Essex Safeguarding Children Board

Child Safeguarding Practice Review

CHILD I

REVIEW REPORT

Independent Reviewer: Alex Walters

CONTENTS

Item	Page
1. Introduction	3
2. Process for conducting the review	3-4
3. Family Structure and views	4-5
4. Relevant background information prior to the timeframe under review and brief summary of engagement	5-6
Chronology and summary of practice engagement: 5. Key Practice Episode 1 - June 2017 - March 2018 6. Key Practice Episode 2 - March 2018 - December 2020 7. Key Practice Episode 3 - December 2020 - February 2021	6-11
8. Findings & analysis - Multi-agency planning and risk assessment - Substance Misuse - One Plan/Early Help arrangements - Engagement of Fathers	11-14
9. Effective Practice 10. Recommendations	14 14-15

1 Introduction

1.1 Essex Safeguarding Children Board (ESCB) commissioned a Child Safeguarding Practice Review (LCSPR) following a Rapid Review process as required by Working Together 2018, undertaken in May 2021, following the death of a child. This requires all agencies to undertake a review of their records, to submit a timeline, analysis, summary of agency involvement and suggested areas of improvement.

1.2 This review relates to the tragic death of a 15 month old child, known as Child I who was found by Father caught in a high chair, became asphyxiated and subsequently died. The Inquest for Child I in May 2021 made a ruling of accidental death and criminal proceedings were not pursued.

1.3 Child I was the third child of four children and their Mother sadly died of natural causes 2 months prior to Child I's death. Following Mother's death a Section 17 social work assessment had been initiated to assess the risk and support needs of Father. Following Child I's death, the three surviving siblings became subject to Care Proceedings and are now placed on a Special Guardianship Order with their Maternal Grandmother.

1.4 This 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 circumstances and key agencies' engagement with the family.

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, not holding individuals or agencies to account.

2. Process for conducting the LCSPR

2.1 ESCB recognised there was potential to learn from this review regarding the way that agencies work together in Essex to safeguard children.

2.2 A Panel was established and met in October 2021 to discuss the Rapid Review and scope the Terms of Reference (TOR). It was agreed that the timeframe under review would be from July 2017 - February 2021. Relevant information prior to these dates was also considered, particularly historical involvement with the family.

2.3 The Panel was attended by the Independent Reviewer Alex Walters. Alex is an independent safeguarding consultant, experienced Local Safeguarding Children Board and SCR Panel chair and SCR/LCSPR author, fully independent of ESCB and its partner agencies.

2.4 Agency reports were then commissioned from 7 agencies - Children's Social Care, 2 Health Trusts providing hospital, midwifery and health visiting: the CCG for the GP, Police, Housing and Education. The reports provided agencies with the opportunity to consider and analyse their practice and identify any systemic issues. They provide details of the learning from the case within their agency, but

also allowed agencies the opportunity to reflect on the Terms of Reference and make recommendations for improving practice within their own services.

2.5 The Authors of the agency reports and the LCSPR Panel then met together in December 2021 to discuss the reports, identify the learning, areas of effective practice and identify any further information required. The Independent Reviewer through the review of key documents subsequently sought additional information and clarification.

2.6 A central component of the LCSPR process is understanding the perspective of front-line practitioners and the opportunities and challenges about the 'system' within which they work to analyse why incidents occurred and the contributory factors rather than just what occurred. The Independent Reviewer met with groups of practitioners supported by their LCSPR Panel lead member between January- March 2022.

- Essex Children’s Social Care - Social Worker and Social Work Assistant
- The GP surgery – Practice Nurse and Practice Manager
- The Managers from the children’s Pre school
- The Health Visitor and Head of Service.
- Midwifery - two safeguarding midwives and the named nurse

Practitioners considered key themes identified by the Independent Reviewer. The perspectives and opinions of all practitioners involved were discussed at the meetings, were most helpful and have significantly informed this LCSPR report and its recommendations.

2.7 The contribution of family members is an important part of the review. It was agreed that Father and Maternal Grandmother would be informed of the LCSPR process and invited to participate. With the support of the social worker, contact was made and facilitated with the Maternal Grandmother by phone call. Unfortunately it was not possible to achieve contact with Father despite the best efforts of the social worker. Maternal Grandmother’s views were most helpful and highly valued by the reviewer in identifying improvements and are incorporated into the review and its recommendations.

3. Family Structure and views

3.1 The relevant family members in this review are:

Family member	To be known as:
Subject child	Child I
Father to subject child	Father
Mother to subject child	Mother
Maternal Grandmother	Maternal Grandmother
Sibling 1 to subject child	Sibling 1
Sibling 2 to subject child	Sibling 2
Sibling 3 to subject child	Sibling 3

3.2 The Independent Reviewer had a helpful discussion with Maternal Grandmother and a further discussion to feed back the learning and recommendations from the Review. Maternal grandmother had very strong views on Father and his historical controlling behaviour towards Mother, which she felt, did not improve over time. She described Mother as very private and very proud. Maternal Grandmother felt Father would be more amenable with herself and Mother's sister as they would more overtly challenge Father.

3.3 Maternal Grandmother stated that historically Mother had not "trusted" Children's Social Care and that Father used notifying them as a threat towards Mother. Maternal Grandmother described historical Child In Need meetings where she felt that information provided by Mother about Father was shared with Father and that Mother would then retract her statements. She felt coercive controlling behaviour was not well understood by practitioners.

3.4 Maternal Grandmother was clear that in her view Father would not be able to care for his children following Mother's death as he had previously undertaken very little child care. She stated that she felt distressed and angered that Father was "allowed" to care for the children and that she had not been able to care for all four children following Mother's death. She felt this was in their best interests and felt Children's Social Care had not accepted this view but had said that they required evidence. Although Maternal Grandmother accepted this to some extent and felt she had shared her views with Children's Social Care, she remains distressed that her grandson died and that she felt neglect had been evident. The learning is that it is always important to recognise the need to ensure that the views of members of extended families are formally heard and there is evidence of overt consideration and reflection, which is documented. **Recommendation 6**

3.5 Maternal Grandmother reported Mother had always spoken very highly of the support she and the children had received from the pre School. Maternal Grandmother had also felt the pre school had been a significant and positive support for the children.

4. Relevant background information on the family prior to the timeframe under review

4.1 Both parents and the four children in this family are from a White British heritage. It is understood from information shared by Maternal Grandmother that Mother and Father began a relationship in 2014. Mother was born in London and is one of four children and lived in various locations in London until 2016 when she moved to Essex with Father and Sibling 1 due to housing difficulties. Mother previously reported in assessments that she got on well at school and had not had any difficulties in learning and communicating. Mother also previously stated that she was diagnosed with PTSD and depression in 2013 but had not accessed any therapy or any medication.

4.2 In addition to his four children with Mother, Father has other children from previous relationships. Assessments undertaken by two previous London Boroughs

in 2015/16 in relation to Sibling 1 highlighted concerns surrounding Father's mental health, drug use, homelessness and a coercive relationship between Mother and Father. Mother reported that at the beginning of their relationship Father was very controlling over her, but that this improved over time and Mother was able to have a lot of contact with her own Mother and sibling who lived in Essex.

4.3 It is understood Father self reported that he had some learning difficulties, was unable to read and write and he also had communication difficulties although there is no evidence that a learning disability had been formally diagnosed. Father stated he started school late and had spent time in care as both of Father's parents died when he was a teenager.

4.5 Information from the GP stated that Father has a history of drug abuse including cocaine and cannabis use. This has also been highlighted in information from other Local Authorities. Father had been diagnosed with depression and had a history of mental health problems in the form of psychosis and low mood requiring hospital admission prior to his relationship with Mother.

4.6 The family moved to Essex in December 2016 when Sibling 1 was aged 7 months and Mother was pregnant with Sibling 2. When living in London, there was Children's Social Care involvement and Sibling 1 lived with Maternal Grandmother for 3 months due to Mother and Father's homelessness but then returned to their care.

5. Key Practice Episode 1- June 2017 –March 2018 -Brief chronology/summary of engagement with agencies

5.1 Following the move to Essex with Sibling 1 in 2016, Mother was pregnant with Sibling 2. The midwife made a referral into Children's Social care in June 2017 due to Mother missing antenatal appointments for her pregnancy and concerns about conditions in the accommodation and potential substance misuse. A Child and Family S.17 assessment was undertaken, which resulted in Sibling 1 and Sibling 2 being placed on Child in Need (CIN) plans in July 2017. The focus of the intervention was support in the community. It was noted that in London, the assessments identified issues in respect of both parents' mental health, but particularly Father's mental health. It was reported that he had suffered with psychosis requiring hospitalisation and was said to regularly use cannabis. This information may not have been known by all agencies.

5.2 In the social work assessment at that time, support was offered to Mother to help with her relationship with Father– he was said to have been historically controlling and manipulative, identified in previous assessments. There were however no specific domestic abuse incidents reported to the police. The family home was said to be in a poor state, it was untidy and cluttered. There were ongoing concerns around Sibling 1's development. Intervention centred on working with the Children's Centre and Social Work Assistant with both parents as part of the Child In Need plan regarding play and stimulation and at the closure of the plan it is documented there had been progress made.

5.3 In January 2018, an Independent Child in Need Reviewing Officer (CINRO) chaired a Child In Need meeting and there was then felt to have been significant improvement in the family circumstances; Mother had engaged well with the Child In Need plan and so the unanimous decision was made to end the Child In Need Plan and Children's Social Care closed the case in March 2018. Review of the Child In Need minutes does identify that concerns were expressed by the social worker regarding Father's ability to communicate with the children and meet their needs, however, at this point Mother was the main carer for the children with father having limited input into their care.

6 Key Practice Episode 2- Brief chronology and agency involvement - March 2018 - December 2020.

6.1 From March 2018 until December 2020, the family received universal health services from the GP, midwifery and health visiting services and Sibling 1 and Sibling 2 began pre school. During this time Child I was born in 2019 and Sibling 3 in 2020.

GP

6.2 Father was seen at the GP surgery who were aware of his mental health history and he was offered annual reviews. He was seen in 2017 but then declined most future appointments. Father was not on any medication throughout this time period and he presented no concerns about his physical or mental health. Mother and the children had no significant contact with the GP surgery other than pregnancy related and immunisations for the children.

Health Visiting

6.3 In October 2018 the Health Visitor referred Sibling 1 to the child development centre and speech therapy for assessment of global developmental delay, behavioural and cognitive issues. Tests undertaken excluded a chromosomal / genetic cause for Sibling 1's difficulties and it was subsequently confirmed in July 2021 that Sibling 1 had a diagnosis of Autistic Spectrum Disorder.

6.4 The Health Visitor was contacted by Mother in February 2019 as the family had no food. This request was responded to by a home visit and provision of goods but there appears to have been no follow up contact until September 2019. At this time, the Health Visitor made an antenatal home visit as Mother was pregnant with Child I and was concerned about living conditions. They were recorded as dirty and that the children had dirty hands and feet, however although conditions were recorded as poor they were deemed adequate.

6.5 The Hospital notes said they referred Sibling 1 to the Health Visitor in July 2019 following an outpatient appointment, as they were concerned about Sibling 1 appearing dirty and unkempt. However there is no evidence this communication from the hospital was received in the Health Visitor records.

6.6 Following the birth of Child I, the Health Visitor visited in December 2019 and undertook a 6-week follow up visit in January 2020. The parents were reported to be responsive to the Health Visitor's advice and to Child I's needs. The home was

reported to be cluttered and smoky and advice was given by the Health Visitor regarding risks associated with smoking and Sudden Unexpected Death in Infancy (SUDI). The family were identified as "universal plus" status due to their vulnerabilities, however, mother denied domestic abuse was an issue and declined additional health visiting support. As there were no significant or immediate safeguarding concerns identified the family were placed on a universal caseload by the Health Visitor.

6.7 The Health Visitor undertook a virtual antenatal contact with Mother in August 2020 and also dropped off baby equipment to the home but was not allowed access due to Covid concerns by Mother. Home conditions were not therefore assessed. The Health Visitor assessed maternal mental health was not indicative of low mood/ depression. The Health Visitor also undertook a virtual telephone 1 year developmental review of Child I in November 2020 and no concerns were identified.

Midwifery

6.8 Mother had involvement with midwifery for Sibling 2, Child I and Sibling 3. Midwifery appropriately referred concerns to Children's Social Care in 2017 re Sibling 2. There were no concerns with Child I's pregnancy. Mother confirmed there had been previous Children's Social Care involvement but the case was closed, she denied any ongoing abuse but reported feeling down and described having little interest or pleasure doing things. The midwife supplied contact details and signposted to 'Therapy for You'.

6.9 With Sibling 3 Mother informed midwives she had never used any substances and had no mental health problems. There is no documentation to show that information shared by Mother at this time was cross referenced against previous records and information held and how safeguarding notes were shown in the electronic record at this time. This is recognised by the hospital as a learning point and has been addressed by a unified records system, accessible to professionals on all three hospital sites. Safeguarding documentation forms part of the electronic record for all sites and is accessible to all staff.

6.10 Midwifery however did refer Mother to Children's Social Care in November 2020 due to non attendance at ante natal appointments with Sibling 3. Children's Social Care spoke to Mother who said she had not received the appointments and to the Health Visitor who did not flag concerns and so the outcome was no further action. Sibling 3 was delivered at 38 weeks by Caesarean section and there were no medical concerns at that time.

Pre School

6.11 Sibling 1 began attending a local pre school in September 2018 and Sibling 2 in September 2019. Due to concerns recognised by both the Health Visitor and the pre school, Sibling 1's development was supported with a "One Plan" approach, which sets out the child's needs and support. Meetings were held at the pre school involving the pre-school, Health Visitor and parents.

6.12 The pre school had some concerns regarding nappy rash and the children's clothes being damp after washing but the children were generally clean. Pre school staff were clear that Mother loved and was proud of her children. Father did occasionally bring/pick up the children with Mother but was described as shy and quiet. The pre school's experience was that if Mother was unwell, the children would not attend consistently. There is reference to Mother being unwell with Sibling 3 pregnancy and this impacted on other appointments i.e. Sibling 1 development centre attendance. Father struggled to take the children to pre school/appointments due to perceived anxiety.

6.13 Significantly from March 2020 the Covid pandemic impacted and the children's attendance fluctuated as Mother was very anxious about Covid and was pregnant with Sibling 3. In September 2020 the pre school tried to initiate an Early Help TAF (Team Around the Family) meeting but Mother refused to engage. This process can only work if there is parental consent. A virtual One Plan meeting was held in November 2020 and a plan was formulated to support Sibling 1 and Sibling 2's attendance at pre school. The pre school were collating information in order to apply to the Local Authority for an EHCNA (Education Health and Care Needs Assessment) for Sibling 1. This is the process, which if agreed can lead to the issue of an EHCP (Education, Health and Care Plan) which is required for consideration of entry to a special needs school.

Police/Housing

6.14 There was no involvement from the Police with the family and Housing's involvement was simply relating to Housing Benefit claims. There were no safeguarding concerns identified by any agency.

7. Key Practice Episode 3- December 2020 - February 2021 - Children's Social Care and agency involvement.

7.1 In late December 2020, a referral was made to Children's Social Care following the birth of Sibling 3 by a Midwife who had visited the home. There were concerns that the living conditions were poor, and there was a strong smell of cannabis and Mother had been readmitted to hospital and was critically ill. The case progressed to the Assessment and Intervention team for further assessment. A S.17 assessment to assess risk and support needs was initiated and is required to be completed within 45 working days. Mother then sadly died unexpectedly when Sibling 3 was only 11 days old. The focus of the assessment then became specifically on how Father would cope with four children under 6 given Mother had been the primary carer.

7.2 In the immediate week following Mother's death Maternal Grandmother cared for all four children by agreement with Father. Father then requested that Child I be returned to him. Sibling 1 and Sibling 2 subsequently returned to Father's care a week later and Sibling 3, a few days after that. However within a few days Father returned Sibling 3 to Maternal Grandmother but continued to care for Child I and Sibling 1 and Sibling 2. Sibling 1 and 2 were both at full time pre school so during the day Father only had care of Child I.

7.3 It is important to note that this involvement by agencies was during the Covid pandemic and the third national lockdown, which had had a significant impact on both families and practitioners. Despite this, a comprehensive safety plan was agreed by the Social Worker, which included undertaking announced and unannounced visits and for Maternal Grandmother to also undertake unannounced visits. Father was to be referred for an advocate and to Adult Social Care. Father to also be supported by two sets of his neighbours. During this 6 week period until the death of Child I, the Social Worker visited the home frequently as did Maternal Grandmother to provide support and monitor the children and assess how Father was coping. The Health Visitor changed due to organisational issues but also visited twice, once jointly with the Social Worker. In addition a Social Work Assistant had regular phone contact with Father to focus on basic parenting skills. The phone contact rather than face to face contact was due to management advice re COVID restrictions and obviously made this support and assessment more challenging. Neighbours and Father's extended family were very involved in supporting Father, cleaning the home and preparing meals in these early weeks, which made it difficult to objectively assess Father's capacity.

7.4 The pre school who had established positive relationships with the children and Father following Mother's death offered to have the older two children, Sibling 1 and Sibling 2 full time and this was agreed. There were no concerns expressed about their presentation or attendance. The Health Visitor completed a 14-month assessment for Child I and Child I's development was assessed as being within normal parameters. Positive attribution was heard during the visit, and Father appeared sensitive to Child I's cues/needs.

7.5 The Social Worker undertook a thorough social work assessment during this time period. It was child focussed and clear that despite support, although Father understood what was required the evidence was that he was not able to manage taking children to health appointments or make school applications for Sibling 1 and Sibling 2. It was felt that his practical abilities to cook, feed and wash the children and maintain acceptable standards of cleanliness in the home was very limited. The children were not being toilet trained and Sibling 1 was still in nappies at 5.5 years.

7.6 Father denied smoking cannabis and stated that he stopped sometime between summer and Christmas of 2020, which he described as being quite difficult. The social worker did not smell cannabis on visits but noted a text on Father's phone which implied purchase of cannabis.

7.7 The conclusion of the S.17 assessment was that there was an overall level of chronic neglect of the children affecting different areas of development including education, health and basic care needs. An application for an EHCHA for Sibling 1 had not been made as the pre school were waiting for Father's input to process this. Father had received several reminders for this verbally from pre school staff and simply required a signature. In addition the deadline for applying for school places for both Sibling 1 and Sibling 2 had been missed.

7.8 Due to the nature of the concerns and the ongoing patterns of behaviour over the years, it was felt that no significant change has been made even with Mother in the home, given the recent concerns of the midwife over home conditions and the smell of cannabis. Since Mother's tragic death, it would seem that Father was coping, however much of this was due to support from others in the community and this was not felt consistent enough to ensure long term change and sustainable improvement for the children. The assessment states, "Due to a lack of change, lack of consistent engagement with professionals and continuing concerns raised around neglect, recommendation is for the case to be taken to child protection consultation with a view to initiate ICPC (Initial Child Protection Conference)" The Social Worker undertook a child protection consultation and confirmed the intention to move to Child Protection Conference on the day of Child I's death.

8. FINDINGS and ANALYSIS

8.1 At the time of Child I's death, Children's Social Care were undertaking a S.17 assessment of the capacity and support needs of Father to care for his children following the tragic and unexpected death of Mother. There were historical concerns about Father's mental health, capacity to process information and communicate and substance misuse. However at that point there were no immediate concerns for his mental health other than the impact of his wife's death and the resulting shock and grief he would be experiencing. However Mother had clearly been the primary carer and Maternal Grandmother was very concerned about Father's ability to provide basic care for his children. A safeguarding plan was set out by the Social Worker involving Maternal Grandmother, Father's family and neighbours and the Health Visitor and Social Work Assistant whilst the assessment was undertaken.

8.2 It is the view of Children's Social Care and the Reviewer that there was no evidence during that period of time to consider potential removal of the children but at the conclusion of the assessment there was sufficient concern to escalate to an Initial Child Protection Conference. Sadly Child I died at that point.

8.3 As with any Review, the process of reflection has identified some areas where the current systems and processes could be improved. Some agencies involved with Child I's family have identified their own learning and captured single agency improvements identified in this report. The themes identified below set out additional multi-agency learning identified by the Independent Reviewer and have resulted in six recommendations.

Theme One - Multi-agency planning and risk assessment.

8.4 The decision by Children's Social Care, following assessment, to move to Child In Need (CIN) plans for the Siblings 1 and 2 in July 2017 was appropriate. However the CIN plans and the measures of improvement did not identify substance misuse as a specific issue although this was one of the main reasons for referral. With hindsight too much emphasis was placed on parental cooperation and self reporting which was clearly a positive but a CIN plan of 8 months duration was potentially not sufficient enough to ensure all issues had been addressed and progress was sustained.

8.5 In discussions with agency authors and practitioners, the need for a more formalised step down to Early Help would have been a preferable outcome and is current practice. Practitioners also identified the need to avoid a "start again" process of referral. The Reviewer is aware of a "What if" procedure developed for CIN plans in other Local Authority areas. This process identifies specific issues that if they arise can ensure Early Help services can escalate back into CIN/Child Protection. **Recommendation 1.**

8.6 At the point of Mother's unexpected death, Father was left with four children under 5.5 years to care for including a child with special needs and a newborn baby. Professionals had historically not assessed his parenting capacity, as Mother had been the main visible carer. The Hospital referred their concerns to Children's Social Care in late December 2020 and the Health Visitor requested a Strategy discussion. Children's Social Care were clear that the threshold for a strategy discussion was not met. This is a professional judgement and it is recognised that the S.47 response to potential harm due to neglect as opposed to abuse is open to debate. However, Children's Social Care immediately initiated a Children and Families S.17 assessment with the strong involvement of Maternal Grandmother and a Social Work Assistant to support and monitor the situation, which involved frequent visits to the home.

8.7 It is the Reviewer's view that if the threshold for a strategy discussion was not met, it would have been helpful to have had the opportunity to bring all the agencies involved with the family together to share information and assess risk and agree a support plan. This action was left to the Social Worker to liaise in bilateral discussions with the Health Visitor, Midwife, Pre school and GP.

8.7 In discussions with agency authors and practitioners as part of the Review process, it is clear that partner agencies accepted that a strategy discussion threshold had not been met and was not appropriate. However agencies were clear that they would like to see professionals only meetings to be used more frequently to provide a multi-agency reflective space to consider the risks and needs for families. It is known that another large safeguarding children partnership has recently introduced this policy and procedure and this could be useful for Essex partners to consider and evaluate. **Recommendation 2.**

Theme Two – Substance Misuse

8.8 Father clearly had abused substances historically and at one point this resulted in a drug induced psychosis and psychiatric hospital admission. Throughout the engagement with services from 2017, there were consistent concerns raised around the smell of cannabis inside and around the family home. Father would consistently deny that he smoked cannabis, the concerns were consistent and although the social worker saw no evidence at the home, it would appear Father had subsequently stated he had continued to use cannabis.

8.9 It has become clear to the Reviewer that cannabis use has become increasingly normalised over the last few years and is prevalent in many families. In discussions with practitioners, it feels that they are not sure of the level of risk attached to its usage and even if risk is identified, there is not clarity on the threshold of referral

to Children's Social Care and the multi-agency response that should be offered. **Recommendation 3**

Theme Three – Early Help/ One plan alignment

8.10 Sibling 1 was identified by both the Health Visitor and pre school as having additional needs with concerns around his development. The Health Visitor referred Sibling 1 to the Child Development Centre and speech therapy at the age of 2. The pre school staff were hugely supportive of the family and initiated a "One Plan" approach, including meetings, which brought together the parents, health and education practitioners. Pre school practitioners intended to discuss and initiate an Early Help Plan, which would have widened the focus onto the whole family and enabled wider support to address ongoing concerns about the accommodation and standards of cleanliness and substance misuse. Father was not significantly involved with the pre school prior to Mother's death and Mother was anxious and did not want to always avail the family of the support available.

8.11 With the birth of each child the pressure on the family will have increased. Sibling 1's developmental delay created additional demands on the family and although Sibling 1 was being supported by One Plan meetings the focus was on Sibling 1 rather than the family as a whole. A Team Around the Family (TAF) would have offered a more robust form of family support and could have been considered although without consent of Mother, this is clearly a challenge for practitioners to implement.

8.12 In discussion with practitioners and agency authors, the challenge of obtaining consent from parents to initiate Early Help processes was discussed. Practitioners are aware that families need support and as in this case frequently go out of their way to support families but consent is often a barrier. Practitioners are aware there is not sufficient evidence to escalate to Children's Social Care but are left with a perceived responsibility to provide support to parents who may be only willing to engage on certain issues. This issue requires further consideration by ESCB.

8.13. There also needs to be further consideration of how to align the processes with pre school children around the One Plan arrangements for children with additional needs and Early Help arrangements for the whole family through use of a TAF. It would be helpful to practitioners to receive support and training on how these processes can be better supported and aligned. **Recommendation 4**

Theme Four – Engagement of Fathers

8.14 Until the tragic and unexpected death of Mother, Father had had minimal contact with all agencies involved with his children. This may have been due to issues in his childhood and his care experience. It was recognised by practitioners and Maternal Grandmother that Mother took on the majority of the household duties and care of the children. This was accepted by midwifery, health visiting and pre school practitioners but of course made it extremely challenging to assess Father's parenting capacity at a point of crisis. It was known that there had

been historical domestic abuse, substance misuse, mental health issues with Father but a lack of shared knowledge of the impact on his cognitive functioning and parenting ability was unknown.

8.15 Health practitioners described the impact of an electronic booking system used within midwifery, which can feel too prescriptive and does not support professional curiosity, particularly about Father's histories to enable assessment of risk. The hospital have recognised the need to ensure Midwifery services need to move to a place of practice where they engage and involve both parents inclusive to mothers and fathers of babies and those who as the partners of mothers take on a caring/parenting role for children.

8.16 The National Safeguarding Practice Review Panel published a thematic review about the engagement/invisibility of men in September 2021 "The Myth of Invisible Men" particularly to universal services. It identified a number of areas of learning and made a number of recommendations nationally to support the assessment and engagement of men and a 'Think Family" approach. **Recommendation 5**

9. Effective practices that had a positive impact on Child I

9.1 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. There is much evidence of effective practice in this review with practitioners working hard to support this family through the exemplary support provided by the Pre school, the Health Visitor and Midwifery services making appropriate referrals and providing support and the Social Worker undertaking an excellent comprehensive social work assessment.

10. Recommendations

10.1 The Review concludes with recommendations to the ESCB, which build on the areas already identified for learning by single agencies. The following additional multi-agency recommendations are made to improve systems and for ESCB to facilitate partner agencies to implement the recommendations and to monitor progress.

Recommendation 1 – ESCB to incorporate into the current work to update the ECC Child In Need guidance a 'What if procedure' for children who are stepped down from Child in Need/Child Protection to Early Help. This would be for the multi-agency partnership and would identify potential risks and support escalation by partner agencies back to Child in Need if required is timely and effective.

Recommendation 2 - ESCB to consider developing appropriate criteria for Professionals meetings to be formally integrated into local Child Protection procedures to provide a multi-agency reflective space to consider risk and support for families.

Recommendation 3 - ESCB to develop a multi-agency substance misuse strategy. This will provide clarity on the impact of different substance misuse, particularly cannabis on parenting capacity and guidance for practitioners in relation to escalation and effective interventions.

Recommendation 4 - ESCB to consider how to support practitioners to manage the interface with One Plan arrangements for children with special/additional needs within Early Help arrangements.

Recommendation 5 - ESCB to consider the learning and undertake a multi-agency self-assessment and any resulting actions from the national panel's thematic review "The myth of invisible men" 2021 to support practitioners in improving the engagement, involvement and assessment of male carers.

Recommendation 6- ESCB to consider the learning from this review and the national Panel's review "Child Protection in England" 2022 to ensure that the views of family members are always considered in assessments of risk.

Alex Walters V5

24/01/23