asked during the Level 1 risk assessment completed by SWPFT, Joanne answered that she was not drinking although she did state that she was keen to access therapy to prevent future relapse. SWYPFT have accepted that given the history of alcohol misuse the issue should have been revisited. No other agency appears to have revisited this issue with Joanne and no work done with her to maintain this positive change. Linked to this are wider questions about coping mechanisms, where alcohol is known to have been used previously as a coping mechanism an

exploration of what alternatives are being used would have been good practice. This is especially so when Joanne became under increasing stress and reporting her mood to be low following the first (reported) incident of domestic abuse on 28.5.18.

### Research supporting additional Finding 6

Parents who are struggling with combinations of problems such as poor mental health, substance misuse or domestic abuse are less likely to be able maintain change in the long term (Duffy and Baldwin 2013; Skinner et al., 2010

Assessing Parental Capacity to Change when Children are on the Edge of Care: an overview of current research evidence
Ward,H., Brown, R., and Hyde-Dryden, G.

"What would I have to do to cause a relapse?" You don't need to do anything. Stop using alcohol and other drugs, but continue to live your life the way you always have. Your disease will do the rest. It will trigger a series of automatic and habitual reactions to life's problems that will create so much pain and discomfort that a return to chemical use will seem like a positive option. The relapse process does not only involve the act of taking a drink or using drugs. It is a progression that creates the overwhelming need for alcohol or drugs. Relapse does not happen when the addict takes the first drug or drink. Relapse is a process not an event."

37 Warning Signs of a Relapse: The Phases and Warning Signs of Relapse by
Gorski & Miller

Moos and Moos (2006) found that 42% of people who received treatment for alcohol misuse had relapsed within 16 years (2.216). Hibbert and Best (2011) also found recovery from alcohol addiction to be a gradual process of change…The findings from these studies all support the argument for providing long term light touch support to help parents maintain progress, once an intensive period of intervention has been completed. However there is considerable evidence to suggest that pressure to close cases means social work services are often withdrawn prematurely, with inadequate arrangements for stepping down support (Farmer et al 2011; Farmer and Lutman, 2012; Ward, Brown and Westlake, 2012).

Assessing Parental Capacity to Change when Children are on the Edge of Care: an overview of current research evidence
Ward,H., Brown, R., and Hyde-Dryden, G.

## Good practice evident in this case

1. Safe sleeping advice was given on 4 separate occasions and by 2 agencies
2. Routine enquiries were made about domestic abuse by midwifery and health visiting services.
3. Upon receipt of the information in relation to Joanne's older children being subject to a CAFCASS assessment the Midwife made an immediate and appropriate referral to Children's Social Care

4. Joanne's health visitor and mental health team developed good relationships with Joanne, who felt able to share information with both sets of professionals
5. The Police response to domestic abuse incidents and Mark's mental health crises was swift and appropriate
6. Domestic abuse incidents were referred appropriately to MARAC
7. Considerable intervention was provided by SWYPFT to both parents
8. The pre-birth assessment was completed in good time and ensured that a birth plan was in place
9. A clear and recorded rationale for closing the Child in need case was given by the social worker who also sought guidance from her manager in relation to the case
10. Upon case closure the social worker gave detailed advice about facilitating safe supervised contact

## Reflective questions

1. How is the workforce understanding of domestic abuse and the effective application of this knowledge into practice be evidenced?
2. What does "acting protectively" mean in the context of domestic abuse?
3. How can practitioners move from a description of events or recording a narrative given by parents to a truly analytical assessment?
4. What barriers do practitioners face to effective, comprehensive information sharing and keeping clear up-to-date records and how can these be overcome?
5. What are the best practice expectations of all agencies in relation to de-escalation of cases?
6. Should the closure of a Child in Need case be done in the context of a multi-agency discussion?
7. How can practitioners who are providing an "adult facing" service ensure they are routinely asking questions about and assessing the safeguarding needs of any children of or in contact with their client?
8. What role does the Mental Health in Families team play in facilitating closer working relationships between SWYPFT and Children's Social Care?
9. How can we respond effectively to parents who are presenting in mental health crisis on multiple occasions?
10. How do adult facing organisations such as Adult Mental Health Services ensure that the opening and closing of cases are appropriately flagged to Children's Social Care when the client is a parent?
11. How effective is the safe sleeping advice given to new parents? Should a tiered or different approach be considered when working with parents who have identified as having additional needs and being at higher risk?
12. What assessments or direct work is prompted (or should be prompted) with a parent who has identified previous alcohol or substance misuse issues?
13. How are the adverse childhood experiences of parents taken into account and explored when assessing parenting capacity?
14. How confident is the workforce understanding of relapse, how to identify this quickly and intervene effectively?

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# Appendix 1: Relevant Findings / learning points from previous reviews referenced in this addendum

## Child A

**Learning Point 1:** The chronology from Children's Social Care was incomplete and this may be because there are records missing from their involvement with this family. If so, this may have implications for the accuracy of their records in respect of other families that may have had some involvement with social care during this period.

**Learning Point 7:** Child in Need plans should be de-escalated to a Team Around the Family plan if low level concerns still need to be addressed when a decision is made to close the plan

**Learning Point 8:** Children's social care should explore how their expectations around child contact should be communicated to parents and professionals. This should include clear consequences for failure to adhere to agreed contact arrangements, recommendations for professionals in other agencies to record/flag the arrangements for supervised contact; and a clear process for reporting breaches to contact arrangements.

**Learning Point 17:** Police should ensure that information about domestic incidents, including available evidence (i.e. visible injury, signs of struggle), is effectively shared with social care

**Learning Point 20:** Coercive control has a detrimental impact on victims and may affect their capacity to assess risk and appropriately safeguard their children. Victims should not be expected to take sole responsibility for keeping their children safe from perpetrators, particularly when perpetrators have parental responsibility for their children.

**Learning Point 23:** Perpetrators of domestic abuse, particularly those with parental responsibility for their children, should be directly spoken to about the impact of their abusive behaviour children and included in the assessment process/safety plan for children

**Learning Point 33:** Children's social care to ensure assessments of risk to children include a thorough exploration of the ongoing, cumulative impact of coercive control on victims and children

**Learning point 34:** Key frontline professionals should continue to assess risk, and provide support for victims and children, post-separation in recognition of the increased risk posed by perpetrators during this period

## Child B and C

**Finding 3**

The application of local thresholds for access to children's social care were based on a "rule of optimism" and impaired child centred decision-making. This included the decision to allow the twin babies to be discharged into the care of their parents following their hospital birth.

**Finding 5**

There is no evidence that messages from research and lessons from serious case reviews were used to inform the rationale behind decision-making for these children.

## Child D

4. **How did practitioners know that what they were doing was reducing risk?**

- To seek assurance that routine ongoing analysis takes place to include; whether or not risk is decreasing/ increasing/ static particularly paying attention to patterns of behaviour/ capacity and willingness to change.
- Non –compliance with plans should be explicitly addressed at child protection meetings.
- Contingency plans should be explicitly described and agreed and timescales set for intended outcomes/ interventions.

**5. How were the risks associated with males, including Child D's father, identified and assessed and responded to?**

To seek assurance from partners that their current single and multi-agency risk assessment approaches encourage and facilitate 'big picture' analysis of risk

7. **Were single and multi-agency actions including communications and information sharing appropriate, accurate and acted upon?**

- Where there would otherwise be delays between Core Groups or other Inter or multi-agency meetings alternative arrangements must be made. A substitute chair person must be identified and the arrangements communicated with all agencies.
- Whilst there is a rationale for why information in respect of the two incidents of alleged threats to children by Adult A was not shared, the KSCB and partners may wish to consider how 'cross checks' are carried out in future incidents of a similar nature.
- Consider whether there are any common themes from previous serious case reviews or critical incident reviews and the effectiveness of agency's actions in relation to these.

9. **Determine whether National, Regional and Local policies, procedures, thresholds and practice expectations of the agencies were followed.**