Warwickshire Safeguarding

Warwickshire Safeguarding Partnership

Local Child Safeguarding Practice Review

FARA

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06 August 2024

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Appendix A: References

1. Statutory Framework:

1.1. This Local Child Safeguarding Practice Review (LCSPR) was commenced in 2021 and undertaken in accordance with the guidance contained in Working Together to Safeguard Children 2018 [1] which outlines that reviews should be completed in a way which:

- Reflects the child's perspective and family context.
- Is proportionate to the case under review.
- Focuses on potential learning.
- Establishes and explains the reasons why events occurred.
- Invites families to contribute.
- Fully involves practitioners.

2. Review process:

2.1. The decision to undertake a LCSPR was made by the Warwickshire Safeguarding Partnership following the Rapid Response process, as it was considered there was the potential for more in-depth learning. Agencies were asked to submit a succinct agency report, focusing on the key decision-making points and addressing specific issues, e.g. response to late booking in pregnancy, engagement with father, context practitioners were working in.

2.2. An online Practitioners' Reflective Event was held, after which the Lead Reviewer drafted the report. A further Practitioners' Reflective Event was then held to discuss the analysis, learning and recommendations. Hence, practitioners and managers were able to make an important contribution to the final report.

3. Background:

3.1, Mother is White British, with a supportive extended family. She has a history of anxiety and depression and of substance misuse. Her first period of drug treatment was in 2017, when she did not fully engage with the service offered. Her second period was from January 2019; she became drug-free and successfully reduced her drug usage from February to August, supported by an opiate substitute treatment and psychosocial support. From January 2019 she was prescribed sleeping tablets by her GP for anxiety and depression.

3.2. Father is an Iraqi Kurd and an asylum seeker. His parents are deceased. He has no right to work in the UK or to claim financial support. Father has a history of substance misuse and commenced drug treatment for opiate dependency in 2017. His engagement was poor and his discharge in 2018 was unplanned. In 2019 he was found guilty of possession of Class A drugs, with intent to supply, and of possession of a prohibited weapon, and received a custodial sentence.

[1] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Department for Children, HM Government July 2018.

4. Engagement with the family:

4.1. The parents and wider family were informed that the Local Child Safeguarding Practice Review was taking place and that their views would be sought in due course to inform the learning. Subsequently, Mother met with the Lead Reviewer and Partnership Manager. The Partnership would like to acknowledge the contribution Mother has made to the learning from this review. Her views have been integrated through the report.

4.2. In a statement issued to the media, the family stated that the child was 'enormously loved and adored by us all; she was our daughter, granddaughter, great granddaughter and niece.' She 'only ever knew happiness and our love and devotion' and 'was our little miracle, perfect in every way, and the most loved and adored little princess there could ever be.' In discussion Mother confirmed that Fara was adored and much loved; she was a happy child, who enjoyed playing and singing. She was thriving and meeting her milestones.

4.3. Mother had some important messages for agencies and central government and also for parents who may be at risk of substance misuse which are set out below:

Firstly, for agencies and the government:

- There needs to be more advice and support for asylum seeking adults, who are unable to work or financially support their families in the UK. This creates considerable stress and financial difficulties.

Secondly, for parents:

- Serious accidents are more likely to happen if you use drugs or alcohol. You may lose concentration or fall asleep for a short while when a child can be unintentionally seriously harmed or die, e.g. through a fall, a fire.

- DO NOT be frightened to ask for help. You may be worried that your child or children will be removed and placed in foster care, but they do not want to take your child but rather help you. That is a better option than a tragedy happening to your child.

- The dependency on drugs can be stronger than anything else, parents need help and support. The risks of not asking for help are just too high.

- You may have to live with a tragedy for the rest of your life.

5. Scoping Period:

5.1. In May 2019, Father was released from prison under the supervision of the Community Rehabilitation Company (CRC). No conditions were in place in respect of drug treatment, and he did not seek this. Soon after his release Mother presented at her GP. She was 28 weeks pregnant; the GP referred her to the Midwifery Service.

5.2. Mother's ante-natal booking-in appointment was at 30 weeks of pregnancy, i.e. a late booking. Mother informed Midwifery of her drug reduction programme but provided no information regarding father's background. In view of the late booking the Midwife continued to visit Mother at home and a referral was made to the Multi-Agency Safeguarding Hub (MASH). Initially this was treated as a consultation but, following a review of historical information, a decision was taken to undertake a single assessment. No toxicology tests were undertaken during pregnancy.

5.3. The Providing Information and Positive Parenting Midwife also notified the Health Visiting service in writing of Mother's pregnancy, noting the late booking and opiate reduction programme. This initiated a targeted ante-natal contact.

5.4. Mother informed the drug treatment service of her pregnancy, and a second referral was made by the service to MASH. Mother was keen to reduce and cease her opiate substitute treatment in view of her pregnancy, however, the drug treatment service advised against reducing too quickly, as this could pose a greater risk to the baby due to withdrawal symptoms. Mother accepted this advice and continued to be supported by the service and remained stable. There was no communication between Midwifery and the drug treatment service.

5.5. Mother informed the drug treatment service that her partner had been released from prison and was drug-free. Prisons can liaise with local drug treatment services if treatment is required following release, but no contact was made,

5.6. A Social Worker from the Initial Response Team, Children's Social Care (CSC), was allocated the single assessment, undertook one home visit and spoke with both parents. The assessment concluded that the parents had addressed their drug-use and had good family support. Therefore, a '*planning forum was not required*' and the case was closed. Early Help was not considered nor a Child In Need plan.

5.7. In June, a deportation order was made in respect of Father. The Home Office was not aware of his partner's pregnancy and did not factor this into the decision making. Also, during June the CRC Officer assessed Father post release and identified the risk factors as: his drug use, his partner's drug use and his immigration status. His lack of a right to work was viewed as a risk factor to reoffending.

5.8. Health Visiting service undertook two ante-natal visits, one of which was an additional visit in view of the late booking. Mother's mental health was assessed using the Whooley and Outcome Star Assessment tools and no issues of concern were noted. Father was not present on either of these visits and no information was gained in respect of his background, e.g., criminal history, substance misuse. The Maternal Grandmother was present, and the Health Visitor formed the view that the Maternal Grandparents were supportive. Mother was well prepared for the birth and informed the Health Visitor that she had applied for housing for herself, Father and baby. The

family was assessed as requiring a Universal Plus Offer [2] and Mother was referred to Baby Steps, a support service for vulnerable mothers, offering four pre-birth and two post-birth visits. However, the late booking meant that the pregnancy was too advanced for Mother to access this service, hence the additional home visit by the Health Visitor to discuss labour, birth and early development.

5.9. Towards the end of July 2019 Fara was born, Father was present at the birth. Mother was still on an opiate withdrawal treatment. A toxicology screen of the baby was not completed. Midwifery had liaised with Paediatrics and a Paediatrician assessed the baby at birth for signs of drug-withdrawal. No concerns were noted. CSC was informed of the birth. Midwifery was advised that there were no concerns, but professionals should monitor the situation in view of parental drug misuse.

5.10. Two post birth visits were undertaken by Health Visiting, good interaction between mother and baby was noted and at the six weeks review Fara was smiling. Father was not present at either of these visits. It was decided the family required the basic Universal Service. [3] It was identified that as Fara's Father is an Iraqi Kurd the baby would require a tuberculosis vaccination (BCG). Fara was also seen by the GP for the six-week baby check, all was well, and routine immunisations were given two weeks later. However, Fara was not taken to the appointment for the BCG immunisation in October at the Hospital NHS Trust and the Was Not Brought policy was not followed.

5.11. Father's statutory appeal against the deportation decision was dismissed in September 2019. The Immigration Judge was aware of the birth of Fara. No further representations were received by the Home Office '*to consider any further the family life involving the child or the impact of the father's deportation on that family life'*.

5.12. In October, the parents and Fara moved to their own accommodation. When making the application to the Borough Council, Mother had made a request to be allocated a property away from the town centre in view of her history of substance misuse. A request was made for supporting information from the drug treatment service. The Borough Council informed the Practitioners' Event that no response had been received, but the service confirmed that there was evidence of an email response in October 2019. The Housing Provider was not informed of Mother's history of substance misuse and neither the Borough Council nor the Housing Provider were aware that Mother had a partner who would be living at the property.

5.13. In the early months of 2020, Father experienced depression, anxiety and psychotic symptoms, with visual and auditory hallucinations, and was referred to mental health services by his GP. There was no communication by the GP with the Health Visitor nor discussion at the in-house safeguarding meetings attended by Health Visitors.

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[2] **Health Visiting: Universal Plus Offer**. To identify vulnerable families, provide, deliver and co-ordinate evidence- based packages of additional care, including maternal mental health & wellbeing, parenting issues, families at risk of poor outcomes and children with additional health needs. National Health Visiting Service Specification, 2014/2015, NHS England.

[3] **Health Visiting Universal Offer:** Working in partnership with parents and carers to lead and deliver the full HCP from ante-natal care through to school entry. National Health Visiting Service Specification, 2014/2015, NHS England.

5.14. The Psychiatrist's diagnosis was that Father was suffering with a major depressive disorder; medication was prescribed, and psychological intervention recommended. The decision was taken to cease input in March due to the difficulties of engaging with Father over the telephone, which had become necessary due to the Covid restrictions. A psychiatric review took place in May; Father was advised to recommence medication, seek support from his GP and discharged. The letter to GP noted Father was not sleeping and had lost weight.

5.15. Father's period of supervision by CRC finished in April 2020. The high level of staff turnover meant there had been changes of Officers and the home visit post Fara's birth, which is a requirement of CRC's Public Protection and Safeguarding Children Policy, was not undertaken.

5.16. In the three-month period from April to July 2020, many reports from neighbours were received by both the Housing Provider (5 reports) and the Police (8 reports). These related to allegations of anti-social behaviour and drug dealing from the family property, with cars and people frequently coming to the home. Housing shared this information with the Police, liaised with the local officers and were advised that the Police were monitoring closely and collating intelligence. The reports were discussed with Mother by the Housing Officer at the six months review; she denied the allegations, stating they were malicious, and explained that Fara's Father visited for contact.

5.17. Information reported to the Police was passed on to the Safer Neighbourhood Team (SNT) and to the Harm Assessment Unit (HAU) by the Intelligence Processing Unit but was not flagged as a priority. In June two reports to the Police provided the information that a young child was living at the address. The intelligence log passed to the HAU at the end of June was not viewed by staff until December 2020, six months later. Despite the June reports, there is no evidence in Police records that they were aware of who lived at the address until the Local Beat Officer emailed the Housing Provider on 18 July 2020. There was information in Police systems that linked Father and Mother, and in respect of Father's drug offences, but this connection was not made. A referral was not made to the Multi Agency Safeguarding Hub.

5.18. During June, the Health Visitor had difficulty contacting mother to arrange Fara's ten-month developmental review, despite delivering a letter by hand. In July Mother was informed that if there was no response to the message, a referral would be made to CSC. Telephone contact was made, Mother informed the Health Visitor that the family had moved, and so Health Visiting responsibility was transferred to a new team. The Health Visitor was concerned that Mother had moved from the supportive environment of her family and made direct contact with the new Health Visitor. This Health Visitor sent a letter arranging the developmental review at the end of July.

5.19. In mid-July Mother presented at A & E with an injury to her knee. Despite her explanation that the injury was accidental, staff were concerned that it was caused by self-harm and informed the GP. The GP phoned Mother and left a message, but there was no response. Mother attended the surgery for the removal of stitches.

5.20. Towards the end of July, Housing received a report that alleged drug dealing was taking place in a local car park and the child was being taken there. The same

day Housing made a referral to MASH. Management direction was to gain consent from Mother to complete 'lateral checks', with no reference to Father. This was rated as 'amber' and allocated to a social worker for follow up.

5.21. Eight days later, Fara was not brought to the developmental review; the Health Visitor contacted MASH and was advised to complete a referral, which she did. This referral was rated as 'green' and assigned to a Family Support Worker. It was not identified that this case was already being dealt with by MASH, which meant the referral was duplicated, although no work had yet been undertaken following the referral by Housing.

5.22. Early in August it was identified that MASH had created two PAM tracks for the family, and these were merged. MASH had difficulty contacting the parents by phone and a decision was taken to dispense with parental consent to the lateral checks being undertaken. Enquiries were made with Police, CRC and the drug treatment service.

5.23. On 5 August Father was seen to enter the property, this was the first time the Police had known that he was linked with the property. Plans were put in place for an Officer from the SNT and a Detective Sergeant, CID, to visit property on 7 August.

5.24. On the same day the case was transferred to the Initial Response Team, CSC, for a single assessment to be undertaken. A Strategy meeting was not held, nor a Section 47 initiated.

5.25. The following day an ambulance was called to the family address, Fara had suffered a cardiac arrest, was taken to hospital and pronounced deceased. Police Officers found evidence of substance misuse in the family home and both parents presented as under the influence of drugs. Further investigations confirmed the child had drowned in the bath whilst both parents were under the influence of drugs. The mother was convicted of manslaughter by gross negligence and child cruelty and the father of child cruelty. Both parents received custodial sentences.

5.26. Father was also convicted of supplying drugs and received a further custodial sentence.

6. Analysis:

6.1. Effectiveness of the local safeguarding network:

6.1.1. A significant number of agencies had contact with the family during the Scoping Period of the Practice Review and have contributed to it. These agencies include GP, Midwifery Service, Health Visiting, drug treatment service, Community Rehabilitation Company, Police, Mental Health Service, Children's Social Care (MASH), Local Council and the Housing Provider. However, the lack of communication and co-ordination between these agencies is striking.

6.1.2. Both the Midwifery Service and drug treatment service recognised concerns about Mother's late presentation in pregnancy [4] and made referrals to MASH, which triggered the single assessment by CSC. However, there was no contact between these two services and Mother's consent was not sought for this. Midwifery accepted Mother's account of her opiate substitute treatment, without confirming this with the drug treatment service. It would have been in both the Mother's and the unborn baby's interests for Midwifery to liaise with the Drug Treatment Service as they were providing ante-natal care and therefore should have had confirmation of the treatment she was receiving. Both services recognise this would have been good practice and are revising their procedures accordingly. **(Learning Point and Recommendation 4)**

6.1.3. The Health Visitor undertook a thorough assessment of Mother's wellbeing on the first ante-natal visit and identified no immediate concerns, e.g., about her mental health, support network, but in recognition of the family's circumstances recommended the Universal Plus Offer. However, the view of the agency's Report Author is that given the history of substance misuse, housing issues and Father's immigration status, it would have been appropriate for the Health Visitor to make a referral to Early Help for additional support and advice for the family. This would have enabled '*the needs of the family to be identified and appropriate services to be co-ordinated to meet those needs'*. Therefore, this was viewed as a missed opportunity to provide co-ordinated support to the family,

6.1.4. The Community Rehabilitation Company undertook a safeguarding check with CSC before Father was released from custody and placed under their supervision. On his release the Officer completed an OASys assessment[5] and identified '*an entrenched pattern of Class A drug use and offending, and, due to unemployment and inability to work, there was a clear financial motive to fund his drug use'*. Drug use was assessed as '*a primary criminogenic factor'*. [6] Therefore, the Officer correctly made the link between Father being unable to work and criminality and this concern was raised with the parents when they were seen in the office in July and were struggling financially. However, no other action was taken, e.g., no referral to drug treatment services or signposting for immigration or financial advice. Neither was there any contact between CRC and Mental Health Services despite both agencies

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[4] **Late presentation in pregnancy:** If an appointment for antenatal care is made late (beyond 24 weeks), the reason for this must be explored and fully documented. It is important to consider that unless the woman has genuinely not been aware of the pregnancy up until the point of access to care, she has still concealed her pregnancy in the first instance. A woman who presents for antenatal care late in pregnancy should continue to be assessed with the reasons for delay in presentation and associated risks forming part of the overall assessment. Guidelines for the Provision of Care in the Presentation of Concealed Pregnancy or Late Booking in Pregnancy. Hertfordshire Safeguarding Children Partnership.

[5] **OASys** is an actuarial risk and needs assessment tool used by the prison and probation services in England and Wales. The OASys is composed of 14 subsections and generates a summary risk score in order to assess likelihood of reoffending and risk of harm to self and others. Risk Management Authority.

[6] **Criminogenic:** Criminogenic needs are characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood to re-offend and commit another crime. ... Generally, these are structural elements of a person's life that personally led them to commit crime.

being involved with Father at the same time. Again, this was a missed opportunity for agencies to co-ordinate the services provided to the family.

6.1.5. The GP referred Father to Mental Health Services early in 2020 due to serious concerns about his mental health, i.e., anxiety, depression, hallucinations. GP records noted that Father had no thoughts of self-harm as his child was a protective factor. However, despite knowing of the young baby in the family, the GP did not consider the child's welfare and did not contact the Health Visitor or discuss the family at the in-house safeguarding meetings attended by the Health Visitors. This was a missed opportunity to alert Health Visiting to the family's difficulties and potentially offer additional support, e.g., Early Help. **(Learning Point)**

6.1.6. In the three months, April – July 2020, the Housing Provider (5 reports) and Police (8 reports) received a large number of reports of alleged drug dealing at the property, as well as visitors and vehicles frequently coming and going. Housing Officers shared information with the Police and were informed that the Police were monitoring the situation and collecting intelligence. The Police intelligence reports had been passed to the Safer Neighbourhood Team. They were also passed to the Harm Assessment Unit (HAU), indicating that safeguarding had been considered. However, the HAU's heavy workload meant that the information was not prioritised for assessment. There was direct contact between the Housing Provider and Safer Neighbourhood Team, but this sharing of information did not result in actions that would safeguard the child in the household. A further missed opportunity for agencies to work collaboratively to safeguard the child.

6.1.7. It appears that the Police were not aware who was living in/visiting the property until early August when Father was seen entering the property. On 18 July 2020, the Beat Manager had asked the Housing Provider who resided at the property, indicating that previously the Police either did not have this information or had not recorded it. Both possibilities are concerning as Mother was the tenant, and on the Police's electronic information systems her details are linked with the Father's. Therefore, this information should have been available to the Police, or requested, much earlier and, given Father's criminal history, was likely to have triggered more urgent action.

6.1.8. In response to the Review the Police Communications Centre Supervisors have reviewed all the calls reporting alleged drug dealing activity at the address. The findings were that in only two out of the eight calls received, either the call taker asked who resided at the property or the information was provided, including that a child lived there. On neither occasion did the call taker ask the age of the child. The Police Force has already identified this as an area for targeted development.

6.1.9. Until the end of July, the reports to Housing and the Police in the main were viewed as anti-social/criminal behaviour and not as child safeguarding concerns, despite the report to the Police in mid-June providing the information that there was a child living in the property. The Housing Provider always reports allegations of drug dealing in the area to the Police. However, there is no evidence that consideration was given to the impact of the alleged drug dealing from the family home, as well as the comings and goings, on a vulnerable baby, i.e., what were the risks and potential harm to a baby? Sadly, this was a failure to think about the child's welfare and fulfil

the agency's safeguarding responsibilities. Housing eventually made a referral to MASH following a complaint from a tenant of alleged drug dealing with the child in a local car park.

6.1.10. The NSPCC Briefing: Housing services learning from case reviews [7] identified that Housing Providers often have a unique insight into the lifestyles of their tenants. They receive complaints and conduct inspections and are likely to know about a number of issues, e.g. parental substance misuse, ASB and domestic abuse, before other agencies. The learning from case reviews highlighted that *'housing services should consider the impact that tenants' lifestyles and behaviour are likely to be having on their children.'* Complaints about ASB could indicate that children are living in an unsafe environment and such concerns should be reported to Children's Services/MASH. **(Learning Point).**

6.1.11. The Police Agency Report Author notes that the Police should have considered various tactics between April and June. It was important to establish who lived at the address, *'to better assess and understand the issue'*. Disruption tactics, enforcement action and safeguarding measures could then have been considered earlier.

6.1.12. Practitioners need to 'think child' and consider carefully what does the information that they have, or is being shared with them, tell them about the potential risks of harm to a child; they need to demonstrate professional curiosity. If there are allegations of drug dealing from a family home, with frequent visitors coming and going, what does this mean for the child's day-to-day life and safety? Where concerns as above are identified, a referral should be made to MASH, so that information can be pulled together, and an analysis of risk be undertaken. **(Learning Point)**

6.1.13. A significant decision which affected how agencies worked together was the concluding recommendation of CSC's single assessment in June 2019 that '*a planning forum was not required',* leading to the case being closed. The single assessment is considered further in 5.3. If a referral had been made to Early Help or a Child in Need Plan put in place, then there would have a mechanism for sharing information and co-ordinating the work of agencies. Other agencies, e.g. Health Visitor, could also have made an Early Help referral. **(Learning Point)**

6.1.14. In summary, there were many practitioners, from a wide range of agencies, who had involvement with the family, but there was a lack of meaningful and effective information sharing and co-ordination of their activities, which would have benefitted the family and offered greater protection to the baby. There were many missed opportunities for agencies to co-ordinate their activities and potentially safeguard the child.

6.2. Engagement with Father and understanding of his ethnic and cultural background:

6.2.1. The information provided to the Practice Review evidences that Father was facing challenges which would undoubtedly have placed considerable stresses on

[7] Housing services learning from case reviews: Summary of risk factors and learning for improved practice around the housing sector. NSPCC 2014

him, on his mental health, the relationship with his partner and his parenting capacity. These difficulties would also have created additional stress for Mother who was caring for a young baby. These include:

- Father is an Iraqi Kurd asylum seeker, without the right to work or claim financial support in the UK, leading to severe financial difficulties. He was also facing deportation, after his asylum claim failed. No further information had been offered following the loss of his appeal.

- Concerns about his mental health, with the diagnosis of a Major Depressive Disorder linked with family bereavements and traumatic experiences in, and travelling from, Iraqi.

- Uncertainty about his English language and comprehension skills. Were there language and cultural barriers to engagement?

- Long-term substance misuse, linked to criminality. Lack of evidence of completion of a drug treatment programme.

6.2.2. It is apparent that no one agency had an overall picture of, and understanding of, the difficulties that Father, and hence the family, faced to enable the appropriate services to be offered. Until October 2019, the family were living with the Maternal Grandparents who offered support, including financial. Following their move to independent accommodation it is not known whether this support continued as the only agency that had direct contact with the family during this time was the one visit from Housing in April 2020. The Independent Reviewer has undertaken other reviews where the move from the protective environment of a Grandparents' home has been a significant factor in the subsequent harm to a young baby. [8] This was recognised by the Health Visitor when in June 2020 she discovered that the family had moved in October 2019. **(Learning Point)**

6.2.3. Father's level of English was discussed at the Practitioners' Event. Whilst practitioners believed he had a reasonable level of English language, it was not clear what this meant for his level of comprehension, e.g. of immigration processes. None of the agencies had considered if it was necessary to use an interpreter/translator. The Health Visiting Report Author highlights that the first Health Visitors thought Father's English was limited and suggests that the use of an interpreter may have improved his engagement with the service. Certainly, this should have been a consideration for Mental Health services, given Father's difficulty in engaging by phone and the need to use Mother as a conduit to communicate with him.

6.2.4. Warwickshire Safeguarding Partnership has recently undertaken another LSCPR, regarding a young person, Simon, where concern was identified about the lack of provision of an interpreter for the family by the hospital which impacted on the parents' ability to make a contribution to the assessment and planning process. This was highlighted in the recommendations of that LSCPR. The NHS has a legal duty to ensure that interpretation and translation services are available in order that the

[8] Madison Serious Case Review, Wakefield Safeguarding Children Partnership, Published June 2018.

services they provide are accessible to all sections of the community they serve. **(Recommendation 9)**

6.2.5. The Mental Health Service diagnosed Father with a serious condition, requiring medication and psychological input. However, the practitioners found difficulty in communicating with him over the telephone as was necessary due to the Covid restrictions in place. So, despite Father being diagnosed with a major depressive disorder, the service ceased involvement after one month and he was given advice to seek medication from his GP. It would appear this left Father, and hence his family, in a vulnerable position. A discharge letter was sent to the GP by Mental Health but there was no direct communication with the GP or any other agencies.

6.2.6. A question for the Review is, what services could have been offered to Father, and the family as a whole, to support them with these difficulties? CRC raised the issue that a condition of drug treatment was not put in place when Father was released from prison, which would have been highly appropriate. The Officer was prophetic in identifying the risk to further offending due to Father's lack of the right to work, i.e. to earn a living and support his family. However, there was a lack of action in response to this insight. This was a subject for discussion at the follow-up Practitioners' Event and the view was that, whilst there may not be so many services for asylum-seeking adults locally as are available in nearby Coventry, i.e., Refugee Centre, Law Centre, the local Family Information Service could have signposted practitioners and the family, and nationally there is information available. It is evident that there is a need to raise practitioners' awareness across agencies. **(Learning Point & Recommendation 8)**

6.2.7. The NSPCC Briefing: Neglect: learning from case reviews, December 2022 [9] highlights the impact of risk factors on the parents' ability to provide safe and appropriate care, and to meet their children's needs. These included, parental domestic abuse or drug and alcohol misuse, parents with mental health problems or learning disabilities. young parents, social isolation, financial problems including housing problems, homelessness, poverty and unemployment, many of which have been identified in this family. The Briefing noted that '*Adult Services working solely with parents, especially fathers or male carers, didn't always make the connection between their work and potential child safeguarding concerns. This meant important information about the risks children were exposed to wasn't shared appropriately.'* Evidence presented to the LSCPR indicates that this connection was not made by CRC and the Mental Health Services and appropriate action, e.g. discussion with/referral to Children's Social Care, was not taken. **(Learning Point)**

6.2.8. The Health Visiting Report Author acknowledges that Health Visitors nationally have struggled to engage with fathers. In 2017 the Warwickshire Health Visiting Service undertook an audit of records including whether information was documented about fathers, which evidenced that the quality of information recorded was variable and there was a need for improvement. Recently funding has

[9] Neglect: learning from case reviews. Summary of key issues and learning for improved practice around neglect. NSPCC: December 2022

been secured for a 'Dad Pad', which aims to promote the engagement with Fathers, encouraging them to be included and involved, recognising parents as equal parenting partners. (**Recent Development)**

6.2.9. In summary, as in many reviews nationally, Father's background, the challenges he faced, as well as the potential risks he posed to Mother and Fara, were not well understood and addressed in terms of the services offered to the family.

6.3. Quality of assessment of needs and risks:

6.3.1. Several assessments were undertaken during the Scoping Period by the Health Visiting service, CSC, and CRC. All of them were significant in terms of the decisions made about the services that were, or were not, offered to the family.

6.3.2. Following Mother's presentation to the GP at 28 weeks into the pregnancy and her booking-in appointment with Midwifery at 30 weeks, a referral was appropriately made by Midwifery to MASH, which is their normal practice, although there are no local multi-agency procedures for dealing with late presentations and potential concealed pregnancies. A number of LSCPs do have such procedures, with a concealed pregnancy considered to be after 20 or 24 weeks' gestation. These procedures outline the action to be taken by agencies, including referral to CSC/MASH with consideration of holding a Strategy Meeting and undertaking a Section 47 investigation to identify any child protection concerns and/or support needs. [10]

6.3.3. In discussions with the Lead Reviewer and Partnership Manager, Mother explained that a fertility issue had been a factor in her late presentation. Her perception was that she was seen as a '*methadone mum'* and treated differently, i.e. more harshly, compared to other women. This information has been shared with the Midwifery Service as It may highlight that women with a history of substance misuse will be sensitive as to how they are viewed and treated, and Midwives need to take this into account in their interactions.

6.3.4. The Regional Child Protection Procedures for the West Midlands do not currently contain guidance regarding late presentations for practitioners. The Midwifery Service is developing procedures in such circumstances, including agreeing a definition of a 'late booking', and it could be helpful for this to be a multi-agency task, involving the Health Visiting Service and CSC/MASH. **(Learning Point and Recommendation 3).**

6.3.5. The Health Visiting Service recognised the implications of the late booking for ante-natal care, initially offered the Universal Plus service and undertook two ante-natal visits to Mother. Post–natally the new birth visit was undertaken, followed by the six-weeks review, and, as Fara was progressing well and good interaction was noted, the decision was taken to step down to a Universal Service, i.e. the support offered to all families. This decision meant that post-natally the family received a Universal Service, and Fara would not be seen again by a Health Visitor until the ten-month developmental assessment, unless Mother attended a baby clinic. Given the

[10] Leicester and The Leicestershire and Rutland Safeguarding Children Partnership's Procedures Manual.

difficulties in arranging the developmental assessment with Mother, Fara was not seen again by a Health Visitor.

6.3.6. There is a danger in hindsight, but it is worth reflecting as to whether the decision to step-down the service when Fara was just six weeks of age was the right one, and in the baby's best interests. There had been an extremely late booking, which meant Mother had received limited ante-natal care, combined with a history of maternal and paternal substance misuse. In addition, the family were planning to move into independent accommodation, away from the supportive wider family environment, which they did six weeks later. Once the Health Visiting service reduced, there was no practitioner who was able to monitor Fara's health and wellbeing. It can be argued that the family should have continued to be offered the Universal Partnership Plus Offer [11], which provides ongoing support from the Health Visiting Team, plus a range of local services that assist with more complex issues, e.g., drug and alcohol related problems, complex family circumstances. **(Learning Point)**

6.3.7. The Author of the Health Visiting Report noted that the Health Visitors understood the potential safeguarding risks if parents were misusing substances. However, there was *'an over-optimistic view that mother's drug issues were in the past'* and there was little information about Father. It was known that he was living in the family home, but there was no information regarding his substance misuse and criminal history, and his role in caring for the baby was not explored or understood. The Author considered that there was a lack of professional curiosity and use of a 'Think Family Approach', the involvement of other agencies would indicate the need for Universal Partnership Plus service with a multi-agency targeted and co-ordinated package of support.

6.3.8. It should be noted that, despite the family receiving a Universal Service, when the Health Visitor had difficulty in arranging the 10 months developmental assessment, she reviewed the records and, due to the previous history, used her professional judgement and persevered, eventually learning that the family had moved. Health Visiting responsibility was then transferred, but the concerns were appropriately flagged by telephone with the new Health Visitor. This demonstrated professional curiosity and concern for the baby and meant that the new Health Visitor was prepared to act when the appointment was missed for the baby's developmental assessment later in the month.

6.3.9. As referenced above the referral from Midwifery Services led to a single assessment being undertaken by the Initial Response Team, CSC, the outcome of which was a recommendation for no further action. The assessment was completed based on one visit to the family home, when Mother, Father and Maternal Grandmother were present.

6.3.10. The CSC's Report Author noted the assessment was brief and the referral was closed after a week. Contact was made with drug treatment service, which confirmed Mother's engagement, and with CRC, but not with the Health Visiting service. There was a lack of exploration and understanding of the reasons for Mother's

[11] **Health Visiting Universal Partnership Plus Offer:** Health Visiting Universal Partnership Plus Offer: To work in partnership with parents and agencies in the provision of intensive multi-agency targeted packages where there are identified complex health needs or safeguarding needs. National Health Visiting Service Specification, 2014/2015, NHS England.

very late presentation in pregnancy. Both parents were open about their past use of drugs; they reported that Mother was engaging with the drug treatment service and Father was drug free. However, there was no evidence that Father was drug free or engaging with drug treatment services. There is reference to the risks the baby would be exposed to with regard to drug and criminal activity, e.g., a chaotic lifestyle, poverty, inadequate and unsafe accommodation, but there was no consideration of the risk that Father may pose to Mother with regard to his drug use and offending behaviour and the impact this could have on her own recovery or their relationship. Neither was there any consideration of what would happen if the parents started using drugs again, for example, would the MGM report this to agencies, what protective action would she take?

6,3,11. There was a discussion about Father's immigration status, but no offer of support regarding this, e.g., signposting for financial support or legal advice regarding an appeal against deportation. There appeared to be a lack of understanding of Father's history and cultural background and the possible impact of this on his mental wellbeing and parenting capacity. In her discussion with the Lead Reviewer and Partnership Manager, Mother spoke about the difficulties facing families where a person is an asylum seeker, without the right to work or claim financial support in in the country, and the additional pressures when an asylum claim fails. This leads to emotional and mental health difficulties as well as severe financial problems, particularly when caring for a child or children. The parents had sought legal advice and attended court to appeal the deportation order, but this was unsuccessful. Mother's view is that they had to prove that it was dangerous for the family to go and live in Iraq, where there would be risks to her husband and no housing, health or welfare provisions. The family were keen to be independent and Father did work illegally for a period, but this did not last.

6.3.12. The Maternal Grandparents were viewed as a strength; they were supportive and would be a protective factor for the unborn baby. However, living with the MGPs was not a long-term option and the parents were planning to move to independent accommodation; there was no consideration of the impact of this move on the welfare of the unborn baby. There was no discussion with the Grandparents about how they saw their future role and whether they would be capable of safeguarding the baby should this become necessary. It is vital that assessments look to the future and consider the impact of a significant change on the family functioning and the potential risk to children.

6.3.13. There was limited management oversight, mainly in relation to processing the assessment, but no evidence of reflective discussion in supervision, which is essential in ensuring the quality of the assessment, promoting professional curiosity and guarding against an over-optimistic approach.

6.3.14. The single assessment was a missed opportunity to identify the support needs of the family, and the protective factors and risks to their unborn baby, and to provide appropriate services. CSC's Report Author considers that it lacked depth and was over-optimistic, accepting the information provided by the parents without questioning or professional curiosity. '*Early Help Support should have been offered to the family and the closure was overly optimistic.*' **(Learning Point)**

6.3.15. An early help plan would have promoted information sharing and co-ordinated the work of agencies involved with the family and assisted in identifying longer-term risks. During the course of the review there has been evidence that, deliberately or not, Mother had failed to be open and honest with agencies, notably about her partner, i.e. not telling midwifery about her partner's history of drug-use, informing the drug treatment service that he was drug-free and not informing Housing she had a partner who would be living in the home. The later was significant when Housing made the reports to the Police about suspected drug dealing at the property, knowledge of who was residing there may have prompted a quicker response.

6.3.16. MASH's response to the later referrals from Housing and Police does not evidence consideration as to whether the baby was at risk of significant harm nor the need to arrange a Strategy Discussion, which would have ensured all information was shared. There were unacceptable delays by MASH in responding to the referrals, which is a serious concern. CSC's Report Author suggested that there was a '*lack of awareness of the potential risks to the baby who was vulnerable'* and had not been seen for many months. Each concern was managed in isolation, rather than pulling the wider picture together. There should have been a Strategy Discussion or same day visit to check on the baby's welfare. Again, there was a lack of management oversight and a missed opportunity to assess the risks to the child.

6.3.17. It should be acknowledged that the Social Worker who completed the contact and referral on 5 August, noted '*homes in which substance abuse is prevalent are often unpredictable and chaotic and would leave a child in a living environment that lacks structure'*. This demonstrated an awareness of the potential risks to the child.

6.3.18. The West Midlands Regional guidance 'Children of parents who misuse substances' [12] highlights that substance misuse has been identified nationally as one of three significant factors present in families where children have died or been seriously harmed. '*Drug and/or alcohol misuse can consume a great deal of time, money and emotional energy, which will unavoidably impact on an adult's capacity to parent a child. This behaviour also puts the child at an increased risk of neglect and emotional, physical or sexual abuse either by the parent/carer or because the child becomes more vulnerable to abuse by others within and/or outside of the family environment.'* The guidance refers to the importance of the implications for the child being properly assessed; having full regard to the parent's/carer's ability to maintain consistent and adequate care, as well as to the child's level of dependence, vulnerability and any special needs. It should also be noted that the risk was increased in this family in view of Father's mental health difficulties, parental mental health needs have been highlighted nationally as a significant risk factor.

6.3.19. Mother recognises that they needed help, but they were reluctant to ask for this. Her parents would have cared for Fara for a short while, but they had been very committed to her remaining drug-free and it would have been hard to disappoint them. Approaching any of the agencies, e.g. Drug and Alcohol Service, Children's Services, was a worry for fear of Fara being removed from their care.

[12] Regional West Midlands Child Protection Procedures: Children of parents who misuse substances.

6.3.20. The NSPCC Briefing: Parents who misuse substances learning from case reviews [13] highlights that substance misuse is recognised as one of the factors that can put children at increased risk of harm. The biggest risk being that parents are unable to keep their children safe when under the influence of drugs or alcohol, e.g. overlay through co-sleeping, accidents through lack of supervision. The Briefing emphases the need for child centred assessments, which should be a dynamic rather than a static (one off) process, so that risks and protective factors are reviewed in the light of emerging evidence. The briefing highlights the following points which very much reflect the learning from this LCSPR:

- Need for a child-focussed assessment, which prioritises the needs, safety and welfare of the child.
- Must analyse the adults' substance misuse and behaviour to understand its impact on the child in their care.
- Professionals too often trusted the parents' self-reporting of their drug and/or alcohol consumption.
- Risks of over-optimism.
- Risks increased with non-family visitors to the home, criminal activity, ASB, stress, withdrawal from treatments programs. **(Learning Point)**

6.3.21. The First Annual Report of The Child Safeguarding Practice Review Panel [14] pulled together the learning from 538 rapid reviews and identified a number of practice concerns also relevant to this review including:

- **Optimistic Thinking:** Overly optimistic in practice decisions. It is Inherently human to look for best outcomes which highlights the importance of reflective supervision.
- **Information sharing:** Need for information to be shared, discussed and analysed – what does this information tell us, what are the risks and what actions should be taken. **(Learning Point)**

6.3.22. In summary, there was a lack of an in-depth analysis and understanding of the family; the difficulties, strengths, protective factors and risks to the baby from parents' history of substance misuse, alongside parental mental health concerns. It is crucial that the child remains the focus of any assessment, conclusions are future proofed, and decisions are based on the welfare and safety of the child. Additionally, there is substantial research regarding working with families where there are concerns about substance misuse which should inform practice and management oversight.

6.4. Context practitioners were working in:

6.4.1. It is important to understand the context that practitioners and managers were operating in during the Scoping Period. The evidence presented to the review indicates four areas where demands were extremely high and there was a lack of capacity and effective systems to meet these demands in a timely way. These are the Police's Safer Neighbourhood Team (SNT) and Harm Assessment Unit (HAU), the

[13] Parents who misuse substances learning from case reviews: Summary of risk factors and learning for improved practice around parents with substance misuse problems. NSPCC 2013,
[14] Annual Report, 2018 – 2019. The Child Safeguarding Practice Review Panel: Patterns in practice, key messages and 2020 work programme

Multi-Agency Safeguarding Hub (MASH), the Health Visiting service and the Community Rehabilitation Company (CRC).

6.4.2. **Police**: **Safer Neighbourhood Team** was functioning with two members of staff. There had been a significant increase in the construction of housing developments in the area, leading to a huge increase in population with diverse issues and increased demands placed on the SNT, e.g. neighbour disputes, ASB, Covid breaches. It is understood that the Team had received no additional resources.

6.4.3. **Police: Harm Assessment Unit:** There is evidence that the HAU had not reviewed the Intelligence logs sent through by the Intelligence Processing Unit six months previously. Due to the Covid restrictions the Unit was working from a variety of work locations and the work queues were extremely high. In addition, the intelligence logs were not flagged as priority. **(Recommendation 2)**

6.4.4. In response to this Review the Communications Centre Supervisors have reviewed all the calls reporting alleged drug dealing activity. The findings were that in only two out of eight calls, either the call taker asked who resided at the property or the information is provided, including that a child lived there. On neither occasion did the call taker ask the age of the child. Clearly this is an area for urgent development. **(Recent development)**

6.4.5. **Multi-Agency Safeguarding Hub:** There was no action for 9 working days following the referral from Housing, as well as the confusion with the referrals from Housing and the Health Visitor being treated independently.

6.4.6. Information has been provided to the Review that MASH was operating under considerable pressure at this time. Cases continued to be dealt with by MASH for too long and staff had high caseloads, with approximately 300 referrals being managed. There was a high level of demand, together with high levels of staff sickness/shortages. In addition, there were changes of management and changes in the processes, which can be a risk to the consistency of services being offered to families. All of this led to a service struggling to cope.

6.4.7. The referral in MASH was allocated to a Social Worker already managing 20 PAM tracks, two of which were flagged as 'red'. Due to the lack of management cover, the Social Worker was also assisting with assigning tasks to workers.

6.4.8. In response to Fara's death and the findings of the Rapid Review, a review has been undertaken of how MASH was operating. It is understood MASH now has a more stable management team and an increase in workers, leading to improved effectiveness and timely decision making for children, young people and their families. Action has been taken to avoid any potential for the duplication of referrals. Management oversight must be recorded, with the actions to be taken on receipt of a referral. Professional curiosity is encouraged and there is increased focus on engaging with fathers.

6.4.9. Workshops have been organised in respect of information-sharing, consent, Strategy Meetings, thresholds for MASH and partner agencies. **(Recommendation 1)**

6.4.10. **Health Visiting service:** The Health Visitors who attended the Practitioners Event advised that the service was under considerable pressure due to staff vacancies, and

this has resulted in six-week developmental assessments not consistently being undertaken. Additionally, Health Visitors are being encouraged to continue with telephone contact, and to invite families to baby clinics, post the Covid restrictions. This conflicts with plans to revise the Healthy Child Programme and recommend two additional visits to the Universal Offer, at four and six months. The recruitment of Health Visitors is known to be a challenge across the West Midlands, as well as across the United Kingdom as identified in The State of Health Visiting; UK Report, published in January 2023. [15]

6.4.11. **Community Rehabilitation Company:** The CRC's Report Author references the '*disjointed approach'* to Father's period of supervision, due to the high turnover of staff, highlighting the lack of liaison with drug treatment services and the lack of any safeguarding enquiries regarding the new baby and of the required home visit. A major reorganisation of the National Probation Service and the CRC is currently underway. This may help to address the concerns regarding capacity.

6.4.12. The Triennial Review of SCRs (2014 – 2017)[16] identified that the '*challenges facing practitioners are strongly evidenced particularly working with high caseloads and high levels of staff turnover. Practitioners feeling overstretched and overwhelmed came through frequently in the reviews studied. Workload and budgetary pressures stand out as factors that threaten professional practice and through that imperil children's safety and welfare.'*

6.4.13. Discussions during the review also highlighted concern about the moral distress and injury sustained by practitioners, notably by health workers, when staff shortages and high workloads mean that they are unable to provide the service to patients that they wish to. *'This is a result of the institutional and resource constraints healthcare staff face, meaning they often cannot provide the high level of care they want and expect to be able to deliver.'* (British Medical Association)[17]

6.4.14. In view of the workload demands and staffing challenges in the SNT/HAU, MASH, CRC and Health Visiting, the above issues would appear to have relevance for the practitioners engaged in this review. The question for the Warwickshire Safeguarding Partnership is whether the lack of capacity and delays identified in this review are a wider issue, hence continuing to place babies and children at potential risk of serious harm. **(Recommendations 1, 2, 10)**

6.5. Impact of Covid Restrictions:

6.5.1. There is evidence that the limitations and pressures placed on services due to the pandemic impacted in some respects on the services offered to the family and there may be learning for the future.

6.5.2. The Mental Health service in the main was providing a telephone service to their service users. Clearly this did not work for Father, maybe because of a language/cultural barrier, and the service was withdrawn very soon after the

[15] The State of Health Visiting: UK survey report. A vital safety net under pressure. Institute of Health Visiting, January 2023.
[16] Complexity and Challenge: A triennial analysis of SCRs 2014-2017. Department for Education, March 2020.
[17] Moral distress in the NHS and other organisations survey and report. BMA 2021.

diagnosis of a Major Depressive Disorder being made. Given that Father had a serious mental health condition, Mother, with a young baby, was then placed in the position of supporting him. Was there any way that Mental Health services could have continued to offer a face-to-face service in these circumstances?

6.5.3. The Health Visiting services available to families with young babies were significantly reduced at this time, e.g., baby clinics, due to staff sickness, self-isolation and requirements for infection control procedures. This meant that the support normally available to families with young babies was not being provided. Additionally, previously had there been challenges in contacting the family to arrange the baby's ten-month developmental assessment, the Health Visitor would have knocked on the family's door to make contact. Thus, their move would have been identified much sooner. The National Guidance on Covid 19 prioritisation within Community Health Services did not include the 10-month developmental assessment as one of the priorities. Despite this, the Health Visitor was tenacious in making contact with Mother.

6.5.4. Prior to the pandemic, monthly Partnership Problem Solving Review meetings were held in the locality involving a number of agencies, including the Housing Provider and Police's SNT. The meetings were chaired by a Police Inspector and focused on emerging issues and plans to deal with them. COVID restrictions and competing demands meant that the meetings were postponed between March and December 2020. This was unfortunate as it would have been the forum to discuss and agree actions given the emerging issues at the property.

7. Links with previous Serious Case Reviews/LCSPRs

7.1. A search of the NSPCC's national case review repository has identified a number of reviews where tragically children have died in similar circumstances, and it is interesting to note the common themes in those reviews which reinforce the learning from this LCSPR.

7.2. These themes include:

- Neglect
- Parental substance misuse
- Parental mental health difficulties
- An over-optimistic approach and lack of professional curiosity.
- Communication between maternity services and other agencies known to the family,

7.3. Additionally, in one review there was limited information known about the father, and no consideration was given to him being an unidentified adult in the household, and in another it was identified that housing providers may have indications that families with young children are struggling and may benefit from support and should take appropriate action.

7.4. The LCSPR Panel has discussed the importance of raising public/parental awareness of the dangers to children when adults are under the influence of drugs

and alcohol and this need has been reinforced when considering the findings of similar reviews. **(Recommendation 6)**

8. Good practice:

- Due to concerns about Mother's late presentation, Midwifery made a referral to MASH, notified the Health Visitor and arranged for the Paediatrician to be present at the birth to assess the health of the baby.

- The Substance Misuse Treatment Service made a referral to MASH. The service continued to support Mother during her pregnancy, enabling her to reduce her opiate treatment programme, but at a pace that did not increase the risk to the health of the unborn child,

- In view of the late presentation, the Health Visiting Service initiated targeted ante-natal contact as part of the Healthy Child Programme and two home visits were made prior to the birth to establish a relationship with the family, provide information and gain an understanding of the home/family environment.

- Despite the family receiving a Universal Service, the Health Visitor was persistent in attempts to contact Mother to arrange the baby's 10-month developmental assessment, identifying that the family had moved. She directly shared information with the new Health Visitor, who made a timely referral to MASH

9. Recent Developments:

- **Health Visiting Service:**

    - Action taken to increase Health Visitors' awareness of Early Help services and since November 2020 Safeguarding Champions have been identified to liaise with Early Help Leads and identify services that can be offered to families.

    - Developing a Dad Pad to encourage involvement of fathers and to acknowledge parents as equal parenting partners.

- **Family Front Door arrangements for children and families:**

    - **September 2021:** Integrated Front Door arrangement replaced MASH as first point of contact for safeguarding concerns for children and young people.

    - Brought together Early Help and Children's Social Care, Health and Police and includes additional partners; Drug and alcohol service, Refuge (Domestic Abuse) and Child and Adolescent Mental Health Service.

    - All enquiries and contacts are triaged upon receipt and directed to the appropriate service, with the aim of providing a seamless process with

children and families receiving a service proportionate to their needs in a timely way.

- **January 2023:** Quality assurance visit undertaken by members of Warwickshire Safeguarding Executive Board. Sought assurance regarding:
  - Multi agency capacity
  - Application of thresholds
  - Timeliness and quality of decision-making
  - Recording children's voices
  - Evidence of management oversight

- **Police:**

  - Communications Centre - Two Quality Assurance Supervisors working with Shift Supervisors to develop a Quality Assurance process for monitoring and benchmarking calls.

  - Control Room staff receiving Vulnerability Training, to promote professional curiosity.

  - Harm Assessment Unit: Member of staff to take on role of Single Point of Contact (SPOC) to review all intelligence reports.

10. Key Learning:

1. **Think child:** The needs and safety of the child should always be paramount.

2. **Parental substance misuse** can expose children to risk of serious harm and death through neglect and lack of care, routine and supervision. Assessments should be dynamic, not static.

3. **Parental self-reporting** should not be accepted without further independent confirmation. Parents may find it very hard to be honest and to ask for help for fear of the reprisals, e.g. removal of a child. Practitioners should guard against being overly optimistic and demonstrate professional curiosity. **(Recommendations 5 & 6)**

4. **Asylum-seeking adults**: Practitioners should understand the challenges experienced by asylum-seeking adults, who are not permitted to work or claim financial support in the UK, and the additional pressure when a deportation decision has been made. This will have a detrimental impact on their lives, their mental health, relationships and parenting capacity. Therefore, practitioners should have knowledge of how to access appropriate services, e.g., support, legal and financial advice, interpretation and translation. **(Recommendation 8 & 9)**

5. **Engagement with fathers:** The importance of agencies obtaining basic information regarding fathers and an understanding of their role within the family. The need to promote engagement, encouraging fathers to be included and involved in their children's care, but also to understand the father's background, the challenges faced, and any potential risks posed.

6. **Cumulative impact of parental difficulties** on the risks to children, including substance misuse, mental health, asylum-seeking adults and criminality, which increases with the vulnerability of babies and young children.

7. **Late presentation/potential concealed pregnancy:** Need to understand the significance of this, the reasons for the delay and the potential impact on the care and safety of the child, both pre and post birth. **(Recommendation 3)**

8. **Close liaison between Midwifery, Health Visiting, GP and Drug Treatment/Substance Misuse Services** to ensure a co-ordinated approach to ante and post-natal care. **(Recommendation 4)**

9. **Single assessment:** Their importance should not be underestimated, as the outcome sets the course of agencies' engagement with a family, e.g. Early Help, Child in Need Plan. They should consider forthcoming changes to family circumstances, i.e. be future proofed. Management oversight should not be purely process led but should provide reflective supervision to ensure the outcome is child focused and guards against an overly optimistic approach.

10. **Early Help and Child-In-Need plans** provide essential mechanisms for information sharing and co-ordinating the activities of agencies working with a family. This improves the effectiveness of multi-agency working in supporting families and safeguarding babies and children.

11. **Role of GPs:** When GPs are aware of family difficulties, e.g., substance abuse, parental mental health, which may impact on the care and safety of a young child, they should consider a referral to Children's Social Care and alert the Health Visitor, who can target involvement with the family.

12. **Adult services, e.g. mental health services:** Have a responsibility to be aware of potential child safeguarding concerns when working with parents and should follow their agency's policies and procedures, i.e. discussion with/referral to Children's Social Care. It is dangerous to make assumptions about the involvement/role of other agencies.

13. **Sharing of information** is a dynamic process; it is essential to analyse the significance of the information shared, identify risks, agree the actions to be taken and how these will be reviewed. Sharing information does not pass the responsibility for safeguarding children (or vulnerable adults) onto another agency; agencies continue to share responsibility.

14. **Criminal activity/anti-social behaviour:** It is vital to consider the impact on the family's day-to-day life and care of children in the household – what risks might they be exposed to and what action should be taken?

15. **Housing Providers** should remain alert to safeguarding concerns and can make direct contact with the Police Harm Assessment Unit when there are concerns about a family. Providers may well be the first agency to become aware of concerns about a child's care and safety, e.g. through reports from neighbours.

16. **Housing Providers** should remind families of the importance of notifying health services, e.g., GP, Health Visitor, when they move.

17. **Impact of families moving home**: Practitioners need to be aware of the impact of families moving away from the supportive and protective environment of a family member's home on the welfare of children. They should look to the future.

11. Conclusion:

11.1. This Local Child Safeguarding Practice Review relates to the tragic death of Fara, a much-loved child, against a background of parental substance misuse, mental health difficulties. criminality and the challenges faced by asylum seeking adults, without the right to work or claim financial support in the UK. The review has identified a significant number of missed opportunities by agencies to work together to safeguard the child.

11.2. The first Annual Report of the national Child Safeguarding Practice Review Panel [18] highlights that the *'inherent tension in child protection practice is how best to identify those children most at risk without pulling into the child protection system thousands of families who would never harm their children.'* It further states that we need to create a child protection system that is *'fine-tuned to recognise high risk with likely serious consequences.'* There are two areas of particular concern highlighted by the Panel which have resonance for this review: the quality of information sharing and of risk assessment and decision-making.

11.3. There were many agencies involved with the family during the period under review and practice issues have been identified for both individual practice and multi-agency working which are reflected in the key learning and recommendations.

11.4. The key practice issues include; the importance of keeping the needs and safety of children paramount, how an early single assessment can set the course of agencies' engagement with a family and the need to understand the potential longer-term risks to the children of parents who misuse substances, as well as the impact of the day-to-day challenges facing asylum seeking adults on their mental health and parenting capacity.

[18] Annual Report, 2018 – 2019. The Child Safeguarding Practice Review Panel.

11.5. Multi-agency issues include the need for a co-ordinated approach to late presentations and concealed pregnancies and to parents with a history of substance misuse, mental health needs and criminality. Effective multi-agency working is the key to safeguarding children and young people.

11.6. An additional significant element identified in this review is the context and functioning of the multi-agency safeguarding system and the high demand that the statutory agencies were operating under, which led to the concerns raised not being dealt with in a safe and timely manner. This meant that potential risks to the child's wellbeing and safety were not identified, appropriately risk assessed and acted upon. Crucially, this includes the Multi Agency Safeguarding Hub and the Police Harm Assessment Unit. These concerns have been recognised by the agencies and steps are being taken to address them. The question for the Warwickshire Safeguarding Children Partnership is whether the serious challenges in the system identified in this LCSPR have a wider impact and whether the steps being taken will make a difference for children and families. **(Recommendations 1, 2 and 10)**

11.7. The Partnership would like to acknowledge Mother's contribution to the learning and her wish to use her experiences to raise professional awareness.

11.8. Each of the agencies involved has an action plan which is being implemented and will be monitored by the Partnership. Below are the recommendations for Warwickshire Safeguarding Partnership.

12. Recommendations:

1. The Partnership should continue to monitor the effectiveness of the Family Front Door arrangements, e.g. by conducting periodic assurance visits to the Front Door to gain assurance of the effectiveness of practice in safeguarding children and young people. (as undertaken on 18 January 2023).

2. The Partnership should receive a report from the Police regarding the Force's response to the issues identified in the Agency's Report for the Review, in terms of the resourcing and effectiveness of the Intelligence Processing Unit, the Safer Neighbourhood Team and the Harm Assessment Unit.

3. Multi-agency guidance for dealing with late presentations/concealed pregnancies should be prepared and added to the West Midlands Child Protection and Safeguarding Procedures Manual, and awareness raised across agencies.

4. A protocol should be developed to co-ordinate the involvement of substance misuse/drug treatment and health services, e.g., Midwifery, Health Visiting, GP, pre and post-birth, The Head of Safeguarding/Designated Nurse, Integrated Care Board, should lead the work and the outcome shared with the Review Sub-Group.

5. Review the West Midlands guidance 'Children of parents who misuse substances', to ensure it reflects the learning from this LCSPR and amend the Seven Minute Briefing accordingly.

6. The Child Death Overview Panel should consider how to raise professional and public awareness e.g. a mini campaign, of the risks of serious harm and death to children when parents have consumed drugs or alcohol, from neglect and lack of care and of the dangers of children being left unattended/unsupervised.

7. The Partnership should consider how best to use Mother's offer to share her experience in learning materials for professionals locally.

8. The Partnership should prepare a Seven Minute Briefing to develop practitioners' understanding of the challenges facing asylum seeking adults and their families and of the support and advice services available.

9. The Partnership should seek assurance from partner agencies that they are meeting their legal requirements to provide interpretation, translation and signing services, and importantly staff know how to access these. This should include for people with a range of communication difficulties, e.g. a learning disability, hearing or visually impaired. The 7 Minute Briefing should be circulated widely.

10. The Partnership should receive reports from partner agencies regarding their workforce levels and challenges, for example the recruitment and retention of health visitors, [19] in order to be alert to the potential impact on service delivery and on the Partnership's ability to safeguard children and young people.

11. The learning from this review, in respect of the challenges faced by families where there is an asylum-seeking adult, should be brought to the attention of the Child Safeguarding Practice Review Panel with a view to the Panel undertaking a thematic review and identifying wider learning.

[19] ihv.pdf (localgov.co.uk).

References

APPENDIX A

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