Waltham Forest Safeguarding Children Board

Serious case Review

"Child D"

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Glossary

1. Introduction and reason for review

Under Working Together 2015, the Independent Chair of the Waltham Forest Children Safeguarding Board agreed to the recommendation from the One Panel (multi-agency forum that takes referrals for local or statutory reviews and makes recommendations against the statutory criteria to the independent chair) to undertake a Serious Case Review for Child D who sadly died in November 2018.

This serious case review concerns the unexplained death of a four-month-old baby boy (Child D) and the services provided to Child D and his Mother, during her pregnancy and over the four months of Child D's life until his death in late 2018. His Mother experienced domestic abuse prior to her pregnancy and had to flee from her abuser, the father of the child. Mother then lived in east London and was isolated with a very limited support/friends, and no family. It is imperative that her identity is protected so while the review took account of all Mother's personal circumstances and identity, this report does not include these details.

Mother has been living in Newham when she booked for her pregnancy and before Child D was born, she moved to Waltham Forest where she lived in a Refuge for women experiencing domestic abuse. When Child D was four months old and at the time of his death Child D was in the sole care of his Mother and living in temporary studio accommodation in Hackney, sourced by London Borough Waltham Forest Housing. During the period under review she disclosed to her GP and other health professionals her experience of domestic abuse; both physical and emotional, and identified that Child D's father was the perpetrator. Mother was living in the local women's refuge where she fled due to domestic abuse. Shortly before his death, Child D and his Mother were evicted by the refuge due to her breaching the licensing agreement.

Alternative temporary accommodation was sourced by Waltham Forest Housing and found in the neighbouring borough of Hackney. The accommodation provided was a small studio room with a single bed. The room did not contain a cot, and none was provided. The usual practice at this time would have been if there had been a request for a cot it would have been provided by the property managing agent. Police officers attended the address following the report of Child D's death and treated it as a Sudden Unexplained Infant Death however because of Mother's demeanour and behaviour she was arrested on suspicion of neglect, due to alcohol abuse whilst in charge of a child.

The coroner gave the cause of death as "Unexplained" and noted that there were signs consistent with asphyxiation, an undiagnosed brain condition.

Family Involvement Mother was informed by hand delivered letter that a review had been commissioned and of its purpose. She was subsequently approached and spoken with about contributing but felt too grief stricken to take part. Services have subsequent loss contact with Mother.

2. Methodology and agencies involved

This review has been carried out in a way that reflects the principles of a systems-based approach.

The review seeks to understand why things happened in the way they did. Broadly this means using this case as a 'window on the system', asking the question: ***What does Child D's experience tell us about how systems work?*** The aim is to look for areas that relate to systemic issues, which will lead to changes in practice. The focus of this review is very much on learning and improvement.

The final report has been authored by Dave Peplow, Fran Pearson who are independent of the partnership and Suzanne Elwick, who is employed by the Waltham Forest, is independent of the services reviewed, using information generated by an independent reviewer who has previous experience of leading Child and Adult reviews.

The review period is from November 2017, when professionals first became aware that the Mother was pregnant, until November 2018, when the Mother contacted emergency services as Child D had died.

The Review Group was made up of senior managers from all those agencies that were involved with Child D and his Mother in the twelve-month period before his death. The Review group met with the Independent Reviewer to consider emerging issues and took part in the two workshops with frontline practitioners who knew Child D and his Mother. The Review Team appreciate the professional, open and honest way all concerned conducted themselves throughout the process.

The agencies involved were:

Newham

- London Borough of Newham Children's Social Care (NCSC)
- Newham Vulnerable Women's Team (Maternity) provided by Barts
- Perinatal Mental Health Team in Newham (Cognitive Behavioural Therapist & Psychiatrist)
- Newham Primary Care (GP)

- London Borough of Newham Adult Services (NAS)

Waltham Forest

- London Borough of Waltham Forest (LBWF) Multi Agency Safeguarding Hub
- LBWF Housing
- Women's Aid-Waltham Forest Refuge
- Waltham Forest East London (WEL) Clinical Commissioning Group
- North East London Foundation Trust (Health Visiting and PIMMHS)
- Primary Care

Bart's Health Trust

- Newham University Hospital
- Whipps Cross University Hospital

London Metropolitan Police

- Specialist Case Review Group

3. Findings and learning points

The following section considers the key areas where analysis of practice in this case identifies system level issues that are relevant to the wider safeguarding system.

Comment on housing practice in relation to the risks of co-sleeping

There was extensive discussion in the review process about the availability of suitable housing and the complexity of this issue in inner city London where housing stock is extremely limited.

The accommodation provided to Child D and his Mother was considered appropriate by LBWF Housing and complied with the legislation for a Mother and small child. When Mother was in the refuge there was a Moses basket for Child D. As highlighted in the significant dates table and in finding 4 there were many occasions when Mother chose to place Child D on the bed rather than in the moses basket.

At the time Child D and his Mother moved to temporary accommodation, the independent housing provider of the accommodation had a practice of not providing cots due to incorrect information regarding the risk of Sudden Unexplained death in Infancy. In December 2018, the Director of Public Heath for Waltham Forest, in his role as chair of the child death overview panel provided the latest public health information regarding Sudden Unexplained Death in Infancy and the risk of co-

sleeping to the provider, and together with the LBWF housing this practice has now changed. LBWF housing now ask the managing agent of the accommodation to always provide a cot in relevant circumstances.

Findings

Finding 1	Assessing the needs and risks of families experiencing domestic abuse is a complex task that local children safeguarding system in Newham need to support professionals with, in order to create the best chance of a consistent and child-centred response
Finding 2	For more than five years both safeguarding partnerships in Waltham Forest and Newham have promoted and reviewed the use of escalation processes. This case highlights that some practitioners are still not confident about using escalation
Finding 3	In Waltham Forest and Newham some practitioners do not always record important information which results in significant information not being shared when required.
Finding 4	There is a tendency for some practitioners in Waltham Forest and Newham to minimise the significance of parents using alcohol and being over optimistic about reports by parents of their alcohol consumption.

Finding 1

Assessing the needs of families experiencing domestic abuse is a complex task that the child safeguarding system leaders in Newham need to support professionals with, in order to create the best chance of a consistent and child-centred response

How are these issues evident in this case?

A referral was made to NCSC by Newham University Hospital on the 19.12.2018. The presenting issues to be addressed were domestic abuse and mental health, in the context of a pregnancy where Mother was seeking to leave Child D's father, the alleged perpetrator. The case was allocated for a single assessment under S17. The assessment was being conducted with Mother's consent and therefore would appear to be a under S17 of the Children Act as a child in need assessment, rather than S47 as child in need of protection. Although the allocated social worker can clearly recall a home visit and assessment, there is no record of the visit or the assessment nor the rationale for the assessment framework being that of a Child in Need. It is clear from the limited available records and through conversations with the social worker and practice lead, that the issues of domestic abuse and mental health were not fully explored with Mother. Further information should have been sought to establish a

more accurate picture of Mother's situation and the risk to the unborn Child D. The collating and verification of information is integral to a good assessment process and good decision-making.

Women who are exposed to domestic abuse during their pregnancy (research shows domestic abuse is likely to be exacerbated by pregnancy) that have higher levels of fear and anxiety with higher levels of miscarriage and lower birth rates. Research tells us that women are at higher risk of harm when they leave a violent relationship, but this was not explored or recognised.

> *One of the most important reasons women don't leave is because it can be incredibly dangerous. The fear that women feel is very real – there is a huge rise in the likelihood of violence after separation. 55% of the women killed by their ex-partner or ex-spouse in 2017 were killed within the first month of separation and 87% in the first year (Femicide Census, 2018)*

Application of the nationally adopted and recognised Domestic Abuse, Stalking and Honour based Violence (DASH) risk assessment would have provided a recognised framework for establishing the level of risk to both Mother and child. This assessment was being completed under s17 as a child in need. A good assessment may have established that a pre-birth single assessment under S47 was appropriate. In line with Newham's policy on pre-birth assessments (both s17 and s47) the main purpose of the pre-birth assessment is to identify:

- What the needs of the new-born are?
- What risks are posed?
- Analysing the capacity of the parent/s to respond appropriately to the baby's needs
- How historical concerns might impact on safe parenting
- Reducing the risks

The assessment completed by the social worker did not comply with the policy in that risks were not identified that were knowable at the time if the social worker had demonstrated curiosity in discussions with Mother and had liaised with midwifery.

This was a missed opportunity to establish the necessary rapport with Mother and for information to be elicited, which in turn was compounded by a decision made by the more experienced social care professional supporting the social work and overseeing the quality of practice. This decision was to close the case and was a further missed opportunity. The rationale was that Child D's Mother withdrew consent thereby ending an assessment process being completed under Section 17. It is arguable at this point that based on all the information knowable that the case could have met the threshold for a Section 47 Children's Act inquiry in terms of safeguarding the unborn

child. There is no record that consideration was given to the Mother being referred for assistance through coordinated 'Early Help'. Newham's Pre-birth procedures (2017) indicate that a child may be referred for assessment as early as 6 weeks gestation and that triage research should include details of the expected delivery date (EDD). All pre-birth referrals are required to have a multi-agency meeting within 14 days of allocation. In this case the pre-birth protocol was not followed. No research was conducted and there was no multi agency meeting. This was poor practice.

The three contacts to adult services in Newham, from Mother herself, Mother's psychiatrist and Mother's GP were included as part of the chronology produced for the review which provided significant information regarding the risks to the unborn child. The review was advised that this information was not seen by the workers in NCSC at the time the decision was made to close the case. This raises additional concerns regarding the approach to working with families in Newham and awareness of child safeguarding in adult services.

Does this happen in other cases?

The recent Ofsted Inspection of NCSC highlights that:

> *Many children benefit from good-quality assessments, although the quality is variable, and some assessments are poor*
>
> *Children in need of help and protection in Newham receive services which range in quality from requires improvement, to good, to poor.*

Why does it matter

Children living with domestic abuse form the majority of work for children social care and therefore it is vital that as a partnership we get this right

> "*Domestic violence, which includes that aimed at children or other adults in the household, was the most common factor identified at end of assessment for children in need at 31st March 2018 (Characteristics of children in need: 2017 to 2018 England)"*

Questions for the two Newham Safeguarding Partnerships

Newham Safeguarding Children's Partnership

In line with the improvement actions agreed by all partners following the January 2019 Ofsted inspection of local authority children's services: how do the statutory partners understand their respective roles in supporting a system where "proportionate intervention [is] understood and consistently applied by the multi-

agency partnership and within social care. Records of action; decision and rationale are clear and up to date".?
In line with the improvement actions agreed by all partners following the January 2019 Ofsted inspection of local authority children's services: how do the statutory partners understand their respective roles in supporting a system which "Embed[s] use of Safer Lives tool to identify and assess risk of levels of domestic violence to inform safety planning and support for children and parents."?

Newham Safeguarding Adult's Partnership Board
What is SAB's current understanding of the confidence and competence of all professionals working with vulnerable adults to identify and pass on safeguarding concerns about children including unborn children in line with Working Together to Safeguard Children 2018?

How familiar are board members with the agreed joint protocol *Working Alongside Families in order to support parents and carers with good mental health and wellbeing* which is joint between East London Foundation Trust and Children's Social Care? Could its principles be extended across a wider group of adults' professionals?

https://proceduresonline.com/trixcms/media/1770/joint-mental-health-protocol-final-version-oct-17.pdf

WFSCB Board response to Finding 1

This action is for Newham as this was not felt to be an issue in Waltham Forest evidenced by the recent Ofsted which stated:
"Children assessed to be at risk from domestic abuse receive effective interventions to safeguard their welfare. There is a range of strong and flexible services provided for children and adults. Social workers appropriately assess the risks associated with domestic abuse and honour-based violence. This information is well analysed, and results in sustained interventions. The local authority recognises that there is more to do in ensuring the actions agreed at MARAC meetings are implemented in planning for children."

In addition, in Waltham Forest Safe and Together model is being rolled out across the partnership. Safe and Together (SaT) model is an approach designed to improve the way that safeguarding systems respond to families affected by domestic abuse. It provides a framework for partnering with domestic abuse survivors and

intervening with domestic abuse perpetrators to enhance the safety and wellbeing of children. SaT has had international success in changing services' responses to domestic abuse, increasing the number of children who remain safely with their non-abusive parent and decreasing re-referral rates into services.

Newham Safeguarding Children Partnership (NSCP) response to Finding 1

Newham children's social care has strengthened its training offer in systemic approaches to relationship- based practice. The approach privileges direct work with children, young people and adult family members and will enable practitioners to be clear about the purpose of their interventions, develop their skills to build meaningful relationships and build confidence in using tools to assess and support families to make and sustain positive change. This will support the improvement in the quality and consistency of assessments ensuring they are analytical and proportionate.

Dedicated practitioner workshops focussing on the three key themes of assessment, planning and direct work are being delivered to all practitioners and managers.

These workshops are supported by coaching sessions to embed the learning.
The training programme for Newly Qualified Social Workers has been updated to follow the journey of the child, featuring assessment of need throughout. Experienced Social Workers are given the opportunity to attend.

Multi agency assessments and interventions are supported and informed by the borough's dedicated domestic abuse service, Hestia. This is a community-based service, co- located within services across Newham including the Multi Agency Safeguarding Hub (MASH), Newham University Hospital and police stations

Within Newham Adults Services, the front door Access team have received briefings and guidance on how to ask appropriate and probing questions, for screening safeguarding cases where there are children involved or believed to have been involved.

A checklist of points to consider is being developed in conjunction with the East London Foundation Trust Mental Health services. The Working Alongside Families in order to support parents and carers with good mental health and wellbeing joint protocol is currently being revised and will be relaunched in May 2020 for Mental Health Awareness Week, 18th - 24th May.

Finding 2
For more than five years both safeguarding partnerships in Waltham Forest and Newham have promoted and reviewed the use of escalation processes. This case highlights that practitioners are still not confident about using escalation.

How are these issues evident in this case?

This case identifies seven occasions when practitioners could have escalated their concerns in relation to the outcome of their referrals which did not lead to the assessment they requested. None of the practitioners escalated to the service receiving the referral or within their own agency.

Potential opportunities to escalate:

- Jan 2018 – Cognitive Behaviour Therapist makes referral to NASC
- Feb 2018 – Mother's psychiatrist makes referral to NCSC
- Feb 2018 - GP makes referral to NASC
- April 2018 - WX Midwifery makes referral to WFMASH
- May 2018 – Newham Hospital midwifery contacts NCSC regarding case being closed as Mother not agreeing to assessment
- Oct 2018 - WF Refuge x2 referrals to WFMASH

In Waltham Forest there has been an escalation process in place for over 5 years and this is promoted at all training and events and is on the front page of the WFSCB webpage. Escalation has also had its own spotlight bulletin in June 2019.

Waltham Forest strategic boards has a comprehensive learning and improvement practice work programme which includes multi-agency audits, which are conducted alongside statutory and local learning events. Lack of escalation is an issue that has repeatedly come up in audits and reviews consistently over the last 5 years, despite the escalation process in place.

In Newham escalation is promoted via newsletters across the partnership and is a standing agenda item at the Newham LSCB performance and quality assurance subgroup where they look at themes / outcomes etc.

The practitioners and managers who were part of the review reported that they were aware of the escalation process in their borough and felt it was widely promoted. Despite this, it is evident that practitioners do not generally escalate.

Does this happen in other cases?

The issue of lack of escalation is a common finding in reviews in the experience of the authors of this review and discussion in national fora. However, there is no data which routinely captures this information.

Nationally in the latest Triennial Review of Serious Case Reviews 2011-2014 we learn that most children subject to an SCR were not involved with the child protection system through a child protection plan or a court order, although many were receiving services as 'children in need'. Many of these children and families had also been known to children's services in the past, and as such should be considered by agencies as having recognised and potentially long-lasting vulnerability or risk

The review found lack of escalation to be a factor

> *Professionals in all agencies working with vulnerable families must be persistent in their practice, maintaining consistent support for the family and vigilance towards meeting children's needs. This includes pursuing non-engagement, seeking advice, and escalating concerns where appropriate, as in the following case "(Page 147)*

In discussion with practitioners and managers in the workshop they advised that they were aware of the escalation process and felt it was well publicised in both Newham and Waltham Forest.

Why does it matter

A safe and effective safeguarding system depends on practitioners who are confident to engage in constructive challenge with their colleagues. At times as practitioners we may disagree about threshold judgements and/or the appropriate course of safeguarding action.

Practitioners working with children, adults and families in often complex situations can have different opinions and views on the best way to provide support. Discussion and debate, in a multi-agency context with colleagues, along with constructive challenge, enhances and develops understanding and knowledge. This leads to a fuller assessment and should be part of everyday practice.

If practitioners do not escalate, do not take opportunities for constructive challenge and debate, their concerns remain unchallenged which could lead to children remaining at risk and this is a significant risk to the multi-agency safeguarding system.

The Triennial review comments that practitioners need to feel confident and empowered to escalate and that:

> *"Building cultures of support and empowerment needs strong organisational leadership within Local Safeguarding Children Boards and in their constituent agencies. "(page 205*)

Questions for Newham and Waltham Forest boards

1. How can Newham and Waltham Forest boards build cultures of support and empowerment to enable practitioners to feel confident to routinely escalate appropriately? What will each individual senior leader/board member do in their agency to build this culture?

2. How are Newham and Waltham Forest boards going to monitor if practice has improved and what will they do if practice does not improve?

WFSCB Board response to Finding 2

Waltham Forest Safeguarding Children (WFSCB) and Safeguarding Adults Boards (WFSAB) recognise escalation as a theme in both local and national reviews. Alongside this SCR, escalation is also a theme of a recent Safeguarding Adult Review.

WFSCB and WFSAB discussed the need to learn more about the use of escalation. At present we are only aware that lack of escalation is often a theme in cases that are reviewed. We do not know if escalation is being used appropriately in other cases.

Agencies agreed to monitor escalations for a 3-month period to aid and add to our understanding.

Escalation is to one of four themes for the improving practice programme of work and is due to be delivered through the Strategic Partnerships Unit in March – May 2020.

The Board agreed that there is a need for the escalation process to be promoted by all agencies through multiple routes such as email signatures or screen savers, to direct practitioners to the WFSCB and WFSAB escalation process.

Actions

- All agencies to record, for a 3-month period, details of escalations for child and adult cases that occur, as far as they are able from 27 January 2020 to 27 April 2020

- Strategic Partnerships Unit's next resource pack for improving practice will specifically be around escalation. This will include a practitioner's survey and learning resources to meet different learning styles which can be used for self-study, in supervision and in team meetings including good practice case studies and training exercises,
- Escalation process link to be added to the MASH signature and to referral form.

NSCP response to Finding 2

Newham Safeguarding Children Partnership has an established escalation policy This has recently been updated and will be relaunched across the partnership to drive compliance. A rolling programme of briefings are being delivered across the partnership where the policy will be promoted.

Newham Safeguarding Adults Board (NSAB) acknowledges that effective escalation both within the local authority and its partner agencies requires immediate review. Escalation has been included in the 2019/20 work programme for the Performance and Quality Assurance subcommittee.
Adult Social Care will lead on a draft Adults Escalation policy scheduled to be completed by the end of the 2019/20 year. The NSAB has agreed that there is a need for the escalation process to be promoted by all agencies. Its implementation will be monitored through the Performance and Quality Assurance subcommittee.

Adult Social Care operate Reflective Practice bi-monthly sessions targeted at front line staff, which are an opportunity to learn lessons from case reviews. A case study on escalation is in development for the start of the 2020/21 year.

Finding 3

In Waltham Forest and Newham practitioners do not always record important information which results in significant information not being shared.

How are these issues evident in this case?

In this case there are at least 7 incidents where important information was not recorded by practitioners working with the family:

- No record made by the attending police officer for the basis of his decision in relation to the alleged assault against Mother, which he recorded as a landlord/tenant dispute
- One Newham Police contact where a Merlin was completed but not shared with NCSC in line with policy.
- No record of a home visit taking place by the NCSC social worker
- No record of the assessment completed by the NCSC social worker
- No record in the Health Visitor's record of a request for monitoring by WFMASH
- No record of phone calls in WFMASH, by the Refuge to business support in WFMASH
- Gaps in the Health Visitor records based on indicated HV contact from others.

Does this happen in other cases?

It is reasonable to assume that any authority is likely to have a variable level of practice. This is a challenging area of practice because we do not know what we do not know.

The issue of recording is linked to that of information sharing. If information is not recorded, it cannot be used to inform further assessments and multi-agency discussions and cannot be shared with others. The issue of recording information, sharing information and multi-agency working are all discussed in the Triennial Review and feature frequently in serious case reviews. Record keeping is also linked to professional codes of practices and is a professional standard as well as a safeguarding issue

Why does it matter

Why it matters is because:

> *"No single professional can have a full picture of a child's needs and circumstances. If children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action." (Keeping Children Safe in Education 2018 p.5)*

This quote relates to children in education and is used as it comprehensively illustrated the point about recording information

The context of education provides a useful context for understanding the importance of recording. Kent County Council illustrates this clearly in their guidance which can be translated to any setting for a child:

Accurate and up to date recording of child protection or welfare concerns is essential for a number of reasons:

- It can help educational settings identify child protection or welfare concerns at an early stage
- It can help settings identity patterns of concerns
- It can enable settings to record seemingly minor issues to build a more complete picture of what life may be like for their learners
- It helps settings to monitor and manage safeguarding practices, including decision making, actions taken and agreed joint strategies with other agencies
- It can provide evidence to support professional challenge, both within educational settings and when working with external agencies
- It can support settings to demonstrate action taken to reduce impact of harm to a child
- It helps to evidence robust and effective safeguarding practice in inspections and audits. *(Kent County Council Safeguarding record keeping guidance for education settings Sept 2018)*

Questions for the board

1. How do agencies assure themselves that their staff are recording appropriately? This is asked in the context of "not knowing what you don't know" which may not be the usual way, in which single agency audits ask the question. Are agencies able to complete spot checks to assure themselves. For example, Police cross-checking a child was present with MERLIN being sent.

2. How are Newham and Waltham Forest boards supporting practitioners to improve their practice in recording?

<u>WFSCB Board response to Finding 2</u>

Agencies all regularly undertake audit activity to assess the quality of assessments. Due to the nature of these audits they cannot always confirm if any information is missing. Agencies discussed other ways of highlighting and raising awareness with their practitioners about the importance of record keeping

Care Grow Live: has time dedicated to analysing the quality of notes as well as internal record keeping and provides internal training for staff.

NELFT: The Safeguarding Team multi-agency referral form (MARF) audit asks specific questions regarding both internal escalation in NELFT and external escalation within social care on records where a MARF has been completed.

Police: The training cycle going forward includes a focus on response officers and safeguarding issues which will have an emphasis on recording accurately if children are part of the family – not just present at the time.

Actions

- All agencies that sit in MASH to identify how they provide feedback to staff from their agencies on the quality of recording on the referrals that come into MASH. MASH Strategic Group to oversee this.
- CSC already include discussion with the practitioner as part of the audit process. Audits to include a question about the accuracy and quality of the recording as this can be tested out by the manager when they discuss with the practitioner.
- Barts Health to undertake a spot check audit matching case records to referrals made and identify if record keeping is the same on both

<u>NSCP response to Finding 3</u>

All training referred to in Finding 1 includes a focus on effective recording for Newham Children's Services.

For Newham Adult Social Care (NASC), they have an established programme of case file audits which are undertaken by ASC managers and seniors. Accurate and concise recording is a significant criteria of the audits and the outcomes and themes of the audits are presented to the Newham Quality and Governance Board where improvement plans are agreed.

In addition to this, NASC have the following training as part of the 2020-2021 programme:

- Court Room Skills & Report Writing (for Court of Protection)
- Legal report writing
- Care Act workshops and peer learning sessions

Finding 4
There is a tendency for practitioners in Waltham Forest and Newham to minimise the significance of parents using alcohol and being over optimistic about reports by parents of their alcohol consumption

How are these issues evident in this case?

On at least eight occasions practitioners mentioned alcohol as an issue of concern in relation to the Mother of Child D. However, at times this was often alongside a comment about historical or "not dependent on" without any other evidence or commentary to back up the statement:

- 8 Nov 2017 – Police record notes that Mother "under the influence when assaulted"
- 15 Feb 2018 – Perinatal psychiatrist advised NCSC that Mother "has historical alcohol problems"
- 28 Feb 2018 – Contact with NASC from GP which includes information from letter from same psychiatrist of "history of heavy alcohol use but didn't think she was dependent, and Mother says she hasn't drunk since the pregnancy"
- 10 Sept 2019 – residents in the Refuge report to staff that they are concerned for Child D as they have seen Mother drunk while caring for him. Mother declines referral to alcohol misuse service and denies that she has a drinking problem. The HV is advised of this by the Refuge staff.
- 4 Oct 2019 – other residents disclose concern about Mother smelling of alcohol. When discussed with Mother she appears drunk and unsteady on her feet while holding Child D. Referral to WFMASH advises of potential alcohol use but doesn't include Mother appearing drunk in the morning while holding Child D or that she went out and came back at 2am.
- 5 Oct 2019 - WFMASH discuss referral with Mother who denies any difficulties with alcohol or leaving Child D alone for longer than 5/10 mins. Refuge worker speaks to WFMASH and expresses concern about Mother being drunk all day
- 31 Oct 2019 - health visitor spoke with Mother about her drinking but did not include this in the actions for Mother which did include smoking cessation, attending Toy Library and accessing counselling.
- 9 Nov 2019 – Mother calls the on-call refuge manager at 12.30am and is speaking incoherently and the manager suggests Mother may have been under influence of alcohol. Mother advises call was a mistake.

When the issue of current alcohol was raised by or with practitioners there was a tendency to "believe" Mother's account. For example, when Mother was referred to

WFMASH by the refuge, when WFMASH spoke with Mother they accepted Mother's account that she was not drinking much and only left Child D for 5/10 minutes although the refuge worker reported this differently.

When the Health Visitor spoke with Mother after speaking with the refuge worker, she too accepted that Mother said she only drank occasionally.

When the refuge spoke with WFMASH they did not give the full explanation of Mother's drunken behaviour.

Does this happen in other cases?

Locally in Waltham Forest alcohol was the third highest potential risk factors identified at end of assessment 1 April 2018 – 31 March 2019.

Both the Triennial Review of SCR and the NSPCC learning from case reviews identifies alcohol and assessment of parent's alcohol use as a contributory factor. The NSPCC research evidenced that assessment tended to *often focus on the issues faced by parents who misuse substances without considering the impact on their children*

And identifies further that

Substance misuse by a parent or carer is widely recognised as one of the factors that puts children more at risk of harm. The biggest risk posed to children is that parents, when under the influence of drugs or alcohol, are unable to keep their child safe (including overlay through co-sleeping and accidents caused through lack of supervision). NSPCC learning from case reviews Nov 2013

Significantly in the Triennial Review research the deaths of 31 children (out of 93 children that died) were *presented as Sudden Unexplained Death in Infancy. Most of these children died while co-sleeping with a parent or in other dangerous sleeping arrangements, such as on a sofa, on soft bedding, or in make-shift bedding. Many of these families appear to have led chaotic lives, with frequent house moves, periods of homelessness, or inappropriate housing. Substance and alcohol misuse were common (Triennial Review page 59)*

Where parental mental health problems co-exist with other risk indicators, particularly domestic abuse, but also including drug or alcohol misuse, or social isolation, this should prompt a further assessment of the child's safety (Triennial Review page 84)

Why does it matter

Alcohol is a social accepted "drug" and the volume and amount of consumption by individuals varies in society and as such will vary amongst practitioners. This may influence how some practitioners view the use of alcohol by people when they are experiencing stressful situations such as Mother did.

As a society we do not have a shared view on what is too much alcohol, (aside from the public health information about how to keep health risks from alcohol to a low level) we do not have a shared view as a partnership. Together with the lack of shared view is a tendency to want to support women with children in difficult circumstances. In this case it appears to have led to an over optimism, minimising and lack of challenge.

When Mother spoke about her historical drinking difficulties there is no evidence to suggest this was explored. There was no questioning of how someone who had an addiction or problematic drinking pattern was able to suddenly end when she became pregnant. There was not discussion about the reason in the first place for the drinking, which may have been part of her coping strategy to deal with her experiences of abuse. There is no record of practitioners being curious about Mother's ability to suddenly stop drinking and/or what she was using know as a coping strategy. Is there a lack of awareness amongst practitioners about the significance of addiction and how difficult it is to address addiction?

The context and extent of alcohol use was minimalised by the Refuge in the initial written referral to WFMASH. When the health visitor and Refuge drew up a plan for Mother, they excluded alcohol from the list of areas of attention and therefore missed an opportunity to link Mother's alcohol use to concerns about her parenting.

When asked about her alcohol consumption Mother minimalised it herself and reported very low alcohol intake. This was not the view of the Refuge staff and residents who witnessed Mother drunk on several occasions including first thing in the morning,

The rule of optimism and lack of professional curiosity together leads practitioners to trust parents self-reporting about their consumption despite evidence from others that this is not the case. This is emphasised in the NSPCC learning from SCR which highlights the importance of clear communication with parents about the risks advising that

> *Some parents said they did not feel that the risks of co-sleeping had been explained in such a way that they had fully understood them, or had been able*

to take them on board (Parents who misuse substances: learning from case reviews, NSPCC, 2013)

If practitioners were not able to explore with the Mother of Child D the extent of her alcohol consumption, they may also not have had the opportunity to discuss with Mother fully, in a way that she was able to understand, what the risks were to Child D.

Questions for the Newham and Waltham Forest boards

1. What is the board's understanding of all practitioner's ability to probe, explore and challenge parents as appropriate, about their relationship with alcohol?

2. How confident is the board of the knowledge of all practitioners about addictive behaviours, and the challenges of becoming sober or practicing harm reduction, particularly in relation to pregnancy and post birth?

3. Is the board confident that there is a shared partnership view of what is harmful and non-harmful use of alcohol?

<u>WFSCB Board Response to Finding 4</u>

WFSCB notes the important practice point of "what happened in the past being an indicator of the future". This is not to say that individuals cannot change but requires practitioners to be extra curious and triangulate information. In this case, the Mother had a long history of using alcohol and had previously had a conviction relating to being intoxicated whilst executing her role as a carer.

Additional work to be undertaken to further support practitioners with having challenging conversations and improving understanding harmful use of alcohol.

WFSCB note that Care Grow Live now have a presence in MASH so extra support is on offer at the point referrals are being discussed and also on the ground for CSC staff to have advice on active cases.

Actions

- WFSCB to further promote the bitesize video guide on alcohol use which contains practical advice around having challenging conversations with adults about their alcohol use.
- Strategic Partnerships Unit outreach and improving practice work will explore directly with front line practitioners the challenges and barriers they face in having challenging conversations and also gather good practice ideas and

what would help practitioners. Results will be fed in to a seven-minute briefing that will be circulated widely
- WFSCB to circulate widely the training offer from CGL each quarter on raising awareness of alcohol and substance use.
- Strategic Partnerships to include messages around alcohol use with the 16 days of Activism in November 2020
- Strategic Partnerships to ensure that resources, training and awareness around alcohol use and challenging conversations is included within the Safe & Together training
- Barts to raise awareness across the partnership of the Alcohol Reduction Nurse based at Whipps Cross Hospital

NSCP response to Finding 4

Change Live Grow (CGL) is the commissioned and integrated provider of drug and alcohol treatment services in Newham.

CGL have strong operational and strategic links with Adults, Children and Young Peoples Services, providing training across the partnership through the Newham Safeguarding Children Partnership. The risks associated with being overly optimistic will be incorporated into this training.

Within Adults Services, alcohol and substance misuse is a concurrent theme among a number of NASC customers. Social Care professionals work closely with (CGL) to support customers to reduce addictive behaviours. Adult Social Care Workforce Development will commission suitable training in 2020/21 on alcohol use to upskill frontline practitioners.

4. Summary of learning taken by agencies at the time.

The following action plans have been shared for inclusion in this report. We are aware that other agencies have completed plans that can be made available to each Board.

Waltham Forest MASH

WFMASH conducted a file audit of 100 cases as a result of this case and has implemented an action plan which includes:

1	All actions assigned to Social Worker are checked by the manager to ensure completion

2	Assessment and information gathering should test out what parents are saying and respond back to practitioners
3	Checks on cases where other Local Authority (LA) are mentioned and if checks were completed with the LA
4	Checks on closed cases to see if threshold was appropriate
5	Duty social worker put into place with business support to field telephone calls
6	Business Support staff to complete case notes each time a professional call on a case and case note alert to the management team to review new information.

Waltham Forest Housing has an action plan in place

1	The placement officer must review the information on the appropriate system, Northgate/Jigsaw. Any vulnerabilities, MASH referrals, Social Services Referrals, must be recorded on the Assessment Needs Form (ANF)- A note must be added to the system to confirm the review
2	Any issues that are identified as conflicting/incorrect must be brought to the attention of the relevant caseworker for remedy.
3	The client with the assistance of an officer if necessary, must undertake completion of the Assessment Needs Form (ANF). The information provided on the form must be crosschecked with the client.
4	The household composition must be confirmed, full names, dates of birth, medical needs. Details of any supporting services must be recorded, name and contact details of the supporting officer/worker.
5	Review the details of the property on the void's spread sheet
6	Contact the supplier, confirm the property size, how many people it is intended to accommodate
7	Confirm that a cot will be made available once the booking is confirmed to any household that has a baby and requires a cot
8	If a household refuses a cot, the officer must update Northgate/Jigsaw/TA Checklist with the household's reason/s for refusal, e.g. they have their own cot.
9	Any referring agencies should be advised of the placement once the booking is complete if necessary.

10	Details for the managing agent and the TA team for the purpose of on-going contact should be given to the household at the booking.

Health Visiting Services have completed a health development action plan, which focuses on

1	Record Keeping
2	Use of DASH in assessing Domestic Abuse
3	Escalation process
4	Caseload weighting and Case management

Glossary

BRAG ratings definitions

- **Red**: There is a potential child protection issue (e.g. serious injury to the child).
  Requires immediate action, and information from MASH navigators is expected within 2 hours.
- **Amber**: There are significant concerns, but immediate action is not required (e.g. on-going domestic violence issues in the household).
  Requires information from MASH navigators within 6 hours.
- **Green**: There are concerns regarding a child's wellbeing, but these do not meet statutory requirements (e.g. poor school attendance).
  Requires information from selected MASH navigators within 24 hours.
- **Blue**: There is no safeguarding concern and the issue can be dealt with by a Universal service.
  No MASH response required. Advice or referral to a Universal service may be provided.

DRM –Daily Risk Management Meeting Waltham Forest -The DRM meeting provides the framework to allow regular information sharing and action planning to safeguard high risk cases being received into Waltham Forest's MASH front door.

Guideline-Practice guidance is a tool for reflective practice and identifies the best of current practice using current research.

IAPT - services provide evidence-based psychological therapies to people with anxiety disorders and depression.
MERLIN - is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason.

One Panel - The One Panel is Waltham Forest's Think Family forum, which takes referrals for local or statutory reviews and makes recommendations against the statutory criteria for safeguarding adult reviews and local reviews/national review (previously known as serious case review) to the relevant board chair.

Professional Curiosity- the capacity and communication skill to explore and understand what is happening with a family rather than making assumptions or accepting them at face value.

Protocol- Protocols (and procedures) are sets of rules – they are MUST DO's.

Post-Traumatic Stress Disorder (PTSD) is a type of anxiety disorder triggered by traumatic events in a person's life such as real or threatened death, severe injury or sexual assault.

Section 17 Children Act 1989 -(1) It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part)—

(a) to safeguard and promote the welfare of children within their area who are in need; and

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families,

by providing a range and level of services appropriate to those children's needs.

VAWG Violence Against Women and Girls