KNOWSLEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW IN THE CASE OF CHILD R

TIMELINE: JANUARY 2011 TO NOVEMBER 2015

OVERVIEW REPORT

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1. INTRODUCTION AND CONDUCT OF THE SERIOUS CASE REVIEW

1.1 Incident Leading to the Serious Case Review

At 10.10 hours on the morning of Child R's death, North West Ambulance Service (NWAS) received a 999 call from Child R's mother asking for assistance.

NWAS contacted Merseyside Police advising that they were en route to a baby below the age of twelve months with suspected cardiac arrest. When paramedics arrived at the address they were told that father had attempted cardio pulmonary resuscitation (CPR) and this was continued by paramedics. However, resuscitation was unsuccessful and Child R was pronounced deceased by an advanced paramedic at the home address.

It was reported by the parents that Child R had been in bed with mother; an older sibling had gone into the bedroom to wake mother who did not wake immediately. The older sibling found Child R not moving and told mother. Mother then took Child R downstairs and made several phone-calls. Father then arrived and attempted CPR.

NWAS contacted the local Children's Hospital and informed them of Child R's death and transported Child R to the mortuary.

1.2 Key People

Person	Referred to as:
Child R (deceased)	Child R
Mother of Child R	Mother
Father of Child R	Father
Siblings	Siblings (not referred to individually)
Maternal Grandmother of Child R	MGM

1.3 Confidentiality

Neither the gender nor the exact age of Child R are referred to in this report. It will be apparent from agency contact that Child R was a baby below the age of twelve months when they died.

Pseudonyms are attributed to members of Child R's family and to professionals who worked with the family.

1.4 Rationale for conducting the SCR

A referral was made to the Serious Incident Review Group (SIRG). Following a second meeting of the SIRG a recommendation was made to the Chair of the Local Safeguarding Children Board (LSCB) that a Serious Case Review (SCR) should be undertaken.

Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires a LSCB to undertake a review of a serious case in accordance with the procedures that are set out in chapter four of *Working Together to Safeguard Children (2015)*[1].

A LSCB should always undertake a serious case review when a child dies or has been seriously harmed, and abuse or neglect is either known or is suspected, and there is cause for concern as to the way the authority, the Board or other relevant persons have worked together.

The purpose of the review is to establish what lessons can be learned from the case to improve safeguarding in the future, to improve inter-agency working, and to better safeguard and promote the welfare of children in the local area.

This serious case review has been conducted under the guidance set out in *Working Together to Safeguard Children (2015).*

The principles underpinning the review are that it:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The review was conducted on the basis that the overview report would be published in full.

1.5 Timeline for the Review

The panel agreed that the period under review would be from January 2011 to November 2015 on the basis that this timeline encompasses significant contacts and practice, and is a sufficiently focused and recent timeframe within which to learn from practice and make meaningful recommendations.

The family had a history of contact with agencies dating back to 2004. The panel therefore decided that it was important to reflect the historical context of agency involvement with the family. To that end, the author has included an overview of the historical context and brief summary of agency involvement in this report.

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

1.6 Agencies Participating in the SCR

The following agencies have provided information and contributed to the SCR in accordance with chapter four of *Working Together to Safeguard Children (2015)*, the associated LSCB guidance, and relevant learning and improvement frameworks:

- Children's Social Care (CSC)
- Health Visiting Services (HV)
- Police
- Early Help Service (EHS)
- Family First (FF)
- Primary School
- Midwifery and Maternity Services
- Adult Mental Health Services
- Safer Communities (submitted written information)
- National Probation Service
- GPs, via the GP Safeguarding Lead (Father had a different GP to the rest of the family)

Agencies were asked to submit a chronology of their involvement with the family and a summary of the work they had undertaken. Two learning events took place which were attended by practitioners and managers involved in the case.

Following the learning events, agencies were asked to provide a summary of their learning and an action plan showing how they would implement learning from the review. Agency learning and actions are shown at section five and action plans are provided at Appendix 1.

1.7 Methodology

An independent author was appointed to conduct the SCR.

An adaptation of the Social Care Institute for Excellence (SCIE) *Learning Together* systems methodology was used to conduct the review. The methodology identifies key episodes of practice during the period under review and uses these as the basis for analysis of professional practice. The SCR report does not refer to or analyse all agency involvement during the period under review.

1.8 Research Questions

Systems reviews do not set specific terms of reference. The following research questions were posed by the Review Team to assist in providing focus to the review and constructing and shaping the findings:

1. Did practitioners identify risk factors in the family associated with resistance and unwillingness to change? What actions were taken to address this?

2. Did professionals understand and respond to the daily lived experience[2] of Child R and their siblings?
3. Did professionals make appropriate enquiries and assessments in relation to parental drug misuse and how did professionals act in response?
4. Did professionals enquire and respond to the impact of domestic abuse including possible sexual violence?
5. Did professionals communicate and respond effectively to adult mental health issues?
6. Is there evidence of understanding of the impact of the 'toxic trio'? Was the impact on the children understood and acted upon?[3]
7. Did professionals have a shared understanding of the key issues and did agencies work together to best effect? Were appropriate tools used to assess risks and vulnerabilities?
8. Was up to date advice provided in relation to Safe Sleeping[4]? Does the Safe Sleeping guidance include sufficient focus on parents who use drugs and alcohol?

1.9 Review Team Members

A serious case review team was convened consisting of senior and specialist agency representatives to oversee the collation and analysis of information and outcomes of the review.

Designation	**Agency**
Lead Nurse Safeguarding (Chair)	Clinical Commissioning Group
Assistant Director	Early Help
Assistant Director	Children's Services
Consultant Paediatrician (Designated doctor for safeguarding children)	Clinical Commissioning Group
Lead GP Safeguarding	Clinical Commissioning Group
Head of Service	Children's Services
Youth Offending Service Manager	Youth Offending Service
Senior Manager	National Probation Service
Legal Advisor	Knowsley MBC
Detective Chief Inspector	Merseyside Police
Business Support Officer	Knowsley MBC
Independent Author	

The review team was chaired by the designated Lead Nurse for Safeguarding. The independent author attended every meeting of the review team and the practitioner events.

[2] *Child Neglect: Planning and Intervention*, Jan Horwath, 2013, Macmillan
[3] The 'toxic trio' risk factors are domestic abuse, substance misuse and parental mental ill health http://www.safelives.org.uk/sites/default/files/resources/In_plain_sight_the_evidence_from_children_exposed_to_domestic_abuse.pdf
[4] http://www.sidsandkids.org/safe-sleeping/

The review team met on four occasions to oversee the process, analyse data, report to the LSCB, draw conclusions from the material analysed, and oversee the production of draft and final reports. The case group of professionals met on three occasions.

The review team had access to legal advice from the Local Authority Legal Department.

Written minutes of the review team's discussions and decisions were recorded by the LSCB Business Support Officer.

1.10 Criminal Investigation

Merseyside Police conducted an investigation into the death of Child R. No offences were disclosed in respect of the death.

Mother was informed that a Serious Case Review was taking place but did not respond to communications made in this respect.

1.11 Coronial Matters

The Coroner has returned a verdict of 'unascertained' in relation to the death of Child R.

2 BACKGROUND TO CHILD R AND THEIR FAMILY

2.1 Overview and Historical Context

The family had a history of involvement with services dating back to the birth of the first child in 2008. Father has had contact with adult mental health services since 2004.

Child R was the youngest child in a large sibling group. There is little information recorded about Child R's daily lived experience due to their young age at death, although health records show that when Child R was seen at home by Health Visitors (HV), the home conditions were acceptable and Child R was clean, appropriately dressed and fed, and appeared to have a good bond with Mother.

There had been historical evidence of neglect before Child R was born and the family had come to the attention of Children's Social Care (CSC) on a number of occasions, as outlined in section three below. In 2011 maternal grandmother (MGM) made a referral to CSC because of her concerns for the wellbeing of the children.

Father's mental health history is documented to 2004 when he was first seen by the Merseycare Adult Mental Health service. It is important to note that Father's mental health condition is chronic and enduring and that he continued to experience mental ill health throughout the period under review.

Father was diagnosed with post-traumatic stress disorder (PTSD) which it was thought may have been related to an incident that took place when he was in prison in 2003. His lifestyle appears to have been chaotic throughout the period under review, with frequent intentional overdoses and suicidal ideation (thoughts of taking his life), ongoing drug and alcohol misuse and episodes of violence. Father said that he had been subject to domestic abuse from Mother.

Father had little involvement with his GP and there were no consultations between 2011 and 2015. Father had only been seen once by the GP in 2015 for a matter unrelated to this review; Father informed the GP that he had been in prison and that he had difficulty sleeping. There was some telephone contact by Father with the GP where it was suggested that Father come into the surgery. However, he did not attend any face-to-face consultations.

Mother appears to have had a little contact with services prior to the birth of her first child. She did not consult her GP with any frequency and had only routine contacts during the period under review.

There were reports made by MGM that Mother used drugs. The extent of Mother's substance misuse is not known, however MGM had concerns about Mothers' use of cannabis and cocaine as documented in the referral to CSC in 2011.

Other anonymous referrals to CSC alleged that Mother was using drugs and leaving the children unsupervised. There were also concerns raised in anonymous referrals that unknown men were visiting the family home.

Mother discussed low mood and anxiety with a support worker, although she did not pursue further help with this, despite referral and assessment.

During the period under review, there were several police call-outs in relation to domestic abuse incidents (more detail of these incidents is given below). It should be noted that on one occasion, Father told police that he had been assaulted by Mother when she hit him with a chair.[5]

Mother has had a large number of pregnancies and has received treatment from Sexual Health Services. There is no evidence of assessment being undertaken in relation to wider aspects of domestic abuse including sexual violence.

Child R's older siblings attended a local primary school. One of Child R's siblings experienced behavioural difficulties (possibly related to autism) and was receiving additional support from their primary school.

[5] http://www.personal.psu.edu/mpj/2005%20JFI%20Johnson%20%26%20Leone.pdf

3 AGENCY INVOLVEMENT

3.1 Significant Contacts and Key Episodes of Practice

The integrated chronology submitted to the SCR shows numerous contacts with the family during the period under review. The primary agencies involved with the family were Mental Health Services (Father); Maternity and Midwifery Services; Health Visiting Services; Probation Service (Father); Children's Social Care and Family First/Early Help Services. Police were also involved in relation to domestic abuse call-outs and Father's offending.

The SCR has focused on those contacts which are of greatest significance to the case to provide an overview of agency involvement. There is a more detailed analysis of key episodes of practice which are set out below and are shown in bold italics.

3.2. Contacts in 2011

In early August, police were called to the home address where Mother reported to police that she was separated from Father and that he had attended the home address. She had allowed him access and a verbal altercation had taken place. The children were present but were in a separate room. No offences were disclosed and no damage was caused. Officers noted that Mother was safe and well. MERIT assessments were conducted and rated Bronze.

The day after the above incident, MGM contacted the CSC requesting a welfare check of her grandchildren. MGM said she was concerned that her daughter was using cannabis and cocaine. A visit was undertaken to the family home by CSC who found the home conditions to be of a good standard. All the children were seen and presented appropriately; there was no evidence of drugs or alcohol within the property[6] and no signs of drug use in either parents' presentation.

3.3 Contacts in 2012

In April 2012, an initial assessment was completed following a report that NWAS had visited the family home in response to a call that Mother was unwell. NWAS staff observed that the children were without adequate supervision; they were naked and there was soiling on the floor. NWAS noted that Father was present and they had concerns about drug use. CSC conducted a single assessment that resulted in a referral to Family First for Tier 3 service. There was also a police call-out for domestic abuse.

In October 2012, police were called by an anonymous member of the public who was concerned about the parents arguing while the children were present. Police attended the home address and Father fled the scene. Mother did not make any complaint and said she was 'annoyed' about the police being called. The home was observed to be clean and tidy, the children were present.

[6] Though there were no inspections of the upstairs of the property

3.4 Contacts in 2013

In March 2013, Mother was referred to the Community Mental Health Team with symptoms of low mood. Two appointments were offered which Mother failed to attend.

In May 2013, a domestic incident took place that was rated as high-risk and involved a physical assault on Mother by Father. When police arrived, Mother said that Father had bitten her on the nose, and officers saw blood on Mother's face. Father had by this time run away from the home. Police later found Father and searched him, and found him to be in possession of a 'knuckle duster' and Mother's mobile phone. At the police station, Mother produced a large knife which she said Father had threatened her with during the assault.

The case was referred to a Multi-Agency Risk Assessment Conference (MARAC) by Merseyside Police as it met the MerIT threshold for a Gold score. Father was arrested and charged with a S47 assault[7] on Mother. CSC conducted an initial assessment and a referral was made to Family First.

In July, a single assessment was completed which recommended a Child in Need (CIN) plan. The family signed a contract of expectations stating that Father could only be in the home if supervised by another family member. Around this time, a Health Visitor saw Father present in the family home and reported this to CSC. It appears that although a CIN plan was completed, no CIN meeting took place.

In August 2013, Mother disclosed to a Homestart worker that she was experiencing low mood and felt suicidal; she made threats to harm herself and the children. Police were called for support and a social worker discussed the incident with Mother who said things had been blown up out of proportion. MGM was present and told police that she was very concerned about the children as Mother was taking 'any drugs she could get her hands on'. A family support worker from the Family Centre was allocated for more intensive support, however Mother appears not to have engaged with this service.

Three days later, police were called to a domestic incident between Mother and MGM who were arguing in the street. MGM advised the attending officer that her daughter was using drugs and that she would be prepared to confirm this to any of the authorities, but wanted this to be anonymous.

In September 2013, Mother attended an outpatient appointment for a mental health assessment. Whilst at the hospital, she said that she could not continue with the assessment as she had to take the children to school. Mother was discharged to the care of the GP with advice for re-referral if required.

In September 2013, Father received a 12-month community order for an offence of common assault against Mother (the incident that took place in May). He failed to comply with the order and a final warning and breach letters were issued. In December 2013, the

[7] http://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/47

Order was revoked by the Court and he was re-sentenced to eight weeks' custody with no further probation supervision.

3.5 Contacts in 2014

In February 2014, Father appeared at Liverpool Magistrates Court for possession of a bladed article in a public place and was given a six month custodial sentence. A pre-sentence report does not appear to have been requested by the Court, therefore there was no involvement by probation.

In late May 2014, CSC received an anonymous referral which said that Mother was using drugs, that males were 'coming and going' at the property, and that the children were unkempt. Following this, CSC conducted two unannounced visits at which the children were seen but not spoken to. It was noted that Father was living at the family home (previous assessments stated that his contacts should be supervised). The chronology notes that this is not addressed within the assessment.

In late October, CSC received a contact from Father reporting that Mother was using drugs and not meeting the needs of the children. It was recorded that the children regularly stayed with MGM. No further action was recommended.

3.6 Contacts in 2015

In January 2015, a member of the public contacted CSC to report a concern that one of the children had been in the road for five minutes without supervision.

A single assessment was completed. It was noted that the anonymous report by a member of the public related to one of the children who had autism; parents said that the child was prone to run off and that they usually kept the doors locked, but the child had got out on their own on this occasion. The social worker used the Daniel, Wassel and Gilligan (1999) resilence assessment tool which showed the family to have high strengths and low risks. On the basis of the assessment the SW concluded that Mother was safeguarding the children and meeting their needs. The assessment noted that although the parents were separated, they worked together to meet the needs of the children. Mother would have been pregnant with Child R at this time however there is no reference to pregnancy in the assessment. The record contains information that two of the children were spoken to alone and a 'three houses' tool[8] was completed with them.

The outcome of the single assessment was that there was no further role for CSC. The case was closed with a note of continuing support being provided from school and 'health', although it is not clear how this support was being provided.

In mid-May Mother, presented to maternity services following a failed appointment one week earlier. Mother was 30 weeks pregnant and said that she was a 'late-booker' due to consideration of termination of the pregnancy. She was accompanied by MGM. It was noted in her history from the previous midwife that she had been known to MARAC in 2013

[8] http://www.communitycare.co.uk/2011/11/07/social-work-tools-for-direct-work-with-children-drawing/

following domestic abuse involving Father (who was stated as her current partner). A referral was made to CSC who said they had no concerns about the pregnancy.

In early June, Mother was admitted to SOMH in full labour at 33 weeks gestation. That same day, Child R was born 'in good condition' and transferred to the Special Care Baby Unit. Mother was discharged the same day. One week later, Child R was discharged home.

Two days after Child R's discharge, a HV visited the family home to conduct a birth visit. The home conditions downstairs were noted to be clean, tidy and free of clutter. HV asked to see the upstairs rooms but this was declined by Mother (the local safe sleeping guidance encourages practitioners to make strong representation to view bedrooms however parents are under no obligation to allow professionals to do so). It was noted that there was good interaction between Mother and Child R. Safe sleeping guidance was provided by the HV. Mother reported that she was emotionally well and was supported by friends.

On the same day as the birth visit, police were called to the home address by Father saying that he had been hit over the head with a chair by Mother. Police attended and spoke to Mother who said the argument was about Father seeing another woman. She said that she had not been assaulted. The children were seen safe and well. Father left the address with two other parties.

The day after the incident, the school was informed by Operation Encompass[9] that there had been a verbal argument between the parents and that the children were present.

Over the next three days, police attempted to locate Father who was eventually located in a local hospital having taken an overdose of that same morning. Father had been brought to A&E having been found unconscious in a local park. He had taken 120 co-codamol tablets with alcohol. Father received a full psychiatric assessment and was admitted to the ward.

Three days after this incident, a MASH referral was received in relation to the domestic abuse incident. The information was screened and a senior practitioner recommended that the case be managed at level, 3 to be reviewed after 8-12 weeks and re-referred to CSC if there had been no improvement. The following day, an Early Help Coordinator discussed concerns about the family's history of non-engagement and it was agreed that, if the family could not be contacted within two working days, the Early Help Team would refer back to CSC.

Over the course of the next five days, seven calls were made to Mother by the Early Help co-ordinator, none of which received a response. The Early Help co-ordinator did not see information on the system regarding concerns about non-engagement and was therefore unaware of the stipulation regarding management oversight, and the supervising officer did not follow-up the requirement for management oversight. The Early Help coordinator closed the case five days after the initial referral to MASH following the failed contact attempts.

[9] http://www.knowsleyscb.org.uk/wp-content/uploads/2015/01/Operation-Encompass-overview.pdf

During the seven days following Fathers' discharge from hospital, the 'Stepped Up Care' service attempted to contact him on three occasions at his parents' home, but were unable to do so. On the third occasion, Father's parents said that they had contacted police about his behaviour as he was sending 'strange' text messages to family members. A nephew confirmed that Father was safe and was staying with him.

At the end of June, Father was admitted hospital after being discovered at a train station wanting to jump in front of a train. He was assessed under the Mental Health Act and was placed under Section 136[10]. The following day, he was diagnosed with post-traumatic stress disorder (PTSD), and substance misuse and associated depression were noted.

Eleven days after the domestic abuse incident, one of the children spoke to a staff member in school about arguments at home.

Nine days after the contact was closed by CSC, the HV rang the Early Help Coordinator to follow-up the referral. HV was informed that both CSC and Early Help had tried to contact Mother without success. A new number was given by HV but Early Help recorded that they were still unable to contact her.

That same day, HV conducted a home visit and saw Child R, who was noted to be well, appropriately dressed and feeding well. HV observed Child R to be handled well by Mother. At this time the family were subject to the Universal Child Health Programme, however they subsequently received targeted services due to none compliance with immunisations.

Over the following two days, Early Help made two attempts to contact Mother by phone but received no reply. There was no further follow-up.

Seventeen days after being held under Section 136, Father was discharged with a seven day follow-up. The following day, Stepped Care tried to arrange the follow-up visit by telephone without success.

Two days after discharge, Father telephoned Stepped Up Care saying that he felt suicidal but that he had no plans to take his own life as he was with his children. Staff gained permission from him to speak to his father, which they did.

Five days after discharge, police received a call that Father had become a 'missing person'. He was located on a train station and told police that he was contemplating suicide and that over the past few days, he had taken a lot of tablets and consumed large amounts of alcohol. He referred to an incident that took place in prison in 2003 as the source of his distress but would not say anything further. Police conveyed him to hospital where he was assessed and admitted.

Three days later, a Stepped Up Care meeting took place at which it was noted that Father has regular contact with his children.

[10] https://www.rethink.org/living-with-mental-illness/police-courts-prison/section-136-police-taking-you-to-a-place-of-safety-from-a-public-place

Over the next five days. Father was visited daily by the Stepped Up Care Service. Two days after this, Father was admitted to a local hospital following an intentional overdose.

The following day, a HV conducted the 6-8 week visit at the family home. Child R was noted to be appropriately dressed and was handled well. Mother reported that she found it difficult to visit GP surgery and a referral to the immunisations team was therefore completed.

In early September, Father was seen twice by mental health practitioners. He reported that he was not taking his prescribed medication and that he had taken a very large amount of paracetamol that morning. The following day, he was seen and assessed by the psychiatric liaison service where he agreed to voluntary admission to the psychiatric ward.

Five days later, CSC records show that information on record in the MASH resulted in a decision to continue with Tier 2 support; this decision was based on a single assessment having been completed earlier in the year (January) that had concluded that the children's needs were being met and that Father was engaging with mental health services.

Child R was seen thirteen days later by HV at home. They were appropriately dressed and were given primary immunisations.

Fifteen days after admission to the psychiatric hospital, Father was discharged. He was assessed as being a low-risk to himself and others. It was noted that he had used cocaine whilst on the psychiatric ward. The plan was for further engagement with Stepped-Up Care and to refer Father to a Sexual Assault Referral Centre regarding an historic incident.

Nine days after discharge, Father was re-admitted to hospital following an overdose of 300 paracetamol, other medication and alcohol. Information was sent by 'health' to the MASH. This was noted in the CSC record as requiring no further action as Father was said to be engaging with mental health services.

On 7th November, the incident leading to this Serious Case Review occurred.

4. ANALYSIS OF PRACTICE

4.1 Analysis of Key Episodes of Practice

1. August 2011 - MGM referral to social care regarding alleged drug use and concerns for the children

CSC responded appropriately to the concerns received from MGM in August 2011 by undertaking a home visit to assess the complaints. The home environment was reported as of a good standard and all the children were seen to be appropriately presented. There was no evidence of drugs or alcohol within the property. There was, however, no evidence that the views of the children were recorded.

This was a missed opportunity to further explore MGM's concerns about mother's drug use and its impact on the children. The views of the children do not appear to have been sought or taken into account.

2. April 2012 - Contact received from NWAS that children were observed to have inadequate supervision

The concerns raised by NWAS in April 2012 were responded to by a Duty Visit being undertaken and followed up by an initial assessment. Mother and children were seen and mother was spoken to about the concerns raised by NWAS. The social worker could find no evidence that the children's needs were not being met: the home conditions were of a good standard and there were no concerns about the presentation of the children. There was, however, no evidence that the children were spoken to. An initial assessment was completed and a referral was made to Family First (FF) for Tier 3 service. It appears that the family did not engage with FF and that the case was closed.

This was a missed opportunity to seek the views of the children. The issues of non-engagement with the Tier 3 service was not followed up.

3. May 2013- Domestic abuse incident in which Father commits an assault against Mother resulting in referral to MARAC.

Following the domestic abuse incident in May 2013 Father was arrested and charged with S47 assault. The high risk nature of the incident resulted in referral to MARAC. MARAC considered a number of issues including that weapons had been found at the property. It was noted that Mother was a repeat victim and minimised abuse, but that she would be prepared to support prosecution on this occasion. It was noted at the MARAC that Mother wanted Father to seek support for his (mental health) issues. The MARAC concluded that as the family were currently open to CSC no additional actions were required.

Following the MARAC CSC conducted a single assessment which was completed in mid-June. As part of the assessment, the children were spoken to (although their views were not recorded) and Father was provided with information about the service for perpetrators of domestic abuse. The parents said that they wished to resume their relationship.

Given the high-risk nature of the incident, it would have been good practice to consider a CIN plan at this time. This would have enabled a higher level of coordination of services, support for the family, and management of any current and future risks in relation to domestic abuse and the impact that this had on the children.

In July, the parents signed a contract of expectations stating that Father could only be in the home if supervised by another family member (although it is not clear who this family member was).

4. July 2013 - HV contact regarding concerns that Mother and Father had resumed their relationship as Father was present in the home, contravening the contract of expectations

There is no evidence that the contract of expectations was monitored proactively. That being the case it is questionable whether such a contract had any value as a safeguarding tool.

When the Health Visitor made a home visit, she found that Father was at the family home unsupervised. In line with good practice, this was reported to CSC who completed a single assessment and recommended a CIN plan.

Mother was referred to the local domestic abuse service in Knowsley (KDVS) and a safety plan was put in place to reduce risk when children were having contact with Father and other family members.

There is no evidence of a CIN meeting taking place, or of the children's views being recorded.

5. August 2013 – Concern for welfare of mother who had disclosed to a Homestart worker that she was experiencing low mood and suicidal thoughts. This was followed by a police call-out to a domestic incident between mother and MGM

Police attended the home address in response to the cause for concern being raised. They spoke with Mother who said that she had not made any threats about the children and had not had suicidal thoughts. It was noted that mother was very thin but appeared 'OK'. Mother complained that she contacts 'social services' all the time but that nobody helps her.

Police spoke to a worker at Homestart who said that they would call-out to see Mother that same day to conduct a mental health assessment. In addition, Mother was seen by Mental Health services for assessment in September, however, after the assessment commenced, she said that she had to leave to take the children to school.

The Mental Health team discussed the incomplete assessment and discharged mother to the care of her GP for re-referral if required. Mother did not re-present.

Opportunities were missed to review the case in light of Mother's mental health needs and her lack of engagement in mental health services.

6. May 2014 – An anonymous referral was made to CSC reporting that mother was using drugs and that there were unknown males ‘in and out’ of the home address

In response to the anonymous referral, CSC made two unannounced home visits and completed a single assessment. The single assessment does not appear to be thorough and replicates other single assessments conducted previously.

There is reference to Father being present in the home which contravenes a contract of expectations being agreed with the parents, although this was not addressed. The single assessment refers to the children being ‘too young’ to comment on their home circumstances when their views should have been sought.

This was a missed opportunity to conduct a more detailed multi-agency assessment of the family situation, including allegations of Mother’s drug use and the wishes and feelings of the children.

7. Jan 2015 – An anonymous referral was made to CSC saying that one of the younger children had been out in the road for more than five minutes without any supervision

A single assessment was completed and two of the children were spoken to. The single assessment identified no role for CSC.

There is no evidence of historical information being taken into account in the single assessment.

8. Mid-June - early July - The Early Help Team had seven failed attempts to contact Mother, with no further action taken

CSC screened the referral made in June following a domestic abuse incident. CSC recommended that the case be managed at level 3, suggesting an 8-12 week period and, if there were no improvements, that the case be referred back to CSC.

The EH manager at the time looked at the case and was concerned about non-engagement. A recommendation was made that if Mother could not be contacted within two working days, then the case should be referred back to CSC.

This was logged on the system but was not picked up, therefore after seven failed attempts to contact Mother, the case was closed[11].

This was a missed opportunity to escalate the case to CSC and to conduct an Initial Child Protection Conference based on the concerns of the EHT manager.

9. September 2015 - CSC was notified that Father had been admitted to hospital due to his mental health. This was recorded ‘for information only’ as a single assessment had been completed in January 2015 which indicated that Father was engaging with mental health services.

[11] See agency learning at 5.2.2 regarding changes made to the system

The ongoing and serious nature of Father's mental health issues should have triggered a discussion regarding new information, risk management and parenting capacity.

4.2 Summary Analysis of Professional Practice based on the research questions

Research Question 1 - Did practitioners identify risk factors in the family associated with resistance and unwillingness to change? What actions were taken to address this?

There is no evidence in the records that any agency brought together a full and accurate multi-agency chronology of the family history. Had this been done, significant risk factors such as parental substance misuse, domestic abuse, Mother's vulnerable mental health, long-term neglect and resistance to interventions and Father's mental health would have built a picture of a family with ongoing safeguarding needs.

Historically, there was evidence that the parents had stayed away from services and were resistant to change. Factors within the family such as domestic abuse and mental health exacerbated issues in relation to parenting capacity but these were never fully assessed. There is no evidence that a parenting assessment was ever completed and no evidence of multi-agency meetings to support decision-making. There is no evidence of any work to address resistance to change.

Clinical interventions with Father were in the context of managing his mental health as an adult patient, rather than as a Father with dependent children.

Research Question 2 - Did professionals understand and respond to the daily lived experience[12] of Child R and their siblings?

There is little evidence of attempts by any agency to engage the children and understand their daily lived experience. CSC spoke to the children on one occasion following a domestic violence incident and undertook a 'three houses' piece of work. CSC saw the children following subsequent incidents and at single assessment, however other than the occasion referred to above, their wishes and feelings were not recorded.

One of the children reported to school on two occasions that they had witnessed arguing amongst parents. This information was recorded but not acted upon. The behavioural issues of one of the children were dealt with through a Common Assessment Framework (CAF) which commenced in 2013.

Research Questions 3 and 6 - Did professionals make appropriate enquiries and assessments in relation to parental drug misuse; how did they act in response? Is there evidence of understanding of the impact of the 'toxic trio'? Was the impact on the children understood and acted upon?

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[12] Professor Jan Horwath in Child Neglect: Planning and Intervention. Macmillan

Mother was suspected of using drugs and Father was known to use illegal drugs and alcohol. Three reports were made to CSC regarding Mother's drug use, one of which was made by MGM. MGM confirmed her belief that Mother was using drugs on two further occasions. There is no evidence of an assessment of the risk factors posed by parental drug use and no consideration given to the combined impact of drug use, mental health and domestic abuse in the family (Toxic Trio).

Father's attempts at suicide and intentional overdoses frequently involved large amounts of alcohol and prescription drugs and it was also known by mental health practitioners that Father used drugs on the hospital ward. He was recorded by mental health services as having a drug dependency and was advised to attend drug services, which he declined. This information was known to other services and should have triggered a multi-agency meeting.

Health professionals who went into the home did not witness any drug using paraphernalia, nor did they see or smell drugs (Cannabis) in the family home. They raised the issue of drug use with Mother but she denied that she used any drugs. Mother's accounts were taken at face value, despite information being received from MGM, anonymous referrals and from Father that Mother used drugs. There is no evidence that any agency explored reports of Mother's drug use as a safeguarding issue for the children beyond superficial enquiry.

Research Question 4 and 6 - Did professionals enquire and respond to the impact of domestic abuse including possible sexual violence? Is there evidence of understanding of the impact of the 'toxic trio'? Was the impact on the children understood and acted upon?

Domestic abuse between Mother and Father was well known by all professionals involved in the case. The chronology records several police call-outs to incidents of domestic abuse, one of which resulted in a referral to MARAC and the prosecution of Father for assault. There is no indication that Mother received specific support or safety planning in relation to domestic abuse, although she was referred on one occasion to KDVS, nor that Father received specific targeted interventions as a perpetrator or victim of domestic abuse (although he was referred to the local perpetrator programme). The Single Assessment conducted in January 2015 indicates that Father engaged with the InPact (perpetrator) Programme, but enquiries have revealed that this was not the case.

There is no indication that any professional involved in the case considered the impact on the children of experiencing domestic abuse between their parents; as referred to above one of the children reported to school on two occasions following incidents in 2015 that they had witnessed arguments at home between their parents. School also received notification from Operation Encompass[13] in May and June 2015 of the same domestic abuse incidents. This was recorded for information but no targeted support was offered to the child, nor was the matter raised with parents.

Research Question 5 and 6 - Did professionals communicate and respond effectively to adult mental health issues? Is there evidence of understanding of the impact of the 'toxic trio'? Was the impact on the children understood and acted upon?

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[13] http://www.operationencompass.org/

Father's mental health problem was chronic and enduring. He had frequent contact with adult mental health services in the period under review and was on one occasion admitted under Section 136 of the Mental Health Act.

Professionals in Mental Health Services believed that Father did not live with the children and that he had only supervised access to the children (they were aware that a written agreement had been signed regarding supervised only access, however there was firm evidence that this was contravened on at least one occasion). The likelihood is that Father was accessing the children and spending time with Mother, and this is borne out by domestic incidents at the family home during the time that the written agreement was in place.

There appears to have been a lack of understanding and recognition by non-mental health professionals of the severity of Father's mental illness; both in terms of the risk that he posed to himself and the emotional impact that his behaviours were likely to have had upon the children. The engagement with mental health services was taken as an assurance, without considering whether this engagement actually resulted in an improvement in mental health.

Mental Health Services made one safeguarding referral to CSC when Father was admitted following an overdose. This resulted in no further action by CSC due to a single assessment having been conducted eight months earlier (January 2015), which was given as the rationale for no further action. This illustrates a lack of understanding of the impact of Father's mental health on the family and the dynamic nature of his chronic mental health condition.

Probation made a safeguarding referral to CSC in October 2013, with a response from the Family Centre which said that the children were not subject to a Child Protection (CP) plan and that Father was only allowed supervised contact.

The Homestart worker reported concerns to CSC about Mother's mental health after she had said that she felt low, was feeling suicidal and that she would harm the children. Mother was referred for a mental health assessment which she failed to complete. She was discharged to her GP with no further follow-up. The SCR feels that a follow up appointment should have been offered to complete the assessment.

Research Question 7 - Did professionals have a shared understanding of the key issues and did agencies work together to best effect? Were appropriate tools used to assess risks and vulnerabilities?

There are historical indicators of neglect of the children which fall outside of the period under review. During the period under review, the family was not subject to child protection planning. There had been an earlier CAF in relation to school attendance, but this had closed.

There was only one multi-agency meeting (MARAC) to discuss the family, despite single-agency concerns in relation to domestic abuse, neglect, parental mental health and substance misuse.

Professionals who went into the family home did not see poor home conditions, though there were no formal assessments of home conditions e.g. graded care profile to inform professional judgment.

The reviewer has not seen evidence of a postnatal depression inventory checklist having been conducted following the birth of Child R.

There is no evidence that the police enquiries relating to the previous domestic abuse incident, Father's overdose and his admission to hospital in August 2015 were linked. Father was discharged and was assessed as not presenting any risk to self or others (partner and children). He declined input from drug and alcohol services and a referral was made to his GP for cognitive behavioural therapy. Had these events been linked by any agency, this would have presented an opportunity to call a multi-agency meeting to discuss risk factors. No action was taken to refer to CSC in relation to the safety of the children at this time, and Father's assurances that he was not planning a suicide because of the children were not explored. It is not clear whether discussions with the paternal grandfather at this time included any consideration of the children's safety.

CSC and Early Help did not take account of historical information or appear to effectively use chronologies in their assessments/interactions with the family.

Information-sharing amongst agencies lacked consistency and opportunities were missed to share important information.

Research Question 8 - Was up to date advice provided in relation to Safe Sleeping? Does the Safe Sleeping guidance include sufficient focus on parents who use drugs and alcohol?

Safe Sleeping advice was provided in line with the local protocol and the Universal Child Health Programme. The advice is updated regularly based on evidence and best practice. The key question for this SCR is whether the capacity of parents (in this, case Mother) to act on safe sleeping guidance was impacted by substance misuse and/or mental health. A recommendation is made in this regard.

5. LEARNING FROM THE REVIEW

5.1 Findings

The findings of the SCR fall into five key areas:

- Understanding and responding to the daily lived experience of the children;
- The impact of Father's mental health on family functioning and a lack of integrated responses between adult and children's services, and lack of a 'whole family' view[14];
- Responding to incidents of domestic abuse and their impact on children;
- Identifying and responding to parental drug use;
- Lack of multi-agency working, communication and combined effort to effect behaviour change[15].

5.1.1 Finding 1

The daily lived experience of the children did not influence professional practice in the case.

Opportunities to seek and respond to the children's views were missed on several occasions. There were some attempts to engage the children, however there is only one occasion on which CSC undertook 'wishes and feelings' work with the children following a domestic abuse incident.

There is no record that other agencies assessed the daily lived experience of the children, either by the use of tools to elicit wishes and feelings or by observing the children in the home or school setting.

5.1.2 Finding 2

The impact of Father's mental health on the family was not fully assessed or acted upon. Mother's mental health was not fully explored. Systems need to be strengthened to support joint-working with adult mental health services.

Adult mental health issues impacted on the functioning of the family. Father's enduring mental health problem was largely treated in isolation of the rest of the family. He cited the children as protective factors and this was taken at face value rather than explored.

Mother's mental health may have been impacted by her drug use; there may have been co-morbidity with depression and suicidal thoughts. She attended a mental health assessment but refused to complete it; this was never followed up.

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[14] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-mental-health-problem/

[15] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/330332/RR369_Assessing_parental_capacity_to_change_Final.pdf

5.1.3 Finding 3

Domestic abuse was an ongoing factor in the relationship between the parents. One incident resulted in a MARAC referral, however this did not appear to influence decisions in relation to safeguarding the children e.g. there was no Section 47 resulting from MARAC.

The children appear to have been present at the majority of domestic abuse incidents. Incidents were appropriately reported by police, however follow-up assessments and interventions were not focused on the impact of domestic abuse on the children.

There were two missed opportunities in the school setting to respond to disclosures of domestic abuse by one of the children.

5.1.4 Finding 4

Parental drug use and its impact on the children was not fully explored or addressed.

There is strong evidence that both parents used drugs and that both were chaotic in their use. Despite MGM providing information about Mother's drug use, professionals believed Mother's accounts when she denied using drugs, rather than exploring information received from MGM.

Father's drug and alcohol use was well known to mental health services, but this was addressed in isolation, and without consideration of the impact this had on the family.

5.1.5 Finding 5

Multi-agency working was inconsistent and uncoordinated.

There appear to have been no multi-agency meetings to discuss the family's multiple risks and vulnerabilities. There was no lead professional for the case and no clear ownership by any agency.

6. RECOMMENDATIONS

6.1 Recommendation 1

The LSCB should be assured that:

(a) When a parent has a chronic and enduring mental health problem and has access to children - even if that access is supervised - that strong links are established and maintained with adult mental health services to ensure frequent monitoring and review of compliance with treatment and the ongoing impact on the children.

(b) All practitioners take appropriate action to include assessment of parental mental health issues in parenting assessments.

(c) There is a robust multi-agency response to failure to engage in mental health assessments and services where this may impact on the wellbeing of the children.

6.2 Recommendation 2

The LSCB should be assured that the impact on children of domestic abuse, drug misuse and mental health (the Toxic Trio) is understood by practitioners in all agencies and is taken into account in all assessments and referrals.

6.3 Recommendation 3

The LSCB should be assured that the daily lived experience of the child is sought, understood and taken into account in contacts with all agencies. The daily lived experience (or voice) of the child should influence safeguarding practice in all agencies.

6.4 Recommendation 4

The LSCB should be assured that local Safe Sleeping[16] guidance is not delivered in isolation of other interventions with chaotic and resistant families (i.e. assessment of other risk factors such as drugs, alcohol and mental health).

[16] http://www.knowsleyscb.org.uk/safe-sleeping-campaign/