Local Child Safeguarding Practice Review

Child S

REVIEW REPORT

Independent Reviewer: Alex Walters

FINAL REPORT

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Kent Safeguarding Children Multi-Agency Partnership

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1. Introduction

1.1. Kent Safeguarding Children Multi- Agency Partnership (KSCMP) commissioned a Local Child Safeguarding Practice Review (LCSPR) in November 2020. This followed a Rapid Review process and a discussion with the National Child Safeguarding Practice Review Panel. It was agreed that the circumstances met the criteria for an LCSPR because a child had died, the initial circumstances of the death indicated potential neglect, the child was subject to a Child Protection Plan and it was recognised that there were opportunities for further agency and system learning.

1.2 In the case, a child known as Child S died aged 7 weeks in August 2020. At the Inquest in February 2021, the cause of death was subsequently ruled as Sudden Unexpected Death of Infant (SUDI). The post-mortem had ruled out neglect overlay. Child S had been sleeping with his parents and testing found substances in both parents' systems. No criminal offences were considered to have been committed.

1.3 Child S had one older sibling and one older half sibling who had both been made subject of Care Orders in June 2019 and had been placed for Adoption in March 2020. Child S had been subject to a Child Protection Plan since April 2020 initially as an unborn under the category of neglect.

1.4. The time period of this practice review includes the beginning of the Covid 19 pandemic and the first national lockdown in March 2020. This context is important as many of the processes used by agencies became virtual and will have impacted on the practitioners and family. Most practitioners worked from home, however with this family, the Midwife, Health Visitor and Social Workers /Social Work Assistants continued to undertake home visits. The pandemic also impacted on overall recruitment and retention in agencies and for some practitioners, access to supervision and covering for absent colleagues resulted in increased demand/higher caseloads.

1.5. The purpose of a LCSPR, as confirmed in the current statutory guidance," Working Together to safeguard children 2018": Chapter 4 is clear that the focus is on learning for agencies and practice to secure improvement and not to hold individuals or agencies to account.

2. Process for conducting the LCSPR

2.1. KSCMP recognised the criteria for undertaking a LCSPR were fully met and there was potential to learn lessons from this review regarding the way that agencies work together in Kent to safeguard children.

2.2 There was a delay in initiating the LCSPR and the first Panel meeting was held in March 2021. In June 2021, the Partnership commissioned an Independent Reviewer, Alex Walters, an independent safeguarding consultant, experienced Local Safeguarding Children Board (LSCB) chair and SCR/LCSPR Independent Reviewer, fully independent of KSCMP and its partner agencies.

2.3 A further Panel meeting was held in July 2021, which agreed the scope, and the Terms Of Reference. It was agreed the time frame of focus would be October 19-August 2020. The methodology was a hybrid model including agency reports, access to key documents and discussions with practitioners and the family. An Agency Authors briefing was held in August 2021 led by the Independent Reviewer to discuss the Terms of Reference and the process of the Review. Kent Integrated Children's services (ICS) had already undertaken an internal review. This

was discussed with the Children's Social Care lead and shared with the Independent Reviewer and updated into an agency report shared with other agencies.

2.4 Full agency reports were completed, providing agencies with the opportunity to consider and analyse their practice and identify any systemic issues. They were received from: Kent Police; Kent Integrated Children's Services; Housing-Borough council; Maidstone and Tunbridge Wells NHS Trust (MTW); Kent Community Health Foundation Trust (KCHFT) and Kent and Medway CCG. Reports from East Kent Hospital University Foundation Trust (EKHUFT), Medway NHS Foundation Trust (MFT) and Kent and Medway SCP were also received covering their historical involvement. The reports provide details of the learning from the case within their agency, but also allowed agencies the opportunity to reflect on actions and make recommendations for improving their own practice. These reports were discussed with the agency authors and the Panel together in October 2021 to consider the learning and further information and clarification was subsequently sought. The Independent Reviewer requested and received key documents including Child Protection conference and core group minutes but was not able to see the legal planning minutes.

2.5 Discussions were held from January 2022 with key staff including the community midwife and named safeguarding health professionals in MTW; the social workers, social work assistant and managers including the service manager involved with the case from ICS. Unfortunately the main Health Visitor and her manager were on long term sick leave and others had left the service. Practitioners considered key themes identified by the Independent Reviewer, and the perspectives and opinions of all those practitioners involved at the time were most helpful and reflective and have significantly informed the LCSPR report.

2.6. The contribution of family members is an important part of the review. It was agreed that both father and mother would be informed of the LCSPR process, which was helpfully undertaken in person by the Practice Review Manager and one of the family's previous social workers. The Independent Reviewer subsequently attempted to make contact by telephone, as agreed with Mother on a number of occasions but without success. It is hoped the report can still be discussed with the parents prior to publication.

2.7. This practice review has been undertaken in a proportionate way to ensure the key learning is identified to support improvements in practice. It is, therefore, deliberately not detailed but provides a summary of the family and key agencies' engagement with the family.

3. Relevant background information on parents prior to the timeframe under review

3.1. There is an extensive history of Children's Social Care involvement with the wider maternal family dating back to 2001 which involved Mother and some siblings being removed from her mother's care due to neglect, drug misuse and domestic abuse. Mother went to live with her Maternal Grandmother from 6 to 12 years of age and then returned home. Mother became pregnant aged 17 but did not sustain a relationship with the Father of Sibling 1. Mother was referred to mental health services at 18 by the GP for depression/self harm/anxiety but she did not engage. Mother clearly had experienced adverse childhood experiences which will have impacted on her parenting.

3.2 There is little information on the Father of both Sibling 2 and Child S's background from the information provided to the review. However, it is known that he does have criminal convictions for violence and historical domestic abuse and was known to Probation services in relation to historical offending, which ended in January 2019. There was no mental health involvement.

3.3 Kent Integrated Children's Services (ICS) involvement with Sibling 1 began in January 2018 following several referrals regarding domestic abuse incidents, substance use, homelessness, and neglect. Mother was 18 years old and ICS was not able to meaningfully engage Mother in the support services offered. Father to Sibling 1 played no part in his life. An Interim Care Order was granted in June 2019 and Mother was offered the opportunity to go to a parent child placement but was only able to remain for 12 hours. By this time Mother was nearing term with Child S youngest sibling –Sibling 2 who upon birth joined Sibling 1in foster care and both were subsequently adopted in March 2020. Towards the conclusion of the care proceedings Mother became pregnant with Child S and when aware the Midwife made a request for support for the family to Children's Social Care in January 2020.

4. Family Structure.

4.1 The relevant family members in this review are:

Family member	To be known as:
Subject child	Child S
Father to subject child	Father
Mother to subject child Half Sibling to subject child Sibling to subject child	Mother Sibling 1 Sibling 2

5. Brief chronology of events from October 19- August 20

5.1 During the review period, which covered the pregnancy and birth of Child S, the family received universal health services from the GP, involvement with Housing and Police, universal plus services from Midwifery and Health Visiting to reflect their support needs and specialist involvement from Children's Social Care services in Kent (ICS) from January 20. Neither parent had involvement with mental health or engagement with substance misuse services.

5.2 In January 20, a referral was received by ICS from the midwife for unborn Child S. It noted the known history including mother's poor mental health, domestic abuse, substance misuse and current homelessness. ICS noted little time had passed since the end of care proceedings for the unborn baby's older siblings and highlighted a similar situation.

5.3 The Housing Department offered temporary accommodation to Mother and Father in March 20. A Child & Family Assessment (C&F) was completed by ICS and recommended a strategy discussion. This was held on 20.03.2020 and included representation from police, midwifery, health and housing, and some professionals with recent involvement with Child S's siblings. The outcome was to progress to Initial Child Protection Conference (ICPC) and it was noted a Legal Planning Meeting was also to be convened to consider Public Law Outline (PLO) /Care Proceedings and agree the next steps

5.4 On 17.04.2020, the Initial Child Protection Conference (ICPC) unanimously agreed (unborn) Child S should be supported by a Child Protection Plan under the category of neglect. Mother reported she was smoking one joint of cannabis a day to help her sleep. Father reported he was smoking cannabis throughout the day but wished to stop. Neither reported any current issues with

their mental health. Police information noted most recent domestic abuse notification as November 2019.

The agreed Child Protection Plan was as follows:

- Mother to attend health / midwifery appointments
- Both parents to reduce drug use and work towards being drug free
- Both parents to maintain the tenancy agreement, including paying rent and keeping the flat clean
- Both parents to adhere to COVID-19 guidelines
- Domestic abuse support / intervention to be explored to focus on healthy relationships and the impact on children, including 121 work via the allocated social worker if services not available due to COVID-19
- Pre-Birth Planning meeting to take place
- Midwifery to support Mother to claim maternity grant and explore with Mother how she was feeling with a view to referring to services if necessary
- Allocated social worker to also explore feelings with Mother and support access to Adult Services for Mental Health if necessary and provide helpline numbers.
- Pre-birth assessment to include safety planning (was not completed)
- Family Group Conference referral
- Legal Planning Meeting

5.5 On 19/5/20 the first Core Group meeting was held.

5.6 On 18/5 and 19/5 20 there were 2 domestic incidents involving the parents and the Police, which were not referred to ICS.

5.7 An Initial Legal Planning Meeting was held in May 20, with the outcome to progress to Public Law Outline procedures and a period of pre-proceedings. At the time Child S's estimated date of delivery was 07.07.2020. A Senior Social Work Practitioner was allocated to complete a Parenting Assessment and a referral for a Family Group Conference was made. There is recognition that there was some delay in these processes being initiated given the original referral was in January 20.

5.8 The second Core Group meeting was held virtually on 12.06.2020 involving Mother, the two Social Workers, Midwife and Housing. The minutes note the baby was measuring small and Mother may need to be induced. The Pre-Birth Plan was shared by the Social Worker to the Midwifery team; the plan notes that "***unborn is subject to CPP, Children's Social Care must be informed of birth; Social Worker notes that if Mother and S are well then can be discharged home (if no Midwifery concerns); the plan further notes that*** '***owing to the child being on a Child Protection Plan the unborn is at risk of neglect and poor supervision. There is not an immediate risk to the child as Mother has cared for children in the past. There have been some noted improvements made in her insight and situation, hence why legal orders are not being sought at birth. The Local Authority are currently in pre-proceedings process and there are not currently plans to remove the unborn from their care after birth, thus the unborn will be returning to the parent's home which has been visited and assessed'.***

5.8 On 22.06.2020, the ICS Area Assistant Director agreed to issue care proceedings at birth. However, at the Review Legal Planning Meeting held on the same day the plan reverted to remaining under the Public Law Outline in pre-proceedings with Child S returning to his parents care once born. The meeting was held just over 3 weeks after the Initial Legal Planning Meeting

and the overarching view of attendees appears to be that *'threshold wasn't met.'* Both Social Workers felt the circumstances for Child S were better than for the siblings and a narrative was developed around things being *'not bad enough to warrant removal.'*

5.9 There is a further virtual Core Group meeting on the 23.06.2020. Parents were excused to participate in a Parenting Assessment session and the midwife confirms Mother will be induced the following day. The Core Group discussed the visiting arrangements following Child S's discharge home from hospital. A Social Work Assistant (SWA) was assigned to work alongside Social Workers and support the family. The Core Group minutes of 23.06.2020 note "the Core Group" were concerned about two parents under the influence of substances but there was no further challenge to the proposed safety plan shared by the Social Worker, which required one parent to remain sober.

5.10 On 25.06.2020 Child S is born by caesarean section. The call from the hospital midwives to Kent OOH service to alert them note there are concerns the parents used drugs whilst in hospital i.e. smell of cannabis after a walk. However, this is not communicated to the allocated Social Worker. Due to COVID -19 a physical discharge planning meeting did not take place. Records indicate the Social Worker spoke to a lead midwife at the Hospital on 26.6.2020 and outlined the plan for Child S including level of visiting post discharge and ongoing assessment and care planning. Parents were reported to be appropriate and attentive and neither appearing to be under the influence of substances.

5.11 On 27/6/20 Child S is discharged from hospital home with parents.

5.12 The following home visits were undertaken over the next 7 weeks-both announced and unannounced:

29/5/20- Midwife

30/6/20 Midwife

1/7/20- Social worker

2/7/20- Social Work Assistant

3/7/20-Social Worker

7/7/2- Parenting Assessment (PA) Social Worker

8/7/20 -Health Visitor

10/7/20 -Midwife

14/7/20- PA Social Worker

15/7/20 -Social Work Assistant

19/7/20 -Midwife

22/7/20- Social Worker

29/7/20- PA Social Worker

31/7/20 –Social Worker

2/8/20- Police –following allegation

6/8/20-Police following allegation

6/8/20- Duty Social Worker and Social Work Assistant

7/8/20- Health Visitor

5.13. On 13.07.2021 the Review Child Protection Conference was held virtually. Information / reports were provided by the Social Worker, Police, Housing, Health Visitor, GP and KMPT. By the time of the Review Child Protection Conference, the decision had been made that Child S would remain in the care of his parents whilst Public Law Outline (pre-proceedings) continued. Information from the Police incidents in May and the fluctuating home conditions were not shared. Child S remained subject to a Child Protection Plan.

5.14 On 17.07.2020 Initial Pre-Proceedings meeting held. The parents did not attend but were represented by solicitors.

5.15 On 29.07.2020 the Parenting Assessment concluded with a positive outcome. The social worker felt the basic care the parents gave was good enough, they had engaged well, were insightful of the concerns, which had led to the removal of Child S's siblings and there had been no concerns re domestic abuse or substance misuse. It concluded with recommendations for further support.

5.16 During the period 31.07.20 – 06.08.20 (bank holiday weekend) there was ICS Out of Hours /ICS involvement resulting in 2 police welfare checks due to concerns for the care Child S was receiving from his parents/domestic abuse. Child S was well, but alcohol use was noted to be a contributing factor. Telephone follow up with parents was undertaken, who did not initially disclose full details of what occurred to the Social Worker.

5.17 Following additional information from an anonymous source, a Duty Social Worker and Social Work Assistant undertook a visit to the family on 06.08.20 as the allocated Social Worker was on leave. Before and following the visit, they discussed their concerns with ICS legal adviser in detail who suggested the Social Worker to visit the following week and to discuss the written agreement with the parents.

5.18 On 07.08.2020, the Health Visitor raised concerns by email to the Social Worker about the home conditions and bruising to mother which it is assumed related to events a few days earlier.

5.19 On 10/8/20 a Core Group Meeting was held with the Social Worker and Health Visitor and recent events/concerns discussed. The Social Worker was due to visit on 14/8/20. Sadly Child S died that morning.

6. Involvement of agencies October 19– August 20 and single agency learning

HOUSING

6.1 Mother and Father had been sofa surfing for a number of months but presented to the Housing Department in March 20 and were placed in temporary accommodation. The Housing team had minimal engagement with Child S or his parents during the review period but demonstrated good liaison with ICS to help resolve their housing situation. In addition, Housing were involved in all Child Protection/Core Group meetings and correct action was taken by the housing manager to flag

concerns to ICS around the incidents on 11/8/20 when alerted by the Housing Provider. No additional learning identified by the agency Author or Reviewer.

MIDWIFERY

6.2 Midwifery from the Maidstone and Tunbridge Wells NHS Trust (MTW) became involved in March 20 following a good quality handover referral from midwifery at EKHUFT. One Midwife undertook all antenatal care and post natal care in the community, which enabled a consistent trusting relationship to be developed. In addition, the midwife provided extended Midwifery post natal care for Mother and Child S for a period of 28 days which involved 5 home visits. This is above the normal standard and reflected the Midwife's good understanding of the vulnerability of the family. The Midwife attended the ICPC and Core Groups but was not invited to the RCPC. Safe sleeping advice was provided to the family on each occasion in this post-natal period. The Midwife engaged well with Mother and Father and maintained good liaison with the Social Worker and Health Visitor and informed them of the cessation of her involvement on 22/7/20. The Midwife had no safeguarding concerns around the quality of the care provided by parents although noted that the home conditions were untidy on occasion but that Child S was thriving.

Subsequent changes/improvements in practice for Midwifery identified by the agency author:

- The Named Nurse Safeguarding Children will strengthen the training on Professional Curiosity in line with the recommendations from previous reviews and the current Intercollegiate Document
- The Midwifery Safeguarding team will highlight to staff the importance of Professional Curiosity and having 'difficult conversations'; Safeguarding supervision will highlight and document discussions on Professional Curiosity
- Although staff are aware of the challenge/escalation process this will be highlighted during training and supervision
- Information sharing with Community Midwifery team leaders/senior managers

HEALTH VISITING

6.3 During the review period health visiting was provided the Kent Community Health NHS Foundation Trust (KCHFT). The Health Visitor completed two home visits and three telephone discussions with the family.

6.4 The Health Visitor attended the Strategy discussion in March 20 but was not invited to the Initial Child protection Conference (ICPC) in April 20 but proactively requested information from the Social Worker. When liaising with the GP, there was good antenatal communication and professional liaison, however, liaison with the GP would have been good practice following the 6–8-week review, as there seemed to be a lack of information sharing with the GP once Child S was born, especially as parents were yet to register Child S with a GP.

6.5 On 08.07.2020 during the first home visit the parents had been encouraged to clean/tidy up. It was also noted that Mother had fallen asleep on the sofa with Child S's head unsupported. The Social Worker requesting both midwife and Health Visitor revisit and reinforce information regarding safe sleeping. Health Visitor replied to this email to both Social Worker and midwife advising about the observations at the new birth visit and that safe sleeping was discussed with parents. Health Visitor acknowledgement that home conditions were likely good enough as a result of Social Worker Assistant intervention. Health Visitor advised Social Worker that she would reinforce safe sleeping at next contact in 2 weeks' time and again at 6-8-week contact.

6.6 Safe sleep advice was consistently given by the Health Visiting Service and documented well within the records.

6.7 The Health Visitor did have increased concerns at her 2nd home visit on 7/8/20 around the home conditions and also bruising seen on Mother and proactively raised these with the Social Worker and agreed the Social Worker would visit later that week.

Subsequent changes/Improvements in practice for Health Visiting identified by the agency author:

- Already part of an internal Action Plan for the Health Visiting Service, an action to demonstrate and document professional curiosity when parents/carers report information about themselves and engagement with other services by liaising with such services.
- Health Visiting Service/Children & Young Peoples Operational Services to follow Local Safeguarding Partnership "Resolving Professional Disagreements and Escalation of Professional Concerns" procedures if they are concerned with partner agency's management/lack of escalation regarding a case.

GP

6.8 Father was registered at Practice A but not seen during the time period but was not on any regular medication. There was no information or communication from the ICS service that Father was the father of a child who was subject to a Child Protection Plan. Mother was registered at Practice B and partial Temporary Registration at Practice A but had no face-to-face consultations in the practice during the time period and no medications were issued.

6.9 There was one discussion with NHS 111 at 4 am on 10/4/20 which is significant in that Mother was approximately 23 weeks pregnant and shared she had sex with her partner and 'things got a bit rough'. She reported bruising to her vaginal area. One of the GPs from Practice B attempted to ring her back on 3 occasions to follow up but there was no response.

6.10 This information was shared in response to request from ICS for information from GP services regarding an Initial CP Case Conference (ICPCC) on 17th April 2020 for unborn Child S. The GP shared the tight deadline for providing a report and the information from the April NHS 111 contact. This issue is significant given the history of domestic abuse in the Parent's relationship and raises the possibility of non-consensual sex. The GP also shared that Mother booked late at 17/40 weeks for her maternity care on 24/02/2020.

6.11 However it would appear that this information was not received/shared at the ICPC held on 17/4/20 and this may have been due to late receipt of the letter. This does not appear to have been known to the social worker.

Improvements in practice identified for GP services by the agency author:

- Due to patient choice within the NHS Constitution (2012), parents can also choose to register at different GP surgeries**.** Mother did not register Child S birth despite repeated requests from the practice; particularly as Child S was on a CPP. The Agency Author recognises sharing this information with ICS would have provided more support for the practice as the family social worker could also help support the parents to register Child S.
- There is a national issue around Temporary registration. It lasts for 3 months and only limited records are shared from the Practice where a patient is fully registered.

INTEGRATED CHILDRENS SERVICES- KENT COUNTY COUNCIL

6.12 From January 2020, there was comprehensive engagement by all social workers/social work assistants involved with the family. All statutory processes were followed i.e. Social Work assessments, Strategy meetings, Child Protection Conferences, Core Groups, PLO processes and Child S was made subject appropriately to a Child Protection Plan. There is however recognition that these processes could have been undertaken in a more timely manner which impacted on a reduced timeframe to consider and assess risk. In addition, a specific pre birth assessment which was identified in the Initial Child Protection Conference in April 2020 was not undertaken although a social work assessment had been completed. It is recognised that consideration needs to be given to the support offered to parents who have experienced care proceedings and whose children have been recently removed and there is evidence of other loss and trauma for the parents. ICS have since produced additional guidance for practitioners to clarify pre birth processes and expectations.

6.13 The ICPC in April 2020 was well attended by partners (other than the Health Visitor who was not invited) and the history and risks to unborn Child S were all clearly identified in the Social Worker's reports and minutes. The identified Child Protection Plan actions were undertaken and overall communication between the agencies involved with the family was timely and effective.

6.14 The case was allocated to a Social Worker who was an experienced senior practitioner who had previous knowledge of the family though the previous care proceedings. The Social Worker developed a good trusting relationship with the parents. The social work report to the RCPC in July 20, 2 weeks after the birth of Child S was strengths-based and evidenced positive interactions between Child S and parents. The Social Worker believed the situation was very different to the previous time they were involved, referenced fewer police reports, a lessening of the parents' chaotic lifestyle and lack of domestic abuse reports at that time. The Social Worker saw no reason to doubt the parents' contention they had stopped using drugs and their presentation was significantly different from when they worked with them previously. Concerns about the fluctuating home conditions were mitigated, in part, by the fact they now had a stable home and multi-agency work to address the identified concerns would continue. In addition, the Social Worker felt parents demonstrated insight into the concerns which led to the removal of the older children.

6.15 A parenting assessment had been commissioned and undertaken by a senior social work practitioner over the 4 weeks post birth and the narrative developed with both social workers around the situation being *'good enough'* for Child S to remain in his parents' care under the Public Law Outline as parents had shown insight and appeared to be taking on board advice from professionals. Home conditions were overall acceptable for the age of an immobile child. However, there was no benchmark set or agreed and shared with the multi-agency network for what *'good enough'* looked like, and / or how this could be achieved or tested and what their contributions might be. The narrative assumed the circumstances for Child S were not *'as bad'* as they were with his siblings and it appears the baseline for *'not good enough'* was perceived as immediate removal. Practitioners noted that home conditions are often variable in families which makes risk assessment challenging and also the reality of differing professional and personal perceptions of "good enough".

6.16 With hindsight, there is no evidence the parents undertook any work, or intervention provided to address any of the issues which led to the siblings being removed. Although they engaged with Social Workers and Health practitioners, they did not engage with the FGC over 3 months, with substance misuse services or obtain legal advice on their own for the PLO process as this was

undertaken with the support of the Social Worker. The Parenting Assessment relied heavily on how reflective the parents were being during sessions and their perceived level of engagement. The evidence suggests disguised compliance may have been a factor but there is no doubt of the parent's desire to effectively parent Child S.

6.17 Practice could have been strengthened by co-ordinating with other agencies and the SWA to inform the parenting assessment. There is evidence that what practitioners observed about the fluctuating home conditions in unannounced or planned visits conflicted with what the parents were telling the Social Workers about the changes they were making. In addition, the Parenting Assessment did not consider information from the General Practitioner in April 2020, the Police's information from incidents in May 2020, the information about a cannabis grinder seen at the flat, the co sleeping incident or include updated agency checks. These omissions should have led to more scrutiny of the parents' self-reported improvements, motivation and capacity to sustain change. It did not include the Police incidents in July 2020 but they took place just after the assessment concluded. However, in terms of risk factors, none of the practitioners witnessed or smelt cannabis use during the 7-week period other than the observation of the cannabis grinder.

6.18 The positive feedback from the Parenting Assessment was instrumental in the decision to continue the Public Law Outline at the Legal Planning Meeting on 22/6/20 rather than issue care proceedings, even though the Parenting Assessment was incomplete at this point and not reviewed /quality assured. There was challenge to this view from the Service Manager, but legal advice was that there was insufficient evidence for separation and therefore alternative placements i.e. Parent and child were not considered. However supported accommodation for vulnerable families with CCTV might have been a preferable option. This has identified learning for ICS around issues of threshold, test for interim separation and care planning.

6.19 Learning also highlights the necessity of ensuring the quality assurance of assessments is robust and considered in the wider context, by those who have sufficient experience, knowledge, and skills to critically analyse and reflect on the evidence base. In addition, there also needs to be a clear agreement at the start of specialist assessments such as a Parenting Assessment which identifies exactly what is being assessed, including baseline information and minimum expected / required outcomes, which may or may not include parenting "teaching" sessions to support assessment. This should be understood and endorsed by the network of professionals working with a family.

Improvements in practice in children's social care as identified by the agency author:

ICS have undertaken substantial learning and review from this case prior to the decision to undertake a LCSPR. The following outlines the activity and development to date to address learning.

- *Delays*- The importance of the Pre -birth assessment period as a framework to analyse the likely care Child S would receive from his parents, and whether this could be achieved safely. The parenting assessment did consider parents' preparations for the baby, however, was not started until very near to Child S's birth. Intervention in relation to managing & maintaining home conditions also started around the time Child S was born when there were earlier opportunities.

- *Supervision/Management oversight*- There were several practitioners involved with the family, this was a strength as practitioners had existing relationships and knowledge of the family history. Practitioners would have benefited from joint supervision; this could have

helped an analysis of parental capacity to change, baseline parenting skills, needs & expectations and supported an understanding of "good enough" parenting. This should be extended to multi-agency partners. There may be future opportunities to extend joint supervision to include key multi agency professionals working with a family.

- *Substance Misuse*- Expectations and planning regarding substance use need to be specific. Assessment & planning should involve expertise from specialist substance misuse services to properly assess and develop interventions and safety planning and inform professional networks about risk and impact of substance use. ICS report a pilot multiagency workshop commenced in September 2021 where ICS commissioned senior practitioners from domestic abuse, substance/alcohol and mental health services to lead on a group discussion on an identified case. This is supporting understanding of the different perspectives as well as informing best practice regarding any of the factors or a combination. This is now going through the scale up process to be delivered across KCC.

- *Trauma informed practice*-ICS has implemented training and development regarding trauma informed practice, this will support understanding and assessment when working with trauma- experienced parents, in this case, parents who have previous children removed.

- *Care proceedings/PLO* Where there may not be the threshold for separation, consideration should always be given as to whether care proceedings should be instigated where previous children were recently removed from parental care. This will ensure judicial oversight when testing out the sustainability of positive parental change in the context of disguised compliance and to avoid any unnecessary delay to permanency planning for the child. There may be an opportunity to develop partner agency understanding of the Public Law Outline - this could strengthen external challenge regarding decision making- see multi-agency recommendation. A thematic audit into the pre-proceedings process was undertaken which involved surveys being completed by the multiagency and provided important further learning in this area.

- *Assessments*-Practitioners should ensure they review and use all available information from the multi-agency network when completing assessments, reports and reviews. Practitioners need to challenge poor quality or late reports for Conference.

KENT POLICE

6.20 Kent Police have been involved with Mother since 2005 when child protection concerns were raised in relation to her, her siblings and her mother. A number of records are held in relation to domestic abuse incidents within her family when she was a young person. Father has been known to Kent Police since 2003. He has a number of criminal convictions including offences of violence, drugs and domestic abuse incidents,

6.21 In August 2019, September 2019 and November 2019 there were three incidents of domestic abuse between the parents both involving intoxication of both. The incidents were recorded and no further action taken. In relation to the August incident, the file had been sent to CPS for a charging decision, it was returned in December 2019 with an action plan. However, by the time

the file was returned to CPS it was out of statutory time limits for charging (6 months) in relation to common assault. This has led to single agency learning.

6.22 On 18/5/20 there were two incidents involving the Police. In the first, a neighbour reported an argument to police but was unsure if it was at the parent's property. Police attended the property and spoke to both parents who denied any argument stating they had been watching television and there had been no incident. The address had a flag on the police system that requested that any calls to the address be notified to Social Services. This did not happen on this occasion.

6.23 The next day several calls were received from members of the public in relation to a male and female arguing and the female being assaulted at the property. Police attended twice and Mother was described as intoxicated. Later after midnight neighbours reported screaming and arguing, that it had been going on all day and that police had already attended previously but the shouting had continued. Officers attended and located Mother who stated the shouting had been her partner not wanting her to leave the property as she was upset but she had 'no issues' with her partner. Mother was escorted back to the property. It was apparent that this was an on-going incident to the calls recorded on the 18th. Unfortunately, a CP referral, as required, was not made to ICS on either occasion.

6.24 On 11th July 2020 a police report was prepared for the RCPC, 13/7/20. The incidents on 17th and 18th May 2020 are referenced but they not discussed at the RCPC and Police did not attend the meeting.

6.25 Following Child S's birth, Police involvement with the family was attendance on two occasions. On both occasions officers submitted CP referrals due to their concerns.

6.26 On 31/7/20 a Social Worker called police stating that she had received a call from a member of the public concerned that they had seen Mother bang the baby buggy hard up and down with the baby inside and then left baby in the buggy outside a property alone in another area. Officers attended the home address to conduct a welfare check but there was no response. It is apparent there was confusion as to where the individuals were at the time of the incident. The Police attended again but it was two days -2/8/20 before police successfully conducted a welfare check at the home address. Child S was checked and considered to be well, but it was noted that the property was filthy and cluttered and not appropriate for a newborn. A Child Protection referral was appropriately submitted.

6.28 In addition, late on the 31st July into 1st August 2020 SECAMB called Police to report that they had attended a call to a woman having a cardiac arrest. On attendance the female was very intoxicated and became abusive to her partner and walked off. It transpired the female was Mother and she was near to MGM home. Officers attended the property and spoke to MGM who would not allow them into the property and stated Mother was intoxicated but asleep. It later became apparent that there was no reference or knowledge of a baby and the two incidents of concern on the 31st July/1st August were linked, following which a welfare visit was conducted as outlined above, which led to a CP referral being submitted.

6.29 Late on 6/8/20 a security officer from the building in which Mother lived called police to report a female arguing loudly and being aggressive towards a male, a baby could be heard crying, the caller was unsure which flat the noise was coming from. Officers attended and confirmed the arguing couple were Mother and Father. Father was described as intoxicated and advised to leave the property for a period to 'cool down'. Child S was asleep in his Moses basket at the time of officers' attendance. He was checked appeared to be fine and considered to be safe in the care of his mother. A Child Protection referral was submitted. The incident was assessed as medium risk.

Improvements to Practice for Kent Police identified by the agency author:

- The practice of flagging persons/addresses with a marker of "Child Protection" concern to be reviewed to establish whether this process remains effective or requires improvement.
- Further work is required to ensure Police specialists in child safeguarding are aware of terms and the meaning of "professional optimism" and "respectful uncertainty".
- A review of child death investigations is currently being commissioned (not homicides conducted by Major Crime Unit).
- In common assault cases officers must expedite cases to ensure statutory time limits do not prevent a prosecution to give the court opportunities to further protect victims.
- The minutes of RCPC's must be reviewed by a Detective Sergeant to ensure they are in agreement with any decisions taken. At the current time this is a requirement in Police Policy (SOP O23a, para 3.18.9). From the research undertaken by the Agency Author, it appears that minutes of the meetings are rarely assessed on receipt and are often simply filed electronically. It appears that at this time Police do not have a 'voice' at RCPC's other than providing a report with any new information.

Additional learning relates to the non notification by Police to ICS following the May DA incidents which did not follow procedure despite unborn Child S being subject to a CPP and impacted on the risk assessment. This issue is identified for Kent Police as a single agency action.

7. FINDINGS and ANALYSIS

7.1 Child S sadly died at the age of 7 weeks from SUDI. Child S's parents had demonstrated they wished to parent positively for Child S and had engaged with practitioners well. In the first 5 week period there was no evidence of substance misuse or domestic abuse impacting on the care of Child S. However, in the last two weeks there was evidence of 2 incidents of alcohol misuse and domestic incidents which may have led to practitioners reassessing the risk to Child S.

7.2 As with any review, the process of reflection has identified some areas where the current systems and processes could be improved. All the agencies involved in Child S's family have identified their own learning and have captured a number of single agency recommendations into action plans. The themes identified below capture additional learning identified by the Independent Reviewer and has resulted in ten recommendations.

Theme One-RISK ASSESSMENT AND DECISION MAKING

7.3 Child Protection Processes-

a) It was highlighted that in the majority of Agency Reports, particularly those submitted by Health services, that minutes from the Child Protection Conferences or Core Group were not shared with those present. In addition, the Midwife was invited to the pre birth ICPC but not the July RCPC conference, which meant that her information following significant involvement over 28 days was not included. The Health Visitor was not invited to the pre birth ICPC which would have helped her understanding of the history and the potential risks to Child S. Effective administration processes for Child Protection Conferences are crucial to the effectiveness of risk assessment and decision making. The family had moved location during the period of involvement and this will have impacted on communication /changes in practitioners but this issue needs to be prioritised by the CP Conference service. **Recommendation 1**

b) The Police attended the pre birth ICPC but not the Review Child Protection Conference. There is an impact on Child Protection conferences being held without all the key significant agency representation. The Police agency author identifies that the minutes are "reviewed" by Police but there is no Police voice/analysis of risk. These are Statutory Partners and should be invited and should attend these statutory multi agency Child protection fora. **Recommendation 1**

c) Families are often mobile with changes of addresses and GPs. It may be helpful at the start of each CPCC, for the Chair/IRO to ascertain whether there are any changes of address or GP practices since the last Conference. **Recommendation 1**

d) Key information in the General Practitioner's (GP) ICPC Conference Report was not discussed at the ICPC or RCPC. This could have provided an opportunity to gain an insight into the dynamics of the parents' relationship and assess whether the changes they were reporting were evidenced. The GP's report for ICPC is in the form of a letter dated 22.04.2020 and is not noted on the minutes of the ICPC as being received but may have been received after the ICPC. Standard templates and audit of engagement by agencies to be undertaken by KSCMP. **Recommendation 1.**

e) The quality assurance of information being provided by partner agencies. It was felt that more awareness raising on the importance of quality assuring information submitted for all child protection meetings was needed. Within this case, there were emails sent to the Child Protection Conference from Mental Health with very little information, and no analysis of risk / potential risk. The GP reports came in the form of letters, and the police report for RCPC was received very late and contained many "blank" sections. Each agency will have their own accountability mechanisms to quality assure and sign off reports for Conference however the above approach does not reflect the statutory multi-agency requirements of Child Protection processes and support effective decision making. **Recommendation 1**

f) Core Group effectiveness- Core Groups were held but their effectiveness was limited by them often sharing information rather than reviewing progress against the CPP. The Social Work Assistant was also not invited and the Health visitor was not invited until post birth.

g) The GP for the Father was not involved or invited to child protection processes by ICS and the practice were unaware of previous involvement and removal of children or that Child S was subject to a CPP. A robust "Think Family" approach would have been challenging for the GP practice if Father had presented with mental health issues, drug misuse or disclosed domestic abuse. This lack of knowledge around Father's history would also have impacted on the voice and lived experience of Child S. This issue continues to reinforce the theme of "Invisible Fathers" by agencies, which was the subject of a thematic review by the National Child Safeguarding Practice Review Panel in 2021. This identified the frequency in which Fathers are not identified or involved by agencies in risk assessment and decision making processes. **Recommendation 2**

h) Escalation and professional challenge- KSCMP and individual agencies have done much work to raise awareness of the procedure and to encourage constructive professional discussion. The review is assured that practitioners used safeguarding supervision to discuss concerns and were aware of how to escalate. The key learning issue in this review is that practitioners need to be supported to understand the processes of care proceedings and PLO and the relevant thresholds in order to best placed to raise any concerns.

Care Proceedings and use of the Public Law Outline (PLO) process.

i) The learning from this case highlights the need within ICS for there to be a review of the current arrangements and impact of the legal advice provided to front line practitioners which will consider the effectiveness of these arrangements and the impact on decision making.
Recommendation 4

j) It has also became clear to the Reviewer from discussions with practitioners that agencies are not clear about the Public Law Outline processes and evidence thresholds and how decisions link into the multi-agency child protection processes and procedures. The professional terminology used by ICS can be difficult to understand and potentially impact and provide some misplaced assurance.

k) In addition the legal planning meetings and PLO meetings do not include other partner agencies and the minutes are deemed confidential and cannot be shared. Other agency practitioners are therefore not able to actively inform the assessment of risk presented by the Social Worker/s in these meetings and importantly may not understand the rationale for decisions. A multi-agency survey initiated by ICS in 2021 demonstrated that partner agencies know what the term PLO means but less than half of those involved with a family during a period of pre-proceedings felt they had been involved 'always' or 'often' in the discussions about increasing levels of risk and decisions to seek legal advice. Only around a third of those practitioners during a period of pre-proceedings felt they were kept up to date about assessments & interventions and considered they or their agency had contributed to assessment or intervention during pre-proceedings. The significant majority of all agencies felt they or their agency needed further input to improve their confidence in pre-proceedings.
Recommendation 3

Theme Two-DEFINITION AND UNDERSTANDING OF NEGLECT.

7.4 The parents of Child S had had their older children removed due to concerns around neglect as well as domestic abuse and substance misuse. After Child S returned home to his parent's care in June 20 there were home visits undertaken by the Midwife, Health Visitor, Social Worker, Social Worker undertaking the parenting assessment and the Social Work Assistant. In addition the Police undertook two home visits following concerns raised.

7.5 It is clear that the home conditions varied significantly over this 7-week period. Some practitioners described the home as "clean and tidy", a day later as "filthy and poor conditions". The issue within this family was their ability to sustain good enough home conditions and ensure that these conditions did not adversely impact on their child. These ongoing concerns around sustaining change aligned with the later incidents identified by the Police of substance/alcohol use and domestic abuse between parents may well have led to escalation and a decision to review the current plan for Child S.

7.5 In discussions with practitioners, it became clear that the KSCMP neglect strategy had not existed at the time of the incident. However, although there is now a Neglect strategy and toolkit developed by KSCMP and published in January 21, it is generally not seen as a helpful guide and not clear enough in its descriptions of neglect in the home, and both the impact of poor home conditions and the impact of inconsistency of poor home conditions on children. Practitioners felt it was dependent on their subjective judgement on what constitutes "good enough" home conditions but this didn't feel particularly evidence based.

7.6 Additionally in this family, the parents were receptive to practitioner concerns and attempted to improve the home conditions but this effort was not sustained. It would have been helpful for a multi-agency shared log of the home conditions to have been maintained so the inconsistencies could have been more easily identified as well as descriptors of "good enough". The

inconsistencies in professional observations of parenting and home conditions over a very short period likely reflected the lack of an agreed professional baseline to support ongoing assessment, and lack of parental understanding of what was expected, alongside gaps in parenting ability.

Recommendation 5

Theme Three-SUBSTANCE MISUSE-

7.7 Both parents had a history of substance misuse which had contributed to the removal of their older children. Understanding of parent's substance use is important in assessing risk. At the ICPC Mother reported she was smoking one joint of cannabis a day to help her sleep. Father reported he was smoking cannabis throughout the day but wished to stop. During a statutory Child Protection home visit at the parent's new property on 3/6/20, both reported to the social worker they were smoking one joint of cannabis at night to help them sleep. The Social Worker agreed to refer to the local substance misuse service, but parents didn't engage due to the imminent birth of Child S but did not pursue further. However, both parents following birth of Child S confirmed they had stopped smoking cannabis. At the parenting assessment visit on 7/7/20 by the Social Worker undertaking the Parenting assessment notes significant concerns describing conditions as "filthy" with clutter and rubbish all over the floor and surfaces" and a cannabis grinder was observed on the table.

7.8 None of the practitioners witnessed or smelt cannabis use during the 7-week period other than the observation of the cannabis grinder. The parents' contention they had ceased using cannabis however required further challenge or testing, during the child protection process and Public Law Outline and the safety plan showing little exploration or analysis informing the plan, i.e. how much was being used, what was the impact on parenting capacity and how feasible was it to expect parents to use separately and safely, including where parents would be using, how they obtained the drugs and if this meant other adults were coming to the property etc.

7.9 The ICS Agency Author states Social Workers felt as the parents were being open and honest about their drug use, it was unnecessary to consider Hair Strand Tests (HST) within Child Protection or during Public Law Outline. Hair Strand Tests would have provided a baseline picture of usage and provide further evidence to support the assessment within the pre-birth period. This would also have supported ICS in understanding whether the parents were being honest about their drug and alcohol use and confirm or refute the contention the parents were making changes.

7.10 In discussion with social work practitioners, managers and the Reviewer, they described the threshold needed via an internal Panel to obtain HST funding given the associated financial costs. Their view was clear that this threshold had not been met. Practitioners also described the unreliability of some forms of testing and the challenge for all practitioners of understanding/measuring the risk of all substance misuse on parenting.

7.11 It has become clear to the Reviewer that substance misuse and in particular cannabis use has become normalised within many families. There are issues about practitioner understanding of the strengths and impact on parenting. Unless a threshold is reached, although addressing substance misuse may be part of a child protection plan, it relies on parental consent to engage with any agencies and this is frequently not undertaken. Health practitioners described the challenges of being aware of the need to refer concerns around substance misuse. However, their view is that unless there are other safeguarding concerns this is unlikely to meet a threshold for ICS assessment.

7.12 My conclusion is that substance misuse may be identified as a risk factor by agencies but the response to addressing the potential risk and the expectations about how to address the concerns are not clear or understood by practitioners on the frontline. This feels an opportunity for the KSCMP to develop a Substance Misuse strategy to support front line practitioners to agree a multi-agency definition and an agreed partnership response to families where substance misuse is a feature including the regular use of HST to monitor rather than rely on self reporting. **Recommendation 6**

Theme 4 – SAFE SLEEPING

7.13 It is clear from the agency reports and discussions that all practitioners involved with the family frequently reminded the parents around risks and provided safe sleeping advice and to use the moses basket for Child S. Discussions with parents and reinforcement of the safer sleeping and prevention of Sudden Infant death (SIDS) information was well documented in the Health Visiting and Midwifery records. However, Child S had been found in the sofa bed with his parents and both parents were found to have differing substances in their systems.

7.14 Safe sleeping guidance and advice for infants has been promoted and undertaken by KSCMP and agencies to raise awareness with practitioners, the general public and parents. However, it remains a key feature of this case and the link between use of substances and risk of co sleeping needs to continue to be raised in a public campaign with clear practical advice to all practitioners. **Recommendation 7**

8. Effective practice

8.1. The focus of this Review is to learn and improve services. As such, it is important to learn from practice that is considered effective and supports good outcomes for children. Good practice from professionals has been acknowledged and this includes,

8.2 Overall the practitioners from all agencies worked well together and shared information effectively. The Community Midwife continued her engagement postnatally for 28 days reflecting her understanding of the vulnerabilities of this family and her documentation was of a high standard. The Social Worker wrote and shared a Pre-Birth Plan with Midwifery and Health Visiting staff and home visits were undertaken by social work practitioners despite the impact of Covid. Antenatal communication between the health providers was particularly good from the GP, Midwifery in the Acute health provider Trusts (MTW and EKHUFT) and the Health Visiting service, particularly at a time when the whereabouts of Mother were broadly 'unknown'. All practitioners involved with the family engaged well and made significant efforts to work sensitively, constructively and transparently to support this family to care for Child S.

9. Recommendations

9.1. The Review concludes with recommendations to the Kent Safeguarding Children Multi-Agency Partnership (KSCMP), which build on the recommendations and actions already identified for learning by single agencies during the process of researching their involvement in this case. In a number of cases, actions have already been taken to improve arrangements/systems.

The following additional recommendations are provided to ensure that Kent SCMP and its partner agencies are confident that any other areas are addressed and that the Kent SCMP is able to monitor progress.

Theme One-Risk Assessment and Decision making

1. KSCMP to undertake an audit of the processes of convening child protection conferences to review the attendance of key agencies, the quality of the reports submitted by agencies and that minutes are undertaken and distributed in a timely way. A specific focus should be on ensuring that all relevant GPs are involved particularly with mobile families.
2. KSCMP to consider the learning from the National Safeguarding Practice Review Panel's thematic report "Invisible men" to consider how learning can be disseminated across the partnership of the need to ensure the overt engagement of men in risk assessments.
3. KSCMP to undertake work on raising awareness and understanding of the Public Law Outline process across all agencies so that practitioners are clear of the processes and aware of opportunities to influence risk assessment and decision making.
4. ICS to undertaken audit activity to review the arrangements for risk assessment and decision making in the PLO process and the interface between the legal advice received and the decisions taken to ensure this is a constructive process with sufficient challenge.

Theme Two- Neglect

5. KSCMP to review the current Neglect Strategy to discuss how to develop a clear shared understanding of "good enough" home conditions that provide practitioners with an agreed baseline.

Theme Three- Substance Misuse

6. KSCP to develop a Substance Misuse strategy with a specific focus on cannabis use to support practitioners to have a shared understanding of the risk, appropriate interventions and decisions on threshold for concern/escalation.

Theme Four- Safe Sleeping

7. KSCMP to continue to promote and raise public and practitioner awareness of the need to deliver safe sleeping advice particularly where substance misuse by parents is a feature for the parents.

Alex Walters – 7/6/22