concerns observed. The baby was last seen by BSP1 on the 22.12.16 and SSW1 on the 30.12.16 with no concerns noted.

174. The Police enquiry and trial evidence suggested that the baby sustained a single lateral fracture to the 7th rib between the 13th and 20th December 2016, some ten to twenty days before death. The baby was therefore subject to an assault by the mother during this time for which the latter was found guilty of a S.20 wounding. These dates would have included the baby having been seen by several professionals during this period. However, there was no evidence that the baby presented with any obvious signs of distress to professionals and the rib fracture would not have manifested itself by any external signs of injury.

Did professionals consider the lived experience of the baby? Were they professionally curious*?*

175. 'Lived experience' is defined as '*Personal knowledge about the world gained through direct, first hand involvement in everyday events rather than through representations constructed through other people. It may also refer to knowledge of people gained from direct face to face interaction rather than through a technological medium'* (Oxford English Dictionary).

176. Clearly, the baby was not old enough to communicate to the various professionals about its experience of being cared for by the mother. Therefore, the baby's lived experience was mediated through the mother's self-reporting, which was positive. Arguably, it was in the mother's interests to have provided a positive narrative to the professionals. As shown by the later Police enquiry, the evidence (in hindsight) was that she pursued a convincing and successful 'disguised compliance' strategy regarding her substance and alcohol misuse.

177. As previously noted, there was frequent and regular visiting from and contacts with professionals in line with the child protection and pre-proceedings plans. These were mainly focused on the baby's health and development and how well (or not) the mother was managing her baby's needs and safety. There was no evidence of the mother having contact with any males and her parents who were seen to be supportive did not identify any concerns about the baby's care. The overall professional perception of the baby's care and development was positive as described in previous paragraphs. As previously mentioned, the mother had successfully masked her drug and alcohol misuse from the professionals and in hindsight had, to some extent, pursued a strategy of disguised compliance by presenting as a plausible individual.

178. As previously mentioned, there should have been more professional curiosity and challenge in respect of the mother's substance misuse, for both illegal drugs and alcohol. Suitable arrangements should have been made as part of the child protection and pre-proceedings plans for the mother to have undertaken a structured substance misuse and robust drug testing programme that was not dependent on self-reporting in regard to current use. There was no evidence of any challenge or response by Birmingham Children's Services social workers to the mother's request of having a glass of wine (made on the 02.12.16, see paragraph 99 above) over the festive season, albeit that there had only recently been a change in the social worker. The report of her drinking

wine in the pub on the 23.12.16 (see paragraphs 114-115 above) should have been addressed by the management of Birmingham Children's Services, albeit the timing of the pre-Christmas weekend was problematic.

179. There was a lack of professional curiosity shown at the baby's attendance at the Paediatric Assessment Unit (see paragraphs 102-103) regarding checks being made for safeguarding alerts. The baby was subject of a child protection plan at this time. Despite the mother informing staff of the involvement of a social worker no questions were asked about why and what for?

Were there any issues around communication, information sharing or service delivery that impeded agencies working with the family?

180. As previously mentioned at paragraphs 128-132, there was a delay in IASS sharing the Solihull pre-birth assessment in a timely way with BSW1. This contributed to delays in holding the ICPC (this was a key recommendation from the Solihull pre-birth assessment), safeguarding planning, and timely arrangements for support and risk management.

181. As mentioned at paragraph 64, the Solihull social worker (SSW1) did not attend the ICPC held on 26.10.16 due to the late receipt of the invitation. This was despite having made the transfer referral on the 31.08.16, sending a copy of her pre-birth assessment on the 02.09.16 and, at BSW1's request, resending it on the 16.09.16. is not fully known[37] why there were problems in BSW1[38] receiving SSW1's pre-birth assessment and the late invitation. SSW1's presence at the ICPC would have afforded an opportunity to have given the full historical background and findings of her assessment; albeit that these were similar to the Birmingham assessment provided for the ICPC.

182. There was a twenty-day gap between the ICPC and partner agencies (particularly health) receiving the outline child protection plan, which should have been done in five days and the minutes in ten days.[39]

183. A key issue was the mother's two moves between Solihull and Birmingham and back again. The resultant inter-local authority case transfers caused significant disruption in regard to the continuation and consistency of effective implementation of the child protection plan. Her move to Solihull on the 10.11.16, some nine days after the discharge from hospital, meant a change in health visitor and the later discontinuation of important Birmingham services such as Family Action who finished on the 12.12.16. The mother had found this service very supportive and it was not around during the critical Christmas/New Year period. The proposed Birmingham CS family assessment scheduled for mid-December, a key element in the overall child protection plan, did not occur due to the move. The absence of drug intervention and testing for the mother was

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[37] Reportedly related to IASS (now CASS) transition and communication processes which were poor in 2016. Remedial action has since been reportedly taken within the CASS that has seen improvements, evidenced by frequent internal and multi-agency audits and Ofsted inspections.

[38] BSW1 was an agency worker who left Birmingham Children's Services on the 24.11.16. It has not been possible to speak with BSW1 to clarify the reasons why SSW1 did not receive a timely invitation to the ICPC.

[39] Now 48 hours for child protection plans and under negotiation for circulation of minutes.

in part a function of the transfer of case responsibility between the two local authorities and as already alluded to, was a very significant missing element in the child protection plan.

184. Compounding these difficulties was the precipitate departure of BSW1 on the 24.11.17. This would have added to the sense of discontinuity and lack of consistency in the case regarding trust relationships with professionals and the mother, the cohesiveness and knowledge of the core group and effectiveness of services in managing risk to the baby, albeit that there was adequate management case oversight.

185. Thus, the transfer from Birmingham to Solihull led to the cessation of services for contractual reasons[40], changes in key professionals at a critical time in the child protection plan and the diminution of its potential effectiveness.

186. In short, the Birmingham child protection plan never really took off, given BSW1's departure, the absence and withdrawal of the key elements mentioned above due to the proposed transfer to Solihull agreed on the 08.12.16 and the scheduling of the receiving-in ICPC for the 05.01.17. Between these two dates the plan essentially consisted of monitoring visits by BSP1, SHV2 and SSW1 pending the transfer of case responsibility to Solihull on the 05.01.17.

187. This case demonstrates the difficulties for agencies in safeguarding children in families who move rapidly across local authority and organisational boundaries. Differences in threshold and eligibility criteria for resources, service priorities and differing contracting arrangements with private and third sector agencies, within a context of financial constraints, can make for problematic case management and militate against the avoidance of delay, drift and disruption in assessment, planning and intervention.

188. Self-evidently, what is needed is a clear and effective transfer protocol, underpinned by a set of framework principles[41] that inform agreed inter-authority arrangements, protocols and processes that are child-centred,[42] promote case continuity, effective safeguarding, and minimise case transfer, disruption and delay.

Were the decisions taken in relation to case work by the two children's services departments' child-focused or resource led? Was the referral to Solihull Children's Services made at an appropriate time?

189. Solihull Children's Services acted in good faith by accepting the referral for a pre-birth assessment from the specialist substance misuse midwife (SMW1) in late May 2016. The mother had originally given the address of her male friend in Solihull to SMW1 who had passed this on to Solihull Children's Services, but at the time was actually staying with her female friend in Sheldon, Birmingham. This only became known to Solihull Children's Services some four weeks later on making actual contact with the mother in early July, by which time the pre-birth assessment had started. In the Lead Reviewer's

[40] i.e. The important family support service from Family Action.
[41] Ideally, West Midlands wide although it is recognised that this would be a very complex exercise.
[42] Ideally, the framework would also include vulnerable adults.

BIRMINGHAM Safeguarding Children PARTNERSHIP

opinion, the decision to accept the referral (given the mother had stated a Solihull address) was both procedurally compliant and child-focused.

190. With the benefit of hindsight, it would clearly have been in the interests of the baby for the case to have remained with Solihull Children's Services rather than have been transferred to Birmingham in early September 2016. However, this SCR has sought to understand the rationale for decisions and actions taken by professionals within the prevailing circumstances of the time. On that basis, this Review would contend that the decision by Solihull Children's Services to transfer the case to Birmingham Children's Services in late August 2016 was reasonable and defensible.

191. An alternative, albeit in hindsight, scenario/option was that the pre-birth assessment would only have started in early July on making physical contact with the mother who was staying on a temporary basis with her female friend in Birmingham. Moreover, she had told SSW1 that she was not minded at that time to be rehoused in Solihull, had extensive housing debts and had had no involvement with Solihull Children's Services for four years. Given these circumstances with her location, arguably, Solihull could have contacted the Birmingham IASS and the two departments could have agreed that according to existing policy Birmingham would accept case responsibility for the pre-birth assessment and any subsequent follow up safeguarding actions. The mother's expected date of delivery was November and in early July there was a significant degree of uncertainty as to where she would eventually be living. Thus, it would have been reasonable for Solihull Children's Services to have made a referral to Birmingham Children's Services in early July. This may have led to an earlier ICPC and sufficient time for suitable safeguarding arrangements to be in place prior to the baby's birth in late October, rather than holding the ICPC the day after the birth.

192. However, even if this option had been pursued, the mother and baby's move to Solihull on the 10.11.16, the subsequent referral to Solihull Children's Services and its acceptance on the 08.12.16, cut short the Birmingham child protection plan and led inexorably to the disruptive outcomes mentioned above in paragraphs 186-188. Given these developments and (the then) existing inter-local authority arrangements, it is hard to see how continuity and consistency in implementing the original child protection plan and service delivery (mindful of the contractual arrangements of some agencies) could have been maintained and disruption avoided.

193. Once it became clear on the 08.12.16 that the mother and baby had been accepted by Solihull Community Housing for permanent accommodation in the district, Solihull Children's Services was obliged by regional procedures[43] to accept case responsibility and duly arranged a receiving-in ICPC for the 05.01.17, within the 15 working days requirement.

194. Therefore, within the terms of the existing regional framework, the referral by Birmingham Children's Services to Solihull Children's Services was procedurally compliant and timely. Whether it was child-focused remains a moot point and highlights the need to review the current regional transfer framework that locates the welfare of the

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[43] Viz, West Midlands Regional Safeguarding Network, 'Protecting Children Who Move Across Local Authority Borders' (revised, January 2013). See chapters 8, 9 and 10.

BIRMINGHAM Safeguarding Children PARTNERSHIP

child as paramount, particularly around the necessity for continuity and consistency of service.

Was the level of planned support and intervention during the period of transfer to Solihull in readiness for the 'receiving-in' Initial Child Protection Conference on the 05.01.17, appropriate for the level of need identified? Did the plan of support and intervention for mother over the Christmas/New Year period consider the maternal grandparents?

195. Mindful of hindsight and outcome bias, the complexities of child protection and the subsequent revelations of the Police enquiry regarding the circumstances leading up to and accounting for the baby's manner of death, this SCR submits that in relation to the Christmas/New Year period, the planned level of support underestimated the level of need and risk. The reasons are as follows:

196. Firstly, in the opinion of the Lead Reviewer there were several potential risk factors that objectively could have indicated the probability of raised risk levels over the said period. These included the possibility of the mother using drugs and engaging in alcohol over the Christmas/New Year period, at a time of reduced contact with agency professionals. This eventuality (which tragically actually happened) was compounded by the lack of any random drug testing, reliance on the mother's self-reporting of substance abstinence and no evidence of having taken any concrete steps to address her substance misuse through involvement in a structured programme. The contractual arrangements not allowing Family Action to continue working with the mother once she had moved to Solihull, the reduced social work and health visiting cover and the lack of a detailed safety plan over the Christmas/New Year period, also constituted additional risks and the raised possibility of an adverse incident arising for the baby. Compounding this was the crucial factor of the case being in a state of transfer between the two local authorities and the attendant risks this could present. Additionally, the objective research evidence (see Appendix 3) on the link between infants under one year old and the risk of non-accidental injury was never considered and factored in to the overall risk matrix.

197. Secondly, in all of the circumstances, it would have been reasonable to think that a dynamic multi-agency risk assessment[44] taking into consideration all of these factors, could have been undertaken by Birmingham Children's Services professionals and the core group. Such an assessment, in addition to considering the above, could have been underpinned by including the possibility of mother's disguised compliance[45], especially in light of her request on the 02.12.16 to drink over Christmas and the report of her drinking wine in the public house on the 22.12.16. On this basis, appropriate steps could have been taken to mitigate any identified risks to the baby by way of a risk management plan. There was no evidence that this took place, nor that the grandparents had been actively involved in the support arrangements over the period.

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[44] Defined as 'The continuous process of identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing, in the rapidly changing circumstances of an operational incident', (Thornton. D (2002); Constructing and Testing a Framework for Dynamic Risk Assessment; A Journal of Research and Treatment; 139-153

[45] Albeit, in hindsight she was very plausible in giving the appearance of co-operation with the agencies.

198. In the opinion of the Lead Reviewer the safety plan should have involved enhanced multi-agency support and monitoring oversight by Birmingham Children's Services and the core group, including:

- Giving the mother a very clear follow up (from her query to BSW2 on the 02.12.16, see paragraph 99) message that under no circumstances was it acceptable for her to drink any alcohol or use illicit drugs over the holiday period. Any evidence of substance/alcohol misuse would be a breach of the pre-proceedings agreement and could result in the start of care proceedings.
- Family Action being enabled to continue its service provision until the receiving-in ICPC in early January 2017.
- Arrange for unannounced visits by Birmingham Children's Services professionals (if not the social worker then EDT) over the period until the Solihull receiving-in conference.
- Having a clear agreement with the maternal grandparents setting out in detail what their involvement would be over the period.
- Consideration by the Birmingham Children's Services/Solihull Children's Services team managers of the report of the mother drinking wine in the pub on the 22.12.16 and timely follow up.

199. Thirdly, the support and intervention level over the said time period was based upon an inaccurate perception of need and risk. It did not consider the prescient words of the principal officer child protection (POCP1) at the ICPC in the previous October (see paragraph 64 above). It was perhaps shaped by the succession of positive professional reports that led to an underestimation in the perception of risk to the baby.

200. That said, in the opinion of the lead Reviewer, it would have been unrealistic and unreasonable to have concluded that in all of the circumstances, the level of risk was such as to result in the death of the baby whilst in the care of the mother. There were no known antecedent indicators or evidence that this was a likely outcome and the mother's control of the narrative gave a convincing perception of an attentive parent who was meeting her baby's needs.

201. As later shown by the Police enquiry, the baby sustained the mortal injuries (notwithstanding the earlier serious, albeit non-mortal, rib fracture incurred between ten and twenty days prior to the death) some four to twelve hours before death, following the mother's imbibing of alcohol in the public house on the night of the 01.01.17 and later probable cocaine use. The combined effect of alcohol and cocaine can lead to violent behaviour, lack of impulse control, disinhibition and the taking of careless risks, depression; and the production of a poisonous bodily substance called cocaethylene.

'The combination of the disinhibiting effect of alcohol and confidence inducing cocaine with the addition of cocaethylene leads to a heightened possibility of impulsive or reckless behaviour and even violence.' (http://www.substance.org.uk/harm-reduction-information/cocaethylene-cocaine-alcohol)[46]

[46] See appendix 3 for details

Such a totally unsuitable situation combined with the demands of a two-month-old baby produced a set of highly dangerous circumstances that led to the catastrophic event of the assault and eventual tragic death of the baby.

202. The Police enquiry report included the opinion of the prosecuting barrister that *“The assault on [the baby] that caused [its] death undoubtedly represented an escalation of violence, perhaps reflecting the deterioration in [the mother’s] emotional resilience, undermined by successive bouts of heavy drinking and cocaine abuse”.* This SCR would concur with this view.

<u>Part 5: The Mother’s Views</u>

203. In response to being asked by the Lead Reviewer what she thought of the services provided to her, the mother said that she could not fault them and that she had had previous experience of similar services during the time with her first child. She said that from the period when she was pregnant with the baby and involved with the midwifery service she understood why social services would have to be involved and that she was fine with that.

204. She felt that the First Birmingham social worker was good and supportive when she was in hospital at the baby’s birth. It was a bit of shock when he left suddenly in November, one day he was there, then he was gone the next day.

205. The mother was asked about the issues around her drug and alcohol misuse. She said that alcohol was her main issue, although she admitted to ‘dabbling’ with cocaine. That was eight years ago and she did it as a way of coping with the domestic violence when she was with her first child’s father. She said that she stopped drugs after her first child was taken away from her. She claimed also to have been teetotal for 18 months before the death of the baby and didn’t have a problem with drink; she was able to drink socially. She had worked with an alcohol agency in Solihull for two to three years and has never had a problem since. She admitted to taking cocaine once in her pregnancy in May 2016. She did this to cope with the death of her male friend who was like a father to her.

206. She said that if social services had got her to undergo regular drug testing as they should have, they would have seen that she was not using. She had brought up the subject at every meeting and claimed not to have known why it did not happen.

207. Regarding the glass of wine at Christmas she said that this was agreed by one of the local authority children’s services, but was not sure which one said yes and the other said no.

208. In regard to agency support she found ‘Family Action’ to have been very good and got on well with the allocated worker, particularly around her past history with men and issues of safety for her and the baby. ‘*It was gutting to have to stop it’*. She felt sufficiently supported in the transition from Birmingham to Solihull services, in addition to her family and friends and ‘*never lacked support’*.

209. In response to a question about the child protection plan she said that everything was ok and that she was willing to follow the plan. She said that she was open and honest with the professionals and that she worked with everyone as she did not want to lose her baby. She did miss a couple of appointments for drug testing but claimed to have been on holiday for one and was unwell for the other. If they had tested her, they would have known that there were no problems. She felt let down that the testing was not completed.

210. The mother said that drugs and alcohol were not a problem; otherwise she would have experienced prison by withdrawing and needing medication which was not the case. She did a slow reduction programme with the Solihull drugs programme involving one to one and group work, drinks diary, work on why we drank and completed a gradual reduction. She was told that if she did not stop drinking she would be dead by the age of 26.

Part 6: Key Findings and Lessons

211. There was no information or evidence available to the agencies and professionals involved at the time that would have led them to be able to predict the tragic outcome in this case. The mother must take full responsibility for the tragic death of her baby.

212. Effective work was done by the midwifery service in identifying the mother's substance misuse history and other early risk factors. A timely safeguarding referral was made to Solihull Children's Services who conducted a thorough pre-birth assessment that identified all of the relevant risk factors and appropriately recommended the need for an ICPC and a child protection plan.

Effective Inter-Authority Early Communication and Co-ordination Regarding Case Transfers

213. The two local authority pre-birth assessments were of a good standard that accurately identified the risks and needs for the baby and the mother. However, the lack of early and effective information sharing between Solihull Children's Services and Birmingham Children's Services, lead to a delay in the IASS forwarding the pre-birth assessment to BSW1. This contributed to delays in holding the ICPC (this was a key recommendation from the Solihull pre-birth assessment), safeguarding planning, timely arrangements for support and risk management and SSW1's absence at the ICPC on the 26.10.16.

214. The Review identified that Birmingham Children's Services staff could have used the Solihull pre-birth assessment at an earlier stage of the Birmingham assessment, given the latter's inclusion of the known historical and contemporary risk factors for the baby. If this had been done the assessment could have been completed quicker and in a timelier manner. The delays had knock on effects for the later safeguarding arrangements, particularly around robust drug testing for the mother.

215. Solihull Children's Services, believing that the mother was residing in Solihull, acted appropriately, in good faith and in a child-focused way in both accepting the referral from

the specialist substance misuse midwife (SMW1) in late May 2016 and completing the pre-birth assessment in late August 2016.

216. Birmingham Children's Services, in early September 2016, promptly accepted without demur and commendably took responsibility for, the mother and the unborn baby, in a child-focused manner.

217. A timely referral was made by Birmingham Children's Services to Solihull Children's Services in December 2016 which was child-focused and procedurally correct. Solihull Children's Services made a defensible decision to wait until the outcome of the housing decision on the 08.12.16 before accepting the referral.

218. ***Key Learning Point 1:*** *There is a need for effective liaison and communication between the two local authority social care teams in the early sharing of pre-birth assessments and the resultant working towards the making of timely safeguarding arrangements for the unborn child.*

219. The mother's moves between Solihull and Birmingham caused significant disruption to the continuity and effectiveness of the baby's child protection plan. The planned case transfer from Birmingham to Solihull in early January 2017 led to the cessation of important supportive services for contractual reasons and changes in key professionals at a critical time in the child protection plan.

220. This case shows the difficulties for agencies in safeguarding children where families move frequently and rapidly across local authority boundaries. Differences in threshold criteria for resources, service priorities, diversity in contracting arrangements with private and voluntary sector agencies and financial pressures, all make for a degree of complexity that result in a myriad of challenges to effective case management, especially regarding the avoidance of delay, drift and disruption in assessment, planning and implementation of child protection plans.

221. ***Key Learning Point 2:*** *The current (2013) regional transfer protocol did not meet the requirements of this case. An effective inter-authority transfer protocol should be developed that is child centred, promotes case continuity, effective safeguarding and avoids disruption and delay.*

222. In this regard, the review team understand that Birmingham Children's Trust and Solihull Children's Services are progressing a piece of work clarifying the arrangements for transfer across authority borders. It will seek to address the principles of such arrangements as well as agreed practice guidance. This will be further strengthened by regular liaison work at team manager level. These arrangements will apply to children in need and in care as well as those subject to child protection plans. When finalised, it is hoped that the arrangements will be adopted at regional level.

Professional Scepticism Regarding Substance-Misusing Carers and the Need for Structured Intervention and Clarity about Agency Referral Criteria and Regular Drug Testing

223. The mother's substance abuse issues and the potential impact on her parenting were well recognised at an early stage, both by the two local authority pre-birth assessments and at the ICPC.

224. Because of CGL's acceptance criteria, the mother did not receive any structured substance misuse intervention or drug testing, two very key elements of the child protection plan. She was expected to self-refer to SIAS on moving to Solihull, which given the lack of any intervention to address her substance misuse, was unlikely to motivate her into doing this.

225. A more proactive and robust approach within both the child protection plan and the pre-proceedings process should have been taken in ensuring that the mother engaged with a structured substance misuse programme that included regular and unannounced drug testing.

226. Caution should be taken by professionals when accepting the veracity or otherwise of parents/carers who self-report abstinence from drug and alcohol without any evidence, such as a successful completion of a structured substance intervention programme (along with a robust risk assessment) and/or regular, unannounced drug testing. In these cases, it is legitimate for professionals to be respectfully challenging with parents/carers.

227. The Area Resource Panel system was insufficiently needs-focused at the time of resource allocation regarding the child protection plan, particularly in relation to the commissioning of robust drug and substance intervention and testing for the mother. This has now been addressed whereby identified need and risk are matched by appropriate agency resource.

228. ***Key Learning Point 3:*** *Professionals and service commissioners should understand the addictive nature of drug and alcohol dependency and consider that without structured intervention and regular testing from an agency with clear referral criteria, the chances of a substance-misusing individual controlling such behaviour is minimal.*

229. ***Key Learning Point 4:*** *Effective partnership intervention for drug and alcohol dependent parents requires professionals to closely monitor parental engagement in structured intervention and the outcome of regular testing. Patterns of non-attendance at substance misuse appointments could be an indicator of substance misuse.*

230. ***Key Learning Point 5:*** *There was a breakdown in the continuity of substance misuse intervention and family support during the transfer between local authorities in late 2016. There is an opportunity to explore whether regional commissioning could enhance support for drug and alcohol dependent families.*

231. There was no parenting assessment done by Birmingham Children's Services in mid-December 2016 as per the child protection plan because the mother and baby were by then living in Solihull and awaiting a receiving-in ICPC.

232. Reasonable efforts were made by the two local authorities to try and establish the paternity of the baby. The mother chose not to disclose this. There was no evidence to suggest that the mother was in an ongoing relationship with the baby's father.

233. There was no evidence to indicate to the visiting professionals that the baby was in distress or was suffering abuse prior to 31.12.16.

Professional Curiosity, Respectful Challenge and Disguised Compliance

234. The baby was not old enough to communicate its lived experience to professionals, which was mediated through the mother's positive self-reporting. Professionals could have been more curious regarding the baby's admission to the PAU and being subject of a child protection plan. More robust challenges should have been made in regard to being tested for substance and alcohol misuse, particularly following eight missed appointments with the substance misuse midwife, not attending a structured programme and reports of her wine drinking before Christmas.

235. ***Key Learning Point 6:*** *The mother was able to plausibly present and project a narrative of an attentive parent who was meeting her child's needs. She successfully masked her drug and alcohol misuse from the professionals (albeit she had failed a drug test in May 2016 and missed six subsequent appointments for testing) and was able to pursue a strategy of disguised compliance.*

Dynamic Risk Assessment and Mitigatory Risk Management

236. Over the Christmas/New Year period the planned level of support, monitoring and risk management was not appropriate. It was based upon an inaccurate and static perception of need and risk and overly influenced by the positive professional reports that led to an underestimation in the perception of risk to the baby.

237. The ending of Family Action's support due to contractual reasons beyond their control, at a period of heightened risk just before the Christmas/New Year break, added to the discontinuity of support and monitoring, coming at a crucial time in the evolution of this case.[47]

238. ***Key Learning Point 7:*** *Social workers and other relevant professionals need to be mindful of disguised compliance and an over optimistic mind set. They need to be cognisant that risk and need in child protection are dynamic, contextual entities that are contingent on changing circumstances and of the need to develop suitable risk management plans commensurate with the assessed and accurate degree of perceived risk.*

[47] N.B See paragraph 230 above regarding pan regional commissioning.

Part 7: Professional Challenge and Action Planning

239. The Birmingham and Solihull Safeguarding Children Partnerships and relevant agencies should consider the above key findings and lessons. An appropriate action and implementation plan should be devised that results in lasting improvements to practice and services aimed at safeguarding and promoting the welfare of children in Birmingham and Solihull.

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Glossary

BSCB/P	Birmingham Safeguarding Children Board/Partnership
BHV1	Birmingham health visitor 1
BSW1	Birmingham social worker 1
BSW2	Birmingham social worker 2
BSSW1	Birmingham student social worker 1
BSWTM1	Birmingham social work manager 1
BSWTM2	Birmingham social work manager 2 (covering manager)
BSP1	Birmingham Senior Practitioner 1
CMW1	Community midwife 1
CGL	Change Grow Live (substance misuse agency)
DW1	Drugs worker 1 (CGL)
DfE	Department for Education
FAW1	Family Action worker 1
BP	General Practitioner (doctor)
HMW1	Hospital midwife 1
IASS	Information Advice and Support Service
ICPC	Initial Child Protection Conference
LPM	Legal Planning Meeting
MASH	Multi-Agency Safeguarding Hub
MBC	Metropolitan Borough Council
PAU	Paediatric Assessment Unit
PLO	Public Law Outline
POCP1	Principal Officer Child Protection (Chair of ICPC)
SATM1	Solihull Assistant Team Manager
SCR	Serious Case Review
SGO	Special Guardianship Order
SIAS	Solihull Integrated Addiction Services
SHV1	Solihull health visitor 1
SHV2	Solihull health visitor 2
SFSW1	Solihull Family Support Worker 1
SMW1	Specialist midwife 1 for substance abuse
SMW2	Specialist midwife 2

SSCB	Solihull Safeguarding Children Board
SSW1	Solihull social worker
WMP	West Midlands Police

BIRMINGHAM Safeguarding Children PARTNERSHIP

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Escalation Guidance: Birmingham Children’s Trust: June 2019

Appendices

Appendix 1

2.1 Purpose

The overall purpose of this SCR is set out in Government Guidance[48], namely to undertake a rigorous, objective analysis that will:

- "Look at what happened in this case, and why, and what action needs to be taken to learn from the Review findings.
- Action results in the lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm.
- There is transparency about the issues arising from this case and actions which the organisations are taking in response to them.
- Including sharing the overview report with the public"

(Working Together 2015, 72)

2.2 Key Issues for Analysis

1. What was the quality of intervention pre-birth?
2. What were the reasons why the substance misuse midwife objected to discharge planning? How was the situation resolved?
3. Did agencies fully recognise the impact that drug and alcohol misuse and domestic abuse might have on day to day parenting capacity?
4. Did members of the core group have a good understanding of domestic abuse and coercive control?
5. Did members of the core group consider mother's parenting skills and history in determining whether she would work openly and honestly with agencies?
6. What efforts were made to establish the paternity of the baby?
7. Did mother give any indication that her relationship with the baby's father may still be on-going? If so, how did agencies respond?
8. Were agencies curious enough around this?
9. Was there anything about the baby's presentation that indicated it was distressed or suffering abuse? If so, how did agencies respond?
10. Did professionals consider the lived experience of the baby? Were they professionally curious?
11. Were there any issues around communication, information sharing or service delivery that impeded agencies working with the family?
12. Were the decisions taken in relation to casework by the two Children's Services Department's child-focused or resource-led?
13. Was the referral to Solihull Children's Services made at an appropriate time?
14. Was the level of planned support and intervention during the period of transfer to Solihull in readiness for the 'receiving-in' Conference on the 5th January 2017, appropriate for the level of need identified?
15. Did the plan of support and intervention for mother over the Christmas / New Year period consider the maternal grandparents?

[48] Working Together to Safeguard Children (2015): HM Government/Department for Education

Impact of Alcohol use on the Individual

The effects of alcohol can include:

- Reduced feelings of anxiety and inhibitions, which can help you feel more sociable.
- An exaggeration of whatever mood you're in when you start drinking.
- A wide range of physical health problems, either as a result of binge drinking or from more regular drinking. The problems caused by alcohol include high blood pressure, stroke, liver disease, cancers and falls and other accidents.

Mixing cocaine and alcohol

This combination can produce a poisonous substance in the body called coca-ethylene that may affect your heart and stays in your system longer than cocaine alone. Mixing cocaine, a stimulant, with a depressant like alcohol can hide some of the other effects of the cocaine. This makes it easier to overdose as you take more to achieve the same high.