REPORT OF THE SAFEGUARDING CHILDREN PRACTICE REVIEW REGARDING

C92 & C93

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Report completed 28th October 2022

CONTENTS

1. THE TRIGGER INCIDENT THAT LED TO THE REVIEW:

1.1 On the 17th of December 2021, the boy's mother suffered from an acute and transient psychotic episode.

1.2 During this episode, she developed the belief that C92 was the devil. C93 came home and found the mother holding C92 on the bed and trying to force him to take a liquid substance. The mother stabbed C92 multiple times in his back and once to the front of his torso. C93 intervened to protect his brother and received a small wound in doing so.

1.3 C92 ran to his neighbour's home and sought help where emergency treatment was sought for both boys.

1.4 The mother was arrested, placed into custody and later transferred to a secure mental health hospital.

1.5 The children's father had died from coronavirus shortly before the trigger incident in December 2021.

2. THE REVIEW PROCESS

2.1 The background to the review, terms of reference and a description of how the review was carried out are shown in the Appendix to this report.

3. SUMMARY OF FACTS

3.1 FAMILY COMPOSITION

Family member	Relationship	Ethnicity
C92	Child concerned	White British
C93	Child concerned	White British
--	Mother	White British
--	Father	White British
--	Maternal aunt	White British

4. BACKGROUND HISTORY OF THE REVIEW

4.1 Neither of the children were open to children's services before the trigger incident.

4.2 There were two reports of domestic abuse in 2008 which took place in a neighbouring authority. One of these reports made reference that the parents had been drinking.

4.3 The mother and father had an 'on-off' relationship until 2021 when they decided that they would marry and live together. The family lived together between November 2011 and June 2014 and again in 2021 for periods of time leading up to the 8th of December 2021, when the father died.

4.4 The father had a manual job and the mother was employed in a local hospital. During the Covid 19 Pandemic, she was considered a key worker.

4.5 Both boys attended local schools and their education was unremarkable in that neither of the boys had any additional needs. C93 was removed 3 times from school to home educate him, this resulted in him missing school for 7 months. He also had some time out of school due to school refusal and anxiety linked to a phobia he experienced.

4.6 There were periods in the family history where the mother appeared to be struggling. At these times she took time off work due to stress and professionals observed that she smelt of alcohol, she self-reported that she was drinking too much and also posted videos on social media, very intoxicated. At one time she sent C93 to live with his father in a neighbouring authority.

4.7 There were three referrals made to children's services during the children's lives. In two instances this was in relation to injuries the children had received and one referral about the mother's drinking. Another separate report was made by a member of the public to the police that the mother was very intoxicated and was driving whilst drunk.

4.8 In September 2021 the mother stole some medicines and equipment from work. This included the remains of a small vial of a controlled drug.

4.9 The family experienced multiple stressful events in 2021. The mother was a health key worker and was working in a stressful environment, due to the impact of the coronavirus. In February 2021 the maternal uncle had a serious accident and was partially paralysed. In March 2021 the boys' father had a heart attack, in August 2021 the mother's close friend died of cancer. In early December 2021, the father and C93 contracted the coronavirus and were hospitalised, the father died from the coronavirus in hospital.

4.10 At the time of writing this review, both children were safe and their permanent placement had been secured.

5. LIVED EXPERIENCE OF THE CHILDREN

5.1 Both boys have a very good sense of humour and were described by their social worker as "vibrant". C93 was protective of C92, even more so following the trigger incident. He was described as "delightful, sociable, polite and caring". He enjoys football. His teachers observed that he had a close friendship group at school.

5.2 C92 is less mature, likes playing video games and enjoys imaginative play. He was always very close to his mother and was treated as a child younger than his years by his mother. He is an articulate boy who can express his emotions well. He didn't experience any interruptions in his school attendance and has a close group of friends. His school is a source of support and stability for him.

5.3 C92's lived experience differs from C93's. There was a degree of protection for him as the 'baby' of the family.

5.4 C93 has shared his view that his mother's drinking had been problematic for some time and it had become worse after his father's death.

5.5 He recalled a period in September 2020 where his refusal to go to school resulted in his mother taking him to live with his father, in a neighbouring authority. He had not had consistent contact with his father before this. This was a very significant life event for C93, who felt abandoned by his mother.

5.6 C93 is aware that his mother's drinking sometimes took priority over meeting his and his brother's basic needs. He recalled having an ill-fitting school uniform but felt that his mother always had money for cigarettes and alcohol. His recollection of not having the right size school uniform was corroborated by the school. C93 recalls that they didn't have boundaries put into place by their mother and that they didn't do homework or online work during the closure of schools during 'lock down'[1]. Again, this recollection was corroborated by the schools. The lack of home support for the children's education had an impact on their attainment.

5.7 C93 recalled being punched in the chest by his father, whilst his mother was out at a nightclub. He felt that after he told his mother about this that she didn't care. The children's father returned to his home in the neighbouring authority the next day. C93 was returned to his father's care a few weeks later.

5.8 From C93's description of his life, living with his mother was unpredictable and although being sent to his father's care was a traumatic event for C93 he felt that living with his father was more predictable. His description of his mother was a view shared by some of the professionals working with the mother.

6 THE VIEWS OF THE ADULT FAMILY MEMBERS

The maternal aunt shared her view that it would have been helpful if the hospital had made a referral to children's services when the mother discharged C93 in December 2021.

6.1 The independent author met with the mother in the secure hospital setting. Unfortunately, the meeting was cut short due to her feeling very angry. She was angered by the content of the report. She did not agree with the description of the events on the 17th December 2021, or that C93 had been removed from school by a parent. She did not accept that she had removed C93 from school in October 2020 with the intent to home educate him or for him to be taught at home in February 2021, due to health vulnerabilities that would have made him more prone to coronavirus infection.

6.2 She felt that she had not neglected the children's needs and did not have any issues with alcohol.

6.3 Despite her views she agreed with the recommendations for practice improvements arising from the report.

7. ANALYSIS

7.1 The analysis of the family history shows some opportunities where agencies could have gained a greater understanding of the lived experience of the children, specifically concerning the children's exposure to maternal alcohol misuse. Whilst these are missed opportunities, it is clear that the events of the 17th of December 2021 were not preventable. The mother experienced an acute and transient psychotic episode which developed rapidly in the context of extreme stress. This was the first psychotic episode that the mother had experienced, which developed a few days after the death of the father. There were clear signs that the mother was experiencing acute stress in December 2021, but there were no opportunities to anticipate the extreme nature of her psychotic episode.

7.2 REACHABLE PERIODS

Reachable period 1: September 2012 to April 2013

[1] Schools closed when the prime minister imposed domestic restriction to curtail the spread of coronavirus

In September 2012 C93 had been in school for approximately a year. At this time school staff noticed that the mother smelt of alcohol. In November 2012 C93 told staff at the school that he had been hit by his father which had caused a bruise on his ear. A child protection investigation was commenced. When interviewed, C93 described that his father had not hit him but pushed him off the sofa, this account was corroborated by the father's account. C93 also said that his parents 'fight'. He was five years old at this time. A decision was made by children's services that no further action was required.

7.3 It is positive that a child protection investigation was commenced. However, there was a lack of analysis in the assessment and a lack of understanding of the lived experience of the child.

7.4 In the days following the start of the child protection investigation there were a further 3 observations that the mother smelt of alcohol and 1 observation that C93's personal hygiene needs were not being met. These factors were not considered in the assessment which was concluded in December 2012. This assessment did not identify the neglect and domestic abuse safeguarding concerns. The early signs of neglect alone should have triggered a referral to early help. Given the additional concerns about the mother's drinking, it seems highly likely that this would have resulted in the threshold being met for children's services to carry out an assessment of the children's needs. It has not been possible to establish why these factors were not taken into consideration in the assessment due to the historical nature of this investigation.

7.5 Reachable period 2: October 2016 to August 2018

Between October 2016 and August 2018, the mother was signed off sick for several short-term periods. In total, she had 11 periods of short-term sickness and 1 extended period of certified sickness[2].

7.6 This coincides with the start of new observations that the mother smelt of alcohol when collecting the children. There were 5 instances in this reachable period. The school did speak to the mother about their concerns. She responded that she would often go for a drink with her mother after work but would never drink and drive. On one occasion, she gave a rationale for drinking that she had received bad news about her sister. On another occasion she reported not feeling well and told staff not to get too close to her.

7.7 In August 2018 there was an anonymous referral made. The mother reportedly told the referrer that she was a "self-confessed alcoholic" who "often drank and drive". This triggered a MASH enquiry[3] and checks were carried out with a range of agencies. However, this referral was made in August and the schools were closed for the summer holidays. This resulted in the assessment being completed without the observations of the school who had noted that the mother had smelt of alcohol on the following occasions:

- October 2016
- November 2016
- December 2016
- June 2017
- July 2017

7.8 This was critical information for the assessment.

[2] Certified sickness refers to sickness certified or validated by a medical professional.

[3] Where information is collected from agencies that sit in the Multi agency Safeguarding Hub

7.9 In total the school had noticed that the mother smelt of alcohol on 11 occasions between 2012 and 2018. The school did speak to the mother about their concerns in June 2017 but she was not signposted to any local alcohol support services. Practitioners that took part in the review reflected that, as the mother did not present as intoxicated, they did not feel that the threshold was met for a referral to children's services. Practitioners knew about local support services for alcohol misuse but did not refer her to this service as they believed that this was a self-referral service only, which is not correct.

7.10 A referral to early help was not considered an option at the time as it was believed that the mother would not take up services. Early help services are only provided to parents who consent to receive services. In this case, it was believed that she would not give her consent for a referral early help.

7.11 Practitioners reflected that there was not a strong early help offer in 2018 and at that time services were not provided promptly. This meant that by the time families were provided with services, their crisis had passed and parents tended to withdraw. The combined belief that the mother would not consent to services and a lack of confidence in the early help offer at the time, resulted in the family not being referred for early help.

7.12 Had the assessment taken in all the available information about the family this would have highlighted the risk to the children from the mother's use of alcohol. If this risk had been appropriately assessed this would have triggered a referral to the Local Authority Designated Officer (LADO) whose role is to consider risks where adults are employed in positions of trust that come into contact with children. Procedures set out that the LADO should be alerted to cases where a person who works with children has:

- Behaved in a way that has harmed, or may have harmed a child
- Possibly committed a criminal offence against, or related to, a child
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children

Including:

- The person's behaviour with regard to his/her own children
- The behaviour in the private or community life of a partner, member of the family or other household member
- A person's behaviour in their personal life, which may impact upon the safety of children to whom they owe a duty of care.

7.13 The referral in 2018 links to concerns about the mother's use of alcohol in her private life which had potential risks to her own children and the welfare of children in her employment. The combined information from the school and the anonymous referral would have painted a picture of problematic alcohol use which would have triggered a referral to the LADO. This did not happen as the information available to the MASH at the time did not show that the mother had been drinking excessively. Therefore, the referral was closed with a recommendation for no further action.

7.14 The outcome of the assessment which was skewed due to missing information and the subsequent failure to refer to the LADO was a significant reachable moment. This was important as from 2018 C93 moved up to secondary school and C92 began to walk to school with friends. This resulted in much less face-to-face contact with the mother. The reduction in the observations about the

mother's presentation in the next part of the family history was likely to be due to a reduction in face-to-face contact rather than a change in the mother's alcohol use.

7.15 Reachable period 3: September 2020 to May 2021

C93 went to live with his father in a neighbouring authority in October 2020. His mother removed him from school stating that she intended to home educate him. Thereafter the Elective Home Education team in Torbay were informed by his Torbay school and his school place ceased in Torbay.

7.16 By December 2020 the Torbay Elective Home Education team were concerned that no school place had been secured for C93 and they wrote to the mother twice. They had not been informed that C93 had gone to live with his father.

7.17 The parents applied for a place in a college near the father's home address in February 2021 but this was full. Until February 2021 the neighbouring authority was not aware that C93 was in their area.

7.18 A place was offered for C93 in a local school at the end of February 2021. The parents were concerned about C93's clinical vulnerability[4] in March 2021, following the school reopening after closures due to the coronavirus. The parents requested that he be educated at home, online, despite the school being open.

7.19 In March 2021 the father suffered a heart attack and both he and C93 reunited with the mother and C92 in Torbay. Although C93 was offered a school place in February 2021, he was not placed on the school roll until May 2021 by which time he had moved back to Torbay. C93 was not placed on the school roll as he was being educated at home via online teaching methods. This was due to a clerical error. When a child is not on roll with a school and not in education this means that they are not visible.

7.20 More localised learning for the neighbouring authority is the need to place a child on the school roll as soon as a place has been accepted. If this had happened the receiving school would have been responsible for C93's education from February 2021 and not May 2021 and their performance would have been judged on the basis that one of their children had not attended school for 3 months.

7.21 Statutory guidance concerning children who are missing education sets out that local education departments should have joint working and information sharing arrangements. In this case, this did not happen effectively and C93 got lost between the two local education authorities.

7.22 Reachable period 4: August 2021 to 17 December 2021

During this period the family were living together following the father's heart attack in March 2021. That August the mother told her doctor that she was concerned about her drinking. She reported drinking 20 units a week and was worried that she was drinking too much and struggling with her mental health. This was a missed opportunity to signpost the mother to early intervention services concerning her alcohol use. She was drinking above the recommended levels of 14 units per week and had expressed concern about her drinking. The records suggest that she was not referred to alcohol support services as she was considered to "have insight".

[4] Clinical vulnerability to coronavirus refers to individual with health conditions that resulted in a higher risk of severe illness from coronavirus.

7.23 The mother reported she was drinking 20 units a week when she was actually drinking very heavily, having 'cut back' to 7 bottles of wine per week, spread over 3 days[5]. This equates to 2.3 bottles of wine per day and approximately 70 units of alcohol per week. She did not fully disclose the extent of her drinking to her doctor and therefore this information was not knowable at the time.

7.24 C93 was assaulted by his father in September 21 but did not tell anyone about this at the time. In the same month, the mother took the vial of controlled drug from the hospital. She took a range of medication and equipment from the hospital. It is not known why she took the drugs. Medical practitioners that took part in this review indicated that the amount of the controlled drug that was stolen would not have any impact on a person's wellbeing, mood or functioning, due to it being a small amount.

7.25 The taking of this controlled drug was not detected. This was due to the previous system by which controlled drugs were signed for when they are taken, but the remainder of any vials of controlled drugs were not signed back in to be disposed of. This system has since been reviewed and there is a signature required by two health practitioners when taking the drug and a signature required by two health practitioners confirming the disposal of any unused controlled drugs.

7.26 In November 2021 there were clear signs that the mother was struggling and this was impacting on the care of the children. There was a referral from a member of the public to the police that the mother was driving whilst under the influence of alcohol. Officers in the local area were made aware and requested to look out for the mother's vehicle. She was not seen driving. This referral was not linked to the children as it pertained to an adult only and was not linked to an address.

7.27 Colleagues of the mother noticed posts on social media where she was extremely intoxicated. The mother tended her resignation on the 25th of November as she planned to move to a neighbouring authority. She never presented as intoxicated at work or smelt of alcohol. Most of the observations of her being intoxicated happened outside of work and tended to coincide with periods of sickness.

7.28 C93 was removed from school by his parents in November 2021. This was the third time that he had be removed from school to be home educated. He remained out of school until the trigger incident. There was no follow-up from the neighbouring authority after he was removed from school. The importance of C93 being removed from school was not apparent to the neighbouring authority. They were not aware that he had been previously taken out of school on 2 occasions in Torbay. Therefore, the significance of this was lost and C93 fell through the gaps between the two local authority education departments.

7.29 In December both C93 and his father contracted the coronavirus. This marked the start of a period of acute stress and distress for the family. The mother was able to see C93 in hospital but not her partner. C92 remained at home and due to the coronavirus self-isolation requirements the mother was unable to ask for help caring for C92 from her wider family and she could not bring him into the hospital. He was left home alone with neighbours 'looking out for him'. He was then aged 10 years old and immature for his age. The mother has described how she was torn between her partner who was gravely ill in intensive care, her son who was very ill and her youngest son at home. On the 7th of December 2021, the mother told staff at the hospital that she was "having a meltdown".

7.30 The father's health deteriorated quickly thereafter and he died on the 8th of December. The same day the mother discharged C93 from hospital. The hospital did consider making a referral to children's

[5] Taken from an expert report in the Care Proceedings.

services but did not. Contact was made with the family GP to share concerns that the family would likely need additional support. The GP did not share any concerns at this point. By contacting the GP and not children's services this created a missed opportunity.

7.31 If a referral had been made to children's services the following information could have been pieced together to develop an understanding of their needs:

- Historical domestic abuse.
- Mother struggling with C93 as a young baby.
- History of alcohol concerns.
- A child protection investigation into an injury which resulted in no further action.
- C93 significant periods of missed education and being removed from education 3 times by his parents.
- An anonymous referral that the mother was a "self confessed alcoholic".
- Concerns that the children's basic needs were not being met.
- The mother's report to the GP that she was drinking too much.
- A report to the police that the mother was drink driving, "stank of" alcohol and was "staggering".
- C92 being left at home unsupervised.
- The stress caused by the illnesses of the father and son and subsequent death of the father.
- The mother's decision to remove C93 from hospital against medical advice.

7.32 . With the information contained in paragraph 7.31 and the stress the family were experiencing, it is highly likely that if a referral had been made to children's services that the threshold to carry out a child and family assessment would have been met.

7.33 Interventions from children's services and other agencies at this time would not have prevented the mother's psychotic episode, but it could have resulted in supportive services being offered to children in acute distress.

8. IDENTIFIED GOOD PRACTICE

There was evidence of good joint working by Torbay education professionals in February and March 2019. The mother withdrew C93 from school stating that she intended to home educate him. The school promptly informed the Elective Home Education team who made timely contact with the mother. It became clear that she had concerns about C93's school rather than wanting to home educate him. By working closely together the school, Elective Home Education Team and Admissions team found a new school and C93 had a school place within 20 days.

9. LESSONS LEARNT AND RECOMMENDATIONS

The purpose of a child safeguarding practice review is to establish if there are lessons to be learnt for agencies, to prevent children from experiencing abuse or harm and to highlight good practice.

9.1 It is difficult to see how the actions or inactions of any of the agencies could have anticipated or prevented the mother from developing the acute and transient psychotic episode, or the subsequent physical harm and trauma the children experienced.

9.2 However, there were missed opportunities in respect of the mother's alcohol use and the impact of that on her capacity to parent. The boys have described the care given by their mother as unpredictable, they have been exposed to seeing their mother very intoxicated and out of control.

Their basic needs were not always met, including protection from harm of C93 when hurt by his father.

9.3 Research shows that parental alcohol misuse can lead to parents having "chaotic, unpredictable lifestyles" and that they may "struggle to recognise and meet their children's needs[6]. This echoes the experiences of the boys.

9.4 Neither boy disclosed any concerns about their mother's drinking to professionals until after the trigger event. Her drinking had likely become normalised for the children, given there were patterns of excessive drinking dating back to September 2012.

9.5 Children living with alcohol dependent parents can feel stigma, shame and guilt and feel reluctant to betray their parents[7]. It is therefore important that professionals working with children have the skills and knowledge to identify parental alcohol misuse and neglect and intervene for children who are not able to voice their experiences.

9.6 Learning from other case reviews shows that there tends to be an over optimism about parent's self-reporting and that quite often substance misuse is known about but not seen as excessive[8]. In this review, practitioners reflected that they were aware of the mother smelling of alcohol but as she was never observed to be drunk. As a result, they did not consider it to be an issue requiring a referral to children's services.

9.7 Substance misuse practitioners that contributed to this review stated that to be smelling of alcohol in the morning is a sign of significant consumption of alcohol, whether this is linked to morning consumption of alcohol or excess drinking the night before. In instances where an individual smells of alcohol but there is no evidence of intoxication this may reflect that they have a tolerance for alcohol at harmful or dependent levels. The more alcohol that is consumed, the higher a person's tolerance is.

9.8 The regularity with which the mother was drinking during the day was also a flag to indicate that she was drinking to excess and had a high tolerance[9]. Local specialist substance misuse practitioners have also shared that any person drinking in excess of 20 units per day (in this case it was estimated to be 25 units; 2.5 bottles of wine) is at significant risk of developing physical alcohol dependency which has an associated high tolerance and risk of death and seizures upon immediate cessation. This situation requires specialist intervention to manage and alcohol dependency is not conducive to sole parenting of any children.

9.9 There were opportunities in 2012, 2013, 2016, 2017, 2018 and 2021 to identify and intervene concerning parental alcohol misuse. It will be important going forward that professionals working with children in schools, GPs, children's services and police use professional curiosity and identify and understand the impact of parental alcohol misuse on children. If a referral had been made to

[6] Parental substance misuse | NSPCC Learning accessed on 22.07.2022

[7] Rossow I, Felix L, Keating P & McCambridge J (2016); Public Health England (2016); 57 Rossow I, Keating P, Felix L & McCambridge J (2016); Kelly, Y.J. et al. (2016; Whiteman S, Jensen A, Mustillo S & Maggs J (2016) cited from Houses of Parliament Postnote Feb 2018, Parental Alcohol Misuse and children.

[8] Learning from case reviews briefing: parents who misuse substances (nspcc.org.uk) accessed 22.07.2022

[9] Alcohol addiction | Signs & symptoms of alcoholism (ukat.co.uk)

local substance misuse services, they would have been in a position to show professional curiosity about the mother's reported levels of drinking and to assess this against objective measures such as breathalyser readings, when it is felt that inconsistencies are present. As an adult with parenting responsibilities the impact of the alcohol use upon parenting capacity would have been routinely assessed within the first 12 weeks of any treatment episode.

Linked recommendation 1:
For Torbay Safeguarding Children Partnership to seek assurance that practitioners have sufficient training and development to enable professionals that work with children to understand the impact of parental alcohol misuse and recognise and respond to children exposed to parental alcohol misuse.

9.10 The anonymous referral in 2018 was a reachable moment for the children. Children's services carried out checks with the police and health colleagues. Health colleagues were able to check if the mother was open to substance misuse services or if there was a history of alcohol misuse known by the family's doctor. These checks did not indicate any concerns. The omission of information from the children's school was a significant one. If information had been taken from the school, it would have shown evidence of problematic drinking from 2012 and a pattern of increased concerns from 2016 to 2018. This level of concern would have triggered an assessment and intervention from children's services.

9.11 There are some schools in Torbay that are contactable during the school holidays but this is not consistent across all education settings such as schools, early years and further education.

Linked recommendation 2:
For the Torbay Safeguarding Children Partnership to seek assurance from TESS, that local education settings have an effective policy and systems in place to ensure that information is available to inform decision making by the MASH during school holidays.

9.12 This review has shown that there was low confidence held by practitioners about the early help offer and concerns that when referrals were accepted, services were not being offered in a timely manner. The Torbay children's service inspection carried out in May 2022 complimented the early help offer and the timeliness of the provision of services. There have been improvements to the early help offer since 2018 and therefore there is no linked recommendation in relation to early help.

9.13 There has been learning in this review about children missing education. Torbay education services worked effectively to get C93 into school in 2019. However, he fell between the two education departments when he was taken to live with his father in a neighbouring authority. As a result, he did not receive any education for 4 months. C93 is significantly behind in his reading attainment and this gap in his education contributed to him falling behind.

9.14 The issue of children missing education and the risks associated with children moving between education authorities undetected are well recognised and there is evidence that children with poor school attendance have fallen through the gaps in the education system even more so following the

pandemic[10]. There has been a call to develop a national database for children that are missing education.

Linked recommendation 3:
The findings of this review to be highlighted to the National Panel and Children's Commissioner as further evidence to support the development of systems to track children moving between education authorities.

9.15 C93 was given a school place in a neighbouring authority. He did not start classroom based learning immediately due to his parent's concerns that he was clinically vulnerable to the coronavirus. Despite being given a place in this school he was not placed on the school's roll which is not in line with expected procedures.

Linked recommendation 4:
That the Torbay Safeguarding Children Partnership contact the neighbouring education authority and request that they carry out assurance activity to ensure that children are put on school roll immediately that a place is accepted and that this is not a systemic problem in their area.

9.16 The detection of the controlled drug in the children's home raised questions in this review as to how this could be taken from the hospital. There are strict procedures in hospitals relating to how controlled drugs are accessed and administered. This review has shown that the correct procedures were followed when the drug was signed out by two healthcare professionals. At the time there was no procedure in place to control how the remains of vials of controlled drugs were disposed of. Since this finding was highlighted there has been a procedure put into place which requires two healthcare professionals to sign for the disposal of the remainder of any vials of controlled drugs. As a result of the new procedures, there is no linked recommendation in relation to the disposal of controlled drugs.

9.17 The mother was a healthcare professional that come into contact with children in her role. Where there are concerns that an individual's conduct in or out of work could compromise the safety of a child, it is expected that this risk is referred to the Local Authority Designated Officer. The referral in 2018 was not shared with the LADO. The assessment missed critical information from the school. Due to this, the threshold for making a referral to the LADO was not met as there was no evidence available to the MASH that the mother was misusing alcohol. The failure to report the mother's alcohol misuse to the LADO at this point was not indicative of a poor understanding of the LADO's role or compliance with procedures, but more reflective of the poorly informed assessment. As a result, there is no linked recommendation about awareness of and compliance with LADO procedures.

9.18 Finally, there was an opportunity for the children to be offered support immediately after the father's death. It will be important that the learning from this review is shared, to emphasise the importance of the role MASH in bringing multi-agency information together and building a holistic picture of children's needs.

[10] Children Commissioners report: Voices of England's missing children. June 2022

Appendix 1

PRACTITIONER INPUT TO THE REVIEW

Individual agency practitioners met with the reviewer in 1:1 meetings. The draft report was shared with practitioners to ensure that their contributions had been accurately represented.

PARALLEL PROCESSES

The conclusion of the care and criminal proceedings coincided with the drafting of the final report. This is significant as it impacted the levels of participation by the family and the children. The care and criminal proceedings were extremely stressful and demanding for all the family members so sensitivity was shown to their views that they wanted limited participation in the review.

FAMILY INPUT TO THE REVIEW

Despite this sensitivity around the timings of the conclusion of the proceedings, some views were obtained from the wider family. The boy's views were gathered extensively by their social worker, Guardian and experts that were commissioned in the care proceedings. Their views have been taken from these professionals and their reports.

The review report draft was shared with family members. They did not make any further comments or corrections to the final draft.

The mother was met by the author. She was provided with a copy of the report in advance of the planned meeting. Unfortunately, she was very angered by the contents of the report which limited her contribution to the review.

Comments that she had made on the report were given to the author at the end of the meeting. These comments, where they could be, have been incorporated into the final draft.

She was invited to make any other comments on the review by email. At the time this review was signed off, no further communication had been received by the mother.

Appendix 2

TERMS OF REFERENCE