Serious Case Review
Overview report

Serious Case Review in respect of	Matthew
Born	October 2017
Author	Jonathan Chapman
Date of submission	4th April 2020
Version	Version 9

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1. Introduction

1.1 At the beginning of June 2019, an ambulance was called to an address where the subject of this review, Matthew (1 year and 7 months at time), was reported to have ingested approximately four tablets, which are used in the treatment of psychotic conditions. Matthew was conveyed to hospital where his condition was described as extremely poor. Matthew developed significant side effects including involuntary muscle movements and agitation requiring intravenous medication, a rapid heart rate and life-threatening hyperpyrexia[1] resulting in him requiring intubation and ventilation and was transferred to the Paediatric Intensive Care Unit. These conditions were considered life threatening.

There had been significant previous agency involvement with Matthew's family.

1.2 The case was discussed at a rapid review meeting in accordance with Working Together 2015, and it was agreed that the case met the criteria for a Serious Case Review for the below reasons.

- A child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons, have worked together to safeguard the child.
- And abuse or neglect of a child is known or suspected.

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt, and services improved to reduce the risk of future harm to children. [2]

2. About the Author

2.1 The author in this review is Jonathan Chapman, he has no prior involvement with the case and is not connected to any of the agencies involved. He is a retired senior police officer, who had responsibility for strategic and operational safeguarding and was a senior investigating officer.

[1] Hyperpyrexia is another term for a very high fever. The medical criterion for hyperpyrexia is when someone is running a body temperature of more than 106.7°F or 41.5

[2] Working Together 2015 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

He has undertaken serious case reviews, safeguarding adult reviews, MAPPA case reviews and domestic homicide reviews, with various boards across the country. He has also worked with Clinical Commissioning Groups, The Church of England and the third sector on safeguarding matters.

3. Terms of reference and methodology

3.1 Working Together 2015 allows local safeguarding children boards to determine their own processes for review. The Case Review Sub-Group of the Herefordshire Safeguarding Board decided that the review would be undertaken by a facilitated professional and practitioner events.

3.2 A scoping exercise was conducted to understand which agencies should be consulted and included.

3.3 Each identified agency was asked to research their information, and where necessary interview key staff, and to prepare a chronology which would help to inform the information sharing and discussion event.
The below agencies and staff were involved in the information sharing and discussion event.

- Herefordshire Children Social Care
- Wye Valley NHS Trust
- Clinical Commissioning Group
- 2gether NHS Foundation Trust
- West Mercia Police
- West Mercia Womens Aid
- Addaction
- West Midlands Ambulance Service
- West Mercia Community Rehabilitation Company

3.4 The review panel discussed and developed terms of reference. When preparing chronologies agencies were asked to focus on the time period 1st June 2018 until beginning of June 2019. In addition, agencies were asked to consider any information which could be relevant to this review.

3.5 When reviewing information agencies were asked to consider the below specific areas, which the panel considered relevant to this case.

- MARAC risk assessment and decision making in respect of risk to the safety and welfare of the children
- Effectiveness of MARAC/ CP planning interface in keeping children safe

- Recognition of 'hidden harm' factors (domestic abuse, poor mental health, drug and alcohol misuse) – assessment of risk and effectiveness of interventions
- Quality of multi-agency engagement at key points in the family history, including response to referrals in MASH, decision to discontinue CP plan, decision to discontinue child in need plan
- Quality of management supervision, oversight and input into key decisions noted above.
- Direct engagement with managers (as well as practitioners) to ascertain the level of awareness, quality of risk assessment and quality of evidence informed practice in the context of hidden harm.
- What consideration was given to the family history when making decisions and assessing risk.

3.6 In any review seeking the views of the family or others who are close to the case are important to ensure that their views are reflected. In this case, this was considered from an early point, but this was not possible during the course of the review, due other processes taking place. The author has been able to speak to a family member who did not wish to discuss the case in any detail. Their overall feeling is that they and the family did not receive adequate support, but the review has been unable to achieve more context to this view.

4. Background

4.1 Matthew's mother and father formed a relationship in 2014. In April 2016, Matthew's sister was born, and Matthew was born in October 2017. Both of Matthew's parents have experienced challenging aspects in their lives and as a result have been involved with a number of agencies.

4.2 Matthew's father had suffered with drug and alcohol addiction over an extended period of time. He is described as a well-known local character having spent periods of time living on the streets. His lifestyle has meant that he has come to the notice of police, mostly for what would be described as minor acquisitive offences, which would be indicative of a person funding addiction.

4.3 At the time of the incident which led to this review, Matthew's mother was 28 years of age. When Matthew's mother was younger, she had a challenging child and experienced a number of adverse childhood experiences.

4.4 In April 2016, Matthew's sister was born. Children Social Care (CSC) undertook a pre-birth assessment and as a result a Child in Need plan was put in place between January and June 2016. This was then stepped down to a CAF.[3] Part of the

[3] CAF – Common Assessment Framework - a national, standard approach to assessing any additional/unmet needs a child or young person may have and for deciding how any such needs can be identified and should be met effectively

CAF was that any contact between the father and Matthew's sister would be supervised by the paternal grandmother

4.5 In December 2016, the mother informed services that she was no longer in a relationship with the father. This tended to be a feature throughout the case where the mother informs professionals that the relationship has ended but there is evidence to the contrary.

4.6 In June 2017, the CRC (Community Rehabilitation Company) noted concerns regarding the father's substance and alcohol addiction, poor health and prolific offending. He was to become a father again and they questioned his parenting capacity. This was the first indication to agencies that the mother was pregnant with Matthew. The CRC made a referral to the MASH regarding their concerns.

4.7 It was confirmed that contact with Matthew's sister was supervised. As it was believed that the mother and father were living apart a pre-birth assessment for Matthew was considered in accordance with levels of need guidance and deemed not to require a pre-birth assessment from a social worker.

4.8 When he was young Matthew did display some developmental concerns, his motor skills and speech were delayed. It was noted that the back of his head was slightly flat and may have been indicative of him spending an excessive amount of time laying down. Generally, professionals observed warmth in the relationship between the mother and Matthew. There were some concerns regarding neglect. This was mainly a decline in the state of the living conditions, which did improve when challenged but also regarding the mother's intermittent use of alcohol and the decisions she made regarding relationships.

5. Summary of Facts

5.1 In late June 2018, the father was sentenced to a 24 month Suspended Sentence Order for the offence of possessing a weapon in a public place in April of that year. The sentence included a 12-week curfew and Rehabilitation Activity Requirement (RAR) to address his drug and alcohol dependency.

5.2 The father was allowed to change the details of his curfew address without sufficient checks were made on the change of address and whether this presented any safeguarding concerns.

5.3 In mid July 2018, the father was being supported by the substance misuse service. The father disclosed that he was using crack cocaine and at the time being supported by Probation. The father disclosed that he was living with his ex-partner. The CRC made a referral to MASH that there was a court order requiring the father to reside at the mother's address.

5.4 A strategy meeting was convened with CSC, police, drug services, Probation (CRC) and health visiting service in attendance. The meeting discussed that the father had been recently convicted of an offence and there was a court order, with a curfew, requiring him to be at the mother's address where the children lived. It was discussed that since the conviction the father had been arrested for drugs offences and that his engagement with substances misuse services and probation was poor. It was agreed that there would be a single agency s47 enquiry undertaken by CSC and a date for an Initial Child Protection Conference (ICPC) was set.

5.5 At the ICPC, in early August the decision was made that Matthew and his sister would be made subject of a Child Protection Plan under the category of neglect. A condition of the Child Protection Plan was that the father was not to reside at the address with the children. At this time, it was a condition of the father's suspended sentence to reside at the address. Due to this and the poor engagement of the father the CRC commenced proceedings for a breach of the court order. These proceedings were subsequently withdrawn.

5.6 In mid-August 2018, the police and the substance misuse service were contacted to raise concerns over the father's welfare by a family member. They stated that he was in a 'dark place' that he had not been engaging with services. The father contacted the substance misuse service and informed them that he was drinking daily and using heroin every other day. Throughout September there were reports of the father being involved in low level theft offences, which would be indicative of him supporting his substance misuse.

5.7 During September 2018, CSC visited the mother and established that the father was not at the address when the visits took place. Despite this, social workers who visited believed that the father was still involved with the family. In mid- September the core group meeting for the Child Protection plan was cancelled as both the children were ill.

5.8 In late September 2018, the father was discharged from the substance misuse service support due to lack of engagement. He had not collected his methadone prescription since the beginning of August. The father informed the service that he was currently homeless.

5.9 At the beginning of October 2018, the health visitor contacted CSC to enquire when a core group for the child protection plan would take place. There had been a core group meeting 10 days after the initial child protection conference but there were no minutes for this meeting, due to an administrative error. The health visitor was informed that there would not be a further core group meeting until the Review Child Protection Group (RCPC).

5.10 Shortly before the RCPC the health visitor visited the mother at home, she saw both children who appeared well cared for. The flat was in good order and there were no concerns noted by the health visitor. The mother stated that she was not having any contact with the father. Matthew was observed to have two small bruises on his forehead, which the mother gave a plausible explanation for.

5.11 On 22nd October 2018, the RCPC took place, it was attended by CSC, police, CRC and health visitor. The substance misuse services could not be present but provided a report. A new social worker who had only been involved in the case for the previous week provided a report. The social worker indicated that they had not been involved long enough to evidence the changes being reported by the mother and that the father was not engaging with services. It was the view of the social worker that often professionals relied on self-reporting of parents, in view of this and the fact that there had been no core groups the child protection plan should remain in place. It was the view of other professionals that the plan could be stepped down to child in need on the basis that the father was no longer involved with the children. The decision of the meeting was the case should be stepped down to child in need. The records indicate that a child in need (CiN) plan was discussed but the details are not recorded in the minutes.

5.12 CSC records indicate that a comprehensive CiN plan was formulated with actions given to relevant agencies. There is no evidence of any CiN meeting being arranged. The CiN plan included an action for the social worker to make a referral to MARAC, which was done. It is not clear on what basis this referral was being made as there had been no reported or recorded domestic abuse. In November 2018, a CiN meeting took place but due to an administrative problem there is no record of the meeting or who attended. It is known that the CiN plan was to continue with another meeting scheduled for the beginning of January 2019.

5.13 In December 2018, the father was adopted into the Integrated Offender Management (IOM)[4] cohort. Whilst this was positive step, there does not appear to have been any liaison with the agencies that had been involved with the children.

5.14 In December 2018, the referral from the social worker was heard at MARAC. The information from the social worker stated the father was well known to police, there were ongoing issues with substance misuse, violence in the community, sporadic engagement with agencies and he was on bail for an offence of offensive weapon. The information that the father was visiting the mother's address was provided by the housing association. This information was recorded by CSC, but it

[4] Integrated Offender Management (IOM) -) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.

did not result in any other action. The action from the MARAC meeting was for CSC to convene a strategy meeting, this did not occur.

5.15 At the beginning of January 2019, a second CiN meeting took place with the social worker, health visitor, and children's nursery. The attendance of Matthew's sister at nursery was discussed but it does not appear that the information regarding the father attending the address was raised. It was agreed that the CiN plan would continue.

5.16 Around the same time the father engaged with the substance misuse service, he reported an increase in heroin and alcohol use. It was apparent that his health was deteriorating, and he said that he was going to stay with his mother. It was known that there were 5 children, including the father's own child (by another relationship), at this address but there was no consideration by the substance misuse service regarding the appropriateness of the father using this address.

5.17 In January 2019, CSC decided to close the CiN plan. It does not appear that any of the other agencies party to the CiN plan, or agencies previously involved with the family, were informed or consulted on this decision. The health visiting service were not informed of the decision until the beginning of February.

5.18 The same month, the mother reported that she had been the victim of a serious crime at her home; available information indicates that mother and the assailant had been under the influence of alcohol. After reporting the incident, the mother did not wish for any further action. The mother declined support from other agencies. Whilst this information was known to the police in the MASH it was not referred to other agencies to make them aware.

5.19 In late January 2019, a referral was made to CSC to express a concern that the mother's mother (Matthew's grandmother) had moved into the address. It was stated that the grandmother had renewed her relationship with a man who had previously been considered a risk to children. At the same time there was a referral from a community based health professional that the grandmother had expressed anxiety over thoughts she had concerning harming her grandchildren. CSC spoke to the mother who confirmed that her mother had moved into the address as she was unwell, but she was never left unattended with the children.

5.20 During early February it is clear that the father's health was deteriorating, there were reports of him with open sores, suffering from suicidal ideation and discharging himself from hospital. These concerns led to a professionals meeting to discuss possible treatment options for the father.

5.21 In late February 2019, police were called to an incident where the father and another female were drunk and disorderly in the street. It transpired that the father

and others had been with the mother, all of whom had been drinking. The father and other female went out to seek retribution for the serious crime allegation made previously by the mother. The female was arrested for public order offences. The police attended an address where the mother was looking after eight children, 6 of these being the arrested females and the other two were Matthew and his sister. The mother was found to be drunk and considered not fit to be caring for the children, to the extent that she was unaware how many children were actually present.

5.22 The mother and children were taken to the maternal grandmothers address to be cared for. The police and subsequently the probation service made a referral to CSC. The decision by CSC was that this latest concern did not meet a threshold for further action.

5.23 In early March 2019, the health visitor made an unannounced visit to the mother's address. The condition of the flat had deteriorated slightly, and the mother had re-homed a dog, which was now in the flat. The health visitor was not aware of the recent allegation of serious crime, and the incident which clearly showed the mother and father were associating, and that she had been incapable, through alcohol, of caring for the children. The mother informed the health visitor that although the father had been pestering her on the phone, there had only been one visit when he was told to leave and there had been no contact with the children. The health visitor offered the mother an Early Help Assessment, but this was declined by the mother.

5.24 The following day the health visitor contacted the health representative in the MASH with her concerns, that the mother was not being honest regarding contact and was declining Early Help. There is no record of this concern initiating any action or that it was shared with the MASH social worker or manager. In mid- March 2019, the health visitor raised a concern in her own agency that her previous discussion with MASH had not resulted in any other assessment.

5.25 In early March 2019, professionals including probation, substance misuse services, IOM coordinator, public health commissioner and homeless outreach met to discuss the father and the recent incident and the fact that it was not formally escalated. The information discussed indicated that the mother and father were back together, and the mother had indicated that she was happy for the father to return if he was detoxed. This information was not passed to the MASH at this time.

5.26 In late March 2019, the health visitor again visited the mother and children at the home address. The flat was noted to be in a better condition and there were no concerns noted regarding the children except some delayed developmental milestones for Matthew. The mother disclosed that the father had visited the flat and she was willing to have him back as he had a letter from drug services indicating

that he was 'clean'. The health visitor submitted a referral to the MASH setting out the concerns regarding the ongoing contact, the mother's honesty and apparent disguised compliance regarding the contact and the previous history which had caused concerns.

5.27 The referral was reviewed by the duty social worker in the MASH who also contacted the mother and discussed the concerns. The mother gave reassurances to the social worker which were considered appropriate. The social worker discussed the incident in late February when she was caring for the children whilst intoxicated, which the mother likewise gave reassurances for. The mother declined the offer of Early Help. The referral was compared against levels of need guidance and not deemed to be level 4 therefore no assessment was undertaken. The health visitor's intention was, in fact, to challenge the earlier decision for no assessment and not to make a further referral.

5.28 The information regarding the father being 'clean' was not substantiated by other reports at the time. The substance misuse service saw the father who was described as shaking and acting unusually. The pharmacy who dealt with the father's prescription also contacted the substance misuse service to report that they had seen the father shivering.

5.29 On the same day, the nursery attended by Matthew's sister, contacted first the health visiting service and then the MASH education representative by phone to inform them that the sister had not attended nursery for the past week and despite the mother being contacted on a daily basis, there had been no contact. The nursery also informed the education lead in the MASH that the mother had been offered Early Help, which she had declined. This was the third agency who had offered and had declined Early Help. The nursery was advised to undertake a home visit. In early April the nursery was contacted by text by the mother to inform them that the sister would not be attending the nursery anymore but would be moving to another.

5.30 In early April 2019, the father spent a spell in hospital. Later in the month he started to engage with the substance misuse service and was providing clear drugs test, although it was clear he was still using alcohol. On a visit the worker noted that he was called on numerous occasions by his wife. He stated that he was back with his wife. It is of note at the same time the mother contacted her GP to say that she was suffering with anxiety and was prescribed Propranolol.[5]

5.31 The father continued to engage with substance misuse services and by the end of April 2019, he was reported no drug use for over one month. He appeared to

[5] Propranolol – NHS UK - Propranolol slows down your heart rate and makes it easier for your heart to pump blood around your body. It is usually prescribed for high blood pressure and other heart problems, but it can also help with the physical signs of anxiety, like sweating and shaking.

have improved and stated that he was staying with the mother and children intermittently. The father disclosed that he was concerned regarding the mother's own drinking. This concern was not shared. In May, the father confirmed that he was moving in with the mother on a full-time basis and around the same time both the mother and father viewed a nursery together for Matthew's sister.

5.32 In early June 2019, the ambulance service was called to the home address where both the mother and father were present. It was reported that Matthew had found a number (perhaps 4) Olanzapine[6] tablets down the sofa and sucked them. Matthew was conveyed to hospital in a very serious condition, described as life threatening and was transferred the same day to a paediatric ICU.

5.33 It was established that the mother had not been prescribed Olanzapine since 2012 and that the father had never been prescribed this drug.

6. Analysis of involvement

6.1 Identification of risk and appropriate interventions.

Pre - birth

6.1.1 Whilst the focus of this review does not start until June 2018 it is important to consider the background and historical information as this was available to agencies and should have been used when assessing any risk.

6.1.2 The mother had a challenging early life and suffered a number of significant adverse childhood experiences. Understandably, these had a considerable impact on the mother. Over a period of time the mother demonstrated some chaotic behaviour in abusing alcohol, self-harming and being involved in some offending which brought her to the attention of criminal justice system.

6.1.3 In 2015 and 2017 the mother became pregnant with the sister and Matthew respectively. A pre-birth assessment was undertaken for Matthew's sister and as a result a CiN plan was initiated. For Matthew a pre-birth assessment was considered but as the mother was seen to be engaging with Early Help and it was believed that there was not contact with the father, it was deemed that Early Help was appropriate, and no further assessment was undertaken by a social worker.

6.1.4 The Regional Child Protection Procedures for the West Midlands[7], to which Herefordshire subscribe set out the procedure for assessing a pregnancy at an early

[6] Olanzapine – is an antipsychotic drug for the treatment of schizophrenia, moderate to severe manic episodes and for the prevention of recurrence in patients with bipolar disorder.
[7] The Regional Child Protection Procedures for the West Midlands – Pre birth procedures - http://westmidlands.procedures.org.uk/ykpzl/statutory-child-protection-procedures/additional-guidance#s537

stage where there are concerns for the welfare of the unborn child. The procedure sets out some criteria, for guidance, under which a pre-birth assessment should be considered. This includes some of the circumstances experienced previously by the mother.

6.1.5 The father was known to have had a chaotic lifestyle, he had lived on the streets and was known to abuse alcohol and drugs. He had a record with the police for offending dating back to 1997. Both the mother and father had a history of poor engagement with services.

6.1.6 The risk that the father presented to the children was recognised at an early stage in the initial CiN plan, which had as a condition that any contact with Matthew's sister should be supervised by the paternal grandmother. Whilst there was no restriction on contact between the mother and father, the pregnancy with Matthew gave a strong indication that the relationship was far from over and a more in-depth assessment would have helped to understand the relationship between the mother and father.

6.1.7 A pre-birth assessment for Matthew would have given the opportunity for a clear analysis of the risks and concerns that the mother and father presented as parents and what mitigation in the form of intervention and support would have been appropriate.

Post birth

6.1.8 In June 2018, the father was sentenced to a suspended sentence for possession of a weapon in a public place. The sentence also had a Rehabilitation Activity Requirement for 12 days activity. This was to be supervised by CRC. The suspended sentence also had a condition of night curfew, initially to the father's address but was changed to the address of the mother, Matthew and his sister. There is confusion on how this change of address was achieved but there were insufficient checks on the suitability of the mother's address. It would appear that there was no liaison between agencies to understand whether the risk presented by the father's presence at the address was acceptable. Had this been subject of discussion the fact that there had previously been a plan in place to supervise contact could have been shared. In any case, it would be important to understand what consideration is given to safeguarding children when assessing the suitability of addresses.

6.1.9 There was only recognition of a risk to the children presented by the father being at the address in early July 2018. This recognition initiated a contact with CSC

and subsequently a referral was made by the CRC. This referral resulted a strategy meeting being convened.

6.1.10 At the time of the sentencing it was known that the father was involved in substance misuse and this was a factor in his offending. At this time, the father was under the treatment of the substance misuse service and in receipt of a methadone prescription. It is surprising that there was no pre or post sentence liaison between the National Probation Service and CRC and substance misuses service. The substance misuse service was not aware of the concerns regarding the use of the mother's address until invited to the strategy meeting. Knowledge of the concerns and the fact that the father was residing at an address with children would have allowed the substance misuse service to consider safety measures, such as a drug lock-box for the address.

6.1.11 The strategy meeting was generally well attended by the appropriate agencies, although the housing provider was not invited. The decision was that there would be a single agency assessment and a date was set for an ICPC. The subsequent ICPC could not be attended by all agencies but reports were submitted. The decision of the meeting was to place both children on child protection plan under the category of neglect. The plan included the father having no contact with the children and that he engaged with substance misuse services.

Child Protection

6.1.12 The minutes of this meeting were not received by all agencies and this is a feature of this and other meetings in this case. There was some discussion[8] regarding the category utilised for the child protection plan and it was agreed that the case could have been adopted under the categories of neglect or physical abuse. The discussion also focused on whether the case met the threshold for child protection at this time. This hinged on whether there was contact at the time between the father and children. Although the mother had said that the contact was ceased, there was a feeling, particularly from the social workers involved, that the mother was not being honest regarding the level of contact. On this basis the decision for child protection at this stage was considered the correct one.

6.1.13 The decision of the ICPC and the plan condition that the father should not be at the address was contrary to the curfew order made by the court. It is not clear how or if this was conveyed to the court and what the impact of the father effectively having no residence had on the suspended sentence and RAR. This confusion is highlighted by the father being arrested for breach of the order but the proceedings subsequently being dropped at court.

[8] Where there is reference to discussion it pertains to the facilitated practitioner/learning event which formed part of this process.

6.1.14 Other factors which should have impacted or caused a review of the suspended sentence was that in September 2018 the substance misuse service discontinued their support to the father due to his lack of engagement and he had been arrested on a number of other occasions, including for drugs offences.

6.1.15 In October 2018, the health visitor enquired as to when a child protection core group meeting would be convened. CSC informed there would be no core group and there would not be a further meeting until the review meeting which was set for October 2018. There had been one core group meeting since the ICPC in August but due to an administrative error there were no minutes available. There were no further core group meetings.

6.1.16 The discussion focussed on the reasons why there were no core group meetings in this case. CSC, at the time of this case, were experiencing delays in transferring cases from the assessment team to the child protection court team. The case should have transferred to the court team on the day of the conference, but this did not happen. These difficulties were caused by capacity issues within the teams. It was discussed whether the same problems were still in existence. It was said that there had been an improvement which had not been sustained and capacity issues within the teams were still a concern.

6.1.17 On considering the reasons for lack of capacity it was identified as an increase in the number of assessments being undertaken. It was recognised that referrals coming into the MASH were of a better quality, which has led to more cases being accepted and requiring immediate intervention or assessment by the MASH (level 4).

6.1.18 At the review conference it was agreed that the case should be stepped down to a CiN plan. This decision was agreed by all the participants at the meeting except the social worker. In the discussion it was recognised that the social worker had only recently become involved in the case and was not confident that there had been evidenced change. Although the mother claimed that there was no contact with the father there was a sense that the mother was not being honest. The social worker stated that there was too much reliance on the self-reporting by parents.

6.1.19 The decision was made on the basis that on a number of visits made to the address by CSC, the father was never witnessed as being at the address. It was accepted that there could have been more creative methods to try to establish whether there was contact with the father and information could have been triangulated more effectively.

6.1.20 The Child Protection plan was not as explicit as it could have been. The risk was considered to be contact with the father due to his alcohol and drugs misuse, which led to chaotic and risky behaviour. If this behaviour could not be changed

then contact had to be restricted. Whether the plan was Child Protection or CiN actions to deal with this behaviour needed to be more explicit and evidenced as adhered to.

Child in need plan

6.1.21 Having made the decision to step the case down to CiN, a robust CiN plan was formulated but there is not enough evidence that the plan was effectively applied. One of the actions was for the social worker to make a referral to the MARAC. This was duly done. The MARAC referral is an anomaly, as there had been no domestic abuse in the past and there was no recorded perceived coercive control. The contention was at that time, and this was later borne out, that the mother wanted contact with the father and was not being honest about the level of contact. If the MARAC referral was made on the basis that there was contact, but it was unwanted by the mother, this was not supported by the information. If there was contact, then there was a requirement for a plan to be in place to ensure the children were protected. The action from MARAC was for CSC to convene a strategy meeting but this did not occur, in fact the CiN plan a short time later was stepped down to Early Help. At the MARAC meeting the housing provider also confirmed that there was contact between the mother and father.

6.1.22 Around this time the father was accepted as part of the IOM cohort. This was aimed to manage him as a prolific offender. It is apparent that the effort being expended to manage the father was not coordinated with that to protect the children. The IOM team had good information that the relationship between the mother and father was ongoing, in fact strength was being drawn from the fact that the father had the support of the mother. Better coordination of the safeguarding plans and the IOM plan would have made both more robust.

Step down to Early Help and opportunities to reassess

6.1.23 There was one CiN meeting, but due to administrative problems there are no records of this meeting. One week later on 9th January 2019, there was a management supported decision by CSC to close the CiN plan, this actually occurred on the 17th January. No other agencies were consulted or informed of this decision; the health visiting service only established this was the case on making an enquiry in early February.

6.1.24 The decision to close the plan was made on the basis that the mother was engaging with services and there had been no contact with the father. This was not the case made out some weeks earlier at the MARAC meeting. Suspected contact between the parents was also highlighted by the housing provider. At this time Matthew's sister was failing to attend nursery and concerns were being raised

regarding this. There was also information that the father's health was poor and deteriorating.

6.1.25 The rationale to close the plan at this time was flawed and the method by which it was closed with no multi-agency engagement was not good practice.

6.1.26 Four days before the actual closure of the CiN plan the mother reported she had been the victim of a serious crime. She ultimately wanted no action taken regarding this offence, but it does raise a number of concerns. The offence occurred when both parties were drunk and at the home address of the mother. There does not appear to have been consideration of the risk posed by the excessive use of alcohol or what risk the male offender or behaviour displayed could pose to the children. This information did go to the police representative in the MASH but was not shared with other partners. Knowledge of this incident would have allowed the facts to be considered in the cessation of the CiN plan and a further assessment of risk factors.

6.1.27 This incident led to an equally concerning incident in February 2019, which confirmed that the mother and father were in direct contact. At the end of February police were called to a disturbance, it involved the father and another female who were seeking the offender of the alleged serious crime perpetrated on the mother. They both were drunk. The other female was arrested for public order offences. When the police went to the home address, they found the mother was caring for eight children. This included Matthew and his sister and the six children of the arrested female. The mother was also drunk to the extent she could not recall how many children were on the premises.

6.1.28 This incident presented a number of risks for consideration. It was apparent that the mother and father were in contact. That there was ongoing animosity towards the offender of the alleged serious crime and the father was not opposed to confronting him. That the mother in particular was drunk whilst caring for her and other's children. The police and probation service both made referrals to the MASH which were assessed and deemed not to reach the threshold for any further assessment. This should have initiated a strategy discussion to allow full sharing of the available information and assessment of the risk. In the discussion it was noted that this was a poor decision.

6.1.29 On the basis that CSC had stated that the recent incident did not meet a safeguarding threshold, professionals who were supporting with the father met to discuss what alternatives there were available for treatment. Whilst there was no clear outcome from the meeting, the information they had clearly showed that the mother and father were in contact and this was not shared with the MASH.

6.2 Challenge and escalation

6.2.1 Following a visit to the home address, the health visitor had concerns that the mother was not being honest regarding her contact with the father. It was felt that there was disguised compliance and that the sister was not attending the nursery, and this was causing a concern. The mother was continuing to decline Early Help which had been offered by the health visitor, CSC and the nursery. The health visitor submitted a referral (MARF) to the MASH. Checks were undertaken and it was deemed that that the circumstances did not meet the need for statutory intervention or assessment (level 4 threshold document). The following day the health visitor spoke to the health representative in the MASH to share concerns from home visit. The health representative in the MASH did not share this information with social worker or MASH manager to enable the decision to be reviewed. The health visitor then escalated the concern in their own supervision and was advised by health manager to submit a further referral (some weeks later) to challenge the MASH decision. This should have been an escalation conversation with MASH manager and then, if required, the head of service. There was referral by the HV, a decision of No Further Action by the MASH, a discussion the next day with the health representative in the MASH and then the same information was submitted as the HV service were not happy with the original decision. Instead of re-submitting the same information the escalation procedure should have been followed. This was unpicked and discussed in the practitioner event and CSC agreed with this.

6.2.2 The persistence and professionalism of the health visitor should be recognised as good practice but unfortunately as a further referral was made it was not treated as an escalation. In the discussion there was some confusion and sometimes a reticence to use the Herefordshire Safeguarding Children Board policy – Resolution of Professional Disagreement about a Safeguarding Children Response.[9] The Safeguarding Board has done a lot work to encourage the use of the policy and for professionals to appropriately and healthily challenge a decision that they feel is not right or does not protect the child. Despite this there is still reticence to use the policy. It was felt that some of this was due to the policy sounding confrontational and that Herefordshire was a small area where staff may not want to upset the status quo.

6.2.3 It was agreed that this area required more work and awareness and may benefit from a rebranding of the policy to make it more child focussed. It was also

[9] Herefordshire Safeguarding Children Board policy – Resolution of professional Disagreement about a Safeguarding Children Response - http://westmidlands.procedures.org.uk/local-content/4gjN/escalation-policy-resolution-of-professional-disagreements/?b=Herefordshire

suggested that on a MASH referral form there could be a link to the policy to highlight to staff that there is an avenue if they feel the correct decision has not been made. There should also be clarity and understanding of when a professional discussion has taken place with an agency representative in the MASH or a referral has been made and what action can be expected from partners.

6.2.4 Towards the end of this case the father started to indicate some abstinence from drugs but was still using alcohol. At this stage the father disclosed a concern to the substance misuse service that the mother was drinking heavily. The father had no reason to make spurious allegations against the mother. This disclosure was not shared. The reason for this was discussed and it was said that the worker receiving the information had felt that there had been no action in more serious circumstances, so this information was unlikely to initiate action. There were other instances when the substance misuse service should have considered making referrals, notably in July 2018 when the father disclosed being back in the family home and in January 2019 when the father admitted increased drug use. He stated that he was going to stay at a family member's address where there were several children. This feeling demonstrates the importance of the rationale for decisions being clearly conveyed to professionals.

6.3 Effective information sharing

6.3.1 Information sharing is raised with regularity in reviews, but it still remains an issue and was at times a feature in this case. In discussion professionals did recognise that agencies should not be passive and expect information to be furnished, but where there are concerns, they should be proactive in seeking the right information to assist decision making and to protect children.

6.3.2 The health sector has so many components, it is often difficult to obtain the right information. The hub for this information is the GP, but through no fault of their own the timely contact with GP's is often challenging.

6.3.3 It was agreed that for MASH to be able to make safe and timely decisions either the health representative within the MASH has access to the relevant health systems or that all the component parts of health need to be represented within the MASH.

6.3.4 It would seem achievable that the right health professional could be equipped with the information systems and be able to make safe and appropriate decisions regarding the sharing of information in a safeguarding context. If this is not achievable the Safeguarding Partnership may wish to communicate to practitioners, the rationale to alleviate any feeling that there has been no consideration.

6.3.5 In some areas it was conceded that there was a lack of joint understanding of the thresholds being applied by CSC and decision making, this could lead to frustration and a loss of trust in the system. This may be addressed by widening the participation in the MASH Partnership Forum. This could assist with the understanding and help to build networking and trust.

6.4 Non- dependent alcohol use

6.4.1Much of the focus of the concern and identified risk emanated from the father's substance misuse, which was more obvious and well recorded. One of the aspects that comes through the history of the case in a less obvious manner is the use of alcohol by the mother. The consideration therefore is what the impact of this was on the children

6.4.2 Whilst there is no suggestion that the mother was dependent on alcohol there are repeated incidents where it caused concern. The mother was known to abuse alcohol from the age of 16 and this contributed to a number of challenges in the mother's early life. More recently, in January 2019, the mother reported being the victim of a serious crime at her home address, and alcohol being a factor in this incident. In February 2019, the mother was found by police to be caring her own and other children whilst being considered by police incapable due to the effects of alcohol. In April 2019, during a period when the father's condition had improved, he disclosed to substance misuse services that he had concerns over the mother's drinking.

6.4.3 It is estimated that 30% of children live with an adult binge drinker, 22% with a hazardous drinker and 2.5% with a harmful drinker (UK, under 16 years – Manning et al., 2009). A report by the Children's Commissioner – Silent Voices[10] recognises that different levels of consumption (not just parents who are dependent drinkers) and particular styles of drinking (such as binge drinking) may affect children and it cannot be assumed that higher levels of consumption equates to greater harm. Similarly, the impact of lower levels than would incur intervention but which can still be harmful, is not well understood and this is an area which has not been well researched.

6.4.4 Whilst the mother's use of alcohol may not have had the effect of normalising excessive alcohol us to the children, due to their age it still had on effect on the mother's ability to care safely for the children and exposure of them to risk. The agency knowledge of the level and frequency of alcohol intake relies only on what was discovered or reported, and it cannot be established what the day to day

[10] Silent Voices – Children's Commissioner 2012 - http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp28102017.pdf

experience for the children was, but an indication may be the concern articulated by the father.

7. What are the learning points from this case?

7.1 There needs to be clarity on a single referral pathway into the MASH to avoid confusion.

7.2 This case allows for the promotion of the awareness of the pre-birth procedures and the Herefordshire Safeguarding Board Pre-Birth practice handbook for professionals.[11]

7.2 There needs to be a closer link and more consideration of safeguarding children when assessing sentences for criminal offences. Where offenders are being managed through structures like the IOM there should be close liaison with any safeguarding plans. There is potential for joint objectives to be achieved and for a more coordinated approach which may allow for more creative thinking in managing behaviour and keeping children safe.

7.3 Behaviour will only be changed by an explicit plan that is monitored and to which there is good adherence. It is important that any plan is communicated and shared in a timely fashion to all partners, particularly those expected to support and monitor conditions of the plan. Any closure of a CiN plan needs to be a multi-agency decision and not one taken by a single agency. This is explicit in the CiN procedures and should be embedded with staff.

7.4 Where a plan is stepped down to Early Help or where a parent/carer refuses the support of Early Help consideration must be given as to whether this will adversely impact the child's safety, health and/or development and, therefore, meet the threshold for Statutory Assessment at Level 4, in accordance with the Herefordshire Levels of Need Thresholds Document.[12] Agencies would benefit from a greater understanding of the levels of need to help them to appreciate decisions being made.

7.5 There needs to be continued awareness of the Safeguarding Board escalation/ disagreement policy. This needs to build on the work already undertaken but should

[11] Herefordshire Safeguarding Children Board *Pre-birth Practice Handbook for Professionals – Guidance for all agencies working with parents of unborn children* - http://westmidlands.procedures.org.uk/assets/clients/6/Herefordshire%20downloads/Pre%20birth%20practice%20handbook%2008.09.2019%20FINAL.pdf

[12] Herefordshire Levels of Need Threshold Document - http://westmidlands.procedures.org.uk/assets/clients/6/Herefordshire%20downloads/HSCB%20New%20Levels%20of%20Need%20v1.0%20Dec%202017%20(R).pdf

include what the cultural barriers are on agencies being able or willing to challenge one another.

7.6 There are some areas where the sharing of information could be more effective by building on existing structures. This should include looking to ensure that there is appropriate sharing of information in the MASH, that a proportionate approach to sharing health information in the MASH is discussed and implemented. There is potential to involve other organisations in the MASH assurance processes thereby increasing the understanding and trust in decision making.

7.7 There could be more awareness of the risks to children from parental alcohol misuse, particularly to consider those parents who are not alcohol dependent but where there is evidence that the use is having a negative impact on children.

8. Recommendations

8.1 In February 2020, The Safeguarding Children and Young People Partnership in Herefordshire (SCYPiH) Safeguarding Partners Board and Quality and Effectiveness Group hosted a workshop chaired by the Partnership Independent Scrutineer. This group comprises of senior leaders from agencies involved in safeguarding. The author presented this and another case, which has similar themes. The Scrutineer and author worked with the group to identify themes and resulting actions to address the learning identified in this review. This process has assisted in achieving joint agreement, understanding and collective responsibility of the identified areas of learning and development.

8.2 The areas of recommendations were classified as following; -

a. The partnership improvement priorities for SCYPiH Partnership.

b. Key areas of partnership activity that SCYPiH should seek assurance on.

c. Any matters that need to be brought to the attention of and/or addressed by other strategic partnerships.

d. Identified learning opportunities

8.3 The agreed priorities will form part of the new partnership strategic plan and the partnership will be held to account by the Independent Scrutineer, Quality and Effectiveness Group and annual reporting to ensure that the areas are addressed.

The partnership improvement priorities for SCYPiH Partnership.

1. **Framework of need and pathways –** To ensure that there is a joint understanding and agreement in the application of thresholds of all levels of need and that referral pathways are clear and understood. That both Child in

Need and Child Protection Plans and processes are robust, outcome focused and clearly understood and owned by all agencies.

2. **Multi-Agency Safeguarding Hub –** to develop one access point, that there is robust and consistent management oversight. That the functions are collaborative and there is a clear and understood collective responsibility. To ensure that information is effectively shared to make effective and safe decisions including in domestic abuse cases.

3. **Neglect –** The multi-agency responsibility to identify and respond to all aspects of neglect. To include educational and emotional neglect and the effects of non-dependent alcohol use by parents and the impact of these on children.

Key areas of partnership activity that SCYPiH should seek assurance on.

1. Communication and case transfer between National Probation Service (NPS) and Community Rehabilitation Companies (CRC), particularly through the transition arrangements for both organisations.

2. Application of thresholds, to be undertaken by multi-agency audit.

3. Escalation and professional disagreement policy.

4. Neglect

5. Safeguarding arrangements in substance misuse services.

Any matters that need to be brought to the attention of and/or addressed by other strategic partnerships.

1. Community Safety Partnership and Integrated Offender Management Board – a focus on safeguarding and understanding risks to children and young people.

2. Criminal Justice Board – the learning from this review in transfer of cases between NPS and CRC and the risk presented during the transition of services between the two.

Identified learning opportunities

1. Training on the cycle of change and motivational interviewing.

2. Escalation and professional disagreement.