Cheshire East Local
Safeguarding Children Board

MULTI-AGENCY CASE AUDIT REPORT CONCERNING

Children living with substance misusing Parents/Carers

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Section1: Introduction

1.1 Background

1.1.1. The Children Act, 2004[1] places a statutory duty on partners to safeguard and promote the welfare of children, and the statutory guidance 'Working Together to Safeguard Children' 2013[2], expects children and adult services to work cooperatively together.

1.1.2. Local Safeguarding Children Boards (LSCBs) are required, as part of their statutory duties and functions, to quality assure the effectiveness of its members' practice.

1.1.3. Multiagency audits of case files that relate to a specific theme are considered to be an effective way of providing the LSCB with assurance, particularly if practitioners and their managers are involved in identifying what they are doing well and where improvements need to be made.

1.1.4. Cheshire East Safeguarding Children Board (CESCB) has established a rolling programme of multiagency audits which are in line with the Children's Improvement Board's Quality Assurance Framework.

1.1.5. A report by Ofsted, 2013[3] entitled 'What about the children?' concluded that LSCBs did not have a clear grasp of the quality of joint working between adult and children's services as evaluation and auditing of this were not well established.

1.1.6. The theme of this audit concerns children living with substance misusing parents/carers. The potential impact of substance misusing parents/carers on the life of children continues to be of significant concern nationally.

1.1.7. This report draws on evidence from eight cases involving children who live with parents that misuse substances, and the agencies involved in supporting them. It describes the audit process, and it provides an overview of the findings under each of the headings used in the audit questionnaire, leading to conclusions and recommendations.

1.2 Terms of reference

1.2.1. The established terms of reference for CESCB multi-agency audits are as follows:

- Bi-monthly audit with an alternate emphasis on quantitative and qualitative information through audits of 8 cases.
- The cases shall be selected to represent a theme as confirmed by CESCB Executive Group on the basis of knowledge of CESCB priorities and performance data.
- Engagement of practitioners directly involved, and with children and their families where possible and appropriate.
- Audit reports will be provided to the CESCB Executive Group and the Children's Improvement Board.

[1] The Children Act, 2004

[2] Department for Education (2010), March 2013 "Working Together to Safeguard Children": A guide to inter-agency working to safeguard and promote the welfare of children.

[3] Ofsted, *2013,* What about the children? Joint working between adult and children's services when parent's or carers have mental ill health and/or drug and alcohol problems

Section 2: Audit Methodology

2.1 Aim

2.1.1. The multiagency audit tool used in this audit (see appendix 1) was designed to explore how universal, targeted, and specialist services work effectively together to provide services to children; this being from the point of needing help to receiving help.

2.1.2. An important part of the audit was to draw lessons from practice and share learning across the partnership.

2.1.3. The audit was of the files of children who live with parents/carers that misuse substances (drugs or alcohol).

2.2 Process

2.2.1. A sample of eight children was identified by the CESCB's Business Manager using the Children's Services electronic data system (see appendix 2 for a brief outline of each case).

2.2.2. The criteria used to select the cases included: substance misuse as a key factor in the case, and where possible a mix of ages, sex, and ethnicity, differing levels of intervention, and cases from across Cheshire East, with lead professionals from Children's Services in both the Crewe and Macclesfield offices.

2.2.3. Partner agencies were are asked to check their records to see whether the index child, their siblings or those with parenting responsibility were known to their agency.

2.2.4. Auditors from each agency were identified and tasked with auditing the selected cases.

2.2.5. Auditors were asked to review records for a maximum of 24 months preceding the referral to Children's Social Care.

2.2.6. Auditors were asked to complete the audit tool and comment on how the work of practitioners and services considered the child. This applied to those services whose core work is with adults as well as those that are children's services.

2.2.7. Agencies were required to act on any findings about practice in their own agencies.

2.2.8. The CESCB appointed an independent auditor to analyse the findings and produce a report.

2.2.9. Practitioners involved in the cases were invited to a workshop in order to consider some key findings and to provide a view.

2.2.10. A number of families, whose files were subject to the audit, were contacted in order to ascertain their views on how agencies worked together to meet their needs.

2.2.11. A number of strategic leaders from the agencies involved in the cases were contacted in order to gain a view on the emerging findings.

2.3 Learning from the process

2.3.1. The auditors found the audit tool to be too long and repetitive. The repetitive nature of the questions also made the overall analysis difficult.

2.3.2. Twenty four questionnaires were completed, thirty five had been distributed.

2.3.3. No questionnaires were completed by schools/nurseries, the Drug and Alcohol Team (DAT) Police or General Practitioners (GPs). In the main this was because the questionnaire was too complicated and did not lend itself to the work of an agency or would be too time consuming to complete.

2.3.4. The Police provided very helpful information on the cases but were unable to complete the detailed questionnaire.

2.3.5. Some adult agencies did not link the child to the parent/carer that they were working with and therefore did not complete the questionnaire. In future adult details must be circulated.

2.3.6. Disappointingly therefore, there was not a complete set of questionnaires from every agency working with a particular child (ren) and their families.

2.3.7. The questionnaire is very comprehensive and would form the basis of a very useful tool for practitioners and their supervisors and managers when considering the risks associated with substance misuse.

2.3.8. As with any small audit there is a need to ensure findings are not generalised whilst taking sufficient account of emerging issues and views.

2.3.9. Information obtained from speaking to parents, strategic leaders and practitioners was extremely useful in providing clarification about some of the findings.

Section 3: Analysis

3.1 Brief overview

3.1.1. Of the eight cases involved in the audit: two were unborn at the point of referral, three children were under two years of age, two children were under five years of age and one child was under ten years of age. There were no teenagers represented in the audit.

3.1.2. In five out of the eight cases the mother misused alcohol. In one case the father misused alcohol as well as the mother. Four mothers were binge drinkers and the risks and the unpredictability associated with this are very evident throughout the findings

3.1.3. In another case a mother used drugs and not alcohol.

3.1.4. In two cases the father misused alcohol and in one of these cases the father used drugs as well.

3.1.5. In five of the eight cases domestic abuse was a factor, in another case domestic abuse had taken place in the past. There were therefore only two cases where domestic abuse had not been reported. Three cases had been discussed at a Multiagency Risk Assessment Conference (MARAC.)

3.1.6. Mental health issues were a common feature throughout the cases.

3.1.7. In six of the eight cases there was some evidence of effective joint working and positive outcomes; there was also learning and fresh insights identified in these cases which will feature in the analysis.

3.1.8. In two cases there was significant concern about the decision making with agencies being slow to act.

3.2 Identification, assessment and analysis of risk

This section of the audit focused on the response of individual agencies to the identified concerns

3.2.1. There were particular strengths noted about the management of cases three and four, where the children were unborn. The mothers' were very late to present in pregnancy. One of the cases showed the drug and alcohol service, midwife and social worker sharing information and assessments quickly and the case was escalated to child protection and legal proceedings.

3.2.2. In another case, case two, the child has clinical needs and the hospital ensured communication flowed to the General Practitioner (G.P), Health Visitor (HV), Paediatric Department and partner agencies, and the hospital were appropriately invited to the case conference

3.2.3. In case one all three auditors concluded that an initial incident of domestic abuse in 2010 should have resulted in an assessment of risk. Both parents had apparently been drinking all day and father had used cannabis.

3.2.4. In the same case the HV was not notified of the initial incident and therefore not alerted to concerns around domestic abuse and substance misuse. This information may have informed her assessments and decisions and increased opportunities for early help.

3.2.5. According to the social worker's notes; the police's CAVA (safeguarding information system) stated the risks to the child were low because the children were in bed at the time. This is a concerning comment as there was no evidence to suggest the children had been spoken to, they may have had a different view. In addition father had a history of domestic abuse with other partners and this did not feature in the judgement that the risks were low. It is highly likely in this case therefore that domestic abuse had been taking place over a long period. This will be explored further under the impact and outcomes for children

3.2.6. After a second incident the same case was escalated to Child In Need (CIN). The poor decision making in this case meant the child had to endure the impact of further incidents

3.2.7. In discussion with a Strategic Leader in the police force it is clear that these issues have been recognised. In the new Vulnerable Persons Assessment there is a focus on the voice of the child and ensuring all historical information is considered. Police officers are to receive more training on the voice of the child.

3.2.8. In case two there were record keeping deficits in the HV records. There were no minutes filed of key safeguarding meetings in the HV records. Whilst there is an issue about the distribution of minutes, which is explored later in the report, professionals need to be much more proactive about requesting minutes if they are not received. In case one the social worker (SW) recorded inaccurate details of family members confusing who was at risk and from whom. This could place a child at risk.

3.2.9. Well kept records assist others to understand and manage the risk and to avoid drift in managing a case. They prevent new workers starting again and wasting valuable time in protecting children. One of the parents who were spoken to actually referred to new workers starting again.

3.2.10. Limitations in the recording of reflective analysis which is informed by research and serious case reviews, featured in several cases. When analysis featured strongly the decision making was much clearer. Practitioners at the workshop would like the CESCB website to be where the latest research, assessment tools and best practice examples can be accessed, so as to help inform their thinking.

3.2.11. Whilst knowledge and skills is covered in a later section, in the cases where individual practitioners applied research and lessons from serious case reviews to their analysis of risks and their practice in general, it was much clearer to see how the focus was remaining on the child. Assessments need to incorporate research more explicitly.

3.2.12. Not all agencies assessments included a detailed and reflective analysis of the impact of substance misuse on a child's daily lived experience. This lead to delays in recognising the extent of the concerns and the identification of those manipulative parents who disguise compliance.

3.2.13. In case six the alcohol service had been working with a mother for a year before a referral was made. The baby was a couple of months old at the time of referral to the Drug and Alcohol Team (DAT). Mother was a binge drinker and would apparently drink until she was unconscious on occasions. The fragility of babies alone makes them very vulnerable as emphasised by Ofsted, 2011,[4] so even if the DAT had no concerns about mother's compliance this case should have been seen as high risk.

3.2.14. It is understood that the DAT undertook breathalyser tests and it is believed this was at appointments; any negative results could indicate that mother was able to manipulate the process. If this was the case it is likely to have given a false sense of reassurance and makes the test meaningless unless undertaken without warning at unannounced contacts. This is relevant to the learning around disguised compliance

3.2.15. The HV was unaware that the DAT was involved with this case. The HV had accepted mother's history that she had been a binge drinker and was now drinking sensibly. The HV therefore did not explore triggers for the binge drinking or safety networks, or check if other services were involved. The HV visits would probably have been by appointment giving a binge drinking mother an opportunity to hood wink the professional. Taking reassurances from a binge drinker at face value must be questioned.

3.2.16. Both the DAT worker and HV should have adopted a healthy scepticism, and been aware of the ability of the mother to by disguise compliance as well as the fragility of the baby. This is a theme of serious case reviews and some areas have introduced routine information sharing from DAT to HVs because of the risks associated with very young children/babies. HVs also need to be more proactive and contact the DAT if there is a substance misuse history.

[4] Ofsted, 2011. *Ages of concern: Learning lessons from serious case reviews A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31st March 2011*

3.2.17. A parent, who was spoken to, referred to the HV and DAT worker not knowing about each other's roles and arguing at a meeting. If this was the case it is concerning behaviour, it also allows the attention of a meeting to move away from the parental issues and risks to the child.

3.2.18. Generally the audit showed that when adult services did identify concerns that reached the threshold for Children's Services intervention, they made appropriate referrals. This raises a question however about whether the threshold is clear for cases where there is a toxic mixture in the family and very young children.

3.2.19. In case seven the referral to Children's Services should have come sooner when family support was not influencing positive change and the child was a baby. The mother did not want services to be involved and this may well have influenced the decision making. Again where there is a toxic mix of familial isolation, mental health, drinking, plus a baby; the lack of consent should have been overridden and a referral made. The heightened risk to babies cannot be underestimated.

3.2.20. In the same case however the Family Support Service and other partners had worked extremely well together and made a very informative joint referral. They believe this prevented drift and the referral was classed as being successful because it was accepted by Children's Services.

3.2.21. There is clearly a tension here about how to manage cases where substance misuse is of concern. This case would have been referred from a social worker to the Family Support Service; it is questionable in light of the learning from: this audit, serious case reviews (SCRs) and national audits, whether this was the right level of intervention.

3.2.22. In discussion with the Strategic Leaders it was highlighted that it can take several attempts to have a referral accepted by Children's Services. Both Strategic Leaders from Children's Services agreed that we should not be waiting in these cases and that this case was too focused on process.

3.2.23. The balance between early help and family support and the need to safeguard and promote a child's welfare needs to remain in focus when substance misuse is an issue.

3.2.24. This audit and the Ofsted audit of 2013, shows that in such cases outcomes for children are much improved if Child in Need (CIN)/Child protection processes are used sooner and then the case can safely move down the continuum. This will require a shift in current thinking and an agreed framework.

3.2.25. One auditor believes an agreed process is required if a Common Assessment Framework (CAF) is refused within this type of context. This additional process would potentially add to the delay.

3.2.26. Additionally in case seven the child, who was two months when the above referral was made to Children's Services, has now been an open case for one year. It remains unclear how the successes of the interventions are currently being measured or whether the case is drifting. For such a young baby, workers must be mindful of the timeline and the longer term outcomes particularly when there is such a toxic mix within the household.

3.2.27. In case eight the effectiveness of the Family Support Service in terms of challenging missed appointments and undertaking unannounced and announced visits, made a positive contribution to the outcome for the children and family.

3.2.28. In the same case however the HV could have intervened earlier. The child was behind with immunisations, had missed a seven – nine month developmental check, and had attended Accident and Emergency. This information appears to have only been considered together, when the SW made child protection enquiries. It is unclear if this is a practitioner issue or a wider systems issue re how quickly information gets to the health visitor from the various health departments.

3.2.29. In case six incidents of domestic abuse were not shared by the police until requested as part of child protection checks and in the same case communication was poor between the midwife, HV and alcohol worker. Information sharing is critical and there needs to be arrangements in place to access information from a range of agencies regardless of who the lead professional is and at what level the intervention is at.

3.2.30. When domestic abuse was a major concern the auditors felt that the focus on substance misuse was lost, even at MARAC. The Detective Inspector leading MARAC said this did not resonate with her and she gave assurances that substance misuse is always discussed and the DAT is in attendance. The correlation between alcohol and domestic abuse is well researched and must inform practice.

3.2.31. In one case for example the Independent Domestic Violence Advocate (IDVA) asked all the right questions around domestic abuse but not about the additional risks of substance misuse

3.2.32. There were several examples when workers did not assess the extent of alcohol misuse and its impact on the children. In several cases mothers who were binge drinking were not asked about the triggers. A mother who was spoken to was aware that health professionals knew of the drug problem but had not asked about it or about the impact on the child.

3.2.33. Practitioners at the workshop felt parents must be challenged on their reactions, relationships and responsibilities. Agencies need to apply a healthy sceptiscm or satisfy their professional curiosity. They need to agree where parents are up to in the cycle of change so as to avoid delay for the children.

3.2.34. Whilst drugs as well as alcohol featured in the cases audited there appears to be an obvious lack of structure and confidence around the assessment and management of alcohol misusing parents particularly binge drinking mothers.

3.2.35. Apart from the Coordinated Action Against Domestic Abuse (CAADA), Domestic Abuse, Stalking and Honour-based Violence (DASH), and Risk Identification Checklist (RIC) which was referred to as CAADA DASH RIC, no other assessment tools were recorded. Several auditors recognised the need for a substance misuse assessment tool that is easy to use in complex situations.

3.2.36. Practitioners who attended the workshop raised concern about the cultural acceptance and norm amongst very powerful and influential parents in Cheshire East, particularly about their drinking habits; they felt more public awareness was required.

3.2.37. The audit highlighted the need for a multiagency framework that draws in latest research and lessons from SCRs and includes assessment tools and the type and level of response required when working with the toxic mixture of substance misuse, domestic abuse and mental health issues.

3.3 Review of multi-agency work

This section of the audit focused on thresholds, escalation, collaboration and communication between agencies

3.3.1. In the cases that worked particularly well it was the obvious strength of practitioner leadership that made the difference. In case two there was a consensus by the auditors of the excellent partnership working with clear evidence of attempts to engage all partners, and appropriate professionals were invited to, and attended multiagency meetings.

3.3.2. The MARAC as a forum to engage agencies and share information came through as a particular strength.

3.3.3. As has already been highlighted , sharing information was good when all the agencies were involved further down the line which raises questions about arrangements to share information much earlier when the toxic trio is a feature.

3.3.4. Contacting key professionals when a case was being initially assessed was inconsistent meaning some professionals working with the family were unaware of emerging risks to children.

3.3.5. There was also an issue in several cases about minutes of strategy, professional only, and CIN meetings not being sent to all who needed them. Whilst professionals present should have recorded the agreed actions; if you were not invited but should have been, or if you sent apologies, there is a risk that actions are not known.

3.3.6. As previously stated, two unborn baby cases were handled extremely well; case four in particular showed how analysis, in terms of the impact on the unborn child, should be undertaken and recorded, this was good practice by both the midwife and SW. This will be detailed under outcomes for the child/child's voice

3.3.7. Two cases stood out for the positive way family support was delivered and the difference this made to the outcomes for the children and families

3.3.8. In case two there was enough information from partners to implement an early risk assessment, and information sharing at the case conference was very good. Interagency working was very good in this case.

3.3.9. In case one there was scant reference to partner agencies in the social work records which made it impossible to know whether the right agencies have been involved and have informed the assessment of risk.

3.3.10. In case four the mother had a twenty year history of drug misuse and denied it. She was pregnant. She refused help due to her denial and was apparently not offered a service from the DAT as per their protocol. In light of the risks to the unborn baby, other partners have questioned whether more could have been done by the DAT to engage the mother.

3.3.11. This case had all the right agencies involved there were joint visits with the SW and midwife and proactive work by the Family Support Service including unannounced and joint visits and missed appointments were challenged.

3.3.12. Agencies were not always alert enough to how the needs of parents can mask the needs of children.

3.3.13. As highlighted earlier Ofsted, 2013, highlighted the need for agencies to provide a very quick response to any concerns about a baby's welfare and development. While the speed of response is important for all age groups, the fragility of babies and their rate of development in the early months mean that agencies' swift response is even more essential.

3.3.14. Case five was effectively led by a HV initially via a common assessment framework (CAF) it was then escalated to CIN and has returned to a CAF with the HV leading the arrangements.

3.3.15. Case eight highlighted good multiagency working and positive outcomes for the children and families. Whilst this case was escalated to child protection from a CAF the improvements are such that it will soon be moving into CIN.

3.4 Outcomes for children (including the child's voice)

3.4.1. The need to remain focused on the child's timeline and avoid drift cannot be overstated, and also the need to be very mindful of the risks associated with the toxic mix of mental health, drugs, alcohol and domestic abuse. This focus need was evident in some but not all the cases audited.

3.4.2. Case one showed evidence of unclear thinking in relation to the toxic trio; the auditor stated that "there seems to be unclear thinking about how the issues are interchangeable, moreover the impact on children." In some cases more focus was required on the child's daily lived experience.

3.4.3. An emphasis on the voice of the child featured strongly in the audits although the way this was analysed in recorded assessments varied particularly for very young children. The most encouraging examples were when records noted observations of the child that concerned interactions and development and these were recorded alongside the child's daily lived experience

3.4.4. In case one, the child's positive and confident behaviour seemed to overshadow what she was saying. When asked what worried her she would say without hesitation "*when daddy hits mummy"* Whilst eventually the outcome was good for the child the response was late.

3.4.5. In case two substance misuse was not apparent in spite of six years of support from Children's Services. The outcomes for the children would have been much worse if this had remained unaddressed. School attendance of the older child was excellent and yet nursery attendance of the index child was sporadic. This may well be another example of disguised compliance by the parents; it may also indicate that professionals did not routinely inquire about substance misuse.

3.4.6. In case three the SW remained focused on the implications for the unborn child from: drug dealers, domestic abuse lifestyle, threat to child safety, and exposure to drugs and alcohol in utero. The child was born withdrawing from drugs. The child was removed at birth.

3.4.7. The midwife focused on the outcome for the unborn child in her risk assessments in case four. The midwife listed the risks as: potential low birth weight, premature delivery and associated morbidity, risk of foetal death in utero and the risk of sudden infant death syndrome. Risks of foetal alcohol syndrome and withdrawal from drugs were implicit.

3.4.8. Professionals seem to become extremely concerned about risks to unborn babies particularly when they are powerless to stop the impact of substance misuse upon them; this frustration was echoed at the practitioner workshop. The midwife in one of the unborn baby cases undertook more regular foetal observations, did home antenatal visits, and other agencies then highlighted to the midwife any missed appointments.

3.4.9. In case six where the mother was a binge drinker and would sometimes drink until she was unconscious; the response was delayed but the outcome for the child has improved since the interventions with a clear safety plan in place.

3.4.10. There was an opportunity to identify issues with an older child in case seven; this child did not want to stay at home, was unhappy and late for school. The baby in this case was taken to the pub, strapped in the buggy for long periods, left in the high chair to watch TV and left alone when mum smoked outside. The voice of the older child and the observations of the baby within the known context could have been put together sooner.

3.4.11. In case eight the work undertaken at a child protection level means that the children can now enjoy a loving and caring relationship with their drug misusing father who is no longer at home. Both parents have more insight into the needs of the children and the impact of father's behaviour. The case will be able to move to CIN more safely.

3.4.12. Assessments, when considering the voice of and outcomes for the child need to be clearer about potential long term impact. Most assessments only detailed the immediate and short term only.

3.4.13. Several auditors highlighted the need for multiagency training around substance misuse and its impact on parenting and outcomes for children. This training must involve the DAT and mental health services and needs to be underpinned by single agency training and robust supervision. Supervisors of staff need to be targeted for training to ensure robustness across the partnership.

3.4.14. The CESCB's "Toxic Trio" training was praised by practitioners at the workshop however there is a waiting list. This is likely to mean that not all staff have the knowledge required to work effectively together in these complex cases.

3.5 Workforce and management

3.5.1. Supervision and support for staff was inconsistent across the agencies, for example there were six out of eight cases in which, according to the auditor, social work supervision and management oversight fell below expected standards; and in health visiting and IDVA work there was insufficient focus on substance misuse.

3.5.2. Poor supervision is very concerning in substance misusing cases as the risks to the child include: drift, thinking going unchallenged, professionals' not recognising manipulation and disguised compliance, neglect of a child(ren) and loss of focus on the child(ren).

3.5.3. The practitioners at the workshop recognised the value of good, regular supervision including group supervision and reflective practice sessions. Supervisors need the knowledge and tools to be effective in these types of cases where the risks to a child can become high very quickly.

3.5.4. Good supervision and manageable caseloads were noted in the Family Support Service audits, whereas practitioners at the workshop stressed the need for smaller social work caseloads. There was concern by practitioners regarding staff turnover and lack of consistency of workers.

3.5.5. Record keeping is critical, the audit has highlighted some very good written analysis; it has also highlighted gaps in recording and inaccuracies. It is difficult to determine if the gaps in record keeping equate to lack of knowledge, assessment and analysis skills or just poor recording. Nevertheless a sloppy record gives the impression of sloppy care.

3.5.6. Domestic abuse specialists arrange for a fire service assessment when the risk of domestic abuse is high. There was only one case, case five, in which the HV arranged such an assessment where substance misuse was the key risk. Risks from fires in substance misusing families have featured in serious case reviews.

3.5.7. The most effectively managed cases linked child and adult plans, this was most evident with the worker's knowledge about the risks associated with substance misuse, domestic abuse and mental health issues and the correlation with children's behaviour and emotional and physical health was very clear.

3.5.8. Cases three and four highlighted a deep understanding of the issues by the midwife, SW and family support worker. Their actions illustrated knowledge of research and lessons from serious case reviews.

3.5.9. In case five where the HV led the CAF it was successfully used to draw in specialist services including DAT and acute hospital services. There was constant analysis of the changing needs and the case was escalated at the point of disengagement. Information sharing was timely and there were open discussions with the mother. Missed appointments were monitored and unannounced and joint visits took place.

3.5.10. The acute hospital trust fully participated with the CAF in case five. The child had clinical needs risk assessments were linked to treatment compliance, attendance, parental capacity and the impact on the child.

3.5.11. It was reported that IDVAs are not always invited to multiagency meetings. IDVAs would have significant information to share about the parents; they will also hear other agencies concerns about the children. It was recognised that IDVA's need to embed their "client to parent tool" into practice.

3.6 Parenting capacities that may affect their ability to respond to a child's needs

This section of the audit was aimed at agencies providing services to Adults. Questionnaires were not completed by the police, G.Ps or the DAT and therefore the findings are drawn from the views of the auditors who do not just work with adults.

3.6.1. In the two unborn baby cases there was a lack of scope to improve the mother's understanding of the circumstances and therefore limitations on the support that could be provided. They were late to present in pregnancy and in case four after twenty years of drug abuse, there had been no rehabilitation attempted.

3.6.2. In several of the cases it took time and a higher level of intervention for the parent's to show some insight into the impact of their behaviours on the children

3.6.3. It was not uncommon that the needs of the adults came first, even when they had very small children and babies.

3.6.4. When assessing parenting capacity the midwife, in case four , documented evidence of the baby's daily lived experience, preparation for the birth, attachment of the mother to her unborn child, prioritisation of the baby and the effect of lifestyle on the developing foetus. The SW documented evidence that the mother had not made changes in her life to enable her to care for a baby.

3.6.5. In case seven, and on the face of it, the mother was working within the CAF but when this was delved into more deeply the changes required were not happening. The mother was reluctant to engage with services. This is evidence of disguised compliance and manipulation.

3.6.6. Case eight showed how insight by the parent's increased with the child protection process and with high levels of support to the mother and children, the mother now has an increased confidence and the risks have reduced.

3.6.7. This audit seems to show that that intervening at a child protection level and then safely bringing this down was very effective. It made a difference to the child's life. A finding supported by Ofsted in 2013.

3.6.8. The need to discuss and assess the impact of alcohol and substance misuse on parenting and record in the child health records, and in the safety plan has been previously discussed.

3.7 Other sources of data

Additional information was gained through: telephone conversations with three mothers involved in the cases, telephone conversations with three strategic leaders and by discussions with staff involved in the cases at a practitioner workshop. Where appropriate these comments have been included in the main report and they are not replicated in full in this section.

3.7.1. Of the three mothers contacted two had children subject to a child protection plan and one a child in need plan. The parents saw safeguarding/child protection as being the remit of SWs and not really other agencies like health and schools.

3.7.2. The parents were able to describe what they found to be the most helpful which covered eleven points. For example one parent said *" Once they had explained what they thought was wrong, I did understand what they were trying to do and why they thought it would help me"* Another parent spoke of the need for staff reliability and it was helpful when staff "*gave you back what they thought".*

3.7.3. Six themes emerged from the conversations with the parents which were:

- Agencies need to explain better and earlier why they are worried about the children, why they are involving social care what they want to happen.
- Agencies need to make sure that they give the parent time to read any reports well before the conference date and explain what the terms are that they use and why.
- Where possible agencies need to make sure there are clear contingency plans that parents are aware of including when they go on leave or sick.
- Agencies need to make sure that if there is a change in worker the new worker is informed/ has read the history and circumstances for the family and discussed them with members of the core group who have remained involved.
- Agencies need to take a shared responsibility for meetings taking place even when the lead professional can't attend.
- Agencies need to make sure that they understand each other's roles and make sure this is reflected in the plan.

3.7.4. The conversations produced a lot of data, there were however points that directly relate to the findings in the audit and they include issues around communication with families e.g. one mother said the HV and GP knew of the drug problem but neither of them said or asked about the effect on the children and did not say anything was wrong until social services were involved. In terms of the issue of continuity of workers, a parent commented that when someone new comes along it is like starting all over again. One mother commented on the HV and alcohol worker not knowing about each other's roles and getting into a bit of an argument.

3.7.5. Parents also talked of delays in services.

3.7.6. Discussions took place with two Strategic Leaders from Children's Services and a Detective Chief Inspector (DCI). Time constraints prevented further conversations with other agencies.

3.7.7. The DCI talked very highly of the role of the DAT at MARAC meetings particularly around information sharing. When discussing the number of CAVA and Niche reports (police information systems) in some cases a discussion ensued re whether enough information is sought/provided outside of child protection and MARAC processes.

3.7.8. The particular concerns about alcohol misuse were echoed by the DCI.

3.7.9. The DCI was able to confirm that substance misuse is always discussed at MARAC and some actions are mandated to the Probation Service via licence. The findings in this audit that substance misuse had not been discussed did not resonate with her at all. The police have introduced a Vulnerable Person Assessment and a process for adding historical information and re-grading assessments accordingly.

3.7.10. Both strategic leads from Children's Services agreed with the conclusion that in a minority of cases - we are waiting too long and wasting too much time on process. This emphasised the need to keep focussed on what you are dealing with and the risks. There was also a view that some partners were waiting until a problem was bad enough to refer to Children's Services, having not taken a lead earlier.

3.7.11. A discussion ensued re the case where the high quality referral from the Family Support Service, which involved three agencies, was deemed to be *"successful*" whereas the social care auditor felt it had come too late. It was confirmed that this referral would have been made to Family Support by a SW initially, and it was said that it can take three referrals to get it accepted back into social care.

3.7.12. The issue re the variable distribution of minutes was accepted and work is underway to address this issue and the importance of noting and circulating the agreed actions. It was said that in terms of working together the quality of interventions is variable and not as robust as is required, this supported a finding in the audit.

3.7.13. The Strategic Leaders were not surprised about the concern by staff re the challenge of dealing with some very able, well connected and powerful parents in Cheshire East, who are drinking to excess.

3.7.14. The workshop with practitioners was extremely informative in terms of what is working well and what needs to improve. As discussed above staff recognised the particular challenge of managing alcohol misusing parents, they felt they needed agreed assessment tools and agreed responses to tackling the issues. A common language amongst partners and the community was required. They felt public health campaigns were necessary.

3.7.15. Staff recognised the risks associated with disguised compliance and the need to share all information available more quickly although there is a lack of infrastructure to assist the sharing of confidential information electronically.

3.7.16. Staff recognised the need to undertake reflective and collective analysis using each other's perspective and to undertake joint visits and unannounced visits particularly with binge drinking parents. There was concern about continuity of staff and SW caseloads being too large.

Section 4: Conclusions

4.1 Summary of findings

4.11 The extent to which adult and children's services worked effectively together to assess risks and to support and challenge substance misusing parents and carers was variable.

4.12 Some cases stood out for the strength of partnership working and the confident leadership and knowledge of practitioners. In these cases all relevant agencies were involved and there was clear analysis of risk and the focus on the child was maintained.

4.13 Sometimes there were delays in recognising the extent of the concerns, and in particular the fragility of babies and young children and their daily lived experience. In some cases those manipulative parents who disguise compliance took time to identify. This risk featured amongst those parents who binge drink.

4.14 When parents are misusing substances there is a need to access and share all available information quickly in order to recognise the potential risk to the children. Information sharing works well at child protection and MARAC levels particularly the sharing of police and DAT information.

4.15 The audit found that not all the right staff are being invited to multiagency meetings and there are reported issues with the distribution of minutes.

4.16 In complex parental substance misusing cases the support and intervention for children through child in need or child protection plans makes more of a difference to the children and to their parents understanding of the impact of their lifestyle. This finding is supported by the findings of Ofsted in 2013.

4.17 Staff supervision, across all agencies, needs to focus on the risks of the toxic trio and in such cases the need to improve record keeping, and to undertake and record reflective analysis. Staff need to have easy access to assessment tools, the latest research and best practice examples.

4.18 Staff are challenged by the cultural norms around drinking and particularly dealing with powerful and influential parents in Cheshire East who drink too much. Parents were sometimes not asked about their substance misuse even though it was a known factor. The community of Cheshire East need to be informed and challenged about the impact on children if their parents drink to excess.

Section 5: Recommendations

Recommendation One

In order to ensure consistency of assessments, timely responses, and a common multiagency understanding - CESCB to consider developing a multiagency framework for working with children of substance misusing parents.

Recommendation Two

In order to enhance joint working, staff knowledge and confidence - CESCB to consider increasing the availability of the Toxic Trio training course and ensure it is informed by the findings of this audit. The targeting of supervisors from all agencies is essential.

Recommendation Three

In order to improve working together and to manage risks effectively – CESCB to seek assurance, from all partners, that supervision is focusing on the risks associated with the toxic trio through: reflective analysis, good record keeping and timeliness of actions.

Recommendation Four

In order that risks are known and actions understood – CESCB to seek assurance that the right people are being invited to multiagency meetings concerning children of substance misusing parents/carers and that the minutes of strategy meetings, professional only meetings, CIN/CP meetings are being distributed to all that need to know

Recommendation Five

In order to manage risk and share information in a timely manner – CESCB to ensure work continues with the DAT: covering information sharing at an earlier stage, engagement in planning and understanding of the impact on children.

Recommendation Six

In order to support practitioners in their analysis of the impact of substance misusing parents/carers on their children - CESCB to consider making the latest research, practice framework and good practice examples accessible via its website.

Recommendation Seven

In order to improve multiagency communication and ensure a speedy and fully informed response - CESCB to consider recommending the establishment of a multiagency forum to consider referrals that contain domestic abuse, substance misuse and mental health issues.

Recommendation Eight

In order that the community of Cheshire East fully understands what is meant by the safeguarding implications of parents who drink to excess – CESCB to be advised by Public Health leads of the most appropriate approach to raising public awareness of the risk to children.

Appendices

Appendix 1: CESCB Multiagency audit tool – substance misuse

Section 1: Identification, Assessment and Analysis of Risk

This section focuses on the response of your Agency to the identified concerns.

1. When did your agency first become concerned about substance misuse and this family?
2. How risk to the child/ren was first identified to your agency/service?
3. Were religious, language and cultural needs considered?
4. How was intelligence from different agencies shared and used to provide: a. Early help/ intervention? b. Risk management?
5. How did the practitioner, whilst hearing about the risks from the adult, evidence their thinking about the impact of substance misuse on the child? (neglect, emotional, physical and sexual abuse)
6. How was the voice of the child evident in the assessment?
7. Was the on-going analysis and quality of this assessment compliant with expected best practice to inform the plan for the child? (comment on e.g. analysis, focus on child, information sharing, TACs, joint working)
8. Have risk factors associated with substance misuse - criminal offending, multiple moves, aggression, drugs, alcohol, mental illness, episodes of violence, an adults return to the household, been actively considered?
9. Has there been an episode of domestic abuse and if so how effectively were the risks reassessed and managed?
10. What risk assessment tools were used in the assessment?

Overall Judgement: your agency's early identification and response to (audit topic) risk to the child
If inadequate, what steps have been taken to address this with the practitioners?

Section 2: Review of Multi-Agency Work

This section focuses on thresholds, escalation, collaboration and communication between Agencies

1. Was a referral made to Children's Services or another specialist Agency?
2. Did the referral meet the referral criteria of the specialist service/Social Care?
3. Did the referral from your Agency reflect the risk and history known to your Agency?
4. Were the right questions asked to properly analyse the risk to the Child?
5. Were professionals in agreement to this referral? If not, how was the matter resolved?
6. If Children's Services did not take up your referral and you disagreed, how was this escalated/challenged?
7. How was the Child/Carers kept informed? How was the parents' perspective considered?
8. If the work was not taken on by Children's Services, what was your practitioner's plan to address the risk with the family?
9. Is there evidence that the right partners were engaged to inform assessment and intervention with this Child?

Judgement on review of Multi-Agency work

Section 3: Outcomes for Children

1. How does parental substance use impact on school attendance?
2. What is the Child's view of parents' behaviour? Are they worried, frightened or embarrassed?
3. Is the Child displaying any behavioural or emotional problems? If so, is the parent able to respond appropriately? How is their ability to respond to the Child's needs affected by substance use?
4. Are children taking on caring responsibilities for other children, or parents? Are children left alone to look after themselves, or siblings, including whilst parents are using or procuring substances?
5. What difference has your Agency's intervention made?
6. Could anything have been done differently to improve outcomes for children?

Judgement: did the work undertaken/intervention make a difference to the Child?

Section 4: Workforce and Management

1. Is there evidence of clinical or management oversight of this work?
2. Is there evidence that agreed actions have been followed through?
3. How does the Assessment evidence practitioner knowledge of substance misuse and risk to children?
4. Is there any evidence that access to resources affected the work or the outcome for this Child?
5. Is learning from Serious Case Reviews (SCRs) evidenced in the case? e.g. Fire Service Assessments, baby safe sleeping advice, use of unannounced/joint visits, response to missing health appointments/child not going to school, risks in pregnancy etc.

Section 5: Auditors Comments

1. What learning have you identified in conducting this Audit?
2. Do you think the Audit shows an understanding of the impact of any risks to children through substance misuse? Does it show appropriate intervention, management and support to change behaviour and keep children safe?
3. Have you any comments/concerns about single agency or partnership work in this case?
4. Do you have any recommendations you would like to make to CESCB about partnership work on substance misuse? Please include any comments about the Audit Template/Process for the next audit theme.

Section 6: Parenting Capacities that may affect ability to respond to a child's needs.

This section is for agencies providing services to Adults.

1. Exactly what substances are used, in what quantities, including alcohol and prescribed medication?
2. Is the drug/alcohol use: *Occasional/Recreational; *Bingeing (periods of much higher use followed by reduced use/abstinence) *Chaotic (no regular pattern and usually involving multiple substances) *Dependent
3. Are drugs taken in the home? If so, where are the children when substances are being used?

4. Are drugs or alcohol used in response to specific triggers, and if so, what triggers? How does drug/alcohol use affect the users behaviour? (mood, alertness, temper). What about 'before' and 'after' use of substance, and the impact of withdrawal?
5. How frequently are the adults intoxicated i.e. would not be able to respond to the needs of the Child? Is there a drug-free/alcohol-free partner or other adult in the household?
6. How drugs/alcohol are procured *Where are the children whilst drugs or alcohol are being procured? *Are children taken to places where they may be vulnerable? Are dealers coming to the home?
7. Have the parents been arrested, charged, cautioned or sentenced in relation to criminal offences? *Is offending linked to drug or alcohol use? *Is the family home being used for selling drugs, stolen goods or prostitution?
8. Parental perception of drug/alcohol use. *Do they see drug or alcohol use as harmful to themselves or their children? *How do they seek to minimise the impact of their substance use on the children?
9. Is the home accommodation adequate for the children?
10. Does the client/patient have a dual diagnosis (mental health and substance misuse) and is there evidence that staff are aware of the potential additional risks to children?
11. What support is available from family and friends?
12. Do parents know what support may be available? Are there barriers to accessing help?

Multi-agency audit summary sheet

The lead auditor for each Agency should complete the Audit sheet for all of the audits completed, and bring along to the Plenary Session.

1. What is working well within your own Agency?
2. What is working well within the Partnership?
3. What should we worry about within your own Agency?
4. What should we worry about within the Partnership?
5. What should happen next? Actions within your own Agency?
6. What should happen next? Actions within the Partnership?

Appendix 2: A brief overview of each of the cases

Case 1: 6 year old female on CIN plan due to mother's partner's alcohol and drugs misuse and domestic abuse between parents. Originally referred in 2010 as a result of Domestic abuse incident at family home between mother and her partner resulting from alcohol abuse. Came off CIN plan in 2011 on the basis that the parents' relationship had ended and they were living separately and supervised contact arrangements had been put in place. Since that time, the parents recommenced their relationship and historic patterns of behaviour continued leading to child and sibling back on CIN plan from May 2014. However due to significant improvements in the family home and mother's partner receiving support for alcohol and drug misuse, case recommended for support under a CAF from end of September 2014.

Case 2: 3 year old male on child protection plan. The family had previously been known to Children's Services in September 2013 when concerns were raised in respect of sibling's sexualised behaviour in school. A Combined Assessment was completed and a plan was put in place which was managed under the Child in Need plan which deescalated to the CAF process.

In November 2013 Children's Services received a referral from the Home Office to say that father had been convicted of importing controlled drugs and is currently serving a prison sentence. Throughout the process of assessment it has become clear that mother required support in the following areas:

- Mother's emotional health and depression & inconsistency in consumption of prescribed medication
- History of domestic abuse and mother has shared that this may be a feature in her current relationship
- The use of physical chastisement and parenting difficulties in enforcing boundaries
- Mother is due in court on 29.1.2014 charged with being intoxicated whilst in charge of children as well as a charge of criminal damage

Again managed under a CIN plan until May 2014 when escalated to child protection plan under the category of emotional abuse (includes concerns around mother's substance misuse), following professional's concern in relation to the progress made under Child in Need plans.

Case 3: Unborn at time of referral 5 month old female on plan before she was born due to mother's historical addiction to drugs. Placed in foster care following birth after hospital discharge due to parent's continuing drug use.

Case 4: Unborn baby due 8.11.14 on child protection plan before birth under category of neglect due to mother's history of drug and alcohol misuse and older son subject to a care order due to mother's drug use and lifestyle.

Case 5: 3 year old male on a CIN plan, originally referred to Social Care due to missed appointments as child had significant medical problems that needed regular appointments. Assessment raised and identified father's alcohol misuse putting a strain on the family and putting stress

on mother to be able to take child to hospital. Significant improvements have been made resulting in case being managed through the CAF process.

Case 6: 1 year old female on child protection plan under the category of neglect as a result of mother's alcohol misuse. Referral made by Drugs Team who had responded to call to say child' mother intoxicated in the garden. Child and sibling spend between mother and grandmother due to mother's alcohol abuse. Concerns raised around grandmother's alcohol consumption as well.

Case 7: 1 year old male, health visitor raised concerns around mother's mental health and alcohol consumption. Sibling had expressed not wanting to return home due to mother's alcohol consumption. On CIN plan from September 2014.

Case 8: 1 year old female on child protection plan under category of physical harm, originally on CIN plan from February 2014. Case referred to CSC due to concerns about the children, it was reported that mother was struggling with the children and managing her money, concerns heightened due to father's alcohol use and levels of aggression. Subsequent assessment identified parental alcohol and drug related addictions resulting in domestic abuse.

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