SSCB should raise awareness across the partnership of the impact of parental alcohol misuse and take steps to ensure that:

- Commissioners of alcohol misuse services assure themselves that these services are fit for purpose in respect of their role in safeguarding children and that they provide advice and consultation to professionals working with children as well as direct work with parents.
- The roles and responsibilities of professionals in both adults and children's health and social care services are clear in respect of parental alcohol misuse.
- Specialist alcohol misuse services are invited, and contribute to child protection conferences where alcohol misuse is an issue.
- Child protection plans adequately address and measure change where alcohol misuse is an issue.

SSCB should raise awareness regarding the significance of bruising in non mobile babies and ensure that all practitioners in partner agencies, particularly in Health and Children's Social Care are aware of the steps to take. if found to be present.

Children's Social Care and Health organisations should reinforce the correct use of child protection procedures where there is suspected physical abuse, including ensuring that child protection medical examinations are carried out.

SSCB should require all organisations to review their processes for accessing historical family information and ensure that all practitioners are aware of the process and retrieve and analyse information when a parent has been in the care of the local authority, on a CP plan as a child, or Statement of Educational Need.

SSCB should take steps to understand the barriers to implementing learning from SCR's and develop a strategy to address any barriers identified.

Children's Social Care and Community Health Organisations should review their staff development programmes and assure the SSCB that these include support for practitioners in developing and sustaining skills in working with avoidant families.

All organisations should ensure that practitioners receive effective supervision which enables them to reflect critically on the factors that may be impacting on their practice including the emotional impact of the work, personal biases and intuitive responses.

SSCB should promote the use of early help assessments. Health organisations in particular should ensure that these assessments are routinely used where there are concerns about a child and inform decisions about when a referral should be made to Children's Social Care.

SSCB should require partners to ensure that when a case is closed by Children's Social Care but support is still required, "step down" procedures ensure that appropriate help is provided underpinned by a clear outcome focused plan.

surrey safeguarding CHILDREN BOARD

LEARNING FROM A SERIOUS CASE REVIEW

Child S

The SSCB conducted a SCR as a result of a critical incident in 2011 when a two month old baby, Child S, and his one year old half sibling were found alone, Child S was seen to have a bruise on his forehead. He was subsequently found to have serious injuries. Both children and their half sibling age four were subject of child protection plans at this time.

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Synopsis

Mother was on a child protection plan for sixteen months from the age of two and placed in foster care on a care order from the age of five to seven. Records indicate that as a result of her experiences she suffered mild learning disabilities, emotional difficulties and was the subject of a statement of special educational need. She was homeless from the age of sixteen following physical abuse.

In 2007 when pregnant with half sibling 1 there were allegations of domestic abuse which continued after the birth, There were also the first indications of Mother's reluctance to engage with services, with Half Sibling 1's first health check and immunisations being late. A need for an enhanced health visiting service was identified and referrals were made to Children's Social Care.

In 2008 Mother was cautioned for being unfit to look after a child due to drunkenness.

In Feb.2008 half sibling 1 was made subject of a C.P. plan. There were further D.A. incidents. Police expressed concern about the state of the home and noted that Mother had been drinking.

In Feb.2009, there were no further reported incidents of D.A., half sibling 1 was making progress and a child in need plan was put in place.

In May 2009 there were two incidents on the same day where Mother was drunk when caring for half sibling 1, who was found lying face down on a mattress, wearing a soiled nappy.

In June 2010 half sibling 2 was born, Mother had not attended antenatal care. Children's Social Care were briefly involved. From this point until Mother's pregnancy with Child S there were two further domestic disputes recorded. Half sibling 2's registration with GP was delayed and she was not taken to appointments for immunisations. Regular visits and weighing revealed concerns about half sibling 2's failure to thrive and developmental delay.

In 2011 Mother was pregnant and did not wish to keep the baby, her sister wanted to adopt the child. Mother and sister were advised about private adoption. At the point of closure the health visitor noted that half sibling 2 had two bruised eyes, which Mother explained had occurred as a result of a fall from a sofa. Due to developmental delay half sibling 2 was a non mobile infant at this point.

Concerns continued after the birth of Child S and a tight visiting plan was agreed

In August 2011 all three children were made subjects of a child protection plan under the categories of neglect and emotional abuse.

A pattern of missed appointments continued, along with Mother's reluctance to work with social workers. At the age of eight weeks, ten health appointments for S had been missed.

An injury to the hand of Child S was noted and Mother was encouraged by both the social worker and the health visitor to take Child S to the GP. This appointment was not kept. The family support worker conducted an unannounced visit. Child S and half sibling 2 were found home alone. Child S was taken to hospital and initial examination revealed injuries indicative of physical abuse.

The main lessons that have emerged

There was inadequate recognition by a number of professionals of the significance of interacting risk factors including: failure to engage with services, lack of antenatal care, substance misuse, domestic violence, ambiguous feelings towards two pregnancies and a troubled parental history as a child.

Practitioners did not fully appreciate the implications of parental misuse of alcohol and take action to reduce risk to the children.

Practitioners in Children's Social Care and Health did not recognise the significance of bruising/injuries in non-mobile babies.

Practitioners in Children's Social Care and Health did not ensure that when a child on a child protection plan sustains an injury this is examined by a suitably qualified and experienced doctor.

Accessing mother's historical records presented challenges to the review team and this lack of access also fundamentally impacted on practitioners in this case.

This case has features similar to those found in previous serious case reviews in: engaging with fathers, recognising the significance of family history, risk assessment in situations of domestic violence, substance misuse and working with resistant families.

Working with resistant families requires practitioners to have highly developed interpersonal skills supported by effective supervision which addresses the emotional impact of such work .

When the case was closed to Children's Social Care there were missed opportunities for a more structured approach to the assessments undertaken and help given to the family.

Key recommendations

SSCB should assure themselves that children's social care, health and those responsible for providing D.A. substance misuse and mental health services to adults are using evidence based tools to assess potential risk to children and that these are embedded in practice and practitioners are trained in their use.