01. BACKGROUND

South Tees Safeguarding Children Partnership commissioned a Child Safeguarding Practice Review following Liam, nearly three years, who presented at hospital having ingested multiple substances including cocaine.

02. THE CASE

Liam's father had had been at home caring for Liam. Paternal grandmother brought Liam to the hospital and claimed that he had fallen from a ladder. Tragically, whilst Liam was in the hospital Father took his own life. Liam along with his siblings was subject to a child protection plan at the time of the incident. He recovered and was discharged into the care of the local authority.

03. CASE HISTORY

There had been significant agency involvement since 2005, Mother had seven children, four living in family home. Neglect was a concern, as was anti - social behaviour and criminal activities. Liam had a health condition and development reviews identified concerns. Domestic abuse was evident which may have impacted parenting capacity. Both parents misused drugs and alcohol for many years. Mental health issues were a factor for both parents. The detailed history was considered by the review.

04. MAIN THEMES

· Embedding learning from previous similar reviews
· Prioritising the voice of the child and lived experience
· Understanding and professional curiosity of the impact of abuse upon Mother and parenting capacity
· Identifying, assessing and responding to parental substance and alcohol abuse
· Opportunities for agencies to work better together
· Missed opportunities in identifying risk indicators and not recognising the cumulative picture or contextual risk factors.
· Disproportionate focus on the risks and issues of parents and other siblings, and lack of professional curiosity in establishing Fathers parental status.
· Missed opportunities for collective oversight and joint decision making at key points.

05. RECOMMENDATIONS

· How learning from previous reviews and this review will be embedded into practice.
· Processes, assessments, thresholds and care plans to include the voice of the child and their lived experience should be evidenced and prioritised.
· involve relevant partner information, including historical context and all cumulative and contextual risk factors.
· changes to parenting capacity takes into account historical information and the impact of impact of mental illness, domestic abuse, drugs/ alcohol, trauma and bereavement.
· Protocols and guidance for future cases around safe storage, safe use and the risks of ingestion of drugs to ensure adequate management, discussions, assessments by parents and partners.
· Multi-agency meetings involve all partners and information is effectively shared between and within organisations.
· Develop guidance and raise awareness with regard to · cumulative and contextual factors when interpreting the voice and lived experience of the child and involves wider partners.
· extend learning to increase awareness of the patterns and impact of domestic abuse to facilitate safe and open conversations with victims of abuse.
· Professional curiosity and responding to disguised compliance, parental coping mechanisms and failure to engage with partners.
· Management oversight evidences professional scrutiny and challenge and the difference both make to outcomes for children is evidenced.

06. WHAT HAVE WE DONE?

· 25 Professionals involved in CSPR process · Multi-agency Learning Events have been held · Multi-agency training impact to be reviewed · Tees Procedures updated/reviewed · Health Intervention & Liaison Team (HILT) have been re-commissioned and are operational around South Tees

07. CSPR REPORT

To be published on the STSCP Website.
Follow the link: https://stscp.co.uk