Child Practice Review Report

Child Practice Review Report

North Wales Safeguarding Children Board

Concise Child Practice Review FLINTSHIRE 2019 1

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

Legal Framework

A Concise Child Practice Review was commissioned by the North Wales Safeguarding Board in October 2018. The criteria for Child Practice Reviews are laid down within the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

Regional Safeguarding Children's Boards have a statutory responsibility to undertake Multi-Agency Child Practice Reviews in circumstances of a significant incident where abuse or neglect of a child is known or suspected.

A Safeguarding Board have a statutory responsibility to undertake Multi- Agency Child Practice Review(s) in circumstances of a significant incident where abuse or neglect of a child is known or suspected.

A Concise Child Practice Review must be held in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected, and the child has:

- Died;
  or
- Sustained potentially life-threatening injury;
  or
- Sustained serious and permanent impairment of health or development and the child was neither on the Child Protection Register, nor a Looked After Child on any date during the 6 months preceding;
- The date of the event referred to above;
  or
- The date on which the Local Authority or relevant partner agency identifies that a child has sustained serious and permanent impairment of health and development.

It should be noted that the child was neither on the Child Protection Register nor a Looked After Child on any date during the 6 months preceding.

The purpose of a Review is to identify learning for future practice and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child or family. The output of a Review is intended to generate professional and organisational learning and promote improvement in future interagency child protection practice.

Methodology

- A Review Panel convened with a Chair;
- Two Reviewers appointed;
- Timelines developed for each agency identified;
- A summary/analysis of each services' involvement produced;
- The reviewers speak with the child's mother and maternal grandmother;
- A Review Report produced with learning points and presented to the Review Panel;
- Review Panel met to finalise the report;
- Action plan developed from recommendations;
- Review Report presented by Reviewers and Chair of the Review Panel to the Regional CPR Subgroup and the North Wales Safeguarding Children's Board;
- Submission to Welsh Government;
- Feedback to Family;
- Publication of Report on NWCSB website.

Timeline

The timeline for the Review was from the **1st of March 2014** until the **29th of July 2015.** This includes the period before the birth of the child and mother's engagement with services. Agencies were also asked to consider their involvement prior to the timeline, if relevant. Information was made available in regards to mother's involvement with Mental health Services.

Circumstances resulting in the review

On the 5th of July 2014, the child was born by caesarean section and admitted to the Special Care Baby Unit due to prematurity. A multi-agency planning meeting was held to agree the Child in Need Plan and discharged home with their mother on the 11th of July

2014.

On the 29th of July 2015, the child was found unresponsive in the bath and was later pronounced dead upon arrival at hospital. The initial findings from the police investigation indicated that the cause of death was accidental drowning.

Further police enquiries revealed that whilst the child and sibling were in the bath, their mother was engaged in a telephone call for approximately forty-seven (47) minutes to her partner. Immediately following the call, a further call was made to another number, which was connected for approximately eight (8) minutes.

This 8-minute call was very close to the alert made to Ambulance Control for assistance. Following the death of the child, safeguarding concerns were raised by children's paternal family. The paternal family had not previously raised concerns for fear that the mother would stop all contact.

For these reasons, a police investigation was commenced to investigate potential Child Neglect and to seek to understand how the child died. As a result of the police investigation it was concluded that there was sufficient evidence of neglect. North Wales Police held further discussions with the Crown Prosecution Service and proceeded to charge the mother with manslaughter on the grounds of neglect. At the court hearing on the 13th March 2019, the mother was found guilty of gross neglect manslaughter. As a result of the guilty verdict, the case was re-referred to the Child Practice Review Group in October 2018.

The case was initially referred to NWSCB Child Practice Review Group in September 2015. It was decided the threshold for a Child Practice Review had not been met given the initial findings regarding the cause of death was accidental. However, at the Child Practice Review meeting held in October 2018 the panel were notified that North Wales Police had charged the mother with manslaughter due to neglect. She was subsequently convicted and therefore it was deemed that the threshold for a Child Practice Review had been met.

The child and her sibling were known to Social Services Department prior to the incident, however their names were not on the child protection register at the time of death, nor during the 6 months prior.

The sibling is cared for by the paternal grandmother who has subsequently been awarded a Special Guardianship Order and has parental responsibility.

Background Information

On the 14th December 2013, the mother contacted the community midwife when 6 weeks pregnant. A 12-week scan confirmed pregnancy and mother attended a booking in visit with the General Practitioner (GP).

Prior to becoming pregnant, the mother had been known to Substance Misuse Services and Community Mental Health Services. Whilst the timeline commenced when mother made contact with midwifery services it is important to note that prior to this period mother was open to Adult Mental Health Services. According to the records mother was under the care of a Consultant

Psychiatrist from the 4th October 2012 to the 20th August 2013. A further referral was made to Adult Mental Health Services on the 6th March 2014 due to low mood and a Mental Health Assessment was completed by a Community Psychiatric Nurse. Mother was assessed as having no psychotic thoughts, no suicidal ideation, and not suffering with low mood. The Community Mental Health Service referred her back to her GP and mother was provided with a prescription for anti-depressants.

At approximately 11 weeks gestation the Community Midwife referred the mother to the Substance Misuse Service (SMS) Midwife due to history of substance misuse. The mother had a history of misusing amphetamines, cannabis and MCAT. Initially mother failed to engage with the SMS Midwife and a home visit was undertaken on the 28th January 2014.

A SMS Midwife completed an initial assessment on the 19th February 2014 and a urine test result for substances was negative. The SMS midwifery service is an opt-in service and there was no further intervention following the assessment. The rationale being that mother stated she was no longer using substances. There is no evidence that consideration was given to keeping the case open for relapse prevention support.

On the 19th of May 2014 a Child in Need referral was submitted to Social Services by a Health Professional, as concerns had been identified following the completion of a Health Pre-Birth Assessment (HPBA). The concerns related to risks associated with the putative father of the unborn twins, history of substance misuse and housing problems.

The decision on allocation was for the case to be open under Child in Need and for a Social Worker to undertake a Pre-Birth Risk Assessment. This process was completed as per the Framework of Assessment.

Practice guidance recommends that a pre-birth assessment should be undertaken by any professional involved with a mother and her partner in order to establish what history may exist; either in terms of their upbringing, any concerns about previous relationships or children, socially and medically. It should also establish what support may be needed when the baby is born. In line with safeguarding responsibilities, consideration should be given to actual or likely significant harm to the baby during pregnancy and following birth, and whether a more formal pre-birth risk assessment is needed. This assessment is led by a social worker and involves contribution from partner agencies. The challenge for an assessment of this nature is addressing the parents' understanding of the expected baby's needs and the appropriateness of their preparation. On this occasion, the assessment posed a number of challenges, as there was no experience of previous parenting to consider.

Following on from this, a multi-agency planning meeting was held on the 25th of June 2014 and mother along with her new partner attended the meeting. This meeting set out the proposed Child in Need Plan. This process was completed within timescales and followed practice guidelines. The process identified that the mother had mental health issues, disclosing that this was relating to trauma further to sexual abuse as a teenager. At the time of the Child in Need planning meeting, mother presented positively with no identifiable mental health needs that would immediately impact on her wellbeing and parenting capacity. The Child in Need Plan identified that Mother acknowledged she had a history of substance misuse but had ceased use when she had become pregnant. A urine test was completed after two appointments and the

results were negative.
Baby was born on the 5th July 2014 and discharged home following a discharge planning meeting on the 11th July 2014. The discharge-planning meeting was well attended by all relevant practitioners and a plan was in place. The meeting established that mother and baby would initially stay with her mother on discharge and her partner was taking time off work to offer support. The plan focussed on practical support including housing needs and further assessments in regards to the putative father. Referral to Action For Children for safe carer assessment was assigned as a task by the Social Worker.

Subsequent review Child in Need Meetings were held on the 20th of August 2014 and the 15th of October 2014 to monitor the progress of the plan. The review documentation indicated that mother had formed a good attachment with the baby who presented as clean and appropriately dressed. In addition, a Family Group Meeting was held on the 26th of September 2014 and attended by the maternal family. The purpose of the family Group Meeting was to enable the parent along with friends and family to come together and coordinate their own support plan.

During the period of the initial Child in Need plan, the mother advised professionals that the father was a male friend. During the assessment it was identified that this person was known to Social Services and was considered a risk to his other children. There is limited information available within the documentation viewed for the purpose of this review. The mother was given appropriate advice and guidance about any future contact.

It was later established, further to a DNA test on 14th of November 2014 that paternity was notably another friend of mother and following on from this, contact was arranged with paternal grandmother. It was noted that this person was known to agencies due to his poor mental health.

On the 30th of January 2015, Social Services received a telephone call from the Health Visitor expressing concerns about mother's behaviour at family accommodation at a Children's Hospital, where the Child's sibling was an inpatient. The sibling had been admitted for planned surgery. It was noted within the records that the sibling was unkempt on admission. The hospital staff had informed the Health Visitor that Mother had received a final warning for her behaviour after having a party and could be evicted from the hospital accommodation. Also a student nurse had advised staff that she had smelt cannabis on Mother. A further referral was submitted to the Emergency Duty Service on the 2nd of February 2015 as hospital staff were concerned that mother presented as vacant and not engaging. Mother spent very little time with the sibling whilst on the ward. The referral was not processed as a child protection referral and therefore did not progress to section 47 investigation.

A further referral was submitted on the 8th February 2015 by staff at the Children's Hospital, raising concerns about Mother's presentation, of smelling of alcohol and slurring her words. The referral was not processed as a child protection referral and therefore did not progress to a Section 47 investigation. Following on from the referral on the 9th of February 2015, two welfare visits were conducted by a Social Worker however, mother had not been at home at the time. There was no further information recorded until the Child in Need meeting held on the 17.02.2015.

On the 17th of February 2015 a Child in Need review meeting was held and the decision reached by all those professionals involved was that the case could be closed and support would be provided by Flying Start and for mother to access parenting groups in the community. There

appeared to be elements of professional optimism and despite the concerns raised by the hospital, the case was closed.
On the 29th of July 2015 the child subject to the review sadly died.

View of the family

It was the intention of the reviewers to visit mother in prison to inform her of the review and to gain her views. However, due to the COVID-19 Pandemic, this was not appropriate and with the support of Prison Probation Officer, the reviewers spoke to the mother in the presence of the Probation Officer via speaker phone. Mother did not highlight any concerns and stated that she felt that she had good support from all agencies at the time. She did not wish to add anything further.

The reviewers arranged to visit paternal grandmother in March 2020. Grandmother cancelled this appointment due to illness. For the purpose of this review, the reviewers held a telephone consultation with Paternal Grandmother on the 7th of October 2020. Paternal Grandmother was keen to share, that she believes a number of concerns were overlooked, in particular when the sibling was an inpatient at a Children's Hospital. She also went on to say that mother continued to use drugs and alcohol when the child was born and that she would often leave the child in the care of friends. Paternal Grandmother believes that there were many warning signs and if mother's background had been checked properly, things may have been different. Paternal Grandmother went on to say that her son had visited on one occasion and there were no sheets in the cot and there were cans of alcohol in the room. Paternal Grandmother feels that mother was able to convince professionals that she was doing okay. Paternal Grandmother did not alert the authorities of these concerns at the time and stated that she was worried that mother would stop all her contact with the children.

Paternal Grandmother now has a Special Guardianship Order (SGO) and parental responsibility for the sibling. The sibling is thriving, happy and doing very well at school.

Learning Event

A Learning Event was scheduled to take place on the 25th March 2020. Unfortunately, this was two days after the country was placed into full lockdown in response to the COVID-19 pandemic.

The Chair and Reviewers met to discuss and consider how we could progress with the review. A number of approaches were explored and in summary:

- It was felt that a Learning Event via a virtual platform was not appropriate given the sensitivity of the matter;
- A Learning Event within social distancing requirements was considered. The risk mitigation work required at the time would have been considerable. It was also felt that to proceed with this option; we would have been emphasising physical distance when we would need to be encouraging collaboration and trust;
- It was decided that the reviewers would draw the learning from work and panel discussions to date;
- The report would then be shared with the Review Panel for their reflection and consideration within their agencies in relation to an achievable Learning Action Plan;

- A Review Panel meeting would be held to allow for feedback to the reviewers;
- The reviewers would then complete the report and recommendations;
- A full Learning Event would not take place. However when the report is due for publication there will be an opportunity for agencies to meet with the Chair and the reviewers for a reflective discussion;
- Welsh Government were consulted by the NWSCB Business Manager and the agreement was reached for all panels to develop their own strategies for capturing identified learning.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

The identification of the practice and organisational learning has been obtained from the following:

- The production of a merged multi-agency timeline & agency analysis;
- Family's perspective
- Discussions within Review Panel meetings;
- Panel members discussions with practitioners involved in the review;
- Chair's and Independent Reviewers Analysis;
- Evidence based-practice.

The review highlighted good practice as well as learning throughout the process. It is important to note that learning identified was with the benefit of reflection and hindsight.

Impact on parenting capacity in regards to substance misuse/mental health

A key message emerging from serious case reviews and child practice reviews is that practitioners need to gather and better analyse information; they "must be encouraged to be curious, and to think critically and systematically" to understand how the difficulties affecting families interact (Brandon et al, 2008, p98). Unless professionals are sufficiently curious, questions will go unasked and important information will be missed.

On the 26.03.2014 a Health Pre Birth Assessment (HPBA) was commenced, mother was 29 weeks pregnant. A Child in Need referral was made to Social Services on the 16th May 2014 due to concerns about the father. The father was known to be having supervised contact only with his older daughter. The case was allocated to a Social Worker on the 25th May 2014. Good practice guidance recommends that the assessment start at the 20 week stage of pregnancy. This allows sufficient time to gather information and meet with the parents to gain their views and to identify appropriate services or support to improve parenting capacity prior to the birth of the child.

The North Wales Safeguarding Board has recently updated the Multi-Agency Pathway for undertaking a Pre-Birth Assessment originally completed in 2016, and reviewed and updated on 13th September 2019. This provides guidance for professionals in considering a number of factors but does not consider the possible risk associated with multiple births.
https://www.northwalessafeguardingboard.wales/wp-content/uploads/2019/12/Multi-Agency-Pre-Birth-Pathway.pdf

A Pre- Birth Risk Assessment was completed and the outcome decision was to work in partnership with mother under a 'Child in Need Plan'. At the time of allocation, the assessment undertaken by the Social Worker demonstrates good collaborative working and a number of agencies were contacted including child health, mental health and substance misuse service. The views of professionals who engaged in the assessment could have been better brought together to inform the plan. Following on from this a multi-agency planning meeting was held and Mother along with her partner attended the meeting. This meeting set out the proposed Child in Need plan and this process was completed within timescales and followed policy and practice guidelines. Subsequent review Child in Need Meetings were held to monitor the progress of the plan.

Whilst the Child in Need plan explores the children's health needs, mother's mental health and history of substance misuse, the plan does not appear to be clearly outcome focused. Since the implementation of the Social Services and Wellbeing (Wales) Act 2014, all plans are required to be outcome focused with emphasis on collaborative working. This act came into force on 6th April 2016 and introduces a distinct legal framework for social care provision in Wales. Ensuring that a parent understands the reason why professionals are involved is important to the success of a plan. It was not clear whether the plan was focussing on practical support to mother or the review and progress of the children's development and their mother's ability to meet their needs.

In addition, much of the information shared with the practitioners appeared to be self-reported by mother and it would have been beneficial for professionals to show greater professional curiosity. This would have been particularly relevant when there was a call to Social Services from the Children's Hospital during the period when the sibling was in hospital. Concerns were raised that mother was drinking alcohol and smoking cannabis whilst staying at the accommodation provided for parents.

The referral was made to both Out of Hours Service and from the Health Visitor. It is not clear why this referral was not progressed as a Section 47 Child Protection Enquiry under the Children's Act 1989. Records indicate that a welfare check was undertaken but mother was not at the home address.
Whilst mother reported to have ceased any substance misuse during pregnancy that transition in her lifestyle must have been significant and evidence supports that this was not true. It is not evidenced that further enquiries were made following the child's admission to hospital. Mother reported that she had taken no illicit substances from 8 weeks prior to her pregnancy. However, records note that Mother had a chaotic lifestyle where substance misuse was a feature.
The Substance Misuse Midwife completed a full assessment on 19.02.20. Mother disclosed previous use of amphetamines, cannabis and MCAT and alcohol at weekends. This questions whether Mother's transition from substance misuse to abstinence was as straightforward as initially indicated and would warrant further exploration. The Pre-Birth Assessment could have

considered this issue in relation to what we understand about the cycle of change and Mother's motivation to sustain long term abstinence.
Relapse, when struggling with an addiction, is, unfortunately, common. It's estimated that 40-60% of people struggling with substance use disorders relapse at some point in their recovery process. Addiction recovery is a lifelong process. People who have gone through detox and rehab would need to learn how to live a sober life, even with temptation around them. While it might become easier over time to live a sober life, there are triggers that can make a person relapse. Often, those suffering from an addiction would relapse when they have experienced emotional, mental or physical tolls in their life and need to find a way to cope. Lapses are common especially in pregnant women who have the additional stressors of being pregnant. https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

Relapse has three components to it: emotional, mental and physical. A relapse can occur because a person is under emotional stress, is mentally struggling with their addiction and can no longer resist the physical urge to take the substance.

There are certain triggers for relapse, and the most common is depression. Depression causes feelings of worthlessness and hopelessness. These feelings make substances seem like an appealing option. Due to depressive episodes, people would feel unable to control their emotions and feelings without external stimuli. Exhaustion is another likely trigger for relapse. Lack of sleep and feelings of being burnt-out make individuals look for comfort.

Research indicates that 'the direct link' between parental substance misuse and potential harm to children can be difficult to untangle because of the likelihood that the misuse will be one of a number of factors at play. Parents' own childhood experiences of neglect, abuse or other trauma may be one of the reasons they are misusing drugs or alcohol and may also be affecting their parenting capacity. There may be domestic abuse between parents or between a parent and partner and/or one or both parents may have mental health problems. In addition to this the family may have housing problems, or be homeless, and be coping with poverty (Forrester and Harwin, 2011; Cleaver et al, 2011; Taylor, 2013; Humphreys et al, 2005; Alcohol Concern, 2006).

Mental Illness of a parent

It is estimated that mental illness will affect 1 in 4 of us at some time in our lives. Many children will grow up with a parent who, at some point, will experience mental illness. Most of these parents will have mild or short-lived illnesses, which will usually be treated by their General Practitioner. Few children live with a parent who has a severe mental illness. Many more children live with a parent who has a long-term problem, such as alcohol or drug addiction, personality disorder or *depression* (Royal College of Psychiatrists 2012).

Problems are more likely to arise if children:

- Are separated repeatedly from a parent who needs to go into hospital;
- Feel unsure of their relationship with the parent with a mental illness;
- Basic needs are neglected;
- They are being physically abused;

- They are a Young Carer;
- They are being bullied or teased by others;
- They hear unkind things being said about their parent(s);
- They live in poverty, poor housing or have many changes of home address;
- They witness a lot of arguments or violence between their parents;
- They live with carers who have a history of not complying with treatment / medication.

Research examining the links between childcare and mental illness has shown the latter to be a significant factor when considering the safety and welfare of the child. At the very least, it is likely that the quality of parent - child interaction is affected. Consideration needs to be given to supporting the adult's parenting capacity in order to meet the needs of their child(ren) (Manning & Gregoire 2009).

Substance misuse

Few social issues impact so comprehensively on society as substance misuse. Many children and young people who live with substance misusing parents and carers are suffering its ill effects. They often suffer from neglect, witness and are negatively impacted from domestic abuse and are at an increased risk of misusing alcohol and illegal drugs themselves.

Research suggests that children who live with substance misusing parents may have a higher risk of having mental health problems themselves, have a greater rate of drug and alcohol use in adolescence, suffer impaired intellectual and academic functioning, have higher levels of anxiety and depression and have lower self-esteem than the norm.

These children may feel different from their peers and may worry that their friends may find out about their parent(s) drug misuse. Therefore, they may miss aspects of childhood many children take for granted, for example, having friends visit them at home, and participating in pleasant rituals such as birthdays and Christmas.

However, it is acknowledged that not all substance users have problems with parenting (Welsh Assembly Government (2008) Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018 Cardiff: Welsh Government).

In many cases, it will be necessary to make an assessment, which includes the substance(s) used and behaviour of the parents, and any impact of this upon their parenting.

The Purpose of the **Supporting Children, Supporting Parents: A North Wales Multi-Agency Protocol, Parents with severe mental health problems and/ or substance misuse: A framework for safeguarding children** is**:**

- To safeguard and protect children;
- To enable coordinated responses from all services involved with the child and their family;
- To improve communication between and all services involved with the child and their family;

- To ensure the early identification through joint assessment by adult Mental Health and Substance Misuse Services, of those children and unborn children who may be at risk of harm;
- To ensure that the impact of parental mental illness and or substance misuse on parenting capacity is considered with particular emphasis on the impact on the child's development;
- To support effective and well-coordinated service delivery to these families.

This protocol was originally approved in 2012 and has been regularly reviewed since. All professionals working with adults must consider the impact the adult's presentation/ condition may be having on children in their care. The safeguarding needs of the children must feature within assessments of the adults needs.
There is no reference to this Protocol in any of the documentation provided for this review.

Professional curiosity, disguised compliance and considering the rule of optimism

Mother is reported to have had a history of substance misuse and this appears to have been referred to but with no detailed analysis. The children were always well presented and, on the whole mother engaged well with support services. However, there appears to be limited concerns raised from professionals in terms of the paternity, her association and relationships with males known to social services who were considered a risk. The mother demonstrated risk taking behaviours in her own life through the substance misuse and engagement in chaotic relationships. There does not appear to be any consideration by professionals in relation to how this may have impacted on her parenting. Jones et al (2019) argue that it is therefore important for any assessment of parenting to build a clear and accurate understanding not just of what the child's needs are, but also how the child experiences the relationships in his or her life. On reflection, it would have been helpful to have explored further Mother's relationships and whether this evidenced further risk taking behaviour which could impact of parenting capacity.

Whilst mother attended most appointments there were some indicators of behaviour that is referred to as 'disguised compliance. 'Disguised compliance' first emerged in Reder et al. (1993) and was used to describe the behaviour of parents or carers who had periods of non-engagement with professionals. It has become most widely used as a way to articulate practitioners' concerns or difficulties when working with families who appear to be superficially engaging with social workers or other professionals and may believe they are not really committed to change. Sometimes the reason initially given by a parent for why something is or isn't happening is not the real depiction of what's going on. The parent may not want to reveal the real reason for fear of showing they are struggling to cope or of disappointing the professionals involved. The parent may attempt to take a similarly authoritative position about professional involvement in their life, or withdraw from the relationship altogether.

However, we need to try and continually reflect on our practice throughout the relationship and especially if parental engagement changes. A useful way to evidence this is with the use of a chronology, which will assist in identifying patterns of behaviour or times of poor engagement. A complex situation when parents have started to withdraw can deteriorate even further if they feel they are being stereotyped as 'bad parents'. As Webb (2006) has identified, the distress that can be caused by perceived misrecognition can lead to reactions such as disengagement, hostility and anger. This can not only provoke conflict between practitioners and parents but also

leave parents feeling that there is little point in trying to effect change when they have already been deemed a failure.

Within the timeline there is information relating to mother's poor mental health. Within the social workers reports It is acknowledged that mother is prescribed fluoxetine for depression. However, it is not clear whether any formal enquires were made with the GP to ascertain whether this medication had been reviewed and that the mother was concordant with her medication. Further analysis of the information available could have identified any potential safeguarding concerns.

Key pointers to consider:

Death by drowning.
Mother had been given the information in regards to home safety and bath safety on a couple of occasions by the Health Visitor but it is difficult to measure the understanding of the mother to the risks. However mother only had one bath seat. This is not unusual as the siblings could be bathed separately and the bath seat shared. At the time of the death the child and sibling were in the bath together, but there is evidence that the bath seat was not being used.

There is limited relevant research available in relation to child deaths through drowning as most of the research focuses on death through drowning in swimming pools or in the sea. Research suggests that Multi-Component Home Safety Education was ineffective in preventing children from being left alone in the bath (Kendrick & Colleagues 2012). They stated there was a lack of evidence of all safety interventions were effective in preventing children from being left alone in the bath. A review of the use of bath seats based on two studies concluded there was a link between supervision and drowning risk (Purnell & McNaught 2008). Report (RSPoAr 2015) concluded that lack of supervision of young children in the bath posed a risk of drowning. Parents may over-estimate a child's ability to stay safe in water and underestimate the dangers of the water itself. Risks in the home may be over-looked because people feel secure in familiar surroundings. Parents need to be reminded of the dangers and need for supervision in all water-related settings, including from starting to run the bath until it is drained, paddling pools containing any water, uncovered water butts, unlocked hot tubs and the risks in neighbour's gardens (Thematic review if deaths of children and young people through drowning- Child Death Review Programme. Public Health Wales 2016.)

Disguised Compliance Pre birth

The Health Visitor had undertaken antenatal visits as per Flying Start Guidance. There were two 'failed to attend' appointments with the Substance Misuse Midwife and Community Psychiatric Nurse. The Substance Misuse Midwife offered an alternative appointment setting which was closer to the mother's home address following 2 missed clinic appointments for assessment. A urine test to detect substances was undertaken 8 weeks after the initial appointment with the service, 11 weeks post referral. The urine sample would have been provided and tested earlier had mother engaged with appointments. The Substance Misuse Midwife was only able to obtain a urine sample through attending another appointment to engage the mother. The SMS Midwife and Community Psychiatric Nurse took the opportunity to attend an antenatal clinic to gain access to the mother to obtain the urine sample. This is considered good practice

Post Birth

There was evidence within the health records that the mother's engagement with services was only good when professionals visited the home. The Health Visitor had to facilitate registering the birth of the child by liaising with the registrar and the birth was registered on the last day within the legal timeframe. In addition the child was taken to a routine paediatric follow up appointment following discharge from Special Care Baby Unit. Whilst the home conditions were not of a significant concern, the Health Visitor was instrumental in ensuring the home was de-cluttered in order to accommodate baby. Mother had failed to take baby for their first and second immunisations and the Health Visitor rearranged the appointments to ensure immunisations were up to date. Mother failed to attend a GP appointment in relation to her low mood and medication review, there was no consideration at the time about how this might have impacted on parenting capacity. Two Child in Need meetings were cancelled by the mother with the rationale being, the mother was out of area at the time. This could indicate mother was not prioritising the needs of the children.

Seeing through the eyes of the children

The Children's Hospital reported that mother had been under the influence of alcohol and smelt of cannabis whilst the sibling was an inpatient. It is not clear if a formal referral was submitted to the Local Authority Social Services and the case was closed 2 months later following discussion at a Child in Need meeting. In addition there were concerns raised about mother whilst at the hospital in regards to the limited time spend with the child. If we are to consider this through a child's eyes this must have been a distressing experience. The child would have been alone without their primary care giver, in a strange place, with little familiarity. This was a clear indicator that mother was not prioritising her child.

In addition, there is no child focus meaning given to the question of paternity. Initially mother identified one male as the father. The mother allowed the child contact with the male: thus allowing the potential for an attachment to develop. Later, when this male began to make allegations of drug use, mother named another male as the father. DNA evidence showed that that this was the case: and the child's contact with the first male terminated. It is not clear what relationship the children had with these males in their lives and whether the children did develop an attachment to the first male. Knowing what we do about the impact of disrupted attachments in early life, this may have been a relevant focus for professionals if they were seeing the world through the eyes of a child.

There appeared to be no concern raised that the mother was not prioritising the needs of the twins or the importance of engaging in the Child in Need process. There were a number of no access visits, cancelled visits and missed appointments, which indicated disguised compliance. It is possible that professionals were too focused on making sure mother did not relapse, they were not seeing events through the children's eyes. Mother's decision making poses the question 'how do we know that the children are the priority and what are the other distractions in this situation for a Mother on her own struggling with twins'? The indicators of a risk taking, chaotic lifestyle were evident and this could have been considered in relation to capacity to parent safely.

Good Practice

Whilst professionals were aware of mother's relationship difficulties, this was not explored in relation to the potential impact on mother's ability to focus on the twins.

Practitioners worked very well together and there is evidence of excellent communication and record keeping.

GP services were delivered appropriately, however a warning letter had been issued in relation to missed appointments. There were also some concerns in relation to communication between Medics in the local District General Hospital and GP in relation to prescribed medication.

The Reviewers have identified lessons for practice improvements in the following areas:

- Disguised Compliance and Professional Curiosity;
  The reviewers recognise that Disguised Compliance was an identified learning in a previous CPR, NWSCB 2018 CPR Wrexham 1. An action from this CPR was to develop a Multi-Agency Protocol: Working with Families Who Display Disguised Compliance;
  A further CPR, Concise Child Practice Review Conwy 2019/1 captured Professional Curiosity as an identified learning. An action from this CPR was for all agencies to review their training packages and provide assurance training is developing workforce skills in professional curiosity. The lessons are therefore learnt;
- Recognising and dealing with Parental Substance Misuse and Mental health and the impact on parenting capacity;
- Raising further awareness in relation to the 'Supporting Children, Supporting Parents: A North Wales Multi-Agency Protocol.

The reviewers would like to acknowledge the contribution made to this process by all agencies. Their involvement and co-operation have been appreciated.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the Board and its member agencies and anticipated improvement outcomes:-

(what needs to be done differently in the future and how this will improve future practice and systems to support practice)

Recommendations

- Promotion and re-launch of the Supporting Children, Supporting Parents: A North Wales Multi-Agency Protocol;
- Develop training packages and 7 Minute Briefing to assist professionals to raise their awareness of substance misuse and parenting;
- Consideration of an individual assessment should be explored for pregnant women, including multiple pregnancies, with a history of substance misuse. The case should be allocated for relapse prevention interventions;
- NWSCB to develop a multi- agency safety information leaflet highlighting the risks associated with bathing a baby.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 *(Signature)*	L. M. Collier	**Reviewer 2** *(Signature)*	C Thomson
Name *(Print)*	Lynda Collier Area Safeguarding Manger BCUHB	**Name** *(Print)*	Cindy Thomson Service Manager Safeguarding Denbighshire
Date	04.02.2021	**Date**	04.02.2021

Chair of Review Panel *(Signature)*	Anwen Hughes
Name *(Print)*	Anwen Hughes
Date	04.02.2021

References

Brynna, K & Taylor A (2007) Community Care Inform (2007) Research: How parental substance misuse affects children: lessons from research.

Calder, M C (2013) 'Pre-birth assessments: context, content & collaboration' In: Calder, M C and Hackett, S (eds) Assessments in child care: Volume 2. Theory, research and practice applications. Dorset: Russell House Publishing

Cleaver, H, Unell, I and Aldgate, J (2011) Children's Needs: Parenting Capacity. Child abuse: Parental mental illness, learning disability, substance misuse, and domestic violence (2nd edition)

Forrester D & Harwin J (2011) Parents who misuse drugs and alcohol: Effective Interventions in Social Work and Child Protection. John Wiley & Sons pub

Humphreys C,Regan L, River D & Thiara RK (2002) Domestic Violence and Substance use: Tackling complexity. British Journal of Social Work 35(8):1301-1320

Jadwiga L (2018) Community Care Inform: Practice Guidance, Disguised compliance' a relationship-based approach.

Jones, D., Hadcroft, L. & Platt, D. 2019. Contemporary perspectives on parenting assessment. In: Horwath, J. & Platt, D. (eds.) The Child's World: The essential guide to assessing vulnerable children, young people and their families. London: Jessica Kingsley.

Kendrick, D, Coupland, C, Mulvaney, C 9 2012) Home safety education and provision of safety equipment for injury prevention. Cochrane Database of Systematic Reviews, 2012.

Manning C & Gregoire A (2009) Effects of Parental Illness on Children. Psychiatry Vol 8 Iss 1.

Mc Govern R (2010) Practice Guidance- Community Care Inform: Child development: the impact of parental substance misuse; Author: Ruth McGovern. Updated 2011, 2016.

Public Health Wales NHS Trust (2015) Research evidence review report to Child Death Review Programme Team. Drowning in children and young people. Public Health Wales Observatory
.

Purnell M and McNoe B. (2008). Systematic review of drowning interventions and risk factors and an international comparison of water safety policies and programs. Otago: University of Otago. Available at: http://www.srknowledge.org.nz/research-completed/systematic-review-of-drowning-interventions-and-risk-factors-and-an-international-comparison-of-water-safety-policies-and-programs

Reder P, Duncan S, Gray M (1993) Beyond Blame: Child Abuse Tragedies Revisited. London: Taylor and Francis

Royal College of Psychiatrists (2012) Mental Health and Growing Up Factsheet: Parental Mental Illness: The impact on children and adolescents. RCPSYCH.

Symonds J (2019) Community Care Inform: Practice Guidance, Parenting assessments.

Taylor A (2013) The impact of parental substance misuse on child development. Research in practice: Frontline pub.

The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015
Webb. S.A (2006) Social Work in a Risk Society: Social and Political Perspective.

Welsh Government (2008) Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008 – 2018. Cardiff Welsh Government.

Welsh Government, (2014), Social Services and Well-being (Wales) Act 2014: Working Together to safeguard People: Volume 5 – Handling Individual Cases to Protect Children at Risk. Cardiff: Welsh Government Publication.